PROGRAM SUMMARY BRIEF

SEPTEMBER 2021

Quality Improvement Center
Collaborative Community Court Teams

NATIONAL QUALITY IMPROVEMENT CENTER COLLABORATIVE COMMUNITY COURT TEAMS

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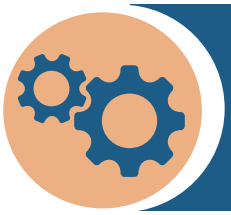
OVERVIEW

The Administration for Children, Youth and Families, Children's Bureau, launched the Quality Improvement Center for Collaborative Court Teams (QIC-CCCT) in 2017. This brief highlights the efforts of these teams to enhance and expand their capacity to support and improve safety, permanency, well-being, and recovery outcomes for infants, families, and caregivers—including the 2016 amendments to the Child Abuse Prevention and Treatment Act (CAPTA) related to infants affected by prenatal substance exposure. Several agencies and individuals helped implement the QIC-CCCT.

They include the Center for Children and Family Futures (CCFF) and its partners, the National Center for State Courts, Advocates for Human Potential, the American Bar Association Center on Children and the Law, the Tribal Law and Policy Institute, and nationally recognized experts who acted as consultants to the sites.

From April 2018 to December 2020 QIC-CCCT staff and consultants worked intensively with 14 sites to design, implement, and test approaches to support infants, parents, and caregivers affected by prenatal substance exposure.

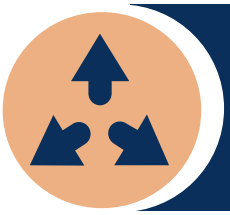
The QIC-CCCT had four main goals:



IMPLEMENTATION
Enhance the capacity of CCCTs to appropriately implement the provisions of the Comprehensive Addiction and Recovery Act (CARA) amendments to the CAPTA

CAPACITY
Enhance and expand CCCTs' capacity to effectively collaborate on supporting infants, young children, and their families/caregivers affected by SUDs and prenatal substance exposure

SUSTAINABILITY
Sustain the effective collaborative partnerships, processes, programs, and procedures implemented to achieve the goals of each site



DISSEMINATION
Provide the field with lessons they can apply about effective practices for implementing the CARA amendments to CAPTA while meeting the needs of children and families affected by SUDs

The QIC-CCCT initially focused on enhancing existing court programs to better serve infants with prenatal substance exposure and their parents or caregivers involved with the court jurisdiction. However, all court teams quickly recognized the need to engage families *before* they became involved in the court or child welfare systems. The collaborative court teams thus expanded their target populations to include families at risk of child welfare or court involvement, including pregnant women and their families. Nearly all sites enhanced and coordinated prevention and intervention services and supports, most notably by implementing Plans of Safe Care (POSC) during the prenatal period. Court teams did not envision prenatal POSC as an innovation at the onset of the QIC-CCCT.

WHAT IS A PLAN OF SAFE CARE?

POSC are a requirement of child welfare legislation; they are designed to ensure the safety and well-being of an infant affected by prenatal substance exposure following release from a health care provider. POSC provide services and supports that respond to the safety, health, and developmental needs of the affected infant, and the health and SUD treatment needs of the affected parents or caregivers. See the National Center on Substance Abuse and Child Welfare website for more information on POSC.

ABOUT THIS BRIEF

This is one of two briefs highlighting the efforts of these collaborative court teams to enhance and expand their capacity to support and improve safety, permanency, well-being, and recovery outcomes for infants, families, and caregivers—while accomplishing the goals of the QIC-CCCT. This brief focuses on implementation strategies, accomplishments, and lessons. The Evaluation Summary Brief highlights quantitative cross-site evaluation findings. Both briefs help collaborative partners improve systems and services for infants and parents affected by prenatal substance exposure. For more information about the initiative, and to access other QIC-CCCT resources, please visit our website.

BACKGROUND

Over the last two decades the U.S. has experienced a fourfold increase in opioid use disorders (OUDs) among pregnant women, and a threefold increase in rates of neonatal abstinence syndrome (NAS) among infants.[1] Prenatal substance exposure can disrupt mother-infant attachment and may affect physical, behavioral, and cognitive development in children.[2] The long-term success of these children and parents improves with early identification and interventions—which requires a data-driven, multisystem collaborative approach. Dependency courts, which sit at the intersection of these systems, can be effective in convening stakeholders and leading change. The QIC-CCCT intended to leverage the power of collaborative court teams to produce effective, sustainable, and replicable approaches that respond to the health and developmental needs of infants and children and the SUD treatment needs of their parents or caregivers—while informing practice in communities across the country.

QIC-CCCT DEMONSTRATION SITES OVERVIEW

To select the 14 demonstration sites, the QIC-CCCT used a rigorous and competitive process that included a written proposal and an in-depth follow-up virtual consultation and assessment. The QIC-CCCT developed two pathways for prospective demonstration site applicants:

- Administrative court offices, other state agencies, and Tribal governments were eligible to submit a proposal designating demonstration sites within their state or Tribe. State administrative court offices in Alabama, Ohio, and Georgia, along with the Oklahoma Department of Mental Health and Substance Abuse Services, acted as the lead agencies for nine sites, designating local court teams within their states. The Northern California Tribal Court Coalition applied on behalf of the Yurok, Karuk, and Hoopa Tribes for joint jurisdiction courts between Tribes in Humboldt and Del Norte Counties. Creating a pathway for state or Tribal consortium agencies to apply and designate local sites within their jurisdiction facilitated broader system leadership engagement and oversight.
- Local court teams could also apply directly as demonstration sites if their state or Tribal governments did not submit a proposal. Court teams from Duval County, Florida; Palmer, Alaska; Harris County, Texas; and Maricopa County, Arizona, submitted proposals under this option.

The diverse group of 14 sites included family treatment courts, infant-toddler courts, and Joint Jurisdiction Family Healing to Wellness Courts. See the QIC-CCCT website for profiles of each site.

QIC-CCCT Demonstration Site Map

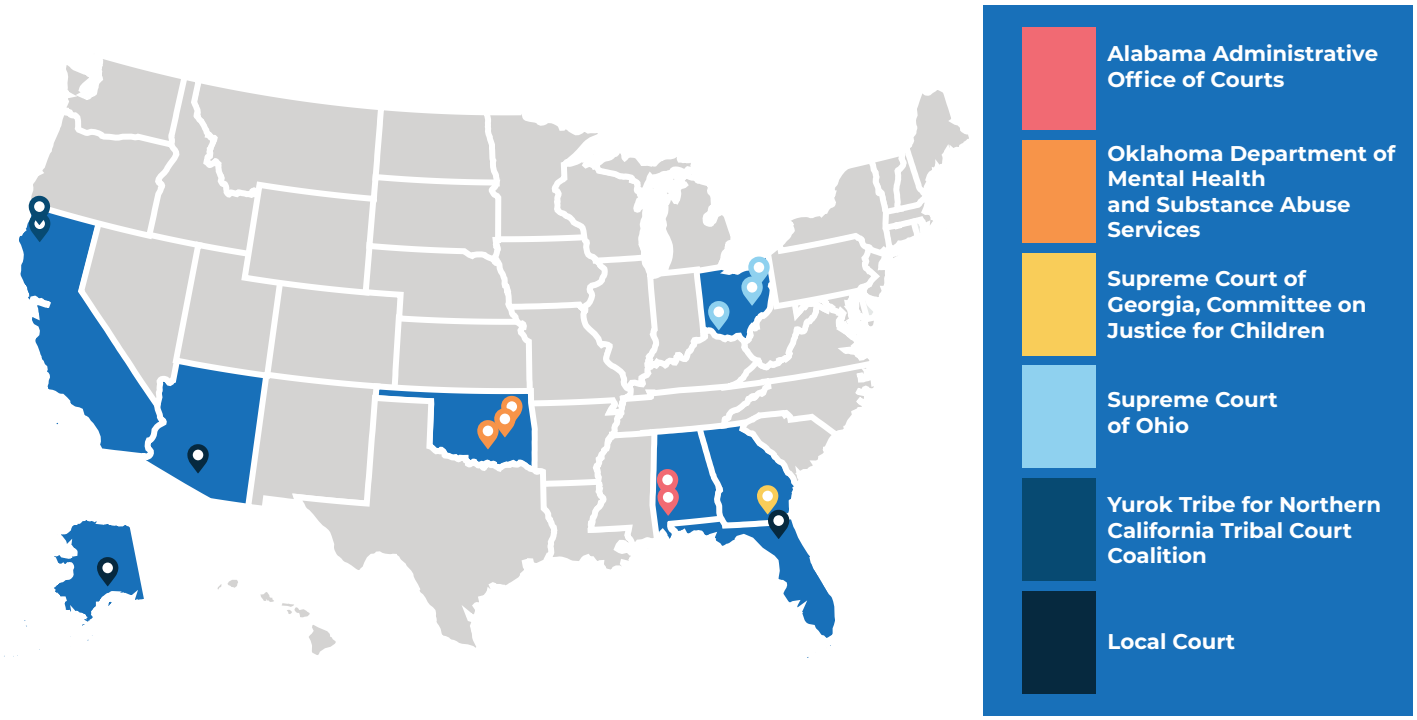


Table 1. QIC-CCCT Demonstration Sites

Site Name	Lead Agency	Type of Court/Program
Oklahoma County (OK)	Oklahoma Department of Mental Health and Substance Abuse Services	Family Treatment Court
Okmulgee County (OK)	Oklahoma Department of Mental Health and Substance Abuse Services	Family Treatment Court; Pre-file court (Family Preservation Court)
Tulsa County (OK)	Oklahoma Department of Mental Health and Substance Abuse Services	Family Treatment Court
Humboldt (CA)- Yurok, Karuk, and Hoopa Tribes	Northern California Tribal Court Coalition	Joint Jurisdiction Family Healing to Wellness Court
Del Norte (CA) – Yurok Tribe	Northern California Tribal Court Coalition	Joint Jurisdiction Family Healing to Wellness Court
Jefferson (AL)	Alabama Administrative Office of Courts	Family Wellness (Treatment) Court (Pre-Petition Track) Treatment Court
Jackson (AL)	Alabama Administrative Office of Courts	Family Wellness (Treatment) Court (accepts non-child welfare and non-court-involved cases)
Coshocton (OH)	Supreme Court of Ohio	Family Dependency Court
Fairfield (OH)	Supreme Court of Ohio	Family Dependency Court
Trumbull (OH)	Supreme Court of Ohio	Family Treatment Court
Douglas (GA)	Supreme Court of Georgia, Committee on Justice for Children	Family Treatment Court; Early Childhood Court
Family Support Services of North Florida, Inc. – FSSNF (FL)	Family Support Services of North Florida, Inc.	Early Childhood Court
Maricopa (AZ)	Arizona Superior Court in Maricopa County, Juvenile Department	Family Treatment Court
Palmer (AK)	Palmer Families with Infants and Toddlers Court	Infants and Toddlers Court

TOGETHER, THE QIC-CCCT SITES SERVED

871 adults

1,114 children

Enrollment varied by site—ranging from 42 to 370 participants—with an average of 152. Typical adult participants were female, White, and approximately 30 years old. The children were more racially/ethnically diverse; the average age was 2, with 35% under a year old. Approximately 25% of females were pregnant at enrollment. Of the 192 infants with data on prenatal exposure, most (86%) had been identified at birth as affected by substance use.

Table 2. Demographics of Adult and Children Served by QIC-CCCT Sites

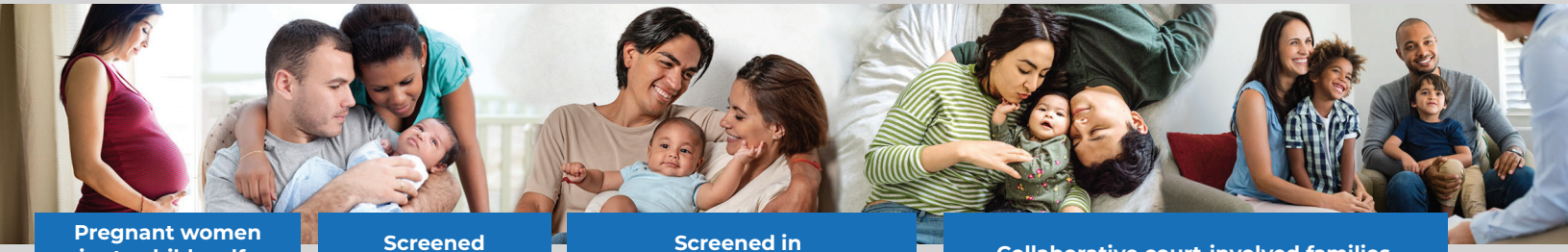
	Adults	Children
Gender	76% female; 24% male	50% female; 50% male
Age	30 (average)	2 (average); 35% under 1
Race/Ethnicity:		
White	76%	60%
Black	12%	15%
Native Hawaiian or Other Pacific Islander (NHOPI)	1%	0%
American Indian or Alaska Native (AI/AN)	8%	10%
>1 Race	3%	15%
Asian	0%	0%
Latinx/Hispanic	10%	11%

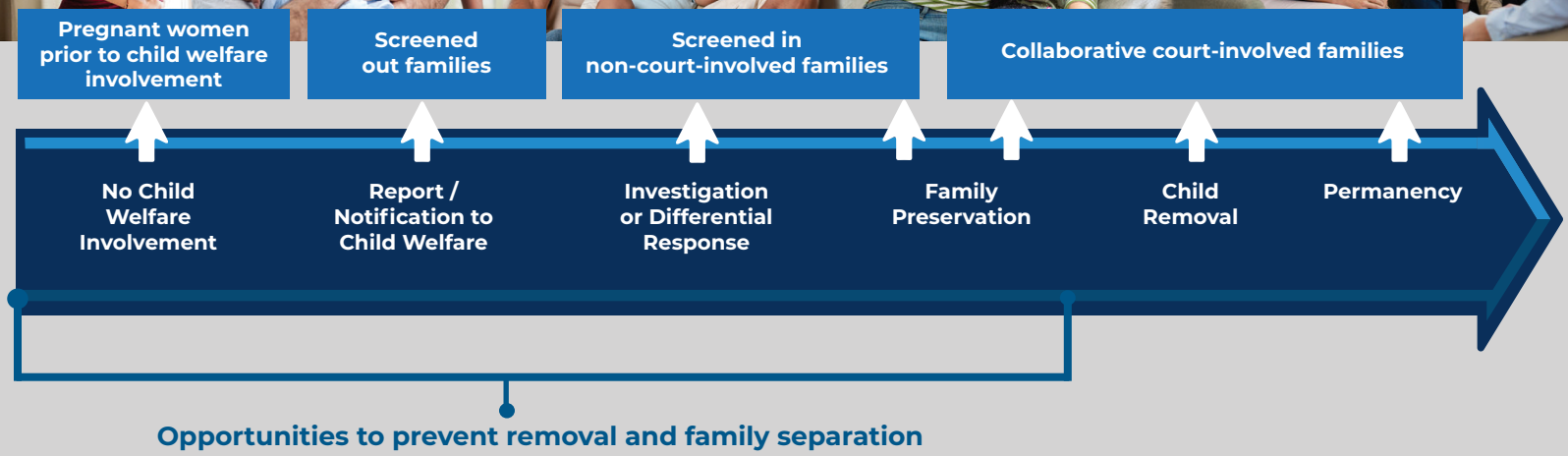
EXPANDED FOCUS AND TARGET POPULATION

The QIC-CCCT initiative focused initially on serving parents and their children already involved in the court system. Its goals were to enhance or expand the court teams' existing programs to better serve infants with prenatal substance exposure and their parents or caregivers. During the early planning stages of their engagement with the QIC-CCCT TA team, sites realized they needed to expand their focus beyond families involved in court whose children had been removed. Sites expanded their target populations and scope of services to parents and pregnant women outside of either court or child welfare, or prior to removal and placement in foster care.

By building coordinated support systems across a continuum of early intervention points, sites helped prevent child welfare or court involvement, as well as out-of-home placement.

Continuum of Intervention Points





These dramatic shifts in focus brought challenges. To effectively reach more families, sites had to work through significant barriers, including:

- Prevention and early intervention service gaps
- Lack of engagement and service coordination with maternal and infant health care and SUD treatment providers
- Stigma of pregnant women with SUDs
- The limited role of child welfare and the court during the prenatal period

Sites responded by engaging new partners from a wide range of systems—strengthening their collaborative practices, changing attitudes and values toward this population, and creating support systems that promote family preservation over separation.

EFFECTS OF THE PANDEMIC

Sites experienced significant changes due to the pandemic, including reductions in referrals and enrollment, increased staff turnover, limited family engagement, and budget cuts. This required sites to adapt and modify their action plans to meet their QIC-CCCT goals.

Specific demonstration site and service system challenges and adaptations included:

- **Courts:** Many sites ceased court operations entirely or suspended court hearings, except for essential hearings (e.g., emergency shelter hearings or permanency dispositions). Court coordinators and other team members maintained virtual connections with families to keep them engaged. Sites adjusted budgets to buy and enhance virtual meeting platforms while developing innovative solutions to manage the adverse effects of the pandemic.
- **Child Welfare:** Some communities reported fewer child abuse and neglect cases, with fewer children entering care. For most sites, child welfare social worker in-person contact ceased during the beginning of the pandemic. Services related to parenting, children, and home visiting were either suspended or done virtually.
- **SUD Treatment:** Most communities suffered disruptions because of social distancing and stay-at-home measures. Providers began using virtual platforms to conduct group and individual counseling. Some organizations also faced high rates of staff turnover due to restrictions on in-person services, budget cuts, and hiring freezes.
- **Tribal Communities:** In Yurok and Hoopa Valley, Tribal and county offices closed entirely, and the already limited resources focused exclusively on basic needs and essential services. As reported by the Yurok and Hoopa Valley sites: "There's been a whole history of epidemics that have devastated Tribal communities, and COVID-19 is only the most recent one." Yurok and Hoopa reported seeing increased anxiety and trauma triggers in the target population.

  They still expressed optimism and reported that the "Yurok and Hoopa peoples are resilient and will survive. We know how to come together in spite of the mandatory physical distancing because of our strong family/community connections, cultural ties, and worldview."
- **Family Income and Employment:** Families of low socioeconomic status faced challenges meeting basic needs, such as food, infant care, cleaning supplies, and transportation. Sites responded by redirecting funds and assisting families with meeting these basic needs.

IMPLEMENTATION ACTIVITIES AND LESSONS

The remainder of this report covers the four QIC-CCCT goals: Implementing CARA Amendments to CAPTA (Goal 1), Building Capacity (Goal 2), Sustaining Successes (Goal 3), and Disseminating Lessons (Goal 4). Each section contains demonstration site activities, accomplishments, and key lessons.

IMPLEMENTING CARA AMENDMENTS TO CAPTA (GOAL 1)

Background on CARA, CAPTA and POSC

The Comprehensive Addiction and Recovery Act of 2016 amended the Child Abuse Prevention and Treatment Act related to infants affected by prenatal substance exposure and their affected families or caregivers. The statute requires the development of a POSC to ensure the safety and well-being of infants "born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or an Fetal Alcohol Spectrum Disorder (FASD)," by "addressing the health and substance use disorder treatment needs of the infant and affected family or caregiver."

Additionally, the statute:

- Further specified those requiring a POSC as infants "born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder." **Note: This definition specifically removed the word "illegal."**
- Specified **data to be reported** by states to the maximum extent practicable
- Required the development of a POSC to ensure the safety and well-being of affected infants, include the infant's health needs, and the health and substance use disorder treatment needs of the affected family or caregiver
- Required states to develop and implement "monitoring systems regarding the implementation of such plans to determine whether and in what manner local entities are providing, in accordance with state requirements, referrals to, and delivery of appropriate services for the infant and affected family or caregiver"

Prior to becoming QIC-CCCT sites, most court teams did not know what a POSC was or how to use it to engage vulnerable parents or caregivers and provide access to an expanded array of services. Most sites did not implement POSC for infants and their parents or caregivers, or pregnant women outside of the child welfare system; none implemented prenatal POSC. Sites faced challenges engaging maternal and infant healthcare providers, including hospitals. Several county child welfare agencies did not see the need to change their current practices to serve this population of infants and their parents or caregivers.

Court teams became catalysts for implementing POSC as an effective intervention for infants and their parents or caregivers involved with the court, as well as a preventive strategy for infants and their parents or caregivers at risk of, but not involved in, the child welfare system.

- **Judges** convened community leaders and helped ensure that POSC were developed with parents or caregivers coming before their court.
- **Court coordinators** acted as liaisons between participants, community service providers, and other court personnel. They took on roles creating POSC, monitoring progress, and identifying and resolving challenges to accessing services.
- **Peer support specialists** helped create POSC with parents they served, in addition to keeping parents engaged and providing the team with important insight into barriers.

> **The director of the Jefferson County Department of Human Resources was a champion of the use and value of POSC—not just as a legal mandate but as an effective tool her social workers could use to better engage families.**
>
> **–Jefferson County Family Wellness Court Team**

- **County child welfare agencies** supported court team engagement of parents not involved in the child welfare system—including using POSC for pregnant women to inform their response when notified of an infant affected by prenatal substance exposure.

Preventing Child Welfare Involvement or Family Separation

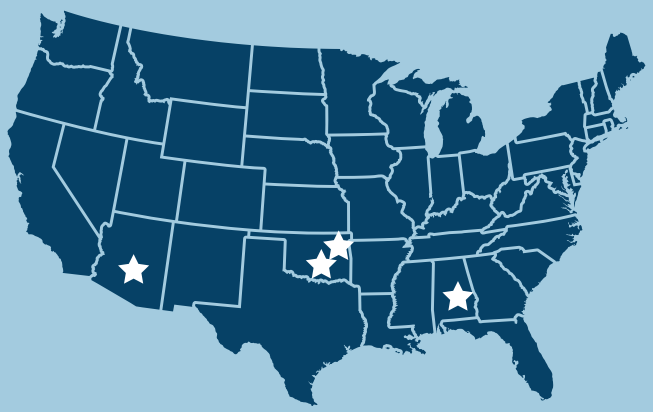
As sites began implementing POSC, they recognized it as an opportunity to expand beyond the parents or caregivers involved in the child welfare system and participating in their court. POSC allowed them to intervene to mitigate child welfare involvement or prevent infants being removed from their families at birth. This required community partners other than child welfare to develop POSC.

- Sites worked with SUD treatment providers and the medical community to identify and support pregnant women with SUDs. They provided prenatal POSC and significantly enhanced their community's capacity for early engagement.

- Several sites added a physician to the core team—one who helped establish relationships with other physicians and prenatal health care practitioners.
- Court team members and partners (such as POSC coordinators, peer support specialists, and case managers) helped health care practitioners provide links to SUD treatment and other community services for their patients. Several sites co-located assessment or case management services at healthcare facilities.

> **We created a prenatal Plan of Safe Care in hopes of preventing child welfare involvement, but what it did was empower families and impact our staff as positively as it did the families. It really wasn't so much about the POSC binder as the philosophy and ideology of the wraparound care, and the process of reviewing and monitoring with the families—that was 'the secret sauce.'**
>
> **–Tulsa County Family Treatment Court Team**

SITE SPOTLIGHTS: PREVENTING FAMILY SEPARATION AT BIRTH



POSC for pregnant women helped inform child welfare practice and prevent removal when notified of an infant affected by prenatal substance exposure. Across all sites, 71% (n=76) of babies born during the QIC-CCCT remained with their families.

Site-level accomplishments include:

Tulsa County - Prior to QIC-CCCT, infants experiencing NAS stayed in the NICU for an average of 90 days, received immediate pharmacological interventions, and were placed in out-of-home foster care for an average of one year. By the end of the project, prenatal POSC and improved postnatal care had resulted in 100% (n=20) of infants remaining with their families following birth—with no NICU stays or pharmacological interventions.

Jefferson County - 87% (N=48) of infants remained with their families following birth; 62% of all program participants had no open child welfare cases.

Maricopa - 87% (n=81) of infants remained with their families following birth; 86% required no pharmacological care.

Okmulgee - 91% (n=11) of infants remained with their families following birth.

Summary of POSC Implementation Accomplishments

By the end of their QIC-CCCT engagement:

- All but one site had implemented POSC for court and non-court participants. Sites worked with healthcare and SUD treatment providers to identify and support pregnant women with SUDs; they developed POSC during pregnancy, significantly enhancing their community's capacity for early family engagement.
- Sites helped infant and maternal health care providers learn about the purpose of POSC in the context of their work while involving them in POSC development.
- Eight sites added or enhanced peer support specialists to strengthen parent engagement and retention, assist with developing POSC, and help the court team resolve barriers for families accessing services and supports.

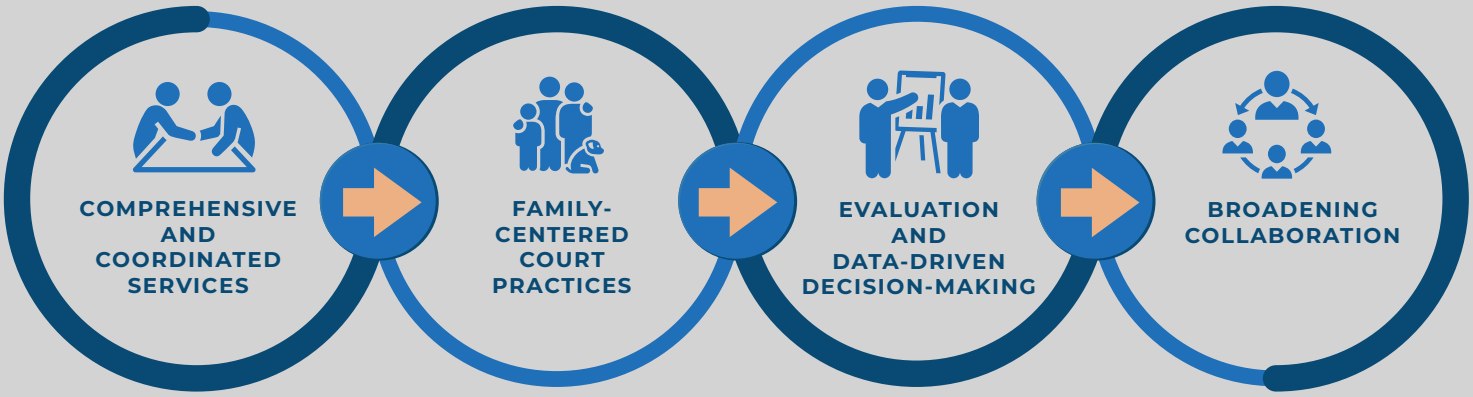
KEY LESSONS

- Implementing prenatal POSC is an effective strategy to inform child welfare system's response to notifications of infants with prenatal substance exposure and help prevent removals of infants. Prenatal POSC also serve to empower families to advocate for their own needs both before and after birth.
- To successfully engage families during the prenatal period, healthcare providers need to understand the purpose of POSC in the context of their work. Engaging medical providers is challenging and requires ongoing time, attention, and training.
- Coordinating pre- to postnatal care supports families and provides continuity of services. POSC are a useful tool to plan, provide access to, and monitor equitable service access during this transition.
- Formalizing cross-system partnerships through co-location of partner agency staff, co-visiting families, and team monitoring of POSC provides an opportunity to deepen collaborative relationships and strengthen practice.

Building Capacity (Goal 2)

Meeting the needs of infants, young children, and parents affected by prenatal substance exposure and SUDs is complex and requires enhancing multiple dimensions of capacity.

Dimensions of Capacity Building



Comprehensive and Coordinated Services

Court teams strengthened and expanded partnerships to implement new services, increase access to existing community services, and coordinate systems of care. Sites identified and closed gaps in services, supports, and resources in the following areas:

- *Prevention and early intervention services* for families not involved in their courts or the child welfare system
- *Children's services* by expanding partnerships with community providers (e.g., Early Intervention, Home Visiting, Head Start, and Early Childhood Care and Education)
- *SUD treatment* for pregnant women and other adults—including access to medication-assisted treatment (MAT) and residential treatment for pregnant and postpartum women, and infants
- *Mental health services* by improving screening and assessment, developing new partnerships, and paying special attention to infant mental health needs
- *Prenatal and postnatal services and supports,* such as prenatal screening and postnatal family-centered supports, by engaging healthcare providers in program development and conducting intensive outreach and training
- *Evidence-based parenting and parent/child interaction services*
- *Essential support services* such as rent and utility assistance, supplies for infants, groceries, and transportation

SITE SPOTLIGHTS:
INFORMING POLICY AND PRACTICE CHANGE

Ohio demonstration sites advocated with other stakeholders and state partners to change eligibility criteria for early intervention services and improve access to services for infants with prenatal substance exposure. As of July 1, 2019, the state expanded automatic eligibility for Early Intervention to include children diagnosed with NAS and children with elevated blood lead levels (≥5ug/dL). This significant shift in policy illustrates how local practice changes can help inform state policy and practices.

Family-Centered Court Practices

Court teams expanded their capacity for family-centered court practices by:

- Expanding eligibility to serve families whose children remain in the home and using pre-petition court models to serve families earlier
- Implementing best practice standards, such as becoming more trauma-informed, and expanding use of motivational interviewing and positive reinforcements
- Engaging new systems partners to attend collaborative court hearings, and fostering enhanced links between the court and service providers
- Modifying court practices/protocols, including how the court reviews and monitors POSC

Evaluation Capacity

Sites developed their capacity to collect, manage, analyze, and use data to inform a continuous quality improvement approach; inform and adapt program implementation; and make data-driven program improvements.

Sites used data to:

- Understand community needs and the prevalence of prenatal substance exposure
- Establish baseline measures and track progress towards intended goals
- Regularly monitor programs and effectively adapt their programs
- Make the case for resources and sustainability

Key drivers to successful evaluation capacity-building included:

- Leadership buy-in and commitment to data at all levels of governance
- Data systems infrastructure
- Data dashboards or other data communication tools
- Knowledgeable and trained data and evaluation staff

Broadening Collaboration

As court teams expanded their target populations for families outside of the child welfare system, they had to engage new partners from a wide range of systems (beyond the court, child welfare, and SUD treatment). Health care and public health were key systems missing from collaborative teams at the start of the initiative. Engaging these systems required ongoing outreach and training.

> By the end of the grant, all 14 sites identified at least one healthcare provider as a core partner in their collaborative work, while 13 identified at least one children's services provider (including home visiting and early intervention).

For some sites, expanding their collaborative teams suffered from a lack of trust and shared vision and mission between systems—especially for child welfare and health care—as well as Tribal, county, state, and federal systems. Health care providers expressed concern over child welfare responses to notifications that may result in family separation. Trust and shared vision for the program improved when child welfare engaged in the collaborative team and actively supported implementation. Child welfare staff also benefited from collaborating with community partners engaged in implementing POSC.

> Fairfield Children's Services stated that due to the trust and communication between systems, "child welfare staff feel supported by community members in decision-making, and confident in closing lower-risk cases due to the continued monitoring of POSC when applicable."

Sites identified strong leadership and governance structure as drivers for successful collaboration. Engaged cross-system leadership helped teams make policy decisions and implement systems-level changes. Judges played an important role in convening community partners, strengthening outreach, and making the case for expansion and increased resources.

Sites strengthened their collaborative practice and decision-making by:

- Identifying and resolving barriers to effective collaboration, including poor identification and referral systems, lack of communication protocols, and limited staff capacity or buy-in
- Formalizing communication protocols, developing standardized memorandums of understanding (MOUs) and releases of information (ROIs), and establishing referral pathways and links between systems
- Engaging new partners across multiple points of intervention (prenatal, birth, neonatal, and infancy) to identify and engage families early, develop and implement POSC, and improve access to community services and resources

KEY LESSONS

Comprehensive and Coordinated Services

- Building coordinated service systems between health care, child welfare, and SUD treatment for pregnant and parenting women requires building trust at the systems and family level.
- Use peer recovery supports to engage families in voluntary services prenatally or prior to child welfare involvement.

Family-Centered Court Practices

- Collaborative court programs integrate into larger prevention and early intervention systems of care to prevent court involvement when possible, while ensuring coordination and continuity of care when necessary.
- Pre-petition court models and expanded eligibility criteria allowed court teams to engage families earlier and prevent unnecessary removal.

Evaluation and Data-Driven Decision-Making

- Analyzing and reviewing short-term process measures, such as referral, enrollment, engagement, and completion rates to monitor programs on a regular basis allowed teams to adapt and respond to implementation challenges effectively and efficiently.

Broadening Collaboration

- Child welfare system buy-in for broadening community responsibility and support for implementing POSC, especially for families not involved in the child welfare system, helped prevent referrals to child welfare, or family separation upon birth of an affected infant.
- Expanding new partners across multiple points of intervention (prenatal, birth, neonatal, infancy, and postpartum) can identify and engage families early, develop and implement POSC (including prenatal POSC), and improve access to community services and resources.
- Developing a shared vision and mission, garnering support from leadership, identifying cross-system champions, and implementing a strong governance structure are essential to effective cross-system collaboration.
- Building strong relationships among systems partners can foster community-wide shifts in both culture and practice, break down silos between systems, and reduce stigma for families affected by SUDs.

Sustaining Successes (Goal 3)

Thirteen sites sustained at least some components of their overall program expansion or enhancements. These included services to adults and children, staffing, collaborative partnerships, court capacity enhancements, and evaluation. Court team partnerships played a substantial role in sustaining children and parents services and continuing to engage in collaborative processes.

- Of the 12 positions funded by the QIC-CCCT, nine used a combination of strategies that included obtaining new grant funding, having a partner agency absorb the position (allowing for third-party billing), obtaining state funds (e.g., CAPTA funding, state court administration funding), or absorbing positions into local court budgets.
- State lead agencies played a significant role in sustainability planning, implementation, and dissemination for sites within their jurisdiction.
- Court teams incorporated collaborative processes (e.g., core team and steering committee meetings, multidisciplinary team meetings) into existing collaborative initiatives.

> **Most of the collaborative efforts made as a QIC-CCCT demonstration site did not require funding. They required commitment and investment by all involved parties to systems change and improved practices—collaboratively and individually—as providers and entities working with the target population. The benefit is that most of the efforts and accomplishments will be maintained in some form or another.**
>
> **–Maricopa County Family Treatment Court Team**

KEY LESSONS

- Drivers for successful sustainability planning include: 1) beginning in the early stages of program implementation, and 2) actively engaging all cross-system partners in assessing sustainability strengths and gaps, while also identifying sustainability resources.
- Use the convening power of judges and court teams to engage new partners (e.g., healthcare providers) while providing access to and sustaining services for families not involved in the court, such as prenatal POSC.
- State agencies can support local implementation sites by identifying state-level resources, disseminating successful program strategies, and planning for expansion to other counties.

Disseminating Lessons (Goal 4)

Sites used local implementation results and lessons to sustain local practice changes and inform policy change more broadly at the regional and state levels. Court team and partner leaders acted as catalysts for this change. Sites engaged in the following activities:

- Convened forums with community partners to disseminate results and implementation lessons
- Showcased their results and implementation lessons to make the case for expansion and increased resources
- Used state-level partnership to disseminate local results and influence statewide practice changes to improve support for pregnant women and families affected by SUDs
- Coordinated regional and statewide webinars and training events to share innovative local practices

SITE SPOTLIGHTS: INFORMING STATEWIDE EFFORTS

Many states used their local QIC-CCCT sites' efforts as a model to expand to other communities in the state. State leadership accomplished this by aligning with federal priorities on prevention and showcasing the work of demonstration sites.

The Ohio Department of Job and Family Services collaborated with the Ohio Department of Mental Health and Addiction Services and the Ohio Family and Children First Council to develop the "Community of Support" grant program. This will support existing and new local community planning and coordinated service delivery efforts. One of the funding priorities is implementing POSC, modeled after POSC practices developed by Ohio demonstration sites.

The Oklahoma Department of Mental Health and Substance Abuse Services' child welfare service contracts, beginning in FY 2022, will include a requirement that treatment agencies develop prenatal POSC for their clients. Oklahoma's demonstration sites will help develop training to support implementation of this new requirement.

Partnerships between state and local officials benefited all involved. Local sites that engaged state-level offices benefited from their help implementing local practice changes that could then be disseminated statewide. State offices assisted with local implementation by releasing POSC or policy and practice guidance, coordinating between other similar initiatives, and assisting with accessing administrative data. At the same time, as sites tested new approaches and strategies, their successes informed and incentivized states to consider practice changes. Local champions led these efforts and provided state offices with valuable information about local needs, implementation successes, and challenges.

State and Local Partnerships

KEY LESSONS

- Drivers for successful dissemination efforts include using data and successful family experiences to tell the program story, developing state or Tribal government level partnerships, tailoring products and marketing materials for diverse audiences, and creating opportunities for convening partners and securing support.
- Disseminating site innovations to inform broader systems change requires local and state leadership and partnerships; each one plays a role in determining local strategies and results—while influencing change.
- Opportunities for statewide expansion are more likely when coordinating with related parallel initiatives and aligning with local, state, and federal priorities (e.g., the Family First Prevention and Services Act priority on prevention; 2016 CARA amendments to CAPTA).

MEASURING QIC-CCCT PERFORMANCE

The QIC-CCCT evaluation included analyses of outcomes related to POSC, adult residential and employment status, family functioning, family safety, placement and custody, child well-being, and adult SUD recovery.[3] Sites collected outcome data at baseline and exit/closeout for most measures. Highlights of the analyses include:

- **SUD treatment:** The average time between treatment referral and enrollment was 16 days; the average stay in treatment was 117 days, or nearly four months
- **Preventing removal:** Most children (81%) in-home at time of court program enrollment remained at home with their parent(s) throughout QIC-CCCT involvement. Additionally, 71% (n=76) of babies born during the QIC-CCCT remained with their families.
- **POSC:** Nearly all women (93%) who were pregnant at program enrollment had a POSC by the time of exit/closeout
- **Family functioning:** Across all domains in the North Carolina Family Assessment Scale for General Services and Reunification (NCFAS-G+R), the percentage of families rated as having relevant strengths increased significantly between enrollment and exit/closeout. Reunification, self-sufficiency, parental capabilities, and family interactions had the largest percentage increases. Child well-being, family health, and family safety had the highest overall strength ratings at program exit.
- **Employment:** Adult employment increased from 38% at enrollment to 57% at exit/closeout—a 50% increase.
- **Disproportionality and disparities:** Black/African American, American Indian/Alaskan Native, and biracial/multiracial children were less likely than White/European American, Asian American, or Native Hawaiian/Other Pacific Islander to live at home at exit/closeout and to reunify with their families during QIC-CCCT, even after controlling for other variables. Disparities related to race did not appear in other analyzed outcomes, including the likelihood of getting POSC; improvements in living situation or employment status; and changes in overall family functioning, family safety, child well-being, and parental capabilities in relation to substance use.

For more information about the evaluation and a full report on outcomes and significant findings, please see the QIC-CCCT Evaluation Summary Brief.

CONCLUSION

The QIC-CCCT sought to demonstrate and test collaborative court strategies designed to meet the health and SUD treatment needs of infants, young children, and their parents or caregivers affected by prenatal substance exposure, while implementing the provisions of CAPTA related to developing POSC.

While most court teams did not know about the POSC requirements prior to their QIC-CCCT engagement, they recognized the need to support families in their courts, while also engaging expectant parents, focusing on preventing family separation and child welfare system involvement. This challenged court teams to expand their partnerships to support these families. None of the sites at the onset of the QIC-CCCT envisioned implementing POSC during pregnancy.

Court teams became catalysts for implementing POSC for court participants and families not involved in the child welfare system. These teams, with judicial leadership, initiated services to prevent child removals by implementing POSC for families not coming before their courts—demonstrating that courts can play a major role in achieving one of the Children's Bureau's (CB) goals: strengthening the capacity of communities to support children and families.

These practice, policy, and systems changes resulted in improved outcomes for children and families. Most notably, family functioning across all NCFAS-G+R domains improved, children remained with their families, and parents received timely treatment while improving their employment and living situations. However, historically disadvantaged racial groups did not experience the same success as others. Other court teams and related collaborative initiatives should use data to identify disproportionality, unequal access, and disparate outcomes, while developing strategies to mitigate these differences.

> **"Jackson County Family Wellness Court's most significant accomplishment is the positive impact the QIC-CCCT project made on serving pregnant women abusing substances and infants prenatally exposed to substances. The QIC-CCCT project was implemented in a community that once did not offer services to women who were abusing substances while pregnant. These infants, prenatally exposed to substances throughout their mothers' entire pregnancies, were placed in out-of-home care at birth. As a result of the QIC-CCCT project, Jackson County Family Wellness Court, Jackson County Department of Human Resources, and Best Start have formed a partnership that has transformed countless lives."**
>
> **–Jackson County Family Wellness Court Team**

States are revisiting how they implement the 2016 CAPTA amendments while responding to the effect of SUDs on families, communities, and the child welfare system. Three states with QIC-CCCT sites have initiated state-level efforts to modify their practices to implement POSC resulting from the innovations developed by their collaborative court teams.

The QIC-CCCT demonstrated that collaborative court teams can inspire systems change in their states, Tribes, and communities to meet the needs of infants, parents, and caregivers affected by prenatal substance exposure.

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2 Behnke, M., & Smith, V. C. (2013). Prenatal substance abuse: Short- and long-term effects on the exposed fetus. *Pediatrics, 131*(3), 1009-1024. https://doi.org/10.1542/peds.2012-3931

3 Individual-level data collection activities included adult and child enrollment details and demographics; health and behavioral health data; child welfare data; adult and child adverse childhood experiences (ACES); North Carolina Family Assessment Scale (NCFAS); and service use data collected through REDCap, as well as child Ages and Stages Questionnaire (ASQ) data collected through the ASQ online system.

4 The NCFAS-G+R includes 10 domains, each with specific indicators and an overall assessment of family functioning within that domain. For each NCFAS item, the family is rated at one of the following levels: clear strength, mild strength, adequate, mild problem, moderate problem, or serious problem.

5 Overall family functioning, family safety, child well-being, and parental capabilities in relation to substance use were all measured using the NCFAS-G+R.

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For more information about this initiative, email us at contact@cffutures.org

Additional resources are available on our website at www.cffutures.org/qic-ccct

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