Infant-Toddler Court Program

ZERO TO THREE
Early connections last a lifetime

Connecting Families to Services and Supports:

What it Takes and What it Means for Creating More Robust Community Prevention

Introduction

This is a snapshot of one infant-toddler court team (ITCT) and community in Pueblo, Colorado. This story illustrates what it takes for an ITCT to connect families with the services and supports that help them heal, be healthy, and keep their young children safe. It also explores barriers families experience to obtaining support and services before they become the subject of a child protection concern. The story of the Pueblo County Safe Babies Court is augmented with information about similar work going on in Saint Louis County, Minnesota (see page 10). The insight from these examples is intended to help ITCT implementation around the country. In addition, understanding the challenges families face in accessing services, particularly the more "upstream" preventative services might suggest how community-based prevention strategies everywhere could be strengthened.[i]

A National Picture: Challenges and Success

Families participating in ITCTs have multiple, daily challenges that put parents and children alike at risk of poor long-term outcomes in physical and psychological health. Parents often have long histories of suffering and trauma and experience multiple difficulties in adulthood due to lack of opportunity, poverty, generations of discrimination, and personal struggles with mental illness, domestic violence, and/or substance use disorders (SUDs).[ii] In one study conducted at multiple ITCT sites (N = 196), only 26% of mothers were referred for a well-woman-visit.

The national Infant-Toddler Court Program provides training and technical assistance to infant-toddler court teams across the United States. It's goal is to improve the health, safety, well-being, and development of infants, toddlers, and families in the child welfare system, including those who have experienced or are at risk for significant maltreatment. The program addresses gaps in evidence-based practice and systems coordination by (1) improving the response to very young children and families involved in, or at risk for involvement in, the child welfare system, and (2) promoting a community-driven, preventative approach to strengthening families, preventing child maltreatment, and advancing long-term health and development. The program uses two-generation, trauma-informed interventions that concurrently address the needs of parents and children and mitigate the multigenerational transmission of trauma. In addition, in contrast to what is often the norm in public child protective services, Black, Native, and Latinx children experience positive outcomes at the same rate as White children.

There are many reasons for this small percentage, including lack of providers, incarceration, the mother was receiving in-patient treatment for SUD, missing data, COVID-19 restrictions, and refusal of services. However, of those women referred, 90% received a well-woman visit. Families also face food insecurity and unstable housing. In a 2019/2020 survey of 153 stakeholders from evaluation sites (including judges, court staff, attorneys, ITCT community coordinators, child welfare caseworkers and supervisors, and services providers) reported on service gaps and barriers. The main gaps/barriers identified were (1) affordable housing (identified by 98% of stakeholders), (2) transportation (76%), (3) resources to meet parent's concrete needs like food and shelter (61%), (4) resource caregivers that align with the SBC approach (58%), (5) residential SUD treatment (53%), (6) infant and early childhood mental health providers trained in an evidence-based treatment, including child-parent psychotherapy (47%), and (7) funding barriers for evidence based treatments (47%).[iii]

As of the end of September 2021, among sites participating in an evaluation since April 15, 2020, the National ITCT had data for 282 children who participated in ITCTs across the country. The racial composition of the children was predominantly Caucasian (41%) or African American (32%), followed by 27% Hispanic. Approximately a third of children (34%) were identified as having one or more of the following conditions: premature birth, low birth weight, small for age, medically fragile, physical disability, or failure to thrive. Based on the Ages and Stages Questionnaire-3 developmental screening[iv] 18% of children had one or more developmental area identified as concern. Among 322 parents, a third (38%) had their own housing or were renting, less than a third (32%) were employed, and 30% did not complete high school. More than half of parents (57%) were identified as having mental health problems and 79% had substance use disorders.

Despite these challenges, a recent evaluation of the program found that (1) children exit foster care sooner and are less likely to reenter foster care and (2) overall, the caregivers displayed high levels of well-being after case closure.[v] **What does it take to achieve these results?**

On the Ground in Pueblo, Colorado

Pueblo County, located in southeastern Colorado, has a long history of being a hub of activity, first with trading and then rail, becoming an industrial center in late 19th century relying, in part, on immigrant labor from around the world. It continues to be a manufacturing hub today. The public sector is also a driver of the economy as Pueblo is home to the Colorado Mental Health Institute with nearly 500 inpatient beds and a state-run maximum-security prison for nearly 300 youth offenders.

"We do not have anywhere for anybody to live. There is nothing available. Renting a trailer or renting an apartment a year ago would have been about $300 a month. Now [July 2021] it is $1200."

Pueblo's history is not without conflict and trauma.[vi] Despite treaty guarantees and US citizenship, many Mexican landowners lost their land rights after the Mexican-American War that claimed the area as US territory in 1848.[vii] Multiple indigenous tribes inhabited the land well into the 19th century, but by 1868 the major tribes—Cheyenne, Arapaho and Utes, Apache—had been removed to reservations in Oklahoma and other parts of Colorado.[viii] Current demographics reflect Pueblo's history. Approximately 49% of Pueblo city's population identify as Latino or Hispanic, about 45% identify as non-Hispanic White, and the remaining portion represents African American, Native American, and individuals of two or more races.[ix] Many families have lived in Pueblo for generations, dating back to its early days, and families often have multiple living generations, often in the same homes. One observer thought the multiple generations made Pueblo "vibrant" and described Pueblo as being "a survivor community" overcoming adversities.

Despite its industry and declining unemployment rate, Pueblo County grapples with many of the same challenges found in other communities: poverty, substance use, a poor public transportation system, and affordable housing shortages. Nearly 64% of children qualify for free or reduced-price lunch; about 67% are enrolled in Medicaid; and almost 50% of children receive program vouchers from the Women Infants and Children program.[x] About 24% of children in Pueblo live in poverty compared to almost 11% of all Colorado children.[xi] A 2016 report on behavioral health in Pueblo County identified "mental health and substance use as two of the three top priorities" to be addressed emerging from a community health assessment.[xii] The same report also attributed some of the county's mental health needs to a growing number of people without housing. The number of homeless people had increased 54% between 2013 and 2014. In 2019, it was estimated that 15% of the county population was experiencing homelessness.[xiii] This situation has only gotten worse in the last year. One service provider referred to family homelessness in Pueblo as being "dire." In addition, this region has some of the highest rates of opioid-related deaths in the state and has 3 times the state rate of age-adjusted heroin-related overdoses from 2011 to 2016, the highest out of any Colorado county.[xiv]

Safe Babies Court™ in Pueblo County

The Pueblo County infant-toddler court team (referred to as the Safe Babies Court), was established in 2019. The site's community coordinator is based in the Rocky Mountain Children's Law Center, which provides backbone support for the initiative while also providing a range of other legal services to children and families. Originally, it was staffed by one community coordinator working closely with the Department of Human Services' established Intensive Child Services unit (see box for description of unit.) In 2021, the program added another community coordinator. Each coordinator has the capacity to serve 20 families, and it was just ramping up to full capacity in early summer of 2021.

As of end of September 2021, the SBC had enrolled a total of 54 families. Among 61 children, 35 had closed cases. All of the children were 3 years or younger at the start of their involvement in the SBC. Of these children, 92% were with their permanent caregiver within 12 months or less from removal. Half of children were reunified, 3% adopted, and the remaining children (47%) found permanency with relative caregivers. Among 323 children across evaluation sites with a closed case since 2015, 83% were with their permanent caregiver within 12 months or less, 46% were reunified, 24% adopted, and 29% were with relatives.

The program philosophy emphasizes:

- **Focusing on family experience and encouraging personal agency.** Families should be given the information they need and opportunities to make their own decisions.

- **Viewing the family as a system.** Family members who are important to the child and parents being served by SBC should be engaged, wrapping services and supports around all.
- **Assuming the best intent.** Presume everyone –family members and professionals–is operating from a place of positive intentions.
- **Communicating transparently and frequently.** There should be "no surprises" for anyone–parents, case workers, or attorneys–when sharing progress or challenges with the judge.
- **Continually reflecting on how systems are working for families.** This requires reviewing the protocols put in place and engaging community service providers and other stakeholders to assess what is helping families succeed and what is getting in the way that leadership and stakeholders can change.

This program philosophy is operationalized through the work of the community coordinators, a culture of accountability established by the judge, and frequent contact with families that strives for collective, flexible problem solving.

As soon as the Department of Human Services refers a family to the SBC, a community coordinator arranges to meet with the family and their attorney to share program information with the family and determine together if they want to participate in SBC. At this meeting, the community coordinator asks the parent(s) to share information about their child(ren), their family life together, and when they had last seen them. She explains the court process and the role of the attorney. If a family agrees, this decision to participate is authorized at the initial disposition hearing. By the time of the initial hearing, the community coordinator will have spoken with the resource or kin caregiver where the child(ren) is placed as well as the parent(s).

The Pueblo County Department of Human Services Intensive Child Unit is designed to have one supervisor and 5 workers who carry a caseload of up to 20 families each. The members of this team receive on-going training and professional development from the Community Coordinators, starting with an orientation to the Safe Babies Court Team™ approach and how it is being implemented in Pueblo, followed periodically by issue or practice topics that are important for successfully serving families.

Progress is frequently assessed through regular court hearings and family team meetings. These encounters are opportunities to (1) ensure families are getting what they need and (2) problem solve when they might be overwhelmed by all the tasks they are expected to complete and, in many cases, staying sober. The community coordinator and the judge strive to create a "safe space" for parents to share what is happening in their lives and what might be preventing them from making expected progress. They are encouraged to be the drivers of their case while the providers are there to assist, not take over. At the same time, they are direct with parents about the consequences of delayed progress. Concurrent plans for child permanency are openly discussed. The judge expects the Department of Human Services, attorneys, and service providers to meet family needs for frequent visitation and immediate service access. If a parent says they are ready for treatment, the judge will pause the hearing and call a provider to make arrangements immediately.

Families Experience Support and "Promises Kept"

The parents interviewed for this brief did not single out a particular service coordinated through the SBC but lifted up the community coordinator again and again. The community coordinator played a critical role in mobilizing the Family Team to support parents' having access to materal needs such as diapers, formula, clothing, and transportation. She connected them to Child-Parent Psychotherapy providers, peer supports, Early Head Start and early intervention services, and she encouraged parents to get involved in activities. Most, if not all, received therapeutic residential substance abuse treatment that they credited with helping them achieve sobriety.

The predominant theme emerging from all the parents interviewed focused on trusted relationships. The community coordinator advocated for them–supported them by believing in them. They experienced professionals who kept their promises.. Team members were consistent and followed through on what they said they would do. The team did not judge or shame parents when they showed up "high" at a family team meeting or relapsed. The judge and team members were transparent and direct, but not harsh or judgmental, about the consequences of continued substance misuse.

Prevention: Opportunities and Challenges

Although some observers characterized Pueblo as a "service desert" and believed it to be less resourced than smaller communities and more "reactionary" than preventative, it does have providers who offer home visiting programs, parenting education, and a diaper bank.[xv] Some service providers have satellite locations throughout the county and offer shuttle services to supplement public transportation. In addition, because of the rural nature of the area outside Pueblo City, some providers were already providing telehealth services before the Covid-19 pandemic. It also has a growing number of community-based resources that could help families with young children. In fact, it is the home to several pilot programs not found in most Colorado counties. Similar to other locations, however, primary prevention–universally supporting families **before** there is a concern raised or issue identified–is still limited. Many families are not connected with services and supports they might need until they have raised a community concern, and the door to help is through child protection services.

Available Services and Supports

As a Family Resource Center, the Catholic Charities Diocese of Pueblo is a primary provider of family strengthening services and supports. Most recently, in 2021, Catholic Charities began implementing a fatherhood support program being offered in only seven Colorado jurisdictions. The goal of the program is to "strengthen fathers' well-being and prevent child maltreatment through wrap-around services and supports".[xvi] Catholic Charities also operates the Colorado Community Response (CCR), a program of the Colorado Office of Early Childhood. CCR "provides prevention services to families who are referred to the child welfare system" but where there is no child maltreatment concern. As of July 2021, Catholic Charities is serving families who are referred to child protection services but whose issues are "screened out" as not being child maltreatment and families who have closed child welfare cases. Participation is voluntary, but families must be referred by county child welfare staff. Three family development specialists are dedicated to engaging families, helping them identify goals, and working with them to achieve the goals. Some flexible funding is available to help families resolve pressing issues, for example car repair. They serve about 100 families a year, but many more are eligible. Each family development specialist has caseload of about 20 to 30 at a time and may keep serving a family 4 or 5 months. However, despite repeated attempts, through various mechanisms, families are not always connected to services. A 2018 evaluation report of CCR revealed that 77% of the families referred in Pueblo declined–either directly or they could not be reached after several attempts.[xvii] Current program estimates suggest approximately 30% to 40% of the referred families are engaged in services.

To address the substance abuse issues in the county, a service coalition has come together to form the Substance Use Response Ecosystem (SURE). This coalition, created in late 2017, is designed to address the spectrum of substance misuse in the county, from prevention to recovery. In its first year, the work of the coalition has more than doubled the number of Medication Assisted Treatment providers.[xviii] In addition to SURE, Pueblo County added Law Enforcement Assisted Diversion/Let Everyone Advance with Dignity (LEAD) in 2018. It has a harm reduction focus and provides a case management team to help participants connect to services and supports they need such as temporary housing, clothing, and transportation.[xix] It is one of four jurisdictions in Colorado implementing this approach, funded by revenue from the Marijuana Tax Cash Fund.

In recent years, the health care system has become more involved in outreach and being a bridge to services for families. For about 5 years, Catholic Charities has had a HealthySteps program specialist at the Southern Colorado Family Medicine Clinic. The specialist, who receives referrals from the physician, meets with the parents to assesses needs–from diapers to behavioral concerns–and makes referrals to appropriate resources.

A pilot program to address the impact of adverse childhood experiences (ACEs) on the health and well-being of children and families in Pueblo was also initiated by Catholic Charities and the Southern Colorado Family Medicine Clinic. The Support, Connect, and Nurture (SCAN) project (1) provides families with a clinic-based family development specialist; (2) connects families with evidence-based, community parenting programs and other support resources; and (3) provides routine office visits enhanced through educated health care.[xx] SCAN is now delivered in three primary care clinics, six offices of the Women, Infant, and Child (WIC) program, and the only labor and delivery hospital in Pueblo. The expansion is intended to build engagement around the importance of reducing the transference of ACEs from parent to child through a multidisciplinary, two-generation approach.[xxi]

Families Do Not Always Reach Out for Help

Much of the current "prevention" network requires families to ask for help, or be referred by child welfare. With the exception of SCAN being introduced at the birth of a child, no services could be considered "universal" where families might be encountered without any preconceived assumptions about their condition or needs. Families and many service providers have similar perspectives on what gets in the way of families asking for help, including

- **Stigma.** Family members are afraid of what their family, friends, or neighbors might think of them if it appears that they have a mental health or substance abuse issue.[xxii] Families can be very private, and there are often multiple generations that have always considered themselves self-sufficient and wary of outside help.
- **Fear.** Will acknowledging a problem to a service provider prompt child welfare involvement and their child being removed? Families don't know, but do not want to risk it. This sentiment emerges consistently in research on family engagement in child welfare services. It is also supported by the perspectives of parents on the ITCP National Advisory Group for Parents' Voices.[xxiii] When parents are uncertain about the helper's intentions, they will decline to "share information or act in ways that might prompt a child protection services (CPS) report ... Shielding adversities from view may protect against CPS intervention, but also isolates families from institutional resources and supports".[xxiv]
- **Acknowledging they need help parenting makes parents feel very vulnerable.** Related to fear and stigma is a sense of vulnerability, of failure when asking for parenting help. As one member of the Pueblo team observed, it is easeir to reach out for things like food or housing, but "*when it comes to parenting, it's such a vulnerable place to admit that you need help... it is a societal thing of, 'Oh, you should just naturally know how to parent' and it's not the truth.*"
- **Isolation and insufficient formal supports and healthy relationships.** One parent talked of being detached from everything while in a "toxic" relationship, working from home, and likely suffering some postpartum depression that prompted a heroin addiction relapse. Others spoke of not having any family in the area or dependable supports despite the common perception that there are many multiple-generation families in Pueblo.

- **Readiness.** Individuals are not prepared to seek help until they are ready to acknowledge that they need help. As one parent noted, they were simply "stuck" in their substance use disorder. They needed the message they heard from their SBC team and the connection to SUD treatment, coordinated by the SBC, to take the necessary steps to enter treatment.
- **Unaware, unable to navigate system.** For some, knowing where to go, what they might be eligible for, and how to ask for help can be overwhelming, or even worse, a total mystery.

When Families Do Reach Out, Their Efforts Can Be Hindered

As noted, "readiness" and knowing who to ask and how to ask for help can be stumbling blocks for many families. It is also discouraging for parents to get the courage to seek help, only to encounter barriers imposed by communities and systems, including:

- **Resource availability.** Services are not always available when families are ready.[xxv] Contracts provide priority slots for system-involved parents; but self-referrals may confront waitlists, leaving parents unable to get timely help when they acknowledge they need it. This is not unusual when resources are limited. Often, availability must be prioritized for those who have court orders to obey. Or, in the case of the CCR strategy described previously, the support of a family development specialist is restricted to families who are referred by child welfare with an unrelated child maltreatment need. As reported for Pueblo County in 2016, "initial observations regarding the number of mental health providers in Pueblo County seems favorable. However, after further analysis while the number of providers is accurate, the number that are available to the general public is less than reported. Due to the location of the Colorado Mental Health Institute-Pueblo (CMHIP) within the community the number of providers recorded is high. However, CMHIP providers are unavailable for the general public and can only be accessed through the court system".[xxvi]

  "I know from personal experience that anyone who has tried to go to a program here in Pueblo without having some kind of involvement from the court or child welfare have had issues getting in any treatment."
- **Resource accessibility.** When an individual is ready and the service is available, parents may not be able to get to there because of location or schedule. Parents juggling nontraditional work schedules or relying on public transit may not be able to take advantage of the services. In Pueblo, the public transit system has a limited schedule with no evening buses after 6:00 pm. Once connected to services, like SBC, providers can more easily offer rides to clients to ensure they are able to make their appointments.
- **Provider unfamiliarity or lack of knowledge about who can help and how.** Where an organization sits in the community gives its representatives different perspectives of the community assets and needs. Some providers, often medical providers, are not as familiar with community resources as others and they do not know to whom they can refer families when they identify a need. Still others are hesitant to screen for the full range of needs for fear of not having a solution or resource to meet the needs.[xxvii]

Implications for ITCT Implementation and Community Prevention Efforts

This snapshot of needs and services gaps in Pueblo CO and St. Louis MN counties point to opportunities and strategies for helping families before a concern leads to child welfare involvement.

Implementing an Infant-Toddler Court Team: Stay True to the Approach

When considering "what it takes" for an infant-toddler court team to connect families to the services and supports they need and help them be successful, this look at Pueblo County implementation reflects the framework and core components of infant-toddler court teams and illustrates three principles. First, the Pueblo ITCT is **clear with all partners about the fundamental philosophy** they are expected to operationalize with families and with one another. Second, **trusting relationships are established through collective, mutual accountability.** Often times in child welfare, accountability can be a one-way street with expectations only placed on the parents. Infant-toddler court teams have the opportunity to ensure mutual accountability—holding service providers, lawyers, and case workers accountable to the parents as well. Accountability engenders trust, a sense that promises will be kept, or that the promise maker will be held accountable for letting the team down. Third, **problem solving must be approached with creativity and flexibility, not blame or judgement,** as families are different, circumstances are different, and, as is often said, "one size does not fit all."

Seizing Opportunities to Strengthen Prevention: Awareness and Advocacy

Infant-toddler court teams operate at the system level, as well as faciliating child and family access to needed services and supports. Judges, child welfare leadership, and community stakeholders representing the array of prevention-to-treatment services work together as an Active Community Team (ACT) to address gaps and barriers. These stakeholder groups are well-positioned to advocate for increased attention to primary prevention in their communities.[xxviii] They know first-hand the strengths and struggles of families with young children who can often be judged by others or be invisible. The ACTs in both Pueblo and Saint Louis counties represent a diverse range of providers who know the community well and play invaluable roles in coordinating services and problem solving to meet the needs of families. Many team members represent organizations who frequently support families who are not involved with the infant-toddler court team—reaching families earlier.

The community leadership on the ACT can look for and create opportunities to strengthen primary prevention in their communities—creating safe and trusting places and encouraging trauma-informed, nonjudgmental responses by all to families seeking help or raising a concern to the community. These opportunities may fall along a continuum, requiring different investments of time and financial resources. Examples include:

- **Expand ACT representation.** If the ACT does not already have representatives of public health departments and clinics, engage them and add them to the team. They bring an important perspective to how families may be served, as Saint Louis County, is learning. Look to see what other early childhood service providers could also be engaged.
- **Continually promote community awareness and collaboration.** Not everyone who encounters families in need of help knows how to respond. Regular meetings, newsletters, and other correspondence can help:
    - Ensure all social service providers, medical homes, early childhood education providers, and community institutions such as houses of worship and schools know what is available for families and how they can help families access the resources.

- Educate people in the community who have mandated child maltreatment reporting responsibility not just about their legal responsibility to protect children but their role as "mandated supporters" for families–working to understand family needs and offering trauma-informed responses to all family members.
- Make sure the ACTs are aware of needs assessments and strategic plans developed by public health, behavioral health, and other related sectors.

- **Advocate for more resources to strengthen communities.** ACTs may take several steps that not only increase awareness of assets and needs but motivate action, including:
  - Engaging in community mapping to fully understand what is available to families and follow up as necessary with setting community goals, strategic planning, and advocacy to fill identified gaps.
  - Creating a door to services for families that is community-based, not dependent on a child welfare encounter or intervention.
  - Increasing needed services so as to be available to families when they are ready–removing waitlists and funding them separately from contracts with public institutions such as child welfare and law enforcement.
  - Adding more universally available and offered services. Many communities like Pueblo have one or more HealthSteps programs. And, they may have something like SCAN that reaches families prenatally and at birth. But like in Pueblo, the numbers of families reached often does not address the full need for universal screening and response. ACT members can advocate for their expansion or implementation where none exists.

Saint Louis County, MN

Located 1,200 miles northeast of Pueblo County, CO, the Public Health unit of the Department of Public Health & Human Services of Saint Louis County, MN, is implementing ITCTs in two different communities– Duluth and Virginia. As in Pueblo and elsewhere around the country, some families face similar economic challenges and struggle with poor mental health and chemical dependency.

The MN ITCTs are housed within the local public health department, providing a direct connection to the prevention services and community supports offered by the St. Louis DPH. The community coordinators know and value the role public health nurses play in supporting a family and ensure families are connected to them. "As one parent stated", *"especially young parents or new parents, a public health nurse is literally one of the most valuable people that you can build a relationship with for you and your kid."* Public health nurses do home visiting, giving them the opportunity to understand the conditions a family may be experiencing and build a relationship with them. In addition, public health nurses frequently can offer long-term support because their program funding is often associated with the age of a child, not court involvement or case plan requirements.

By collaborating with public health, the community coordinator in Virginia is familiar with what is being done for pregnant women who are struggling with chemical dependency. In one effort, the community coordinator participates in an advisory group that also includes a substance abuse counselor, a public health nurse, and a child protection representative. Each month, this group reviews reports made to child protection alleging prenatal exposure to non-medical/illicit drugs and alcohol. The review prompts a response by public health, rather than child welfare. A nurse visits the families and completes an assessment, offering education, encouraging the parents to obtain treatment, and connecting them to public health programs. In one of the public health programs the mother might be referred to, she could receive support and assistance from a public health partner and a licensed alcohol and drug addiction counselor during her pregnancy and up to 2 years after the child is born.

Duluth offers what they refer to as "safe babies support" by becoming involved with families after they have had an encounter with child welfare but before foster care services are court ordered. In these circumstances, the community coordinator facilitates biweekly family team meetings and coordinate services to families who receive voluntary services for up to 90 days. In some cases, the families agree to a voluntary placement but in others the children remain in the home. For children who are placed out of home, the community coordinator facilitates frequent parent-child contact. Should there still be concerns after 90 days and court intervention is necessary, the community coordinator has already established a relationship with the family, which can help the child achieve permanency more quickly.

Endnotes

i. This brief was informed by interviews with parents, service providers, and other stakeholders in Pueblo County, CO and Saint Louis County, MN, and documentation and research supplied by ZERO TO THREE The National Advisory Group on Parents' Voices also provided insights and perspectives.

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xxvii. In talking with pediatric clinics across the country, the Center for the Study of Social Policy learned that medical providers are often fearful of opening "Pandora's box" by screening for family needs that are not strictly medical–something they know how to treat from their training. See Doyle, et al. (2019) *Fostering social and emotional health through pediatric primary care: Common threads to transform practice and systems.* Center for the Study of Social Policy.

xxviii. ZERO TO THREE. (2021). *The Safe Babies Court Team approach: Core components and key activities.* https://www.zerotothree.org/document/1512