ZERO TO THREE
Early connections last a lifetime

Naomi Goldstein
Deputy Assistant Secretary for
Planning, Research and Evaluation
Department of Health and Human Services
Washington, DC 20201

From:
Matthew E. Melmed, Executive Director
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Dear Dr. Goldstein:

Thank you for the opportunity to comment on the development of the Clearinghouse on Evidence-Based Practices under the Family First Prevention Services Act (FFPSA). This ability to channel funding to preventing children from being placed in foster care and thereby keeping more families together has the power to transform child welfare practice, if it is implemented in a cohesive way.

ZERO TO THREE is a national nonprofit organization, located in Washington, DC, whose mission is to ensure that all babies and toddlers have a strong start in life. We translate the science of early childhood development into useful knowledge and strategies for parents, practitioners, and policymakers. We work to ensure that babies and toddlers benefit from the family and community connections critical to their wellbeing and healthy development. Nowhere are those connections more important than for children and families in the child welfare system. For the past decade, we have applied the science of early childhood development to transforming child welfare practice for infants, toddlers and families through the Safe Babies Court Teams.

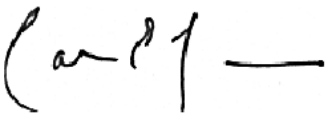
We provide detailed recommendations in the attached comments, based in large part on our experience in the field, which includes a deep understanding of the impact of trauma on child development as well as parents' own lives. Highlights of our recommendations include:

- Including in the Clearinghouse comprehensive approaches that will yield the maximum benefit from FFPSA funding. Such approaches encompass the individual services identified in the FFPSA statute, but start with a coordinated effort by community stakeholders working at the systems level to identify and fill evidence-based service gaps and address barriers to family success; and at the child and family level to provide a comprehensive approach for assessing and addressing child and parent needs in a holistic way.
- A recommendation that the Clearinghouse ensure that interventions appropriate for the range of age groups and subpopulations in the child welfare are included, so that states do not exclude a group of children and families because interventions are scarce; and that HHS and the Clearinghouse develop an applied research agenda to identify areas where more intervention development and testing is needed and work with states to implement that agenda.
- The need to recognize that the gold standard of evaluations, the Randomized Controlled Trial, is challenging to implement in a child welfare context, because random assignment of this vulnerable population is controversial and scrutiny by Institutional Review Boards can add time to the process. We urge the Clearinghouse to give appropriate consideration to other evaluation methods that will still yield reliable results without raising concerns related to such a vulnerable population.

- A recommendation for inclusion in the Clearinghouse of the Safe Babies Court Teams approach, a comprehensive, judicially-led approach that leads community stakeholders in working for systems change while transforming child welfare practice for infants, toddlers, and families. The program works both with children who remain in the home as well as those in foster care. Evidence-based practices in the areas identified in the statute are used within this approach, which works to expand the availability of such interventions and assist sites in choosing appropriate interventions for the families they serve. Children who have participated in the program experience a recurrence of maltreatment at a rate of less than 1 percent, while the vast majority reach permanency within a year.

If you have questions or need more information, please do not hesitate to contact Patricia Cole, Senior Director of Federal Policy (pcole@zerotothree.org, 202-857-2632).

Sincerely,



Matthew E. Melmed
Executive Director, ZERO TO THREE

ZERO TO THREE Comments On Development of FFPSA Clearinghouse

Contact: Patricia Cole (pcole@zerotothree.org)

2.1 Program or Service Eligibility Criteria. In 2.1.1, the Notice says HHS intends to limit eligible services to "mental health and substance abuse prevention and treatment services, in-home parent skill-based programs (including parenting skills training, parent education, and individual and family counseling), and kinship navigator programs."

We urge HHS to consider and give priority to programs and models that are evidence-based, but provide a comprehensive approach to meeting families' needs, working at the community level to coordinate among service providers and effect systems-level change. Such an approach would encompass the individual services in the statutory list, preferably by bringing together relevant stakeholders in the community; but it also would provide a case management and oversight structure within which to properly assess families' needs, coordinate and provide appropriate services, and provide support to children and families as they address their problems and build on their strengths. Such approaches better ensure family needs are addressed holistically and comprehensively. They also promote more effective use of resources through careful assessments, matching with services, and frontend provision of services and family support. Such a structure could fulfill FFPSA statutory requirements for assessments and delivery of trauma-informed services that may be difficult for child welfare workers to provide. It avoids a scattershot approach where caseworkers may "prescribe" from a list of programs eligible for funding, but do not have the necessary expertise to determine what services would actually be most beneficial. For example, without expert mental health screening, a caseworker may not be able to determine whether a disturbed parent-child relationship needs the support of a home visitor or more intensive early childhood mental health services from a qualified clinician. We describe such an approach, the Safe Babies Court Teams (SBCT), below in responding to 3.0, Recommendations of Potential Candidate Programs and Services for Review.

The comprehensive community-wide structure of an approach such as SBCT has a systems-level benefit that we believe speaks to the intent of the major shift in child welfare funding at the heart of FFPSA. The Community Stakeholder team not only focuses on the needs of individual families, it also works across the service areas in the community to identify and problem-solve around service gaps and barriers to helping families be successful. Starting with such a coordinated community stakeholder effort, which also carries this coordinated approach down to working with individual children and families, will ensure that FFPSA truly helps transform the child welfare system and that the newly available prevention funds are used to maximum effect.

Evidence that Congressional intent would allow for a comprehensive program or model is found in the requirements around trauma. Congress required that "The services or programs to be provided to or on behalf of a child are *provided under an organizational structure and treatment framework* that involves understanding, recognizing, and responding to the effects of all types of trauma and in accordance with recognized principles of a trauma-informed approach and trauma-specific interventions to address trauma's consequences and facilitate healing." [Emphasis added.] As we discuss below, this requirement seems to indicate an intent that multiple interventions may be needed within an overall framework that provides a comprehensive and coordinated trauma-informed approach.

Along these lines, a distinguished group of researchers has suggested that HHS *Consider a comprehensive array of interventions that meet the diverse needs across families*. Given that foster care placement has a multifactorial etiology, programs and services must take an ecological perspective[v]. As such, we recommend being inclusive of interventions delivered to individuals, families, and in community settings. The need for breadth in service delivery is particularly salient for child-welfare involved families because their needs vary widely. For instance, child-welfare involved families tend to be difficult to engage in traditional therapeutic approaches after generations of devastating experiences with the child welfare system and associated services; therefore, comprehensive service delivery must include community-based prevention programs, expanding beyond individualistic approaches. Furthermore, as child maltreatment is not monolithic, the service needs of families vary widely. It would be ill-advised to limit the pool of programs and services to the individual- and family-level at the expense of community programs delivered by trained and qualified staff.

We also offer our insights on restricting parenting services to those provided in the home and urge HHS to take into account the fact that it is not always desirable or feasible to provide such services in the family's home. We recommend allowing interventions that may use other locations, as appropriate, in addition to the home. We note that the statute allows services to children in kinship placement. Such children may still be candidates for reunification with their parents, and services may need to be provided in neutral locations.

2.2.1. Types of programs and services: The Notice requests "comment on the scope of programs and services and topic areas of interest within the aforementioned categories that should be prioritized for inclusion."

We recommend that HHS work to ensure that programs and services included in the clearinghouse take into account the needs of various age groups and subpopulations of children and provide sufficient interventions for states to make an adequate array of evidence-based services available for each group. Otherwise, some groups of children and families may be less likely to receive the vital services that can prevent the children's placement in foster care. A helpful course for HHS would be to work with states and other parties to develop an applied research agenda to identify needs in the array of evidence-based services and work to test interventions in those areas, to fill those gaps. Of particular concern are interventions appropriate for infants and toddlers and their parents. For example, evidence-based practices to address the social-emotional (i.e., mental health) impacts of maltreatment on infants and toddlers, who comprise the largest age-group entering foster care, may be particularly scarce. We strongly recommend that evidence-based practices such as Child-Parent Psychotherapy be included in the Clearinghouse as part of an array of interventions suitable for this age group. Moreover, from our

experiences in supporting communities and courts seeking to address the unique needs of infants and toddlers under their care, we know that in many cases, clinicians qualified and certified to provide evidence-based practices such as Child-Parent Psychotherapy may themselves be in short supply. While not part of the scope of this Notice, we recommend that guidance to states allow funding to be used for training clinicians in specific evidenced-based interventions when a connection to an effort to prevent foster care placement can be demonstrated.

2.2.2. Target populations:
The nature of target populations considered "similar" to child welfare populations depends to some extent on how states define the population at imminent risk of entering foster care. The broader the definition, the broader the types of programs and services that could be considered. In our review of evidence-based interventions likely to benefits infants, toddlers, and their families involved with the child welfare system,[i] ZERO TO THREE applied the Children's Bureau framework that describes a continuum of prevention services as Primary, Secondary, or Tertiary (https://www.childwelfare.gov/topics/preventing/overview/framework/?hasBeenRedirected=1) . Our review selected only those interventions categorized as Secondary or Tertiary, defined as:

- "Secondary prevention activities with a high-risk focus are offered to populations that have one or more risk factors associated with child maltreatment, such as poverty, parental substance abuse, young parental age, parental mental health concerns, and parental or child disabilities."
- "Tertiary prevention activities focus on families where maltreatment has already occurred (indicated) and seek to reduce the negative consequences of the maltreatment and to prevent its recurrence."

We believe these two categories capture the populations that might be considered by states and that the families targeted by secondary prevention activities would be similar in many cases to the child welfare population. We caution against selecting interventions that are simply aimed at a low-income population, but rather look for risk factors signaling more complex problems, such as substance abuse, housing issues, or issues of family trauma. The Clearinghouse information should clearly note the intervention's relevance to the child welfare population and whether it was developed specifically for that population; for a broader population where implementation includes providing services to child-welfare involved children and families; or for a broader at-risk population with no direct experience serving child welfare-involved families.

We suggest that as it establishes the Clearinghouse, HHS identify gaps in available interventions for specific populations or interventions that could be expanded and their efficacy studied for a child welfare population. HHS should create a research agenda in concert with states to develop interventions to fill these gaps and to test applicability of more interventions.

2.2.3. Outcomes: We offer suggestions for overall state program outcome measures to which individual interventions should contribute. These are based on our experience with infants and toddlers, and their parents. We note that individual interventions, such as mental health therapy, may contribute to the overall family outcome by, for example, helping a parent to overcome depression, but a study of the intervention may not find the ultimate outcome that is the goal of prevention funding. HHS needs to be clear on the different levels of outcomes that might need to be defined, the individual intervention level and the family and child welfare program level.

- Reaching a permanent outcome by closing the case with the family intact or placing the child permanently with a relative, with a goal of closure within a year.
- Reducing entries into foster care.
- No recurrence of maltreatment.
- Strengthening families in terms of improved parenting abilities and parent-child relationship; parents' ability to make healthy life decisions and cope with basic needs; improved overall health and mental health for parents and children; children on appropriate path to meet developmental milestones.

We note that families go through many changes, and it is conceivable that a child may need an out-of-home placement while the family is participating in preventive services. It does not make sense that these services should cease and families be left with no support that could help secure a timely reunification. In the event that such placements occur, we suggest monitoring for indicators and outcomes that promote healthy development and reunification, if possible.

Permanency-Related (if children are placed in foster care while participating in the program):

- Purposeful case plans and concurrent planning
- Reduced time to permanency
- Placement stability

2.2.7. Trauma-Informed: The Notice asks for comment on the feasibility of prioritizing trauma-informed programs in the review.

We believe it is essential that HHS prioritize programs with a history of implementation according to principles recognizing the origin and impacts of sources of trauma in both children and parents. Trauma is central to the impacts of maltreatment on young children as well as their parents' ability to parent and manage their own lives. The goal of FFPSA services is to successfully work with families whose children are at risk of being removed and placed in foster care. In the current child welfare system, many of those children have been placed in foster care in the absence of services. From our work both types of families with infants and toddlers, we know that traumatic experiences are prevalent for both children and parents, with well over half of both groups having four or more Adverse Childhood Experiences.[ii] The parents' past trauma often explains current behaviors, such as substance abuse, as they carry the scars from childhood abuse or other traumatic experiences. It can also affect their parenting and ability to establish a close relationship with their children. Thus, long-term effects of early childhood trauma cannot be treated in isolation from their root cause. While caught in a cycle of negative coping mechanisms, parents are unable to develop the skills they need to appropriately care for their children. Identifying and addressing the parent's trauma history is as essential to improving the family's functioning as ameliorating the effects of the child's own trauma.[iii]

However, "trauma-informed" is a broad term and difficult to define or operationalize. Basically, being trauma-informed means asking, "What happened to you?" instead of asking "What did you do?" For parents, that question means "What happened earlier in your life that contributed to behaviors such as substance use or unhealthy ways of interacting with your child?" While many researchers and organizations talk about "trauma-informed programs," there is not a current consensus for its definition. As the Clearinghouse evaluates interventions on whether or not they are trauma-informed, it must go

beyond any self-labeling, as some programs may respond effectively to trauma without labeling the services as such.

In actual practice, it may be more useful to think of *systems* that are trauma informed, which may be the intent in the statute: "The services or programs to be provided to or on behalf of a child are *provided under an organizational structure and treatment framework* that involves understanding, recognizing, and responding to the effects of all types of trauma and in accordance with recognized principles of a trauma-informed approach and trauma-specific interventions to address trauma's consequences and facilitate healing." [Emphasis added.] Thus, we could think of a definition such as:

A Trauma-Informed Child-Serving System: [iv]

- Acknowledges and responds to the role of trauma in the development of emotional, behavioral, educational, and physical difficulties in the lives of children and adults.
- The System recognizes and avoids inflicting secondary trauma that occurs when child serving system re-traumatizes a child through policies and procedures.

At the community and family level, addressing trauma within child welfare families will require an integrated approach that includes:

- Training and education for all personnel involved with child welfare cases in early childhood, later childhood, and adolescent development as well as the impact of trauma experienced on this development and appropriate responses.
- Interventions that specifically address the effects of trauma (e.g., Child-Parent Psychotherapy for infants and toddlers and their parents) or are aware of the role trauma plays in successful therapy (e.g., substance abuse treatment incorporating/addressing past trauma).
- Other interventions that may be needed to address other side effects in the young children, such as developmental issues through early intervention or comprehensive early learning and development supports through Early Head Start. Those providers need to understand the child's trauma and how it affects her behavior and emotional wellbeing and be prepared to support her needs while cooperating with mental health practitioners.

We suggest that HHS develop a rubric of questions to determine if an individual intervention can be considered "trauma-informed," so that a state would know how it fits into an array of services in a systemic approach:

- Do staff working in the intervention or program receive training and education as part of the program model on (1) early childhood, later childhood, and adolescent development, (2) the impact of trauma experienced early in life on this development, and (3) the impact of childhood trauma on subsequent adult behavior and parenting behaviors?
- Does the intervention or program incorporate that knowledge into its approach and if so, how?
- Does the intervention specifically address an aspect of mental health, behavioral, or developmental effects of trauma in a manner that provides evidence of an awareness of underlying causes?

2.3 Study Eligibility Criteria

While Randomized Controlled Trial (RCT) are the gold standard, their implementation in studies that involve the courts and child welfare are challenging. The random assignment of highly vulnerable children is controversial among stakeholders, and subject to intense scrutiny by multiple Institutional

Review Boards that may take years before obtaining approval, putting at risk the feasibility of the RCT. We encourage the Clearinghouse designers to give appropriate consideration to other evaluation methods that will still yield reliable results without raising concerns related to such a vulnerable population.

Quasi-experimental designs with a comparison group of children involved with the child welfare system are feasible through the use of the National Survey of Child and Adolescent Well-Being (NSCAW), the only nationally representative sample of children involved with the child welfare system, currently in the field for the third cohort. Comparisons groups can be created by using Propensity Score Matching (PSM) to select a subsample of children with a maltreatment investigation and placements history of similar characteristics of the target population of an intervention. PSM 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 rather than to selection bias. This quasi-experimental design has been used for example to evaluate the time to permanency of young children participating in Safe Babies Court Teams compared to a subsample from NSCAW I of young infants and toddlers in out-of-home care (McCombs-Thornton & Foster, 2012). To use NSCAW, researchers need to request the requisite investigator license to access restricted release versions of NSCAW data (free of charge) from the National Data Archive on Child Abuse and Neglect (NDACAN).

Natural experiments are another evaluation option that can take advantage of the rotational assignment systems in the child welfare system. Assigning subjects to treatment and control groups through a quasi-random process such as rotational assignment is increasingly accepted as practical alternative to a fully randomized design for answering whether or not any observed changes in children and families can be attributed to the activities conducted under the target intervention, and if such outcomes are different from those that would have been achieved under typical conditions. For example, in Cook County (Illinois), DCF has used for the last 20 years rotational assignment to assign foster care cases to DCF teams and private child welfare agencies. Even though rotational assignment is not a fully randomized process, the State's experience with this assignment mechanism under its successful IV-E waiver indicates that rotational assignment successfully balanced the waiver services and treatment-as-usual groups on many of the observed characteristics that affect permanency, safety, and child well-being outcomes, including children's special needs, race/ethnicity, and type of placement.

2.3.6. Usual care or practice setting. The Notice requests comment on the definition of "usual care or practice setting."

We take this language to mean that interventions should have either grown out of community needs (i.e., an outreach research program) or have been developed in a laboratory or other controlled setting and applied and tested in real-world settings, that is, the places where children and families usually receive services or practices occur. This language seems meant to exclude interventions developed in a laboratory or university setting where the environment is well controlled, but which have not been translated into the more realistic environment in which children and families exist, as do courts, child welfare agencies, and service providers. Further along on a continuum would be interventions that have been applied in a child welfare setting, but only in a tightly-controlled experiment overseen by researchers. While we agree that interventions need to be tested in a real-world setting, we also note that this Clearinghouse will need to include many different interventions, some in areas where there

may be few candidates. We recommend that the Clearinghouse take this need into account in some manner, to help take the next steps for research to validate interventions in a usual practice setting.

2.4. Study Prioritization Criteria: We recommend such considerations as:

- Developed for the child welfare population or includes child welfare families among its target population in evaluation studies.
- Directed at a population at highest risk for placement in foster care, such as infants and toddlers.
- Encompasses an array of interventions and services to address all aspects of a family's needs.

2.4.1. Implementation Period: The Notice invites comment on whether studies with program or service implementation periods of longer than 12 months should be considered for review. Based on our experience and SBCT results in terms of reaching permanency within a year, completing work with a family and making a decision to either close a case, remove a child, or another outcome should be feasible in the vast majority of cases, but not all of them. We recommend that special situations should be considered. Not all interventions reach their desired impact according to a set period, and it would seem disadvantageous to children and families in special situations to disregard an effective intervention because it might need a few extra months to work. Moreover, programs with longer intervention periods could be viewed in the context of their contribution to case decisions that might occur at or before 12 months as well as their likely continuing support for a family should the case be closed out. For example, home visiting models typically work with families for multiple years, but families are likely to see improvement within the first year and this improvement could contribute to closing the case within a year. If the family were able to remain in the home visiting program until its conclusion, that program could provide the ongoing support to ensure the family continues in a positive direction, as well as the receipt of booster sessions, or support during transitional or challenging developmental periods. We realize that the funding for such an extension is problematic, meaning actual case closure may not be the most desirable option.

2.5 Study Rating Criteria:

Rating Criteria should include consideration of quality of the study, outcomes, and time period. While maintenance of outcomes 6 and 12 months after closing is an important criterion, tracing vulnerable families longitudinally is highly expensive and challenging. An intervention under review may show positive outcomes in all areas (safety, permanency, child well-being, parent well-being, and quality of parent-child relationship) at closing, but after closing attrition may compromise the longitudinal study of well-being outcomes, but use of administrative data allows for longitudinal follow up in the areas of maltreatment re-reports and recurrence and placements. A mixed timeline for the report of outcomes from closing to multiple follow up period should be flexibly considered for the rating criteria.

3.0 Recommendations of Potential Candidate Programs and Services for Review: Safe Babies Court Teams

The Safe Babies Court Teams (SBCT) is an evidence-based community approach to comprehensively addressing the needs of infants, toddlers, and families in the child welfare system. SBCT applies the

science of early childhood development, including the impact of trauma on young children and later in adulthood, to transform how courts, child welfare agencies, and communities work with and support the families of young children experiencing maltreatment. This approach uses the services specified in the FFPSA statute, applied as appropriate as part of an individual family's plan.

The Court Team is led by a judge and overseen by a Community Coordinator, who is a child development specialist. The Court Team is made up of key community stakeholders who commit to restructuring the way the community responds to the needs of infants and toddlers who are maltreated. The team includes child welfare staff, attorneys, other professionals, community service providers and, at the case level, the families themselves. Birth parents, many of whom have experienced high levels of trauma in their own lives, are valued, and the team works to build strong, respectful relationships with them. The goal with individual families is to assess and arrange services that will address the specific needs identified and to provide frequent case monitoring through monthly meetings to ensure service provision stays on track. SBCT provides an overall structure for working with these young children and families that itself has been evaluated through independent evaluators following national standards (CFSRs indicators, and the previously mentioned quasi-experimental design with a comparison group from NSCAW for outcomes related to time and type of permanency). The overall approach works with courts and communities to apply evidence-based interventions to specific issues identified through various assessments not only for the young children, but most critically, for their parents, who often carry with them their own past trauma.

Safe Babies Court Teams in conjunction with Program and Service Criteria

2.1 Program or Service Eligibility Criteria

Types of Programs and Services:
SBCT is an evidence-based approach to promoting wellbeing, safety, and permanency among infants and toddlers in the child welfare system and their families. Within this overall framework, the Court Teams use a range of individual evidence-based and evidence-informed practices, depending on the needs of the families, including services providing mental health and substance abuse treatment and parenting services, both in the home and in other settings. Because the team functions at the community level, it works to identify specific evidence-based services and expand community capacity where needed. In addition to successfully accessing substance abuse and mental health treatment within a week to a month for most parents who need such services, SBCT frequently uses interventions such as Child-Parent Psychotherapy (CPP), Step-By-Step Parenting, Nurse Family Partnership, and Parent Child Interaction Therapy to improve parenting skills and strengthen the child-parent relationship..

The Court Team works at a systems level to identify barriers to meeting the needs of families and develop strategies to overcome them. Successes at the systems level that helped boost the availability of evidence-based practices included increasing the capacity of mental health clinicians in Florida to provide CPP by supporting participation in a special certification effort. In the area of parental substance abuse, the SBCT has been the catalyst for broad-based solutions to the need for Medication Assisted Treatment (MAT), as well as increasing attention to Fetal Alcohol Spectrum Disorders in both children and parents. While increasing access to services is not an outcome permitted for programs under this notice, nevertheless, the ability to pay for certain scarce services such as substance abuse treatment is only useful if the services can be accessed. Parental substance abuse figures frequently in child welfare

cases, including in 90 percent of SBCT cases. In one case, the SBCT judge was confronted by a parent overdosing on heroin in court. In seeking a solution to opioid-involved families, cases which the family drug court judge indicated he did not take, the judge discovered there was only one available MAT program in the area, a provider who was not cooperative with the human services agency. The SBCT community coordinator was able to bring the parties together and heal this breach, opening the door to treatment. But the work went further. As the only MAT provider in the area, this provider could not take all cases needing it as well as provide behavioral therapy. So, an agreement was worked out that other providers would provide the behavioral therapy, freeing up the only MAT clinic in the area to work with more patients. This cooperation opened up more treatment services for all courts. As the judge noted, who would have thought that a court focusing on babies could have such a broad effect.

Book/Manual/Writings:

Manual: Hudson, L. *ZERO TO THREE Guide to Implementing the Safe Babies Court Team Approach* https://www.zerotothree.org/resources/2061-zero-to-three-guide-to-implementing-the-safe-babies-court-team-approach

Writings:
Complete overview of SBCT evaluations: https://www.zerotothree.org/resources/515-safe-babies-court-team-a-proven-solution

Casanueva, C., Harris, S., Carr, C., Burfeind, C., & Smith, K. (2017, September 30). *Final evaluation report of the Quality Improvement Center for Research-Based Infant-Toddler Court Teams.* Research Triangle Park, NC: RTI International.

Osofsky, J.D., Lewis, M.L., & Szrom, J. (2018). *The adverse experiences of very young children and their parents involved in infant-toddler court teams.* Washington, DC: Quality Improvement Center for Research-Based Infant-Toddler Court Teams.

Casanueva, C., Smith, K., Harris, S., Carr, C., & Burfeind, C. (2018). Adverse childhood experiences, family risk factors, and child permanency outcomes of very young children involved in Safe Babies Court Team™ sites. Prepared for ZERO TO THREE, Quality Improvement Center for Research-Based Infant-Toddler Court Teams.

Evaluations
Safe Babies Court Teams has been evaluated using a quasi-experimental design to assess the time to permanency of young children participating in SBCT compared to a subsample from NSCAW I of young infants and toddlers in out-of-home care (McCombs-Thornton & Foster, 2012).
Major outcomes identified in the study:

- Court Teams children exit foster care faster regardless of the type of exit: the median exit for Court Teams children was about a year faster than the median in the control group.
- Court Teams exited to reunification after a median of about 10 months, compared to a lower bound length of 18 months for NSCAW. Court Teams children typically exited at least 10 months faster among those who were adopted and a minimum of 3 months sooner for children who exited to relative guardianship.

- Court Teams cases experience a different pattern of exits from the foster care system: Reunification is the most common type of exit for Court Teams cases (38%) while adoption is the most prevalent for the comparison group (41%). Overall, Court Teams children were more likely to experience reunification, placement with a relative, or non-relative guardianship.
- Court Teams children reach permanency sooner, regardless of the type of exit, meaning that the difference in rates of adoption do not account for the overall difference in time to permanency. McCombs-Thornton, K. L., & Foster, E. M. (2012). The effect of the ZERO TO THREE Court Teams initiative on types of exits from the foster care system - A competing risks analysis. *Children and Youth Services Review, 34*(1), 169-178. doi: 10.1016/j.childyouth.2011.09.013

Relevance: Time to permanency is a useful indicator in assessing the feasibility of satisfactory family progress within the one-year timeframe set by FFPSA. If they are truly trying to reduce placements in foster care, states will be using FFPSA funding to work with the same population as the SBCT—i.e., families whose children currently are entering foster care, but where foster care placements might be prevented with robust comprehensive services. In addition, SBCT children were more likely to be reunified than NSCAW children and less likely to be adopted. This finding is relevant to the FFPSA goal of keeping more families together, given a service-rich approach. Below we discuss the most recent time-to-permanency findings compared with federal standards, which strongly confirm the feasibility of addressing the needs of families with serious risk factors within a twelve-month period.

Comparison of Outcomes with Federal Standards

Safety outcomes—Recurrence of Maltreatment: While not part of the McCombs-Thornton study, a previous non-experimental evaluation found positive outcomes for safety: 99.05 percent of infants and toddlers served by the Court Teams were protected from further maltreatment.[v] A more recent evaluation of infants and toddlers in SBCT as part of the Quality Improvement Center for Research-Based Infant-Toddler Court Teams evaluation found that maltreatment recurrence within 12 months (CFSR 3, Safety outcome 2) among 251 children across sites using the SBCT approach was just 1.2 percent.[vi] Since that evaluation, updated analysis of 430 cases at SBCT sites between April 2015 (or date of site initiation up to 2016) to July 2018 **have reduced the maltreatment recurrence within 12 months to 0.7 percent.**[vii] These findings compare to:

- National standard of the Children's Bureau for Safety Performance Area 2, recurrence of maltreatment during a 12-month period: **9.1**%[viii]
- Analysis of data that combined the second National Survey of Child and Adolescent Well-Being (NSCAW) and the National Child Abuse and Neglect Data System of cases with a median time of 12 months of children regardless of age, substantiation status, and placement out of home, found that 6.9% of all children had maltreatment recurrence, but among a subsample of caseworkers who were interviewed at follow up (because the case was still open or there had been contact with the CWS since closing the investigation), maltreatment recurrence was 24.1%.[ix]
- The latest data on child welfare outcomes based on 2014 reported a national median of 4.9% for recurrence of maltreatment among children of any age within a 6-month period.[x]

Permanency and Stability: The QIC-CT study found permanency outcomes that echoed the earlier evaluation and by far exceeded the federal standard. 84 percent of children with closed cases reached permanency within a year, double the national standard expectations established by the Children's

Bureau of 41 percent. This impressive outcome occurred in a caseload where parents had more risk factors than a nationally representative sample (NSCAW II) of children investigated for maltreatment: 90% of SBCT children with closed cases had one or both parents with substance use disorders, compared with 10% of primary caregivers in the national sample; close to two-thirds of the SBCT children had parents with mental health problems, compared with 15% in the national sample. Over half of the children had a parent who had been incarcerated. As with the earlier evaluation, reunification was the permanency outcome in a large proportion of cases, 49 percent. Adoption was more prevalent where parents had extremely high ACE scores (7-10 ACEs), but reunification was possible in 30 percent of those cases with high risk factors.[xi]

Program or Services Prioritization Criteria

Types of Programs or Services: Safe Babies Court Team approach encompasses all of the programs and services contained in the statute, with an overall structure to tailor these services to individual family needs, integrate them into a comprehensive plan for both parent and child, and provide ongoing support to reach the best outcome for the family. The systems-level aspect of the support sites receive promotes overall awareness of evidence-based practice, assists sites in selecting appropriate practices, and ensures that services are developed in the community if they are lacking. As discussed, the approach infuses the science of child development and the impact of trauma into every aspect of the team and the services provided. Services included in the statute that the community service providers work within the team to provide include: mental health services for both parents and the infants and toddlers; substance abuse treatment; and parent skill-based training, which can be provided in the home. These services are integrated as needed with other services such as early intervention and comprehensive early childhood development. Given the limited array of services in many communities, as well as the absence of EBPs, a key feature of the SBCT approach is the provision of regularly updated information about EBPs for infants and toddlers and their families, as well as support in the selection of and training for the selected EBPs, exemplified in the provision across sites of CPP training by nationally recognized experts. We strongly urge HHS to include comprehensive approaches such as SBCT to ensure that families receive the wrap-around support they need and public prevention dollars are used with maximum efficiency and effectiveness.

Target Population of Interest: SBCT works with children under age three and their families in the child welfare system under the court supervision, both intact families and families where children have been placed in foster care. Infants and toddlers experience the highest rate of substantiated abuse and neglect and comprise the largest group of children coming into care. The percentage of infants coming into foster care has grown from 16 percent of the total in 2013 to 18 percent in 2016. These events happen at a time of the most rapid brain development, leaving these infants and toddlers particularly vulnerable to the negative effects of maltreatment and other traumatic experiences. Yet, it is also a window of opportunity, when those effects can be ameliorated by intervention. We believe it is critical to reach this group of children and families to prevent the poor health and behavioral outcomes we know await many of them in adulthood, as well as to address their parents' needs, breaking the cycle of trauma and abuse that many families experience. We also note, however, that the community team is made up in large part by community service providers. Therefore, once in place, its structure could be used to support any group of families with multiple risk factors in a community.

Target Outcomes:

- Trauma informed courts and CWS
- Use of the science of early development by courts and CWS
- Use of EBPs appropriate for infant, toddlers, and their families and caregivers
- Permanency within a year
- Safety
- Race/ethnicity equity
- Court team sustainability

Number of Impact Studies: One impact study has been completed. A second impact study is currently underway with the American Institutes for Research (AIR), which is conducting a natural experiment that relies on the random assignment of families to judges that naturally occurs in three sites currently implementing SBCT. This study will answer questions about length of time in foster care, rate of exposure to reoccurring abuse or neglect, and level of family and child well-being.

In Use/Active: The SBCT approach is in use or in the process of being implemented in approximately 70 sites in 22 states and continues to expand. The approach has garnered widespread attention and support from the judges and communities that have adopted it. Interest from judges and communities in bringing the approach to their locations has grown significantly over the past four years. For example, Tennessee passed legislation to establish 10 Court Teams. The State of Maryland recently began a Court Team with IV-E waiver funding. Court Teams in Florida's statewide program have expanded from 5 teams supported by the ZERO TO THREE Court Teams staff to 21 teams.

Implementation and Fidelity Support: SBCT sites receive technical assistance on implementation and Continuous Quality Improvement ZERO TO THREE's Safe Babies Court Team staff. Methods of support include:

- Technical assistance from ZERO TO THREE SBCT staff as well as consultants via Skype or in person, which can be tailored to specific needs
- Training on early childhood development, Infant-Early Childhood Mental Health, CPP, the impacts of trauma on children and parents, etc., provided to entire community team
- Free on-line training modules (available Fall 2018)
- Community of Practice for Judges and Community Coordinators
- Community Coordinator Academy
- Annual Cross-sites training conference
- Technical assistance on use of the SBCT data collection system and use for Continuous Quality Improvement
- Assessments and reassessments to determine progress

Trauma-Informed: SBCT's approach is infused with an understanding of trauma and its effect on both the young children in the program and their parents. We know that no other child-serving system encounters such a high prevalence of trauma and adverse childhood experiences, both of which are associated with a high risk of health problems in adulthood. As noted above, risk factors such as parental substance abuse, mental health disorders, and domestic violence, are present for a far higher proportion of SBCT children than in a national sample. Training on trauma and its impacts on children and parents is a standard part of the SBCT curriculum, and special consultations with trauma experts are available. Resources on trauma-informed child and family service systems, including a special series of

webinars developed by Dr. Joy Osofsky of the LSU Center for Health Services, are available on the QIC-CT website at http://www.qicct.org/trauma-informed .

Comprehensive developmental, medical, and mental health services are incorporated into the case plan to ensure that the child'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. More than 97 percent of SBCT children studied received developmental screenings. About half of families needed Child-Parent Psychotherapy, which the program was able to provide in 94 percent of those cases. In contrast, only 29% of children 1.5 to 10 years old at risk for a behavioral or emotional problem received any specialty behavioral health services in NSCAW II.[xii]

Parents receive comprehensive medical and mental health assessments, including evaluation for their own childhood trauma, prenatal alcohol exposure, substance use disorders, and domestic violence. Referrals to screening and, where needed, substance abuse or mental health treatment occur in a speedy manner, with the majority of parents referred to treatment within a week to 30 days after screening.

Most importantly, the trauma-informed approach is not limited to mental health interventions, but is infused into the whole program. Ongoing support as parents work through their addiction problems is provided through the Court Team staff, support networks of family and friends, and foster parents. Children receive early intervention and in some cases Early Head Start services to address developmental needs. The judges understand the need to ask parents what happened to them, not what did you do, and set the tone for the entire team.

Delivery Setting for In-Home Parent Skill-Based Programs and Services: The SBCT approach emphasizes supporting the parent-child relationship leading to a strong secure attachment for both parent and child. Sites use a variety of evidence-based curricula to conduct supported visits, which we call Family Time, that provide guidance and coaching within the family interaction. Our manual includes an extensive chapter on how we approach working with parents. Family time coaching is an opportunity for parents to learn about friendship and mutual respect. Guided Interactions for Family Time (GIFT) uses this approach. As mentioned above, SBCT sites often incorporate Step-by-Step Parenting, because they encounter many parents who themselves have intellectual disabilities. Other parenting curricula that SBCT communities are using in individual sessions with parents:

- SafeCare (http://www.cebc4cw.org/program/safecare/)
- The Positive Parenting Program, known more commonly as Triple P (http://www.cebc4cw.org/program/triple-p-positive-parenting-program-system/)
- Nurturing Parenting (http://www.cebc4cw.org/program/nurturing-parenting-program-for-parents-and-their-infants-toddlers-and-preschoolers/)
- Circle of Security (http://www.cebc4cw.org/program/circle-of-security-home-visiting-4/)
- The Incredible Years (http://www.cebc4cw.org/program/the-incredible-years/)

Each of these programs is described on the California Evidence-Based Clearinghouse website (http://www.cebc4cw.org/). SafeCare is supported by research evidence, and Circle of Security–Home Visiting–4 shows promising research evidence. All except Triple P and The Incredible Years are listed among the programs that address child abuse and neglect. Triple P and The Incredible Years are

intended to address behavior problems in children and adolescents, and because of that focus they earned only a medium rating for relevance to child welfare.

Family time parenting support can be provided in the home setting, often a place where the parent feels most comfortable. Some sites have worked with home visiting programs to provide parenting support and coaching. Parenting coaching focuses on a strengths-based approach using four principles: empowerment of the parent, empathy for the parent and child, responsiveness and teachable moments, and active parenting.

It is important to note, however, that parenting support plans be individualized, taking into account a range of intensity that may be needed, from relatively light coaching to intensive mental health interventions. Equally important is the need to understand trauma and its impact on parenting: at the start of intervention, the parent may be just beginning to process her own trauma history and address current issues such as domestic violence and substance abuse. It is nearly impossible for her to focus on or appreciate her child's specific needs when she is distracted by these problems and has no support system in place for processing what she is confronting. The form and duration of support likely will change over the course of time. In addition, it may be beneficial if some sessions do not take place in the home, which is why we encourage HHS adopt some flexibility about requiring that all parenting-related services be provided in the home.

[i] Quality Improvement Center for Research-Based Infant-Toddler Court Teams. (2015). A review of evidence-based Interventions for families served by infant-toddler court teams. Washington, DC: ZERO TO THREE. http://www.qicct.org/sites/default/files/AReviewOfEvidenceBasedInterventions080615.pdf

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[iii] Hudson, L., Beilke, S., & Many, M. (May 2016). "If you brave enough to live it, the least I can do is listen": Overcoming the Consequences of Complex Trauma. ZERO TO THREE Journal, 36(5), pp. 4 – 11.

[iv] Osofsky, J. (2017). Webinar on Understanding the Effects of Trauma on Children and Being Trauma-Informed. Sponsored by LSU Health Sciences Center and the Quality Improvement Center for Research-Based Infant-Toddler Court Teams. Definition drawn from the National Child Traumatic Stress Network, and work by Michael Howard and Frank Putnam. http://www.qicct.org/trauma-informed

[v] Hafford, C. & DeSantis, J. (2009). Evaluation of the Court Teams for Maltreated Infants and Toddlers: Final Report. Arlington, VA: James Bell Associates.

[vi] Casanueva, C., Harris, S., Carr, C., Burfeind, C., & Smith, K. (2017). Final Evaluation Report of the Quality Improvement Center for Research-Based Infant-Toddler Court Teams. Research Triangle Park: RTI International.

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[viii] Administration for Children and Families. (2015). Statewide Data Indicators and National Standards for Child and Family Services Reviews. Washington, DC: Department of Health and Human Services, Administration for Children and Families.

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[x] Administration for Children and Families. (2017). Child Welfare Outcomes 2010-2014: Report to Congress. Washington, DC.

[xi] Casanueva, C., Smith, K., Harris, S., Carr, C., & Burfeind, C. (2018). Adverse childhood experiences, family risk factors, and child permanency outcomes of very young children involved in Safe Babies Court Team™ sites. Prepared for ZERO TO THREE, Quality Improvement Center for Research-Based Infant-Toddler Court Teams.

[xii] Quality Improvement Center for Research-Based Infant-Toddler Court Teams (2018). Services support for young children and families in the child welfare system. Washington, DC: ZERO TO THREE.