EVALUATION SUMMARY BRIEF

2021

Quality Improvement Center
Collaborative Community Court Teams

NATIONAL QUALITY IMPROVEMENT CENTER COLLABORATIVE COMMUNITY COURT TEAMS

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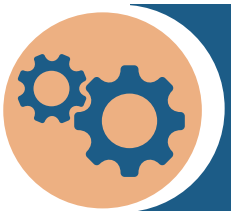
OVERVIEW

The Administration for Children, Youth and Families, Children's Bureau, launched the Quality Improvement Center for Collaborative Community Court Teams (QIC-CCCT) in 2017. This brief highlights the teams' efforts to enhance and expand their capacity to support and improve safety, permanency, well-being, and recovery outcomes for infants, parents, 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 lead agency 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, the QIC-CCCT worked intensively with 14 sites to design, implement, and test approaches to support infants with prenatal substance exposure, and their parents or caregivers affected by substance use disorders (SUDs).

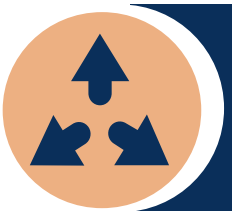
The QIC-CCCT had four main goals:



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. However, all court teams quickly recognized the need to engage families prior to court or child welfare involvement. The collaborative court teams thus expanded their target populations to include families at risk of child welfare or court involvement, including pregnant women. 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. The Program Summary Brief focuses on implementation strategies, accomplishments, and lessons. This 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.

EVALUATION HIGHLIGHTS: AT-A-GLANCE

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

Despite the data suggesting equal access to POSC and similar improvements across key outcomes and clinical measures of family functioning, 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.

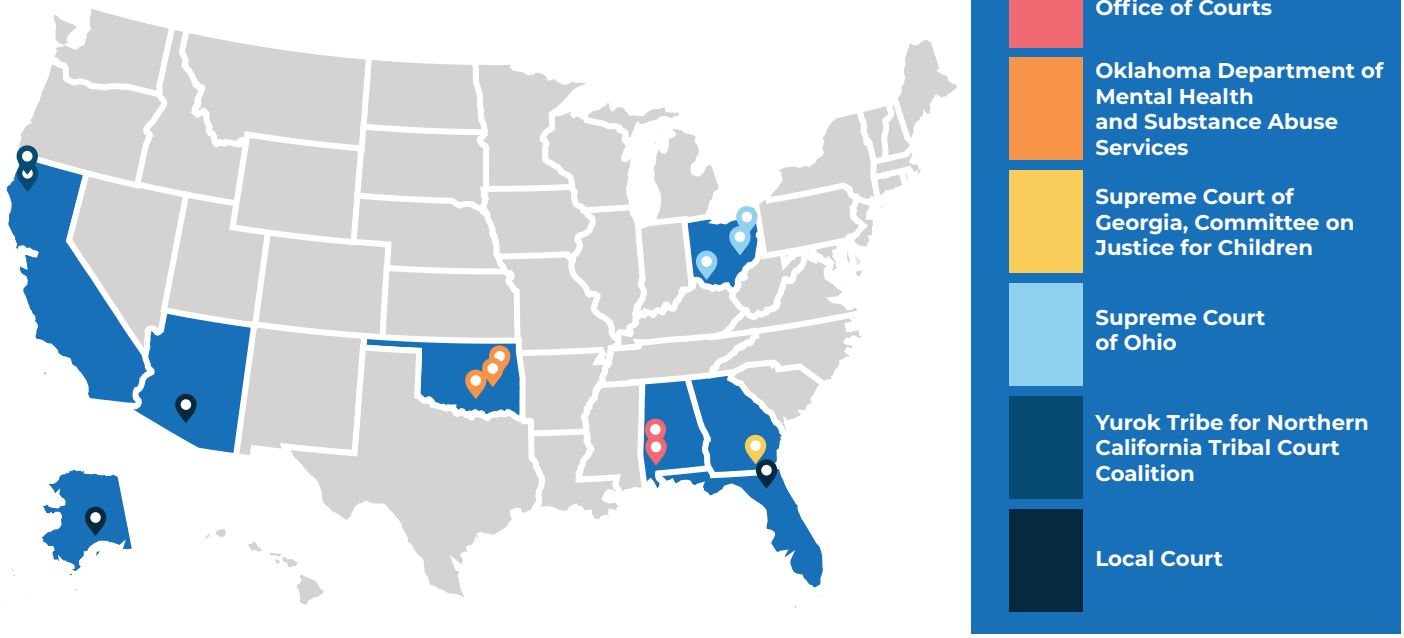
QIC-CCCT DEMONSTRATION SITES OVERVIEW

To select the 14 demonstration sites, the QIC-CCCT used a rigorous and competitive process that included both 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, or Tribal governments were eligible to submit a proposal designating demonstration sites within their state or Tribe; local court teams could also apply directly as demonstration sites if their state or Tribal government did not submit a proposal. 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.

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

QIC-CCCT Demonstration Site Map



MEASURING QIC-CCCT PERFORMANCE

The QIC-CCCT evaluation consisted of a mixed-methods approach incorporating process/implementation, performance measurement, and outcome evaluation components. Quantitative data included:

- Adult and child enrollment, demographics, health and substance use, and mental health data
- Service use data
- Clinical assessment data, including the adult and child adverse childhood experiences (ACES), the North Carolina Family Assessment Scale for General Services and Reunification (NCFAS-G+R), and Ages & Stages Questionnaire—Social Emotional Questionnaire (ASQ-SE 2nd edition; referred to as ASQ in the text that follows)[1]

The remainder of this brief focuses on changes in individual and family outcomes over the course of the QIC-CCCT implementation. The outcomes selected for analysis include those related to POSC, living situation and employment status, family functioning, family safety, placement and custody, child well-being, and adult SUD recovery.[2] For each outcome, the QIC-CCCT Evaluation Team first analyzed change over time and then conducted multivariate analysis using a set of key predictors described in the Multivariate Analysis section below.

Who did the sites serve?

Of the 871 adults[3] and 1,114 children served by sites, 622 adults (71%), 657 children (59%), and 522 families enrolled in the evaluation.[4] The exact number of participants varies for each outcome based on the availability of baseline and exit data. Table 2 shows the number of adults, children, and families participating in the evaluation overall as well as the number having each of three categories of data. The final column in the table shows the number of sites reporting at least 10 adult, child, and family evaluation participants (first row) or submitting enrollment and exit data for at least 10 participating individuals or families (second through fourth rows).

Table 2. Total Baseline and Follow-up/exit data for ASQ and NCFAS-G+R

	Adults	Children	Families	Sites with >= 10
Total enrolled in evaluation	622	657	522	12
Enrollment and exit data	579	616		12
Baseline & follow-up ASQ		64		7
Enrollment & exit NCFAS-G+R[5]			232	7

Enrollment varied by site with an average of 152 participants and a range of 42 to 370. Adult participants were on average 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, staff reported that most (86%) were identified at birth as affected by substance use, based either on a health care professional's assessment of the baby as a newborn or on the staff's own knowledge of maternal use during pregnancy.

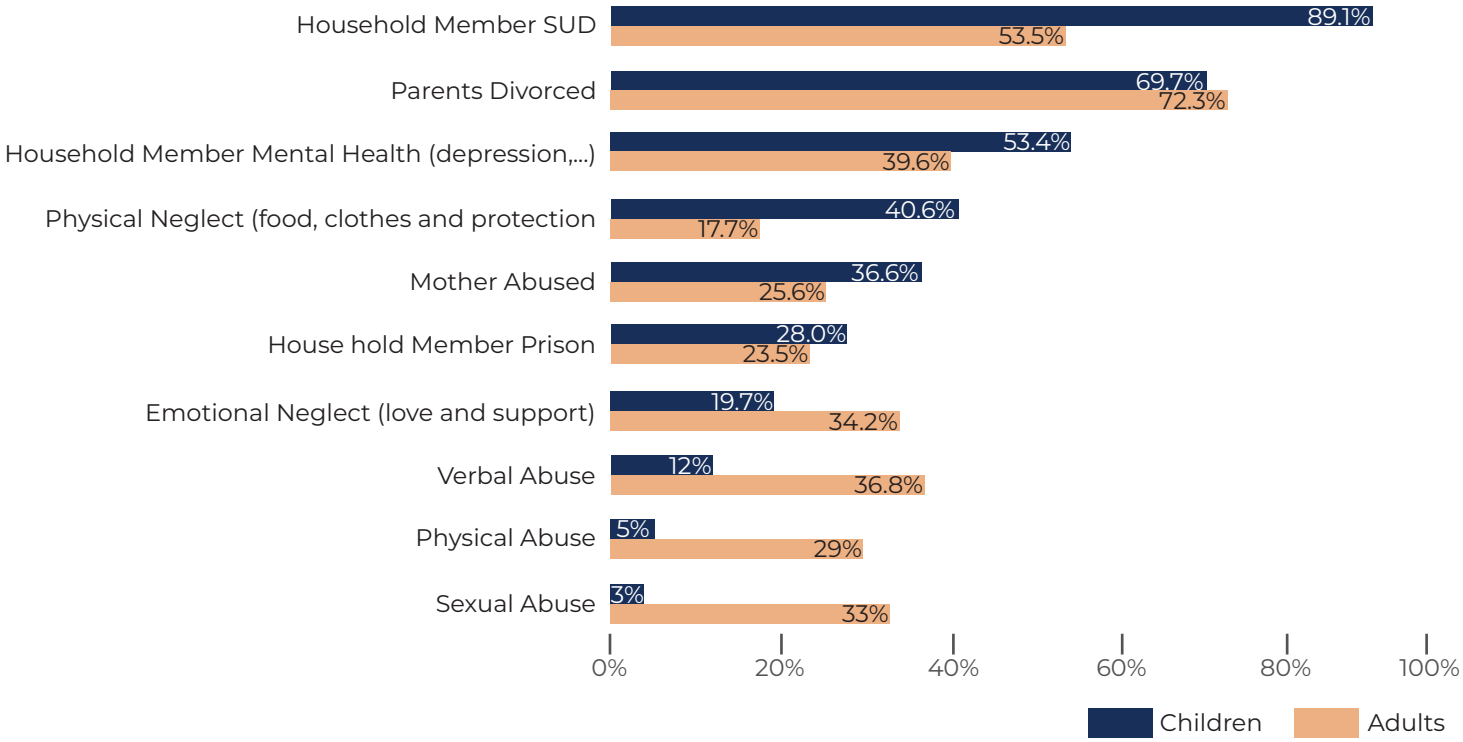
Table 3. Demographics of Adults and Children Served by QIC-CCCT Sites

	Adults	Children
Gender	76% female; 24% male (n=617)	50% female; 50% male
Age	30 (average) (n=599)	2 (average); 35% under 1
Race/Ethnicity:	**(n=600)**	**(n=558)**
White	76%	60%
Black	12%	15%
Native Hawaiian or Other Pacific Islander (NHOPI)	1%	0%
American Indian or Alaska Native (AI/AN)	1%	0%
>1 Race	8%	10%
Asian	3%	15%
Latinx/Hispanic	0%	0%

Adverse Childhood Experiences (ACEs)

The average ACEs score for adults was 3.6; close to half (45%) had a score of four or more. Children's average ACEs score was 3.6; more than half (52%) had a score of four or more ACEs. Four or more ACEs is associated with higher rates of heart disease, depression, and suicide.[6]

ADULT AND CHILD ACES AT INTAKE



To what extent did families engage in QIC-CCCT programs?

Demonstration sites expanded their eligibility criteria by engaging pregnant women and parents/ caregivers to prevent family separation and child welfare or court involvement. They improved access, engagement, retention, and completion rates by coordinating with partners, streamlining protocols, and implementing innovative strategies. This process included peer recovery supports to engage pregnant women, and parents/caregivers in voluntary services in the prenatal period or prior to child welfare involvement.

- **63%** of the 1,380 eligible adults referred to QIC-CCCT programs enrolled; 20% declined to participate, and 17% did not enroll in QIC-CCCT programs for other reasons.
- Adults spent an average of:
  - **143 days** between child welfare case opening and QIC-CCCT entry
  - **27 days** between QIC-CCCT referral and entry
  - **Eight months** in QIC-CCCT programs (for adults who exited the QIC-CCCT program by the end of the original funding period (September 30, 2020))
- **40%** of adults successfully exited the QIC-CCCT program by either completing their QIC-CCCT program or obtaining another type of successful closure; 47% stopped participating or were terminated from services; and an additional 13% had a neutral exit.

What services did families access and engage in?

To meet the complex needs of infants and parents affected by prenatal substance exposure, court teams strengthened and expanded partnerships to implement new services and increased access to existing community services. Sites submitted data on a range of services for 302 children and 355 parents and pregnant women.[7] Nearly all adults and children (91%) who enrolled in parent or child evidence-based practices (EBPs) either successfully completed at least one of these services or remained engaged in at least one at the time of closeout. Family-based services—such as parent education, reunification and visitation services, and POSC development—were commonly reported for both adults and children.

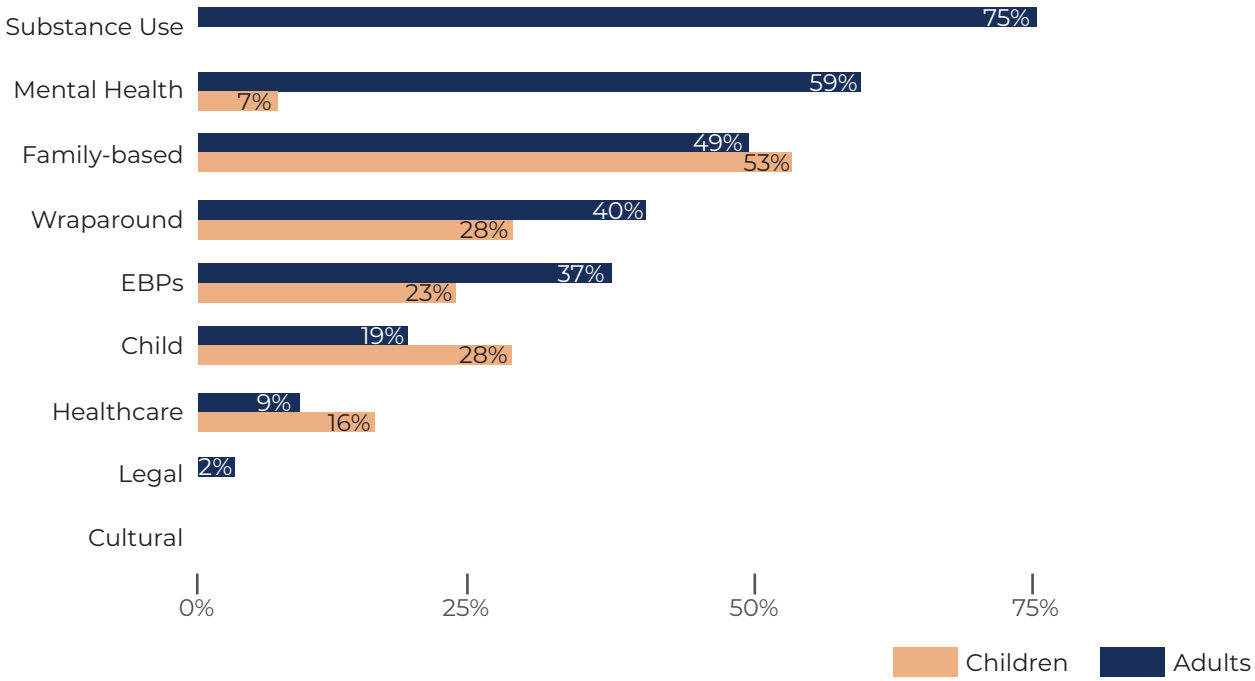
Children were most referred to or received:

- Family-based services **(53%)**
- Child services **(28%)**
- Wraparound services **(28%)**
- Evidence-based practices (EBPs)**(23%)**

Adults were most referred to or received:

- Substance use services **(75%)**
- Mental health services **(59%)**
- Family-based services **(49%)**
- Wraparound services **(40%)**
- EBPs **(37%)**

CHILD AND ADULT SERVICES MOST FREQUENTLY REPORTED



What were families' outcomes?

In assessing change over time at the cross-site level, the analysis includes all participants or families for whom there were data at both enrollment and exit/closeout. The QIC-CCCT Evaluation Team then assessed change over time at the site level for all those with 10 or more participants or families having data at both timepoints.

Plans of Safe Care (POSC)

The CARA amendments to CAPTA require the development of POSC for infants born with and identified as affected by substance abuse or withdrawal symptoms resulting from prenatal substance exposure, or a Fetal Alcohol Spectrum Disorder. 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.

Prior to becoming QIC-CCCT sites, most court teams did not know what a POSC was—or how to use it to engage vulnerable families and provide access to an expanded array of services. By the end of their QIC-CCCT engagement, all but one site implemented POSC for court and non-court participants.

Sites submitted data on whether children had been identified at birth as affected by substance use (based on either health care provider assessment or staff knowledge of maternal use during pregnancy), whether those children had a child welfare notification, and whether children and pregnant women who gave birth during QIC-CCCT had a POSC at enrollment and at exit/closure.

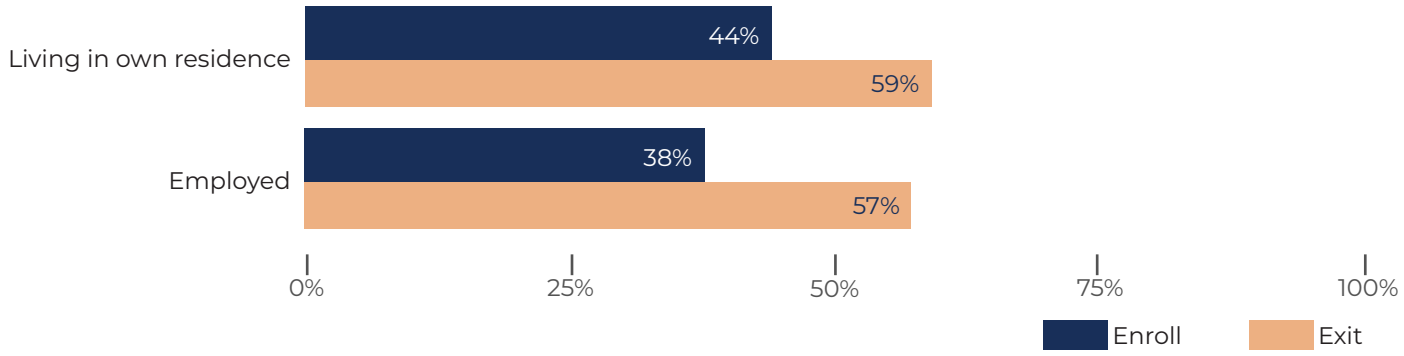
- **86%** of infants (child evaluation participants 12 months and under at the time of enrollment) were identified at birth as affected by substance use.
- **95%** of affected infants had a notification to child welfare.
- **70%** of infants had a POSC by the time of exit/closeout.
- **93%** of pregnant women who gave birth during QIC-CCCT had a POSC by the time of exit/closeout.

Living Situation and Employment Status

In addition to treatment and therapeutic services, families faced self-sufficiency issues related to housing, employment, income, and food security. Those needs increased during the pandemic as families experienced greater isolation, loss of support, economic uncertainty, and job loss. Despite these multiple challenges, families made significant improvements in housing and employment. Compared to enrollment, more adults lived in their own residence and remained employed.

- The percentage of adults living in their own residence increased from 44% to 59%, a 34% increase.
- Adult employment increased substantially, rising from 38% at enrollment to 57% at exit/closeout, for a 50% increase.

ADULT LIVING SITUATION AND EMPLOMENT STATUS IMPROVED OVER TIME

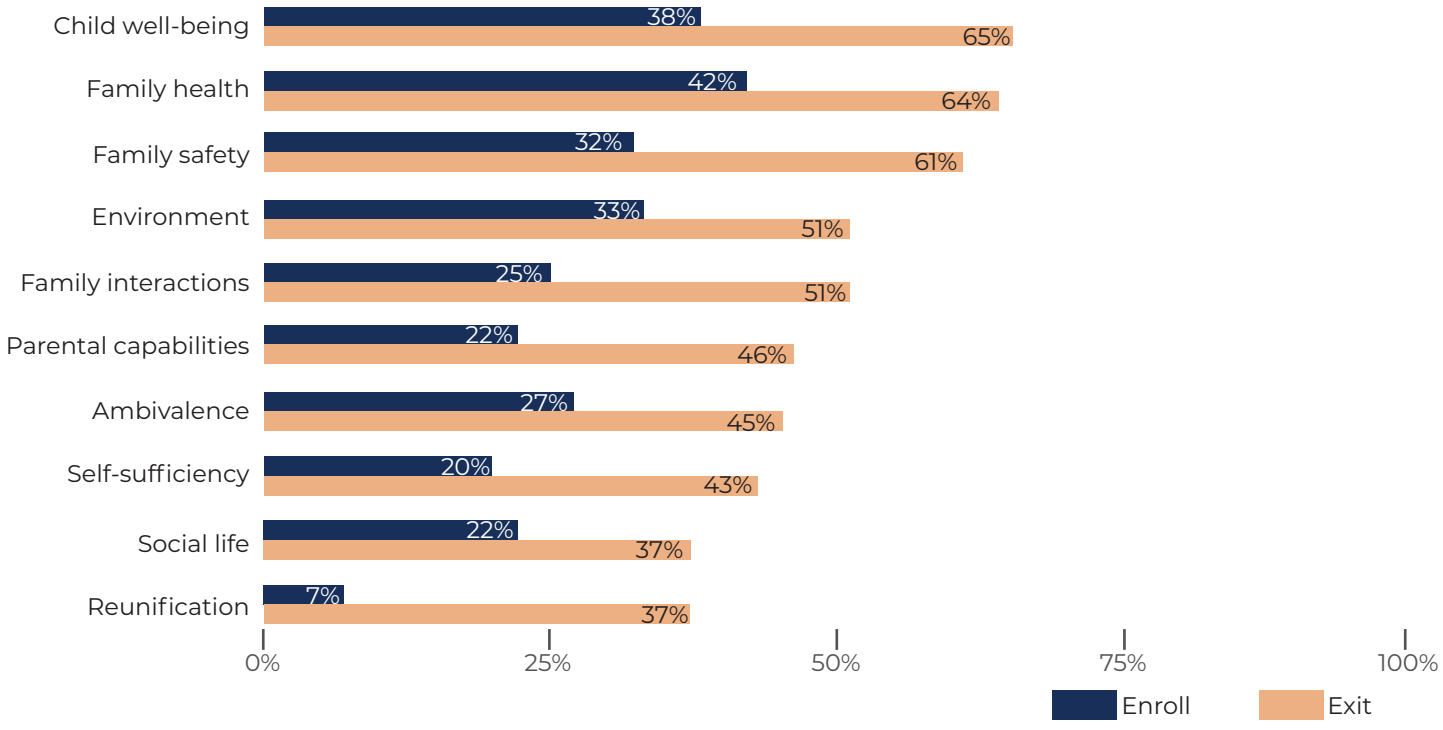


Family Functioning

The NCFAS-G+R includes 10 domains: environment, parental capabilities, family interactions, family safety, child well-being, social life, self-sufficiency, family health, caregiver/child ambivalence,[8] and readiness for reunification. Each domain consists of a set of specific indicators and an overall assessment of family functioning within that domain. For each NCFAS-G+R item, the family receives a rating at one of the following levels: clear strength, mild strength, adequate, mild problem, moderate problem, or serious problem. Across all domains, the percentage of families rated as having relevant strengths increased significantly between enrollment and exit/closeout.

- Areas of greatest need at enrollment: Readiness for Reunification, Self-Sufficiency, and Parental Capabilities
- The percentage of domains for which families received strength ratings (or summary NCFAS-G+R score) nearly doubled over time: Families received strength ratings in an average of 28% of NCFAS-G+R domains at enrollment, but by exit/closeout, that number nearly doubled to 51%.[9]
- The Readiness for Reunification, Self-Sufficiency, Parental Capabilities, and Family Interactions domains showed the largest increases between enrollment and exit/closeout.
- Child well-being, family health, and family safety had the highest strength ratings at exit/closeout.

FAMILIE'S NCFAS DOMAIN STRENGTH RATING IMPROVED OVER TIME

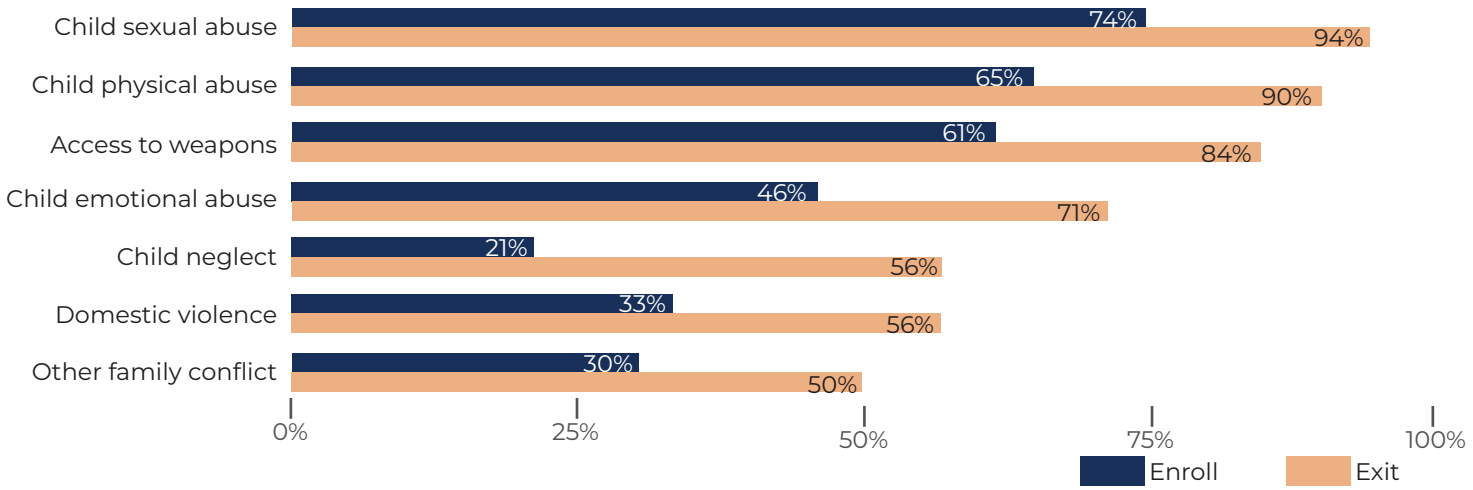


Family Safety

The NCFAS-G+R family safety domain items and summary item measured family safety outcomes. This domain includes family functioning issues related to domestic violence; child neglect; and child physical, sexual, and emotional abuse. Strength ratings on these items indicate such maltreatment has either not occurred, or the family has successfully engaged in treatment since it did occur.

- For all items, more families rated as having relevant strengths at exit/closeout than at enrollment. Similarly, the overall domain item strength ratings increased significantly over time from 32% to 61%, a 91% increase.
- Child Neglect had the lowest percentage of strength ratings at enrollment yet showed the largest improvement between enrollment and exit.

STRENGTH RATING ON ALL FAMILY INDICATORS IMPROVED OVER TIME



Placement and Custody

The QIC-CCCT Evaluation Team measured placement and custody outcomes through enrollment and exit/closeout data on child placement as well as the NCFAS-G+R readiness for reunification domain; closure ratings on the NCFAS-G+R overall readiness for reunification domain rating are highly associated with reunification success.[10]

- Most children (77%) in home at enrollment remained in home through QIC-CCCT involvement. This pattern largely held true at the site level, with almost all sites reporting “remained at home” rates of 60% or higher.[11]
- Across sites, 40% of children in out-of-home placements at enrollment reunified with their families. Five of the 12 sites showed reunification rates of 50% or higher.
- Of the 76 infants born during QIC-CCCT, 71% remained with their families.
- While only 7% of families were rated as having reunification-related strengths at enrollment, at exit/closeout, 37% of families--over five times as many--had strength ratings in this domain. All sites with sufficient data also showed an increase over time of families with overall readiness for reunification domain item strength ratings.

Child Well-Being

The QIC-CCCT Evaluation Team measured child well-being outcomes through the NCFAS-G+R child well-being domain, as well as through the ASQ, which was submitted for children 6 and under at timepoints based on age. The ASQ is scored to categorize children assessed as: 1) needing further assessment, 2) needing monitoring, or 3) appearing to have on-schedule socio-emotional development. The NCFAS-G+R child well-being domain encompasses children's behavior, school performance, relationships, and motivation to stay with their families; the NCFAS-G+R also includes additional related items including child mental health, physical health, and disability. As with the readiness for reunification domain, ratings on the child well-being domain's "overall" item correlate with reunification success.[vi]

- On all these NCFAS G+R child well-being items, strength ratings increased between enrollment and exit/closeout.
- While only 38% of families rated as having strengths related to this overall item at enrollment, there was a significant increase in this measure over time. At exit/closeout, 65% of families had a strength rating for this domain, a 71% increase.
- At the time of children's first ASQ assessment, 75% of children appeared to have on-schedule socio-emotional development. By the time of their second or final ASQ assessment, this percentage had increased significantly to 86%, a 15% increase.

Recovery and SUD

The QIC-CCCT Evaluation Team measured parental SUD and recovery outcomes using a NCFAS-G+R item within the Parental Capabilities domain called "Use of Drugs/Alcohol Interferes with Parenting." A strength rating on this item indicates that substance use does not impair caregiving.

- Only 15% of families rated as having strengths related to substance use and parenting at enrollment. By exit/closeout, 51% of families--over three times as many--received strength ratings on this item.
- For SUD treatment episodes, the average time between referral and enrollment was 16 days; the average length of stay in treatment was nearly four months.

What factors influenced families' outcomes?

Following the cross-site and site-level analysis described above, the QIC-CCCT Evaluation Team analyzed the degree to which exit/closeout values were predicted by a set of other measures that might potentially influence outcomes:

- **Court versus non-court status:** Family court involvement
- **Risk of disproportionate child welfare involvement:** The level at which racial identity is associated with an increased risk of experiencing disproportionately high child welfare involvement at a national level (Black/African American, American Indian/Alaskan Native, or two or more races versus Asian American, Native Hawaiian/Other Pacific Islander, White/European American)[12]
- **QIC-CCCT tenure:** Length of involvement in the QIC-CCCT program
- **Exit status:** Participant's status at exit (or at program closeout) as rated by program staff in categories of successful, neutral, and unsuccessful
- **Adult SUD treatment referral:** A QIC-CCCT agency referral of an adult to substance use treatment
- **EBP referral:** Referral of an adult or child to an EBP
- **Enrollment NCFAS-G+R scores:** Ratings at enrollment of family strength in the following NCFAS-G+R domains: readiness for reunification, safety, child well-being, and parenting capabilities in relation to substance use

The QIC-CCCT Evaluation Team developed and tested a series of multivariate models to assess the relationship between combinations of the variables above and the key outcomes described in the previous section.[13] The narrative below discusses both broad patterns in the outcome model findings and some notable exceptions; a table depicting these findings is in the appendix of this brief. Due to the possibility of bias arising from non-random patterns of missing data across sites and informants, and the large number of tests conducted, these results should be considered suggestive and indicative of broad patterns, not as definitive and indicative of isolated findings.

The length of engagement in a QIC-CCCT program was a factor in most models, with families enrolled for longer periods—and in some cases, those still enrolled at closeout—generally more likely to have favorable outcomes.

Nearly all favorable outcomes—living situation, employment, NCFAS-G+R summary scores, family safety, readiness for reunification, child placement at exit, child well-being, and parental capabilities related to SUD—positively correlated with longer tenure. This finding is consistent with expectations and the design of QIC-CCCT services, which were intended to provide families with ongoing support over an extended period. The surprising finding that infants whose families were enrolled for more than one year were less likely to have a POSC than those enrolled for less than six months could be an artifact of the "scaling up" of POSC over the course of the project. Specifically, families enrolled early in the project are less likely to have the opportunity to have a POSC, but more likely to have been in QIC-CCCT for more than a year while still exiting prior to October 2020.

Black/African American, American Indian/Alaskan Native, and biracial/multiracial children were less likely to: 1) live at home at exit/closeout, and 2) reunify with their families during QIC-CCCT compared to other racial/ethnic groups—even after controlling for other variables.

Among children in out-of-home placement at enrollment, only 31% of those identified as Black/African American, American Indian/Alaskan Native, or two or more races, were reunified—compared to 49% of White/European American, Asian American, or Native Hawaiian/Other Pacific Islander children. This is consistent with broader child welfare practices that often result in disparate outcomes for children of color, including more time in foster care and lower reunification rates.[14] These findings speak to the need for specific strategies to mitigate system bias particularly in decisions about preventing child placement and reunification of families.

Racial disparities were not found in other key outcomes: The likelihood of getting a POSC; improvements in living situation; improvements in employment status; removals before or during QIC-CCCT involvement; and changes in overall family functioning, family safety, child well-being, and parental capabilities in relation to substance use were not associated with participant racial identity.

Despite disparities in reunification, Black/African American, American Indian/Alaskan Native, and biracial/multiracial children had equal access to POSC and achieved similar improvements across key outcomes and clinical measures of family functioning when compared to other racial groups.

While the relationship between risk of disproportionate involvement and NCFAS-G+R readiness for reunification scores did not meet the level of statistical significance, it came very close, and was not observed in any of the other NCFAS-G+R outcome models.

Court status (i.e., having a child under court oversight) positively predicted employment at exit/closeout.

This positive association may be influenced by the distribution of court/non-court participants. The non-court prenatal programs often served women who would have been parenting infants—with or without older siblings—at exit/closeout and may have been less likely to have outside employment as a result. Also, it is possible that some or all of the court programs either facilitated access to employment services, had employment-related graduation requirements, or both.

Court status (i.e., having a child under court oversight) was inversely related to POSC, family safety, and child well-being outcomes.

The finding that, for infants, court status aligned with a lower chance of having a POSC by exit/closeout may be of particular interest. As the QIC-CCCT Evaluation Team was not able to incorporate "site" as a predictor in this model, it is possible that some of the relationships may be accounted for by differences among the QIC-CCCTs population focus and program model. Those differences may be a factor in the timing of participating in the QIC program and the development of the POSC, which typically happens at the time of discharge from the hospital. For example, when court teams initiated their QIC-CCCT program, including implementing POSC, they enrolled families who were already court participants who did not have a POSC when their infants were born.

There were sites with programs dedicated to serving families with children not under court oversight, either prior to any child welfare involvement, or receiving non-court child welfare services. Some of these programs made POSC a particularly high priority, potentially influencing the inverse relationship between court status and having a POSC. Additionally, several sites did not begin implementing POSC for court participants until near the end of their engagement, resulting in a smaller number of court participants with POSC compared to their overall number of court participants. The inverse relationship between court status and family safety and child well-being ratings may relate to the higher needs of families involved in the court. Higher needs would result in differences in family safety and child well-being ratings when compared to families not involved in court.

LIMITATIONS AND FUTURE RESEARCH

The variation in data availability from site to site limited the degree to which site variation could be analyzed; such analysis represents one opportunity for future evaluations of similar court programs to build on these findings. One possible approach would be to collect ongoing (perhaps monthly) quantitative or quantifiable data on the depth and breadth of collaboration (e.g., stakeholders who can meet the specific needs of these families who are involved in the collaborative, ways in which they were involved, extent of involvement). Then, use the data to characterize courts' collaborative evolutions while investigating the relationship between quality or extent of collaboration and participant outcomes.

The observed racial disparities in child placement at exit/closeout, and in reunification during QIC-CCCT involvement, indicate an urgent need for further investigation within collaborative court initiatives. While similar patterns have been established within the broader child welfare field, future collaborative court evaluations could first assess whether disparity is evident among program participants' access to services and supports that could affect outcomes for children of color. Tracking disparities in access during program implementation can inform program modifications to improve child welfare outcomes. Evaluations could then examine whether other factors contribute to disparate outcomes including system bias and child welfare decision making practices.

CONCLUSION

The QIC-CCCT sought to demonstrate and test collaborative court strategies to meet the health and developmental needs of infants, and young children affected by prenatal substance exposure, and the SUD treatment and other needs of their parents or caregivers, while implementing the provisions of CAPTA related to developing POSC. The QIC-CCCT cross-site evaluation measured changes in individual and family outcomes related to these initiative objectives, including POSC status, living situation and employment status, family functioning, family safety, placement and custody, child well-being, and adult SUD recovery.

QIC-CCCT evaluation data point to substantial and consistent cross-site change over time, with all outcomes analyzed showing improvement between enrollment and exit/closeout. On most outcomes, there was marked variation in change over time at the site level—with most showing improvements—while others showed little or no change for a particular outcome. Taken together, these findings suggest: 1) collaborative court team participants showed a general pattern of improved family functioning, child well-being, and adult recovery, and 2) site and program characteristics influenced the degree of improvement observed.

ACKNOWLEDGEMENT

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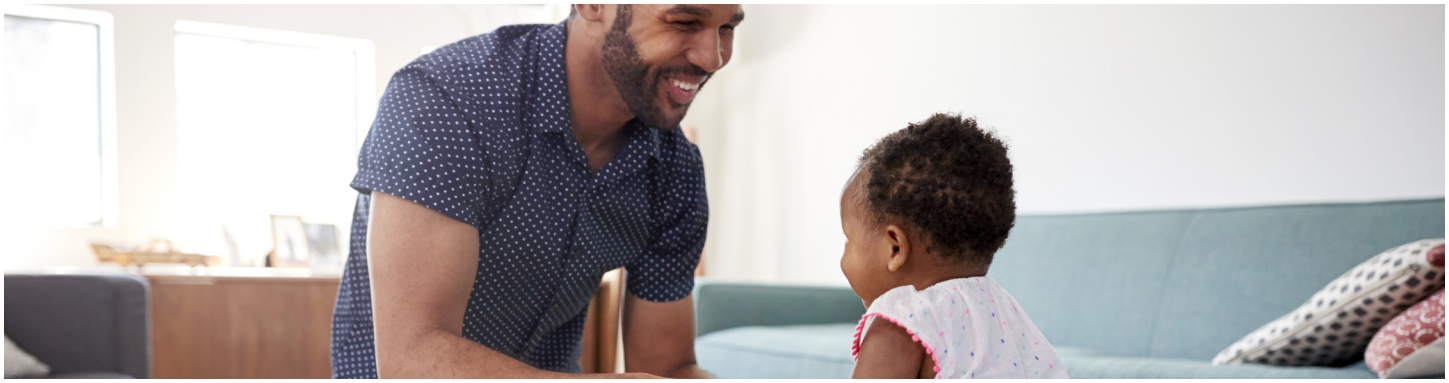
The majority of QIC-CCCT evaluation data were collected through REDCap, supported in part by the National Institutes of Health (NIH/NCATS UL1 TR000445).



REFERENCES

1 For more information on the NCFAS-G+R, see the National Family Preservation Network website. For more information on the ASQ, see the ASQ website.

2 Outcome data were collected at baseline and exit/closeout for most measures. The ASQ, a measure of child well-being, was an exception to this rule: ASQ timepoints were dictated by child age.

3 Adults are comprised of pregnant women, or parents or caregivers of children being served by a QIC-CCCT program.

4 Findings for most individual outcomes stem from enrollment and exit/closeout data submitted for 579 adults and 616 children. For both adults and children, the exact numbers of participants vary among outcomes based on the availability of data for each data element used to compute an outcome. See Table 2 for total baseline and follow-up/exit data for The Ages and Stages Questionnaire (ASQ) and North Carolina Family Assessment Scale for General Services and Reunification (NCFAS-G+R).

5 The exact count of families varies by NCFAS-G+R item.

6 For more information on ACEs, see the Center for Disease Control and Prevention website.

7 While sites customized service lists to reflect what each site planned to track as part of implementation, the QIC-CCCT Evaluation Team summarized types into the nine categories shown for each participant type in the charts shown.

8 The caregiver/child ambivalence domain reflects the degree to which attachment between the caregiver(s) and the child remains intact, the extent of caregiver responsiveness to the child and child comfort in the presence of the caregiver, and the nature of home visitations.

9 To create the NCFAS summary score, the QIC-CCCT Evaluation Team calculated the percentage of domains with strength ratings for families with ratings in at least seven of the ten at both enrollment and exit/closeout. For example, a family with ratings in nine domains at enrollment, and strength ratings in seven of those, would have 78% of their domains rated as strengths at enrollment.

10 Kirk, R. S. (2002). Final Project Report: Tailoring Intensive Family Preservation Services for Family Reunification Cases Final Results of Field Testing and Validation of the North Carolina Family Assessment Scale for Reunification. Author's report to the National Family Preservation Network and the David and Lucile Packard Foundation. Author's report to the National Family Preservation Network and the David and Lucile Packard Foundation. Available online at https://www.nfpn.org/media/8d86bb5036535a6/ncfas-r_research_report.pdf

11 Four sites had fewer than 10 child participants living at home at enrollment, which suggests their rates should be interpreted with caution.

12 See https://www.childwelfare.gov/pubPDFs/racial_disproportionality.pdf

13 The QIC-CCCT Evaluation Team fit three models for each outcome: a base model with the first four predictors, a model adding the two service use indicators (adult SUD treatment and EBP referral), and a model adding intake NCFAS scores. This arrangement was due to the large amount of missing data for the services measures and the NCFAS. To analyze individual and family-level outcomes using these predictors, which were measured either at the individual or family level, the QIC-CCCT Evaluation Team aggregated individual-level measures to the family level when analyzing family outcomes and applied family-level predictors down to the individual level when analyzing individual outcomes. Except for POSC outcomes—which related only to whether a POSC was in place by the time of exit/closure rather than whether there was change over time—all models controlled for the enrollment value of the outcome in question. Because of the smaller number of children with ASQ data at two or more timepoints, the QIC-CCCT Evaluation Team could not conduct multivariate analysis on ASQ scores; similarly, the small number of prenatal POSCs in place precluded multivariate analysis of that outcome.

14 Child Welfare Information Gateway. (2021). Child welfare practice to address racial disproportionality and disparity. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. https://www.childwelfare.gov/pubs/issue-briefs/racial-disproportionality/

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Appendix: Multivariate Analysis Results

Predictor Variables							
Outcome	**Court Status**	**Risk of Dispro-portionality**	**Tenure**	**Exit Status**	**Adult SU Tx.**	**EBP**	**Intake NCFAS**
Plans of safe care - infants	-		-			-	
Living situation status			+	+			-Safe; +CHILD WELLB
Employment	+		+	+			+SU
>=70% NCFAS strength rating			+	+			
Family safety	-		+	+			
Readiness for reunification			+				
Children living at home		-	+				+SU
Child well-being	-		+				
Parental capabilities/ SUD			+	+			

+sig=positive predictor; -sig=negative predictor; gray cells not tested; Intake NCFAS domains are: Safe: Safety, SU: Substance use, CHILD WELLB: Child well-being