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

December 2017

RTI INTERNATIONAL

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Finally, we respectfully acknowledge the 251 maltreated infants and toddlers who were the focus of the Infant-Toddler Court Teams' intervention. Their vulnerability and the need to support their healing along with the healing of their parents are the focus of this report.

The use of the image on page 16 has been authorized by Janice Lewis of ZERO TO THREE.

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

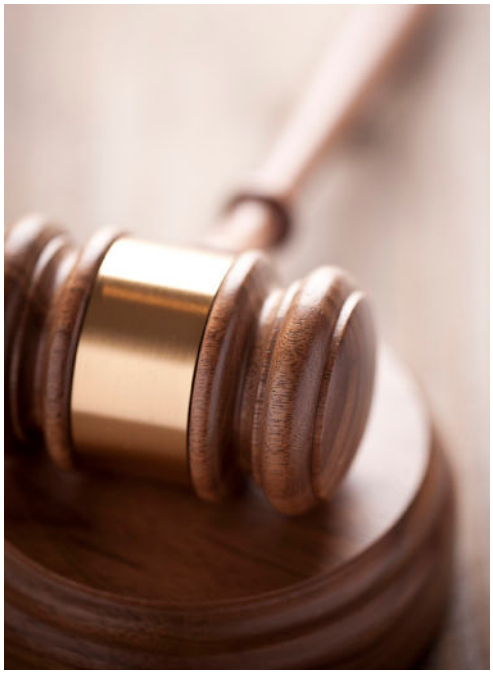
SBCT is "a community engagement and systems-change approach focused on improving how the courts, child welfare agencies, and related child-serving organizations work together, share information, and expedite services for young children in the child welfare system" (QIC-ITCT, 2016). The SBCT approach 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.

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)

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 from73.7% 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 intensive 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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Section 1. Introduction

a. Organization of the Report

This report includes six sections. First, in this introduction, we present background information about young children exposed to abuse and neglect, the history and core components of the Safe Babies Court Team (SBCT) approach as a response to the needs of the most vulnerable children reported for abuse or neglect, and information about the Quality Improvement Center for Research-Based Infant-Toddler Court Teams (QIC-ITCT). This first section ends with a description of the QIC-ITCT evaluation design.

The second section focuses on describing sites, provides information about children and families involved with the infant-toddler courts, and describes the training and technical assistance provided by the QIC-ITCT.

The third section focuses on program implementation and indicators of success. This section describes partnerships and collaborative efforts across systems and agencies involved in the initiative; changes in practices; organizational and systems conditions supporting the implementation of evidence-based programs (EBPs) to better support children and families; and changes in professional behavior, knowledge, and attitudes of court team members as perceived by their peers. The second half of the third section presents outcomes as evidenced through site visits and in-person interviews with judges, community coordinators, attorneys, caseworkers and child welfare agency (CWA) staff, and services providers; data from responses by sites' stakeholders to Web surveys; and secondary data analysis of the data provided by sites through the SBCT Web portal. This section describes children's developmental status, services needs and receipt, safety, placement, and permanency. The third section ends with a description on limitations.

The fourth section describes common challenges to the implementation of the SBCT approach. These include the need for reduced staff burden and turnover, trauma-informed courts and systems, effective family team meetings, practices to support child safety, and parents' engagement.

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, a summary of main challenges, and potential next steps based on the evaluation.

b. Background

Child Maltreatment: The Need to Support Children and Families

Child maltreatment is any act of commission or omission by a parent or caregiver that results in harm or has the potential for harm. Acts of commission, also known as child abuse, include physical abuse, sexual abuse, and psychological abuse. Acts of omission, also known as child neglect, include failure to provide (physical, emotional, medical/dental, or educational neglect) and failure to supervise (inadequate supervision, exposure to violent environments) (Leeb, Paulozzi, Melanson, Simon, & Arias, 2008).

The number of children in need of child welfare system (CWS) services is staggering, as no other child-serving system encounters such a high prevalence of trauma (Greeson et al., 2014) and adverse childhood experiences (ACEs) (Stambaugh et al., 2013), both of which are associated with a high risk of health problems in adulthood (Anda et al., 2006; Widom, Czaja, Bentley, & Johnson, 2012).

Unfortunately, children who have experienced child maltreatment do not always receive needed developmental and mental health services. For instance, although over a third of children aged 0 to 3 years involved in CWS were in need of early intervention services, only 13% of these children in need had a plan to receive these services (Casanueva, Cross, & Ringeisen, 2008). Based on preliminary results of the third round of the Children and Family Services Review across 24 states, child welfare outcomes are not improving, and a large number of children (33%) and parents (39% of mothers and 54% of fathers) do not receive needed services. At the same time, the number of children in care is rising, mostly related to neglect linked to substance abuse and trauma (Children's Bureau, 2017). As summarized by the Casey Family Programs "we have a well-intentioned system that is operating in a policy and practice construct that doesn't align with what research on child development tells us" (Calpin, 2017, p. 2).

While the needs of CWS-involved children and families remain high, state and local child welfare agencies face shrinking budgets and new challenges (Testa, 2014a). There are increasing demands on CWS agencies, greater federal accountability, and regular lawsuit charges for failures to conduct timely investigations or provide children in foster care with adequate living conditions (Testa, 2014b). States are facing these challenges with fewer resources and higher demands on staff to complete timely investigations and manage increasing workloads (U.S. Department of Health and Human Services, 2005, 2015). This has increased caseworkers' perceptions of inequitable workloads and pay (Chenot, Boutakidis, & Benton, 2014), and produced high turnover rates likely due to caseworker burnout and secondary trauma (Salloum, Kondrat, Johnco, & Olson, 2015).

At the same time, client characteristics are changing: the youngest children are now the most likely to be victimized (Administration for Children and Families, 2017a); the proportion of Latino children coming into contact with the CWS is now the same as the proportion of African American children (U.S. Department of Health and Human Services, 2015); and more children are placed with kin than non-kin foster caregivers (U.S. Department of Health and Human Services, 2014). In response, states are increasingly deploying reform efforts such as differential response.[1] The number of differential response cases nationally is reaching a percentage of children that approximates the number of substantiated cases of maltreatment (11.6% and 17.6%, respectively) (U.S. Department of

[1] Differential response is a less adversarial model than traditional child protective services that separate maltreatment referrals into two tracks: (1) families with low to moderate risk are supported to receive prevention services, referred to as alternative response; and (2) families with high risk receive traditional maltreatment investigations which includes collecting evidence and identifying perpetrators (Fluke et al., 2016).

Health and Human Services, 2015). Meanwhile, questions remain about the disproportionate resource allocation to families initially classified as low risk and the ultimate impact this will have on CWS program costs (Fluke, Merkel-Holguin, & Schene, 2013). States have also restricted the use of out-of-home placement, reflecting policies that promote permanency through family preservation efforts, adoption, guardianship, and kinship care (Children's Bureau, 2013). These developments have changed the profile of caregivers served by the CWS, and challenged states to consider how best to support older and poorer kin caregivers (Testa, 2002).

Policy makers continue to struggle with how to measure success in the CWS and whether to focus narrowly on child safety and permanency or expand the focus to also include social and emotional well-being (Testa, 2014b). In the last decade, the Administration for Children and Families (ACF) has promoted the use of meaningful and measurable child well-being indicators, including trauma, in child welfare policy development, program evaluation, and reform (Administration for Children and Families, 2012b). The Keeping Children and Families Safe Act of 2003 (PL 108-36) demonstrates this interest in children's well-being through service provision and support for stable families. This act includes specific supports for the referral of young maltreated children to early intervention services. Similarly, the Fostering Connections to Success and Increasing Adoptions Act of 2008 (PL 110-351) provides kinship guardianship assistance; the 2010 Reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA; PL 111-320) requests differential response measures in state plans. A critical issue has been identification of children and families that fail to receive adequate protection and treatment (PL 108-36).

The operational context of CWS agencies is expected to go through profound changes. The forthcoming 2019 child welfare finance reforms focus on opportunities to align federal investment with best practices (Testa, 2014b; The Annie E. Casey Foundation, 2013). At the core of these proposals are reforms to address flaws in Title IV-E funding: support for out-of-home care rather than preventive services, diminishing eligibility rates, and disincentives to reduce foster care caseloads (Casey Family Programs, 2010). Reform proposals support shifting resources from less effective approaches like congregate care to evidence-based interventions (Casey Family Programs, 2012). There are many voices in the field concluding that what we are doing in the CWS is not working. As stated by Casey Family Programs, funding sources are not aligned with providing services in response to children's and parents' needs, support evidence based practices, and improve well-being (Calpin, 2017). In response to the needs of traumatized young children in the CWS, the Safe Babies Court Team (SBCT) approach was developed to support change across systems to better engage with infants and toddlers and their families. The SBCT is an innovative approach to addressing poor outcomes. In the next section, we present a summary of the status of young maltreated children and describe the SBCT.

Maltreatment Among Young Children

Approximately 7.2 million children in the United States were involved in 4.0 million referrals to the 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. Data from the first two cohorts of the National Survey of Child and Adolescent Well-Being (NSCAW), the only nationally representative study of children investigated for maltreatment, shows that among children investigated for maltreatment about a third aged birth to 3 years have developmental delays (Casanueva et al., 2008) and half of these preschoolers have high developmental or behavioral needs (Stahmer et al., 2005). Based on NSCAW II, over half of families involved with CWS are living at or below the federal poverty level (Dolan,

Smith, Casanueva, & Ringeisen, 2011). The youngest children, those 0 to 2 years old, are more likely than all other age groups to be reported for physical neglect (19%), substance exposure (9%), and domestic violence (14%) (Casanueva, Ringeisen, Wilson, Smith, & Dolan, 2011a).

Exposure to abuse or neglect during childhood is a toxic stressor that can cause severe disruption in the life course. 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. Maltreatment alters the young child's need for parental physical closeness and care and heightens normative fears of early childhood, including fear of losing the parent, losing a parent's love, being hurt, and being bad (Lieberman & Van Horn, 2005). For children involved with 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 resulting sense of profound loss and fear overwhelms the child's capacity to cope. At a physiological level, the chronic stress of maltreatment and of being removed from the home and placed in out-of-home care causes prolonged activation of the child's stress response system, which impacts the child's developing brain. This complex clinical picture, which has been described as developmental trauma disorder, can propel the child along a trajectory of accumulating problems that can lead to wide-ranging and persistent pathologies (van der Kolk, 2009). 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

> "ZERO TO THREE's Safe Babies Court Teams (SBCT) focus on concrete strategies that allow the professionals who interact most directly with families to improve the parents' and their children's experience of the child welfare system. The SBCT approach is based on 12 core components that articulate a developmentally sensitive way to respond to child maltreatment of infants and toddlers…. While we have always focused on foster and birth parents (newly added as Core Components 5 and 7), we have not previously carried that focus into the core components. Carried across all 12 core components is the SBCT aspiration to address the poverty, trauma, and racism that most of our families confront. Every one of the 12 core components contributes to our racial equity and human dignity platform" (ZERO TO THREE, 2016, p. 1).

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 SBCT approach consists of 12 core components (ZERO TO THREE, 2016):

1. *Judicial Leadership*

Judicial authority focused on infants, toddlers, and their families promotes system collaboration. This leadership position, because of the unique authority in the processing of child welfare cases, is a catalyst for change. The judge and a counterpart in the CWS convene the initial information meetings with community stakeholders and support building collaboration across the different organizations involved with the family to better support young children.

2. *Local Community Coordinator*

The community coordinator is a pivotal team leader who facilitates collaboration across the court system, child welfare and other public agencies, and community service providers to transform the standard of care for infants, toddlers, and their families into an evidence-based continuum that recognizes the unique strengths and needs of each family. Each court team community requires a full-time local community coordinator who provides child development expertise to the judge and the court team, and coordinates services and resources for infants and toddlers. Due to the dual role of the community coordinator (case-specific coordination and system-level reform), the court team should adhere to a caseload limit of no more than 20 open cases at one time.

3. *Active Court Team Focused on the Big Picture*

Each community has a team of key stakeholders devoted to restructuring how the community responds to the needs of maltreated infants and toddlers. The team meets monthly to learn about available services, identify gaps in services, and discuss issues raised by the cases that members of the court team are monitoring. Members can include judges, child welfare agency staff, attorneys, healthcare providers, childcare providers, law enforcement, child/family advocates, and anyone else in the community whose work touches the lives of maltreated infants, toddlers, and families.

4. *Targeting Infants and Toddlers in Out-of-Home Care*

The court team focuses on foster care cases involving children younger than 36 months. Children are identified prior to removal, and at the first hearing, the community coordinator reaches out to parents directly or through the parents' attorney to describe the project, provide a package with information, and invite the family to participate. Comprehensive developmental, medical, and mental health services are incorporated into the case plan document to ensure that the children's well-being is given primary consideration in the resolution of the case. The list of services in the case plan should be available to the judge for inclusion in the judicial orders or incorporated when the judge accepts the CWS's case plan.

5. *Valuing Biological Parents*

The court team recognizes that the parents of young children who enter the CWS have suffered their own history of trauma. As the first goal is to help parents and children reunify, parents should receive comprehensive medical and mental health assessments including evaluation for childhood trauma, prenatal alcohol exposure, substance abuse, and domestic violence.

6. *Placement and Concurrent Planning*

To reduce placement changes, the court teams use concurrent planning, a technique that requires the quick identification of, and placement with, caregivers who are willing to become the child's permanent family if reunification becomes impossible. These caregivers must see themselves primarily as supports to the birth parents in achieving reunification, and secondarily as a child's forever family should the need arise.

7. *The Foster Parent Intervention; Mentors and Extended Family*

Foster parents are important members of the court team. Training and support from the child welfare agency is given prior to and while foster parents are engaged with a child and his or her family. Training and support are needed to support foster parents' role, which includes providing loving care for children placed with them, advocating for the children in their homes, and mentoring the biological parents, siblings and extended family. Extended family members are considered as options for foster care, but not at the detriment to the parents' ability to successfully reunite with their children.

8. *Pre-Removal Conferences and Monthly Family Team Meetings*

Pre-removal conferences are held prior to the child being placed in foster care. This gathering 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 who are frightened and communicates to parents that the goal is reunification. Each month, the family, community coordinator, and a team of service providers, attorneys, and child welfare agency staff hold a family team meeting to review the family's progress and track the referrals made, services received, and barriers encountered. Family team meeting goals are to bring quicker resolution of cases, build trust and communication among those invested in the child's case, and speed access to services.

9. *Parent-Child Contact (Visitation)*

Independent of the quality of the relationship between a child and her parents, young children are attached to them and separation is painful. The goal of frequent parent-child contact is to provide continuity through regular time together, build a stronger parent-child bond, provide a model for good parenting, and improve the parents' responsiveness to the child's needs. Frequent contact allows the team early in the case to observe whether parents can commit to the process. Research shows frequent parent-child contact increases the likelihood and speed of reunification, reduces time in out-of-home care, and promotes healthy attachment. The determination of frequency of contact should be made on a case-by-case basis. The court team focuses on increasing parent-child contact by expanding the opportunities (e.g., doctor's appointments) and locations (e.g., foster home, birth parents' home). Substitute caregivers are supported by the team to help the child and parents build and maintain a healthy, loving relationship. The SBCT approach considers the assessment of the quality of the parent-child relationship and subsequent creation of an individualized plan

for parent-child contact to be critical to provide the amount of interaction that is best for the child. The type of contact may range from light daily supervision with the parent living in the relatives' home, to intensive psychotherapeutic dyadic and individual work for parents overcome by their own trauma history. Each visit should be an opportunity to support parents' strengths and improve the quality of the parent-child relationship by learning nurturing behaviors, reasonable developmental expectations, how to establish safe limits, and how to delight in their child's discovery and exploration of the world around them. For cases involving parents who have traumatized their children through physical abuse or severe neglect, parent-child contact can further traumatize children. Clinicians with expertise in maltreatment and trauma should be involved in the assessment, parent-child contact plan, and intensive treatment, providing guidance and recommendations to the team about further contact.

10. Continuum of Behavioral Health Services

Children who experience child maltreatment and the subsequent separation from their biological parents may need mental health services. The services plan should be guided by the parent-child relationship assessment, which includes

(a) a structured interactional play assessment that measures:
    i. the parents' ability to provide emotional support, create structure and set limits, and help the child learn
    ii. the child's ability to show affection, regulate feelings, and respond to learning situations and to adults' requests.
(b) an interview with the adults to assess the internal "working model of the child" including negative perceptions of the child and unrealistically high expectations of the child's developmental capacity and behaviors.

Based on the assessment, clinicians provide recommendations to the team and the court on the types of evidence-based interventions needed by the family, including visit coaching, psychoeducational parent education, and Child-Parent Psychotherapy. Parents also may need mental health and substance abuse treatment services to help them address the underlying mental or emotional concerns. Delivery of EBPs can address underlying trauma and promote healing for infants, toddlers, and their parents, which can in turn strengthen parenting and the parent-child relationship. To meet these needs, each SBCT develops a continuum of mental health services.

11. Training and Technical Assistance

ZERO TO THREE staff and consultants provide training and technical assistance to the court team community on topics such as infant mental health, historical racism and trauma, racial disparities, fetal alcohol spectrum disorders, infant and toddler development, parenting interventions, services available to foster children in the community, trauma, parental substance abuse, domestic violence, mental illness, and poverty. Technical assistance from ZERO TO THREE includes weekly team meetings and individual supervisory calls by the director and other supervisory staff to the local community coordinators. Training also includes participation in the annual ZERO TO THREE conference and cross sites meeting, and access to ZERO TO THREE resources, including videos, books, guides, and reports. The goal of training and technical assistance is to strengthen the professional development; create a shared knowledge base across professionals on issues related to early child

development, the impact of trauma, and effective interventions; and support changes in roles and behaviors of the court team during court hearings.

12. Understanding the Impact of Our Work (Evaluation)

Each court team evaluates its work. The approach is focused on bringing key participants into continuous quality improvement (CQI) and evaluation planning. CQI is a process for identifying areas of strength to build on in future work and challenges to address through deliberate action. To evaluate its work, each court team collects information on knowledge enhancement among child welfare professionals, systems change, and outcomes for children and families. Staff provide support to sites to standardize data collection and analysis, with the goal of helping child welfare agencies and courts measure the impact of their work locally. Measuring results across communities in a consistent way builds the evidence base for the effectiveness of the model, which can promote replication.

The first SBCTs were initiated in 2005 and the approach has since been implemented in more than 20 sites across the country, some under the guidance of ZERO TO THREE, 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 Quality Improvement Center for Research-Based Infant-Toddler Court Teams

The QIC-ITCT began in 2014 and is 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, the National Council of Juvenile and Family Court Judges, and RTI International.

As described in the QIC-ITCT documentation and on its Web page,[2] 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-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:

1. 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
2. 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

[2] http://www.qicct.org/about_qic_ct

(these sites were part of the 15 applications submitted). 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 Teams, Connecticut

By October 2015, demonstration sites in Florida and Mississippi expanded their work into neighboring communities. Florida added four Judicial Circuits: Judicial Circuit 1, Okaloosa County; 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 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***.

QIC-ITCT Partners

ZERO TO THREE is a national nonprofit founded in 1977 that provides parents, professionals, and policymakers with the knowledge and know-how to nurture early development. As described on their Web site[3]:

> "ZERO TO THREE works to ensure that babies and toddlers benefit from the early connections that are critical to their well-being and development.
>
> Our **mission** is to ensure that all babies and toddlers have a strong start in life.
>
> At ZERO TO THREE we **envision** a society that has the knowledge and will to support all infants and toddlers in reaching their full potential.
>
> ZERO TO THREE has advanced the proven power of nurturing relationships by transforming the science of early childhood into helpful resources, practical tools and responsive policies for millions of parents, professionals and policymakers."

ZERO TO THREE operates the QIC-ITCT.

The **National Council of Juvenile and Family Court Judges** (NCJFCJ) has a mission to provide all judges, courts, and related agencies involved with juvenile, family, and domestic violence cases with the knowledge and skills to improve the lives of the families and children who seek justice. As part of the QIC-ITCT, the NCJFCJ is committed to advancing judicial understanding of recommended

[3] https://www.zerotothree.org/about/about-us

dependency court practice; infants, toddlers, and families in the court system; and judicial leadership for systems change.

The **Center for the Study of Social Policy** (CSSP) is a national, nonprofit organization recognized for its leadership in shaping policy, reforming public systems, and building the capacity of communities. CSSP provides demonstration sites with training on common visions, data and evaluation, collaborations, resources, financing strategies, and policy making to promote the sustainability of the SBCT approach.

c. Supporting Stakeholders

The **Honorable Connie Cohen**, Iowa Associate Juvenile Judge, provides training and individual coaching for demonstration site judges. Judge Cohen was appointed to the Juvenile Court bench in Iowa in 1994 and retired in June 2014. Her jurisdiction included dependency, delinquency, termination of parental rights, involuntary juvenile commitments, and adoption, and she served as the Presiding Judge for the Des Moines Safe Babies Court Team. She is a former member of the board of trustees of NCJFCJ, and continues to serve on the Permanency Planning Committee.

As part of the QIC-ITCT effort to ensure that families have access to high-quality, evidence-based services, QIC-ITCT works with **Dr. Joy Osofsky**, Chair of the Departments of Pediatrics and Psychiatry at Louisiana State University Health Sciences Center, to offer training to all demonstration sites in Child-Parent Psychotherapy (CPP), an intervention developed specifically for infants and young children to mitigate the impact of maltreatment and other prolonged adverse experiences (i.e., toxic or traumatic stress). CPP is currently on most of the registries for evidence-based programs (e.g., SAMHSA National Registry of Evidence Based Programs and Practices, California Evidence Based Clearinghouse for Child Welfare), with high scores for scientific evidence and high relevance for the child welfare system. As a relationship-based approach, CPP assumes the harm sustained by the infant as a result of maltreatment must be healed within the context of the parent-child relationship (Lieberman & Van Horn, 2008).

Dr. Marva Lewis provides training on historical racism and its legacy in child welfare. She is an associate professor at Tulane University with a PhD in Sociocultural Psychology. Her past clinical experience includes work as a psychotherapist on interdisciplinary teams working with high-risk infants placed in foster care and work as a child protection social worker. Dr. Lewis has published *Childhood Experiences of Racial Acceptance and Rejection*, and other works on intergenerational stress associated with internalized oppression and family conflict resolution. She also developed tools for individual and organizational audits on stereotypes and emotions associated with topics of diversity.

Dr. Larry Burd provides community-wide training on fetal alcohol spectrum disorders (FASD) at the demonstration sites. He is a professor in the Department of Pediatrics at the University of North Dakota School of Medicine & Health Sciences, as well as the director of the North Dakota Fetal Alcohol Syndrome Center and FASD Clinic. Dr. Burd has been with the Pediatric Therapy Program for 31 years where he has evaluated more than 15,000 children with birth defects, developmental disorders, and mental illness and published more than 130 professional papers on topics dealing with development and behavior in children and adolescents.

The QIC-ITCT also created an **Expert Advisory Workgroup** comprised of experts in child welfare, early childhood development, trauma, physical and behavioral health, cultural responsiveness, and the delivery of evidence-based interventions. These experts come from leading academic, policy, and practice organizations at the national and state levels. The Expert Advisory Workgroup meets via

conference call two to four times a year to support the QIC-ITCT research and dissemination efforts and connect the QIC-ITCT with the latest findings on evidence-based programs and early childhood development.

d. Evaluation Design

The evaluation component of the QIC-ITCT project was conducted by RTI, based on the logic model provided in ***Exhibit 1*** 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 successful 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 result for infants and toddlers served by the infant-toddler court team? (referrals made, services received, stability of placement, 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?

Exhibit 1. Program Evaluation Logic Model

PROCESS EVALUATION COMPONENTS		OUTCOME EVALUATION COMPONENTS	
QIC SITE INPUTS	*PROGRAM PROCESSES*	*OUTPUTS*	*OUTCOMES*
• Systems coordination • Site's Action Plan Development • Training on EBP (CPP) • QIC-ITCT training and technical assistance • National dissemination activities (Cross Sites, ZERO TO THREE conference, sites meetings, resource materials)	• Case management • Court team activities, meetings, subcommittees • Family team meetings • Pre-removal Meetings • Post-removal meetings • EBP implementation • Families engagement • Families needs' support and services receipt	• Types of stakeholders trained • Types of training and technical assistance • Number of families and children involved with court teams • Number of families and children referred to services • Number of families and children served	**Stakeholder-Level Outcomes** • Increased knowledge of trauma and child development • Better practice • Positive changes in roles and behaviors during hearings • Change in perceptions **System-Level Outcomes** • Successful partnerships • Improved collaboration • Improved communication **Child- and Family-Level Outcomes** • Improved identification of developmental and emotional needs • Improved support for provision of EBPs • Placement stability • Low maltreatment recurrence • Permanency in 12 months.

Evaluation Goals. The evaluation methods included a process and outcomes evaluation. The process evaluation included site visits with in-person interviews of stakeholders; observations of hearings, family team meetings, and court team meetings; and a Web survey at baseline and follow up. The outcome evaluation was a non-experimental design using secondary data analysis across sites. Child outcomes data include case-level information on child safety, placement, permanency, and child/treatment utilization available in the dataset maintained by the QIC-ITCT.

A de-identified dataset was used for secondary data analysis. Results of this analysis are presented in ***Section 3***.

Evaluation Components. The QIC-ITCT evaluation included both quantitative and qualitative data collection, as outlined below.

1. Ongoing **document review** of sites' self-assessment tools and action plans, and documentation generated by QIC-ITCT.

2. **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 (see ***Section 3***).
3. 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 (see ***Section 4***). 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.
4. Two 3-day **site visits** conducted once at baseline before the QIC-ITCT program implementation and once at follow up after training were completed. Site visits consisted of:
    - **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, 2012a) 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.

All instruments were tested during a pilot visit to a long-standing SBCT site (Little Rock, AR) independent of the selected QIC-ITCT sites. The pilot visit was completed March 30 to 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-ITCT in February 2015 and attended the pilot visit.

Recruitment, Consent Procedures, and Institutional Review Board (IRB) Review. Stakeholders at each site were expected to have actively participated in the application response to the QIC-ITCT's call for sites. Consent forms were prepared to be used at each interview with stakeholders. Although all stakeholders were expected to be highly interested in the study, at each interview they were reminded that their participation was voluntary, the information they provided would be kept confidential, and they had the right to skip questions or end the interview at will. Extensive discussions with RTI's IRB were held to review protocols, which resulted in the classification of this project as a program evaluation.

Contact with Sites and Preparation for Site Visits. As soon as sites (1) had a community coordinator in place and (2) had participated in the first introductory call with the QIC-ITCT, the evaluators worked with the community coordinator to schedule and prepare for site visits. The process included an *introductory e-mail* to the judge, along with a description of the evaluation and a request for permission to observe the court hearings either requested directly by RTI or by the community coordinator. The evaluation team then conducted a *review of program documentation* including sites' applications, progress reports, implementation materials, judicial policies and procedures, state statutes with respect to permanency planning, state definitions of child abuse and neglect, and QIC-ITCT technical assistance materials. The Web survey invitations were sent to stakeholders via e-mail approximately 2 weeks prior to site visits. The Web survey was kept open for about a month after site visits, with reminders sent to stakeholders encouraging them to complete the survey.

Site-Level Reports. All documentation available, including key informant interviews with members of the local infant-toddler court team and community stakeholders, and observations of hearings, monthly family team meetings, and stakeholder meetings were summarized along with detailed notes from natural observations conducted during site visits. Site visit notes were analyzed with NVivo software[4] to identify themes and group information. This documentation, along with site-specific data from the Web survey, was compiled to produce baseline and follow-up site-level reports that were provided to QIC-ITCT to guide their training and technical assistance, as well as for distribution to each respective site.

Secondary Data Analysis. For the final report, the evaluation team analyzed the data collected by the community coordinators or data entry staff through the QIC-ITCT Web portal. Between January and September 2017, the QIC-ITCT and demonstration sites collaborated with RTI on the data cleaning process. SBCT data spreadsheets without any personal identifiers were uploaded to a secured RTI system. Once spreadsheets for a topic area (e.g., placements) were clean, data tables were uploaded into SAS software for programming and analysis. The data include child background, reasons removed, child placement status, child service needs, monthly service detail, parent-child visitation, child case status, number and frequency of case hearings, placements and permanency, safety (maltreatment re-reports), and number and types of referrals and services provided.

We present key findings on the characteristics and safety, permanency and well-being outcomes for infants and toddlers served by sites involved with the 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

[4] NVivo qualitative data analysis Software; QSR International Pty Ltd. Version 10, 2012.

descriptors provided to the Federal Registry (Administration for Children and Families, 2015), preliminary 2015–2016 results for the CFSR3 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. Although the Milford site in Connecticut was not included in the qualitative evaluation, it is included in the secondary data analysis at the request of the QIC-ITCT. To avoid the potential identification of a family or child due to a small number of cases, sites were only included if at least 10 cases were available for analysis. As a result, two sites are not included in the data exhibits (Hillsborough and the Eastern Band of Cherokee Indians). Children 37 months and older at the time of entering the infant-toddler court were also excluded from analysis (these were siblings of younger children), as well as a few children whose parents decided to withdraw from the program. Children who were under 36 months at the time of entry and turned 3 years of age while involved with the court team continued as full participants and were included in the analysis.

RTI, QIC-ITCT, and sites cleaned the data from site initiation through May 1, 2017. New cases that were opened after May 1, 2017 were not included in the analyses. The one exception is in one exhibit in ***Section 3***, which presents permanency within 12 months among closed cases, and expected permanency within 12 months if reunification is not feasible among open cases. Due to an extended data cleaning process that lasted through September 2017, this exhibit includes data collected beyond May 1, 2017 for the 251 infants and toddlers.

The case-level analyses identify the key characteristics of the children served, including demographics (age, gender, race/ethnicity), first placement type, reasons for removing children from the home, and service needs and utilization. Outcomes related to maltreatment recurrence, stability of placements, achievement of permanency, and timeliness in obtaining the permanency goal were examined. The data are arrayed to present child-specific information by site, or cross-site analyses where appropriate and feasible. Information about parents include sociodemographics, risk factors, service needs, and services receipt. Sites in Connecticut were not authorized by the Connecticut Department of Children and Families IRB to enter data in the SBCT database about parents. Thus, exhibits related to parents exclude four of the QIC-ITCT sites (Hillsborough, the Eastern Band of Cherokee Indians, Milford, and New Haven).

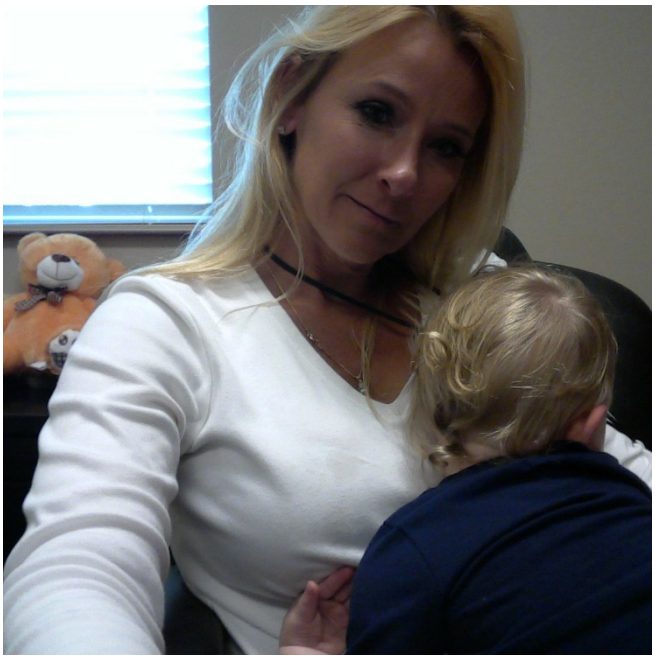
Descriptive statistics were used to characterize the sites on primary safety and placement outcomes, as well as service use by child and family characteristics. Cross-tabulations and significance tests were conducted where applicable (Pearson χ^2 tests) to test for differences by race/ethnicity.

Section 2 | Demonstration Sites and the QIC-ITCT

2. Demonstration Sites and the QIC-ITCT

a. Site Descriptions

Sites with SBCT History



Five of the demonstration sites had experience with the SBCT approach previous to the formation of the QIC-ITCT. Regardless of previous SBCT history, all sites experienced challenges and changes. Among sites with a SBCT history, changes included a period without the SBCT approach or changes in key stakeholders, such as judges and community coordinators. A brief description of each site is provided below.

Forrest County, Mississippi

Forrest County has a population of 75,979 (estimated in July 2016). Close to two-thirds of the county's population lives in the city of Hattiesburg (46,926 in 2016). Based on 2010 data, slightly over 40% of the population in Hattiesburg is White, 53% African American, and 4.3% Hispanic or Latino. Close to a third of the population has a bachelor's degree or higher among those 25 years old and older. The median income in 2015 was $26,852, and over a third of the population (38%) lives in poverty. Less than 10% of the residents of Hattiesburg are children under the age of five (6.4%) (United States Census Bureau, 2017b).

The Forrest County Youth Court hears all juvenile delinquency and child dependency cases. The SBCT community coordinator worked for the Forrest County Department of Human Services (DHS) for more than 25 years before assuming the SBCT position at the end of 2005. The SBCT began in 2006. The Forrest County Youth Court in Hattiesburg joined NCJFCJ's Model Courts Project in 2008 (NCJFCJ, 2016). The Forrest County site has had the same judge and community coordinator since the initiation of the SBCT.

Mississippi DHS was sued in 2004 on behalf of children in foster care under the agency's care. The Olivia Y. case alleged that the foster care system in Mississippi failed to protect children in their custody and provide services, a violation of constitutional rights. The settlement status report by Public Catalyst (2015) concluded that after more than 10 years since the case initiation, many of the commitments were not met and recommended a change of the child welfare structure, which was in full process during 2016 and continued during 2017. Among the challenges identified in the 2015 report was a sharp rise in the foster care population, low availability of foster homes, high caseworker caseload, low staff morale, salary stagnation, staff turnover, and strained relationships between the

CWS and the courts (Public Catalyst, 2015). A media report in 2017 described an increase by about 1,000 children during the year 2016, and the state's agreement to use the next year to increase capacity, supported by a large increase in funding from the legislature to improve the foster care system. The media reported that caseworkers' caseloads were as high as 40 children, and that starting in 2018, Public Catalyst will function as the compliance monitor for the state's new standards that will be developed next year (Gates, 2017).

Polk County, Iowa

Polk County has a population of 474,045 (estimated in 2016). Close to half of the county's population lives in the city of Des Moines (215,472 in 2016). Based on 2010 data, the population in Des Moines is 76.4% White not Hispanic, 12.0% Hispanic, and 10.2% African American. A quarter of the population has a bachelor's degree or higher among those 25 years old and older. The median income in 2015 was $46,290, and 20.0% of the population lives in poverty. In Polk County, 7.4% of the residents are children under the age of five (United States Census Bureau, 2017h).

The Polk County Juvenile Court hears all juvenile delinquency and child-in-need-of-assistance (abused, abandoned, or neglected) cases. The Polk County Juvenile Court joined NCJFCJ's Model Courts Project in 2000, and under the leadership of the previous judge became a Mentor Model Court in 2012. The SBCT began in the fall of 2005. This site had a new judge and community coordinator at the beginning of the QIC-ITCT.

Honolulu, Hawaii

The city and county of Honolulu has a population of 992,605 (estimated in 2016). Based on 2016 data, the population of Honolulu is 43.9% Asian alone, 22.2% White not Hispanic, 9.7% Hispanic, and 9.5% Native Hawaiian or other Pacific Islander. Close to a third of the population has a bachelor's degree or higher among those 25 years old and older. The median income in 2015 was $74,460, and 9.2% of the population lives in poverty. In Honolulu, 6.5% of the residents are children under the age of five (United States Census Bureau, 2017d).

The Honolulu Family Court hears domestic relation cases, child custody cases, juvenile delinquency cases, and cases of abused, abandoned and neglected children. The Honolulu Family Court joined NCJFCJ's Model Courts Project in 1997 as a Victims Act Model Court (NCJFCJ, 2017). Since 1996, the Family Court of the First Circuit has worked to divert families from a formal CWS to community-based programs through the development and implementation of the O'hana Conferencing Project. The SBCT began in 2008. Over the last several years, the SBCT in Honolulu has faced turnover in key stakeholders, including the judge and the community coordinator. The current judge provides leadership to the model court and SBCT.

New Haven, Connecticut

New Haven County has a population of 856,975 (estimated in 2016). Of those, 129,934 live in the city of New Haven. Based on 2010 data, the population in New Haven is 31.8% White not Hispanic, 35.4% African American, and 27.4% Hispanic. A third of the population has a bachelor's degree or higher among those 25 years old and older. The median income in 2015 was $37,192, and 26.6% of the population lives in poverty (United States Census Bureau, 2017k). In New Haven, 7.1% of the residents are children under the age of five.

The New Haven Juvenile Court hears all juvenile delinquency and child protection cases. The SBCT began in 2009 under the leadership of the Department of Children and Families (DCF). This site had a new community coordinator at the initiation of the QIC-ITCT after a period of inactivity.

DCF has been under a federal consent decree related to a 1989 lawsuit for substandard foster care conditions for more than 25 years. In September 2016, the court ordered a new exit plan that specifies the outcome measures and budget needed by DCF (Dwyer & Della Pietra, 2017). By May 2017, DCF's monitor requested the federal court to demand more funding and staff for DCF and the federal judge requested a new exit plan (Kovner, 2017).

Eastern Band of Cherokee Indians (EBCI), North Carolina[5]

The EBCI (Qualla Boundary land trust) is located in western North Carolina and includes almost 13,000 enrolled members. The Qualla Boundary covers more than 68,000 acres (Cherokee Preservation Foundation, 2014). The main part of the Boundary is in eastern Swain County and northern Jackson County, with smaller sections in Cherokee County and Graham County. Swain County has a population of 14,346 (estimated in 2016). Based on 2016 data, the population in Swain County is 64.2% White alone and 29.2% American Indian. Fewer than a fifth (15.9%) of the population has a bachelor's degree or higher among those 25 years old and older. The median income in 2015 was $33,931, and 16.2% of the population lives in poverty. In Swain County, 6.9% of the residents are children under the age of five (United States Census Bureau, 2017j).

The EBCI initiated work on the SBCT approach in 2009 under tribal leadership. In October 2015, the Tribe began the process of transitioning from social services departments run by the counties, to one run by the Tribe. This involved the transfer of all child welfare cases from adjoining counties to the Tribe. In addition to their long-standing community coordinator, Cherokee added a second community coordinator at the initiation of the QIC-ITCT to support the high level of need in this population This second community coordinator transitioned into the primary, and only, community coordinator for the EBCI in 2016.

New Sites

Florida

The Florida Statewide Model Court initiative joined NCJFCJ's Model Courts Project in 2010. Their mission is to improve safety, permanency, and well-being outcomes among children involved in Florida's court system. The initiative includes 43 judges and magistrates, representing 19 of the 20 judicial circuits in the state. With the support of the state court improvement program (CIP), Florida has 18 Early Childhood Courts, 5 of which participate in the QIC-ITCT.

Bay County

Bay County has a population of 183,974 (estimated in 2016). Based on 2016 data, the population in Bay is 79.2% White not Hispanic, 11.3% African American, and 6.3% Hispanic. Over a fifth (22.2%) of the population has a bachelor's degree or higher among those 25 years old and older. The median income in 2015 was $47,368, and 16.5% live in poverty. In Bay, 6.3% of the residents are children under the age of five (United States Census Bureau, 2017a).

The Bay County Juvenile Court hears all juvenile delinquency and child protection cases. Their implementation of the SBCT approach began in 2015.

Hillsborough County.

Hillsborough County has a population of 1,376,238 (estimated in 2016). Based on 2016 data, the population in Hillsborough is 53.7% White not Hispanic, 17.7% African American, and 27.6%

[5] ***Appendix A*** is the case study report for the Eastern Band of Cherokee Indians (EBCI), North Carolina.

Hispanic. Over a quarter (30.6%) of the population has a bachelor's degree or higher among those 25 years old and older. The median income in 2015 was $50,579, and 15.8% live in poverty. In Hillsborough, 6.4% of the residents are children under the age of five (United States Census Bureau, 2017c).

The Hillsborough County Juvenile Dependency Court hears all child protection cases. Their implementation of the SBCT approach began in 2016.

Pasco County

Pasco County has a population of 512,368 (estimated in 2016). Based on 2016 data, the population in Pasco is 80.1% White not Hispanic, 14.3% Hispanic, and 5.9% African American. Over a fifth (21.4%) of the population has a bachelor's degree or higher among those 25 years old and older. The median income in 2015 was $45,064, and 14.6% live in poverty. In Pasco, 5.2% of the residents are children under the age of five (United States Census Bureau, 2017f).

The Pasco County Juvenile Court hears all juvenile delinquency and child protection cases. Their implementation of the SBCT approach began in 2015 but the judge was implementing the approach years before the current project. The SBCT approach started in Pasco County in March 2014 with the judge and the Infant Mental Health Specialist (IMHS) spearheading the effort. A few court team members referred to this period, before the arrival of the community coordinator, as the "pilot." Many of the core components were in place or partially in place by the time a community coordinator was brought on board in October 2015.

Pinellas County

Pinellas County has a population of 960,730 (estimated in 2016). Based on 2016 data, the population in Pinellas is 74.8% White not Hispanic, 10.9% African American, and 9.3% Hispanic. More than a quarter (28.9%) of the population has a bachelor's degree or higher among those 25 years old and older. The median income in 2015 was $45,819, and 13.6% of the population lives in poverty. In Pinellas, 4.5% of the residents are children under the age of five (United States Census Bureau, 2017g).

The Pinellas Juvenile Court hears all juvenile delinquency and child protection cases. Their implementation of the SBCT approach began in 2015 with a part-time community coordinator working 10 hours per month. In 2016, a new part-time community coordinator was able to commit 10 hours per week. Since 2017, a new full-time community coordinator joined the Pinellas County court team has acquired after securing funding from the state legislature.

South Okaloosa County

Okaloosa County has a population of 201,170 (estimated in 2016). Based on 2016 data, the population in Okaloosa is 77.1% White not Hispanic, 10.1% African American, and 8.7% Hispanic. More than a quarter (28.8%) of the population has a bachelor's degree or higher among those 25 years old and older. The median income in 2014 was $55,880, and 11.3% live in poverty. In Okaloosa, 6.7% of the residents are children under the age of five (United States Census Bureau, 2017e).

The Okaloosa Juvenile Court hears all juvenile delinquency and child protection cases. Their implementation of the SBCT approach began in 2015.

Mississippi

Rankin County

Rankin County has a population of 150,228 (estimated in 2016). Based on 2016 data, the population in Rankin is 76.3% White not Hispanic, 20.5% African American, and 2.6% Hispanic. More than a quarter of the population (29.0%) has a bachelor's degree or higher among those 25 years old and older. The median income in 2015 was $58,801, and 9.7% lives in poverty. In Rankin, 6.2% of the residents are children under the age of five (United States Census Bureau, 2017i).

The Rankin County Youth Court hears all juvenile delinquency and child dependency cases. The SBCT began in 2016, piloting working with families under court supervision of cases prior to the children's entry into foster care. The goal is to have children remain in their homes with their parents. Rankin County faces the same challenges as Forrest County related to the child welfare system:

- Mississippi DHS was sued in 2004 on behalf of children in foster care
- The number of children reported for maltreatment increased in 2016
- Caseworker caseload and turnover are high (Gates, 2017).

b. Characteristics of Children and Families

Children

Across QIC-ITCT sites, slightly more than half of children were males (54.1%, see ***Exhibit 2***). 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, etc.), 21.5% Black, and 5.8% Hispanic. Most children's families were living below the federal poverty line (91.3%). About two thirds (67.4%) of children had their father's name on their birth certificates.

As stated in the SBCT core components, "Very young children make sense of their world within the context of their relationships with a few very special caregivers" (ZERO TO THREE, 2016, p. 9). For this reason, around the time of the child's removal, the infant-toddler court team tries to place the child with kin, and within the same county to facilitate parent-child contact. 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%, who were placed with kin willing to be the concurrent plan).

The major reasons for children's removal from home included neglect (72.3%), parent's use of alcohol/drugs (69.4%), sibling risk[6] (25.6%), parent's mental illness (24.4%), and physical abuse (11.6%). The level of exposure to parental substance use was higher than estimates among children 0 to 2 years old in NSCAW II investigated for child maltreatment. In NSCAW II, 9.3% of 0- to 2-year-olds had substance exposure, and 20.1% had a substance abusing parent (Casanueva et al., 2011a).

[6] Sibling Risk is when a "child is removed not because they are believed to be at risk but because of the substantiated maltreatment of a sibling" (ZERO TO THREE, 2017b, p. 26).

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.

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 were within the first 12 months of a case. 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).

Exhibit 2. Child Characteristics at the Time of Entry to the Infant-Toddler Court Team

Child Characteristics	Total QIC-ITCT Sites N = 251* %	QIC-ITCT Sites									
		Bay N = 17 %	Forrest N = 51 %	Honolulu N = 18 %	Milford N = 45 %	New Haven N = 30 %	Pasco N = 12 %	Pinellas N = 18 %	Polk N = 22 %	Rankin N = 12 %	South Okaloosa N = 26 %
Gender											
Male	**54.1**	56.3	56.9	50.0	53.3	63.0	50.0	62.5	38.1	50.0	54.2
Female	**45.9**	43.8	43.1	50.0	46.7	37.0	50.0	37.5	61.9	50.0	45.8
Age											
0 to 11 months	**55.8**	43.8	52.9	66.7	57.8	59.3	58.3	43.8	61.9	50.0	58.3
12 to 23 months	**24.0**	25.0	21.6	22.2	17.8	25.9	25.0	31.3	28.6	25.0	29.2
24 to 36 months	**20.3**	31.3	25.5	11.1	24.4	14.8	16.7	25.0	9.5	25.0	12.5
Race/Ethnicity											
Black	**21.5**	0.0	41.2	11.1	6.7	40.7	25.0	25.0	9.5	16.7	16.7
Hispanic	**5.8**	18.8	0.0	0.0	6.7	11.1	16.7	12.5	0.0	0.0	4.2
Other	**22.7**	6.3	9.8	88.9	35.6	18.5	0.0	6.3	23.8	16.7	16.7
White	**50.0**	75.0	49.0	0.0	51.1	29.6	58.3	56.3	66.7	66.7	62.5
Family Federal Poverty	**91.3**	87.5	96.1	88.9	86.7	100	83.3	68.8	90.5	100	100
Father's Name on Birth Certificate	**67.4**	93.8	64.9	88.9	48.9	52.6	80.0	85.7	66.7	66.7	69.6
Child Setting											
Foster care	**47.2**	37.5	80.0	12.5	35.6	50.0	88.9	50.0	14.3	9.1	56.5
In home	**5.2**	0.0	0.0	25.0	2.2	0.0	0.0	0.0	9.5	45.5	0.0
Kin care no parents	**46.8**	62.5	20.0	62.5	62.2	50.0	11.1	43.8	76.2	36.4	43.5
Kin care with parents	**0.9**	0.0	0.0	0.0	0.0	0.0	0.0	6.3	0.0	9.1	0.0

Child Characteristics	Total QIC-ITCT Sites N = 251* %	QIC-ITCT Sites: Bay N = 17 %	Forrest N = 51 %	Honolulu N = 18 %	Milford N = 45 %	New Haven N = 30 %	Pasco N = 12 %	Pinellas N = 18 %	Polk N = 22 %	Rankin N = 12 %	South Okaloosa N = 26 %
Placement Location											
In county	**76.5**	68.8	46.0	100	84.1	83.3	77.8	93.8	90.5	100	73.9
Out of county	**23.0**	31.3	52.0	0.0	15.9	16.7	22.2	6.3	9.5	0.0	26.1
Out of state	**0.4**	0.0	2.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Child Reasons for Removal (Yes)*											
Medical neglect	**9.9**	12.5	5.9	27.8	4.4	7.4	16.7	18.8	4.8	0.0	16.7
Neglect	**72.3**	31.3	88.2	77.8	97.8	92.6	25.0	25.0	52.4	91.7	54.2
Physical abuse	**11.6**	12.5	9.8	5.6	13.3	14.8	0.0	37.5	14.3	0.0	4.2
Sexual abuse	**1.7**	0.0	5.9	0.0	0.0	0.0	0.0	0.0	0.0	8.3	0.0
Psychological maltreatment	**3.3**	0.0	3.9	11.1	2.2	0.0	16.7	6.3	0.0	0.0	0.0
Alcohol/drugs a factor	**69.4**	56.3	72.6	88.9	66.7	44.4	66.7	43.8	95.2	66.7	87.5
Mental illness a factor	**24.4**	6.3	3.9	16.7	35.6	22.2	50.0	6.3	57.1	16.7	41.7
Sibling risk	**25.6**	0.0	51.0	50.0	13.3	14.8	75.0	6.3	0.0	8.3	25.0
Other abuse	**11.2**	25.0	7.8	16.7	0.0	0.0	25.0	81.3	0.0	0.0	0.0
Case Status											
Closed cases	**14.1**	12.5	13.7	27.8	8.9	11.1	33.3	18.8	19.1	8.3	3.8
Open cases	**85.5**	87.5	86.3	72.2	91.1	88.9	66.7	81.3	81.0	91.7	92.4
Reopened cases	**0.4**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.8

Child Characteristics	Total QIC-ITCT Sites N = 251* %	QIC-ITCT Sites: Bay N = 17 %	Forrest N = 51 %	Honolulu N = 18 %	Milford N = 45 %	New Haven N = 30 %	Pasco N = 12 %	Pinellas N = 18 %	Polk N = 22 %	Rankin N = 12 %	South Okaloosa N = 26 %
Child Health Indicators (Yes)											
Premature birth	**8.4**	11.1	7.8	0.0	6.7	7.7	10.0	0.0	4.8	16.7	23.8
Low birth weight	**9.9**	0.0	9.8	16.7	11.1	7.7	0.0	0.0	4.8	16.7	21.1
Small for gestational age	**7.6**	0.0	5.9	16.7	4.4	11.5	0.0	0.0	4.8	8.3	21.1
Medically fragile	**9.6**	15.4	7.8	5.6	0.0	7.7	20.0	0.0	0.0	8.3	43.5
Physical disability	**0.9**	6.3	2.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Failure to thrive	**2.6**	6.7	4.0	0.0	0.0	0.0	0.0	6.3	9.5	0.0	0.0
Exposure to parental substance abuse	**57.7**	75.0	40.8	55.6	52.3	46.2	88.9	31.3	95.2	41.7	95.0
Smoking	**25.0**	10.0	11.6	27.8	21.6	4.2	88.9	10.0	19.1	33.3	70.0
Alcohol	**14.9**	13.3	4.6	5.9	25.8	7.7	50.0	0.0	28.6	0.0	28.6
Drugs	**52.4**	56.3	42.0	50.0	50.0	36.0	70.0	7.1	90.5	50.0	89.5
FASD - yes	**0.0**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
FASD - suspected but not diagnosed	**11.2**	6.3	0.0	41.2	8.3	7.7	80.0	0.0	9.5	8.3	0.0

* Reported *N*s vary slightly across analyses because of missing data in some variable categories. Sites were only included if at least 10 cases were available for analysis. As a result, Hillsborough and Cherokee are not included in the data exhibits.

Children's Exposure to Adverse Childhood Experiences

All children involved with the infant-toddler courts have one or more adverse childhood experiences (ACEs, see ***Exhibit 3***). 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. Young children involved with infant-toddler courts teams are among the most vulnerable of those in the CWS. As a point of comparison, among children less than 36 months of age in NSCAW II, 38% have four or more ACEs, while among children all ages, 51% had four or more ACEs (Stambaugh et al., 2013).

The most frequent ACEs among children involved with infant-toddler courts teams were parents ever separated or divorced (86.1%), lived with anyone who was a problem drinker or alcoholic or who used street drugs (81.5%), household member depressed or mentally ill or household member attempted suicide (67.7%), did not have enough to eat, had to wear dirty clothes, had no one to protect child or parents were too drunk or high to take care of child or take child to doctor if needed (43.6%), and household member who went to prison (42.7%).

> "The ACE study—one of the largest investigations of childhood abuse and neglect and later-life health—found that early childhood experiences were powerful predictors of adult health, functioning, and well-being. Adverse childhood experiences (ACEs) are stressful or traumatic events, and are often categorized into three areas: abuse (physical, emotional, and sexual), neglect (physical and emotional), and household dysfunction (mental illness, separation and divorce, domestic violence, incarcerated member of the child's household, and substance abuse). As the number of ACEs an individual has increase, so does the risk for negative outcomes" (QIC-ITCT, 2017a, p. 1).

Parents

Slightly less than two thirds of parents involved with the infant-toddler courts were female (62.8%, see ***Exhibit 4***). 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 40.0% 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, 48.1% had been incarcerated during adulthood, CWS had concerns about domestic violence for 44.0% of parents, 33.5% had other family involvement with CWS, 27.1% had experience with the juvenile justice system, and 22.3% were in foster care growing up.

Parents' Exposure to Adverse Childhood Experiences

Parents involved with infant-toddler court teams have also experienced a large number of ACEs (***Exhibit 5***). 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. The range was 0 to 10. The most frequent ACEs among parents involved with infant-toddler court teams were parents ever separated or divorced (77.6%); lived with anyone who was a problem drinker or alcoholic or who used street drugs (60.9%); no one in the family loved you, or thought you were important or special, or family did not look out for each other, feel close to each other, or support each other (55.7%); parent or other adult in the household swore, insulted, put down, humiliated or acted in a way that made you afraid of being physically hurt (50.0%); and household member depressed or mentally ill or household member attempted suicide (47.9%).

Exhibit 3. Children's Adverse Childhood Experience (ACE) Scores

	QIC-ITCT Sites										
ACEs	Total QIC-ITCT Sites N = 251* %	Bay N = 17 %	Forrest N = 51 %	Honolulu N = 18 %	Milford N = 45 %	New Haven N = 30 %	Pasco N = 12 %	Pinellas N = 18 %	Polk N = 22 %	Rankin N = 12 %	South Okaloosa N = 26 %
Total	***202***	6	42	17	42	24	12	16	21	11	11
Children ACEs Score**											
1	**4.5**	0.0	4.8	0.0	4.8	8.3	0.0	0.0	0.0	18.2	9.1
2	**16.8**	33.3	7.1	47.1	9.5	16.7	8.3	50.0	0.0	9.1	27.3
3	**21.3**	50.0	14.3	23.5	26.2	12.5	16.7	31.3	0.0	63.6	18.2
4	**25.7**	16.7	16.7	23.5	50.0	37.5	50.0	18.8	0.0	0.0	9.1
5	**11.9**	0.0	28.6	0.0	9.5	12.5	25.0	0.0	4.8	9.1	0.0
6	**7.9**	0.0	11.9	5.9	0.0	4.2	0.0	0.0	33.3	0.0	18.2
7	**7.9**	0.0	14.3	0.0	0.0	8.3	0.0	0.0	28.6	0.0	18.2
8	**1.5**	0.0	0.0	0.0	0.0	0.0	0.0	0.0	14.3	0.0	0.0
9	**2.5**	0.0	2.4	0.0	0.0	0.0	0.0	0.0	19.1	0.0	0.0

* Reported *N*s vary slightly across analyses because of missing data in some variable categories. Sites were only included if at least 10 cases were available for analysis. As a result, Hillsborough and Cherokee are not included in the data exhibits.

**Across the 10 ACE items (range of scale 0–10), all were selected. The mean and median ACE scores were 4, with a range of 1 to 9. More than half of children (57.4%) at QIC-ITCT sites have four or more ACEs.

Exhibit 4. Parents' Characteristics at the Time of Entry to the Infant-Toddler Court Team*

Parents Characteristics	QIC-ITCT Sites								
	Total QIC-ITCT Sites N = 180** %	Bay N = 17 %	Forrest N = 44 %	Honolulu N = 13 %	Pasco N = 10 %	Pinellas N = 21 %	Polk N = 28 %	Rankin N = 16 %	South Okaloosa N = 31 %
Gender									
Male	37.2	41.2	31.0	40.9	20.0	44.8	38.7	37.5	40.6
Female	62.8	58.8	69.0	59.1	80.0	55.2	61.3	62.5	59.4
Has Employment	40.9	41.2	32.0	40.9	10.0	48.3	40.0	68.8	44.8
Education									
No HS/GED	34.4	47.1	34.1	13.6	50.0	58.6	30.0	25.0	22.7
Completed HS/GED	48.9	41.2	43.2	77.3	33.3	34.5	43.3	56.3	63.6
Beyond HS	16.7	11.8	22.7	9.1	16.7	6.9	26.7	18.8	13.6
Housing at Intake									
Homeless	9.3	0.0	0.0	18.2	20.0	20.7	6.5	0.0	16.1
Double up with family/friend	30.4	37.5	40.8	18.2	40.0	51.7	19.4	31.3	6.5
Own housing	51.0	56.3	55.1	22.7	40.0	20.7	67.7	62.5	71.0
Other	9.3	6.3	4.1	40.9	0.0	6.9	6.5	6.3	6.5

Parents Characteristics	Total QIC-ITCT Sites N = 180** %	QIC-ITCT Sites: Bay N = 17 %	Forrest N = 44 %	Honolulu N = 13 %	Pasco N = 10 %	Pinellas N = 21 %	Polk N = 28 %	Rankin N = 16 %	South Okaloosa N = 31 %
Risk Factors (Yes)									
In foster care growing up	22.3	18.8	10.4	22.2	0.0	20.7	50.0	25.0	18.2
Other family involvement with CW	33.5	31.3	16.3	23.5	40.0	28.6	50.0	50.0	47.6
Had children before age 18	17.7	25.0	20.4	5.6	28.6	17.2	13.3	31.3	11.1
Incarcerated as adult	48.1	25.0	46.5	63.2	88.9	37.9	46.7	25.0	71.4
Experience with juvenile justice	27.1	12.5	21.4	41.2	0.0	17.9	40.0	43.8	23.5
History alcohol or drug abuse	82.4	81.3	76.5	86.4	80.0	69.0	90.0	87.5	93.6
History mental health issues	50.8	62.5	13.0	45.5	90.0	57.1	80.0	40.0	65.4
CPS concerned about DV	44.0	87.5	18.2	77.3	77.8	60.7	20.0	20.0	44.8
FASD									
FASD suspected, but not diagnosed	5.6	12.5	2.3	5.0	55.6	0.0	3.3	0.0	0.0
No evidence of FASD	94.4	87.5	97.7	95.0	44.4	100.0	96.7	100.0	100.0

* There are 208 families represented by the 251 children, for a total of 220 adults. Connecticut does not allow data collection about parents. Milford (38 families) and New Haven (29 families) are excluded from adults' tables.

** Reported *N*s vary slightly across analyses because of missing data in some variable categories. Sites were only included if at least 10 cases were available for analysis. As a result, Hillsborough and Cherokee are not included in the data exhibits.

Exhibit 5. Parents' Adverse Childhood Experience (ACE) Scores

ACEs	QIC-ITCT Sites								
	Total QIC-ITCT Sites N = 180* %	Bay N = 17 %	Forrest N = 44 %	Honolulu N = 13 %	Pasco N = 10 %	Pinellas N = 21 %	Polk N = 28 %	Rankin N = 16 %	South Okaloosa N = 31 %
Total	***181***	16	45	12	10	23	28	16	31
Parents' ACEs Scores*									
0	**13.3**	0.0	28.9	16.7	0.0	8.7	0.0	0.0	22.6
1	**9.4**	18.8	6.7	8.3	0.0	17.4	0.0	6.3	16.1
2	**9.9**	6.3	13.3	0.0	0.0	17.4	3.6	25.0	6.5
3	**8.3**	18.8	15.6	0.0	0.0	8.7	3.6	6.3	3.2
4	**8.8**	6.3	13.3	0.0	10.0	4.4	3.6	31.3	3.2
5	**9.9**	18.8	2.2	8.3	30.0	4.4	3.6	6.3	22.6
6	**16.0**	18.8	11.1	25.0	20.0	4.4	32.1	6.3	16.1
7	**10.5**	0.0	0.0	8.3	30.0	21.7	21.4	18.8	3.2
8	**7.2**	12.5	4.4	8.3	10.0	4.4	21.4	0.0	0.0
9	**5.0**	0.0	2.2	16.7	0.0	8.7	7.1	0.0	6.5
10	**1.7**	0.0	2.2	8.3	0.0	0.0	3.6	0.0	0.0

* Connecticut does not allow data collection about parents so Milford and New Haven are excluded from adults' tables. Reported *N*s vary slightly across analyses because of missing data in some variable categories. Sites were only included if at least 10 cases were available for analysis. As a result, Hillsborough and Cherokee are not included in the data exhibits.

** The mean ACEs score was 4.3 and the median was 5. Close to two thirds of parents (59.1%) at QIC-ITCT sites have four or more ACEs.

c. QIC-ITCT Support

This section presents a summary of the QIC-ITCT support provided to sites. Following a description of the training and technical assistance (TA) provided by the QIC-ITCT, the resources available for sites, and dissemination efforts, we focus on the demonstration sites' experience from baseline to follow up. We describe factors and strategies associated with successful partnerships and collaborative efforts to implement or sustain an infant-toddler court team; changes in practices; organizational and systems conditions necessary to support the implementation of the sites' selected evidence-based programs; and changes in roles and behaviors of infant-toddler court team members.

QIC-ITCT Trainings and Technical Assistance

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. This section describes these key training features.

Judicial Training

QIC-ITCT site judges were encouraged to attend the NCJFCJ Annual Child Abuse and Neglect Judicial Leadership Institute or the NCJFCJ Annual Conference with QIC-ITCT financial support. NCJFCJ provided judges with connections and materials to support understanding of court-based system reform for infants and toddlers. Judge Connie Cohen held monthly individual calls with most demonstration site judges, in-person meetings in Iowa, and monthly conference calls with judges collectively. In between the monthly calls, ad hoc communication via telephone and e-mail was being used with judges in Hawaii, Iowa, Mississippi, and Florida as necessary. Materials created for meetings between Judge Cohen and the site judges include a glossary, a bench card, and a bulletin on questions that judges and lawyers should ask about infants and toddlers in the CWS.[7]

Judge Cohen also gave presentations on judicial leadership at the 2015, 2016, and 2017 Cross Sites meetings, and conducted webinars geared toward judges.

NCJFCJ completed Trauma-Informed Practices Consultation with interested sites. Several judges at sites where a trauma consultation had been conducted described their experience at a plenary of the 2017 Cross Sites meeting, highlighting the value of the trauma consultation visits and actively working with their community using the consultation report's recommendations:

> *"Managing privacy in a better way is critical. The trauma audit helps to question ourselves and how are parents perceiving this. Why was it that all minority families were at the end of the docket?"*
>
> *"We had detention and shelter hearings, people would be waiting for shelter hearings while we did detention hearings, and they would see youth in shackles, and that impacts families. So we received the recommendation to schedule separately and maintain shelter families waiting outside."*
>
> *"You need to know if guards are off-putting and making things more difficult for people who are already scared."*

[7] These resources can be found online at:

- http://www.qicct.org/sites/default/files/QIC-CT%20Judges'%20Glossary%205.12.16.pdf (glossary)
- http://www.ncjfcj.org/sites/default/files/NCJFCJ_ZeroToThree_Benchcard_Final.pdf (bench card)
- http://www.ncjfcj.org/sites/default/files/NCJFCJ_ZeroToThree_Questions_Final.pdf (bulletin)

> *"The recommendation was to make the court more child-appropriate. We needed a play area. I had to gather and combine a group after the [trauma audit] report with judges, attorneys, caseworkers, GALs* [guardians ad litem]*, local shelters, county clerks, and mental health and substance abuse providers, to get together and dissect the report to start making changes. We are working with the local university on training; there is a trauma conference that the department of mental health is sponsoring that will be free for us.* [We] *engage the chamber of commerce, health care communities and they are glad to share. Universities in the area are willing to come over. Security staff* [needed training] *as they sit with families; they can help mitigate stress and help with trauma issues."*

Community Coordinator Training

The process developed by the QIC-ITCT to select and train community coordinators was a success. 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-ITCT sites. Training and technical assistance was provided to community coordinators on their weekly calls with the QIC-ITCT staff. The training curriculum included the following courses:

1. Safe Babies Court Teams: Nurturing Healthy Families for Young Children in Foster Care
2. Basic Information on Early Childhood Development and the Impact of Maltreatment
3. Building a Strong Community Stakeholder Group
4. Partnering with Parents from Day One: Planning a Child's Transition to Foster Care at Pre-Removal Conferences
5. Understanding the Journey from Removal to Permanency
6. How to be a Successful Coordinator
7. Confronting Early Adversity: Working with Parents of Maltreated Babies
8. In the Courtroom: Preparing Reports and Testifying
9. National Council of Juvenile and Family Court Judges' Court-Based Leadership Session 1
10. Ask the Experts: Overcoming Challenges and Obstacles in Your Role as Community Coordinator
11. Community Coordinator Safe Babies Court Team Database Training
12. Family Team Meetings: Building Collaboration with Birth and Foster Parents and Professionals
13. Confronting the Racial Discrimination that Is Rampant in the Child Welfare System
14. National Council of Juvenile and Family Court Judges' Court-Based Leadership Session 2
15. Collaborative Problem Solving
16. The Quality Improvement Center for Research-Based Infant-Toddler Court Teams (QIC-ITCT)
17. Fetal Alcohol Spectrum Disorders: The Elephant in the Courtroom
18. A Decision-Making Framework for Implementing Evidence-Based Practices
19. Implementing Continuous Quality Improvement (CQI)
20. Working with Justice-Involved Families
21. Medicaid 101

The QIC-ITCT offered formal trainings to sites based on their site-specific needs or requests. For example, the TA and training on family team meetings included a half day during the 2016 Cross Sites with a mock family team meeting on a complex case with conflict situations that were

demonstrated by the family team meeting moderator. Similarly, a session during the 2017 Cross Sites on family team meetings was titled "Developing Transparency through Courageous Conversations." This training was organized based on QIC-ITCT observations during TA visits as well as sites' evaluation reports on family team meetings where difficult or contentious issues were skipped or issues related to parents not making the progress required in their case plan were avoided. TA and training provided in this area focused on modeling respect and dignity toward parents, and how to approach conflicts while creating a safe space. Issues generating conflict that required "courageous conversations" covered by TA and training included concurrent planning, father's identity, and pregnancy as a coping mechanism for the loss of a child through termination of parental rights (TPR). The value of this training was summarized by the following comment from a frontline court team member:

> *"In our team, concurrent planning is not as central as it should be, and we need to keep growing in that area. We have the concurrent plan, but we are not working as closely as we should as it is very difficult to work on that. Parent attorneys don't want it, they feel that it places parents in a situation that nobody wanted. So I loved what* [the TA specialist] *said: that every parent needs to have a Plan B if something happens to them, as it normalizes the experience. It is a hard conversation because it is difficult for us in our own life to be honest and talk about the difficult issues."*

Team Training

Team training was provided at sites' kick-off meetings, sustainability meetings, and cross sites training. Team support was provided for the main child welfare outcomes. In the area of safety, for a re-report, the QIC-ITCT conducted a full review of the case and provided the evaluator with a detailed report (with all personal information de-identified) of the reasons that children came into foster care, birth parents' response to the child's trauma history, child caregiving history and relationships, successes, challenges, and areas in need of QIC-ITCT consultation. The re-report review process included a visit to the demonstration site to provide TA that included one-on-one meetings between the judge and Judge Cohen about topics related to the child welfare agency's discretion on reunification, QIC-ITCT training on multiple areas that impact child safety, and clinical TA to service providers related to safety. Dr. Joy Osofsky—and, for some reviews, Dr. Neil Boris—provided clinical support and prepared a summary of cases reviewed, concluding that safety issues were related to the court providing discretion to the CWA to reunify the child with a parent. Dr. Osofsky's recommendations included that judges no longer give discretion to the CWA regarding if and when to permit reunification; focus on the parents' past trauma history and its impact on their behaviors and choices; consider the time needed by clinicians to help parents develop trust and process early traumatic experiences impacting their current behavior; give attention to the parents' ability to keep a child safe; and the court team's need for clinical input about mothers' partners and the continuation of abusive relationships and victimization that should be resolved clinically for successful reunification. As summarized by Dr. Osofsky in her safety report: "All placement decisions need to take into account: 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).

The QIC-ITCT also met with the court team to review their processes, supporting them in implementing the changes to the decision-making process to prevent failed reunifications. As several sites were in the initial implementation stage, failed reunifications were seen as part of the learning process, giving the sites the opportunity to begin in-depth discussions and gain a better understanding of how to implement this complex approach successfully.

Another team training provided by the QIC-ITCT was on continuous quality improvement (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. For these meetings, RTI produced analysis with monthly updates of metrics selected by sites, either based on variables available in the SBCT dataset or new data submitted by sites. Support for sites was successful when the CQI metric selected was based on variables available in the SBCT dataset. Sites that decided to analyze an issue that required them to collect their own data struggled monthly to submit their data, if collected, to RTI for analysis.

Training on Evidence-Based Programs

In response to the common need across sites for service providers trained on EBPs to effectively support improvements in the quality of the parent/child relationship, the QIC-ITCT surveyed the sites about their current resources and services available to support infant mental health. Sites provided information about their general need for training more clinicians in CPP, the current number of courts that receive CPP services, and the number of CPP-trained clinicians needed to support children and families in their communities. This information supported the provision of training for community coordinators on EBPs and the EBP decision-making framework, as well as the planning and initiation of the first CPP training cohort, composed of 32 clinicians. Selected trainees were required to be licensed or licensable (participating with a supervisor) psychologists, social workers, professional counselors, family and marriage counselors, and supervisors. Following an initial 3-day training, clinicians were able to begin providing CPP under the supervision of Dr. Osofsky's staff through regular ongoing consultation. At the conclusion of the 18-month training, clinicians were licensed to provide CPP on their own. At the time of the baseline visits, several sites were already referring families and actively working with clinicians as key members of the court team who were participating in family team meetings and providing information about therapeutic progress during court hearings.

The QIC-ITCT also provided training to the community coordinators on evidence-based and evidence-informed programs, based on the QIC-ITCT review of EBPs and the development of an educational tool and a decision-making framework to be used by infant-toddler court teams in reviewing and evaluating current interventions, understanding the community's gaps, and using the tool to assist in selecting an intervention that addresses those gaps and the needs of the population served by the community.

In the initial stakeholder interviews, court team members were asked what types of trainings they would most benefit from. Most of the sites with a newly implemented infant-toddler court team

requested training on the SBCT approach, infant mental health, child development, support for parents whose rights are being terminated, knowledge of family systems, trauma-informed practice, reflective supervision, and coparenting between foster and biological parents. More experienced sites requested ways to improve their current infant-toddler court teams with trainings on initiating pre-removal conferences, providing peer-level support for fathers, getting attorneys more involved in the court team, and training more foster families in alignment with the SBCT approach. Both new and experienced sites mentioned the need for training additional staff on CPP.

Sites were pleased with the support the QIC-ITCT provided them. Stakeholders reported positive feedback, such as:

> *"I can honestly say that this program would not be able to run without* [the QIC-ITCT's] *support. I joke that they are like my umbilical cord as far as support, mentoring and connecting with a group who understands the concepts of the program."*
>
> "[The QIC-ITCT] *has been amazing; they've been a sounding board, provided recommendations, guidance, and information. Without* [the QIC-ITCT]*, I wouldn't be where I am right now. If I hadn't felt like I had that kind of support, I don't think I would've stuck with it. Their support and that type of technical assistance when you're setting up new programs is invaluable."*

d. QIC-ITCT Dissemination

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*: This document is intended to provide the reader with guiding principles for infant-toddler court teams; questions for thoughtful consideration when implementing the principles; and vignettes that provide examples of how the principles can guide practice when working with infants, toddlers, and families involved with the child welfare system, highlighting both the strengths and challenges that are often faced by infant-toddler court teams.
- *QIC-ITCT Factsheet*: The QIC-ITCT developed a factsheet to introduce the project, including an overview of the purpose, goals in supporting demonstration sites, and goals around national dissemination of best practices and findings, including identification of practices that are transferable to state and local child welfare systems across the United States.
- *Web-based Resources*: These tools are focused on helping child welfare systems and agencies increase their capacity to incorporate EBPs to strengthen parenting and promote healthy development for very young children and families involved in child welfare (www.qicct.org/evidence-based), including:
    - The development of a point-in-time educational tool and a resource providing a decision-making framework comprised of important elements to consider when assessing an intervention's relevance for the infant and toddler population in child welfare in a community.
    - A *Framework for Sustainability* that includes the key elements necessary to understand and leverage to sustain and institutionalize a new approach, practice, or

delivery model (www.qicct.org/sustainability). Each demonstration site has developed individualized action plans tied to this model.

- *Annual Cross Sites Meeting Videos and Presentations:* As a result of the annual SBCT and QIC-ITCT cross sites meetings, the QIC-ITCT produced presentations and video clips available to both attendees and the public on topics including: Overcoming the Psychological and Biological Challenges of Substance Abuse and Exposure; Judicial Leadership; Culture, Race, Ethnicity, and Historical Trauma; Evidence-Based Practices; Supporting Parents: Special Issues Related To Substance Abuse And Mental Health; Fetal Alcohol Spectrum Disorders; Violence and Trauma in the Lives of Young Children; Building a Trauma-Informed System for Families; and Screenings and Assessments for Young Children and Parents.
- *Glossary of Key Terms for Infant-Toddler Court Teams: A Judges' Guide:* Developed by the QIC-ITCT, this guide fulfills a need identified by the judges for a glossary of keys terms used in child welfare and early childhood as a reference for judges and all stakeholders working with infant-toddler court teams. The glossary was created using the expertise of the QIC-ITCT team and consultants and also using guiding language and definitions from the Children's Bureau.
- *Supporting Military Families with Infants and Toddlers in the Child Welfare System:* This document focuses on challenges related to transitions from deployment separations, returning home, and the support needed by military families with very young children in child welfare. This document from the QIC-ITCT provides important considerations and resources in this area.
- *Evaluation Reports*: While site level and overall reports were produced for baseline and follow-up evaluation visits by RTI and QIC-ITCT made the reports available to the respective site, they are not publicly available on the QICCT.org Web site. However, the executive summaries of these reports are publicly available on the QIC-ITCT Web site.
- *Questions Every Judge and Lawyer Should Ask About Infants and Toddlers in the Child Welfare System:* The QIC-ITCT, with leadership from NCJFCJ, released the updated 2002 Technical Assistance Brief. QIC-ITCT consultants Dr. Osofsky and Judge Cohen lent their guidance and expertise in updating this useful brief. The update includes promising practices when working with families with young children. Four new sections cover parent-child contact, domestic violence, fetal alcohol spectrum disorders, and working with parents who have experienced trauma.
- *QIC-ITCT Resources on Child-Parent Psychotherapy (CPP)*: As the QIC-ITCT demonstration sites identified CPP as the evidence-based intervention they most wanted to implement, the QIC-ITCT, in addition to implementing a training for a cohort of clinicians from QIC-ITCT sites, developed several resources in this area, including:
    - *Testifying in Court for Child-Parent Psychotherapy Providers: Helping the Court Understand the Parent, Child, and Relationship*: This document provides guidance to therapists on testifying in court, supporting the work of the therapist to keep the parent fully informed in advance of hearings about progress and any recommendations that will be made to the court.
    - *Child-Family Psychotherapy Brochure for Parents*: The QIC-ITCT, with guidance and input from Dr. Joy Osofsky, developed a family-friendly brochure on CPP that community coordinators can use to better describe what participating in CPP means to families at our sites, some of whom are initially reluctant to engage in CPP with their children.

- *Evaluating and Assuring the Effective and Safe Use of Psychotropic Medications in Children*: Hosted in June 2016 by the QIC-ITCT and NCJFCJ, this webinar assists judicial officers in assessing the use of psychotropic medications in young children involved in the CWS. The webinar is designed to help participants understand how professionals utilize existing resources in diagnosing and prescribing, describe a continuum of care for children, analyze one state's strategies to reduce the frequency of psychotropic drugs among young children, and begin to develop a strategy to evaluate and ensure the effective and safe use of psychotropic drugs. An updated session is also available from presentations made at the 2017 Cross Sites meeting.
- NCJFCJ, the Mississippi Court Improvement Program, and the QIC-ITCT judicial consultants conducted a webinar for judges and attorneys in Mississippi on the practices and services essential to reunification or adoption.
- *A Guide to Implementing the Safe Babies Court Team Approach*: This downloadable guide was produced by the Arkansas Safe Babies Court Team. It includes 12 chapters that cover a comprehensive list of topics important to implementing the SBCT approach. Focused on collaboration with families whose young children are in foster care and across child-serving systems, this is a community organizing tool for improving communities' response to maltreatment of infants and toddlers. The document includes forms, checklists, and examples to bring the work to life in a tangible way.
- Topical briefs in the following areas are currently in development:
    - Engaging Fathers for Improved Case Outcomes and Stronger Families
    - Identifying Parents and Children with Prenatal Alcohol Exposure: Screening Tools for Infant-Toddler Court Teams
    - Guiding Values for Working with Families Affected by Addiction
    - Opioid Use and Treatment
    - Adverse Childhood Experiences of Very Young Children and Their Parents in Court Teams
    - Transparency Among Partners and Families in The Child Welfare System
    - Ensuring Racial Equity
    - Key Considerations for Parental Assessments.

Section 3 | Program Implementation Indicators of Success

3. Program Implementation Indicators of Success

a. Program Implementation

Research reviews conducted by the National Implementation Research Network (NIRN, Frank Porter Graham Child Development Institute, University of North Carolina at Chapel Hill) resulted in the identification of four non-mutually exclusive stages of program implementation: Exploration, Installation, Initial Implementation, and Full Implementation (Fixsen, Blasé, Duda, Naoom, & Van Dyke, 2010; Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005).

Several of the demonstration sites were in the Exploration Stage of implementing an infant-toddler court team when they applied to receive support from the QIC-ITCT. The QIC-ITCT reviewed their applications and selected sites that showed readiness for implementation. The subsequent site assessment, securing of resources, and initial training provided by the QIC-ITCT characterized the Installation Stage. By the summer of 2017, those sites had moved to the Initial Implementation Stage, joining the other demonstration sites that had been at different points in the implementation stages. The Initial Implementation Stage is a learning phase in which sites are applying their new knowledge to establish and maintain system changes under the guidance and support of the QIC-ITCT.

As of September 30, 2017, several demonstration sites are either approaching or have reached the Full Implementation Stage, wherein the infant-toddler court team approach provides high quality services with positive outcomes, becomes the standard way of work, and is sustainable beyond transitions in leadership. Reaching this stage of implementation can take 5 years or more.

Safe Babies Court Team Approach Core Components

Between the baseline and follow-up evaluation visits, there has been marked overall progress across sites on several of the SBCT core components. ***Exhibit 6*** summarizes the evaluator's assessment of the status of these components for each site at the two evaluation timepoints. This assessment is 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-removal conferences and monthly family team meetings, and the foster parent intervention; mentors and extended family.

Exhibit 6. Core Components at Baseline and Follow-Up Based on Site Visits

Sites		Judicial Leadership		Local Community Coordinator		Active Court Team Focused on the Big Picture		Targeting Infants and Toddlers in Out-of-Home Care		Valuing Biological Parents		Placement and Concurrent Planning		The Foster Parent Intervention; Mentors and Extended Family		Pre-Removal Conferences and Monthly Family Team Meetings		Parent-Child Contact (Visitation)		Continuum of Behavioral Health Services		Training and Technical Assistance		Evaluation: Understanding the Impact of our Work	
County	**State**	BL	**FU**	BL	**FU**	BL	**FU**	BL	**FU**	BL	**FU**	BL	**FU**	BL	**FU**	BL	**FU**	BL	**FU**	BL	**FU**	BL	**FU**	BL	**FU**
Forrest	MS	Y	**Y**	Y	**YC**	Y	**Y**	Y	**Y**		**YC**	Y	**Y**		**P**	P	**P**	Y	**Y**	Y	**YC**	Y	**Y**	Y	**Y**
Rankin	MS	Y	**Y**	P	**P**	Y	**Y**	Y	**Y**		**Y**	Y	**Y**		**Y**	Y	**P**	Y	**Y**	Y	**P**	Y	**Y**	Y	**Y**
Polk	IA	Y	**Y**	P	**Y**	Y	**Y**	Y	**Y**		**Y**	P	**Y**		**P**	Y	**Y**	Y	**Y**	Y	**Y**	Y	**Y**	P	**P**
Honolulu	HI	Y	**Y**	P	**Y**	Y	**Y**	Y	**Y**		**Y**	Y	**Y**		**Y**	P	**P**	P	**Y**	P	**Y**	P	**Y**	N	**YC**
New Haven	CT	O	**O**	Y	**Y**	Y	**Y**	Y	**Y**		**Y**	Y	**Y**		**P**	Y	**YC**	Y	**Y**	Y	**Y**	Y	**Y**	Y	**YC**
Pinellas	FL	Y	**Y**	P	**P**	Y	**Y**	Y	**Y**		**Y**	Y	**P**		**Y**	Y	**P**	Y	**Y**	P	**YC**	P	**Y**	P	**P**
So. Okaloosa	FL	Y	**Y**	Y	**YC**	Y	**Y**	Y	**Y**		**Y**	P	**Y**		**N**	Y	**P**	Y	**Y**	Y	**Y**	P	**Y**	P	**P**
Bay	FL	Y	**Y**	Y	**Y**	P	**P**	Y	**Y**		**Y**	Y	**P**		**P**	Y	**P**	Y	**Y**	Y	**Y**	P	**YC**	Y	**Y**
Pasco	FL	Y	**Y**	Y	**Y**	Y	**YC**	Y	**Y**		**Y**	P	**YC**		**P**	P	**P**	Y	**YC**	Y	**Y**	P	**Y**	P	**Y**
Hillsborough	FL	Y	**Y**	Y	**Y**	Y	**Y**	Y	**Y**		**Y**	P	**P**		**P**	P	**P**	Y	**Y**	Y	**Y**	Y	**Y**	Y	**Y**

Key: BL = baseline; FU = follow-up
Y = yes; in place; YC = in place, with challenges; P = partially in place; N = no; not in place; O = Other:
In New Haven County, court team leadership is provided by the CWS, not the judiciary.

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. Respondents were asked, "*To what extent are the SBCT core components in place at your site?*" and the results are shown in ***Exhibit 7***.

Exhibit 7. Core Components at Baseline and Follow-Up Based on Web Survey Responses

Are the following components in place in your community?	Baseline (n = 214)						Follow-Up (n = 136)					
	Yes		No		NA or DK		Yes		No		NA or DK	
	#	%	#	%	#	%	#	%	#	%	#	%
Judicial leadership and judiciary commitment to the infant-toddler court team are present.	182	85%	28	13%	4	2%	115	85%	17	13%	4	3%
A community coordinator facilitates collaboration across agencies.	174	81%	37	17%	3	1%	107	79%	26	19%	3	2%
A collaborative court team is focused on the big picture (e.g. local policy that supports or hinders best practices in child welfare; available services; gaps in services).	156	73%	51	24%	7	3%	107	79%	25	18%	4	3%
Pre-removal conferences are held prior to the child being placed in foster care to introduce the infant-toddler court team and inform parents of goals.	n/a*						50	37%	45	33%	40	30%
Family team case meetings are held monthly to review all open infant-toddler court team cases.	143	67%	42	20%	29	14%	108	79%	17	13%	11	8%
Infant-toddler court team stakeholder meetings are held monthly to support its implementation and sustainability.	154	72%	33	15%	26	12%	112	82%	14	10%	10	7%
Comprehensive developmental, medical, and mental health services for the child are incorporated into the case plan.	n/a						97	71%	24	18%	15	11%
Parents receive comprehensive medical and mental health assessments to evaluate and treat their own trauma history.	n/a						83	61%	37	27%	16	12%
The number of placement changes for infants and toddlers is limited (ideally, to fewer than 2 placement changes).	106	50%	65	30%	43	20%	89	65%	29	21%	18	13%
Concurrent planning simultaneously pursues permanency Plan A (usually reunification) and Plan B (kinship care or adoption) from the start of the case.	138	64%	48	22%	28	13%	100	74%	21	15%	15	11%
Foster parents receive training and support before and while they are engaged with a child and his/her family.	n/a						63	46%	35	26%	38	28%

Are the following components in place in your community?	Baseline (n = 214)						Follow-Up (n = 136)					
	Yes		No		NA or DK		Yes		No		NA or DK	
	#	%	#	%	#	%	#	%	#	%	#	%
Court hearings are held monthly to review the infant-toddler court cases.	159	74%	31	14%	24	11%	100	74%	21	15%	15	11%
Parent-child contact (visitation) is recommended to occur more frequently for infant-toddler court team cases than for typical dependency court cases.**	56	26%	107	50%	51	24%	115	85%	12	9%	9	7%
A policy is in place to increase parent/child visitation toward goal of daily contact.	87	41%	79	37%	48	22%	70	51%	34	25%	32	24%
Regular medical care is provided for infants and toddlers in foster care.	178	83%	16	7%	20	9%	107	79%	11	8%	18	13%
Regular developmental screening is provided for infants and toddlers in foster care.	161	75%	32	15%	21	10%	103	76%	17	13%	16	12%
There is availability of child-focused services for physical health, development, and mental health needs.	164	77%	41	19%	9	4%	107	79%	18	13%	11	8%
Evidence-based practices are in place for parents.	143	67%	54	25%	16	8%	93	68%	28	21%	15	11%
Evidence-based practices are in place for children.	n/a						107	79%	18	13%	11	8%
Training, technical assistance, and resources to support the infant-toddler court team stakeholders and team members are available on an ongoing basis.	135	63%	56	26%	22	10%	100	74%	22	16%	14	10%

*Items listed as "not applicable" at baseline were ones added for the follow-up survey only.

**Due to a difference in sentence structure and wording, this item's counts and percentages are not comparable between timepoints. However, results at each timepoint can be interpreted individually.

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 (83%) and the presence of judicial commitment and leadership (85%). The component least likely to be in place at baseline was parent-child contact being ordered to occur daily, with 50% of respondents reporting it was not in place at their site.

According to the Web survey, the biggest reported improvements in core components between baseline and follow-up were that family team case meetings were held monthly to review all open infant-toddler court team cases (from 67% in place at baseline to 79% in place at follow-up), that the number of placement changes for infants and toddlers was limited to fewer than two placement changes (from 50% in place at baseline to 65% in place at follow-up), and that training, technical assistance, and resources to support stakeholders and team member were available on an ongoing basis (from 63% in place at baseline to 74% in place at follow-up).

At follow-up, the component reported to need the most work moving forward was holding pre-removal conferences prior to the child being placed in foster care to introduce the infant-toddler court team and inform parents of goals (only 37% of stakeholders reported this to be in place, while another 33% reported that it was not in place at their site). The components most often reported to be in place at follow-up were judicial leadership (85%) and parent-child contact (visitation occurring more frequently for infant-toddler court team cases than for typical dependency court cases, 85%).

Evaluation Questions

To answer the evaluation research questions defined in ***Section 1***, 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. The section presents 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?"

Infant-toddler court team members and stakeholders noted several factors and strategies associated with developing and maintaining successful partnerships and collaborative efforts.

Judicial Leadership. Strong judicial leadership was a key factor identified by stakeholders at most sites. Many stakeholders indicated that not only was judicial leadership necessary for successful partnerships and collaboration in general, it was also a necessary component in the implementation of the Safe Babies Court Team approach.

> *"Judicial leadership was the first thing that was in place on our team. Without* [the judge] *this wouldn't be where it is today."*
>
> *"*[The judge] *is on board with the components of the SBCT. He is supportive and leads in terms of the principles of—the trauma-informed component of how a courtroom should be handled, the importance of respect and safety for the family and all those pieces. He does a nice job of leading that."*
>
> *"The judge's leadership has been a big influence on successful partnerships and collaboration. She is a great convener and brings people together. Trying to work on some of these relationships has been important in getting people to want to participate and work with us."*

The judges and other stakeholders acknowledged the importance of a judge's role in bringing the team together. One judge indicated that his primary responsibility is "*convening and running the SBCT.*"

Strong judicial leadership was also cited by many interviewees as the reason for the size and diversity of stakeholder groups. For some sites, judges have leveraged other initiatives they are involved in to help grow and diversify stakeholder groups. Evaluators also observed several SBCT stakeholder meetings during which judges actively participated and engaged stakeholders before, during and after meetings.

A Strong Community Coordinator. It is not surprising that a community coordinator actively working to engage the community was identified as a key factor in terms of successful partnerships and collaborative efforts. As a core component of the SBCT approach, the community coordinator serves as a central team leader who facilitates collaboration among the court system, child welfare agencies, and community service providers to create a continuum of services for infants, toddlers, and their families. This core component is in place at most of the demonstration sites, and the role of the community coordinator in facilitating collaboration was acknowledged by multiple stakeholders.

> *"The community coordinator has been doing phenomenal work coordinating, bringing people to the table, making referrals, working with managers, supporting the team. She has been able to develop relations from prevention to tertiary services, trying to figure out the needs. She has brought presenters to our monthly meeting promoting collaboration and use of services to meet the families' needs."*
>
> *"She has been a very powerful force in reaching out to the community and recognizing 'oh—why don't we bring this team in to educate. Look—they work with children this age.' She has done a terrific job on some of the stakeholder education programs we have going. We are always getting new information. I consider that excellent."*
>
> *"Relations are key, you need the community coordinator that has relations across agencies and people committed, that it is not negotiable. We are all invested, reaching out to community stakeholders. The community coordinator has the personality and drive, people are kept informed on the outcomes so they continue to be invested in the partnership, and they want to see children better prepared to begin kindergarten. They have an investment and share concern on this population."*

Evaluator observations of family team meetings and stakeholder meetings also supported the key importance of the community coordinator. At several sites, the community coordinator facilitated the family team meetings, during which she would actively engage parents and service providers in productive and sometimes difficult discussions. The community coordinator also organizes and facilitates the stakeholder meetings at several sites. Evaluators observed community coordinators' connection to stakeholders; many would greet stakeholders before the meeting and talk with several after the meeting as well.

Informed Stakeholders and a Court Team that Values the Approach. Buy-in from stakeholders, particularly those with decision-making power, such as the judge and the senior management of agencies was noted by several interviewees as critical to the success of partnerships and collaborative efforts to implement or sustain the infant-toddler court team.

> "[The] *buy-in from judicial leadership, buy-in from agency heads, and a belief that getting in early makes a difference: I would say that's what led to our success so far."*
>
> *"The program is blessed by the state, the governor, the commissioner of* [the CWA]*, so you need those levels supporting."*

Knowledge and buy-in as a key factor in terms of successful collaboration is also clear from interviewee comments about the collapse of the system in the absence of knowledge and buy-in. In addition, knowledge and buy-in were noted as not only important for collaboration, but also to realize and sustain the full potential of the SBCT approach.

> *"Until the top people—the top levels—at the top agencies get trained, and comprehend and want to see this program succeed and sustain—because I believe the model* [the SBCT approach] *is a top-down model. If the folks at the top are on the board and see the value—and how it helps and what it does. Not just here at this site but look at the research that shows this actually makes some kind of difference—maybe not with this family but with future kids—that they don't come into the system. At some point, it is shifting a belief system. And that is not something that is done quickly, lightly, or easily."*

Over the course of the project, stakeholders and infant-toddler court team members became more informed on core SBCT topics such as trauma, infant mental health, attachment, and child development, among others via the training provided by the QIC-ITCT. The goal of this training and technical assistance was to strengthen professional development; create a shared knowledge base across professionals on issues related to early child development, the impact of trauma, and effective interventions; and support changes in roles and behaviors of the court team during court hearings. Being well-informed about topics relating to the child welfare system and having a common understanding of issues associated with these topics has facilitated collaboration and communication at several sites. Stakeholder education and training on these topics leads to a well-informed court team that recognizes the value of the approach.

> *"The infant-toddler court teams are respected and credible, not just by the court, but by the lawyers. They have established trust and rapport. Attorneys are glad when their clients get this opportunity. It becomes less contentious."*
>
> *"In the context of death penalty cases you can't defend someone unless you are death qualified. You have to be an expert in this kind of law and know how to do it. I don't know that child welfare cases are any different. If you are going to be a lawyer for pre-verbal kids maybe you should have special training too. That's my thought about it. I think it makes a difference if everyone buys into the idea."*
>
> *"All of the division heads in* [the area] *have bought into…the concept of early childhood court. We know that the child's brain and what they see and trauma from early age stays with them throughout their life."*

Dedicated and Passionate Team Members. Several sites indicated that having dedicated team members who are regularly involved in infant-toddler court team cases has a positive effect on the cohesiveness of the team, including their collaboration, communication, accountability, and trust.

> *"At the regular meetings, most of the time the same people show up and they develop collegial relationships that make it easier to communicate, exchange information and work together. There is a familiarity that makes the work easier—when you know someone, and you've worked with someone for the last 6 months, versus working with someone who just got hired and you have to understand the best way to interact with them, etc. That familiarity is perpetuated by the monthly meetings and the monthly court hearings."*

> "[It's an advantage to have] *the same case manager for all* [infant-toddler court] *cases. Having specific therapists, having a small team, familiar people, and consistency* [all] *leads to better communication."*
>
> *"We are a team. When we sit down at the table and everyone knows everyone, we understand our roles. We listen to each other. If I'm interpreting something one way,* [for example] *the CPP provider can confirm or correct the information."*

Interviewees across sites also pointed to infant-toddler court team members' shared passion and commitment toward young children and their families as a significant factor in the teams' successful collaboration.

Clear Communication. One factor related to successful partnerships that was noted across all sites was open and frequent communication. Infant-toddler court team members reported having an increased level of contact through monthly court hearings, family team meetings, stakeholder meetings, and workgroup meetings, as well as regular e-mail contact and phone calls. They shared that this regular and frequent communication enabled team members to get to know one another, which has increased everyone's comfort level and facilitated more direct and honest communication. The frequency of contact and familiarity with one another has also increased individuals' sense of accountability.

> *"One thing I always notice—all the providers, our team, know each other really well and know our cases. It almost creates less work because we are always communicating with each other."*
>
> *"I think we have a tremendous system of communication. We communicate via e-mail, phone, text message, and pigeon, anything we need to do in order to get what we need for these families. We are available for one another constantly. I think that is a really big benefit to the collaboration. We work really well together. We have a good relationship with one another."*
>
> *"Being compassionate. Understand other perspectives. People need to feel like they are supported and listened to and if they don't it's not going to work."*

A Supportive Court Improvement Program (CIP). The CIP has been a strong factor in successful collaboration at several sites. The CIP has provided training, consultation, support, and another avenue to collaborate across sites. Court team members benefit from conference calls in which circuits can report on their progress and share successes, information dissemination via e-mail, and opportunities for multidisciplinary training and funding. One interviewee said the following about their CIP:

> *"We also have the support of the CIP team. They have been instrumental in bringing up suggestions and pulling people in. You know a stool has three legs. CIP is like the hidden leg. You see the court, have a judge; but without CIP doing a lot of the backup stuff this would be really difficult.* [The CIP was] *helping find and get resources.* [They are] *very much active and involved."*

Web survey respondents were asked, "To what extent has your own agency facilitated your participation in the infant-toddler court team approach?" Results are shown in ***Exhibit 8***.

At baseline, the agency contributions most often reported by survey respondents included providing support for stakeholders to schedule and attend meetings (75%) and approving time needed for infant-toddler court team activities like court hearings and family team meetings (67%). The efforts least cited were providing support for reduced caseloads and hiring staff dedicated to serve on the court team, which were both reported to be in place by 35% of respondents.

According to the Web survey, the biggest reported improvement in the form of support provided by agencies was in the identification of staff's core training needs (e.g., early childhood development, infant mental health, CPP, trauma-informed care, the SBCT approach). The percentage of respondents who cited this as "in place" rose from 52% to 56% and the responses of "no, it was not in place," fell from 35% at baseline to 23% at follow-up.

At follow-up, the agency contribution that was reported to be in place the least was providing funding for reduced caseloads for court team members (reported in place by only 32% of respondents). Similar to the baseline results, agencies providing support for stakeholders to schedule and attend meetings was most often cited as in place (77%).

An indication that several sites were still in the beginning stages of their intervention implementation, even at the time of the follow-up assessment, is the high proportion of "don't know/not applicable" responses to this question, a lack of awareness that may be due to gaps in communication among court team members.

Exhibit 8. Agency Efforts to Facilitate Participation

Has your own agency done any of the following to facilitate staff participation or to help the infant-toddler court team?	Baseline (n = 211)						Follow-Up (n = 134)					
	Yes		No		NA or DK		Yes		No		NA or DK	
	#	%	#	%	#	%	#	%	#	%	#	%
Provided support for the infant-toddler court's stakeholders and team members to schedule and attend meetings.	159	75%	38	18%	14	7%	102	77%	16	12%	15	11%
Provided support (either through funding or administrative decision) for reduced caseloads for infant-toddler court team members.	74	35%	76	36%	61	29%	43	32%	39	29%	52	39%
Approved time needed for infant-toddler court activities (hearings, monthly court team meetings).	140	67%	35	17%	35	17%	94	70%	14	10%	26	19%
Re-allocated roles and responsibilities to focus on infants and toddlers.	97	46%	68	32%	45	21%	61	46%	36	27%	37	28%
Hired staff dedicated to serve on the infant-toddler court team.	83	39%	80	38%	48	23%	52	39%	45	34%	37	28%
Conducted regular reviews to assure that policy and effective practice components of the infant-toddler court initiative are congruent (e.g., caseworker time to support frequent visitation aligned with daily visitation policy).	73	35%	76	36%	62	29%	50	37%	35	26%	49	37%

Has your own agency done any of the following to facilitate staff participation or to help the infant-toddler court team?	Baseline (n = 211)						Follow-Up (n = 134)					
	Yes		No		NA or DK		Yes		No		NA or DK	
	#	%	#	%	#	%	#	%	#	%	#	%
Identified staff's core training needs (early childhood development, infant mental health, CPP, trauma-informed care, Court Team approach).	110	52%	74	35%	27	13%	75	56%	31	23%	28	21%
Provided services (treatment or other)	120	57%	49	23%	41	20%	79	59%	17	13%	38	28%

In response to evaluation question 1, 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. The majority of Web respondents indicated that their agencies provided support for collaboration to schedule and attend meetings. Other influential factors noted across sites included stakeholders' passion and buy-in, engaging in frequent communication, having dedicated, stable infant-toddler court team members, and receiving the support of the state 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?"

Positive changes in practice in terms of policies, programs, and stakeholders were identified during site visit interviews and observations of court hearings, family team meetings, and stakeholder meetings.

Policies and Procedures

Positive changes in policies and procedures have occurred at each site; this is reflected in interviewee comments as well as Web survey responses. In Florida, efforts to support the Early Childhood Courts (ECCs) have culminated in a draft of the "State of Florida Early Childhood Court Best Practice Standards" and a bill to be presented in the next state legislative session to support the current ECC sites, which will include funding for 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. Not surprisingly, across sites many of the changes in policies or procedures are related to core components of the SBCT approach being put in place. Some of the most noteworthy changes are related to court hearings, meetings, parent-child contact, earlier referral to services, and training.

Preparation for Court Hearings. Not only are hearings being conducted more frequently, but many court teams have developed or modified the way they prepare for court hearings. For example, one infant-toddler court team has institutionalized meetings a week in advance of the court hearings to review files. The team created a "cheat sheet" for each file that summarizes the basic information about the family and the court team professionals involved. In addition, a CPS report form was developed that identifies the child as a 0- to 3-year-old child, and the largest section is on child well-being with observations about the quality of the parent-child relationship. The CPS form includes a listing on dates of all parent-child contact and services received. In addition, access for attorneys to court reports was changed, allowing attorneys to review critical information before hearings.

One community coordinator meets with the judge and lawyers (parents' attorneys and state) about 30 minutes before court to have a candid discussion about what was discussed at the family team meeting. This provides the attorneys, who do not attend the family team meeting at that site, the opportunity to hear what transpired, helps to avoid the possibility of surprises during the court hearing, and gives them time to prepare how to address an issue. A similar pre-court meeting was established by another site because of scheduling difficulties. This informal pre-court meeting is held in the courtroom immediately preceding the case review hearing. Court team members, including attorneys but excluding the judge and the parents, use this time to review topics that will be addressed before the judge. Another site holds a series of case staffings prior to hearings. Case staffings include the judge, professionals, and staff involved with the family, but the family members, themselves, do not attend. They occur 30 minutes before the hearings, are led by the judge, and designed to provide any new updates, challenges, or successes. Family team meetings also serve as an opportunity to prepare for court hearings; these will be discussed in more detail later.

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. The ECCs in Florida have a final draft of the Early Childhood Court Best Practice Standards that stipulates the frequency of status hearings (at least every month), in addition to other court-related policies, such as having the ECC judge maintain a regular and separate ECC docket that has families appear before the same judge throughout their participation in the court.

> "Monthly court hearings and/or family team meetings expedited progress and intercepted potential problems far more quickly than had been the case when court involvement was limited to hearings every three to six months—or less" (ZERO TO THREE, 2017a, p. 12).
>
> "ASFA [the Adoption and Safe Families Act] requires that the status of each child in out-of-home care be reviewed at least once every 6 months by either a court or an administrative review [1 1 42 U.S.C. § 675(5)(B) (2015)]. In addition, under ASFA, a permanency planning hearing must, at a minimum, be held within 12 months of the date the child entered care and every 12 months thereafter to review and approve the permanency plan for the child" (Child Welfare Information Gateway, 2016, p. 2).

While ASFA 1997 (P.L. 105-89) established a minimum of one hearing every 6 months, the SBCT approach promotes monthly hearings as a mechanism to support close judicial oversight of the progress and challenges of each case. 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 less than 2 months after the previous one (***Exhibit 9***). 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 more. Even at sites without active judicial leadership (sites in Connecticut), the infant-toddler court team made a constant effort to have frequent hearings, with close to half of hearings occurring within 1 to 2 months. The few hearings that occurred more than 6 months after the previous one (5.8%) were in Connecticut and Forrest County, Mississippi. Parent attendance at court hearings was very high. Of the 675 hearings with information about parents' presence, 85.8% indicated that at least one parent attended the hearing.

Family Team Meetings. Most demonstration sites now have monthly family team meetings in place. At one site, during a monthly review of CQI indicators that included frequency of family team meetings, the judge realized that these meetings had a lower than expected frequency. The judge court-ordered monthly family team meetings, which prompted the change of the child welfare agency

regulations to establish monthly family team meetings. The ECCs in Florida have formally included in their policy draft conducting monthly family team meetings, as evidenced in their ECC standards documentation.

> "The PRC [Pre-Removal Conference] sets the tone for the FTMs [family team meetings] that occur monthly. The SBCT Community Coordinator or a trained facilitator lead these gatherings of the team of service providers, attorneys, and child welfare agency staff working with individual families to review the family's progress. **Parents and their chosen circle of support are key participants in these meetings.** FTM provide a forum for the parents and others at the meeting to develop a shared plan of action that everyone commits to seeing through. This monitoring process in and of itself can help prevent very young children from falling through the cracks and ensure that the services they are receiving are addressing identified needs. FTM's take place outside of the courtroom and the judge learns about the family team's recommendations during the court hearing" (ZERO TO THREE, 2016, p. 12).

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 (***Exhibit 10***). Across QIC-ITCT sites, 42.5% of family team meetings occurred at least a 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 more. In Forrest County, family team meetings were occurring in intervals of 3 to 6 months before the site transitioned to monthly family team meetings. Parent attendance at family team meetings was very high. Of 609 family team meetings with information about parents' presence, 88.7% indicated that at least one parent attended the meeting. Only one site, Pinellas County, Florida, is not included in ***Exhibit 10***. Although Pinellas County holds court and family team meetings every 2 weeks for infant-toddler court team cases, with parents attending family team meetings at least once per month, no data about family team meetings had been entered in the SBCT dataset for this site's cases. As described in the introduction, this site was recently able to obtain funding for a full-time community coordinator position, replacing the 10 hour-per-week position previously in place.

Exhibit 9. Frequency of Court Hearings and Presence of Birth Parents

	QIC-ITCT Sites**																	
	Total QIC-ITCT Sites N = 251		Bay N = 17		Forrest N = 51		Milford N = 45		New Haven N = 30		Pasco N = 12		Polk N = 22		Rankin N = 12		South Okaloosa N = 26	
Court Hearing	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Time between Hearings																		
*Total Number of Court Hearings**	**872**		104		207		146		104		104		97		57		53	
Within 1 month or less	**324**	37.2	73	70.2	63	30.4	33	22.6	18	17.3	56	53.9	9	9.3	46	80.7	26	49.1
Within 1 to 2 months	**312**	35.8	28	26.9	85	41.1	48	32.9	30	28.9	41	39.4	45	46.4	10	17.5	25	47.2
Within 2 to 3 months	**100**	11.5	3	2.9	26	12.6	19	13.0	8	7.7	6	5.8	35	36.1	1	1.8	2	3.8
Within 3 to 6 months	**89**	9.7	0	0.0	29	14.0	31	21.2	16	15.4	1	1.0	8	8.3	0	0.0	0	0.0
More than 6 months since previous one	**51**	5.8	0	0.0	4	1.9	15	10.3	32	30.8	0	0.0	0	0.0	0	0.0	0	0.0
Presence of Birth Parents																		
Total number of hearings with information on parents	**675**		53		198		137		86		44		89		57		11	
Parent present	**579**	85.8	45	84.9	168	84.9	133	97.1	75	87.2	35	79.6	87	97.8	40	70.2	8	72.7

* This exhibit only includes time periods that there is a subsequent hearing to allow estimating the time between two hearings. The total number of hearings is larger than the N reported for this analysis as cases with only one hearing reported were excluded from these analyses.

** Pinellas is not included due to missing data. Pinellas holds court every 2 weeks for infant-toddler court. Families attend at least one time per month, more frequently if necessary.

Exhibit 10. Frequency of Family Team Meetings and Presence of Birth Parents

Frequency of Family Team Meetings and Presence of Birth Parents	QIC-ITCT Sites**																	
	Total QIC-ITCT Sites N = 251		Bay N = 17		Forrest N = 51		Milford N = 45		New Haven N = 30		Pasco N = 12		Polk N = 22		Rankin N = 12		South Okaloosa N = 26	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Time between Family Team Meetings (FTMs)																		
*Total number of FTMs**	***765***		89		88		252		108		72		43		35		78	
Within 1 month or less	**325**	**42.5**	62	69.7	9	10.2	134	53.2	35	32.4	36	50.0	7	16.3	9	25.7	33	42.3
Within 1 to 2 months	**282**	**36.9**	23	25.8	16	18.2	98	38.9	48	44.4	31	43.1	13	30.2	17	48.6	36	46.2
Within 2 to 3 months	**93**	**12.2**	2	2.3	34	38.6	14	5.6	12	11.1	3	4.2	19	44.2	8	22.9	1	1.3
Within 3 to 6 months	**52**	**6.8**	0	0.0	27	30.7	4	1.6	13	12.0	2	2.8	4	9.3	1	2.9	1	1.3
Over 6 months of previous one	**13**	**1.7**	2	2.3	2	2.3	2	0.8	0	0.0	0	0.0	0	0.0	0	0.0	7	9.0
Presence of Birth Parents																		
Total number of FTMs with information on parents	***609***		39		70		235		106		37		42		30		50	
Parent present	**540**	**88.7**	35	89.7	69	98.6	219	93.2	83	78.3	28	75.7	41	97.6	27	90.0	38	76.0

* This exhibit only includes time periods that there is a subsequent FTM to allow estimating the time between two FTMs. The total number of FTMs is larger than the N reported for this analysis as cases with only one FTM reported were excluded from these analyses.

** Pinellas is not included due to missing data. FTMs are held every 2 weeks by staff, with parents attending at least once per month. Parents' needs are addressed in these meetings once a month, or if needed every 2 weeks.

Pre-Removal Conferences. A newer addition to the infant-toddler court and one not yet implemented at all sites is the pre-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-removal conferences. This conference is held prior to the child being placed in foster care 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. These conferences can provide an opportunity for the parent to be involved in the decision-making process in terms of their child's placement. One demonstration site has institutionalized pre-removal conferences as standard practice; interviewees commented on how valuable these conferences are to establishing a relationship with family, facilitating clear and honest communication, and setting a strengths-based approach from the beginning:

> *"We have something called PRCs—pre-removal conferences—at the PRC—everyone tries to make it very clear—strength based for the parents involved and say this is what you're doing right. We know you love your children and we love that. We want you to reunify so that is everyone's goal, but the law requires that we have a plan B, so we have to declare we have a plan B in case something happens but everyone wants you to be with your child. I think people do a pretty good job. I've never had an issue with that. I've never had a parent come to me upset about that."*

Parent-Child Contact. The SBCT approach encourages as much parent-child contact as possible as long as there are no concerns that the visits might negatively impact the child's physical or emotional well-being. Thus, parent-child contact is recommended to occur more frequently than standard child welfare practice. Therefore, sites had to make changes to their regular operating procedures to modify both quantity and quality of parent-child visits. The SBCT approach focuses on increasing time spent together by expanding the opportunities (e.g. doctor's appointments, Part C screening) and the locations (e.g. the foster home, the birth parents' home) for parent-child contact. Examples of additional parent-child contact opportunities reported by sites include attending therapy together; using Facetime, telephone calls, letters, email, or Skype to communicate; attending birthday celebrations or extracurricular activities; and using the 2-4-2 Book Project (program created by Judge Cohen in which the caregiver and the parent have the same children's book; the parent reads the book over the phone to their child while the foster caregiver turns the pages). Some court teams have created a library and play area largely dedicated to the infant-toddler court to encourage opportunities for positive family contact while at the courthouse. Another site developed a partnership with a local center to host family contact in a family friendly environment.

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. One site has put parent activities in place that provide extra opportunities for parent-child interaction and allow parents to practice skills that they can use with their families daily. Another site uses specialized visitation services that offer a continuum of family time programs, including therapeutic family time. Several sites received the Guided Interaction for Family Time or GIFT training from the QIC-ITCT, a support highly valued by stakeholders across sites.

"Training on infant metal health issues has been huge, the training on the GIFT it is phenomenal, staff that were there have been talking so much, the part on what is quality visitation, what should happen and what you should observe and report back to court, it was the best training they ever had."

"I have seen the practice improve with QIC-CT trainings. Training from QIC has probably been the best thing we have gotten across all of these years. The GIFT training [big smile] …my people took a lot out of that one. They are now sitting in and observing, and their documentation now goes over attachment and bonding, so I can see it is being used. The quality of the court report has improved tremendously in terms of the parent-child relationship and they understand child development at a new level, understanding how much the child should need to progress, and connecting with the right services providers. Caseworkers are showing commitment to get those early intervention services."

"Very young children become attached to their parents whether the parents are able to provide consistent loving care or not. While the quality of that attachment may be insecure or even disorganized, separating a young child from his parents is still painful. The goal of parent-child contact is to permit the child and parent to keep the other a living presence in their lives and to improve the parent's responsiveness to the child's needs" (ZERO TO THREE, 2016, p. 12).

"It is the job of the SBCT family team to create an individualized visitation plan that meets parents and children where they are and is designed to provide the level of contact and support, ranging from relatively light supervision up to intensive mental health interventions."

"When there has been serious physical or emotional abuse, parent-child contact should proceed only under the care of an experienced mental health clinician who can judge whether contact is beneficial for the child. In these instances, parent-child contact can further damage the child. If visits occur at all, they should be limited to those that are deemed appropriate for the child and can be supervised by this clinician as part of an overall treatment approach for the child. If the parent is able to become consistently nurturing and to assure the child that this is so, more relaxed supervision and more frequent visits can begin" (ZERO TO THREE, 2016, p. 13).

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. Thus, ***Exhibit 11*** presents data on the most recent visitation plans available. 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. The weekly frequency of parent-child contact is in contrast with policy across states. Based on a survey of states nationwide, of the 40 states with policies on frequency of parent-child contact, only 1 (2.5%) requires daily contact and 12 (30.0%) require parent-child contact at least once a week (Child Trends and ZERO TO THREE, 2013).

Exhibit 11. Most Recent Plan for Parent-Child Contact (Recommended) and Actual Contact

Most Recent Parent-Child Contact Recommended and Actual	QIC-ITCT Sites										
	Total QIC-ITCT Sites N = 251* %	Bay N = 17 %	Forrest N = 51 %	Honolulu N = 18 %	Milford N = 45 %	New Haven N = 30 %	Pasco N = 12 %	Pinellas N = 18 %	Polk N = 22 %	Rankin N = 12 %	South Okaloosa N = 26 %
Court Team Recommended Plan for Parent-Child Contact											
Total	***232***	16	48	18	44	24	12	16	21	10	23
1 or 2 per week	**25.4**	37.5	6.3	33.3	40.9	58.3	41.7	6.3	9.5	0.0	17.4
3 to 5 per week	**45.7**	43.8	72.9	16.7	36.4	25.0	33.3	68.8	42.9	10.0	60.9
Daily	**19.0**	0.0	10.4	38.9	15.9	12.5	8.3	6.3	42.9	70.0	17.4
No visitation	**5.2**	12.5	10.4	0.0	2.3	0.0	16.7	0.0	0.0	20.0	0.0
Other	**4.7**	6.3	0.0	11.1	4.6	4.2	0.0	18.8	4.8	0.0	4.4
Court Team Recommended Plan for Child- Siblings Contact											
Total	***139***	11	23	13	36	19	11	2	8	6	10
1 or 2 per week	**8.6**	9.1	0.0	15.4	13.9	15.8	0.0	0.0	12.5	0.0	0.0
3 to 5 per week	**3.6**	0.0	0.0	15.4	0.0	10.5	9.1	0.0	0.0	0.0	0.0
Daily	**56.1**	54.6	65.2	69.2	47.2	36.8	45.5	100.0	50.0	83.3	80.0
No visitation	**18.0**	9.1	17.4	0.0	19.4	31.6	27.3	0.0	25.0	16.7	10.0
Other	**13.7**	27.3	17.4	0.0	19.4	5.3	18.2	0.0	12.5	0.0	10.0
Actual Contact Parent-Child											
Total	***168***	7	24	17	44	24	6	5	21	10	10
1 or 2 per week	**25.6**	28.6	8.3	11.8	34.1	50.0	33.3	60.0	19.1	0.0	10.0
3 to 5 per week	**34.5**	42.9	58.3	17.7	31.8	29.2	33.3	0.0	33.3	10.0	70.0

Most Recent Parent-Child Contact Recommended and Actual	QIC-ITCT Sites										
	Total QIC-ITCT Sites N = 251* %	**Bay N = 17 %**	**Forrest N = 51 %**	**Honolulu N = 18 %**	**Milford N = 45 %**	**New Haven N = 30 %**	**Pasco N = 12 %**	**Pinellas N = 18 %**	**Polk N = 22 %**	**Rankin N = 12 %**	**South Okaloosa N = 26 %**
Daily	**25.6**	28.6	16.7	52.9	15.9	12.5	0.0	40.0	42.9	70.0	0.0
No visitation	**7.7**	0.0	16.7	11.8	4.6	4.2	16.7	0.0	0.0	20.0	10.0
Other	**6.6**	0.0	0.0	5.9	13.6	4.2	16.7	0.0	4.8	0.0	10.0
Supervision Parent-Child Contact											
Total	***176***	9	24	18	42	22	11	12	20	10	8
Relative	**50.6**	44.4	16.7	22.2	26.2	13.6	27.3	16.7	55.0	10.0	37.5
Foster parent	**3.4**	11.1	4.2	0.0	0.0	0.0	0.0	8.3	5.0	10.0	12.5
DHS/caseworker/CASA/ staff at visitation or inpatient	**5.1**	22.2	75.0	22.2	59.5	72.7	45.5	58.3	40.0	10.0	37.5
Other	**26.1**	22.2	0.0	0.0	7.1	4.6	9.1	8.3	0.0	10.0	0.0
Unsupervised	**14.8**	0.0	4.2	55.6	7.1	9.1	18.2	8.3	0.0	60.0	12.5

* Reported *N*s vary slightly across analyses because of missing data in some variable categories. Sites were only included if at least 10 cases were available for analysis. As a result, Hillsborough and Cherokee are not included in the data exhibits.

**Community coordinators report on all the people involved in the supervision of parent-child contact. A summary variable was produced following the following hierarchy: relative, foster parent, DHS/caseworker/CASA/staff at visitation or inpatient, other, and unsupervised. Thus, if among supervisors a relative was identified, supervision was classified as “relative." Reported Ns vary slightly across analyses because of missing data in some variable categories.

Community coordinators reported on all the people involved in the supervision of parent-child contact. A summary variable about family time supervision was produced with the following hierarchy: relative, foster parent, agency' staff (CWA; caseworker; CASA [court appointed special advocates]; visitation center; inpatient center), other, and unsupervised. For example, if a child's relative agreed to supervise visits, the supervision was classified as "relative." For more than 85% of the most recent parent-child recommended contact, supervisors were identified in the visitation plan. Half of children had parent-child contact that was supervised by relatives with or without other support (e.g., CWA, caseworker, mentor). Close to 15% of parent-child visits were recommended to be unsupervised.

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.

> *"Every case gets referrals to Early Steps for developmental screenings. That* [is] *something presented to them upon intake of the family."*
>
> *"In baby court—referrals are given right away. Compared to other cases not in baby court—baby court is the example."*
>
> *"Interventions are happening quicker, right after removal, so families can receive services. In the past* [for] *many of our cases it would be months before we saw a case* [receiving services]. *The court team provides referrals right away and that is a huge improvement."*

Some interviewees also expressed that referrals and services are more appropriate and tailored to individual families. Court teams understand the value of assessing families early to identify the most appropriate services.

> *"We like to do evaluations of parents really early, as soon as they come in. It used to take 3–6 months."*
>
> *"*[Referrals] *are faster, more appropriate, and more tailored for the families."*

Interviewees also commented that there are better procedures for follow-up in terms of services because of the high level of involvement of the court team and the discussion of services in family team meetings and court hearings.

> *"There is more follow-up on referrals. Because so many people are involved. Referral gets handed at court. Better turn around as well."*

At one site, the CWA with the support of infant-toddler court team stakeholders, created an *Early Childhood Practice Guide*. It describes the CWA's policies and practices that are used across the state, including the training of CWA supervisors in collaboration with the state's Association for Infant Mental Health. The policies outlined in the guide are consistent with the recommendations of the SBCT approach.

"The *Early Childhood Practice Guide* on policy and practice has been released and established across the state. Caseworkers are in the middle of implementing the guidelines to work with young children. One of the court team subcommittees synthesized the guide into a pocket guide and created the training. Partners wanted it to be a really reflective experience as our work is very concrete and we need the reflective component as part of our practice."

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.

For example, at one site, the community coordinator, the case management supervisor, two case managers, a kinship care supervisor, the GAL supervisor, the GAL volunteers, and two CPP therapists have attended the Brazelton Touchpoints training. This is a strengths-based approach for working with families that "combines understanding of child development with respect for the importance of key relationships in young children's lives."[8]

At another site, training and support for reflective supervision were mentioned by several interviewees as a critical element necessary to promote a better understanding of birth parents, their needs, and the type of reactions that staff may have when working with birth parents:

> *"*[There is a] *growing appreciation for the importance of regular, safe supervision, not just administrative, also clinical and reflective, especially for caseworkers, around people's reactions to parents, particularly negative reactions. You need to understand from where that is coming in yourself and what is causing that reaction that is so negative and destructive to the relationship. And see that before the parent reaches you in ways that you are pushed to the limit that someone taking your child rips a part of you, and the primitive feelings in parents get expressed. We need to understand where they come from, not condone but not villainize them when they are behaving that way. And we need to communicate so parents can maintain their dignity and capacity to communicate."*

In addition to taking advantage of trainings they have received from the QIC-ITCT, judges and court team members at some sites also coordinate their own trainings. One site reported that monthly trainings are held to address gaps in knowledge identified by the team.

> *"We have had ongoing training regarding the ZTT* [ZERO TO THREE] *programs. If we have any kind of issue we let the community coordinator know and if she can't handle it, she'll address it with her boss. We had a training yesterday regarding HIV. We wanted to be more familiar with the signs and symptoms of that."*

[8] https://www.brazeltontouchpoints.org/

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. At one site, close to half of the children involved with the infant-toddler court are not removed and families are being helped in their home. As described in the introduction, this site chose to implement court-supervised in-home cases with the goal of preventing removal. At another site, nearly all children served by the team are placed with relatives. Not only does this increase the child's connection to family, but it also appears to positively impact the stability of the placement; only a few children have been moved from their initial placement. That same site also conducts pre-removal conferences during which the child's placement is discussed. Several interviewees indicated that having pre-removal conferences and ensuring that the parent is part of the decision making is likely a factor in the high percentage of placements with family members.

> *"I think that a lot of it has to do with* [the CWA] *empowering the parents to have a say. A lot of times the parents don't feel like they have a choice. Giving the parents a say. We always say nobody knows your kids better than you do. Where do you think they'll thrive best?"*

Some sites are trying to identify an initial placement that can become a permanent placement if needed or when kin placement is not feasible. At one site, children who are aged 0 to 3 are supposed to be placed in foster-to-adopt homes, and the GAL is affirmatively asking, up front, if the placement team is making sure this is a prospective adoptive family.

> *"These are pretty stable placements. We try not to move kids around too much, especially when they are really young. We try to keep them stable because* [instability] *can be very detrimental to the child."*

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.

> *"You do not put children through multiple placements. Just placing children for convenience, those days are over.* [The child welfare agency] *knows better now."*

One site created a placement workgroup to address placement issues, and have identified foster care homes as a potential area of improvement. At that site, they have found that most of the placement changes are occurring in foster homes and the court team is thinking of ways to strengthen that area.

> *"We're seeing a lot more movement in licensed care. We're trying to figure out how we can prevent those movements. We're looking to see the type of training foster parents are receiving, what type of information are they getting, are they prepared, and are services coming with the child. That's been a common thing, the support for foster parents."*

> *"If there is going to be a removal, we do have a meeting called the placement stabilization meeting. One of the areas of focus for the placement workgroup is to move that meeting and make sure it's not happening two days before the foster parent says the child must go but to have a regular ongoing meeting that doesn't just happen when a problem arises."*

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

> *"We've talked about starting a meeting right after removal with all the team players to make sure the caregivers or foster parents have all the tools they need…like caregiver funds, and daycare and all those things. Sometimes we aren't very good at that."*

Programs

There were also several positive changes in practice related to programs, bringing new service providers to the stakeholders' court teams, as well as establishing memoranda of understanding (MOUs) and service agreements to expand the quantity and type of services available for children and their families.

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. A component of this continuum is having a clear understanding of the existing resources in the community. The community coordinator plays a key role in identifying, learning about, and reaching out to existing community resources that can benefit the children and families served by the court team. Some sites have also formed services workgroups to learn more about services in the area. Sites have identified specific programs that are being used regularly, such as the Family Intensive Treatment (FIT) Team. FIT provides targeted, intensive, team-based, family-focused, comprehensive services for parents who have issues with substance abuse and are in contact with the child welfare system. Sites have become far more aware of the range of resources available and are connecting children and family to these resources.

For some sites, key factors that contributed to revamping the continuum of mental health services were collaboration and partnerships. One site has expanded mental health services by forming a partnership with a local university. The university partner has supported this team by streamlining the assessments and using mental health interns in addition to therapists to cut back on costs.

> *"What's unique is that we have access to a university that is a huge part of the mental health process. With their help, we've been able to get parents and children evaluations much quicker than regular cases."*

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 QIC-ITCT recommends the use of evidence-based and evidence-informed practices that are:

- Supported by evidence of efficacy and a strong theory of change with infants, toddlers, and families in the child welfare system
- Guided by elements of early development and attachment between young children and parents/caregivers
- Informed by family, community, and professional values.

The primary evidence-based intervention used with infant-toddler court cases is Child Parent Psychotherapy (CPP). 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. A central goal of CPP is to support and strengthen the parent-child relationship. CPP assists parents in understanding how to best help their young children feel safe and secure. It helps parents learn that "behavior has meaning" and with that understanding, help their children name and cope with strong feelings (Lieberman & Van Horn, 2005, 2008). 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.

> *"CPP services are remarkable. I think when the infant mental health specialist does appear in court she brings a different view—it is the child's view, more so than the parent's view. She brings that child mindset to the equation and that helps a lot."*
>
> *"We have an outstanding CPP program here. Our therapists are top notch. They come to our table every staffing. I wish it was something that was available for all families. I've had so many of our parents that will stand up and say how much they appreciate what that has provided."*

The training provided to sites on EBPs for infants and toddlers has also supported the sites' efforts to expand the network of providers to offer Child First, Circle of Security, Triple P, Structured Decision Making, Nurturing Parent, Parent-Child Interaction Therapy (PCIT), Dyadic Developmental Psychotherapy, Healthy Families America, Healthy Steps, Parents As Teachers, Period of Purple Crying, SafeCare, and Step-by-Step Parenting.

There is also an increased focus on customization of services at many sites. With more knowledge of the challenges faced by the children and families they work with as well as the available resources, sites have an understanding that one size does not fit all, and are putting more effort into creating customized plans.

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. Several sites use the 2-4-2 Book Project already mentioned, as well as Ice Breakers, which are conducted between foster parents and biological parents to build and strengthen

the coparenting relationship. In addition to continuing with the court team-facilitated Ice Breakers between all caregivers (relative, non-relative, licensed foster care) and birth parents, one site is expanding Ice Breakers as a standard practice in the case plan with the goal to continually facilitate the healthy interaction and sharing of information about the child.

One infant-toddler court team developed an infant-toddler court team newsletter for parents. The newsletter provides dates of related infant-toddler court team programs such as family team meetings, court hearings, Circle of Security sessions, and classes. They also contain information about upcoming events and a positive parenting tip of the month, which is generally about child development milestones. Another site has incorporated three parent support programs into the stakeholder team to address parents' basic needs: financial, housing, and nutrition.

One court team hosts a monthly family-focused event on the same day as court hearings during the lunch hour. This consists of a hot lunch, a parent-related activity, and parent/child time. They are designed to transfer knowledge to practice in the form of parenting classes, and to provide an additional visit for parents and their children. This site is working to make sure that parents are not just attending but that they are learning and applying what they have learned. Most interviewees spoke highly of the parent activities. One interviewee talked about the history of this event:

> *"We have these parenting classes that they are going to, but why not make a focus, every month, about something that we think is important for them to learn, whether it's dental hygiene or healthy snacks or how to read to your child. That's how it evolved, from our parenting classes…there are actual groups that come in and help us and do presentations."*

At one site, the infant-toddler court team works with an organization that provides mentoring and support for fathers. There is active and consistent support from other agencies for the mentoring program with the recognition that fathers, as much as mothers, need to develop parenting skills and learn to take care of their infants and young children.

Some sites are working toward Implementation of the Quality Parenting Initiative. This is an initiative created by the Youth Law Center, a "public interest law firm that works to protect children in the nation's foster care and justice systems from abuse and neglect, and to ensure that they receive the necessary support and services to become healthy and productive adults."[9] This is an approach designed to help a site develop new strategies to rebrand foster care, "not simply by changing a logo or an advertisement, but by changing the core elements underlying the brand." When these changes are implemented sites are "better able to develop communication materials and to design recruitment training and retention systems for foster parents."[10]

One site has two working groups focused on engagement—parent engagement and engaging kinship providers and caregivers with families. Some sites are creating an orientation for parents and assembling information about the child welfare system and process to help guide families through this process. For example, for one site's pre-removal conferences, the family is provided with an infant-toddler court binder that includes a calendar, infant-toddler court information, contact numbers, and space to file paperwork. The parents appear to find this helpful, as evidenced by two parents bringing their binder to the family team meeting and using it to help organize themselves.

[9] http://www.ylc.org/about-us/mission/
[10] http://www.ylc.org/our-work/action-litigation/quality-foster-care/quality-parenting-initiative/

Foster parent engagement and buy-in are also being worked on at several sites. Some court team members have met with the Foster Parent Association to share information on the infant-toddler court program, and have also shared program information while teaching foster parent classes. Interviewees reported that educating the foster care community about the infant-toddler court and specifically about the role of the foster parent will not only help foster families understand the significance of their role but hopefully encourage their buy-in as well.

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. To address this gap in support, one judge formed a subcommittee of infant-toddler court team stakeholders led by the director of foster care licensing and recruiting. The group was tasked with reviewing the available resources for licensed foster families and adapting them into a user-friendly guide for relative and non-relative caregivers (who are not licensed).

> *"We need to include what relative care families need to know about visitation, their rights, school enrollment, etc.… a lot of the stuff is said by the child protection investigators but it doesn't sink in with the family at the time of removal."*

During an observation of one of these subcommittee meetings, the subcommittee displayed a mock resource Web site with links to different classifications of resources including cash, Medicaid, food stamps (Supplemental Nutrition Assistance Program, SNAP), medical/birth certificate, school registration and childcare, and others. The subcommittee members discussed the fit of the categories for their audience, the timing and logistics of disseminating this information, and the need for a hardcopy counterpart for older caregivers who may have difficulty navigating the Internet.

Some sites plan to develop and implement birth parent/foster parent coparenting classes, pre-service and in-service training for foster parents, and foster parent training in infant/toddler development, attachment, trauma, impact of transitions, loss, and grief.

> *"With the coaching program, we are working on communication between foster and birth parents, and we do encourage that. We see foster parents sending pictures, allowing telephone calls, which has improved. We have a grant on reunification and therapeutic visitation* [that] *is for all families in need of reunification across all ages."*

Stakeholders/Systems

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; 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.

The growth of the stakeholder group is not only the result of individual stakeholder's interest and commitment, but also the interest and commitment of the agencies and organizations that they represent.

In most sites, stakeholders meet at least monthly, and the meetings are used for a variety of purposes, such as to review and discuss early childhood court policies and procedures, case and system issues, community resources, as well as discuss upcoming trainings and research. In addition, many sites have created workgroups that meet regularly and target specific issues.

Continually Identifying New Stakeholders. Not only have sites developed large and diverse stakeholder groups, but they continually look to identify new stakeholders. For example, one team recognized that one of the stakeholders missing from the infant-toddler court team was a substance abuse treatment representative. One of the parents in the program was struggling with chronic substance abuse and required an intensive in-patient treatment for her addiction, a level of need the court team had not yet encountered. As a result, court team members invited representatives from the local substance abuse treatment facility to contribute to the family's case plan and participate in that case's family team meetings. One of the advantages this new partner brings is its residential treatment program "*that allows women and their infants and young children to live in a homelike setting while achieving recovery*." This organization now reserves an inpatient bed for infant-toddler court cases and is a regular attendee at monthly stakeholder meetings and family team meetings for all cases.

> *"We were worried about substance abuse needs for inpatient services. Through the collaborative discussions we brought* [the substance abuse treatment center] *to the table. They reserved one bed for inpatient, and the child can be reunified with the mother at the inpatient village."*
>
> *"The case management organization has made systems changes within their programs to engage the substance abuse community to make families with young children a priority."*

Another site is going to bring bailiffs into the stakeholder group. Since they are often the first person to interact with a parent at the courthouse the community coordinator sees the value in having them understand the program and how infant-toddler court is different. Another site has recognized the need to engage the placement team, which is currently separate from case management and their infant-toddler court.

Parents as Stakeholders. Though Valuing Biological Parents was only recently formally added as a core component, it has been a distinguishing tenet of the SBCT approach from the outset. The value placed on biological parents was reflected in interviewee comments, observations of family team meetings as well as court hearings, and Web survey responses. 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. The QIC-ITCT developed a parent survey designed to get anonymous feedback throughout the life of the case about parents' perception of the court team process. Several of the sites are using these and the QIC-ITCT was at the time of this report in the process of producing the survey's results.

> *"Within* [infant-toddler court], *we always ask parents how they see the case going and getting their feedback on things. For example, the parent who spoke about the difficultly in providing the urine analysis. From what we've heard it seems like it was a 2-hour wait for the parents. As parents were saying that, the stakeholder immediately set up a meeting to go over the process to see how they can amend that. It's all about getting feedback to improve services."*
>
> *"The court is constantly asking them what they need and what do they like* [about the program]*."*

At some sites, the court team consistently includes birth parents in forming the case plan, identifying their own goals and strategies to meet those goals, and providing regular input on their progress and challenges in court.

> *"*[Parents] *are our number one priority. We encourage them and get them linked to services. If they're…not getting what they need,* [we] *can advocate for them…to get a change."*
>
> *"Our goal is to help them reunify. And to make them part of the process if reunification isn't the way they are going. They are valued in this. Making sure all of their needs are met."*
>
> *"The birth parents are heavily involved in the collaboration with other parties throughout the case.* [They] *have time to speak in court and advocate for themselves more frequently."*
>
> *"Without the parents, we have nothing. We have to put a lot of value on the parents, because we're trying to get the kids back home. We try to get* [parents] *in to the doctor because if they are not healthy, it's hard for them to* [care for] *their child. We try to get them to get their dental* [appointments]. *Parents forget to take care of themselves."*

Foster parents and kin caregivers are increasingly being engaged as stakeholders at some sites as well. For example, the court team at one site recently invited an experienced foster parent to join the stakeholder meetings. Having a foster parent as part of the stakeholder group adds an important perspective and voice to the team, and will likely help to increase foster parent buy-in.

Stability of Court Team and Teamwork Approach. As noted earlier, many sites have a stable group of professionals for infant-toddler court team cases. In addition to the community coordinator and the judge, sites often have a dedicated agency attorney, a dedicated GAL, dedicated CASAs, dedicated CPP providers, and some also have some dedicated parent attorneys, caseworkers, early intervention providers, domestic violence advocates, and substance abuse treatment providers. This stability has positively impacted communication, collaboration, and the overall functioning of the team. Observations of court team members in action supported the idea that they take a teamwork approach to working with families.

Stability of Family Team Meetings. These meetings typically include the family and people they consider their support system (relatives, friends), community coordinator, and a team of service providers, GALs or GAL volunteers, attorneys, and child welfare agency staff. These meetings provide an opportunity to review the family's progress, needs, track the referrals made, services received, and

barriers encountered. Parents are encouraged to talk openly, and often share progress, concerns, and questions. Progress is acknowledged and praised and areas of concern as well as next steps are discussed. Family team meetings inform and empower parents, and demonstrate to the parents that there is a supportive team working to help them.

> *"Family team meetings are positive. Case management is becoming more aware of the importance of their involvement. The team meeting seems to help parents who are frustrated about the lack of progress in the case or who are nervous about the process. We learn as we go.* [The way] *people respond to parents is a lot better.* [We are] *better at addressing their needs and getting to the heart of the problem.* [We] *used to talk in circles trying to figure out what's going on and now we can do it much more quickly. Family team meetings have always been positive but have improved significantly because we have people who understand it more."*
>
> *"The family team meetings are very good. Unlike traditional staffings in dependency—they are more positive for the parents—about helping them understand what it takes to get reunified instead of being like—this is what you didn't do. You have to do x, y, z."*
>
> *"I think they are beneficial. Everything is out on the table and everyone has an input on what's going on."*

Another benefit of family team meetings is that they help prepare parents for court hearings.

> *"*[Because of the family team meetings] *parents know what to expect—what the judge will hear—that is always comforting to them."*

Stakeholders Are More Informed. Thanks to education, training, and technical assistance, stakeholders are 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.

> *"*[This approach] *has raised awareness of how the parents' trauma and actions affect the child."*
>
> *"*[One] *mother said she hadn't understood why her children were removed. She provided them shelter and food. Now she realizes the impact of her abusive relationship with the dad and how it was affecting the kids."*

> *"I think trauma-informed care education has been really beneficial. I have cases that have domestic violence and to look at that data and know—well that's how he was raised and that's normal for him unfortunately and he needs to address that. Things you wouldn't maybe think about. There has been a lot of education around the development of children and why that bond is so important. Prior to me being here—visits were a reward for parents. Not looking through the child's lens. That's what I try to focus on. But you're punishing the child."*
>
> *"I've become a lot more empathetic. Helps me understand long term—how we are trying to really address well-being on a long-term basis. It can't just be about bare minimum of safety. If we focus just on safety, we've lost the point. When we look at well-being as an indicator of success then we are on track to helping long-term the families that we're working with."*

Improved Communication and Collaboration. Interviewees at all sites indicated that collaboration and communication has improved. In Bay County, great improvements have been made in their collaboration efforts to address systemic issues as a team and embracing the SBCT approach. When the site was initiated, the team worked in silos to resolve challenges and case managers created a tense environment for parents. However, observations and interviewees confirmed that the team is now working more cohesively and has made tremendous strides to create a strengths-based and family-centered environment for families. In nearly all interviews, interviewees talked about the workgroups that were just created to address placement issues and learn more about more services in the area. For one site, the stakeholder meetings are a place where collaboration comes alive, solutions are developed, and voices are heard regardless of position. At another site, the community coordinator took the initiative to find some space at the case management office and has been working there about once a week. The proximity to case managers has increased communication about infant-toddler court cases. She has also worked hard to institute a process for being copied on all e-mails related to infant-toddler court cases. This helps her stay current in terms of any issues, and provides the opportunity for her to step in and help address issues earlier in the process.

> *"We have more involvement with the attorneys. The attorneys now are very present and vocal. They have changed the billing system and when they come to our court meeting they can bill for attending family team meetings. They want us to include them in all scheduling and they are giving their scheduling in advance so we don't have family team meetings when there is a day full of OTC* [order of temporary custody] *hearings. Attorneys are being very involved, our relationship with them is stronger, and they are advocates for the* [infant-toddler court team] *program. Attorneys call for new cases, as they want us from the beginning."*

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 an annual cross sites meeting. Interviewees indicated improvements have been made based on these cross sites meetings.

"I really like the cross sites meeting as we always learn something so it rejuvenates our program and we increase our knowledge base, it works well for us as we have seen results. I would like to see increases in team training and being able to bring a team to these meetings…to go through training together and share with other sites."

"The cross site is awesome, hearing from other states, what has worked from them helps us with other ideas. Information sharing is key for this work."

Collaboration with the CIP. As noted earlier, a supportive Court Improvement Program was identified as a factor in successful collaboration. Working with the CIP has resulted in several positive outcomes for infant-toddler court teams. For example, in the interest of promoting timely, thorough, and complete court hearings, one of the state CIPs developed bench cards for judges during dependency court hearings. These bench cards include lists of questions regarding screening and assessing relevant services for infants and toddlers. In Mississippi, the CIP representative is actively supporting the approach and promoting the expansion of infant-toddler courts across the state. The main CIP initiatives are also addressing the training needs of the infant-toddler court team, providing linkages to training on the Mississippi Youth Court Information Delivery System (MYCIDS), electronic youth court data entry, and the Indian Child Welfare Act (ICWA). They also provide support for travel expenses for judges and other stakeholders to attend the NCJFCJ Annual Conference, ICWA Conference, Interstate Compact on the Placement of Children (ICPC) Annual Conference, CIP Grantee Meeting, and the National Conference on Child Abuse and Neglect (NCCAN). The CIP also supports the Parent Representation Task Force, which provides oversight of the six counties piloting parent representation, gathers data, makes presentations to the legislature, and develops standards of practice and standardization of measures and data. The CIP plans include collecting the same data in MYCIDS that are collected through the SBCT dataset, with the goal of determining if providing parent representation leads to faster reunification or faster permanency when reunification is not appropriate, whether the length of stay in care is shortened, and whether quality family contact occurs to maintain the bond between the parent and the infant or toddler. The Mississippi CIP is also developing a "Basic Court Training for Child Protection Services" to help train frontline staff and supervisors regarding the requirements of the various youth courts in terms of written reports, testimony, and conduct in the courtroom.

Community Partnerships. 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. Bay County, Florida has developed community partnerships to help support their families' basic needs. During baseline, the infant-toddler court team was thinking about various funding opportunities that they could explore. Since then, and largely due to the efforts of the community coordinator, the court team has created partnerships with the Homeless Coalition—which is providing housing grants, Wells Fargo, Toyota, The Bird Foundation, United Way, and Florida State University. Because of their support, the team can address families' housing and financial needs as well as provide additional child development programs and activities.

> *"*[For community partnerships]*, we are telling* [supporters] *what we are doing with the funding they are giving* [to the court team]*. And we are letting them know the results. Our partners get the newsletter. Our bank partners get to see that their staff are coming to help our parents. Toyota sees that they are sponsoring a nutrition class for parents. To make that initial investment, we go out and talk about the program and explain our concept. And that goes tremendously well and we are able to retain a lot of outside groups."*

Partnerships have also helped give the program more visibility, which has led to additional support. As one interviewee reported:

> *"The* [library and play area] *project with the law school gave us more exposure and more donations came."*

To further formalize their work with the infant-toddler court team and the Honolulu Department of Human Services, the mental health team has established a memorandum of agreement (MOA) with the Department of Human Services to provide mental health services to all children involved with child welfare agencies.

> *"With the university, it's been huge. They are giving our program a priority. We have CPP and PCIT. On the regular calendar those* [EBPs] *are hard to get into. They have signed an MOA with the DHS to build the program."*

Interviewee reports and evaluators' observations indicate better practice is underway at each program site through implementation of the Safe Babies Court Team approach. Court teams are actively developing and revising policies and processes as well as identifying programs and services that align with the SBCT core components. Stakeholder groups continue to expand, receive, and promote training and education, as well as identify and tackle issues related to child welfare. Communication and collaboration has improved among the court teams as well as the larger stakeholder groups.

Web survey respondents were asked, "To what extent has the infant-toddler court team approach impacted stakeholders' and team members' practice?" and their answers are displayed in ***Exhibit 12***.

The practices reported by survey respondents as most impacted at baseline included the shared understanding of the impact of child maltreatment, trauma, and multiple placements on a child (75%), the expansion of networks and connections (75%), and the improvement in stakeholders' understanding of the needs of infants and toddlers living in foster care (75%). The least-impacted practice was the awareness of how racism affects parents' experience with the child welfare system (only 30% of respondents reported it was in place and 52% reported that it was not in place at baseline).

The greatest changes between baseline and follow-up were reported as improvements in case plans and recommendations provided during hearings (from 48% at baseline to 60% at follow-up), and in collaboration between stakeholders (from 67% at baseline to 76% at follow-up; additionally, those reporting no impact on collaboration reduced from 28% to 18%).

At follow-up, the area with the greatest need for improvement remained the awareness of how racism affects parents' experience with the child welfare system (34% in place). The greatest improvements reported at follow up were in the expansion of networks and connections (80%), in families being praised when there is progress (80%), and in communication with other agencies (78%).

Exhibit 12. Impact on Practice

Has the infant-toddler court team approach impacted stakeholders' and team members' practice at your site?	Baseline (n = 204)						Follow-Up (n = 124)					
	Yes		No		NA or DK		Yes		No		NA or DK	
	#	%	#	%	#	%	#	%	#	%	#	%
Networks and connections have been expanded.	152	75%	41	20%	11	5%	99	80%	22	18%	3	2%
Dialog has been fostered with stakeholders and team members that have divergent perspectives.	143	70%	41	20%	19	9%	96	77%	20	16%	8	6%
Communication with other agencies has improved.	145	71%	52	25%	7	3%	97	78%	21	17%	6	5%
Collaboration (working together to come up with solutions to conflicts and resolve differences between partners) has improved.	137	67%	58	28%	9	4%	94	76%	22	18%	8	6%
Practices or policies have been modified.	n/a*						62	50%	43	35%	19	15%
An understanding of the needs of infants and toddlers in foster care has improved.	153	75%	46	23%	5	2%	92	74%	22	18%	10	8%
A shared language/knowledge on attachment and infants' mental health has been created.	132	65%	62	30%	10	5%	89	72%	24	19%	11	9%
A shared understanding of the impact of child maltreatment, trauma, and placements, including multiple placements, on young children has been created.	152	75%	47	23%	5	2%	96	77%	23	19%	5	4%
There is a better understanding of parents' individual trauma history, family trauma histories, and the historical trauma influencing the community.	136	67%	63	31%	5	2%	88	71%	32	26%	4	3%
There is increased awareness of how racism affects parents' experience of the child welfare system.	61	30%	107	52%	36	18%	42	34%	53	43%	29	23%

Has the infant-toddler court team approach impacted stakeholders' and team members' practice at your site?	Baseline (n = 204)						Follow-Up (n = 124)					
	Yes		No		NA or DK		Yes		No		NA or DK	
	#	%	#	%	#	%	#	%	#	%	#	%
There are pre-removal conferences with parents, CPS, extended family, and other people that can support parents	70	34%	80	39%	53	26%	53	43%	36	29%	35	28%
Hearings occur within 24 hours of child's removal.	99	49%	45	22%	60	29%	61	49%	21	17%	42	34%
Case plans and recommendations provided during hearings by infant-toddler court members have improved.	98	48%	60	29%	46	23%	74	60%	21	17%	29	23%
There is a team work approach among the infant-toddler court team members for each family (problem solving, wrap-around approach).	138	68%	47	23%	19	9%	91	73%	28	23%	5	4%
There is a stable group of professionals for the infant-toddler court team cases.	145	71%	43	21%	16	8%	92	74%	27	22%	5	4%
Parents are key members of the team.	130	64%	54	27%	19	9%	86	69%	33	27%	5	4%
There is an improved focus on the family and their challenges/needs.	144	71%	49	24%	11	5%	95	77%	25	20%	4	3%
Families are praised when there is progress.	145	71%	28	14%	31	15%	99	80%	14	11%	11	9%
If there is limited or no progress, probable consequences of inaction are clearly explained to parents.**	110	54%	47	23%	45	22%	86	69%	20	16%	18	15%

*Items listed as "not applicable" at baseline were ones added for the follow-up survey only.

**Due to a difference in sentence structure and wording, this item's counts and percentages are not comparable between timepoints. However, results at each timepoint can be interpreted individually.

In response to evaluation question 2, interviewees and observations indicated that 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.

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 PCIT and Circle of Security. Interviewees identified multiple factors that support the implementation and sustainability of these EBPs.

Educating and Obtaining Buy-In from Stakeholders. 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. With the support of their judge, several sites have made CPP a requirement of participation in the infant-toddler court program for those in need. In Bay County, for example, for a case to be accepted into the infant-toddler court, an assessment must be completed to determine if CPP is needed. During one hearing, a court team member mentioned that CPP was missing from the case plan and motioned for it to be added. A parent attorney objected to this, stating that it was too soon in the case. The judge reminded the attorney that the case was an infant-toddler court case and having that goal was required for participation; the judge briefly explained the reasoning behind it. The parents agreed to add CPP and the attorney withdrew his objection.

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. In Bay County hearings, after introductions, the therapist began each case with a summary. Judges use the therapist's summary to guide hearings and request additional input from the court team. Not only does this engrain CPP into the infant-toddler court, but it also helped set the tone for the case, created a positive environment, and helped to center the hearings on the well-being of the child and parent. Interviewees also noted the importance of CWA buy-in for successfully implementing EBPs.

> *"For* [CPP] *to be effective it should be* [in the case plan]*."*

Incorporating EBPs, such as CPP, as a standard part of the child welfare process has been a challenge at some sites, where EBPs were not generally talked about or well-known at the CWA. For example, Forrest County interviewees shared that historically the focus has not been on understanding the type and quality of services received by families, nor on ensuring access to EBPs.

> *"If it wasn't for the SBCT program and their training, we would have no EBPs. I don't hear talk about it at* [the child welfare agency]*. It is only because of ZTT. There is no emphasis, you don't hear conversations on 'you need to refer to services providers that have EBPs.' And we are sending families to referrals all day long, but I don't hear caseworkers and supervisor taking about EBPs ever."*

Educating the infant-toddler court team on the EBPs available in the community is crucial to ensuring that they are utilized. Infant-toddler court team members' understanding, buy-in, and support of EBPs was illustrated during interviews and family team meeting observations. At family team meetings, progress in CPP and other EBPs is consistently reviewed, and parents are given the opportunity to talk about how therapy is going. One parent shared that he was "seeing a clearer

picture of what needs to get done" in his work with the psychotherapist, and that he understands that "by being firm with her [the child], I can keep her safe—and she will learn she is safe with me."

Florida interviewees also noted the need for the buy-in of community-based care organizations, as far as their willingness to train or support their staff on EBPs. This is already happening at several sites.

> *"We've had several people trained in Circle of Security in the community—because of the promotion of Circle of Security through ECC—different agencies sent staff to be trained in intervention because of the awareness of it."*

More Providers, Training, and Support. 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 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.

> *"The training for CPP was through QIC-ITCT. We had four therapists. The CPP training has been so beneficial. It's extremely limited what is offered for that age. There are very few providers working with children under 5. So, we have filled a need with the SBCT court and the clients."*

In one county, for example, there is a need for more CPP providers and additional services to support children and families. The court team has put strategies in place to address this through their services workgroup and partnership with the local community-based care organization. Through these efforts, this infant-toddler court team is hoping to bring in more CPP providers and learn about other available services in the area.

The challenges to maintain CPP providers was described by interviewees as an area that needs further work. While the support of QIC-ITCT enabled the training of providers, and a new cohort of trainees began in the summer of 2017, interviewees noted that their site is a transient area and service providers are constantly relocating to larger more urban areas.

> *"For CPP we trained 10 people, but we trained them and they left the agencies. We trained 2 people last year, and they moved to New Orleans. Other people have retired, moved to other agencies. How can you keep CPP in place?"*

Obtaining CPP training for community providers is one of the priorities identified in one site's QIC-ITCT Action Plan. In New Haven and Milford, Connecticut, a broad collaborative to support recruiting and training providers in CPP had been provided by the Connecticut Association for Infant Mental Health (CT AIMH), the CWA, Yale Child Study Center, and several child and adult mental health centers. Reflective supervision trainings are available through CT AIMH. Funding support for training in CPP has been provided through QIC-ITCT and community initiatives, including the SAMHSA-funded Project Launch. Support for CPP treatment billing is through Medicaid (Huskie) with the parent as the client.

Some interviewees 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 CWA. 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.

> *"*[CPP] *is a very demanding role for practitioners, very stressful, and burnout is a big obstacle for practitioners. If there were more money, it wouldn't stop the problems, but it would help. If there were more practitioners there would be a smaller caseload."*

Funding. 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 10 hours for each hour of clinical work (Osofsky et al., 2007). Typically, the collateral work is not a billable service.

At one site, the infant mental health specialist receives a specific amount of funding from a community-based care organization to cover a portion of the infant-toddler court services. She is also able to bill Medicaid or insurance (depending on insurance type) for the therapy she provides. These two sources of funding, however, fall significantly short of covering the wrap-around services that are being provided. This means that to maintain fidelity to the EBP, the service provider is not being paid for all the services she is providing. This is not a sustainable model, and must be addressed for the SBCT approach to successfully continue, let alone expand.

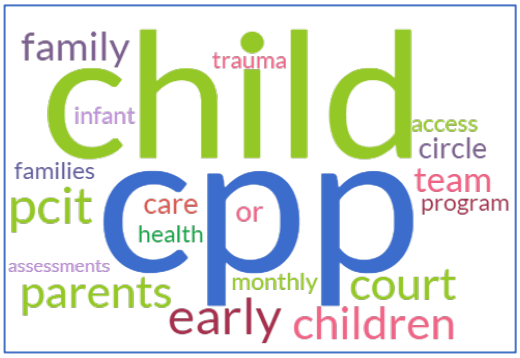
The need for additional funding beyond Medicaid was noted by interviewees at multiple sites.

> *"*[The CPP] *clinic is a* [CWA]*-enhanced clinic, their Medicaid pays for sessions, but there is no pay for collaterals. Family team meetings and court are not covered. Clinicians get the opportunity for training on CPP. They will continue to do the work. That is the mission. There is the funding from* [the CWA] *for the clinic and the fee for service."*

Collaboration and Partnerships. Collaboration and partnerships were also cited by some sites as important in supporting EBPs. At one site, successful collaboration and partnerships were identified as important for the implementation and sustainability of CPP. At baseline, the site was only implementing PCIT, which targets children 2 years of age and older, due to limited capacity and few collaborations and partnerships with university or community-based organizations. At follow-up, however, the site had added CPP to interventions offered, primarily due to a partnership with the local university. Interviewees talked about the organizational and system conditions necessary to support the implementation of EBPs, stating:

> *"Collaboration with professionals who have trainings in the EBPs or who are updated to the new modalities is important. Having strong collaborations with those people and agencies is important. You attend meetings and trainings to know what is available and find the providers who may be offering that service."*

Web survey respondents were asked, "To what extent are organizational components in place to support the evidence-based intervention selected by your site?" and their answers are summarized in ***Exhibit 13***.



Based on a word cloud (an image composed of words used in a particular text or subject, in which the size of each word indicates its frequency), most sites reported on their implementation of CPP at both baseline and follow-up.

Sixty-nine percent of survey respondents at baseline indicated that there was evidence for the intervention in the birth to three population at their site. Sixty-four percent of respondents said the site had provided training, coaching, and supervision for service providers to become proficient in the new intervention.

The biggest improvement between baseline and follow-up 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%). The component least often reported was that case workers received in-service training to facilitate screening and referral to the intervention, which dropped from 42% at baseline to 34% at follow-up). However, this component was also one that elicited 43% of respondents to answer that they did not know whether it was in place.

Exhibit 13. Components Necessary to Support Interventions

Are the following organizational components in place to support the implementation of evidence-based interventions?	Baseline (n = 200)						Follow-Up (n = 119)					
	Yes		No		NA or DK		Yes		No		NA or DK	
	#	%	#	%	#	%	#	%	#	%	#	%
Site conducted a "needs assessment" to identify gaps in the service continuum and identify training needs for intervention.	105	53%	43	22%	51	26%	63	53%	17	14%	39	33%
Site reviewed evidence and/or a rating agency's review of the evidence-based practice for the selected intervention before making the selection.	93	47%	31	16%	75	38%	62	52%	11	9%	46	39%
There is evidence for this intervention for the birth to three population.	138	69%	24	12%	37	19%	90	76%	5	4%	24	20%
Site provided support for service providers to become proficient in the new intervention (e.g. training, coaching, supervision).	128	64%	26	13%	45	23%	75	63%	15	13%	29	24%

Are the following organizational components in place to support the implementation of evidence-based interventions?	Baseline (n = 200)						Follow-Up (n = 119)					
	Yes		No		NA or DK		Yes		No		NA or DK	
	#	%	#	%	#	%	#	%	#	%	#	%
Caseworkers received in-service training to facilitate screening and referral to the intervention.	83	42%	51	26%	66	33%	40	34%	28	24%	51	43%
A family's "wait time" between the referral and initiation of intervention services is monitored for efficiency.	89	45%	34	17%	74	38%	59	50%	19	16%	41	34%

In summary, observations of and interviews with stakeholders point to several organizational and systems conditions that appear to support the implementation and sustainability of evidence-based programs. These include the education and buy-in of stakeholders—including the judge, the CWS, and the infant-toddler court team—training, funding, support for providers, and increasing collaboration and community partnerships.

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.

Frequency and Length of Hearings. Across demonstration sites, court hearings are occurring more frequently, with most sites holding hearings monthly. 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.

> *"She* [the judge] *holds us accountable for what we need to do for specific families."*
>
> *"In this group—because we are in court once a month—it is more beneficial to the parents to be in court and its like having a weekly report to make sure a kid did homework. It helps keep parents on task."*
>
> *"Baby court cases are docketed for a longer time. They are much longer and more thorough."*

Court Team Member Attendance and Participation. Another key change resulting from the implementation of the infant-toddler court team approach lies in the court team members attending hearings. Unlike court hearings in regular dependency court, infant-toddler court hearings include the community coordinator and service providers. In addition, these attendees 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.

> *"The judge is great at getting points of view and going from there. She likes to hear what the parents are doing from everyone.* [You] *don't see the same thing in other dependency cases."*
>
> *"Everything runs a bit smoother. Baby court hearings are a bit different than typical hearings. There is a decreased role of the attorney and an increased need for service providers because they will be speaking more* [at hearings]. *...Everyone knows what to expect now. It's just preparing and building their plan of what they are going to say to the court, rather than be put on the spot like it was in the beginning."*

Interviewees noted that court team members who participate in infant-toddler court hearings are more engaged than they are in regular dependency hearings.

> *"The GAL is more engaged than before with how well child is cared for and parents getting what they need."*
>
> *"In past courts, people didn't speak up as much; the current judge wants to know what the parents' and GAL's positions are. The judge is open enough that people are not afraid to talk and they respect his opinion, so that they are not too upset when he makes a different decision."*

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.

Welcoming Environment. 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.

> *"The whole system now is not so adversarial. It is more an understanding/ compassion type of court. It is gentler. I think our parents realize that too. That we aren't there to harm; we are there to help them."*
>
> *"*[At court hearings] *I think the parents are more relaxed even though we discuss some difficult things sometimes."*

Interviewees across sites described infant-toddler court hearings as more supportive of parents. Some sites indicated that a caseworker or 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.

> *"Case managers are now sitting next to families as a physical show that we are all a part of the same team. It seemed at first that it was the professionals versus the parents. Now we are one, a part of the same team and the parents are a part of that team. Not us against them."*

> *"Our team is becoming more strength focused. The court facilitator now gives an overview of parent staffings in courts…The overview makes the court space positive and strength based."*

Most sites strive to keep the court space family-friendly and strengths-focused. Several sites have created special areas for children and families. One site has a library and play area largely dedicated to the infant-toddler court to encourage opportunities for positive family contact while at the courthouse. A member of the CIP who teaches at a local university started the project with her class in response to the observed restlessness of children during court hearings. The class wanted to promote positive interactions between the parents and children. There are now two library stations filled with books and toys on the same floor as the infant-toddler court. Because these areas are in the courthouse, they were purposely decorated with children's pictures and bright colors to provide a family-friendly environment. The play area was right outside of the parent activity room that was also filled with toys and other child-related items. There are also plans to put in a playground.

> *"We wanted to encourage interaction with parents through reading and give something to do in-between hearings because the children run all over the place. We found that parents and children are using the books. And older siblings are interacting more with their younger siblings. And they are able to take a book and a toy home."*

Interviewees across sites also noted the increased focus on the child in infant-toddler court hearings.

> *"With Baby Court, we are not focusing on the major issues and belaboring* [parents]. *We are talking about the children and how are they doing. And really in-depth finding out—are they doing ok."*
>
> *"There is more inquiry into how the situation is and if there are issues in Baby Court.* [You] *could go the whole docket without* [the judge asking about the child] *in regular cases. It's more about what parents are/aren't doing, what has case management done/not done. Baby Court cases lead with the kid. How are things going with the child, if there are any issues?"*

For most QIC-ITCT sites, court hearings are an opportunity to collaborate, identify challenges, and resolve issues. Court team members' behaviors were collaborative during court hearings in respectful, attentive, and supportive ways.

> *"*[There is] *more listening, we are not fighting. It is not a battle about every service. We are working together and get on the same page quicker."*
>
> *"*[We have] *a collaborative non-adversarial approach that this whole area of law should have. They are working together. Parents and parent attorneys feel like they have a voice. They are being asked what opinion is there. Something that did not exist before."*

> *"I wish we could bring all cases into* [infant court]. *You can feel it. It's just different. No one is being judgmental. We're all there and we're hearing the same thing. And we're all telling the judge. It's a collaborative decision. It's not just the judge's decision. It's everybody's decision."*

Judges' Demeanor, Language, and Interaction. 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.

> *"*[The judge] *is asking more question now…it has changed since September. His frustration, I can see it.* [There was a] *caseworker admitting that she said to* [a child's] *mom that she will never see her child again. The judge was very upset."*
>
> *"We have a judge who is intentional about affirming the strengths of the families in court. He never lets anyone leave the courtroom without those parents knowing that he recognizes the steps they have taken. That's huge because we don't know if that's the first time they're hearing those encouraging words throughout the course of the case. He ensures that in the 0 to 3 cases the agency goes beyond a simple articulation of how things are going. What we see with this judge he goes a step further to get the agency to fully articulate what 'fine' means. Have they met their service agreement? What efforts are we making to ensure that this family is on the right path? Is there anything that we are missing?"*

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.

> *"With this type of court, we try to be cognizant of how what we're saying and how we say it is being perceived by individuals in the courtroom. This is different than other courts."*
>
> *"The judge forges relationships with clients. He doesn't just sit in his robe and hand out orders…The judge gets to know families and can help get the family on board."*
>
> *"*[The judge] *is sort of a horse of a different color—because she really takes the time on every case to find out what's going on with the children, with the parents, with the relatives, with the caregiver. It's kind of apples and oranges when you really compare* [her to other judges]*."*

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.

> *"There are a lot of things that happen in* [the judge's] *courtroom. She is very trauma informed. She wants to make sure these things are addressed. In other courts, they don't care about any trauma stuff: 'This is what you did, this is why we took your children. You didn't go to substance abuse or parenting, then obviously you don't want your children and we are going to take them.' Cut and dry, don't care what's happening. Whereas* [the judge] *wants to find out why. She looks at everything going on. Not just at the person."*
>
> *"Prior to her doing* [infant court]*, her style and demeanor were a lot different. She is now a lot more knowledgeable of the services. Her engagement with the clients are more individual and direct. She's more understanding…She understands relapse, which was something she did not embrace* [before]*. Now she understands that it's part of the process."*
>
> *"*[She] *changed the language in the courtroom. We did fetal alcohol syndrome training. As part of her conversations on the bench, she talks with parents about the uses and damages of alcohol. There's a vocabulary change. She's working on larger system changes around services and how to expedite services to parents."*

Evaluators also observed judges acknowledging the trauma that parents had experienced in their own lives, and the role it played in their current situation. Judges' knowledge and understanding of trauma was demonstrated in hearings and reported by interviewees.

> *"Our judge is very big on trauma therapy—trying to get to the root of the problem—why there is substance abuse and where it's coming from and if it was from previous childhood trauma."*
>
> *"We have a judge who looks at what makes a client so frustrated that they hit a 5-month old. What happened in their background? What happened to this person to make them do this? She understands that no one wakes up and says, 'Ok today I want to be a drug addict.' That isn't a life goal. The substance abuser has deeper trauma. She looks at what happens to the person in their past and asks for trauma assessments…*[and] *asks for services to be started immediately. I find that to be very different."*

Judges complimented parents on progress but were also firm and direct with parents about areas in which additional progress was needed. Judges consistently encouraged parents and a made a point of telling them that the court team wouldn't give up on them.

> *"*[The judge] *is fair, he really wants the parents to have their children back. He says that regularly and that brings comfort to parents. He is constantly saying to parents that they should not give up, to keep up the good work, that there is still time to change. I appreciate that."*

Focus of Hearings. Interviewees across sites reported that infant-toddler court hearings are also different in terms of the topics discussed. Judges in infant-toddler courts are making it standard practice to focus on several topics that are emphasized in the SBCT approach. These topics are covered more frequently and in more depth at infant-toddler court hearings.

Services

In-depth discussion of progress in services and need for and identification of additional services is regularly occurring in infant-toddler court hearings. At several sites, the judge begins discussion of services by asking parents to share progress. Judges also ask therapists (when present) and caseworkers about the services in which the parents are engaged, and the parents' progress. This is very different from regular dependency court, as discussions regarding services are usually focused on the parents' compliance or attendance, and not on milestones signifying progress. Interviewees noted that this level of discussion of services also increases the accountability of caseworkers.

> *"It's just not compliance-based. Sometimes you would get reports saying, 'they are attending' and that would be it. Having everyone at the table to really discuss how mom is showing or not showing insight, for example, really helps us know where families are and helps us to address any issues. Really just understanding where parents are at versus compliance base."*
>
> *"The judge asks caseworkers* [if they are] *following through on service agreements, if the caseworker is pointing parents in the right direction, providing with places that provide substance abuse evaluation on a sliding scale if the parent can't pay."*

Across hearings, evaluators observed judges asking parents if they had any additional needs. If any were identified, the judge would call on the caseworker, the community coordinator, or both to assist in identifying services and providing referrals.

Placements

Judges and other members of the infant-toddler court team are knowledgeable about the impact of placements on children. Given this, it is not surprising that the child's placement is a standard topic at infant-toddler court hearings. At one site, for example, interviewees reported that the child's adjustment to the placement is discussed at every status hearing. Interviewees from another site reported that judges are using a child development framework in working with families and making decisions about child placement and services, and that judges would focus on the quality of care in out-of-home placements. For a few sites, interviewees noted the effect of the judge's emphasis on this topic:

> *"We have a big issue with placement—not with the* [infant-toddler court] *team. The issue is placement at the main community care provider.* [The judge] *is one of the few judges that will call them to task and make placement appear and explain to her why we can't get a kid* [placed within the county]*."*

Parent-Child Relationship

Judges and other members of the infant-toddler court team also have clear understanding of the importance of the parent-child relationship. Judges were observed using a child development framework to explain to caregivers the importance of parent-child contact and attachment of child with parents and caregivers. Evaluators observed parent-child contact discussed extensively at hearings, including identifying and addressing challenges to frequent contact. In one of the hearings, the judge was concerned to hear that the foster caregiver was not being flexible in allowing the

biological mom time on the phone with her child, a plan they had verbally agreed upon. The mom complained that the caregiver would call at different times every day, and if the mom did not answer the phone on the first attempt, the caregiver would stop trying to reach her. She said it would be helpful if the caregiver called at the same time each day, so she would know when to expect the call. The foster caregiver was not present in the courtroom so the judge asked the caseworker to call her immediately, put her on speakerphone so she could participate in the hearing, and had her agree to these terms. The caregiver was resistant to agreeing to call at a precise time each day due to the unpredictability of the child, so the judge announced that she was adding this scheduled call requirement to the court orders. The judge, the caregiver, and the mom subsequently brainstormed together to determine the best time to schedule the daily call. Interviewee comments reflected that parent-child contact is a critical topic in infant-toddler court hearings.

> *"This is something that the judge focuses on—because she orders it, it trickles down and others have to work to focus on it. She orders* [contact] *up to daily across the board. It's a rare case that doesn't have that."*
>
> *"Child visitation has really increased. The judge has tasked us to make that happen."*
>
> *"*[Visitation is] *not a gift to the parent. It's a right for the child. The child deserves to have a relationship with the parent."*

Concurrent Planning

Concurrent planning as a standard practice has been a challenging area for which the QIC-ITCT provided extensive training and TA, including site visits from Judge Cohen. Concurrent planning is happening from the beginning of a case at most sites, and some now require concurrent planning for a case to be part of the program. At many sites, conversations about concurrent planning are starting as early as shelter or arraignment, and parents are hearing about it from multiple people. Interviewees acknowledged this shift:

> *"I've noticed* [the judge] *thinking more about concurrent planning and talking with families about it early on.* [The judge] *participated in a call with Judge Connie Cohen at one point–where that became evident. I've watched her make a concentrated effort to talk about concurrent planning. Really looking at permanency through the eyes of the child—I've seen a shift in that aspect."*
>
> *"The judge explains it well when we are at the case plan acceptance hearing—the preferred goal is reunification but we are planning in case that doesn't happen."*
>
> *"*[The judge] *explains it to the parents. We want you to be reunified but I'm obligated to tell you that we are starting with a concurrent goal. This means that there is reunification but there is also another goal on the table."*

Some sites are still struggling with this component. Interviewees expressed that having a concurrent goal disheartens parents. Thus, more attention has been paid to the way in which concurrent planning is explained and discussed using a child developmental lens so that parents and court team members understand why a concurrent plan is critical for the child. The conversation is about

permanency for the child, not about parental failure. Some judges are going into further detail about concurrent planning using child development principles to validate the process.

> *"I need you to understand that timing with regard to a very young child, especially an infant, is critical. And the court even looks at it in a different way…We are 11 months out from the child being placed in custody, for this young a child, that is too long a period of time without me making a permanency plan. Does that mean me making a change and saying that the window is now completely closed on you? No. But what it does mean is that the window was open at one time, and that window is not only getting close to closing, it is closing…. I am still leaving, as a concurrent plan, reunification. But now, the shoes are completely on your feet, and I mean you better start running."*

In summary, infant-toddler court hearings are very different from regular dependency court hearings. At most sites, they occur monthly and are lengthier and more in-depth. Infant-toddler court hearings typically include service providers as well as community coordinators. Judges encourage participation and attendees are more engaged. Interviewees reported infant-toddler court hearings are more positive, supportive, and family- and child-centered. Judges use simple terminology, and focus more on topics such as placement, parent-child contact, and concurrent planning.

In response to evaluation question 4, interviewees reported several positive changes in court team member behavior during hearings, including an improvement in judges' demeanors and interactions with parents, an increased number of court team members attending hearings, and a more family-focused and welcoming environment.

b. Child and Family Outcomes

At the time of the baseline visits, sites were already actively working on implementing SBCT core components. For example, sites were referring families to services, and working with clinicians as key members of the court team who were participating in family team meetings and providing information about therapeutic progress during court hearings. The QIC-ITCT leadership team was actively preparing for or already providing TA and training support across communities. QIC-ITCT support was highly regarded at each site, and there was a great interest in securing training spots. As there was a relatively short period between baseline and follow-up, the change process was still unfolding as described by interviewees and reported by stakeholders on the Web surveys. By the end of the follow up period, secondary data analysis of the SBCT dataset indicates that sites demonstrated numerous accomplishments related to child welfare outcomes. In this section, we first describe the short-term outcomes and changes between baseline and follow up, followed by child welfare outcomes. For each type of outcome, we present information from interviews completed at sites with judges, community coordinators, attorneys, caseworkers and CWA staff, and services providers; followed by Web survey self-reports and results based on secondary data analysis of data collected by sites through the SBCT Web portal.

Short-Term Outcomes Associated with Infant-Toddler Court Teams

Below we review child and family short term outcomes related to the implementation of the SBCT approach.

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)?"

Provision of Services

> "Zero to three (years) is a critical point in a child's development and is a prime opportunity for interventions to promote positive outcomes related to health, development, and well-being and therefore need to be a critical focus of the case plan. Case plans must include a comprehensive developmental, medical, and mental health assessment and services" (ZERO TO THREE, 2016, p. 4).
>
> "A 'Part C' screening can lead to a full assessment and services to address developmental delays identified in the assessment" (ZERO TO THREE, 2016, p. 5).

At both baseline and follow up, interviewees had a high awareness of positive outcomes associated with the court teams 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.

> *"The community coordinator gets referrals timely, that is huge. Even when we don't have a lack of resources, people would use the same resources even if there is a wait list. The community coordinator makes sure that you are not in a wait list and you get* [the service] *now."*

Interviewees indicated that there have been improvements from baseline to follow up in terms of the quality of referrals made, including the central role that CPP plays across sites as the main EBP. At baseline, the need for CPP providers was commonly described. The training of clinical providers on CPP by QIC-ITCT was highly valued across sites. Sharing of CPP information was observed during family team meetings, stakeholder meetings, and hearings. At some sites infant-toddler court team cases always receive a CPP referral. In addition, several interviewees noted improvements from baseline to follow up in the types of services referred and the speed of referral. Interviewees reported that assessments and service referrals were happening as early as during pre-removal conferences and removal hearings.

> *"We really focused on getting all families assessed now. We have a much better understanding of services they need, as far as mental health.…Those assessments are all done so we have better direction by going off the recommendation from the assessments. We try to get the assessments done in the first couple weeks of entrance to the infant-toddler court team."*

Judicial leadership was identified as critical for changes in assessments, referrals, and quality of services.

> *"Because we come so often to court, we actually see what you are working on in that service. The judge looks into the quality of services and asks parents if they think they should continue with that agency or if they should look for someone else."*

Across sites, at both baseline and follow-up, the constant work of community coordinators to bring community services providers to present at stakeholder meetings and participate in hearings/family team meetings was highly valued by interviewees. These improvements across sites were attributed to a variety of things, including the strength of the team in terms of collaboration and communication

> *"Our provision of services is great; it's all assessment-based, not cookie cutter. In court, we're able to all talk and discuss what's working or not. We conduct assessments quickly and plan specifically to the parent."*
>
> *"Referrals are more appropriate. We are working with the parents longer. We really are focused on infant mental health. We oversee the child visitation to guide services that way."*

When asked about the impact of the infant-toddler court team approach at their sites, stakeholders' open-ended responses to the Web surveys were positive. The word cloud to the right illustrates the most commonly used words in their answers.

At baseline, when demonstration sites were just initiating their TA and training from the QIC-ITCT, one of the most frequently reported effects included the number of children and parents receiving services to improve the quality of their relationships (65%) (see ***Exhibit 14***).

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

At follow-up (range time between baseline and follow up was 6 to 19 months), the same outcomes were cited as the most impacted by the court team: more families participating in services to improve the quality of their relationship (76%), and a higher number of parent services that acknowledge their trauma history (73%). As expected, areas where the least amount of change was observed are also those areas where a high proportion of respondents selected "don't know/not applicable" answers. For example, 49% of respondents at baseline and 55% of respondents at follow-up indicated that they did not know whether more children had a medical home.

Both at baseline and follow up there was a focus on identifying children's early intervention needs within the first months of involvement with the court team. Abuse and neglect of young children can have deleterious effects on their development (Anda et al., 2006; Casanueva et al., 2008; Leslie, Gordon, Ganger, & Gist, 2002; Perry, 1997; Shonkoff & Phillips, 2000) that can be addressed by early intervention (Shonkoff & Meisels, 2000). The federal Keeping Children Safe Act of 2003 amended the Child Abuse Prevention and Treatment Act (CAPTA (Pub. L. No. 108-36)) to require that states develop "provisions and procedures" for referring child maltreatment victims to early intervention services (CAPTA, 2003). The legislation targets children younger than age 3 who are involved in a CPS-substantiated case of child abuse or neglect, and it specifies the delivery of early

intervention services funded under Part C of the Individuals with Disabilities Education Act (IDEA, 21 USC § 106(b)(2)(A)). Part C services are intended to enhance the development of infants and toddlers with disabilities and minimize infants' potential for developmental delay (Casanueva et al., 2008).

Exhibit 14. Observed Changes in Outcomes

Have you observed the following changes in children and family outcomes related to the implementation of an infant-toddler court team at your site?	Baseline (n = 194)						Follow-Up (n = 120)					
	Yes		No		NA or DK		Yes		No		NA or DK	
	#	%	#	%	#	%	#	%	#	%	#	%
Kinship guardians are identified and supported as the preferred placement.	127	66%	37	19%	29	15%	91	76%	16	13%	13	11%
Fewer children have a change in foster home.	88	46%	56	29%	49	25%	60	50%	37	31%	23	19%
Children reach permanency faster.	81	42%	52	27%	61	31%	59	49%	36	30%	25	21%
Children and parents have more frequent visitation.	118	61%	44	23%	31	16%	82	69%	23	19%	14	12%
Parent-child contact occurs in "home like" settings (child welfare offices are a choice of last resort).	74	38%	72	37%	48	25%	57	48%	43	36%	20	17%
Time from referral to service initiation has improved.	97	50%	45	23%	52	27%	69	58%	25	21%	26	22%
More children have a medical home.	59	31%	40	21%	94	49%	39	33%	15	13%	66	55%
More children are screened for developmental delays.	105	54%	38	20%	51	26%	76	63%	19	16%	25	21%
More children and parents receive services to improve the quality of their relationship (e.g., infant mental health services, dyadic therapy, CPP).	126	65%	37	19%	31	16%	91	76%	13	11%	16	13%
Services for parents take into account previous experiences of trauma and biological insult (e.g. prenatal alcohol exposure, substance abuse, mental illness, etc.).	119	62%	46	24%	28	15%	87	73%	21	18%	12	10%

Between baseline and follow-up, sites received several trainings and TA related to developmental needs of young children. Screening during the first quarter of entry to the infant-toddler court team for developmental delays is critical under the SBCT approach, as described in the SBCT core components. Community coordinators entered information about early intervention needs for each child using the SBCT Web portal across the time of the project. 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 for about 70% of children one or more developmental areas needed to be monitored or were below normal development (see ***Exhibit 15***).

Given SBCT'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. After screening, for more than 40% of children, early intervention (including occupational therapy, physical therapy, speech therapy, and early intervention education services) was identified among needed services.

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. These results are similar to findings on the first evaluation of the SBCT approach, reporting that 97% of children received services for routine pediatric care and developmental screening. A key difference with the first evaluation is that 93.9% of children in need of CPP were receiving this EBP. The first evaluation described the limited availability of services to improve the quality of parent-child relationship (Hafford & DeSantis, 2009). In NSCAW II, of those with developmental problems, only 13.1% of children had an Individualized Family Service Plan (IFSP), a proxy for receipt of early intervention services (Ringeisen, Casanueva, Smith, & Dolan, 2011). Receipt of needed services by more than 90% of children contrast with the 67% of children receiving appropriate services reported in the preliminary CFSR 3 results based on 24 states (Children's Bureau, 2017). The finding that 93.9% of children received CPP is higher than the CFSR 3 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 among children 1.5 to 10 years old in NSCAW at risk for a behavioral or emotional problem. Less than a third (28.8%) received any specialty behavioral health service (Ringeisen et al., 2011).

Time to services receipt represents the time that passed between the dates when the service was court ordered or the referral was made if court order data was missing, to the date when the service was first received. This is an area of priority for community coordinators who work diligently to obtain court orders and referrals for needed services early in the life of the case. The time between the courts ordering the service or time of referral (if the date of court order is missing) 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% (see ***Exhibit 16***). 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 over 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.

To analyze time from court order or referral to service receipt by race/ethnicity, time was dichotomized into 60 or fewer days compared to more than 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 (see ***Exhibit 17***). Overall, more than 80% of children received services within the first 60 days from court order or referral to service.

Exhibit 15. Child ASQ-3 Screening, Services Need, and Receipt

Service Need and Receipt	QIC-ITCT Sites																			
	Total QIC-ITCT Sites N = 251*		Bay N =17		Forrest N =51		Honolulu N =18		Milford N =45		New Haven N = 30		Pasco N =12		Pinellas N =18		Polk N =22		Rankin N =12		South Okaloosa N =26	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
ASQ Screening																						
Total	***196***		17		49		0		33		24		12		10		15		12		24	
ASQ screening overall concerns*	**140**	**71.4**	9	52.9	48	97.8	NA	NA	18	54.6	16	66.7	11	91.7	7	70.0	6	40.0	11	91.7	14	58.3
Child Service Needs																						
N	***223***		16		49		11		45		24		12		14		21		12		19	
Child Parent Psychotherapy	**114**	**51.1**	13	81.3	13	26.5	1	9.1	15	33.3	7	29.2	12	100	11	78.6	18	85.7	6	50.0	18	94.7
Dental care	**56**	**25.1**	0	NA	6	12.2	3	27.3	11	24.4	13	54.2	1	8.3	2	14.3	1	4.8	6	50.0	13	68.4
Developmental screening	**223**	**97.3**	16	100	49	100	18	100	45	100	23	95.8	9	75.0	13	92.9	21	100	11	91.7	18	94.7
Early Head Start	**27**	**12.1**	0	NA	3	6.1	0	NA	2	4.4	3	12.5	1	8.3	0	0.0	18	85.7	0	NA	0	NA
Early Intervention	**92**	**41.3**	2	12.5	9	18.4	1	9.1	20	44.4	15	62.5	6	50.0	5	35.7	18	85.7	3	25.0	13	68.4
Child Service Receipt Among Those in Need*																						
N	***222***		16		49		11		45		24		12		14		21		11		19	
Child Parent Psychotherapy	**107**	**93.9**	11	84.6	11	84.6	1	100	13	86.7	7	100	12	100	10	90.9	18	100	6	100	18	100
Dental care	**55**	**98.2**	NA	NA	6	100	3	100	10	90.9	13	100	1	100	2	100	1	100	6	100	13	100

Service Need and Receipt	QIC-ITCT Sites																					
	Total QIC-ITCT Sites N = 251*		Bay N =17		Forrest N =51		Honolulu N =18		Milford N =45		New Haven N = 30		Pasco N =12		Pinellas N =18		Polk N =22		Rankin N =12		South Okaloosa N =26	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Developmental screening	**216**	**97.2**	15	93.8	49	100	18	100	44	97.8	23	100	9	100	11	84.6	21	100	8	80.0	18	100
Early Head Start	**26**	**96.3**	NA	NA	3	100	NA	NA	1	50.0	3	100	1	100	NA	NA	18	100	NA	NA	NA	NA
Early Intervention	**89**	**96.7**	2	100	9	100	1	100	19	95.0	13	86.7	6	100	5	100	18	100	3	100	13	100

* Reported Ns vary slightly across analyses because of missing data in some variable categories. Sites were only included if at least 10 cases were available for analysis. As a result, Hillsborough and Cherokee are not included in the data exhibits.

** ASQ screening overall concerns are defined as one or more of the specific areas of development are described as Monitor or Below. Some children have not needed or completed their screening yet either because they were new born or the case was still within the first 3 months of entry to the court team, which is the period that the SBCT approach defines for obtaining developmental screening.

***Services receipt is among those identified as in need (e.g., 114 children were identified as in need of Child Parent Psychotherapy, of those 107 or 93.9% received the service).

Exhibit 16. Time from Ordered or Referral to Service Receipt for Developmental Screening, Early Intervention, and Child Parent Psychotherapy

	QIC-ITCT Sites										
Time Ordered/ Referred to First Service Received	**Total QIC-ITCT Sites N = 251* %**	**Bay N =17 %**	**Forrest N =51 %**	**Honolulu N =18 %**	**Milford N =45 %**	**New Haven N = 30 %**	**Pasco N =12 %**	**Pinellas N =18 %**	**Polk N =22 %**	**Rankin N =12 %**	**South Okaloosa N =26 %**
Developmental Screening											
Total	***214***	16	49	9	45	23	9	13	21	11	18
Less than a week	**18.7**	37.5	4.1	11.1	20.0	17.4	22.2	38.5	28.6	27.3	11.1
7 to 30 days	**45.3**	31.3	44.9	33.3	57.8	56.5	55.6	30.8	47.6	18.2	38.9
31 to 60 days	**22.4**	18.8	36.7	44.4	11.1	17.4	11.1	15.4	19.1	18.2	27.8
61 to 120 days	**10.3**	12.5	10.2	11.1	4.4	8.7	0.0	15.4	4.8	27.3	22.2
Over 120 days	**3.3**	0.0	4.1	0.0	6.7	0.0	11.1	0.0	0.0	9.1	0.0
Early Intervention											
Total	***135***	3	12	1	24	28	11	5	20	8	23
Less than a week	**12.6**	0.0	8.3	0.0	16.7	14.3	0.0	20.0	20.0	0.0	13.0
7 to 30 days	**41.5**	33.3	50.0	100	37.5	17.9	63.6	40.0	55.0	50.0	43.5
31 to 60 days	**29.6**	0.0	25.0	0.0	25.0	46.4	18.2	20.0	20.0	50.0	30.4
61 to 120 days	**11.9**	66.7	16.7	0.0	12.5	21.4	0.0	20.0	5.0	0.0	4.4
Over 120 days	**4.4**	0.0	0.0	0.0	8.3	0.0	18.2	0.0	0.0	0.0	8.7
Child-Parent Psychotherapy											
Total	***114***	13	13	1	15	7	12	11	18	6	18
Less than a week	**30.7**	38.5	15.4	0.0	26.7	42.9	33.3	63.6	27.8	50.0	11.1

Time Ordered/ Referred to First Service Received	QIC-ITCT Sites										
	Total QIC-ITCT Sites N = 251* %	**Bay N =17 %**	**Forrest N =51 %**	**Honolulu N =18 %**	**Milford N =45 %**	**New Haven N = 30 %**	**Pasco N =12 %**	**Pinellas N =18 %**	**Polk N =22 %**	**Rankin N =12 %**	**South Okaloosa N =26 %**
7 to 30 days	**41.2**	61.5	38.5	0.0	46.7	42.9	41.7	27.3	33.3	33.3	44.4
31 to 60 days	**16.7**	0.0	38.5	100	20.0	0.0	16.7	9.1	22.2	16.7	11.1
61 to 120 days	**4.4**	0.0	7.7	0.0	0.0	14.3	0.0	0.0	0.0	0.0	16.7
Over 120 days	**7.0**	0.0	0.0	0.0	6.7	0.0	8.3	0.0	16.7	0.0	16.7

* Reported *N*s vary slightly across analyses because of missing data in some variable categories. Sites were only included if at least 10 cases were available for analysis. As a result, Hillsborough and Cherokee are not included in the data exhibits.

Exhibit 17. Sixty or fewer days from Ordered or Referral to Service Receipt for Developmental Screening, Early Intervention and Child Parent Psychotherapy by Race/Ethnicity across QIC-ITCT Sites

	Total		Developmental Screening Chi-Square: df (3), 7.28, p = .06 N = 214	Early Intervention Chi-Square: df (3), 2.21, p = .53 N = 135	Child Parent Psychotherapy Chi-Square: df (3), 0.32, p = .96 N = 114
Race/Ethnicity	**N**	**%**	**%**	**%**	**%**
Total	***242***	***100***	86.5	83.7	88.6
Hispanic	**14**	**5.8**	68.4	76.9	92.9
Black	**52**	**21.5**	84.6	77.4	86.9
White	**121**	**50.0**	88.2	87.5	88.4
Other	**55**	**22.7**	93.9	81.8	87.5

* Reported *N*s vary slightly across analyses because of missing data in some variable categories. Sites were only included if at least 10 cases were available for analysis. As a result, Hillsborough and Cherokee are not included in the data exhibits.

Based on secondary data analysis of the SBCT dataset, among the array of services needed by parents (see ***Exhibit 18***), 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 (see ***Exhibit 19***). 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)

Time to services receipt is shown in ***Exhibit 20***. While community coordinators described delays sometimes produced by a limited offer 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%.

Exhibit 18. Parent Services Needs

	QIC-ITCT Sites																	
	Total QIC-ITCT Sites N = 180*		Bay N = 17		Forrest N = 44		Honolulu N = 13		Pasco N = 10		Pinellas N = 21		Polk N = 28		Rankin N = 16		South Okaloosa N = 31	
Service Needs**	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Child care	**25**	**14.8**	5	33.3	1	3.3	3	20.0	1	10.0	14	50.0	1	3.6	0	0.0	0	0.0
Educational	**17**	**10.1**	1	6.7	0	0.0	0	0.0	1	10.0	12	42.9	1	3.6	2	13.3	0	0.0
Employment	**28**	**16.6**	1	6.7	0	0.0	1	6.7	1	10.0	22	78.6	1	3.6	0	0.0	2	7.1
Health care visit	**10**	**5.9**	1	6.7	1	3.3	0	0.0	2	20.0	1	3.6	0	0.0	5	33.3	0	0.0
Housing	**33**	**19.5**	2	13.3	1	3.3	0	0.0	2	20.0	20	71.4	4	14.3	4	26.7	0	0.0
Intensive case management	**16**	**9.5**	2	13.3	0	0.0	8	53.3	6	60.0	0	0.0	0	0.0	0	0.0	0	0.0
Mental health (MH) screening	**94**	**55.6**	6	40.0	8	26.7	1	6.7	8	80.0	19	67.9	27	96.4	5	33.3	20	71.4
Substance abuse (SA) screening	**127**	**75.2**	12	80.0	27	90.0	10	66.7	6	60.0	14	50.0	26	92.9	13	86.7	19	67.9
Psychiatric evaluation	**33**	**19.5**	2	13.3	1	3.3	1	6.7	5	50.0	18	64.3	3	10.7	0	0.0	3	10.7
Psychological evaluation	**40**	**23.7**	5	33.3	6	20.0	12	80.0	1	10.0	6	21.4	5	17.9	1	6.7	4	14.3
SA Inpatient with children	**8**	**4.7**	2	13.3	0	0.0	4	26.7	0	0.0	0	0.0	2	7.1	0	0.0	0	0.0
SA inpatient without children	**21**	**12.4**	4	26.7	1	3.3	1	6.7	3	30.0	0	0.0	8	28.6	2	13.3	2	7.1

	QIC-ITCT Sites																	
	Total QIC-ITCT Sites N = 180*		Bay N = 17		Forrest N = 44		Honolulu N = 13		Pasco N = 10		Pinellas N = 21		Polk N = 28		Rankin N = 16		South Okaloosa N = 31	
Service Needs**	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
SA outpatient with children	**10**	**5.9**	2	13.3	0	0.0	1	6.7	5	50.0	0	0.0	0	0.0	1	6.7	1	3.6
SA outpatient without children	**43**	**25.4**	4	26.7	0	0.0	3	20.0	5	50.0	10	35.7	16	57.1	3	20.0	2	7.1
MH counseling	**77**	**45.6**	1	6.7	8	26.7	7	46.7	7	70.0	23	82.1	27	96.4	1	6.7	3	10.7
MH meds management	**18**	**10.7**	1	6.7	0	0.0	1	6.7	3	30.0	9	32.1	2	7.1	0	0.0	2	7.1
12-step program	**34**	**20.1**	1	6.7	1	3.3	4	26.7	4	40.0	0	0.0	18	64.3	5	33.3	1	3.6
Anger management	**27**	**16.0**	1	6.7	4	13.3	8	53.3	3	30.0	2	7.1	3	10.7	0	0.0	6	21.4
Crisis intervention	**4**	**2.4**	1	6.7	0	0.0	0	0.0	0	0.0	3	10.7	0	0.0	0	0.0	0	0.0
Family counseling	**25**	**14.8**	1	6.7	13	43.3	1	6.7	5	50.0	2	7.1	0	0.0	3	20.0	0	0.0
Parent education	**113**	**66.9**	11	73.3	23	76.7	14	93.3	10	100	18	64.3	16	57.1	4	26.7	17	60.7
Reunification	**30**	**17.8**	2	13.3	4	13.3	1	6.7	1	10.0	21	75.0	0	0.0	0	0.0	1	3.6
Sustaining social support	**12**	**7.1**	1	6.7	1	3.3	0	0.0	2	20.0	7	25.0	0	0.0	1	6.7	0	0.0
Transportation	**16**	**9.5**	1	6.7	1	3.3	0	0.0	1	10.0	10	35.7	0	0.0	2	13.3	1	3.6

* Reported *N*s vary slightly across analyses because of missing data in some variable categories. Sites were only included if at least 10 cases were available for analysis. As a result, Hillsborough and Cherokee are not included in the data exhibits. Connecticut does not allow data collection about parents. Milford and New Haven are excluded from adults' tables.

** N for services needs identifies the number of times a service was identified. Some services (e.g., substance abuse related services) are needed more than once per adult.

Exhibit 19. Parent Services Receipt among Those that Received a Referral to the Service

Service Receipt among Those in Need**	QIC-ITCT Sites																	
	Total QIC-ITCT Sites N = 180*		Bay N = 17%		Forrest N = 44		Honolulu N = 13		Pasco N = 10		Pinellas N = 21		Polk N = 28		Rankin N = 16		South Okaloosa N = 31	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Total	***169***		15		30		15		10		28		28		15		28	
Child care	**22**	**88.0**	5	100	1	100	3	100	1	100	11	78.6	1	100	N/A	0	N/A	N/A
Educational	**10**	**58.8**	0	0.0	N/A	N/A	N/A	N/A	1	100	7	58.3	1	100	1	50	N/A	N/A
Employment	**15**	**55.6**	0	0.0	N/A	N/A	0	0.0	1	100	11	52.4	1	100	N/A	N/A	2	100
Health care visit	**9**	**90.0**	0	0.0	1	100	N/A	N/A	2	100	1	100	N/A	N/A	5	100	N/A	N/A
Housing	**20**	**62.5**	1	50.0	1	100	N/A	N/A	2	100	8	42.1	4	100	4	100	N/A	N/A
Intensive case management	**13**	**81.3**	0	0.0	N/A	N/A	7	87.5	6	100	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Mental health (MH) screening	**88**	**96.7**	4	66.7	8	100	0	0.0	8	100	19	100	27	100	5	100	17	100
Substance abuse (SA) screening	**110**	**90.9**	6	54.6	27	100	6	66.7	6	100	12	92.3	26	100	13	100	14	87.5
Psychiatric evaluation	**28**	**87.5**	2	100	1	100	0	0.0	5	100	14	82.4	3	100	N/A	N/A	3	100
Psychological evaluation	**32**	**84.2**	4	80.0	6	100	9	81.8	1	100	2	40.0	5	100	1	100	4	100
SA inpatient with children	**6**	**75.0**	1	50.0	N/A	N/A	3	75.0	N/A	N/A	N/A	N/A	2	100	N/A	N/A	N/A	N/A
SA inpatient without children	**17**	**81.0**	0	0.0	1	100	1	100	3	100	N/A	N/A	8	100	2	100	2	100

Service Receipt among Those in Need**	QIC-ITCT Sites																	
	Total QIC-ITCT Sites N = 180*		Bay N = 17%		Forrest N = 44		Honolulu N = 13		Pasco N = 10		Pinellas N = 21		Polk N = 28		Rankin N = 16		South Okaloosa N = 31	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
SA outpatient with children	**9**	**90.0**	1	50.0	N/A	N/A	1	100	5	100	N/A	N/A	N/A	N/A	1	100	1	100
SA outpatient without children	**40**	**95.2**	3	75.0	N/A	N/A	1	50.0	5	100	10	100	16	100	3	100	2	100
MH counseling	**69**	**94.5**	1	100	8	100	4	66.7	7	100	19	90.5	27	100	1	100	2	100
MH meds management	**16**	**88.9**	1	100	N/A	N/A	1	100	3	100	8	88.9	2	100	N/A	N/A	1	50.0
12-step program	**33**	**97.1**	0	0.0	1	100	4	100	4	100	N/A	N/A	18	100	5	100	1	100
Anger management	**21**	**80.8**	0	0.0	4	100	5	62.5	3	100	2	100	3	100	N/A	N/A	4	80.0
Crisis intervention	**2**	**50.0**	0	0.0	N/A	N/A	N/A	N/A	N/A	N/A	2	66.7	N/A	N/A	N/A	0	N/A	N/A
Family counseling	**22**	**88.0**	0	0.0	13	100	0	0.0	5	100	1	50.0	N/A	N/A	3	100	N/A	N/A
Parent education	**101**	**93.5**	6	60.0	23	100	10	76.9	10	100	18	100	16	100	4	100	14	100
Reunification	**28**	**93.3**	1	50.0	4	100	1	100	1	100	20	95.2	N/A	N/A	N/A	N/A	1	100
Sustaining social support	**11**	**91.7**	0	0.0	1	100	N/A	N/A	2	100	7	100	N/A	N/A	1	100	N/A	N/A
Transportation	**11**	**68.8**	0	0.0	1	100	N/A	N/A	1	100	6	60.0	N/A	N/A	2	100	1	100

* Reported *N*s vary slightly across analyses because of missing data in some variable categories. Sites were only included if at least 10 cases were available for analysis. As a result, Hillsborough and Cherokee are not included in the data exhibits. Connecticut does not allow data collection about parents. Milford and New Haven are excluded from adults' tables.

** Services receipt is among those identified as in need. N for services receipt identifies the number of times a service was received. Some services (e.g., substance abuse screening) are received more than once per adult. N/A indicates that there was no need for the service at the site, while 0 indicates that none of those in need at the site have received the service.

Exhibit 20. Parent Services: Time from Referral to Receipt for Substance Abuse Screening, Mental Health Screening, Mental Health Services, and Substance Abuse Services

Time Between Order/Referral and First Received	QIC-ITCT Sites																	
	Total QIC-ITCT Sites N = 180*%		Bay N = 17		Forrest N = 44		Honolulu N = 13		Pasco N = 10		Pinellas N = 21		Polk N = 28		Rankin N = 16		South Okaloosa N = 31	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Mental Health Screening																		
Less than a week	**60**	**63.8**	3	75.0	2	25.0	2	100	3	37.5	16	84.2	24	88.9	0	0.0	10	47.6
7 to 30 days	**24**	**25.5**	1	25.0	4	50.0	0	0.0	4	50.0	2	10.5	3	11.1	3	60.0	7	33.3
31 to 60 days	**10**	**10.6**	0	0.0	2	25.0	0	0.0	1	12.5	1	5.3	0	0.0	2	40.0	4	19.1
Substance Abuse Screening																		
Less than a week	**84**	**71.2**	6	85.7	22	81.5	7	58.3	2	40.0	9	69.2	25	96.2	2	20.0	11	61.1
7 to 30 days	**20**	**17.0**	1	14.3	5	18.5	1	8.3	3	60.0	0	0.0	1	3.9	5	50.0	4	22.2
31 to 60 days	**9**	**7.6**	0	0.0	0	0.0	2	16.7	0	0.0	3	23.1	0	0.0	3	30.0	1	5.6
61 to 120 days	**4**	**3.4**	0	0.0	0	0.0	1	8.3	0	0.0	1	7.7	0	0.0	0	0.0	2	11.1
Over 120 days	**1**	**0.9**	0	0.0	0	0.0	1	8.3	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Mental Health Services																		
Less than a week	**70**	**53.9**	2	100	1	4.0	6	66.7	4	23.5	23	74.2	29	90.6	0	0.0	5	62.5
7 to 30 days	**34**	**26.2**	0	0.0	8	32.0	1	11.1	12	70.6	3	9.7	3	9.4	4	66.7	3	37.5
31 to 60 days	**19**	**14.6**	0	0.0	12	48.0	1	11.1	1	5.9	3	9.7	0	0.0	2	33.3	0	0.0
61 to 120 days	**5**	**3.9**	0	0.0	3	12.0	1	11.1	0	0.0	1	3.2	0	0.0	0	0.0	0	0.0
Over 120 days	**2**	**1.5**	0	0.0	1	4.0	0	0.0	0	0.0	1	3.2	0	0.0	0	0.0	0	0.0

Time Between Order/Referral and First Received	Total QIC-ITCT Sites N = 180*%		QIC-ITCT Sites															
			Bay N = 17		Forrest N = 44		Honolulu N = 13		Pasco N = 10		Pinellas N = 21		Polk N = 28		Rankin N = 16		South Okaloosa N = 31	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Substance Abuse Services																		
Less than a week	**59**	**73.8**	2	40.0	1	100	10	71.4	9	81.8	6	54.6	25	96.2	2	33.3	4	66.7
7 to 30 days	**9**	**11.3**	1	20.0	0	0.0	1	7.1	2	18.2	2	18.2	0	0.0	2	33.3	1	16.7
31 to 60 days	**8**	**10.0**	1	20.0	0	0.0	3	21.4	0	0.0	1	9.1	1	3.9	2	33.3	0	0.0
61 to 120 days	**3**	**3.8**	0	0.0	0	0.0	0	0.0	0	0.0	2	18.2	0	0.0	0	0.0	1	16.7
Over 120 days	**1**	**1.3**	1	20.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0

* Reported *N*s vary slightly across analyses because of missing data in some variable categories. Sites were only included if at least 10 cases were available for analysis. As a result, Hillsborough and Cherokee are not included in the data exhibits. Connecticut does not allow data collection about parents. Milford and New Haven are excluded from adults' tables.

Placement Stability

"All too often the transition into foster care carries with it a number of transfers between foster homes. The impact of these placement changes cannot be understated: they damage the child's ability to develop trusting relationships. The lack of trust reduces their natural curiosity and ability to explore, both of which are vital to their success as learners. Perhaps more importantly, the loss of trust has long term ramifications for them in building healthy relationships" (ZERO TO THREE, 2016, p. 9).

A common element across sites was the focus on placement stability. At baseline, a mix of perceptions was observed. Some interviewees reported that there were no differences, while others reported greater placement stability. As court teams learned about the impact of multiple placements on a child's development, stakeholders were progressively committed to minimizing the number of times a child is moved to a new home. This short-term outcome was part of the CQI indicators regularly reviewed during monthly QIC-ITCT meetings with each site.

> *"From what I know—I would say yes. There is less movement. When permanency is not obtained with parents, more likely to be with kinship, which I think has reduced the number of placements because families stick it out longer."*

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. For example, during a hearing after explaining the program and expectations of the court team, the judge went into further detail about the need for placement stability using child development principles to validate the process.

> *"My goal is to help you put the baby first. The community coordinator believes you can do that. But it will be hard work. You will work with the mental health team. The goal is to reach reunification in a year. Within a year's time if you cannot, then we'll go to plan B* [concurrent plan]. *From the time, the baby is born the baby needs stability. And right now, that's with you. But if it's not, it will be plan B. I hope there is not a plan B but we have it if we need it."*

The stability expectation helps parents understand that the focus is on the urgent need of children for a permanent family. As described by interviewees:

> *"It's either going to go really quickly one way or another. The judge doesn't make any qualms about case direction. All my clients know what to expect. They are really good at covering that from the beginning and knowing we have to look at all options. It's because we are meeting every month and during that month people are being held accountable."*
>
> *"More than one placement is one too many for a child. The placement that we identify, that we place the child in, should be either the place that they remain or we're going to work for and try reunification."*

Most children have one or two placements, with an emphasis being on placement with kin who understand that the primary plan is reunification; they are the concurrent plan or "plan B." Several interviewees perceived improvements from baseline to follow-up in terms of stability of placement, and believed that placement with family or with a foster parent willing to be the concurrent plan was a significant factor in this stability:

> *"Most of my clients have been placed with family members and have been in a pretty stable placement. With one there was a problem, and by having the court team we were able to talk through the issues. It would have gone very different without the team. The child was not moved."*
>
> *"In the cases I had, the babies were in the same placements from beginning to end. Because of good judicial leadership,* [the child welfare agency] *knows they better have a darn good reason for moving a little kid when they go see judge. That puts a downward pressure on moves."*

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%) (see ***Exhibit 14***).

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 (see ***Exhibit 21***).

Limiting the number of out-of-home placements for children was the focus of the TA and training for the SBCT approach between baseline and follow-up. Based on the analysis of the SBCT data, 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 (see ***Exhibit 22***). Given that a few sites have children assigned to the infant-toddler court after adjudication, ***Exhibit 14*** also presents analysis of the number of placements since the date of the family initiation with the infant-toddler court team, with almost no differences between the two estimates.

The bottom section of ***Exhibit 22*** presents estimates following the outcomes summarized in the Child Welfare Outcomes Report to Congress, which looks at children who experienced no more than two placement settings among three cohorts of children in out-of-home care: less than 12 months; at least 12 months and less than 24 months; and in care for at least 24 months. Based on the last report to Congress, in 2014 the median was 85.6% and the range from73.7% 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). Among QIC-ITCT sites, the percentage of cases with no more than two placements was over the upper limit of the national range. Thus, 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, and are not included in ***Exhibit 22***.

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 (see ***Exhibit 23***). In other words, court teams seem to serve children of all races and ethnicities equally well.

Exhibit 21. Child Primary Permanency Goal and Concurrent Planning

Permanency Plan	QIC-ITCT Sites										
	Total QIC-ITCT Sites N = 251* %	Bay N = 17 %	Forrest N = 51 %	Honolulu N = 18 %	Milford N = 45 %	New Haven N = 30 %	Pasco N = 12 %	Pinellas N = 18 %	Polk N = 22 %	Rankin N = 12 %	South Okaloosa N = 26 %
Permanency Goal											
Total	***233***	16	50	18	45	24	12	16	21	9	22
Reunify with parent	**90.6**	50.0	92.0	100	97.8	95.8	91.7	100	100	88.9	95.5
Place with fit and willing relative	**1.3**	0.0	2.0	0.0	0.0	4.2	0.0	0.0	0.0	0.0	0.0
Refer for legal guardianship	**0.4**	0.0	0.0	0.0	0.0	0.0	8.3	0.0	0.0	0.0	0.0
Place child for adoption	**6.4**	37.5	6.0	0.0	2.2	0.0	0.0	0.0	0.0	11.1	4.6
Other permanency solution	**1.3**	12.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Concurrent Planning											
Total	***212***	9	50	18	42	24	12	16	21	9	11
Reunify with parent	**5.7**	11.1	4.0	11.1	9.5	4.2	8.3	0.0	4.8	0.0	0.0
Place with fit and willing relative	**8.0**	0.0	0.0	0.0	16.7	8.3	0.0	12.5	14.3	22.2	0.0
Refer for legal guardianship	**29.7**	0.0	82.0	5.6	16.7	33.3	0.0	12.5	4.8	66.7	0.0

Permanency Plan	QIC-ITCT Sites										
	Total QIC-ITCT Sites N = 251* %	**Bay N = 17 %**	**Forrest N = 51 %**	**Honolulu N = 18 %**	**Milford N = 45 %**	**New Haven N = 30 %**	**Pasco N = 12 %**	**Pinellas N = 18 %**	**Polk N = 22 %**	**Rankin N = 12 %**	**South Okaloosa N = 26 %**
Place child for adoption	**45.3**	55.6	6.0	83.3	38.1	41.7	75.0	75.0	71.4	0.0	81.8
Other permanency solution	**4.3**	11.1	6.0	0.0	0.0	0.0	8.3	0.0	4.8	11.1	18.2
Concurrent plan pending**	**7.1**	22.2	2.0	0.0	19.1	12.5	8.3	0.0	0.0	0.0	0.0

* Reported *N*s vary slightly across analyses because of missing data in some variable categories. Sites were only included if at least 10 cases were available for analysis. As a result, Hillsborough and Cherokee are not included in the data exhibits.

Exhibit 22. Number of Placements since Removal, since Family Initiation with the Infant-Toddler Court, and by Time in Out-of-Home Care, Based on Federal Definition

Number of Placements	QIC-ITCT Sites																					
	Total QIC-ITCT Sites N = 251*		Bay N = 17		Forrest N = 51		Honolulu N = 18		Milford N = 45		New Haven N = 30		Pasco N = 12		Pinellas N = 18		Polk N = 22		Rankin N = 12		South Okaloosa N = 26	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Total	***229***		16		47		16		45		24		12		16		19		10		24	
Since Removal																						
1	**136**	**59.4**	7	43.8	25	53.2	8	50.0	29	64.4	14	58.3	6	50.0	11	68.8	15	79.0	7	70.0	14	58.3
2	**61**	**26.6**	4	25.0	14	29.8	8	50.0	9	20.0	7	29.2	3	25.0	4	25.0	4	21.1	2	20.0	6	25.0
3 or more	**32**	**14.0**	5	31.3	8	17.0	0	0.0	7	15.6	3	12.5	3	25.0	1	6.3	0	0.0	1	10.0	4	16.7
Since Family Initiation with Infant-Toddler Court																						
1	**138**	**60.3**	7	43.8	25	53.2	9	56.3	29	64.4	14	58.3	6	50.0	11	68.8	15	79.0	8	80.0	14	58.3
2	**60**	**26.2**	4	25.0	14	29.8	7	43.8	10	22.2	7	29.2	3	25.0	4	25.0	4	21.1	1	10.0	6	25.0
3 or more	**31**	**13.5**	5	31.3	8	17.0	0	0.0	6	13.3	3	12.5	3	25.0	1	6.3	0	0.0	1	10.0	4	16.7
No More than Two Placements																						
Children OOH less than 12 months (N = 103)	**97**	**94.2**	4	100	17	94.4	3	100	26	89.7	11	84.6	4	100	7	100	12	100	7	100	6	100
Children OOH 12 to 23 months (N = 126)	**100**	**79.4**	7	58.3	22	75.9	13	100	12	75.0	10	90.9	5	62.5	8	88.9	7	100	2	66.7	14	77.8

* Reported *N*s vary slightly across analyses because of missing data in some variable categories. Sites were only included if at least 10 cases were available for analysis. As a result, Hillsborough and Cherokee are not included in the data exhibits. Connecticut does not allow data collection about parents. Milford and New Haven are excluded from adults' tables.

OOH: Out-of-home

Exhibit 23. Race/Ethnicity by No More than Two Placements and Time in Foster Care Across QIC-ITCT Sites

	Total Chi-Square: df (3), 2.71, p = .45				Time in Foster Care			
					Less than 12 Months Chi-Square: df (3), 2.47, p = .48		12 to 23 Months Chi-Square: df (3), 2.54, p = .47	
	Total		No More than Two Placements		Total	No More than Two Placements	Total	No More than Two Placements
	N	%	N		N	%	N	%
Race/Ethnicity	229	100	197	86.0	103	94.2	126	79.4
Hispanic	19	8.3	16	84.2	8	100	11	72.7
Black	55	24.0	51	92.7	26	96.2	29	89.7
White	117	51.1	98	83.8	56	91.1	61	77.1
Other	38	16.6	32	84.2	13	100	25	76.0

Time to Permanency

"The major emphasis on permanency is itself a critical element affecting child well-being especially of young children, for whom a permanent home is a critical ingredient of healthy social and emotional development. Thus, the requirements to ensure that cases do not languish by using periodic case reviews (no less frequently than once every six months) and permanency hearings (no later than 12 months after entering care) are both surpassed by the Court Teams' monthly reviews and serve as mechanisms to monitor and ensure service provision to promote healthy development. Federal law also permits states to conduct concurrent planning, a practice used by the Court Teams to ensure that babies are moved more quickly to a permanent home" (QIC-ITCT, 2017b, p. 4).

At baseline, interviewees at most sites either did not know if children reached permanency faster or indicated it was too soon to determine as most sites were in the process of initiating cases. Thus, there were not enough cases, nor enough time to reach the permanency hearing and compare with regular cases. Interviewees also identified other challenges that would impact the speed of permanency including limited concurrent planning, changes in safety assessments, and being reunified before parents with complex needs have received services to resolve them.

At follow up, 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. In 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.

> *"There is another facet to that and that's the adoptions area. We have several cases that are in termination of parent rights but have not achieved finalization of adoption. We have resolved them quicker with those TPRs. That has improved and parents are consenting to the TPR. It's not* [the court team] *that's holding things up, but the adoption end* [that's preventing] *closing the case."*

At other sites although parents were ready, reunification and permanency were delayed due to the housing crisis. For example, in one site many parents have been losing their residences as areas with affordable housing are bulldozed to build high-end developments. Public housing is also very restrictive; parents who have been convicted of a felony are denied the ability to even apply.

> *"Housing is a barrier. Children could have been reunified earlier, but the parent doesn't have housing. The wait list can be months and months so children have to stay in foster care until there is housing."*

As a result of these challenges and the complexity of families involved with court teams, many interviewees indicated that they were not sure, or did not think there were improvements in time to permanency between baseline and follow up. However, several noted improvements in terms of the permanency result, emphasizing the need for time to reach permanency effectively with parents or kin.

> *"I want to say yes, there has been improvements in time to permanency. To me, the criteria for* [the court team] *is that you have to have more extensive issues that are going to take longer than 12 months. You're going to have cases that take 6 months to a year. Those cases don't have the same* [complex] *issues."*

Importantly, one of the CIP state representatives was supporting data analysis of children involved with the infant-toddlers court and compared outcomes with children in regular courts:

> *"Data from the parents' representation program shows that* [SBCT] *children are being returned faster, or achieving permanency faster, less time in foster care, which is also saving the state money."*

Other Short-Term Outcomes

Along with the changes between baseline and follow-up on services received by children and parents, across sites interviewees reported increased sensitivity by stakeholders and frontline court team members to the trauma that both children and parents have experienced and understanding the importance of addressing this trauma. During observations of court team stakeholder meetings at follow up, stakeholders actively discussed lessons learned and provided ideas related to minimizing the trauma associated with the children's removal and separation, training for foster parents to understand and help traumatized non-verbal children, trauma-informed coparenting support, and trauma-informed EBPs and trauma-trained clinicians in the community.

> *"All the time we talk about the history and trauma. That's why we have CPP. We support parents* [by] *recognizing that they are humans and the trauma that they had before; recognizing that people have relapses with drugs, alcohol, domestic violence, or whatever. For example, the clinician talked about how the mother was going back to thinking that the dad is not that bad of a guy. Two years ago, in front of this* [judge]*, this would have resulted in* [the judge] *berating* [the mother]*, telling her what a dumb thing that was to do… But instead she is letting that clinician, whom she trusts, report this, which shows that she knows that parents are going to do these things and the clinician is going to work with the parent on that."*

> *"Our kids have trauma, but when we look at their parents, the parents have trauma, had been sexually abused and now self-medicate. And we have so many successes, we are addressing all the systems and making them work together, we bring the foster parents and the relatives, and we work together as a family system, so there are great successes with the kids and they are reunified with parents."*

Trauma was a training priority area in several sites and part of those sites' action plans. During follow-up interviews, the key factors in supporting trauma-informed court teams were reported as QIC-ITCT training and TA, NCJFCJ Trauma Informed Practices Consultation, stakeholders who are well educated on trauma issues and represent multiple systems, and judicial leadership.

> *"I think trauma-informed care education has been really beneficial. I have cases that have domestic violence and to look at that data and know—well that's how he was raised and that's normal for him unfortunately and he needs to address that. Things you wouldn't maybe think about."*
>
> *"I think we are more trauma-informed. We are looking through the trauma lens and trying to find the underlying factors or causes for the behavior."*

A challenge to trauma-informed court teams identified by sites was rotational professionals (attorneys, GALs) and the turnover of child welfare agencies' staff. Interviewees emphasized that these individuals are not 'dedicated' court team members; they only work on the team if they are assigned an infant-toddler court team case. Several interviewees shared how beneficial it is to have stable infant-toddler court team members, and how challenging it is not to have any dedicated parents' attorneys and GALs, as it is often the case that a parent's attorney or GAL does not understand or buy into the SBCT approach. Interviewees spoke passionately about the negative impact of continuous trauma training for child welfare professionals and partners due to lack of universal knowledge and practice across courtrooms, and felt strongly that implementing change in this area would further the success of sustaining the SBCT approach.

> *"Sometimes the lack of trauma-informed care and lack of understanding of what's going on with the parent can come up—sometimes with the GALs within the courtroom– who are on a rotation and not selected for this work. Missing the piece of what's best for the parent is best for the child. I think there can be a lot of judgement and not understanding what's driving the protective issues with the parent is their own trauma. Some judgement can really come across there. I probably see that more with attorneys that get stuck in that adversarial place. I think our child welfare system has improved in that a lot—but we do have the turnover so it can be hit or miss."*

Interviewees from several sites noted an overall positive impact on other outcome areas that the SBCT approach has had on the families, including establishing a supportive relationship with the court team, gaining insight on the urgent needs of young children to have stability, and parents being able to put the needs of the infant or toddler above their own desire to keep their child; which translates into fewer contested TPRs.

> *"We feel, and parents feel too that the judge is a cheerleader for them. Even those on the TPR track, the judge would say that 'the window is closing but it hasn't closed, you still have an opportunity.' I haven't had a case treated in a negative way by the judge at hearings."*
>
> *"I can't tell you the number of times I've walked out of TPR hearings where the parents' rights got terminated and they still feel fairly treated, still feel like everyone made every effort they could. There's a realization that this baby needs more than I can give right now. If they feel like everybody worked hard to try to support them to get what they need—then they can deal with the trauma of losing their parental rights a lot better."*

In summary, between baseline and follow-up changes in short-term outcomes associated with the infant-toddler court teams were observed at several levels. Provision of services was perceived by interviewees as one of the best short-term outcomes, with both children and parents receiving needed services promptly in the life of the case. This was also reported in the Web survey, and confirmed by secondary data analysis. Across sites, interviewees reported high placement stability, confirmed by the analysis of the SBCT dataset. Time to permanency was perceived as a challenge beyond the control of court teams for some of the longest cases. Even when children were in their final placement for a long time, it was difficult to legally close cases. Importantly, the perception of less contested TPR was a valued short-term outcome across sites. Finally, interviewees perceived as a valued outcome that teams were increasingly better trauma informed, and described the positive impact on how parents are better understood and supported.

c. Main Child Welfare Outcomes Associated with Infant-Toddler Court Teams

Across sites there were generally positive perceptions of the main child welfare outcomes associated with the court teams. Below we present results on safety, permanency, and well-being outcomes related to the implementation of the SBCT approach.

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?"

While at most sites there is a perception of positive outcomes, at new sites and those that started in 2016 and had a follow up visit in less than 12 months, interviewees reported that it is too early in the process to see stable positive outcomes. Among sites that had worked with the SBCT approach prior to the initiation of the QIC-ITCT but experienced a disruption in implementation, interviewees acknowledged that they were working to make improvements to the core components with which they still had challenges, and to institutionalize changes in practices. This was expected as the timeline of the project and the evaluation was determined by the short time period of the grant funding the QIC-ITCT.

Safety

"The new focus ASFA placed on promoting safety, permanency, and wellbeing is found in revisions to Titles IV-B and IV-E of the Social Security Act. Titles IV-B and IV-E and related regulatory policy has been strengthened through subsequent amendments. As the CSFRs suggest, achieving these goals is not easy. SBCTs work to put these goals into practice consistent with key features of child welfare law" (QIC-ITCT, 2017b, p. 4).

At baseline, most sites reported that it was too soon to observe maltreatment re-reports; only two sites described perceiving positive improvements. At follow up, 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 wide 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. There were a variety of factors mentioned in relation to this, including improvements in the team's communication, the services provided to the family, and the frequency of contact with the family.

> *"I think that we are probably addressing more underlying issues—because of the way we are communicating. Through that we have been able to implement some better safety measures and things to monitor and be aware of."*
>
> *"Seeing these cases every month definitely makes them safer because if there is an issue we know about it. Additional services and more contact with the family keep the children safe. After reunification, we keep the cases open 6 months—that keeps the child safe too."*
>
> *"There's so much communication; if there's an issue it comes up right away. We can foresee the situation and mitigate the risk."*
>
> *"Safety is paramount for us. We try to eliminate re-reports and not a single case has come back. Since the program inception, there have been moves but not re-reports."*

Several interviewees noted that the increased knowledge of trauma, trauma-informed care, wraparound services, and child development services likely positively impacts both well-being and safety outcomes.

> *"I think that trauma-informed care—has been nice. It helps me think about the parents and not just looking at how they aren't doing what they are supposed to do but thinking about what happened to them and asking them to deal with what happened to them so they can get to a place where they can parent their child."*

Noticeably, 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.

> *"We have had one family that the child came back. The level of accountability in the court from the judge, the county prosecutor, caseworkers, supervisors, and community coordinator, we all must feel that the changes have happened to agree on reunification. It is not a checklist, accountability is very much valued here."*

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 set 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%. 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 first 12 months. Of the 10 infant-toddler court teams that kept data on safety, 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.

Overall, safety outcomes were very promising. Information provided by interviewees consistently indicated that the focus on addressing the root causes of safety concerns as well as the close monitoring of cases were critical elements supporting positive safety outcomes. Preliminary data for the CFSR 3 on safety, shows that only in 54% of cases analyzed across 24 states appropriate safety plans were developed and monitored (Children's Bureau, 2017).

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 (see ***Exhibit 14***).

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.

> *"As far as we used to be, more cases moved along quickly, reunification is happening, the SBCT court closes files quicker. This is resulting from the agency and caseworkers working more intensively with the parent, and really focusing on the permanency plan. The obvious change is people learning about services, people embracing the timeline, bonding with parents. You see people that begin to get it, and you see diligence, they see is positive. It is a win-win because you get the services. It makes the caseworkers' work easier. They see that the community coordinator and her team work for the family, and they embrace it, because it works."*

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 (***Exhibit 24***). 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.

*Indicator Description: "*Of all children who enter foster care in a 12-month period, what percent discharged to permanency within 12 months of entering foster care?

Calculation: The denominator is the number of children who enter foster care in a 12-month period. The numerator is the number of children in the denominator who discharged to permanency within 12 months of entering foster care and before turning age 18.

This means that if a child discharges from foster care to reunification with parents or other caretakers after a placement setting of a trial home visit during any of the six report periods used for the indicator, any time in that trial home visit that exceeds 30 days is discounted from the length of stay in foster care. In other words, the actual date of discharge to permanency could occur at any time during the three years used to calculate this indicator, and the trial home visit would then be applied to see if it may result in a reduction in the length of time in foster care for the purposes of this data indicator" (Administration for Children and Families, 2015, p. 8).

For closed cases, the percentage that reached permanency in 12 months is higher than the national standard set for CFSR 3. However, for cases still open there is uncertainty about the time to permanency until the case is closed. ***Exhibit 24*** also presents information on the status of open cases. For over half of cases (54.5%), community coordinators reported that the child is already reunified or, if reunification did not occur, the child has been in out-of-home care for more than 12 months and is placed with the caregiver who is the permanency concurrent plan. For most of these cases, children were placed with this caregiver at removal or shortly thereafter. About one fifth (20.8%) of children have not yet reached the 12-month milestone. For 24.8% of open cases, it was unlikely that they would be classified as reaching permanency in 12 months. Even if court teams worked diligently to reach permanency, there were legal reasons that precluded a faster resolution, including sites where cases that entered the legal adoption process changed to a different team of caseworkers specialized on adoption, change to a different court, changes in state legislation requiring evidence of contact and involvement of paternal relatives before TPR approval, or a combination of these factors. While these challenges were a concern for court teams, the results presented here are in line with a previous evaluation of the SBCT approach based on 298 children that were compared to 511 children that were part of NSCAW I. Children in the SBCT group exited to reunification after about 10 months compared to 18 months among NSCAW children. Similarly, children in SBCT exited 10 months faster among those adopted and 3 months faster among those who exited to relative guardianship compared to NSCAW children (McCombs-Thornton & Foster, 2012).

Exhibit 24. Permanency in 12 Months for Children Placed Out-of-Home

Permanency in 12 Months	QIC-ITCT Sites																					
	Total QIC-ITCT Sites N = 251*		Bay N = 17		Forrest N = 51		Honolulu N = 18		Milford N = 45		New Haven N = 30		Pasco N = 12		Pinellas N = 18		Polk N = 22		Rankin N = 12		South Okaloosa N = 26	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Permanency in 12 Months among Closed Cases																						
Total	***41***	***100***	4	100	7	100	6	100	5	100	3	100	4	100	3	100	4	100	4	100	1	100
Yes	**38**	**92.7**	4	100	7	100	4	66.7	5	100	3	100	4	100	3	100	4	100	3	75.0	1	100
Expected Permanency in 12 Months among Open Cases																						
Total	***202***	***100***	12	100	43	100	11	100	40	100	27	100	8	100	13	100	18	100	6	100	24	100
Expected yes**	**110**	**54.5**	7	58.3	28	65.1	7	63.6	21	52.5	6	22.2	4	50.0	10	76.9	13	72.2	2	33.3	12	50
Expected no	**50**	**24.8**	5	41.7	11	25.6	4	36.4	8	20.0	10	37.0	3	37.5	2	15.4	1	5.6	0	0	6	25
In care less than 12 months	**42**	**20.8**	0	0	4	9.3	0	0	11	27.5	11	40.7	1	12.5	1	7.7	4	22.2	4	66.7	6	25

* Reported *N*s vary slightly across analyses because of missing data in some variable categories. Sites were only included if at least 10 cases were available for analysis. As a result, Hillsborough and Cherokee are not included in the data exhibits. Due to extensive data cleaning, this section was based on data beyond May 1, 2017, and includes a longer period than all other analysis.

**Expected Yes: this category represents cases that are still open and community coordinators reported that the child is already reunified or, if reunification does not occur, the child has been in out-of-home care for more than 12 months and is placed with the caregiver that is the permanency concurrent plan, with whom the child was placed within the first year of removal (for most of the cases, children were placed with this caregiver at removal or shortly after).

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.

> *"We are better able to serve the child by involving the caregiver so we (and the birth parent) can hear about child behaviors, developmental, and social needs."*
>
> *"All the children get the mental health and development assessments done. And because of that, we can address any issues that are flagged…early on."*
>
> *"Children are happier and more well-adjusted. They don't have the anxiety or fear of being removed. They appear to be thriving as opposed to just surviving."*

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.

> *"We need to be looking at the trauma issues that may impact child well-being indefinitely. We need to say from the beginning that the focus is the well-being of the child. If we are really working on child well-being, that parent may not be the person. Sometimes children need to be separated from their birth family."*
>
> *"Kin are supported: there are funds for caring for the child, child care, and supervision of meetings with the biological family to heal relationships."*

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."

> *"We see them so frequently we can address needs as soon as they come up."*
>
> *"Once parents really want to engage* [it takes a while], *then* [the approach] *works. They need to take the opportunity."*
>
> *"Child-Parent Psychotherapy is used. This has been most helpful working with the families. It has also been help in the judge making rulings in cases. Monthly court hearings have been very helpful. Increased visitation and quality visits has been a plus."*

> *"On the whole,* [we are] *making sure they are clean and sober, that they get jobs or are in school.…Helping them to keep a stable income has helped them because it's not a stressor and they can help their kids."*

In summary, safety, placement with kin, fewer placements, and support for children and parent well-being were positive outcomes observed at follow up. Data collected through interviews, Web surveys, and analysis of the SBCT dataset were consistent on positive outcomes, as well as the need for more time to determine if there is faster permanency. Overall, interviewees across sites at follow up were generally enthusiastic in their description of short-term and main child welfare outcomes among children and families involved with a court team. Changes supporting positive outcomes between baseline and follow up were related to using a trauma approach with children and parents, providing frontline staff a detailed and balanced comprehension of the circumstances of each family, and facilitating the use of a strengths-based approach while valuing every little step forward. Across sites, interviewees described their belief that children and families can heal, and the critical role of CPP to accomplish healing as the crux across all outcomes.

> *"The work that comes out of* [CPP] *is like nothing I have ever seen. What trauma the parents are dealing with, they receive help with that. How they support the child, and repair the bond…it is the only thing that I have seen that provides that kind of healing."*

d. Limitations

As shown in the exhibits presented in this section, results related to services receipt and child welfare outcomes are promising as compared to national estimates or standards. A large number of children were safe, have experienced only one or two placements, and along with their parents they 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. Moreover, there were differences across sites in the level of implementation of core components that by aggregating data across sites would not be evident. While information at the site level is provided, the number of cases across categories was very small and we caution the reader about conclusions at the site level. For this reason, no testing is provided on comparisons among sites.

Second, it is important to note that families were not randomized to receive the SBCT approach, and at one site all families with children 0 to 3 years old 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. While that bias would only be controlled with a different design, it is important to notice that these were still high risk families with more severe risk profiles than families involved with the CWS for maltreatment investigations reported in NSCAW (Casanueva, Ringeisen, Wilson, Smith, & Dolan, 2011b).

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 child welfare outcomes compared to children in regular court, or how children of color involved with QIC-ITCT sites are faring when compared to children of color in regular court. The QIC-ITCT is interested in being able to make these comparisons in the future.

Fourth, any testing of differences by race/ethnicity was completed for the overall group of QIC-ITCT sites. Since sites still have a limited number of cases and all sites have subgroups by race/ethnicity with fewer than five cases, testing at the level of the site for race/ethnicity was not feasible at the time of this report.

Fifth, it was not possible to obtain the race-ethnicity of children 0 to 3 years old not involved with the infant-toddler court teams in the child welfare agencies. With the current data available, we cannot respond to the question of whether families of all races are receiving equitable opportunities to participate in the infant toddler court teams. The data provide information about what happens once families are in the program, but not if there are equitable opportunities to enter the program. While analyses by race/ethnicity were completed to determine differences in service receipt and placement outcomes, showing no statistically significant differences by race/ethnicity, it is not possible to determine if children of color are proportionately represented on the infant-toddler court teams' caseload. Thus, whether the intervention is reaching all races/ethnicities in the child welfare population remains unknown.

Sixth, as most families have been with the infant-toddler court team for up to a year, there are no long-term outcomes related to permanency and time to permanency for most of the children included in the analysis. Similarly, there are no outcomes related to the direct assessment of children's and parents' well-being as this was beyond the funding available for the evaluation.

Finally, while extensive work was completed for data cleaning, there are always concerns about the quality of the data entered in the SBCT database by sites. Community coordinators have had to dedicate overtime hours to enter data, as their days are full of activities supporting children and families, participating in court hearings, family team meetings and case staffings, searching for community support, and organizing the court team. Moreover, while community coordinators have outstanding skills to work with families and communities, and were extensively trained in how to use the SBCT database and given support from a dedicated staff person on all their questions as they came up, they are not trained for standardized, professional data collection. Thus, we cannot ensure the accuracy and timely update of the dataset, particularly for parent data, as data entry on children was prioritized by community coordinators.

Section 4 | Challenges to Implementation

4. Challenges to Implementation

Numerous challenges to implementation were identified during baseline and follow-up site visit interviews and observations. Many of these were also identified as potential barriers to the sustainability of the infant-toddler court team approach (see ***Section 5***). This section reviews both overall and site-specific challenges related to the SBCT core components and key relevant issues.

a. Judicial Leadership

Two of the nine 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. As a result, infant-toddler court team leadership came from the CWA, but the need for judicial leadership was highlighted by most interviewees. In Cherokee, North Carolina, when the SBCT approach was first implemented in 2009, the sitting judge was very committed to the work. However, when that judge retired, the judge who succeeded him did not sustain the practices recommended by the SBCT approach. At the beginning of 2017, a native EBCI judge who grew up in Cherokee agreed to preside over their SBCT cases. Early reports indicated great progress in terms of judicial leadership. However, in August 2017, a judicial change was made by the Tribe and the site will not participate in Year 4 of the QIC-ITCT.

Interviewees across sites acknowledged that judicial leadership is critical in terms of successfully implementing the SBCT approach.

b. Local Community Coordinator

Four of the nine sites are currently 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. At one site, after a part-time community coordinator (who was working 10 hours a month) retired, the infant-toddler court team turned to the local community-based care agency to temporarily place someone from their organization after being turned down for funding from behavioral health services. The new community coordinator started in July 2016 working 10 hours per week, which limited her ability to fulfill the responsibilities associated with the position. She could provide support to families with the help of the community-based care agency, which offers counseling, psychotherapy, peer mentoring, and case management, but lacked the resources to (1) pursue community outreach activities needed to explore new collaborators and resources; (2) build support from relevant systems, agency leaders, and key stakeholders; (3) explore systemic change; and (4) foster sustainability. The fact that she is from the community-based care agency has created a challenge as well; there is, at a minimum, the perception that having a community coordinator associated with an agency creates a conflict of interest. The need for a community

coordinator funded independently from a community-based care agency was also brought up by interviewees at another site. Interviewees expressed concern that it may lead to conflicts of interest. Although this site began with a part-time coordinator at the initiation of the court team, they now have a full-time community coordinator funded by the state legislature.

At the time of the follow-up visit another site only had 50% of the community coordinator's time. This change was the result of restructuring done last year at the community-based care organization that funds the position. The community coordinator's responsibilities are now shared with the infant-toddler court team manager. The team manager handles some of the larger system-wide duties while the community coordinator facilitates the provider staffings, family team meetings and family contact, recruits additional stakeholders, identifies community resources, and reports on the status of infant-toddler court cases in court. Some interviewees expressed concern that having the community coordinator splitting her time between the SBCT site and another site in the county could negatively affect the recruitment process, as the community coordinator may not be available to connect with a family before the shelter hearing. Concern was also expressed about whether the half-time position allows enough time to both identify and evaluate community resources. At another site, the community coordinator is employed part-time, working 3 days a week. Although she makes the best use of her time, is attentive to the needs of the program, and keeps everyone informed, the need for a full-time coordinator was expressed by interviewees. At the time of this report, the site received approval for full-time funding through a state-wide funding effort.

At other sites, the challenges to this core component were related to the large caseload, as all or most families with children up to 3 years old were enrolled, and there was no cap on the number of cases. Several interviewees reported that doubling the recommended maximum case load of up to 20 open cases was diluting the quality of the work. Interviewees were concerned about how overwhelmed the community coordinator was, as she was working long hours preparing materials, reviewing caseworkers' reports for hearings, entering data into the SBCT database, and attending all weekly hearings. On top of the court-related activities, the community coordinator was actively engaging the community, regularly scanning the community for new members and sources of support for families and children, coordinating services, and organizing and conducting stakeholder meetings. These challenges may increase as the support for the position from QIC-ITCT ended in September 2017, and the local funding obtained by this site is sufficient for only 3 days a week.

c. Active Court Team Focused on the Big Picture

Three of the newer expansion sites are currently facing challenges in terms of this core component. Buy-in to the overall approach, as well as its specific components, such as implementing concurrent permanency goals, seem to be the key challenge at these sites. At one site, interviewees reported that this component is still a "work in progress" and efforts are still needed to get stakeholders' full participation and buy-in into the approach. 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. Among key challenges was having some court team members accept the concurrent goal and moving toward the termination of parental rights when reasonable efforts were made to work with families.

At another site, though there is a large and diverse group of stakeholders, the buy-in from child welfare/case management that was identified as a strength at baseline had substantially decreased at follow-up. This appears to be the result of some senior level staff being replaced with individuals who do not fully understand the approach.

At a third site, the large and active group of stakeholders participating in monthly court team meetings at baseline had problems with continued engagement, and the number of stakeholders had dwindled by the time of the follow-up. Several interviewees described the need for agency decision makers to be represented at court team meetings. Engaging high-level representatives—like executive directors and judges who can influence policies—can have a direct impact on the success or failure of the infant-toddler court team.

d. Valuing Biological Parents

Only one site expressed that they face challenges with this core component, a key element of the SBCT approach that was expanded between baseline and follow-up visits to emphasize that valuing parents is always a priority. 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.

e. Placement and Concurrent Planning

Four sites indicated challenges in terms of the core component of placement and concurrent planning. 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. The team acknowledges that they need to actively and regularly review the concurrent plan with parents and the court team, and ensure that the caregiver is also receiving the support needed to successfully transition to the concurrent goal, should that be necessary. At another site, there appear to be two issues at work. The first is a process issue; all interviewees reported that the case plan goals are already in place by the time the case is transferred into the infant-toddler court, and that the infant-toddler court typically moves forward with the goals already established. This means that if a concurrent goal is not set by the initial judge, it typically is not added. The other challenge interviewees expressed was that parent attorneys often push back against setting a concurrent goal.

At other sites, concurrent planning is in place; the challenge is in terms of placement stability when it has not been possible to place with kin and children are in foster care. In response to this challenge, sites have created placement workgroups to identify solutions, including identifying ways to increase the pace of recruitment of foster families as well as to strengthen, maintain, and recruit new local foster placements.

The placement workgroups report monthly at stakeholder meetings to address placement issues, including planning the provision of trauma-informed training to prepare foster parents for potential crisis. At one of the sites, only a portion of children are removed from the home. The judge and the team continually and carefully assess each case to determine if a child's safety is at risk and if they need to be removed from their home. If no safety risks are found, the team works to put services in place in the home. Regardless of whether the child remains in their home or is placed in out-of-home care, the court team's goal is to provide placement stability and permanency. Court team members support foster parents and in-home caregivers in understanding the case plan, managing expectations, and reminding them of the responsibilities of each stakeholder on the team. The court team supports keeping the child in the home when it is appropriate and believes that it empowers parents, makes it easier to implement services, and reduces the likelihood the child will be traumatized by the experience.

f. The Foster Parent Intervention

This core component was also added between the baseline and follow-up visits. Seven sites indicated challenges in this area. Training, education, engagement, buy-in, and support were noted as the biggest challenges. Needs identified by stakeholders include:

- Training and education for foster parents to better support their role as defined by the SBCT approach.
- Support to help nurture a relationship between foster parents and biological parents, with staff needed prior to and during the time that foster and kin caregivers are engaged with a child and his or her family to provide training and support on multiple topics, including child development, children with special needs, coparenting, and the CWA expectations on court appearances.
- Support to foster parents to follow the expectation for family time at a minimum of three to five times a week.
- Development of systems for expedited reimbursement to foster parents supporting family time, attendance at family team meetings, and frequent contact with the court team.
- Provision of supportive services for kinship resources, including providing information to non-licensed kin on support (e.g., Women, Infants, and Children [WIC], Supplemental Nutrition Assistance Program [SNAP]).

g. Pre-Removal Conferences and Monthly Family Team Meetings

Pre-Removal Conferences

Pre-removal conferences were added to this component 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. As a result, the court team decided to link their initial meeting with the family, which they call post-removal conferences, with the case transfer meeting. This meeting is when the case is transferred from the investigators to the case managers and usually occurs within 7 days after removal. Another site has also implemented a post-removal conference for similar reasons. Although court team members agree that this is a step in the right direction, they continue to question the feasibility of implementing a true pre-removal conference. Though interviewees at three sites acknowledged the benefits of pre-removal conferences, these meetings are not conducted in those sites and there is no plan to put them in place given the legislative framework and the way their system works. In contrast, another site does not currently hold pre-removal conferences, but their stakeholders are interested in putting them in place. The challenge at that site is process-related, namely, identifying how to implement the pre-removal conferences and how the court team will be involved. Another site does not conduct pre-removal conferences either, though some interviewees mentioned that they do have a variation where they meet with the families to discuss issues and solutions.

At another site, the main challenges in terms of putting pre-removal conferences in place relates to resources. Staff need to complete the background checks and home studies as early as possible, which is challenging. They have also experienced difficulty in terms of relatives being unable to meet licensure requirements. At sites with requirements for relatives to be licensed, the infant-toddler court team may want to consider a systems change initiative to replace licensing requirements for kin by an approval that focuses only on the child's safety.

Monthly Family Team Meetings

Some of these sites also experience challenges in terms of 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 connected to the fact that family team meetings are scheduled with short notice. These challenges have been resolved by several sites by scheduling meetings 1 month in advance and requesting attorneys to 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 "having courageous conversations." As described in ***Section 2***, training and TA were developed by the QIC-ITCT to support sites and facilitate the right balance within each family team meetings.

For a few sites, challenges related to family team meetings were still active and court teams were working on developing solutions. For one site, the challenge was that after 3 months of family team meetings, cases continue with monthly permanency meetings that are conducted by the CWA caseworkers without the participation of the community coordinator or the facilitator. Interviewees expressed concern about this abrupt loss of leadership, reporting that they are essential to oversight

and organization. At another site, during the follow up visit, the CWA was undergoing a major change: transitioning from non-specialized to specialized case workers. The transition impacted family team meetings; some families did not know who their newly assigned caseworkers were, others expressed concerns about being unable to contact their caseworker, or having a caseworker tell them that certain tasks were no longer their responsibility.

h. Parent-Child Contact (Visitation)

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.

For example, at the time of the baseline visit interviewees at one site reported that the case management organization had recently put in place a transporter who was dedicated to infant-toddler court cases to address the issue of transportation interfering with parent-child contact. However, this never truly came to fruition, and transportation remains a major roadblock. As a result, that site's team identified possible improvements to policies, procedures, and practices in regard to the frequency of parent-child contact in their child welfare assessment tool. While transportation was a barrier mentioned by interviewees across sites, it was rarely identified as a parent's service need in the SBCT dataset (see ***Exhibit 18***, with only 9.5% of parents identified as in need of transportation). Although this could be explained by the daily effort of community coordinators across sites to support parents with transportation, this need should be entered into the case information and shared with stakeholders. This will allow the teams to create a group focused on transportation need and obtain funding for transportation.

i. 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. At baseline, court team members acknowledged the need for more CPP-trained clinicians dedicated to these cases. Although an 18-month CPP training cycle was initiated by the QIC-ITCT in March 2016 for interested clinicians in Florida, they remain in high demand. Stakeholders interviewed during the follow-up visit echoed the same concerns as those interviewed at the baseline visit, citing a high turnover rate. In addition to recruiting more CPP providers from within the community-based care agency, the court team is also interested in recruiting CPP providers who live in the area and are affiliated with a different agency. One of the difficulties clinicians are having with CPP is an increasing number of parents in need of counseling services before CPP can even begin. Several court team members commented that many parents were not ready for CPP when they became involved with the court team; their therapy was centered primarily on getting them physically and mentally healthy enough to begin and benefit from CPP.

Another site also experiences the continual challenge of needing more service providers in the area. Historically at this site, families have had access to behavioral health services, including EBPs.

However, trained service providers would regularly leave the area and specialists are located 2 hours away. 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.

j. Training and Technical Assistance

Although only one site reported challenges in terms of implementation of this component, it is likely that all sites experience the same challenge to some degree. Some interviewees indicated that time constraints hinder their ability to be involved in trainings and discussed the desire to be notified of trainings and to use the court team to provide additional training. Interviewees at multiple sites indicated that attending training would be difficult due to time and financial constraints.

k. 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.

l. Other Implementation Challenges

Trauma-Informed Courts and Services

According to the National Council of Juvenile and Family Court Judges (NCJFCJ), a trauma-informed court means:

- Educating system stakeholders, community agencies, and youth and family consumers about trauma and its impact on human development
- Utilizing trauma-informed practices, skills and strategies to reduce traumatic stress
- Cultivating resilience and improving the well-being of children and families in their care and the staff that work with them (Marsh, Dierkhising, Decker, & Rosiak, 2015).

These elements fall directly in line with the SBCT approach, and many of the infant-toddler courts already have some of these pieces actively in place. For example, one site had the benefit of receiving a Trauma Informed Practices Consultation from NCJFCJ. Though NCJFCJ reported that the site had one of the most trauma-informed courts that the audit team has visited, they noted the absence of the following components that need to be addressed to become more trauma-informed and likely apply to other sites as well:

- Universal precaution model (treating all parents as if they are at risk of not understanding legal and technical information as professionals cannot accurately identify who understands and who does not)
- Trauma screening protocol to screen families prior to (or early in) involvement with the court
- A clear protocol to protect victims of domestic violence upon entry and exit from the court

- A separate waiting area for perpetrators of domestic violence (especially when an active protection order is in place)
- Key signage in English and Spanish
- Staff at the information desk during peak hours
- A hands-on workshop, or informative panel to help system stakeholders apply some of the trauma knowledge they have gained.

The impact of current and historical trauma is not common knowledge, even among those who provide services to individuals affected by trauma. Because it severely impacts parents and children, it is critical that providers have a thorough understanding of trauma and provide trauma-informed services. Trauma is a topic that many professionals, such as lawyers, do not receive training about. As a result, challenges to creating trauma-informed services include understanding and buy-in of the importance of trauma-informed services and funding for education and training on trauma.

Racial Disproportionality

As noted in the SBCT Race Equity Brief and Tool, "Children and families of color and Native American children and families are disproportionately over represented in child welfare systems and experience disparately negative outcomes than their white peers including, in the case of African American children, longer stays in foster care."[11] Given this, we would expect the children served by the infant-toddler courts to also have a higher proportion of children and families of color and Native American families and children. During the follow-up site visit in Polk County, IA, interviewees shared that they were informed that there was some disproportion in terms of race of the children being served by the infant-toddler court team (the current caseload was not reflective of Polk County's racial breakdown), and that there needed to be outreach to a more diverse demographic.

Given this information, the Polk County infant-toddler court team planned on obtaining a clear understanding of this issue and figuring out strategies to address it. For example, they have reviewed recruiting procedures and developed a plan to increase the diversity of the children served so it is more in line with the racial breakdown of children in foster care in Des Moines. The 2015 Iowa DHS Annual Progress and Service Report describes the availability of Community Team Learning Sessions or Breakthrough Series Collaborative as a resource to address disproportionality.

Safety Re-Reports

Since the inception of the infant-toddler court teams, three Florida cases have been reviewed because of concerns about failed reunification. This review found that the entire court team had not been involved in the process of making some critical decisions, and that the judges had provided discretion to the child welfare agency to reunify the child with a parent. This was not in line with the SBCT approach, in which decisions about placement, including reunification, are supposed to be determined by the judge with input from the court team.

In one case, the case management organization was using a fast-track reunification model/program that expedites reunification within 90 days. This expedited timeline is not supported by QIC-ITCT as 90 days is an insufficient amount of time for identifying and addressing the needs of the child and the parent. The QIC-ITCT had requested their cases be exempt from this approach. The QIC-ITCT's review reports of the cases that went through the fast track program regardless of their recommendation indicated the need for the following:

[11] *See Fact Sheet: Troubling History, Continued Obstacles, Today's Trends*

- More attention to the parent's past trauma history and how earlier experiences impact their behaviors and choices
- Understanding that it may take time for the parent to develop trust in the clinician or with the court team to share and process earlier traumatic experiences which influence current behaviors
- More attention to the ability of the parent to support the child's social and emotional development and to keep the child safe
- More input from the clinician about the mother's poor choice of partners who may continue the abusive experience the mother has come to expect and believes she deserves.

Parental Engagement

The circumstances that bring children and families into court combined with the traditional child welfare processes make parent engagement challenging. Infant-toddler court teams have been trying to address this challenge, as parent engagement is necessary to successfully implement the SBCT approach. The infant-toddler court team at one site and Parent Partners developed a parent survey. This survey asks parents directly about experiences with the child welfare process, such as their involvement with their child's foster family, and with individual court team members. The community coordinator provides the survey to parents at initiation and every 3 months to gauge where improvements have been made as well as additional areas for improvement. Use of parent surveys, in-person interviews, and focus groups with parents who have experienced the infant-toddler court are strategies that across sites can provide information on how to improve parental engagement.

m. Summary

Sites have experienced several challenges implementing the SBCT approach. The most common were related to:

- Funding for:
    - Infant-toddler court team work that is not reimbursable by insurance or Medicaid
    - Training for additional service providers
    - Training of infant-toddler court team members and stakeholders
    - Transportation for parents for parent-child contact and receipt of services
    - A full-time community coordinator
- Buy-in regarding the overall SBCT approach, concurrent planning
- Turnover in key positions on the court team, including judge, community coordinator, and state-level positions
- Turnover in child welfare caseworkers and supervisors
- Engaging biological parents
- Number of service providers and types of services available
- Engaging and supporting caregivers.

The support provided by the QIC-ITCT to address these challenges was described in ***Section 2***. These forms of support are critical during the years of initial and full implementation. As some components were implemented and in place at a point in time, there were regular issues emerging that required a simultaneous process of building and rebuilding at sites. As judges, community coordinators, champions, and stakeholders change, practices that do not follow the SBCT approach re-emerge and gains can be lost.

Section 5 | Sustainability

5. Sustainability

a. Background

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, 2016b). 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.

CSSP prepared a set of sustainability materials and webinars including:

- A brief with a sustainability framework describing elements necessary to institutionalize the SBCT approach (QIC-CT, 2016b)
- A brief on collaboration to sustain practice change (QIC-CT, 2016a)
- A brief on funding requests (QIC-CT, 2017)
- A worksheet for sites to support planning for sustainability (QIC-CT, 2015)
- A presentation on Medicaid financing for children in the CWS (see).[12]

The next sections follow the elements identified in these materials that are required for sustainability and describes sites work in each requirement.

b. Requirements for Sustainability

1. Common Vision

> "Starting with a definition of success is essential to have a clear idea of what collaborators are working to achieve. Success is defined by key elements to be sustained and a description of how systems, providers, and collaborators will interact differently. It will also define the desired culture change for the systems and networks where the work will occur" (QIC-CT, 2016b, p. 3).

[12] www.qicct.org/sustainability

Across all demonstration sites, efforts to promote a common vision and accomplish cultural change within and across systems were described as a permanent endeavor. Most sites provided examples of large cultural changes in the practice of the court, the CWA, early childhood system, and EBPs providers. Each system was actively integrating this common vision into the regular work of their staff.

> *"What we have been doing* [at the CWA directive level] *is instilling this work into caseworkers. Sometimes the infant-toddler court team doesn't pick cases because the caseworker is doing it, and that is what* [the CWA] *wants, that the core SBCT components are part of their practice. So, we are transitioning to caseworkers, they are doing the model.* [The CWA] *wants every worker to do it. We have been planting the seeds with caseworkers."*

Sustaining the infant court teams requires forward-thinking to maintain and bring on board new members who share a common vision. Staff turnover is inevitable, and recruiting and training judges, new counselors, community coordinators, and case managers impacts the entire court team. At some sites, the judge is on rotation. When the judge cycles off the infant-toddler court team, there is no statute in place prescribing that the new judge maintain the approach. At one site, the judge is taking the initiative to document her role on the infant-toddler court team now so that when the time comes, she can ensure that her successor sees the value in maintaining the approach. Ultimately, to sustain the practice change that is occurring, all court team members need to be taking measures to institutionalize the approach.

2. Engaging Partners and Cultivating Champions

"Existing relationships need to be nurtured and new stakeholders need to be engaged. This requires an understanding of other initiatives in the community and how they may complement the work. A goal of collaboration is to identify and cultivate champions-key partners operating in different circles who believe and are invested in the approach" (QIC-CT, 2016b, p. 5).

"These collaborations vary among sites but most often include the child welfare agency, court (including the judiciary and Court Improvement Program), community-based mental and behavioral health providers for both children and parents, parent partners, public agencies including the department of health and the office of early childhood, early intervention programs, attorneys for children and parents, and the state and local universities" (QIC-CT, 2016a, p. 1).

Across sites, interviewees identified continued collaboration from the judicial leadership as a factor that plays a key role in sustaining the infant-toddler court team in the future.

> *"We need commitment from the judicial branch that this is an important thing. Judicial leadership is one of the critical pieces of it. It might mean that the judge doesn't have to take as many of other cases so he can invest more time in these."*

Several interviewees note the importance of judicial leadership in preparing and mentoring the next generation to sustain the infant-toddler court team, especially considering the rotational system for judges in one state, and the number of judges nearing retirement. Implementing the SBCT approach has created a common vision and legacy that members of the infant-toddler court teams are eager to continue:

> *"We can't afford to let the program die. The judge is very passionate and the community coordinator is very passionate. We have to take the torch from them. I will take the path of becoming a judge, or I will work to be a representative so I can work on supporting the SBCT approach. I really appreciate that the judge thought about me, this is what makes my work meaningful, when this works, when the judge says to parents 'you have done so well and we are going to return the child,' and for the child to know that, I cry."*
>
> "[SBCT] *has impacted me tremendously. I came in college and the experience determined my graduate school path. Being part of the infant court team is my priority and I do it through their core components, because it works. The judge appoints parents' attorneys, he appoints GALs, they are young so they are seeing the system and we all stick with it, so we are committed and passionate, so I am very hopeful for my generation that we will carry on."*

Several interviewees described how participating in the court team has changed their professional path, their vision, and their goals.

> "[The infant-toddler court] *has impacted me tremendously, this is my priority. The problem with the legal standard on 'the best interest of the child' is that is vague and that is balanced with the rights of the parents. In* [this state], *we do not define well what 'best interest' is, and ZTT defines it in a more operationalized way and it is so useful. It is the focus on permanency of the child in terms of their best interest, doing that through looking at bonding, attachment, and safety, not just physical but emotional safety. In other courts, I do believe they try to focus on the best interest of the child but that take years and years and by that time permanency happens, so much damage has been done and so many bonds have been broken. The case drags far too long. The system should protect the child, not do further damage. And ZTT establishes a foundation for the best interest of the child."*

The need for an independent community coordinator who is not associated with the institution that has taken their child away and whom families can trust and reach to when in need was described as fundamental to engaging families. As described during interviews, a critical challenge is the inherent parental resentment and lack of trust toward the CWA when their child is removed.

> *"Many parents look at* [the CWA] *as the enemy. They took the kid away. The infant-toddler court team comes and they are not* [the CWA], *have nothing to do with the removal, they are independent, not part of the court, and they can look at the parent and say, 'we are here to help you.' They don't judge, don't have an attitude. They are not the government, they are not the cops. They have an effective way to make parents believe in them."*

For some sites, the continued support from the CIP was indicated as a critical collaboration, with all CIP state representatives identified as champions. At these sites, there is extensive collaborative work with the CIP related to the SBCT approach, from support during times when there have been transitions of the community coordinator, to the provision of a state vision and funding for training or parental representation. Obtaining the support of the CIP has benefitted all sites involved, and would likely be extremely helpful in expanding this work to other counties. In one state, the work of the CIP has been instrumental in establishing 18 infant-toddler court teams, with four more in the initiation

phase across the state. In one state, the main CIP initiatives are addressing the training needs of the infant-toddler court team, providing linkages to training on that state's Youth Court Information Delivery System, electronic youth court data entry, and the Indian Child Welfare Act. As previously reported in ***Section 3***, they also provide support for travel expenses for judges and other stakeholders to attend several related conferences. The CIP also supports the Parent Representation Task Force, which provides oversight of the pilot counties, gathers data, makes presentations to the legislature, and develops standards of practice and standardization of measures and data.

Dedicated infant-toddler court members who have positive working relationships, are regularly involved in infant-toddler court team cases, and have frequent communication and collaboration through monthly court hearings, family team meetings, and stakeholder meetings were also identified as doing collaborative work that impacts sustainability. Interviewees reported that having a specific person from each system working on the infant-toddler court team cases is extremely beneficial. This has a positive effect on the cohesiveness of the team, communication, accountability, and trust. For most sites, a designated caseworker for the court team has an enormous impact on the sustainability of the team and the infant-toddler court team cases.

> *"Working as a team. Everything is mentionable and manageable. You can sit and talk about things that you disagree on. And we can disagree. We can agree to disagree. That is a very important part of the process. But sticking together thorough that disagreement is what forms an actual team and not bailing because you aren't getting an answer you want. That is not a team approach."*
>
> *"If you are looking back on the difference between this court and other courts is the commitment from the* [CWA] *to have a dedicated worker in these cases is a huge difference. The difference in quality of department workers is vast, unfortunately. To have that commitment to have two good dedicated department workers assigned to these cases—and not having to worry about when the case is going to rise and fall based on the level of supervision it gets from the department or caseworker is huge. There is a big improvement."*

Support for a small group of attorneys trained on the SBCT approach and trauma was also identified among the elements to sustain the infant-toddler court teams.

> *"One thing we are working on here is narrowing the parents' attorneys for these cases to a group of maybe eight instead of the general population of court-appointed attorneys."*

Several interviewees across sites noted how critical support by the child welfare agency is in terms of the success and sustainability of the SBCT approach.

> *"The chief factor is getting the support of those that can help it be sustained—so whether it be the* [CIP] *or the* [CWA]. *Preferably you'd have both but at least having one. I think we are having success working with* [child welfare agency] *to sustain."*
>
> *"Strong support from* [the CWA]*—it would not be possible without strong support from* [the CWA]*."*

Collaboration with EBP providers was identified by most interviewees as well. Even among sites that have the professional capacity to sustain EBPs for families involved in the infant-toddler court team, some mentioned wait lists for some services, and the need for additional providers are needed. This may be partly the result of the increased education about EBPs, and the spillover effect the infant-toddler court team cases have had on regular dependency cases.

> *"CPP –we are getting more referrals. Normally we could guarantee that clients could be seen within 2 weeks. Right now, we have a waiting list. We have done a lot of education about the importance of getting these families into CPP immediately. I think as more education is out there they are making referrals and sooner. The problem now is that we have a waiting list and I don't like that."*

3. Garnering Resources

"Resources provide support to children and families and allow for professionals and administrators to support the work and improve outcomes for children and families. Resources include personnel, services, space, and tangible goods" (QIC-CT, 2016b, p. 3).

Interviewees noted that, to grow and improve the infant-toddler court team, they must continue educating the community about the SBCT approach and the service needs of the families, as well as provide support and resources to recruit and keep foster families who can work with parents and promote coparenting.

> "[We need to] *continue to work on expanding resource partner networks."*
>
> "[We need to] *continue to educate the public and community about what we do and what services we have. And educate the parents of young children what services and opportunities are available to them. That is the greatest thing that they can do. Because if someone knows that there is a resource out there, they are likely to tap into it. We're poised to do a better job promoting our resources and connecting our people with resources."*

Some interviewees noted additional services that would be very helpful for parents and foster families, such as the Attachment and Biobehavioral Catch-Up (ABC), intervention medication-assisted treatment (MAT) as an option for substance abuse treatment, and facilities that conduct testing for fetal alcohol syndrome in closer proximity to the site.

4. Tracking Impact Using Data

"Data are critical to understanding areas of strength and identifying opportunities to further support children and families. Continuous Quality Improvement (CQI) is central to this project. Using data will enable tracking of identified outcomes across all sites and ensure that each site is on track to achieve positive outcomes" (QIC-CT, 2016b, p. 7).

Learning to use the SBCT portal and the CQI metrics available in the SBCT dashboard have helped all sites learn about the value of tracking impact data. Regular meetings with sites' stakeholders or among judges to review the SBCT dashboard have increased the motivation to understand and track impact data. For example, in one state, the CIP plans include collecting the same data in the Youth Court

Information Delivery System that are collected through the SBCT dataset, with the goal of determining if providing parent representation leads to faster reunification or faster permanency when reunification is not appropriate, whether the length of stay in care is shortened, and whether quality family time occurs to keep the bond between the parent and the infant or toddler. The CIP is also providing support to analyze and prepare data for presentations targeting policy makers and other key stakeholders.

> *"People want to know if we start the SBCT, how we are going to sustain the approach. Children are reaching faster permanency and that saves the state dollars. That is how are we going to sustain the SBCT. We will present the information on how faster children reach permanency and how much is saved to the state, and we will speak to the legislators. We can do a better job on awareness on SBCT and how crucial is permanency, so children can experience a family life that all children deserve, because we know that foster care is a poor replacement of family life. We will explain that the goals are to get children out of foster care or to never come in, and that the goal is that no child should be submitted to that trauma of being taken away and losing connections. The SBCT judges are the ones that go to the legislators, they will work with* [the statistician] *to provide the info on savings, and they are working on their bullet points. Whenever the data are available,* [the statistician] *is helping and they want to present this year."*

All sites acknowledged the role of data and outcomes results to obtain funding and sustain the infant-toddler court teams. Interviewees expressed interest in learning more about the data being collected. Data on the main child welfare outcomes, as well as an economic evaluation to determine the savings created by improvements in safety, permanency, and well-being are critical. Interviewees highlighted the need for outcomes and the need to collect cost/benefit information to support funding efforts and sustain the SBCT approach.

5. Financing

"Funding is necessary to support and provide the resources necessary to achieve the desired results for children and families and support the ongoing work. This may be through federal, state, or local funds or grants, foundations, cross-agency agreements, social impact financing, or other means" (QIC-CT, 2016b, p. 3).

"Teams should identify which messaging, tone and language will speak the best to the prospective funder" (QIC-CT, 2017, p. 4).

Sites' strategies to fund their infant-toddler court includes diversifying sources of funding. Sites are considering different potential sources of funding for the community coordinator, from integrating the position as part of one of the involved systems (e.g., court staff, CWA) to funding through grants with local foundations. For EBP funding, one strategy to address this included partnering with a behavioral health organization that can access Medicaid dollars for training new providers.

Interviewees at most sites noted how critical minimizing CWA turmoil and stabilizing agencies is in terms of the success and sustainability of the SBCT approach, and the need to invest in resources (e.g., dedicated staff for transportation of families and children, tablets to support field work, more staff with lower caseloads), specialized training, and professional mentoring to develop and improve caseworkers' skills and retain CWA staff.

> *"With the new caseworkers we have, they are really tenacious, we have some really good ones if we can keep them.* [The community coordinator] *is assisting with home studies and helping them as there is no supervisor to mentor them, they are good but need to learn and there are no supervisors to learn from."*
>
> *"There are not enough caseworkers, they are not given the tools, including electronics devices, they don't know how to manage their calendar. They don't have a tablet to enter the information during home visits so they have piles of paper to transfer to a desk computer. It is hours to pick up children and they are expected to do so much. They are given an unreasonable task for any human being and within a week they are gone."*

6. Policy and Legislation

"Achieving policy change and implementation of legislation and regulations that support the common vision is important to ensuring the work is sustained beyond current funding, trends, or leadership" (QIC-CT, 2016b, p. 3).

Efforts to sustain the SBCT approach through policy and legislation varied across sites. In one state, the decision at the CWA to integrate core features of the SBCT approach within their practice has created a powerful platform to expand reach and institutionalize core features as part of their regular work, facilitating the work of the infant-toddler court team. As part of the CWA work, the expectation is to expand the SBCT core features to primary prevention work at the community level.

> *"*[The CWA] *is taking the lead, and embedding the SBCT model into their practice across all ages. It filters down to the other children, as services are frontloads to the practice of* [the CWA]*, it is managing their practice better."*
>
> *"We talk at* [the CWA] *on expanding the* [SBCT] *brand. So fewer children are placed, those placed are reaching permanency faster. And we have so many children exposed that do not come into contact with us that need help. We are pushing beyond* [the CWA]*. If communities had the awareness that SBCT has brought to that it would be so important. And help to create relations with other agencies that can help the family, instead of having the family come to* [the CWA]*."*

In Florida, stakeholders and CIP efforts to standardize the work of Early Childhood Courts (ECCs) and provide guidance to new ECCs have culminated in the drafting of the "State of Florida Early Childhood Best Practice Standards." This document, produced in partnership with CIP, will provide guidance across the state in terms of the target population and eligibility to participate in the ECC, risks and needs of young children, validated assessments for young children, roles and responsibilities of the judge as well as each member of the court team, EBPs for young children, providers' training and credentials, and monitoring/evaluation. The ECC standards were produced through the leadership of the Florida State University Center for Prevention & Early Intervention Policy for CIP, with extensive input from ECC judges, sites stakeholders, and the QIC-ITCT state community coordinator's TA.

7. Other Key Elements for Sustainability

A common theme in interviews was the need for regular and constant training and TA to help obtain the buy-in of new court team members and bring them up to speed regarding the knowledge base needed to support the infant-toddler court team work. Recruiting and training new staff impacts the entire infant-toddler court team. There is an awareness that to sustain the practice change that is occurring, all court team members need to be taking measures to standardize the approach to make it replicable when staff members leave and new ones arrive. For stable court team members, TA and training was described as critical to be up-to-date on scientific developments and new EBPs, and to support trauma-informed organizations. Securing access to training on infant mental health, brain development, and trauma-informed care for all staff assigned to work with the youngest children will facilitate a better understanding of the science, which is at the base of the SBCT approach. This will also increase staff's interest in being part of the infant-toddler court.

As part of QIC-ITCT TA, regular calls with all sites as well as the opportunities provided by the annual cross sites meetings were identified as part of the sustainability activities. Interviewees' referenced knowledge gained and changes made based on information from other sites. For example, post-TPR cases now remain with the infant-toddler court team until adoption at some sites, while other sites are maintaining contact with families after the case is closed to be a continuous resource for parents. Interviewees expressed the motivation to improve the program and remain flexible to change processes. Collaboration with other sites will help continue the improvement of practices.

For sites in Florida that are part of the state-wide ECC initiative, the vision/support of CIP was instrumental in sustaining this program. Court circuits often come together for trainings, observations, and discussions. They also have an annual "All Sites" event that is similar to the QIC-ITCT cross sites meetings, but only focuses on the ECC sites in Florida. The ECC network members support each other to promote the SBCT approach by offering trainings, workgroups, and resources as circuits learn from one another's experiences, successes, and challenges. The following are specific areas that are in line with interviewees' description of training as a critical element to sustain the SBCT approach:

- Training for professionals/CWA workers around preventive pediatric health care, home visiting services, Part C services, and Early Head Start
- Training on trauma for child welfare professionals and partners—including lack of universal knowledge and practice across courtrooms
- Training for case workers on placement matching—foster/adopt homes
- Culturally centered trainings needed for service providers—including attorneys and judges.

Interviewees also shared that collaboration with sites from other states has helped their site improve and sustain their work. Conference calls between sites as well as the cross site meetings were mentioned specifically in this regard.

"We like to network with other sites and figure out what we can take from other people."

"We just had this cross sites meeting with all the QIC, all the ZTT, SBCTs, and I think that was remarkably beneficial to get different court teams together. You try to do it with these monthly phone calls and that type of thing, but it really is about establishing relationships and learning from each other. That is a huge component of this, and to the success. If there is some way to keep that connection. They talk about wanting to expand…and I think they're smart. You need to talk about sustainability because at some point in time this QIC-ITCT funding is going to go away and we want the concept to survive and so we are talking about how to sustain our individual courts and expand them but there isn't much talk about how we are going to come together as a group on a regular basis and I think that is a key to sustaining this."

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, as well as other ongoing sustainability activities incorporated into every stage (Fixsen, Blasé, Horner, & Sugai, 2009a, 2009b; Fixsen et al., 2005). Both the QIC-ITCT and the demonstration sites will need to work on identifying what is feasible to accomplish during the final year of the project, and avoid placing unreasonable expectations on the QIC-ITCT and sites' staff, possibly risking losing sight of the many accomplishments achieved during the short QIC-ITCT timeframe.

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. During the remaining time, preparations for sustainability are critical. As one interviewee indicated, "We have not [implemented the program] that long to see the full effects of it. I think in the future we probably could [sustain the program] but right now, I cannot say." Sustainability and growth of the program depends on the team's 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.

Section 6 | Conclusions and Recommendations

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 involved in the initiative, as demonstrated by the variations observed across the sites participating in the QIC-ITCT. The flexibility of the approach is critical for the implementation of the SBCT as sites have large differences in resources, sources and stability of funding, agencies involved, and types/stability of champions and stakeholders involved. Across all sites, resources are very limited, but court teams work actively to remain focused on providing community support for young children and their families, and proactively frontloading services.

The SBCT approach, while flexible and adaptable, offers to each person involved a supportive network. This support is needed in a highly stressful environment that historically has been adversarial instead of collaborative. Of the core components of the SBCT approach, three are critical to initiate and sustain an infant-toddler court:

- **Strong judicial leadership** is needed as judges are catalyzers of community collaboration to support and actively involve families, and are valued by all agencies involved for making everybody accountable for the progress and support provided to children and families during monthly hearings. The presence of judges in monthly stakeholders' meetings motivates agencies and communities, as stakeholders respond actively to requests for support for children and families, and strive to report back to the judge and their community within the following month.

- A **community coordinator** with experience working with vulnerable families and communities provides the critical "glue" across the core components, and is key to establish successful partnerships and maintain collaborative efforts.

- An **active court team** that values the SBCT approach, with dedicated and passionate members that include both frontline court team members working with children and families as well as agency heads, provide the structure to identify dysfunctional practices, create new policies and procedures, streamline the work across agencies, establish direct and fast lines of communications, and bring needed resources to support families. When the active court team includes the support of the state CIP representative, court teams receive not only specialized support for training, but also bring a vision for the need of state-wide work to improve the work on behalf of infants and toddlers.

When one of these critical components is absent, infant-toddler courts can survive, but the pace of progress is not only slower, but also other core components that are in place begin to falter.

As summarized in this report, since the initiation of the sites with the QIC-ITCT there are multiple examples of better practice promoted by the implementation of the SBCT approach. Changes include new ways to prepare for court hearings; hearings that are supportive of parents and give space to their voice and needs; high focus during hearings on quality of placements and concurrent planning, quality of the parent-child relationship, services and use of EBPs; establishment of strengths-based family team meetings and pre/post removal meetings; engagement of parents as key stakeholders; placement of

children with caregivers willing to be permanent if reunification does not work; and frontloading of services that are critical to support changes within a very short timeline as the permanency hearing is always less than 12 months away once the case is adjudicated.

To support the implementation of EBPs for children and families, training of community clinicians on CPP is fundamental. The QIC-ITCT supported training on CPP and the spots provided were highly valued by the communities. Organizational and systems conditions necessary to support this work include educating and obtaining buy-in from stakeholders, gaining support from clinical centers to provide funded time for clinicians to attend training, and working collaboratively to resolve how the clinical services will be paid, both in terms of the psychotherapeutic hours needed for an intensive intervention that requires a year of clinical work, as well as the collateral work that includes family team meetings and participation in hearings.

Several overarching issues were identified through the evaluation. 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 is described across sites as 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 CWA, learn to trust first their community coordinator, and in time their court team. As summarized by a QIC-ITCT TA specialist during a cross sites plenary:

> *"We ask parents what are their most pressing needs. If they do not have a house, it is difficult to think on anything else. We call parents by their names. We model respectful, caring relationships. We meet parents where they are. We accommodate learning styles and slow down. If a meeting is important, we pick them up and stop for coffee. We think about how you feel with the judge, that a foster caregiver talks about your child, that you are African American and the whole team is white or looks like the ladies at your grandmother's church. We celebrate reunification and we are with parents to celebrate their successes."*

The active work with parents, including their inclusion and active participation in family team meetings and court hearings, is in line with the key components of procedural justice summarized in the recent information memorandum by the Children's Bureau on the need for parents to have a voice and their point of view to be heard, parents need neutrality and a process that they can perceive as unbiased and transparent, parents need respect and dignity, and a benevolent authority foremost represented by a judge that parents can perceive as caring and trying to help throughout the process (Administration for Children and Families, 2017c), including supporting parents who cannot take care for their children and need to go through TPR.

As the opioid and substance abuse epidemic continues to rise, more young children are being reported to the CWS and placed out of home, mostly for neglect related to parental substance abuse and trauma. As stated in different forums by Children's Bureau representatives at the 2017 Cross Sites meeting, what the nation is doing in the CWS is not working. The SBCT approach galvanizes support and motivates sites because it offers a structure through the core components to face systems dysfunctionality. As described across this report, the SBCT approach changes professional practice. Once the core components are implemented, the work of regularly bringing on new stakeholders and champions who are trained on the SBCT approach supports the continuation of the approach even if there are changes in judges, community coordinators, or agency heads.

In the next section, we present recommendations to better support the TA and training needed for the implementation and sustainability of 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.

a) Court processes

- Establish Trauma-Informed Practice Consultation as a standard part of initiating work on implementing the SBCT approach and integrate recommendations as new action plans are developed. Trauma consultations are highly valued by judges and stakeholders; they provide a set of recommendations that better prepare sites to initiate the implementation of the SBCT approach.
- Promote scheduling of the infant-court docket on regular days of the month to facilitate attorneys' regular attendance at hearings. Buy-in from attorneys is critical to implement the SBCT approach. Scheduling that considers attorneys' calendar helps ensure their presence, supports avoidance of continuances, and provides an opportunity to introduce them to the new practices.

b) Community coordinator role

- Consider reviewing the list of responsibilities that are part of the role of the community coordinator given variations in skills with data entry. 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 should be used by sites interested in implementing an infant-toddler court.

c) Court teams

- Active participation of 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.
- The CWAs are facing extensive challenges and problems across sites. These challenges can limit the progress of court teams. Support from CWA commissioners is fundamental to implement the SBCT approach. The state without judicial leadership that has CWA leadership provides an example that future sites may want to review as CWA leadership was actively working to establish partnerships with other agencies, some of which had historically contentious relationships.
- Stakeholders at all sites have limited time for meetings, for professionals to dedicate to infant-toddler court team cases, and overwhelmed and under-resourced staff. Each site needs to develop a detailed engagement plan that provides guidance on how best to maintain continued engagement among stakeholders, and describes how much time and resources are needed to support participation and collaboration. Opportunities to process and reflect, as well as talk to one another are critical to prevent burnout.
- Promote a chapter or subcommittee of head agency representatives to review and set formalized procedures that align across participating agencies, including agreements on sharing of child and family information across agencies and providers to reduce

duplication of efforts, and screening for developmental problems and determining the need for early intervention services.

- There are specific groups whose buy-in of the SBCT approach and participation on the court team would have significant positive effects. As such, engagement of and collaboration with the following should be made standard practice:
    - Departments/groups/divisions that are responsible for the removal and placement of children. Bringing these groups on board would help use the SBCT approach from the beginning of the child welfare process, which could positively affect the relationship with parents and relatives, and the suitability and stability of placements
    - Departments/groups/divisions that are responsible for 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/foster parent related organizations. Foster parent intervention is a core component, so their buy-in and participation is necessary to fully implement the SBCT approach.
- Provide court teams with *A Guide to the Implementation of the Safe Babies Court Team Approach* at the implementation initiation stage. Stakeholders need to identify early in the process roles and responsibilities of court team members, as this was an area interviewees indicated needed clarification. The SBCT Implementation Guide is available at the ZTT bookstore.[13]

d) Monthly family team meetings

- Extend training on family team meetings to the first 12 to 18 months of work for community coordinators. Training on "difficult conversations" (see ***Section 2***) and a strength-based approach requires an extended period of training time while community coordinators and family team meetings facilitators develop key skills to navigate conflicts and setbacks. During the period of training of community coordinators, a minimum number of mock family team meetings and mentoring/TA during family team meetings is recommended (e.g., 10 of each) across the first year of work with families.
- Consider asking TA specialists to complete a check list after each mock and actual family team meeting to track progress and needs. An example is provided in ***Exhibit 25*** to track use of a strengths-based approach.
- Promote scheduling of family team meetings on regular days of the month to facilitate regular attendance by court team members.
- Provide training on family team meetings for all court team members. Request that frontline court team members participate in mock family team meetings and mentoring.
- Make use of the family team meeting summary form distributed at cross sites training a standard practice. Providing this to court team members unable to attend family team meetings in advance of the court hearing will ensure all court team members have up-to-date information about each case.

[13] https://www.zerotothree.org/resources/2061-zero-to-three-guide-to-implementing-the-safe-babies-court-team-approach

Exhibit 25. Strengths-Based Family Team Meeting Check List

- Parents are given a voice in determining the goals of the family team meeting.
- Solutions and agreements are parent driven and relationship focused.
- Facilitator actively engages parents to participate and to express their needs and concerns.
- Parents are asked their opinion on all topics.
- Issues and concerns are contextualized and discussed by attendees in a constructive and non-punitive way.
- Parents can invite family/friends/attorneys to attend the meeting as supports.
- Parents provide information and preferences related to child well-being and placement discussions.
- Parents' strengths are described before problems, and most attendees report on at least one strength.
- Parents can take pride in their accomplishments.
- The tone of the meeting is non-adversarial, and all attendees are asked for input.
- Meeting notes are transparent and available to all attendees.
- Facilitator mediates tensions that arise and redirects the conversation to productively resolving conflicts.
- Parents are motivated and encouraged through their own personal resources and talents.
- Parents achievements are acknowledged.
- Meeting participants use common language

e) 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 for other states. As stated by CWA stakeholders, the ultimate goal is to prevent the removal of children and provide services before families are even involved with CWA.

f) Parent support:

- 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 get to 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 this barrier need to be developed and implemented.
- Provide visit coaching to improve the quality of parent-child contact.

g) EBPs and community capacity building

- Conduct annual needs assessments to identify gaps in services and training.
- Provide community clinicians access to annual training on CPP and other EBPs targeted for young children and their parents, given the high rate of burnout.
- Identify/provide opportunities for clinician support/supervision to combat burnout.
- Identify funding sources for CPP/EBPs training and provide continuous guidance for identifying and requesting funding.
- Along with the need for more CPP providers, sites need other mental health and substance abuse services (inpatient and MAT) particularly in rural areas. This area requires regular

monitoring from the QIC-ITCT and infant-toddler court teams to support sites' access to training and use of EBPs with children and families.

h) TA and training

- Offer annual cycles of training to introduce new members to the approach and boosting sessions for long-term members. TA and training are constant needs due to changes across time of frontline court team members and champions that challenges approach implementation and fidelity to core components, and the completion of 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.
- Develop and provide training tailored for attorneys, given the difficulty of attorney buy-in and the lack of attorneys dedicated to infant-court.
- Develop and provide training tailored for foster parents as well as relative and non-relative caregivers. Training and support is needed to sustain foster parents throughout their involvement with a birth family. This ongoing relationship-building is critical for families serving as the concurrent plan and creating extended families if reunification is successful. Training should be focused on providing care, advocating for the children they care for, and mentoring the biological parents, siblings, and extended family.
- Support expansion of the training capacity at the CWA. Given the high turnover of caseworkers and supervisors, the training provided by the QIC-ITCT should be incorporated into the regular training academies of the CWAs. An example is the training academy of Connecticut's DCF, which includes infant mental health, infant trauma, and attachment and bonding. This is offered by DCF to both staff and service providers. The academy includes DCF instructors and trainers from local universities and the Connecticut Association for Infant Mental Health (CT AIMH).

i) Understanding the impact of our work

- Consider providing a description for a data person to be a member of the court team. 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. Promote that sites identify information needs related to the team goals or for funders to motivate strict monthly updates for each active case.
- Work monthly with data staff on missing data and outliers, looking at the impact/distortion indicated by dashboard indicators.
- Align derived variables in the SBCT dataset and dashboard with the most current federal outcome indicators. This will facilitate court teams' regular checks on outcome status and help with having materials ready for presentations to supporters and potential funders.
- Create indicators to be updated every 3 to 6 months that support court team decisions on reunification based on QIC-ITCT safety reviews: "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)

- Across all indicators that require a date, implement consistency checks (automatic flags) that at data entry alert those entering data about dates out of range or unlikely timelines (e.g., any service receipt three months or more from the date of the court order or referral).
- Services data need uniformity/agreement across sites on the definition of referral and receipt of a service; definitions should be updated in the *SBCT Database Users Guide* so the duration between service referral and receipt can be compared across sites.
- Encourage sites to focus on CQI indicators related to variables in the SBCT dataset. Sites that needed to collect and send data for analysis have struggled to meet the monthly data submission requirement.

j) Evaluation design

- Change the design of the SBCT dataset *Report on Missing Data* for a Data Feedback Form that includes information on outliers and potentially out-of-range values for some items (e.g., missing dates for hearings and family team meetings were a problem for some sites impacting CQI metrics). The redesign of the report should include a section of (1) automated data checks that identify the issue, provide the value entered and case ID, and space for site's comments on needed changes or correct entry, and (2) manual data checks reporting inconsistencies or lack of match across relevant topics (e.g., child removed due to parental substance use, but risk factors do not identify alcohol or drug use by parents, or substance exposure of child).
- Change the evaluation design. While a randomized control trial would be the ideal next step for the evaluation of 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 National Survey of Child and Adolescent Well-Being (McCombs-Thornton & Foster, 2012), or the ECC dataset in Florida. Propensity Score Matching is a method capable of reducing 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.
- Add an economic evaluation to the design. Only one economic evaluation has been completed by Economics for the Public Good, estimating the short-term savings associated with earlier exits from foster care. Other evaluations are needed to estimate a cost/benefit analysis from two perspectives: the societal perspective and the government agency perspective. The societal perspective is the broadest perspective and captures the total costs to all parties within society, including the costs to taxpayers, health care providers, the government, and those clients benefiting from the SBCT approach. Economic evaluations in the peer-reviewed literature typically take this perspective. The taxpayer agency perspective is narrower and captures resources that are funded by state and federal government agencies. The government perspective helps decision makers understand what resources are expended and when, as well as the degree to which cost shifting may occur within and across agencies. Economic evaluation data could be used to help obtain funding.

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Appendices

Appendix A
The Eastern Band of Cherokee Indians: A Case Study

Cherokee, North Carolina is the capitol city of the Qualla Boundary, home of the Eastern Band of Cherokee Indians (EBCI), a federally recognized Native American Tribe that operates as a sovereign nation; it has its own government, sets its own laws[1], and now operates its own child welfare system. The EBCI, like other Tribal communities, has a rich history of culture, beliefs, and traditions that they work hard to preserve. Much of this history is characterized by oppression that still resonates with Native Americans today. As with other American Indian communities, families struggle with many risk factors associated with child maltreatment, including poverty that reaches a third of American Indian and Alaska Native families with children under age 5 in the United States (Malone, Knas, Bernstein, & Feinberg, 2017).

The Child Welfare System. At the time that the EBCI was selected as a demonstration site for the QIC-ITCT in 2015, the Tribe was transitioning from a county-managed child welfare system to one administered by the Tribe. Prior to October 2015, Child Protective Services and Foster Care had been handled by county-run agencies. There was no Tribal child welfare court. EBCI families with allegations of child maltreatment were served by local county Departments of Social Services (DSS) and hearings took place in those respective county[2] courts. Services were fragmented, some being governed by the county and others managed by the EBCI. This resulted in families having to complete the same paperwork multiple times for different agencies and often requiring them to travel off the reservation to access county-provided services.

In 2011, a 15-month old Cherokee child tragically died as a result of being left by county DSS caseworkers in the care of an abusive relative, despite multiple reports of maltreatment and neglect by concerned family members. In response, the EBCI community began discussions about returning child welfare responsibilities to the Tribe. On October 1, 2015, the Tribe launched a new child welfare system called the Family Safety Program.

The transition of child welfare services to the tribe is described by one stakeholder as "a historical step forward." The newly formed Family Safety Program provides comprehensive case management for child welfare cases; they coordinate services referrals, conduct investigations into allegations of child maltreatment, operate their own foster care system, and conduct hearings for child welfare cases in their own Family Safety Court. As a result, Native families have a wealth of local resources near their homes. The child welfare agency, mental health intervention services, child care, substance abuse services, hospital and behavioral health facilities, transitional housing, and nutrition services, were all centralized, reducing the transportation burden on families who once had to travel across the state to receive certain services and meet case plan requirements.

The centralization of these services and the general operation of a child welfare system by the Tribe also addresses the community's need for culturally sensitivity and first-hand knowledge of the EBCI history.

[1] https://ebci.com/government/

[2] Counties in North Carolina inclusive of Tribal land trusts are Swain, Jackson, Haywood, Graham, and Cherokee counties.

The Safe Babies Program[3] in Cherokee. The Safe Babies program was introduced in Cherokee in 2009 as a family preservation approach. It is described as "a systems change initiative, focused on improving how the court, child welfare agencies, and related child-serving organizations work together, share information, and expedite services for young children aged 0-5."[4].

One of the presiding tribal court judges was at the forefront of the Safe Babies implementation effort. He would take notice of Native families appearing in any tribal court docket with very young children at risk for maltreatment and address the family as a whole. He requested that representatives from the local Bureau of Indian Affairs' Social Services Department attend the hearing and refer families to programs like Safe Babies, psychotherapy, transitional housing, behavioral health treatment, and nutrition programs.

> *"He helped us serve; he was a really big support. He went beyond being a judge: he bought books for the families and went out of his way to help families."*

When this judge retired, those who replaced him on the bench did not have the same commitment to sustaining the Safe Babies approach. Not only was there no tribal child welfare court, there was no tribal law that mandated the use of the approach. Workers in the Safe Babies program continued in their efforts in reaching out to vulnerable families with young children and connecting them to wraparound services, but the situation was far from ideal as workers perceived the limited commitment and had to resort to indirect strategies to serve families and children in need.

> *"[We are] treating child abuses cases through a side door, through criminal court and not child welfare cases."*
>
> *"Our judicial system doesn't take Safe Babies seriously enough."*

When the tribe took over jurisdiction of the child welfare system in October 2015, there were hardships associated with the transition of cases from one agency to another, but there were also clear positive changes. The tribe had created an integrated model of preventive care and ongoing support for Native families touched by the child welfare system. Not only were they now able to provide families with localized, comprehensive services, but they also had the authority to examine, assess, and modify practices and policies to suit their families' needs, including the potential for implementing ZERO TO THREE's Safe Babies Court Team (SBCT) approach as it was designed: with the formation of a community court team led by a judge and supported by a community coordinator.

The QIC-ITCT and the SBCT Approach. The QIC-ITCT launched its work in Cherokee with a kick-off meeting in July 2015. Members of the tribe presented on the EBCI culture, their history with Child Protective Services, their Foster Parent Program, and the work they had done to date using the Safe Babies approach. Technical experts from the QIC-ITCT offered sessions on judicial leadership in child welfare, understanding trauma in young children, historical trauma, and behavioral and mental health therapy. Several staff from the hospital were selected to attend Child-Parent Psychotherapy (CPP) training in the coming weeks. CPP is an evidence-based intervention developed specifically for infants and young children and their parents to mitigate the impact of maltreatment and other prolonged adverse experiences (i.e., toxic or traumatic stress). CPP is currently on most of the registries for evidence-based programs (e.g., SAMHSA

[3] Safe Babies is the name used by EBCI to describe the wraparound services and support they provide for vulnerable families with very young children at risk for maltreatment. The Safe Babies Court Team approach is the name of ZERO TO THREE's infant-toddler court team model.

[4] http://www.cherokee-hmd.com/family-safety/index.html

National Registry of Evidence Based Programs and Practices; California Evidence-Based Clearinghouse for Child Welfare), with high scores for scientific evidence and high relevance for the child welfare system. As a relationship-based approach, CPP assumes the harm sustained by the infant as a result of maltreatment must be healed within the context of the parent-child relationship (Lieberman & Van Horn, 2008). The community coordinator began attending monthly technical assistance conference calls with the QIC-ITCT staff. Although judicial training and support were made available to the Cherokee Court judges, neither participated regularly in these meetings and trainings.

In 2015, although the judicial leadership component was not in place, the EBCI had a strong community coordinator and a wealth of resources on the reservation.

> *"Being here now, where we have* [child welfare] *on our reservation, I just feel like now there's more empathy, more understanding. The families can see it's different now."*

The court team was made up of representatives from the judicial system (clerk of court, tribal attorneys, and the attorney general), the new localized child welfare agency (director, social workers), transportation and transitional housing providers, education services (for parents and children), and treatment centers for mental health and substance abuse.

Stakeholders met semiregularly in the courtroom just prior to the Family Safety Court hearings. The meetings were spent discussing the cases on the docket, first without and then with the parents/caregivers. The clerk of court recorded notes from the meeting. Services were offered to families, including mental health support and substance abuse treatment. The local hospital housed several therapists trained in CPP. However, none of the Safe Babies families were receiving CPP. Because the services were not mandated by the judge or by Tribal law, many parents did not follow-through on receiving the services they had accepted.

> *"Safe Babies case plans* [were] *not court ordered. Parents won't follow through with treatment if it's not court ordered."*

Although the program served children who remained in the home as well as children in out-of-home care, concurrent planning began within 5 days of a child's removal. Kinship care was prioritized as the preferred placement for children needing out-of-home care, and the program had undertaken an initiative to recruit, license, and retain more Native families as foster families.

> "*A lot of kids went into foster care off-boundary. We needed more Native American foster care placements*."

Not only did having tribal members as foster parents satisfy a cultural requirement, it also reduced the travel burden on parents and caregivers to facilitate parent-child contact. Frequent parent-child contact was an expectation. Both supervised and unsupervised family time occurred about once a week in a child-friendly room that is part the Family Safety Program facility.

> *"*[Parent-child contact] *is a right for the child. The child deserves to have a relationship with the parent even if the parent is not appropriate.* [We] *create the environment to make it a safe visit."*

From the summer of 2015 to the summer of 2017, the QIC-ITCT continued to support the EBCI demonstration site via the following trainings and technical assistance:

Training and TA
EBCI QIC-ITCT for Infant-Toddler Court Teams Kickoff Meeting
SBCT 101
QIC-ITCT Technical Assistance Site Visits and Conference Calls
Weekly/monthly EBCI conference calls with QIC-ITCT staff
Meetings between TA Specialists and Community Coordinators
Conference calls between states
Demonstration site community assessment
Fetal alcohol spectrum disorders (Dr. Larry Burd)
Clinician training in Child-Parent Psychotherapy (Dr. Joy Osofsky)
Implicit Bias (Dr. Marva Lewis)
Intergenerational trauma (Dr. Eduardo Duran)
Historical trauma (Dr. Marva Lewis)
Sustainability planning training (CSSP)
Judicial Leadership Consultation (Judge Connie Cohen)
The Attorney's Role in SBCT (with SBCT Attorneys in Iowa)
Conferences and Events
ZERO TO THREE Annual Conference
2015 QIC-ITCT/SBCT Cross Sites Meeting
2016 QIC-ITCT/SBCT Cross Sites Meeting
2017 QIC-ITCT/SBCT Cross Sites Meeting
2017 NCJFCJ Child Abuse and Neglect Institute Conference

Intergenerational Trauma. One of the challenges that must be considered when supporting the EBCI infant-toddler court team is intergenerational trauma. The Children's Bureau confirms, "Many Tribal communities feel the impact of intergenerational trauma as a result of the experiences of prior generations exposed to adverse and devastating events and conditions" (Tribal Evaluation Workgroup, 2013). The EBCI history is one of culture, language, and tradition marred by the tragedy of being forced off their homeland in the mid-1800s, and the cultural genocide, poverty, and afflictions that followed.

> *"Trauma is a major issue in this community. There is a high incidence of child abuse and substance abuse with Native Americans.* [There are] *also historical issues of cultural genocide that are still affecting people."*

The EBCI and the QIC-ITCT together continued to address the need for stakeholders to be aware of how their own experiences shaped the way they see families in the system. The QIC-ITCT kick-off meeting in 2015 included a training session on intergenerational trauma with Dr. Eduardo Duran; and in July 2017, EBCI court team members attended a training on implicit bias with Dr. Marva Lewis to better understand how their perceptions and opinions can affect the way they interact with families.

> *"Everybody is aware of* [trauma], [but] *whether or not it directs your actions or how you speak to someone is being played out differently among different team members. We are having implicit bias training at the end of the month. So, we can make sure that the* [stakeholders] *are aware of where each person is coming from so when they talk to*

families in crisis, we can check ourselves, and then we're able to keep the goal, the knowledge of the family in the forefront."

As the narrative of the Cherokee people is passed from one generation to the next, there remains a tension between Natives and non-Natives in the community.

"We had to deal with the "outside entities" we call them (people who live off the reservation). I felt there wasn't an understanding of our culture or our people. Being from this community and working with the people is a lot different than outsiders coming in. They can be disrespectful without even knowing it."

"[We] *had to go sometimes and have meetings at the other counties. There was just a disconnect. They're used to talking to people a certain way – "you're going to do this, and you're going to do that". It's not "how can I help you get this done?" it's "this is what you're going to do." When we left there, we were always angry. Our families don't like being told what to do, but you can explain things to them, honor them, be respectful when you're talking to them."*

However, interactions with non-Native caseworkers and service providers are inevitable, making the judgment-free principles of the SBCT approach difficult to put into practice with families. Community coordinators in Cherokee worked to offer a trauma-informed perspective to caseworkers, Native and non-Native alike. Honor and respect for the families in the system is crucial to securing their trust.

"Service providers may have an issue with the family; they know their background and they're like 'oh, them again'. It's difficult to promote staying objective and positive because a lot of the time it IS the same families over and over again."

"Caseworkers have [said]*, 'I don't know what to do with this family; I tell them and tell them and tell them….' But* [the community coordinators] *need to get into the family's background, 'This is what happened to them; this is where they come from; this is why they react this way.' So once that's established and* [the caseworkers] *understand that, it all makes sense to them. Sometimes they just have to be reminded."*

"[We need to] *understand that we might see these families time and time again, and we just do the best we can. We cannot judge."*

"Always be respectful to these families. These are our people. If you know how we are as Native Americans, once somebody talks down to us, makes us feel lesser, we hold that grudge for a long time and you won't ever get anything out of us."

The EBCI Court Team Today. In June 2017, the EBCI began working to implement the SBCT approach. The team's immediate focus was on children aged 0–3 who were in out-of-home care. The Family Safety Program referred the cases they received that were eligible for the approach to the SBCT community coordinator and the Family Safety Attorney. Together, they approached the parent's attorney and (if possible) the parent to describe the program and request permission to participate. If they declined, the case stayed in the Family Safety Program.

Strengths. At the beginning of 2017, a native EBCI judge who grew up in Cherokee agreed to preside over their Safe Babies Court Team cases. The judge had experience working for the federal government in Indian affairs, and has been an Associate Justice on the EBCI Supreme Court since 2000. She has also served as an Associate Justice on the Mississippi Band of Choctaw Indians Supreme Court since 2008. The judge previously served as an Appellate Court Justice on the Lower Sioux Indian Community Appellate Court (2007–2011) and as an Alternate Supreme Court Justice on the Poarch Band of Creek Indians Supreme Court (2008–2011). Although new to the SBCT approach, the judge demonstrated extensive court experience, and the necessary balance of leadership, and compassion for native families. She received training and guidance from the QIC-ITCT, including one-on-one mentoring from Retired Judge Connie Cohen, and attended the 2017 National Council of Juvenile and Family Court Judges (NCJFCJ) Child Abuse and Neglect Institute. She describes the intensity of this experience on informing her practice:

> *"It was like drinking through a fire hose initially. I couldn't get enough…* [The QIC-ITCT has been] *amazing; they've been a sounding board, provided recommendations, guidance, and information. Without* [the QIC-ITCT]*, I wouldn't be where I am right now. If I hadn't felt like I had that kind of support, I don't think I would've stuck with it. Their support and that type of technical assistance when you're setting up new programs is invaluable."*

The families' reaction to the judge was encouraging. One stakeholder reported that families couldn't believe that "she's one of us!" Others commented about how empowering it was for families to see a member of their own tribe, a woman, succeeding as a judge, proving that growing up on the reservation doesn't preclude you from being anything you want. Other stakeholders described:

> *"The families are positive, they feel more comfortable with her. We've never had a native female judge. She's different. She'll ask questions, she'll be very fair to the families. She really cares about her tribe."*
>
> *"She's very empathetic to our families. She's lived here. We've had people talk really positive about it. Especially some of our families that are going to be working with her. They're just amazed that she is native. I think it makes them realize they can do anything; being native doesn't hold you back, if that's what you want to do. I think it empowers them, that we have a native judge…and a woman. She's so smart and very empathetic to our families and I love that about her."*

Some of the judge's priorities as she began hearing Safe Babies cases included:

- Reinstating stakeholder meetings, promoting collaboration among court team members, establishing a camaraderie with a common goal.

> *"*[Success depends on] *open communication. We need people who are committed to a common goal. I don't believe we have a vision statement yet—we will need to create or revisit that, make sure we are all on board."*

- Giving families a more efficient and effective experience with the wealth of resources and services in the community, without overwhelming them.

> *"Services overlap every now and then, and I don't want families to get so overwhelmed with a lot of people getting involved. That's not the family's fault. We just have to work together to see how one service can be involved instead of two or three doing the same work."*
>
> *"*[Families] *would come to our safety program and we would give them 'requirements' and they just couldn't get them done… You've got to think of their mental state and their education level; they don't really understand; they don't have transportation; they've had their kids taken; and everybody looks down on them…so let's do ONE requirement a month and see what happens. And I'm here to tell you they got that one requirement done and* [a parent] *said 'you know we couldn't get all those done, but when you gave us one we really worked on it...We really managed and got it!' and that made them feel so good."*

- Scheduling specific court times for Safe Babies and Family Safety hearings and reducing the amount of time families have to wait in the courthouse.

> *"I want to be able to give specific court times—and say 'you're going to be here in either morning or afternoon court calls.' Right now, it's all day. Some of our families are sitting there all day waiting for their attorney to show up. Sometimes they don't show up at all; then the family has to come back a second day. From my standpoint, not acceptable."*

In addition to the leadership provided by the judge, the EBCI infant-toddler court team was guided by a dedicated and passionate community coordinator. As an enrolled member of the EBCI, she has an immeasurable connection with the community. She is sensitive to families' backgrounds and empathizes with the Native American history of trauma. She cares about the community and will go above and beyond her regular duties to help families: she will go to their homes to check on them, explain the services available in the area, and provide transportation for those families that do not have their own. Most importantly, families trust her.

> *"She knows our families. She knows their families. It's like if you have a visit and you're not real sure about that person, any family safety worker here will tell you, 'Take* [community coordinator] *with you, it'll go so much smoother.' Because they know her, they trust her. She has a good rapport with the families."*
>
> *"*[The community coordinator] *would go out on home visits with* [the Family Safety caseworkers]. *They used her a lot for their native families, to go in the community because they really don't know people here on the 'res' and they're not familiar with them, and because she looks so native, she can get pretty much what they need quicker than they possibly could."*
>
> *"We would not have the program we have without her. She knows her stuff and she cares and she goes over and above. My only concern about our community coordinator is her ability to take time for self-care."*

The EBCI infant-toddler court team continued to implement the SBCT core components, many of which were in place or partially in place when the new judge took the bench. The court team focused on a small

caseload of children in out-of-home care, emphasizing kin care as a priority placement, and valuing birth families by building trusting relationships with them.

> *"We're going to respect* [families] *and we're going to work hard and we're going to be a support to that family and we're going to build a relationship with them. It's not going to be a judge-family relationship, it's going to be a person-family relationship because* [we] *want them to feel like it's okay for them to say what they have to say."*

Challenges. Among the many strengths in the EBCI community, there are also several challenges that the court team tried to work through, including getting parents engaged in the program, securing stakeholder support for the judge and buy-in for her vision, and finding a logical feasible schedule for attorneys to work with families and be present for hearings.

One of the challenges this site faced is a lack of parent engagement. Prior to the development of the Family Safety Program, service referrals and case plans were established and governed by the surrounding North Carolina counties; the tribe had no jurisdiction to enforce the plans and families were not held accountable by the tribe for following through on the receipt of services. The cultural disconnect between Native families and non-Native caseworkers and service providers perpetuated a feeling of mistrust. When the Tribe took over jurisdiction of their own child welfare system and established the Family Safety court in 2015, the judge gained the ability to mandate that the family complete the requirements in their case plans as steps towards reunification. As such, the community coordinator's role expanded to carefully explaining to families the services and programs available to them and limiting their case plan requirements to a manageable level.

Trust remained an issue: families were wary of participating in programs like CPP for fear that something they disclosed would influence whether they were able to see their child.

> *"We don't have problems getting them to accept* [the referral] *but we do have problems with getting them to* [follow through]. *They won't come out and say they don't want to do it, they just won't show up."*

At the same time, they know that by not fulfilling case plan requirements, they are jeopardizing their chance for reunification. The community coordinator was the essential link between families and court team members; she continually worked toward establishing a trustful, strengths-based environment in which honesty from parents didn't prohibit safe, supervised parent-child contact or the potential for reunification.

> *"It's a mark down for them if they don't do* [the services] *when they come back to court if they want to see their children or want more visitation."*
>
> *"I think it's due to their drug use… sometimes they just can't or won't go; for whatever reason, they don't want to attend."*
>
> *"We would love to have more parents utilizing* [CPP], *taking advantage of that, learning how to parent, how to bond with their child because of the intergenerational trauma. We have the tools in place, we just need a person to open the doors to the silos and eventually remove the silos."*

The QIC-ITCT consulted with the EBCI court team on strategies to improve parent engagement, including formalizing pre-removal conferences (pre-removal conference) to be sure that parents are fully informed and participate in the identification of the best caregiver (usually kin) and out-of-home placement prior to the removal of their child. This involved having the necessary parties present at the pre-removal conference, including the community coordinator and the caseworker. The pre-removal conference was the first opportunity for parents to observe the collaborative interaction of the court team members working together in a non-adversarial manner in the best interest of the child. Pre-removal conferences and subsequent family team meetings were characterized by humility and respect by and for all parties, a critical component in gaining a parent's trust. Stakeholders reached out to parents to make sure they were not overwhelmed by the process and that they were well-informed about how they could benefit from being a part of the Safe Babies Court Team (QIC-ITCT, 2016).

> *"Sometimes if parents don't get it—they're not understanding there are recommendations that they have to do to get their children back, we'd do a private meeting … and if there is something they don't understand they might be more likely to ask us than asking when there's a bunch of people in the room. It would be a more personal meeting, less structured."*

Another challenge facing the SBCT program in Cherokee was stakeholders' resistance to change, in general. The implementation of the SBCT approach requires backing from the members of the court team. When the SBCT judge was introduced to the court community in early 2017, the Safe Babies program, as defined by the EBCI court team, had already been operating for several years without the judicial leadership component. Several stakeholders did not understand the justification for making such a change to a program that had been working, from their perspective, "just fine."

> *"*[We] *needed more education about the role of the court, because the tribe really did have all the other components. There was a lack of real understanding of what the court could bring; what the judicial leadership component added as a part of the court team."*

Others were simply uncertain about how the judicial leadership was going to impact their work. The element of the unknown that is characteristic of any change was the source of their concerns.

> *"Change in general is causing people to be alarmed, thinking, 'Oh no is this something extra that I'm going to have to do?' or 'How is this going to affect what I'm already doing?'."*
>
> *"Some* [stakeholders] *have already worked with Safe Babies—I don't think they have a problem with it, they just don't know what their role might be."*

As late as June 2017, the judge expressed confidence in her ability to secure the buy-in from the few stakeholders who were still grappling with the change.

One of the most frustrating struggles related to gaining support from EBCI court team members was the difficulty in securing attorneys' time, and coordinating schedules to assure families their lawyers will be present in court on days of the hearings.

> *"Scheduling for attorneys is the court's largest ongoing challenge because we have a very small bar."*
>
> *"That is my biggest concern. It's not administrative issues with the court; it's the ability to get enough time in the attorneys' schedule.* [We] *have the support from some of the attorneys to try to work with us. It may be that the cases that come into Safe Babies will be dependent on who the attorney is."*

The attorneys who work in the SBCT court also work in the surrounding counties. They currently commit only 2 days each month to attend all the EBCI Family Safety Court cases. It was apparent to SBCT stakeholders that there was not enough time in those 2 days to get through the Family Safety cases; there certainly would not be enough time for SBCT cases characterized by frequent hearings, family team meetings, and spending extra time with families. Several stakeholders reported on this concern.

> *"Having enough physical days for them in our court is a concern."*
>
> *"We only have so many court dates that we've been given and there's not enough time to fit everybody in on that court date, with* [attorneys] *being in different places. How are we going to make that work within the scheduling and time and the court dates that we're allowed?"*

Sustainability. Based on interviews with stakeholders on the EBCI court team, there were three components that stood out as being crucial to implementing and sustaining their infant-toddler court team: a strong but compassionate judge, a Native community coordinator, and the support of the tribal leadership.

Judicial Leadership. As mentioned, the EBCI Safe Babies program operated without the support of the judiciary for several years. During this time, the community was unaware of the influence judicial leadership could have on their court team.

> *"To date, the court has been the weak link…because there was no link."*
>
> *"Before, working with the new judge, I didn't really see the bigger picture.* [We] *didn't realize that we had been working without a judge until now—'so that's what's missing!'"*

Guidance and leadership from a judge who believes in the SBCT approach was a critical component to implementing and sustaining the EBCI court team. With a new judge in place, there was a clear champion to guide the collaboration among stakeholders to present a respectful, non-adversarial climate for families. Court-ordered case plans, mandated services, and a strengths-based court team provided both support and accountability for families. The EBCI judge was confident that although the SBCT court was starting out on a small scale and building toward an initial 10 cases, its success would trigger its growth in the community and bring more stakeholders to the table.

> "*My eventual goal is to take the Safe Babies approach and implement it across all of our Family Safety Program."*

The judge understood the importance of continuous quality improvement. Her plans included tracking key variables in the SBCT database, and using those data to inform processes moving forward. She also planned for a qualitative self-evaluation:

> *"After I've been with the program a little bit longer and had several court dates, I want us to do a self-evaluation. We will need to assess where we are, do a blind evaluation of cases that we've had, what we could have done better, and determine if there are other programs we could benefit from or* [other stakeholders] *we need at the table."*

Staff turnover is inevitable; recruiting and training new counselors, community coordinators, and case managers impacts the entire court team. The judge recognized the need to document court team members' roles and responsibilities once the approach had been implemented. In the interest of sustaining the SBCT approach despite staff turnover, she believed that all court team members should take measures to institutionalize the approach as standard practice.

> *"It's going to require a strong community coordinator and a strong judge to institutionalize the practices and approach and not make it personally dependent."*

Expansion of the Community Coordinator Position. The traditional community coordinator's role includes working with families, linking families with services, conducting outreach in the community, identifying problems in individual cases that require systems-level solutions, and entering case-level data into the SBCT database for tracking and evaluation purposes. The set up on the Qualla Boundary included both a community coordinator and the support of a social worker from the Family Safety Program. The community coordinator's strengths lay in her work with families; as a member of the EBCI, she knows most of the families in the community and they trust her. Those who do not know her immediately recognize her as a member of the tribe when they see her, establishing a connection from the start and making her outreach more effective.

> *"*[She] *would ask* [families] *questions and they were so comfortable…they would just openly share whatever it was that they needed to share."*
>
> *"She's the strongest component we have here. She has a good rapport with the families. If we lose her, Safe Babies is going to lose a lot. I don't know if the program can survive. I just don't know who could fill that role."*

Being a part of the court team takes a toll on court team members; the work can be overwhelming and taxing, repeatedly being exposed to situations that are difficult to witness. The community coordinator, especially, needs support in handling her responsibilities.

> *"*[We] *come into a job with people with drug and alcohol addictions and custody issues. It's really overwhelming, this job. It really takes a toll on* [community coordinators]*."*

> *"I like to work with* [families] *and I like to support them and I like to be able to show my work at the end of the day. I don't want to be on the phone. I want to be out there and helping 'you'* [the family] *get to where you need to be, helping you with paperwork, or at the jail seeing what we could do to help you, seeing what your next steps are—that's what I want to do...but I'm really going to need some help."*

For the community coordinator to focus on families in the program, a Family Safety worker was assigned to provide her support with intake and administrative tasks. This social worker juggled both Family Safety and SBCT cases. Her responsibilities included attending family team meetings, making sure children in out-of-home care had suitable homes, medical care, childcare, clothes, and services.

> *"We just started; it's a little bumpy. I should get all the 0–3* [year old] *cases. We have to ask them if they want to be in our program and then ask the lawyers. But we were getting so many* [babies]. *There's so much involved with getting new babies. It was getting a little overwhelming."*

In addition to meeting with families and attending to her casework, she was responsible for entering case information into the SBCT dataset, a component critical to evaluating and improving the court team. Several stakeholders acknowledged in interviews that sustaining the SBCT approach was dependent on having two community coordinators.

> *"We've talked about how at some point we may have to have two social workers for Safe Babies. Before the new judge, all the family safety case workers had their own cases. It wasn't* [one social worker]. *I don't know why we can't all work* [the SBCT approach] *together, instead of just one special social worker. Or* [we could] *assign two social workers to Safe Babies."*

Support of Tribal Leadership. As 2017 was an election year for the Tribe, maintaining the support of the Chief and the Tribal Council was critical if implementation of the SBCT approach was to continue. Equally as important was the support needed from the judiciary.

> *"We need the support of chief justice and chief judge. Leadership at the court was the biggest hurdle* [to implementing an infant-toddler court team] *in the past…we can't do it without them."*

Providing regular updates/presentations to Tribal Council about the effect of the SBCT approach on family and child outcomes was proposed as a strategy to help these key stakeholders see the value in its continuance. Court team members knew that support from the Tribe would directly influence the securing of funds for the expanded community coordinator position, the appointment of a native judge with a link to the community, and the backing of attorneys to dedicate time to these families.

> *"People have heard about Safe Babies but they don't know what it is. We really need to present it to our council members, our chief, and vice chief and get them involved. They can be so helpful to us if they're more aware of it. We just haven't had time to do it. Even inviting them to our court hearings so they can understand it."*

If Tribal Leadership understood and valued the SBCT approach, it would be easier for them to dedicate funds to sustaining the court team after the QIC-ITCT grant ends. Several stakeholders commented on this:

> *"Neither the court nor the coordinator can do it alone. They are essential pieces especially in tribal communities - the strong court leadership and really strong community coordinator. Between those two positions, you can get buy-in of the bureaucracy and the community."*
>
> *"*[The community coordinator's] *grant is up in September so* [we've] *been going around and around about what's going to happen in September.* [We] *don't want her to leave."*
>
> *"*[We have] *scheduled time with new chief to seek funding to have* [the community coordinator] *continue in her role. But we need more than just one; we need a co-coordinator."*

Because the court team cannot approach families without the clearance of their attorneys, support from the Tribe would also influence the buy-in of local attorneys, and secure their time to be a part of the court team.

> *"*[We] *need to figure out who is going to be committed—hopefully there will be enough attorneys to draw from—and have them show up* [in court]*."*
>
> *"Perhaps have one or two attorneys dedicated to the Safe Babies court so they can do Family Safety and Safe Babies more than 2 days per month."*

Gaining support from Tribal leadership, maintaining a full-time community coordinator, securing assistance for that coordinator from Family Safety workers, and recognizing the importance of having tribal members in leadership roles are all steps toward assuring the proper implementation and sustainability of the SBCT approach on the Qualla Boundary. With the arrival of a highly-qualified, passionate Native judge in early 2017, it seemed that the EBCI was in a great position to achieve each of these.

Closing. The EBCI court team correctly identified the critical pieces needed to permit the Safe Babies work to prosper: a strong but compassionate judge, a community coordinator who belonged to the tribe, and the support of the tribal leadership. In January 2017, tribal leaders identified a highly experienced Native American judge who provided the leadership, vision, and capacity to mobilize change across the community, engage key stakeholders, and guide the initial implementation stage of the SBCT approach with a gentle but steady hand. In only a matter of months, however, the Tribal Council replaced her with another judge, brand new to the bench. The Community Coordinator, so well loved, resigned her position effective September 29. In September, the EBCI decided not to participate in Year 4 of the QIC-ITCT.

References

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Appendix B
Aggregate Web Surveys, Baseline and Follow-Up

Stakeholders Web Survey: Baseline

1. Please identify your site:

Value	Percent	Responses
New Haven, Connecticut	9.8%	21
Pinellas County, Florida	6.1%	13
Honolulu, Hawaii	4.7%	10
Polk County, Iowa	11.7%	25
Forrest County, Mississippi	14.5%	31
Cherokee, North Carolina	2.3%	5
South Okaloosa County, Florida	9.8%	21
Pasco County, Florida	13.1%	28
Hillsborough County, Florida	13.6%	29
Bay County, Florida	8.9%	19
Rankin County, Mississippi	5.6%	12

Total: 214

2. When did you first become involved with the infant-toddler court team? Select one.

Value	Percent	Responses
Before 2005	0.5%	1
2005	3.3%	7
2006	1.9%	4
2007	1.9%	4
2008	1.9%	4
2009	3.3%	7
2010	5.7%	12
2011	3.8%	8
2012	4.2%	9
2013	7.5%	16
2014	17.9%	38
2015	37.7%	80
2016	10.4%	22

Total: 212

3. How are you involved with the infant-toddler court team? Please select all that apply.

Value	Percent	Responses
Participate in monthly stakeholder meetings	66.8%	143
Was an original stakeholder involved in building the infant-toddler court initiative	26.2%	56
Have partnered with the infant-toddler court initiative	40.7%	87
Work with individual families whose cases are being heard in infant-toddler court	54.7%	117
Attend training sponsored by the infant-toddler court initiative	59.8%	128
Participate in infant-toddler court initiative sub-committees on special topics	35.5%	76
Serve on a work group in which the infant-toddler court initiative is also involved	27.1%	58
Not among the infant-toddler court initiative stakeholders but want to support their work	0.5%	1
Not among the stakeholders but benefit from their work	1.9%	4
Advocate for the infant-toddler court initiative	30.8%	66
Was part of the planning team for implementing a team focused on infants and toddlers	27.1%	58
Was part of the planning team that applied for the QIC opportunity	12.6%	27
Funder of the infant-toddler court initiative	5.6%	12
Other (specify):	11.7%	25

4. What best describes your professional position as it relates to the infant-toddler court team?

Value	Percent	Responses
Community Coordinator	6.1%	13
Agency Attorney	5.6%	12
Parent Attorney	3.3%	7
Child Attorney	1.4%	3
Guardians *ad litem* (GAL)	4.7%	10
Court-Appointed Special Advocates(CASA)	2.3%	5
Child welfare worker/supervisor	22.9%	49
Early Childhood Specialist/ Professional	5.6%	12
Mental Health provider	12.6%	27
College/University staff	2.8%	6
Judge	3.7%	8
Substance abuse treatment provider	4.2%	9
Public Health/Medical Provider	3.3%	7
Early Intervention/Home Visitor	1.4%	3
Parent partner	0.9%	2
Foster parent/advocate	0.5%	1
Public/private agency management	12.6%	27
Other (specify):	6.1%	13

Total: 214

5. To what extent are the following components in place within your community?

	To a great extent	To a good extent	To a moderate extent	To a small extent	Not at all	Don't know / Not applicable	Total Responses
Judicial commitment and leadership to the infant-toddler court initiative Count Row %	136 63.6%	46 21.5%	15 7.0%	11 5.1%	2 0.9%	4 1.9%	214
Community coordinator facilitates collaboration across systems. Count Row %	104 48.6%	70 32.7%	23 10.7%	11 5.1%	3 1.4%	3 1.4%	214
Collaborative court team focuses on the big picture (e.g. local policy that supports or hinders best practices in child welfare; available services; gaps in services). Count Row %	83 38.8%	73 34.1%	40 18.7%	10 4.7%	1 0.5%	7 3.3%	214
Monthly family team case meetings are held to review all open cases in the infant-toddler court initiative. Count Row %	96 44.9%	47 22.0%	22 10.3%	13 6.1%	7 3.3%	29 13.6%	214

	To a great extent	To a good extent	To a moderate extent	To a small extent	Not at all	Don't know / Not applicable	Total Responses
Monthly infant-toddler court initiative stakeholders meetings are held to support implementation and sustainability Count Row %	88 41.3%	66 31.0%	18 8.5%	12 5.6%	3 1.4%	26 12.2%	213
Limiting the number of placement changes (fewer than 2 ideally) for infants and toddlers. Count Row %	45 21.0%	61 28.5%	49 22.9%	12 5.6%	4 1.9%	43 20.1%	214
Concurrent planning that **simultaneously** pursues permanency Plan A (usually reunification) and Plan B (kinship care or adoption) from the start of the case. Count Row %	78 36.4%	60 28.0%	31 14.5%	14 6.5%	3 1.4%	28 13.1%	214
Monthly court hearings are held to review the infant-toddler court cases. Count Row %	118 55.1%	41 19.2%	15 7.0%	9 4.2%	7 3.3%	24 11.2%	214
Parent-child contact (visitation) is ordered to occur daily. Count Row %	24 11.2%	32 15.0%	45 21.0%	29 13.6%	33 15.4%	51 23.8%	214

	To a great extent	To a good extent	To a moderate extent	To a small extent	Not at all	Don't know / Not applicable	Total Responses
Policy in place to increase parent/child visitation toward goal of daily contact. Count Row %	36 16.8%	51 23.8%	37 17.3%	16 7.5%	26 12.1%	48 22.4%	214
Regular medical care is provided for infants and toddlers in foster care. Count Row %	109 50.9%	69 32.2%	13 6.1%	3 1.4%	0 0.0%	20 9.3%	214
Regular developmental screening is provided for infants and toddlers in foster care. Count Row %	89 41.6%	72 33.6%	23 10.7%	8 3.7%	1 0.5%	21 9.8%	214
There is availability of child-focused services for physical health, development, and mental health needs. Count Row %	74 34.6%	90 42.1%	34 15.9%	7 3.3%	0 0.0%	9 4.2%	214
Use of evidence-based programs for parents. Count Row %	68 31.9%	75 35.2%	38 17.8%	14 6.6%	2 0.9%	16 7.5%	213

	To a great extent	To a good extent	To a moderate extent	To a small extent	Not at all	Don't know / Not applicable	Total Responses
Training, technical assistance, and resources to support the infant-toddler court initiative's stakeholders and team members are available on an ongoing basis. Count Row %	60 28.2%	75 35.2%	40 18.8%	14 6.6%	2 0.9%	22 10.3%	213

6. To what extent has your own agency done any of the following to facilitate staff's participation or to help the infant-toddler court team?

	To a great extent	To a good extent	To a moderate extent	To a small extent	Not at all	Don't know / Not applicable	Total Responses
Provided support for the infant-toddler court's stakeholders and team members to schedule and attend meetings. Count Row %	82 38.9%	77 36.5%	24 11.4%	9 4.3%	5 2.4%	14 6.6%	211
Provided support (either through funding or administrative decision) for reduced caseloads for infant-toddler court team members. Count Row %	35 16.6%	39 18.5%	31 14.7%	16 7.6%	29 13.7%	61 28.9%	211
Approved time needed for infant-toddler court activities (hearings, monthly court team meetings). Count Row %	77 36.7%	63 30.0%	20 9.5%	7 3.3%	8 3.8%	35 16.7%	210
Re-allocated roles and responsibilities to focus on infants and toddlers. Count Row %	52 24.8%	45 21.4%	36 17.1%	15 7.1%	17 8.1%	45 21.4%	210
Hired staff dedicated to serve on the infant-toddler court initiative. Count Row %	38 18.0%	45 21.3%	19 9.0%	18 8.5%	43 20.4%	48 22.7%	211

	To a great extent	To a good extent	To a moderate extent	To a small extent	Not at all	Don't know / Not applicable	Total Responses
Conducted regular reviews to assure that policy and effective practice components of the infant-toddler court initiative are congruent (e.g., caseworker time to support frequent visitation aligned with daily visitation policy). Count Row %	32 15.2%	41 19.4%	31 14.7%	22 10.4%	23 10.9%	62 29.4%	211
Identified staff's core training needs (early childhood development, infant mental health, CPP, trauma-informed care, Court Team approach). Count Row %	50 23.7%	60 28.4%	44 20.9%	21 10.0%	9 4.3%	27 12.8%	211
Provided services (treatment or other) Count Row %	61 29.0%	59 28.1%	22 10.5%	12 5.7%	15 7.1%	41 19.5%	210

7. To what extent has the infant-toddler court team had any of the following impacts on stakeholders and team members' practice at your site?

	To a great extent	To a good extent	To a moderate extent	To a small extent	Not at all	Don't know / Not applicable	Total Responses
Expanded network/connections. Count Row %	73 35.8%	79 38.7%	27 13.2%	12 5.9%	2 1.0%	11 5.4%	204
Dialog has been fostered with stakeholders and team members that have divergent perspectives. Count Row %	71 35.0%	72 35.5%	34 16.7%	5 2.5%	2 1.0%	19 9.4%	203
Communication with other agencies has improved. Count Row %	69 33.8%	76 37.3%	34 16.7%	18 8.8%	0 0.0%	7 3.4%	204
Collaboration (working together to build solutions to conflicts and resolve differences among systems) has improved. Count Row %	68 33.3%	69 33.8%	45 22.1%	11 5.4%	2 1.0%	9 4.4%	204
Understanding of the needs of infants and toddlers in foster care has improved. Count Row %	70 34.3%	83 40.7%	32 15.7%	12 5.9%	2 1.0%	5 2.5%	204

	To a great extent	To a good extent	To a moderate extent	To a small extent	Not at all	Don't know / Not applicable	Total Responses
A shared language/knowledge on attachment and infants' mental health has been created. Count Row %	54 26.5%	78 38.2%	41 20.1%	21 10.3%	0 0.0%	10 4.9%	204
A shared understanding of the impact of child maltreatment, trauma, and placements, including multiple placements, on young children has been created. Count Row %	64 31.4%	88 43.1%	31 15.2%	16 7.8%	0 0.0%	5 2.5%	204
Better understanding of parents' individual trauma history, family trauma histories, and the historical trauma influencing the community. Count Row %	60 29.4%	76 37.3%	39 19.1%	23 11.3%	1 0.5%	5 2.5%	204
Increased awareness of how racism affects parents' experience of the child welfare system. Count Row %	18 8.8%	43 21.1%	45 22.1%	30 14.7%	32 15.7%	36 17.6%	204
There are pre-removal conferences with parents, CPS, extended family, and other people that can support parents Count Row %	36 17.7%	34 16.7%	26 12.8%	19 9.4%	35 17.2%	53 26.1%	203

	To a great extent	To a good extent	To a moderate extent	To a small extent	Not at all	Don't know / Not applicable	Total Responses
Hearings occur within 24 hours of child's removal. Count Row %	72 35.3%	27 13.2%	17 8.3%	11 5.4%	17 8.3%	60 29.4%	204
Case plans and recommendations provided during hearings by infant-toddler court members have improved. Count Row %	43 21.1%	55 27.0%	41 20.1%	13 6.4%	6 2.9%	46 22.5%	204
There is a team work approach among the infant-toddler court team members for each family (problem solving, wrap-around approach). Count Row %	66 32.4%	72 35.3%	34 16.7%	12 5.9%	1 0.5%	19 9.3%	204
There is a stable group of professionals for the infant-toddler court initiative's cases. Count Row %	74 36.3%	71 34.8%	32 15.7%	11 5.4%	0 0.0%	16 7.8%	204
Parents are key members of the team. Count Row %	68 33.5%	62 30.5%	34 16.7%	16 7.9%	4 2.0%	19 9.4%	203
There is an improved focus on the family and their challenges/needs. Count Row %	70 34.3%	74 36.3%	34 16.7%	12 5.9%	3 1.5%	11 5.4%	204

	To a great extent	To a good extent	To a moderate extent	To a small extent	Not at all	Don't know / Not applicable	Total Responses
Families are praised when there is progress. Count Row %	92 45.1%	53 26.0%	22 10.8%	5 2.5%	1 0.5%	31 15.2%	204
Families are appropriately admonished for lack of progress and probable consequences of inaction are clearly explained. Count Row %	47 23.3%	63 31.2%	25 12.4%	13 6.4%	9 4.5%	45 22.3%	202

8. To what extent are the following organizational components in place to support the implementation of this intervention?

	To a great extent	To a good extent	To a moderate extent	To a small extent	Not at all	Don't know / Not applicable	Total Responses
Site conducted needs assessment to identify gaps in the service continuum and identify training needs for intervention. Count Row %	44 22.1%	61 30.7%	30 15.1%	11 5.5%	2 1.0%	51 25.6%	199
Site reviewed evidence and/or a rating agency's review of the evidence-based practice for the selected intervention before making the selection Count Row %	49 24.6%	44 22.1%	22 11.1%	7 3.5%	2 1.0%	75 37.7%	199
There is evidence for this intervention for the birth to three population Count Row %	90 45.2%	48 24.1%	20 10.1%	4 2.0%	0 0.0%	37 18.6%	199
Site provided support for service providers to become proficient in the new intervention (e.g. training, coaching, supervision) Count Row %	66 33.2%	62 31.2%	16 8.0%	8 4.0%	2 1.0%	45 22.6%	199

	To a great extent	To a good extent	To a moderate extent	To a small extent	Not at all	Don't know / Not applicable	Total Responses
Caseworkers receive in-service training to facilitate screening and referral to the intervention. Count Row %	43 21.5%	40 20.0%	27 13.5%	17 8.5%	7 3.5%	66 33.0%	200
There is active monitoring of waiting time for infant-toddler court initiative's cases to receive intervention. Count Row %	43 21.8%	46 23.4%	18 9.1%	11 5.6%	5 2.5%	74 37.6%	197

9. To what extent have you observed the following changes in children and family outcomes related to the implementation of infant-toddler court initiative at your site?

	To a great extent	To a good extent	To a moderate extent	To a small extent	Not at all	Don't know / Not applicable	Total Responses
Kinship guardians are identified and supported as the preferred placement. Count Row %	64 33.2%	63 32.6%	28 14.5%	8 4.1%	1 0.5%	29 15.0%	193
Fewer children have a change in foster home. Count Row %	36 18.7%	52 26.9%	35 18.1%	16 8.3%	5 2.6%	49 25.4%	193
Children reach permanency faster. Count Row %	34 17.5%	47 24.2%	34 17.5%	15 7.7%	3 1.5%	61 31.4%	194
Children and parents have more frequent visitation. Count Row %	68 35.2%	50 25.9%	30 15.5%	12 6.2%	2 1.0%	31 16.1%	193
Parent-child contact occurs in "home like" settings (child welfare offices are a choice of last resort). Count Row %	35 18.0%	39 20.1%	42 21.6%	26 13.4%	4 2.1%	48 24.7%	194
Time from referral to service initiation has improved. Count Row %	48 24.7%	49 25.3%	31 16.0%	11 5.7%	3 1.5%	52 26.8%	194

	To a great extent	To a good extent	To a moderate extent	To a small extent	Not at all	Don't know / Not applicable	Total Responses
More children have a medical home. Count Row %	30 15.5%	29 15.0%	22 11.4%	14 7.3%	4 2.1%	94 48.7%	193
More children are screened for developmental delays. Count Row %	65 33.5%	40 20.6%	28 14.4%	9 4.6%	1 0.5%	51 26.3%	194
More children and parents receive services to improve the quality of the relationship (e.g., infant mental health services, dyadic therapy, CPP). Count Row %	66 34.0%	60 30.9%	28 14.4%	9 4.6%	0 0.0%	31 16.0%	194
Services for parents take into account previous experiences of trauma and biological insult (e.g. prenatal alcohol exposure, substance abuse, mental illness, etc.). Count Row %	63 32.6%	56 29.0%	32 16.6%	13 6.7%	1 0.5%	28 14.5%	193

Stakeholders Web Survey: Follow Up

1. Please identify your site

Value	Percent	Responses
New Haven, Connecticut	10.9%	15
Honolulu, Hawaii	10.2%	14
Polk County, Iowa	18.2%	25
Forrest County, Mississippi	8.0%	11
Rankin County, Mississippi	4.4%	6
Pinellas County, Florida	13.1%	18
South Okaloosa County, Florida	6.6%	9
Pasco County, Florida	16.8%	23
Hillsborough County, Florida	5.1%	7
Bay County, Florida	6.6%	9

Total: 137

2. When did you first become involved with the infant-toddler court team?

Value	Percent	Responses
Before 2005	5.1%	7
2005	1.5%	2
2006	0.7%	1
2007	1.5%	2
2008	2.2%	3
2009	2.9%	4
2010	6.6%	9
2011	3.6%	5
2012	4.4%	6
2013	5.8%	8
2014	9.5%	13
2015	34.3%	47
2016	21.9%	30

Total: 137

3. How are you involved with the infant-toddler court team? Please select all that apply.

Value		Percent	Responses
Participate in monthly stakeholder meetings		74.5%	102
Participate in monthly family team meetings		43.1%	59
Was an original stakeholder involved in building the infant-toddler court team		29.9%	41
Have partnered with the infant-toddler court team		38.0%	52
Work with individual families whose cases are being heard in infant-toddler court		55.5%	76
Attend training sponsored by the infant-toddler court team		62.8%	86
Participate in infant-toddler court team sub-committees on special topics		37.2%	51
Serve on a work group in which the infant-toddler court team is also involved		35.0%	48
Not among the infant-toddler court team stakeholders but I want to support their work		0.7%	1
Not among the infant-toddler court team stakeholders but I benefit from their work		0.7%	1
Advocate for the infant-toddler court initiative		28.5%	39
Was part of the planning team for implementing a team focused on infants and toddlers		24.8%	34
Was part of the planning team that applied for the QIC opportunity		14.6%	20
Funder of the infant-toddler court team initiative		4.4%	6
Other (specify):		10.2%	14

4. What best describes your professional position as it relates to the infant-toddler court team?

Value	Percent	Responses
Judge	3.6%	5
Community Coordinator	5.1%	7
State/Prosecuting Attorney	4.4%	6
Agency Attorney	2.2%	3
Parent Attorney	5.1%	7
Child Attorney	0.7%	1
Guardian *ad litem* (GAL)	7.3%	10
Court-Appointed Special Advocate (CASA)	2.9%	4
Child Welfare Caseworker/Supervisor	11.7%	16
Parent Partner/Peer Mentor	0.7%	1
Foster Parent/Advocate	2.2%	3
Public/Private Agency Management	8.0%	11
Early Childhood Specialist/ Professional	5.1%	7
Mental Health Clinician	10.9%	15
Substance Abuse Treatment Provider	5.1%	7
Public Health/Medical Provider	1.5%	2
Early Intervention/Home Visitor	2.2%	3
College/University Staff	5.1%	7
Other (specify):	16.1%	22
	Total:	**137**

5. What support or technical assistance has the QIC-CT provided to your site? Please select all that apply.

Value	Percent	Responses
Technical Assistance Training from QIC-CT Staff (Lucy Hudson, Kim Diamond-Berry, Judy Norris, Josie Brown, Carrie Toy)	55.1%	75
QIC-CT Weekly/Monthly Conference Calls	36.8%	50
Judges Monthly Conference Calls	17.6%	24
Cross-Site Conference Calls	30.1%	41
Community Coordinator Training	25.7%	35
Training webinars for community coordinators on court-based system reform (NCJFCJ)	25.7%	35
Judicial Leadership Training (with Judge Cohen)	21.3%	29
Judges Training (at the NCJFCJ Child Abuse and Neglect Institute or Annual Meeting)	9.6%	13
Child-Parent Psychotherapy Training (with Dr. Joy Osofsky)	33.1%	45
Infant Mental Health Training	26.5%	36
Child Development and Infant Mental Health (with Angela Searcy)	8.1%	11
Intergenerational Trauma Training (with Eduardo Duran)	9.6%	13
Historical Trauma Training (with Dr. Marva Lewis)	19.1%	26
Fetal Alcohol Spectrum Disorders Training (with Dr. Larry Burd)	35.3%	48
Participation in QIC-CT/SBCT Cross-Sites Meeting	42.6%	58
Sustainability Planning Training (CSSP)	19.9%	27
Training Webinars on the use of the Racial Equity Tool and using data for Continuous Quality Improvement (CSSP)	9.6%	13
Participation in ZERO TO THREE Annual Conference	28.7%	39
Other (specify):	13.2%	18

6. To what extent are the following components in place in your community?

	To a great extent	To a good extent	To a moderate extent	To a small extent	Not at all	Don't know / Not applicable	Total Responses
Judicial leadership and judiciary commitment to the infant-toddler court team are present. Count Row %	94 69.1%	21 15.4%	9 6.6%	7 5.1%	1 0.7%	4 2.9%	136
A community coordinator facilitates collaboration across agencies. Count Row %	73 53.7%	34 25.0%	15 11.0%	10 7.4%	1 0.7%	3 2.2%	136
A collaborative court team is focused on the big picture (e.g. local policy that supports or hinders best practices in child welfare; available services; gaps in services). Count Row %	53 39.0%	54 39.7%	22 16.2%	2 1.5%	1 0.7%	4 2.9%	136
Pre-removal conferences are held prior to the child being placed in foster care to introduce the infant-toddler court team and inform parents of goals. Count Row %	30 22.2%	20 14.8%	5 3.7%	8 5.9%	32 23.7%	40 29.6%	135

	To a great extent	To a good extent	To a moderate extent	To a small extent	Not at all	Don't know / Not applicable	Total Responses
Family team case meetings are held monthly to review all open infant-toddler court team cases. Count Row %	74 54.4%	34 25.0%	13 9.6%	4 2.9%	0 0.0%	11 8.1%	136
Infant-toddler court team stakeholder meetings are held monthly to support its implementation and sustainability. Count Row %	75 55.1%	37 27.2%	11 8.1%	2 1.5%	1 0.7%	10 7.4%	136
Comprehensive developmental, medical, and mental health services for the child are incorporated into the case plan. Count Row %	61 44.9%	36 26.5%	18 13.2%	3 2.2%	3 2.2%	15 11.0%	136
Parents receive comprehensive medical and mental health assessments to evaluate and treat their own trauma history. Count Row %	40 29.4%	43 31.6%	25 18.4%	9 6.6%	3 2.2%	16 11.8%	136
The number of placement changes for infants and toddlers is limited (ideally, to fewer than 2 placement changes). Count Row %	38 27.9%	51 37.5%	21 15.4%	5 3.7%	3 2.2%	18 13.2%	136

	To a great extent	To a good extent	To a moderate extent	To a small extent	Not at all	Don't know / Not applicable	Total Responses
Concurrent planning **simultaneously** pursues permanency Plan A (usually reunification) and Plan B (kinship care or adoption) from the start of the case. Count Row %	56 41.2%	44 32.4%	15 11.0%	5 3.7%	1 0.7%	15 11.0%	136
Foster parents receive training and support before and while they are engaged with a child and his/her family. Count Row %	24 17.6%	39 28.7%	19 14.0%	12 8.8%	4 2.9%	38 27.9%	136
Court hearings are held monthly to review the infant-toddler court cases. Count Row %	74 54.4%	26 19.1%	8 5.9%	6 4.4%	7 5.1%	15 11.0%	136
Parent-child contact (visitation) is recommended to occur more frequently for infant-toddler court team cases than for typical dependency court cases. Count Row %	71 52.2%	44 32.4%	8 5.9%	3 2.2%	1 0.7%	9 6.6%	136
A policy is in place to increase parent/child visitation toward goal of daily contact. Count Row %	33 24.3%	37 27.2%	18 13.2%	5 3.7%	11 8.1%	32 23.5%	136

	To a great extent	To a good extent	To a moderate extent	To a small extent	Not at all	Don't know / Not applicable	Total Responses
Regular medical care is provided for infants and toddlers in foster care. Count Row %	72 52.9%	35 25.7%	10 7.4%	1 0.7%	0 0.0%	18 13.2%	136
Regular developmental screening is provided for infants and toddlers in foster care. Count Row %	63 46.3%	40 29.4%	14 10.3%	2 1.5%	1 0.7%	16 11.8%	136
There is availability of child-focused services for physical health, development, and mental health needs. Count Row %	58 42.6%	49 36.0%	15 11.0%	2 1.5%	1 0.7%	11 8.1%	136
Evidence-based practices are in place for parents. Count Row %	40 29.4%	53 39.0%	20 14.7%	7 5.1%	1 0.7%	15 11.0%	136
Evidence-based practices are in place for children. Count Row %	50 36.8%	57 41.9%	16 11.8%	2 1.5%	0 0.0%	11 8.1%	136
Training, technical assistance, and resources to support the infant-toddler court team stakeholders and team members are available on an ongoing basis. Count Row %	44 32.4%	56 41.2%	16 11.8%	5 3.7%	1 0.7%	14 10.3%	136

7. To what extent has your own agency done any of the following to facilitate staff participation or to help the infant-toddler court team?

	To a great extent	To a good extent	To a moderate extent	To a small extent	Not at all	Don't know / Not applicable	Total Responses
Provided support for the infant-toddler court's stakeholders and team members to schedule and attend meetings. Count Row %	59 44.4%	43 32.3%	10 7.5%	5 3.8%	1 0.8%	15 11.3%	133
Provided support (either through funding or administrative decision) for reduced caseloads for infant-toddler court team members. Count Row %	23 17.2%	20 14.9%	10 7.5%	9 6.7%	20 14.9%	52 38.8%	134
Approved time needed for infant-toddler court activities (hearings, monthly court team meetings). Count Row %	62 46.3%	32 23.9%	8 6.0%	4 3.0%	2 1.5%	26 19.4%	134
Re-allocated roles and responsibilities to focus on infants and toddlers. Count Row %	36 26.9%	25 18.7%	15 11.2%	8 6.0%	13 9.7%	37 27.6%	134
Hired staff dedicated to serve on the infant-toddler court team. Count Row %	31 23.1%	21 15.7%	9 6.7%	7 5.2%	29 21.6%	37 27.6%	134

	To a great extent	To a good extent	To a moderate extent	To a small extent	Not at all	Don't know / Not applicable	Total Responses
Conducted regular reviews to assure that policy and effective practice components of the infant-toddler court initiative are congruent (e.g., caseworker time to support frequent visitation aligned with daily visitation policy). Count Row %	27 20.1%	23 17.2%	15 11.2%	7 5.2%	13 9.7%	49 36.6%	134
Identified staff's core training needs (early childhood development, infant mental health, CPP, trauma-informed care, Court Team approach). Count Row %	36 26.9%	39 29.1%	17 12.7%	6 4.5%	8 6.0%	28 20.9%	134
Provided services (treatment or other) Count Row %	50 37.3%	29 21.6%	9 6.7%	4 3.0%	4 3.0%	38 28.4%	134

8. To what extent has the infant-toddler court team approach impacted stakeholders' and team members' practice at your site?

	To a great extent	To a good extent	To a moderate extent	To a small extent	Not at all	Don't know / Not applicable	Total Responses
Networks and connections have been expanded. Count Row %	51 41.1%	48 38.7%	15 12.1%	6 4.8%	1 0.8%	3 2.4%	124
Dialog has been fostered with stakeholders and team members that have divergent perspectives. Count Row %	40 32.3%	56 45.2%	13 10.5%	4 3.2%	3 2.4%	8 6.5%	124
Communication with other agencies has improved. Count Row %	40 32.3%	57 46.0%	12 9.7%	9 7.3%	0 0.0%	6 4.8%	124
Collaboration (working together to come up with solutions to conflicts and resolve differences between partners) has improved. Count Row %	47 37.9%	47 37.9%	13 10.5%	9 7.3%	0 0.0%	8 6.5%	124
Practices or policies have been modified. Count Row %	18 14.5%	44 35.5%	32 25.8%	8 6.5%	3 2.4%	19 15.3%	124

	To a great extent	To a good extent	To a moderate extent	To a small extent	Not at all	Don't know / Not applicable	Total Responses
An understanding of the needs of infants and toddlers in foster care has improved. Count Row %	34 27.4%	58 46.8%	15 12.1%	6 4.8%	1 0.8%	10 8.1%	124
A shared language/knowledge on attachment and infants' mental health has been created. Count Row %	32 25.8%	57 46.0%	19 15.3%	4 3.2%	1 0.8%	11 8.9%	124
A shared understanding of the impact of child maltreatment, trauma, and placements, including multiple placements, on young children has been created. Count Row %	47 37.9%	49 39.5%	18 14.5%	4 3.2%	1 0.8%	5 4.0%	124
There is a better understanding of parents' individual trauma history, family trauma histories, and the historical trauma influencing the community. Count Row %	39 31.5%	49 39.5%	22 17.7%	8 6.5%	2 1.6%	4 3.2%	124
There is increased awareness of how racism affects parents' experience of the child welfare system. Count Row %	14 11.3%	28 22.6%	28 22.6%	16 12.9%	9 7.3%	29 23.4%	124

	To a great extent	To a good extent	To a moderate extent	To a small extent	Not at all	Don't know / Not applicable	Total Responses
There are pre-removal conferences with parents, CPS, extended family, and other people that can support parents Count Row %	30 24.2%	23 18.5%	7 5.6%	8 6.5%	21 16.9%	35 28.2%	124
Hearings occur within 24 hours of child's removal. Count Row %	40 32.3%	21 16.9%	6 4.8%	2 1.6%	13 10.5%	42 33.9%	124
Case plans and recommendations provided during hearings by infant-toddler court members have improved. Count Row %	29 23.4%	45 36.3%	18 14.5%	2 1.6%	1 0.8%	29 23.4%	124
There is a team work approach among the infant-toddler court team members for each family (problem solving, wrap-around approach). Count Row %	49 39.5%	42 33.9%	23 18.5%	5 4.0%	0 0.0%	5 4.0%	124
There is a stable group of professionals for the infant-toddler court team cases. Count Row %	47 37.9%	45 36.3%	20 16.1%	7 5.6%	0 0.0%	5 4.0%	124
Parents are key members of the team. Count Row %	45 36.3%	41 33.1%	19 15.3%	10 8.1%	4 3.2%	5 4.0%	124

	To a great extent	To a good extent	To a moderate extent	To a small extent	Not at all	Don't know / Not applicable	Total Responses
There is an improved focus on the family and their challenges/needs. Count Row %	42 33.9%	53 42.7%	20 16.1%	3 2.4%	2 1.6%	4 3.2%	124
Families are praised when there is progress. Count Row %	66 53.2%	33 26.6%	10 8.1%	4 3.2%	0 0.0%	11 8.9%	124
If there is limited or no progress, probable consequences of inaction are clearly explained to parents. Count Row %	41 33.1%	45 36.3%	12 9.7%	6 4.8%	2 1.6%	18 14.5%	124

9. To what extent are the following organizational components in place to support the implementation of evidence-based interventions?

	To a great extent	To a good extent	To a moderate extent	To a small extent	Not at all	Don't know / Not applicable	Total Responses
Site conducted a "needs assessment" to identify gaps in the service continuum and identify training needs for intervention. Count Row %	25 21.0%	38 31.9%	12 10.1%	3 2.5%	2 1.7%	39 32.8%	119
Site reviewed evidence and/or a rating agency's review of the evidence-based practice for the selected intervention before making the selection. Count Row %	22 18.5%	40 33.6%	6 5.0%	4 3.4%	1 0.8%	46 38.7%	119
There is evidence for this intervention for the birth to three population. Count Row %	50 42.0%	40 33.6%	4 3.4%	1 0.8%	0 0.0%	24 20.2%	119
Site provided support for service providers to become proficient in the new intervention (e.g. training, coaching, supervision). Count Row %	34 28.6%	41 34.5%	9 7.6%	6 5.0%	0 0.0%	29 24.4%	119

	To a great extent	To a good extent	To a moderate extent	To a small extent	Not at all	Don't know / Not applicable	Total Responses
Caseworkers received in-service training to facilitate screening and referral to the intervention. Count Row %	16 13.4%	24 20.2%	15 12.6%	10 8.4%	3 2.5%	51 42.9%	119
A family's "wait time" between the referral and initiation of intervention services is monitored for efficiency. Count Row %	27 22.7%	32 26.9%	11 9.2%	4 3.4%	4 3.4%	41 34.5%	119

10. To what extent have you observed the following changes in children and family outcomes related to the implementation of an infant-toddler court team at your site?

	To a great extent	To a good extent	To a moderate extent	To a small extent	Not at all	Don't know / Not applicable	Total Responses
Kinship guardians are identified and supported as the preferred placement. Count Row %	45 37.5%	46 38.3%	12 10.0%	3 2.5%	1 0.8%	13 10.8%	120
Fewer children have a change in foster home. Count Row %	26 21.7%	34 28.3%	23 19.2%	9 7.5%	5 4.2%	23 19.2%	120
Children reach permanency faster. Count Row %	21 17.5%	38 31.7%	24 20.0%	8 6.7%	4 3.3%	25 20.8%	120
Children and parents have more frequent visitation. Count Row %	34 28.6%	48 40.3%	15 12.6%	8 6.7%	0 0.0%	14 11.8%	119
Parent-child contact occurs in "home like" settings (child welfare offices are a choice of last resort). Count Row %	17 14.2%	40 33.3%	24 20.0%	14 11.7%	5 4.2%	20 16.7%	120
Time from referral to service initiation has improved. Count Row %	19 15.8%	50 41.7%	18 15.0%	5 4.2%	2 1.7%	26 21.7%	120

	To a great extent	To a good extent	To a moderate extent	To a small extent	Not at all	Don't know / Not applicable	Total Responses
More children have a medical home. Count Row %	18 15.0%	21 17.5%	9 7.5%	3 2.5%	3 2.5%	66 55.0%	120
More children are screened for developmental delays. Count Row %	41 34.2%	35 29.2%	12 10.0%	5 4.2%	2 1.7%	25 20.8%	120
More children and parents receive services to improve the quality of their relationship (e.g., infant mental health services, dyadic therapy, CPP). Count Row %	52 43.3%	39 32.5%	9 7.5%	4 3.3%	0 0.0%	16 13.3%	120
Services for parents take into account previous experiences of trauma and biological insult (e.g. prenatal alcohol exposure, substance abuse, mental illness, etc.). Count Row %	42 35.0%	45 37.5%	12 10.0%	8 6.7%	1 0.8%	12 10.0%	120

11. Overall, what has changed at your site as a result of the work with the Quality Improvement Center for Research-Based Infant-Toddler Court Teams (QIC-CT)?