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Practice Summary & Implementation Guidance

Infant-Toddler Court Teams, based on the ZERO TO THREE Safe Babies Court Team™ Approach

Infant-Toddler Court Teams are a collaborative practice that improves, aligns, and integrates systems and builds community capacity to advance the health and well-being of very young children and their families. The practice is driven by an overarching vision of prevention, in which systems-integration and capacity-building strengthens family protective factors and addresses the social determinants of health.

Cutting-Edge | Emerging | Promising | **Best**

Location	Topic Area	Setting
National	Service Coordination/Integration	Community

Population Focus	NPM	Date Added
Cross-Cutting/Systems Building	NPM 6: Developmental Screening	August 2021

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Section 1: Practice Summary

PRACTICE DESCRIPTION

Infant-Toddler Court Teams (ITCTs) are a collaborative practice that improve, align, and integrate systems and builds community capacity to advance the health and well-being of very young children and families who become involved with the child welfare system. Specifically, the target population is children birth to three years of age under dependency court jurisdiction, who are in foster care or at risk of removal, and their families. In the traditional child welfare system, when children are removed from their home, children and parents experience the trauma of separation, a judicial process that is adversarial and punitive rather than collaborative and resiliency-building, and services that can be uncoordinated and do not meet their urgent needs. For children who come to the attention of the child welfare system and are at risk of removal, too often their families do not receive appropriate services and supports that sufficiently build protective factors and children's developmental needs are not identified and addressed. These missed opportunities to intervene in an effective and timely way to support children's developmental health during the critical period of early development can lead to negative long-term physical, psychological, and behavioral outcomes. These are also opportunities lost in terms of strengthening families to prevent maltreatment recurrence, including with siblings or subsequent children, and to promote the family's health and well-being.

More than 15 years ago, in an effort to address these gaps and challenges, a dependency court judge partnered with a psychologist specializing in infant and early childhood mental health to translate the science of early childhood development to change "the usual way of doing business" for young children and their parents in the child welfare system.[1] This groundbreaking work prioritized a therapeutic judicial climate, a collaborative multidisciplinary approach to addressing the needs of the child and parents, timely developmental screening and supports including referral to evidence-based dyadic intervention to repair the parent-child relationship and promote healthy attachment, and a coordinated system of care. ZERO TO THREE built on this early work to develop an innovation called the Safe Babies Court Team™ (SBCT) approach, which takes a fully comprehensive, two-generation, and prevention-driven approach to supporting infants, toddlers, and families involved with the child welfare system – including young children at risk of removal from the home – through cross-system collaboration and problem-solving, trauma-informed family engagement, and enabling services including outreach to improve systems alignment and service integration. At the systems level, the SBCTs promotes infrastructure-building and improvements through active stakeholder collaboration; this systems work includes needs assessment and monitoring, training, policy development, and funding decisions to sustain improvements and build community capacity to meet the needs of young children and their families. In sum, the SBCT approach is driven by an overarching vision of prevention that posits systems- and capacity-building work at both the family and community level will lead to improved social and environmental conditions and community-wide benefits that ultimately will result in lower rates of child abuse and neglect in the first place.

[1] National Public Radio, All Things Considered. (March 3, 2003). *A scientific approach to child custody*. Retrieved from https://www.npr.org/templates/story/story.php?storyId=1181000

In developing the SBCT approach, ZERO TO THREE partnered with experts in the field to integrate the science of early childhood development[2] and infant and early childhood mental health[3] with best practices in the judicial,[4,5] child welfare,[6,7,8] and legal[9,10] arenas. The result is a set of core components aligned with an overarching strategic framework, which provides the blueprint for ITCTs.[11,12] An important distinguishing feature of the approach is that it was purposefully designed for real-world applicability in the complex and heterogeneous ecology of child welfare and court systems.

Today, ZERO TO THREE serves as the National Resource Center for the Infant-Toddler Court Program (the ITCP), which sits within MCHB's Early Childhood Systems portfolio, providing training and technical assistance to support effective implementation of infant-toddler court teams at 106 local sites located in 31 states – including work with seven state-level teams to build capacity for statewide expansion.[13] This work to support alignment with the SBCT approach is carried out in partnership with the American Bar Association Center on Children and the Law, Center for the Study of Social Policy, National Council of Juvenile and Family Court Judges, and RTI International.

CORE COMPONENTS & ACTIVITIES

ITCTs are guided by the strategic framework for the SBCT approach, which comprises five practice areas: (1) interdisciplinary, collaborative, and proactive teamwork; (2) enhanced oversight and

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[2] Center on the Developing Child at Harvard University. (2007). *The science of early childhood development (InBrief).* Retrieved from www.developingchild.harvard.edu

[3] Center on the Developing Child. (2013). *Early childhood mental health (InBrief).* Retrieved from https://developingchild.harvard.edu/resources/inbrief-early-childhood-mental-health/

[4] Gatowski, S., Miller, N., Rubin, S., Escher, P., & Maze, C. (2016). *Enhanced resource guidelines: Improving court practice in child abuse and neglect cases.* Reno, NV: National Council of Juvenile and Family Court Judges. Retrieved from https://www.ncjfcj.org/publications/enhanced-resource-guidelines/

[5] American Bar Association Center on Children and the Law, National Council on Juvenile and Family Court Judges, & ZERO TO THREE National Policy Center. (2009). *Healthy beginnings, healthy futures: A judge's guide.* Reno, NV: National Council on Juvenile and Family Court Judges.

[6] Child Welfare Information Gateway. (2017). *Supporting brain development in traumatized children and youth.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Retrieved from https://www.childwelfare.gov/pubPDFs/braindevtrauma.pdf

[7] Child Welfare Information Gateway. (2018). *Addressing the needs of young children in child welfare: Part C – early intervention services.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Retrieved from https://www.childwelfare.gov/pubs/partc/

[8] Child Welfare Information Gateway. (n.d.). *Supporting and preserving families [Website].* Retrieved from https://www.childwelfare.gov/topics/supporting/

[9] U.S. Department of Health and Human Services, Administration on Children, Youth, and Families. (January 17, 2017). *Information memorandum (ACYF-CB-IM-17-02): High quality legal representation for all parties in child welfare proceedings.* Retrieved from https://www.acf.hhs.gov/cb/resource/im1702

[10] Maze, C. (2010, October). *Advocating for very young children in dependency proceedings: The hallmarks of effective, ethical representation.* Washington, DC: American Bar Association Center on Children and the Law. Retrieved from https://www.americanbar.org/content/dam/aba/administrative/child_law/ethical_rep.pdf

[11] ZERO TO THREE. (2020). *The Safe Babies Court Team™ Approach: Logic model.* Washington, DC: ZERO TO THREE. Retrieved from https://www.zerotothree.org/resources/series/national-infant-toddler-court-program

[12] ZERO TO THREE. (2020). *The Safe Babies Court Team™ Approach: Core components and key activities.* Washington, DC: ZERO TO THREE. Retrieved from https://www.zerotothree.org/resources/services/the-safe-babies-court-team-approach

[13] ZERO TO THREE. (n.d.). *About the national Infant-Toddler Court Program* [Website]. https://www.zerotothree.org/resources/3066-about-the-national-infant-toddler-court-program

collaborative problem-solving; (3) expedited, appropriate, and effective services for children and parents; (4) trauma-responsive support that emphasizes a healing approach in supporting families and building safe, stable, and supportive early caregiving relationships for the very young child; and (5) continuous quality improvement to drive improved practices and outcomes. Embedded in the strategic framework are core components theorized to work synergistically to maximize child, parent, family, and community benefits (see table below). Designed for real-world applicability, effective implementation uses a continuous improvement approach to meeting individual practice and systems change benchmarks.

Core Components & Practice Activities

Core Component	Activities	Operational Details
Judicial and Child Welfare Leadership	The judge/magistrate and child welfare administrator serve on the Site Leadership Team to support infant-toddler court team (ITCT) implementation and engage in the collaborative work of the Active Community Team to drive systems improvements and gaps in equitable services and supports for children and families	Ensure the administrative support for the new practices and procedures required in an ITCT including: • Calendaring a special or regular docket for ITCT cases • Increasing the frequency of review hearings for ITCT cases
Community Coordinator (ITCT-CC)	Builds and coordinates meaningful community connections between the ITCT and array of local services, resources, and supports Identifies and engages community partners for the Active Community Team (see below) Plays an instrumental role in supporting an effective Active Community Team Helps the Active Community Team use data effectively to identify needed system improvements Helps parents understand court and child welfare processes and empowers self-agency in decision-making Facilitates collaborative problem-solving among the professionals on the Family Team (see below) and with the family	Full-time position, recommended 20 families/caseload Requisite knowledge and skills to carry out this role span child and family health and well-being, fundamentals of the child welfare system, collaboration and building relationships, reflective practice, and continuous quality improvement.

	Supports and coordinates child and family access to needed community-based services, resources, and supports Provides a consistent strong voice for the developmental needs of the infant or toddler in case planning and decision-making Promotes a comprehensive and healing approach in addressing the parent's needs and in case planning and decision-making	
Active Community Team	Facilitates access to and participates in cross-system trainings Identifies, responds, and monitors gaps in the availability, accessibility, and alignment of services and supports (prevention to treatment continuum) Installs new policies and procedures at the local/county level that reinforce and sustain best practices across systems	The Active Community Team comprises a wide range of community stakeholders Periodic, regular meetings Supported and coordinated by ITCT-CC
Family Team Meetings	Professionals and family work together as partners, with a major emphasis on empowering parent voice and choice in decision-making Meets regularly and frequently (best practice is monthly) Engages in collaborative problem-solving to expedite timely screenings, assessments, and referrals	Members of the Family Team: • ITCT-CC • Parent(s) • Family/supports for parent(s) • Peer mentors/parent allies • Cross-sector professionals including the child welfare caseworker, parent and child attorneys, service providers
Building a Continuum of Services for Children and Families	Child and family needs are identified through screening and assessment Services and supports are comprehensive and individualized, addressing the social determinants of health Receipt and timeliness of needed services and supports are closely monitored Partnerships and linkages with community providers facilitate timely referral processes and address barriers to access	Child: Regular well-child visits, screenings, immunizations; Part C-Early Intervention; IECMH services Family: Preventive health care, postpartum care; home visiting; attachment-based clinical interventions; trauma-informed adult mental health and substance use disorder (SUD) treatments

Meeting Parents Where They Are	*All professionals working with the family:* Foster a compassionate climate that takes a healing, rather than punitive, approach Engage and value parents with kindness and respect in all interactions Respond to parent histories of trauma and adversity and underlying mental health needs Develop awareness of individual bias and structural racism and discrimination Empower parents by creating opportunities to increase their capacity for self-advocacy, confidence, and motivation Build protective factors including parental resilience Shift individual perceptions and bias about substance use disorder (SUD), recognizing SUD as a recurring medical condition that necessitates a therapeutic approach	T/TA focuses on enhancing practices and systems to promote: • Family engagement and empowerment • Racial equity • Social support networks for families • Trauma-informed support • A healing approach to substance-use disorders
Nurturing Parents' Relationships and Building Social Supports	Formal and informal opportunities for mentoring relationships and social supports for parents, within their community and cultural circle, are cultivated Peer support networks are utilized to help parents navigate the child welfare system and support SUD recovery	ITCTs integrate support from co-parenting programs and peer mentoring programs (such as Washington's *Parents for Parents* program and the *Parent Partner Iowa* program)
Frequent, Quality Family Time (for children in out-of-home care)	Family time (formerly called "visitation") is carefully planned to minimize stress and prevent re-traumatization for child and parent Settings are safe and developmentally appropriate, parent feels comfortable, and environment facilitates nurturing interactions Mentoring/coaching is provided to strengthen the parent's sense of agency and capacity for nurturing, protective caregiving	Occurs immediately following removal and then as frequently as possible (best practice is daily) Utilizes a parent mentor/coach Promotes co-parenting Appropriate settings are identified/developed

Concurrent Planning	A thoughtful individualized plan is developed early in the case process that focuses on nurturing and protective early caregiving relationships for the child, building parent protective factors, and proactive efforts to promote reunification or other lasting permanency outcomes	Concurrent planning begins on Day 1 of the case, in the context of Family Team Meetings Parents are actively engaged in the planning
System Commitment to Continuous Learning Improvement	ITCTs embed a continuous quality improvement (CQI) approach, collecting and using data to track progress and identify areas for improvement with specific attention to racial/ethnic and other disparities Both the Family Team and Active Community share a commitment to using data for needs assessment, monitoring, and planning	Sites receive ongoing training and support on continuous quality improvement methodology Sites complete SBCT Database License Agreement and Confidentiality forms Client intake includes Program and Data Sharing Consent process ITCT-CC (or part-time data analyst) enters data in the national ITCP Database or other state database

HEALTH EQUITY

Health equity is a cross-cutting priority of ITCTs, which at their core focus on addressing barriers to services and supports that address the social determinants of health – particularly for children and families of color who experience disparities in timely access to needed services.[14] Attention to equity is embedded throughout the SBCT approach, with both the Active Community Team and Family Team providing powerful platforms for improvements. The Active Community Team commits to the ongoing work of recognizing and dismantling the discriminatory practices and policies across systems that perpetuate disparities through community-based trainings that increase awareness and promote vigilance, monitoring disaggregated data to identify inequities, and carrying out targeted initiatives and intentional systems reform. The Family Team Meetings engage and empower parents in a participatory planning and decision-making process. Family input is not only valued but considered essential; families are not only supported but respected. This process fuels a trusting relationship between the family and professionals, which opens the door to open communication about the family's needs and challenges. The ITCT Community Coordinator plays a critical role in addressing health equity by collecting data to identify progress in meeting children and families' needs; this case-based data is then aggregated and shared with the Active Community Team to identify systems gaps and needed improvements specific to racial/ethnic and other disparities. In a recent national multisite

[14] Osofsky, J.D., Fraser, J.G., and Huffer, A. (2021). The Safe Babies Court Team™ approach: Creating the context for addressing racial inequities in child welfare. *ZERO TO THREE, Vol 42*(1).

evaluation[15,16], data were analyzed to determine if there were differences in service receipt and placement outcomes by race or ethnicity. The evaluation found no statistically significant differences by race or ethnicity for time from order to service receipt for developmental screening, early intervention, and Child Parent Psychotherapy. Statistically significant differences were also not found for time in foster care by race or ethnicity.

ZERO TO THREE's National Resource Center for the ITCP provides targeted training and technical assistance to support ITCTs in addressing health equity and building equitable systems of care. One major area of work for the Center was the development and ongoing implementation of a self-assessment tool for advancing equity and inclusion in ITCTs. Developed by the Center's consultants/partners, Dr. Marva Lewis at Tulane University in collaboration with experts in race equity in the child welfare system at the Center for the Study of Social Policy, this Race Equity Assessment Tool was designed to drive continuous improvement in ITCTs by fostering 'courageous conversations' about equity in child protective services delivery and dependency court processes.[17] Specifically, the tool guides teams in moving through three fundamental steps: (1) Get the Big Picture – become informed through training, resources, and reviewing national data and trends; (2) Focus on the Local: Lay the Foundation – affirm commitment, ensure representation of diverse perspectives, collect and review local data disaggregated by race and ethnicity; and (3) Focus on the Local: Build the Structure – identify priority areas, develop strategies to address disparities, engage in continuous learning, identify opportunities to institutionalize and scale effective strategies.

The ITCT Race Equity Assessment Tool was originally piloted in 2018 with the ITCT in Pasco County, Florida. The pilot was facilitated by Dr. Lewis and CSSP partners, launching with a two-day training on racial disproportionality and equity. Members of the ITCT and community stakeholders participated through invitation as well as those who expressed interest in moving the work forward. The first day focused on developing a framework for a strategic plan and common vision; the second day focused on the disproportionality in the local child welfare and court system, establishing a safe space for honest and transparent conversations about race. Participants were provided a data template for capturing key data elements key on racial composition of the local child population, child welfare population, and ITCT population and provided a train-the-trainer training about how to discuss and engage with families about their race, ethnicity, and culture. This training highlighted strategies for engaging families to support accurate data collection about race and ethnicity. Child welfare managers responsible for training case management staff in Hillsborough, Pasco, and Pinellas counties and child protection investigators in Pasco County participated in this training. The pilot successfully initiated ongoing race equity assessment and quality improvement work, to achieve the common vision of advancing equity and removing systemic barriers to promote positive outcomes for children and families of color; increased the site's capacity to train workers and community members on engaging families around their race and ethnicity; has implemented strategies to ensure more

[15] Casanueva, C., Harris, S., Carr, C., Burfeind, C., and Smith, K. (2017). *Final evaluation report of the Quality Improvement Center for Research-Based Infant-Toddler Court Teams.* Research Triangle Park, NC: RTI International.
[16] Casanueva, C., Harris, Carr, C., Burfeind, C., and Smith, K. (2019). *Evaluation in multiple sites of the Safe Babies Court Team™ approach.* Child Welfare, 97(1), 85-107.
[17] Quality Improvement Center for Research-Based Infant-Toddler Court Teams. (2018). *Advancing equitable outcomes for infants and toddlers involved in child welfare.* Washington, DC: ZERO TO THREE. Retrieved from: https://www.zerotothree.org/resources/3057-equity-and-social-justice-in-child-welfare

accurate data collection; and is able to disaggregate the local child (ages 0-3) population, county child welfare population (ages 0-3), and court team child population by race. The Pasco ITCT has also identified strategies for using the data about positive outcomes for children involved in the ITCT disaggregated by race and ethnicity to advance sustainability efforts. This work also resulted in identifying stakeholders and voices missing from the Active Community Team at the site, who were subsequently invited. Building on the pilot experience in Pasco County, the ITCP is currently supporting two ITCT sites (Palm Beach County and Broward County, Florida) with race equity improvement work guided by the Race Equity Assessment Tool and process.

EVIDENCE OF EFFECTIVENESS

RTI International is currently conducting a mixed-method multisite evaluation study for the ITCP (2018-2022), a project funded by the Health Resources and Services Administration, Maternal and Child Health Bureau, led by ZERO TO THREE. The study is being conducted by ITCP's external evaluator, RTI International, at 26 evaluation sites across the country. It includes both a process (implementation) and outcomes evaluation. The process evaluation will examine ITCT implementation facilitators and barriers and factors/processes supporting the development of state-level leadership teams for supporting statewide expansion. Data for the process evaluation is being collected through baseline and follow-up stakeholder surveys on collaboration and implementation as well as in-depth baseline and follow-up phone interviews with stakeholders (qualitative data). The outcomes evaluation is being conducted at 10 ITCT sites will assess outcomes related to parent and child health and well-being, maltreatment recurrence, removal from the home, number of out-of-home placements, and permanency. A quasi-experimental design is being used for the outcomes evaluation using a matched comparison group from the National Survey of Child and Adolescent Well-Being, the only nationally representative sample of children involved with the child welfare system. The comparison group will be created by using propensity score matching to select a subsample of infants and toddlers with a maltreatment investigation and a placement history similar to the children served in ITCT sites during the study period.

A previous national multisite evaluation study, also conducted by RTI International, was conducted between 2015 and 2017.[18,19] This mixed-method study included a process evaluation using pre/post in-depth stakeholder interviews and web-based surveys as well as observations of court hearings, Family Team Meetings, and Active Community Team meetings. The outcome evaluation used a non-experimental design with secondary data analysis of data entered by Community Coordinators in a national database administered by ZERO TO THREE at the ten participating sites. The results of that study, which demonstrated improvement in outcomes for both children and parents participating in ITCTs, are described below.

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

[19] Casanueva, C., Harris, Carr, C., Burfeind, C., and Smith, K. (2019). *Evaluation in multiple sites of the Safe Babies Court Team™ approach.* Child Welfare, 97(1), 85-107.

Child- and Family-Level Outcomes:

1) Improved identification of and services to address child's developmental and emotional needs: ITCT staff received trainings and TA aimed at increasing understanding of the developmental needs of young children, the importance of systematic and timely screening and referral, and appropriate services and supports to improve children's developmental health. Based on the ASQ-3 data, more than 70% of children in the study had one or more developmental areas that needed to be monitored or that fell below normal development at entry into the ITCT program. Overall, about 85% of children participating in an ITCT who needed a screening received a developmental screening within 60 days. Close to 90% of children and caregivers (parent and/or foster parent) who were referred for evidence-based trauma-specific treatment (Child-Parent Psychotherapy or CPP) had their first appointment within 60 days. There were no statistically significant differences by race or ethnicity across sites comparing time from court order for services to service receipt for developmental screening, early intervention, and CPP (see table below). Overall, more than 80% of children who needed services received those services within the first 60 days from court order or referral to service.

Race/Ethnicity	Total		Developmental Screening[a] *N* = 214	Early Intervention[b] *N* = 135	Child-Parent Psychotherapy[c] *N* = 114
	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

[a]Chi-Square: df (3), 7.28, $p = 0.06$. [b]Chi-Square: df (3), 2.21, $p = .53$. [c]Chi-Square: df (3), 0.32, $p = .96$.
NOTE: *N*'s reflect the number of children identified as needing the service.

2) Improved identification of and services to address parent needs: Among the array of services needed by parents, the highest need was related to substance use disorder: 75% of parents needed substance use screening, 66.9% needed parent education, 55.6% needed mental health screening, and 45.6% needed mental health counseling. Parents also needed services for basic needs including housing (16.6%), childcare (14.8%), and transportation (9.5%). For those in need, 90.9% received a screening for substance use disorder. Of those identified in need of treatment, 95.2% received outpatient services; a small number were identified as in need and received inpatient treatment. Among those in need of mental health screening, 96.7% received mental health screening; of those parents, 84.2% were referred for and received a psychological evaluation and 87.5% were referred for and received a psychiatric evaluation. Close to 95% of parents in need received mental health counseling. Over 90% (93.5%) received parent education. Receipt of needed services among parents served at ITCT sites contrasts with the 61% of mothers and 46% of fathers receiving appropriate

services as reported in the preliminary CFSR 3 results.[20] While Community Coordinators attributed some delays to limited availability of service in the area, there were also cases for which it took time for parents to engage in the service. Overall, close to 80% of parents received needed 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 parents. Time to receipt of the first mental health service (including mental health counseling, mental health medication management, and family counseling) was less than a week for 53.9% of parents and 7 to 30 days for 26.2%, and for the first substance use disorder treatment 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% of parents.

3) Improved support for the provision of Evidence-Based Programs (EBPs): The primary EBP for ITCT cases was the dyadic, attachment-based intervention Child-Parent Psychotherapy[21,22] At most sites, an important change in practice was to make CPP a key referral and work with families to support their engagement and participation in this service. A central goal of CPP is to strengthen and heal the parent-child relationship, helping parents to understand how best to help their young child to feel safe and secure. CPP helps parents learn that a child's "behavior has meaning" and, with that understanding, to help their children name and cope with strong and scary feelings. Most stakeholders spoke highly of CPP and its positive impact on parents and children. Court hearing and family team meeting observations captured positive statements about CPP made by parents, as well as examples of progress made through the therapeutic process. During the demonstration project period, many sites began work to build capacity in their network of service providers to offer CPP.

4) Placement stability: Judicial leadership, one of the SBCT core components, is critical for placement stability and setting expectations for parents and out-of-home caregivers that a safe, stable, nurturing environment be maintained for the young child. Across all sites, 59.5% of children had one placement, 26.5% had two placements, and 14.0% had three or more placements after removal from the home. Among children in out-of-home care for less than 12 months, 94.2% had no more than two placements, while 79.4% of those in care from 12-23 months had no more than two placements. Analysis by race and ethnicity showed no statistically significant differences in placement change or length of time in foster care.

5) Low maltreatment recurrence: Child safety analysis followed the CFSR 3 definition provided in the federal registry. For Safe 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?"[23] The national standard established for Safety Performance Area 2 sets recurrence of maltreatment at no more than 9.1%. The recurrence of maltreatment among children served at the ITCT demonstration project was 1.2% (3 out of 242

[20] Administration for Children and Families, Children's Bureau. (2017). *Child and Family Services Reviews: Round 3 findings 2015-2016.* Retrieved from https://www.acf.hhs.gov/cb/resource/cfsr-round3-findings-2015-2016

[21] Lieberman, A., Ghosh Ippen, C., & Van Horn, P. (2015). *Don't hit my mommy! A manual for Child-Parent Psychotherapy for young children exposed to violence and other trauma (2nd Edition).* Washington, DC: ZERO TO THREE Press.

[22] Lieberman, A., & Van Horn, P. (2008). Psychotherapy with infants and young children: Repairing the effects of stress and trauma on early attachment. New York, NY: The Guildford Press.

[23] Administration for Children and Families. (2015). *Statewide data indicators and national standards for child and family services reviews.* Retrieved from https://www.acf.hhs.gov/cb/monitoring/child-family-services-reviews

cases). Subsequent analysis conducted at a later point, that included 188 additional ITCT cases, demonstrated an even lower rate of recurrence of 0.7% (3 children/two families, out of 430 cases).[24]

6) Permanency in 12 months: Among 137 children with closed cases followed up to June 2018, 78.1% reached permanency within 12 months following the current CFSR 3 definition of Permanency Performance Area 1: Permanency in 12 months for children entering foster care. Close to half of children were reunified with parents (48.9%), over a quarter were adopted (28.2%), 17.8% were placed with a fit and willing relative, and 5.2% reached another type of permanency (e.g., legal guardianship). Over half of parents retained parental rights (53%), 11.2% relinquished parental rights, 22.4% had termination of parental rights, and 13.4% transferred the custody of the child. There were no significant differences for permanency within 12 months, type of permanency, and parental rights by child's race or ethnicity.

Findings from the stakeholder-level and system-level process evaluation:

Evaluation Question #1: What factors and strategies were associated with successful partnership and collaborative efforts to implement or sustain an ITCT using the SBCT approach?

Stakeholders reported that partnerships and collaboration improved across sites due to several critical factors. First, stakeholders identified the importance of a judge's role in bringing a team together, ensuring a large and diverse stakeholder group, and leveraging other initiatives to help grow and diversify the stakeholder group. The evaluators also observed how judges played an important role personally engaging stakeholders before, during, and after stakeholder meetings. Second, stakeholders identified a strong Community Coordinator as vital to successful partnership and collaborative efforts due to their leadership role on the ITCT – a role that includes facilitating collaboration across professionals representing different sectors and systems and building a continuum of services for infants, toddlers, and their families facilitated by this collaboration. Evaluator observations of family team meetings also noted how important the Community Coordinator was in ensuring neutral facilitation and actively engaging parents and service providers in productive and often difficult discussions. The Community Coordinator also organized and facilitated stakeholder group meetings at several sites, and evaluators observed their personal connections with stakeholders – greeting stakeholders before the meeting and talking with stakeholders afterwards. The third critical factor critical to the success of partnerships and collaborative efforts was buy-in from stakeholders, particularly those with decision-making power, such as the judge and the senior management of agencies. Knowledge about child and parent trauma, infant and early childhood mental health and attachment, early childhood development, and other topics addressed in training provided by the ZERO TO THREE was identified by stakeholders as essential for that buy-in. The training, and TA, strengthened professional development and created a shared knowledge base across professionals that, in turn, contributed to a shared vision and sense of partnership and value in the work. This fostered improved communication across the many professionals involved in a case.

[24] *Quality Improvement Center for Infant-Toddler Court Teams. (2018). Making a Difference in the Lives of Families: The Safe Babies Court Team™ Approach. [Infographic]. Available at https://www.zerotothree.org/resources/3059-evaluation*

Evaluation Question #2: To what extent is there evidence that better practice is underway at each site, reflecting implementation of the SBCT approach?

Most sites demonstrated improvements in practice and reported modifying policies to support those practices. The largest gains were in practice were in the areas of communication and collaboration among cross-sector professionals. Other improvements included more frequent court hearings and implementation of monthly family team meetings. Most sites reported that parent-child contact (visitation) was occurring more frequently, and that the quality of contact was improved (e.g., employing coaching during visits to help build nurturing, responsive parenting skills). More than 70% of children had a visitation plan that recommended frequent parent-child contact, either at 3-5 times per week (45.7%) or daily (25.4%). Nearly 60% of children and parents experienced weekly contact, with 25.6% daily and 34.5% at 3-5 times per week. Based on observations of court hearings and family team meetings, as well as stakeholder reports, parents were highly engaged and valued – encouraged to speak, ask questions, and share their concerns during both. Professionals on the Family Team reported continually looking for ways to improve their practice and the ITCT by seeking feedback from parents. To reduce placement changes, many sites implemented new procedures emphasizing family placements. In most sites, the judge changed their practice to make conversations about placement stability central in court hearings and to monitor that child welfare decisions were thoughtful about placement changes. Many sites established procedures for 'frontloading' referrals and services; as an example, some sites changed procedures to appoint a Court-Appointed Special Advocate automatically to ITCT cases so that the child's needs could be advocated for as early as possible in the court process.

In terms of systems-level improvements, large and diverse stakeholder groups were developed at each site that were meeting frequently (at least monthly). These meetings were used to review and discuss the ITCT policies and procedures, case and systems issues, gaps in availability and accessibility of community resources, as well as to discuss upcoming trainings and relevant research. Many sites' stakeholder groups had created workgroups that were meeting regularly to address specific issues. Across sites, stakeholders reported how training and TA provided by ZERO TO THREE resulted in their being more informed about the needs of infants and toddlers in foster care; attachment and infant/early childhood mental health; the impact of child maltreatment, trauma, and placements; and how a parent and family's trauma history and historical trauma affect the individual and community.

Evaluation Question #3: What organizational and systems conditions have been necessary to support the implementation of the sites' selected evidence-based program(s)?

Most sites reported that they used Child-Parent Psychotherapy (CPP) as their EBP of choice for the ITCT. Some sites also reported using Parent-Child Interaction Therapy and Circle of Security. Stakeholders identified multiple factors supporting the implementation and sustainability of these EBPs including the need for education about what an EBP is and why it's important that an intervention program be evidence-based; this fosters buy-in, particularly by the judge. Also, building capacity to increase the availability of providers, as well as administrative support at the providers' agency to allow for the additional time associated with training and implementing the EBP, were also identified as critical.

Evaluation Question #4: To what extent are there observable changes in roles and behaviors of ITCT members during hearings?

Positive changes in roles and behaviors of ITCTs during court hearings were identified in stakeholder interviews and observations of court hearings. For most sites, court hearings were used as an opportunity to collaborate in identifying and solving problems. Judges asked more questions to identify needs and issues of both children and their parents, set an expectation for a kinder and more healing climate in the courtroom, demonstrated respect and sought to engage parents by speaking directly to them and using simple language that was readily understandable, and frequently checked with parents to make sure they understood what was being discussed in court and how it would affect them and their child. The judge's increased knowledge and understanding about trauma was demonstrated in observations of judges acknowledging the trauma that parents had experienced in their own lives and the role it played in their current situation. Other professionals, in turn, demonstrated more collaborative and less adversarial behavior during court hearings; they were observed to be respectful, attentive, and supportive of one another and of parents. Evaluators observed parents being active participants in hearings, speaking for themselves instead of through their attorneys. Many stakeholders observed in the survey that professionals were making a conscious effort to recognize parents for their progress made. Stakeholders reported that hearings were longer and/or more thorough than hearings in 'regular' dependency court. Community Coordinators were observed to provide critical information about available services during hearings. Most sites had worked to create a physical space in the courtroom that was family friendly and reduced stress, for example by providing developmentally appropriate toys and books that helped parents and children interact in a positive way.

Section 2: Implementation Guidance

STAKEHOLDER EMPOWERMENT & COLLABORATION

Stakeholder Empowerment and Collaboration		
Stakeholder	**How are they involved in decision-making throughout practice processes?**	**Does this stakeholder have lived experience/come from a community impacted by the practice?**
Parents involved in the	At the family level, parents participating in an ITCT site are actively supported and empowered to	Yes

child welfare system	engage in the child welfare case process, particularly by having their voice elevated in Family Team Meetings (FTMs). Parents are valued partners in the participatory planning and decision-making that takes place in FTMs. In this way, FTMs create a context in which a trusting relationship between the family and professionals is cultivated, which opens the door to open communication about the family's needs and challenges. At the community/systems-level, parent engagement in the local Active Community Teams is highly encouraged and supported by the ITCP. The ITCP provides consultation and training to support parent engagement, including applying best practices for family engagement as defined by the Family Voices' Family Engagement in Systems Assessment Tool (FESAT). Additionally, the ITCP systematically seeks input and recommendations from its National Advisory Group for Parents' Voices, made up of parents and parent mentors (paraprofessionals) with lived experience in the child welfare system from across the country including participation in an ITCT.	
Child Welfare Professionals	At the family level, child welfare professionals participate in FTMs and Site Leadership Team Meetings. At the FTMs, the team engages in collaborative problem-solving as they work to prevent children's removal and placement in foster care; promote reunification and other lasting permanency outcomes; strengthen family protective factors including enduring, positive social connections; and protect and build safe, stable, and nurturing early relationships. At the community/systems level, child welfare professionals from frontline to supervisory actively participate in the Active Community Teams. In this way, they are involved in identifying and responding to gaps in the availability, accessibility, and alignment of services and supports for families and in installing new policies and procedures to reinforce and sustain best practices.	Varies; many child welfare professionals – particularly caseworkers - grew up in communities affected by child welfare protective services

Judges/judicial officers	Judges play an important role on Active Community Teams, bringing their perspective to identifying priorities about needed system reforms and engaging in shared decision-making with other stakeholders to move improvements forward. At the national level, judicial consultants with experience leading ITCTs, as well as experts from the National Council of Juvenile and Family Court Judges (NCJFCJ), participate in the ITCP's national Leadership Team. They bring the judicial perspective to the ITCP's strategic planning and ensure key needs and considerations for judicial stakeholders are represented. NCJFCJ is also an important stakeholder in providing training to ITCT judges and for disseminating information about ITCTs to the broader field of dependency court judges and judicial officers.	No
Attorneys	At the family level, parent and child attorneys engage in collaborative problem-solving to drive meaningful assessment of case progress and development of case goals (in the context of FTMs). Attorneys bring their perspective particularly as it relates to the ethical responsibilities inherent in legal representation. As stakeholders in the work of ITCTs, their trust that the program benefits their clients (children, parents, child welfare agencies) must be gained through relationship-building, information sharing about the program's evidence, and reflective discussions. At the community/systems level, attorneys participate in the local Active Community Teams. At the national level, the American Bar Association (ABA) Center on Children and the Law participates in the ITCP's national Leadership Team. As members of the Leadership Team, ABA represents the professional concerns of the legal field and informs key decisions about program activities that impact attorneys representing children and families in the child welfare system. Additionally, the ABA serves as an essential stakeholder in training attorneys participating in ITCTs and	No

	disseminating information about ITCTs to the broader field of child welfare attorneys.	
IECMH Providers who work with children and families involved in the child welfare systems	At the family level, IECMH providers commonly are active participants in FTMs and Site Leadership Team meetings. IECMH providers are critical community partners in providing the services that support the child's early caregiving relationships, including strengthening and repairing the parent-child relationship. At the FTMs, they assure the child and parents mental health is being addressed and facilitate reflective practice. IECMH providers bring their expertise in early childhood mental health 'to the table' to integrate the clinical perspective in case planning and decision-making. At the community/systems level, IECMH providers participate in the local Active Community Teams, bringing their knowledge and understanding of clinical needs and effective services for child welfare involved children and families (evidence-based interventions that are appropriate for very young children and their caregivers, clinical considerations specific to this age group, mental health expertise). In this way, they are vital to planning for building community capacity to better meet the needs of this population.	No
Burgeoning Stakeholder Involvement	The ITCP has been and is continuing to support the building of linkages between ITCTs and maternal and child health services, programs, and systems. This includes building the child's medical home and aligning with the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) and Early Childhood Comprehensive Systems program and grantees. The ITCP is developing resources to support these connections, including a tip-sheet and online tutorial for ITCT Community Coordinators to support outreach and relationship building with local home visiting programs.	No

As referred to above, the ITCP has a variety of structures and processes to ensure meaningful participation of the array of stakeholders salient to the SBCT approach. These comprise local Active

Community Teams, Family Team Meetings (FTMs), the National Advisory Group for Parents' Voices, and the ITCP Leadership Team.

Parent Stakeholder Engagement: At this juncture, the ITCP is focusing on building processes to support the consistent and substantive engagement of stakeholders, with an emphasis on strengthening pathways for parent leadership. To systematically obtain and meaningfully integrate input and feedback from the National Advisory Group for Parents' Voices in carrying out the goals and objectives of the national program, ITCP leadership will define specific steps for obtaining and including the Advisory Group's input in our standard operating procedures for program activities and/or project workplans (e.g., resource development; interpreting findings for reporting). In this way, the ITCP will obtain regular, meaningful parent input and feedback that identifies and prioritizes the services and supports that families need, is responsive to parent insights into the challenges they face and does not unintentionally exacerbate inequities in terms of access to or quality of services/supports. In addition, the ITCP will be collaborating with Family Voices to strengthen parent engagement in leadership activities at the local, state, and national levels. Family Voices will provide expertise and share resources for promoting family leadership. They will provide consultation and training to ITCP staff on their framework for family engagement in systems, including specific guidance for parent mentoring activities that are key to promoting, enhancing, and sustaining family engagement in systems-level initiatives. Community Coordinators will receive training and consultative support on strategies for engaging parents in their Active Community Teams, with consideration of how these engagement strategies can also be applied to enrolling parents in their local ITCT program. Statewide Coordinators will also receive training on strategies for engaging parents in their State Advisory Group with follow-up consultation as needed.

Active Community Team Stakeholder Engagement: The Active Community Teams are designed to bring multidisciplinary and diverse stakeholders together to engage in decision-making and systems change at the local and county level. This stakeholder group comprises leaders and providers from community-based agencies and provider organizations across multiple service systems and sectors. The Active Community Team is instrumental in facilitating local, state, and national trainings to enhance community capacity to meet children and family needs with effective services, resources, and supports. Active Community Team members also engage in continuous quality improvement (CQI), reviewing trends and issues in the data on families served by the ITCT with state data. This CQI work emphasizes attention to racial and other health disparities and identifying strategies to address inequities.

Family Team Meeting Stakeholder Engagement: FTMs are a crucial method for stakeholders to work together to address barriers to needed supports and services. FTMs drive meaningful assessment of case progress and the development of case goals, in partnership with the parent, other family members, and all professional actors involved with the case. FTMs are in alignment with the SBCT approach when all members of the team view the case through a developmentally- and trauma-informed decision-making lens and work in concert to elevate parents' voices and perspectives in the decision-making process.

REPLICATION

Since the SBCT approach was first developed over 15 years ago it has been replicated at sites across the country. The first national multi-site evaluation assessed ten study sites and found improved identification of and services to address child's developmental and emotional needs, improved identification of and services to address parent needs, low maltreatment recurrence, and high rates of permanency within 12 months, among other positive findings.[25,26] Currently, there is a total of 106 ITCTs in 31 states that are operating at various stages of implementation (exploration, installation, initial implementation, and full implementation). The landscape of sites includes individual local jurisdictions/communities that are implementing an ITCT as well as state-level efforts to support implementation at multiple local sites. The state-level work is occurring in seven states: five states supporting uptake of ITCTs in at least 3 local sites that are early in the implementation process (Arkansas, New Jersey, Ohio, South Carolina, Washington) and two states that are supporting multiple established local sites (Florida, Tennessee).

At the state level, the ITCP is providing technical assistance focused on building the state-level infrastructure needed to provide ongoing support, leadership, and guidance to local ITCT sites. At the local site level, the ITCP provides training and technical assistance (T/TA) via a cadre of experienced Regional Field Specialists. This T/TA, which is designed to drive quality improvement and is based on principles of implementation and improvement science, engages local communities seeking to implement the approach in specialized content-driven and relationship-based T/TA. At the direct service level, the focus is on content-driven T/TA by building the knowledge and capacity of professionals to implement SBCT practices and procedures that better support very young children and families. At the systems level, the relationship-based T/TA focuses on supporting sites and states to engage in strategic planning that facilitates enduring practice and systems improvement, including advancing policies that promote and sustain the SBCT approach. The main methods of T/TA provided are collaborative learning models, which emphasize active engagement with peers for shared learning, problem-solving and solution-finding, and developing strong peer-to-peer networks. This method also incorporates 'action periods' for learners to put new knowledge, behaviors, and strategies into practice in-between learning sessions. Collaborative learning can be highly structured in terms of duration, frequency/length/timing of learning sessions, components, and participation or more flexible. The ITCP uses a variety of collaborative learning models (e.g., learning collaboratives, learning communities, and communities of practice).

INTERNAL CAPACITY

Site Leadership Team

- Judge/Judicial Officer
- Court Administrator/Manager
- Child Welfare Agency Regional Director/Administrator
- ITCT-Community Coordinator

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

[26] Casanueva, C., Harris, Carr, C., Burfeind, C., and Smith, K. (2019). *Evaluation in multiple sites of the Safe Babies Court Team™ approach.* Child Welfare, 97(1), 85-107.

- Other key system stakeholder(s)

Professionals Participating in the Family Team

- ITCT-Community Coordinator
- Child Welfare Caseworker
- Child Attorney/Guardian ad Litem (GAL) and/or Court Appointed Special Advocate (CASA)
- Parent(s)' Attorney(s)
- Child Welfare Agency Attorney
- Parent Mentor/Peer Support (where available)
- Child and Parent Service Providers

Other Project Staff

- Data Analyst/Quality Improvement Staff - Part-Time

For state-level work, the State Team comprises a:

- Program Manager
- Statewide Coordinator
- Quality Improvement Manager
- Data Analyst

PRACTICE TIMELINE

Phase: Planning/Pre-Implementation		
Activity Description	**Time Needed**	**Responsible Party**
Focus on assessing fit with and readiness for implementation (1) Identify the fit with local values, culture, and priorities (2) Identify system challenges, opportunities including judicial, child welfare, and other sectors (3) Map community assets to identify services, gaps in services (4) Identify funding opportunities, using the ITCP Federal Funding Guide	Varies, generally takes 6 months (exploration)	The ITCP Senior Outreach Specialist works with a core group of community/local stakeholders to assess fit and readiness

(5) Identify key stakeholders (local and state level) who will commit to supporting the initiative (6) Identify the key local system stakeholders who will commit to facilitative and administrative leadership		
Focus on creating the foundation necessary to initiate implementation (1) Develop a strategic plan to build the infrastructure (implementation drivers) that will support effective implementation of the SBCT approach including solidifying the Site Leadership Team (2) Provide Site Leadership Team with training and support, so it is positioned to facilitate effective implementation (3) Launch Active Community Team with trainings and support, so it is positioned to carry out its functions (4) Obtain funding to support implementation and address gaps in services and resources (ongoing throughout all stages of implementation) (5) Community Coordinator completes onboarding and pre-service training (6) Cross-sector professionals who will serve on the Family Team(s) participate in foundational training (7) Conduct/complete case process mapping (8) Develop/codify referral and other administrative processes	Generally, 6-12 months (installation)	ITCP staff work collaboratively with a core group of community/local stakeholders who engaged in the planning/pre-implementation activities and are ready to commit/support implementation (create enabling context)

Phase: Implementation		
Activity Description	**Time Needed**	**Responsible Party**

Focus on initial application of new knowledge, newly learned skills, and continuous improvement (1) Host foundational training for community to formally launch initiative (2) Launch program enrollment (3) Initiate data collection to assess performance (ongoing performance measurement) (4) Use data to target improvement through Continuous Quality Improvement (5) Monitor and reinforce individual practice changes and systems changes through ongoing training and coaching on core components and protocols and policies to ensure the ITCT is being implemented as intended (6) Attend to emergent needs and manage adaptive and technical challenges that emerge (7) Document and share progress with community stakeholders and leaders (8) Continue to use the ITCP Federal Funding Guide to identify and pursue funding sources, partnerships as needed	Generally, 12 months (initial implementation)	ITCP Regional Field Specialists, Quality Improvement Manager, and other key staff provide training and technical assistance to support initial implementation Active Community Team Site Leadership Team Community Coordinator Cross-sector professionals on the Family Team

Phase: Sustainability		
Activity Description	**Time Needed**	**Responsible Party**
Focus on maintaining fidelity and integration of approach at the practice, organizational, and community levels (1) Engage in regular, periodic fidelity self-assessment to sustain high fidelity practice at the individual practice and systems levels	**Full implementation** generally takes 2-4 years **Sustainability** is addressed from	ITCP Regional Field Specialists, Quality Improvement Manager, and other key staff provide booster/requested training and technical

(2) Attend to emergent needs and manage adaptive and technical challenges including turnover and drift (3) Consider expanding to new courts/jurisdictions in community (4) Document and share progress with stakeholders and leaders (5) Continue to use the ITCP Federal Funding Guide to identify and pursue funding sources, partnerships as needed	the outset, ongoing	assistance to support full implementation and sustainability Active Community Team Site Leadership Team Community Coordinator Cross-sector professionals on the Family Team

PRACTICE COST

Implementing ITCTs in a local community typically costs ~$8,500 per family. The recommended caseload is 20 families per community coordinator at any point in time; the per-family cost estimate is based on approximately 27 families served over the course of a year, which includes families whose cases may have closed and new families that enroll (see table). As sites expand to serve additional families, they may incur additional costs. For example, sites may need to hire a new child welfare caseworker or attorney that is dedicated to working with ITCT families if they are unable to reallocate existing staff. Most sites use a mix of local, state, federal, and/or philanthropic funding to finance and sustain the work. Examples of federal funding sources that ITCT sites have used include Title IV-E waiver, Title IV-B, Medicaid reimbursement, Temporary Assistance for Needy Families (TANF), and Court Improvement Program funds. The ITCP has developed a federal funding guide to assist local jurisdictions/communities in planning for implementation and sustainability (see Resources).

The cost per family is in addition to existing child welfare system costs (and do not include costs incurred by the ITCP provision of T/TA). Many sites leverage existing resources by repurposing some of the time of child welfare and judicial professionals-- including judges, attorneys, and case workers -- to better meet the needs of infants and toddlers and their families. Key cost drivers include:

- **Local site costs ($7,500):** The primary cost for sites is to hire the Community Coordinator, a full-time position. ITCT sites also typically pay for local travel, training for child welfare and judicial staff, and some sites use a full or part-time data analyst position to manage data input, monitoring, and quality assurance.
- **Wraparound services and supports ($1,000):** Because ITCTs focus intensively on systematically identifying the needs of children and their families through timely screening and assessment and support access to services, more children and families utilize needed services. Services for *infant and toddlers* include regular well-child visits where children receive age-appropriate developmental screenings, immunizations, and developmental services and supports (e.g. early Intervention services and infant and early childhood mental health services). Services for *parents* include referral to high-quality, trauma-informed mental health and substance use disorder prevention and treatment services, primary and other needed health care services (e.g., postpartum care), and evidence-based parenting interventions. Although many of these services are covered through existing federal funding sources such as Medicaid, Children's

Health Insurance Program (CHIP), or IDEA, Part C, the increased uptake of services for ITCT families represents an additional cost to local or state human services systems and are therefore included in our cost estimate.

Based on recent outcome evaluation data, ITCTs are estimated to generate over $14,000 in public savings per family served, including $12,000 in child welfare systems savings and $2,000 in healthcare savings. This amount exceeds the projected per-family cost by 64%.

Budget			
Activity/Item	**Brief Description**	**Quantity**	**Total**
Local site costs	• Full time Community Coordinator position • Local training • Full or part-time data analyst position • Wraparound services and supports for children and parents	$8,500 per family, per year	$227,000
		Total Amount:	**$227,000.00**

LESSONS LEARNED

- During the exploration stage (planning) process, it is important to engage both wide-ranging local partners and stakeholders, as well as state-level stakeholders. This ensures the work is connected to existing initiatives and programs. State-level stakeholders include the administrative office of the court/court improvement program, the public defender's office, office of the child advocate, child welfare, public health including MIECHV and Early Childhood Comprehensive Systems, mental health, substance use, Medicaid, the state infant mental health association, parent advocacy groups, resource parent organizations, and other child and family policy and advocacy organizations.
- At the local level, cultivating a cadre of invested champions in the key systems (judiciary, child welfare, early childhood health and mental health) is critical – and takes time. These champions will serve on the local site leadership team and provide the facilitative support necessary for successful implementation.
- Ensure local maternal and child health program/services/system representation on the local Active Community Team to support health integration.
- The role of the ITCT Community Coordinator calls for strong relational and community organizing skills to facilitate collaboration/multi-system partnerships, linkages, and relationships.

- Building a meaningful and effective continuum of care must include prevention services for children and adults, including home visiting, as well as trauma-informed services and supports that effectively address adult mental health and substance use disorder needs.
- Begin planning for sustainability from the outset. This planning must identify short- and long-term financing but, equally important, must also focus on building the infrastructure and commitment to continuous monitoring and improvement for sustained impact over time.

NEXT STEPS

The ITCP is currently developing a fidelity assessment tool and accompanying guidance and resources that will provide communities and states with a practical way to assess and improve alignment with the SBCT approach.

The ITCP is pursuing a multi-pronged expansion strategy to reach more children and families. This strategy focuses on building state-level capacity to implement and spread ITCTs. Towards this end, the ITCP is currently providing support to seven state teams to build the state-level infrastructure needed to provide ongoing support, leadership, and guidance to local ITCT sites. A major focus of this work is building support for policy and practice change at the state level needed to implement best practices for infants, toddlers, and their families who are at risk for involvement and who are involved in the child welfare system. ZERO TO THREE will be releasing a policy framework in 2021 that will be used to guide this work. An additional expansion strategy focuses on increasing reach at local sites by engaging local leadership in the strategic work to build the structure, procedures, and policies that support an increased caseload and that will sustain and build on the local expansion. The ITCP external evaluation is capturing implementation strategies for statewide and local expansion that will be analyzed and applied for efforts in the future.

The ITCP is working to expand its impact in improving access to comprehensive services and supports that prevent child welfare involvement and support infant and toddler healthy development for all children. A primary vehicle for this work is the Active Community Teams, as they mobilize community partnerships and collaboration to build integration and increased capacity for prevention services and supports essential to long-term health and well-being. This includes facilitating children having medical homes and supporting access and continuity of parents' primary health care, home visiting and other maternal and child health programs, legal services, housing, and supports/resources that address the social determinants of health.

RESOURCES PROVIDED

About the Infant-Toddler Court Program:
https://www.zerotothree.org/resources/3066-about-the-national-infant-toddler-court-program
Infant-Toddler Court Program Sites:
https://www.zerotothree.org/resources/3115-hrsa-infant-toddler-court-program-sites
Supporting Sustainability for Infant-Toddler Court Teams: A Federal Funding Guide:
https://www.zerotothree.org/resources/3976-supporting-sustainability-for-infant-toddler-court-teams-a-federal-funding-guide
The Safe Babies Court Team Approach: Featured Resources

https://www.zerotothree.org/resources/services/the-safe-babies-court-team-approach

APPENDIX

- Logic Model
- Core Components document