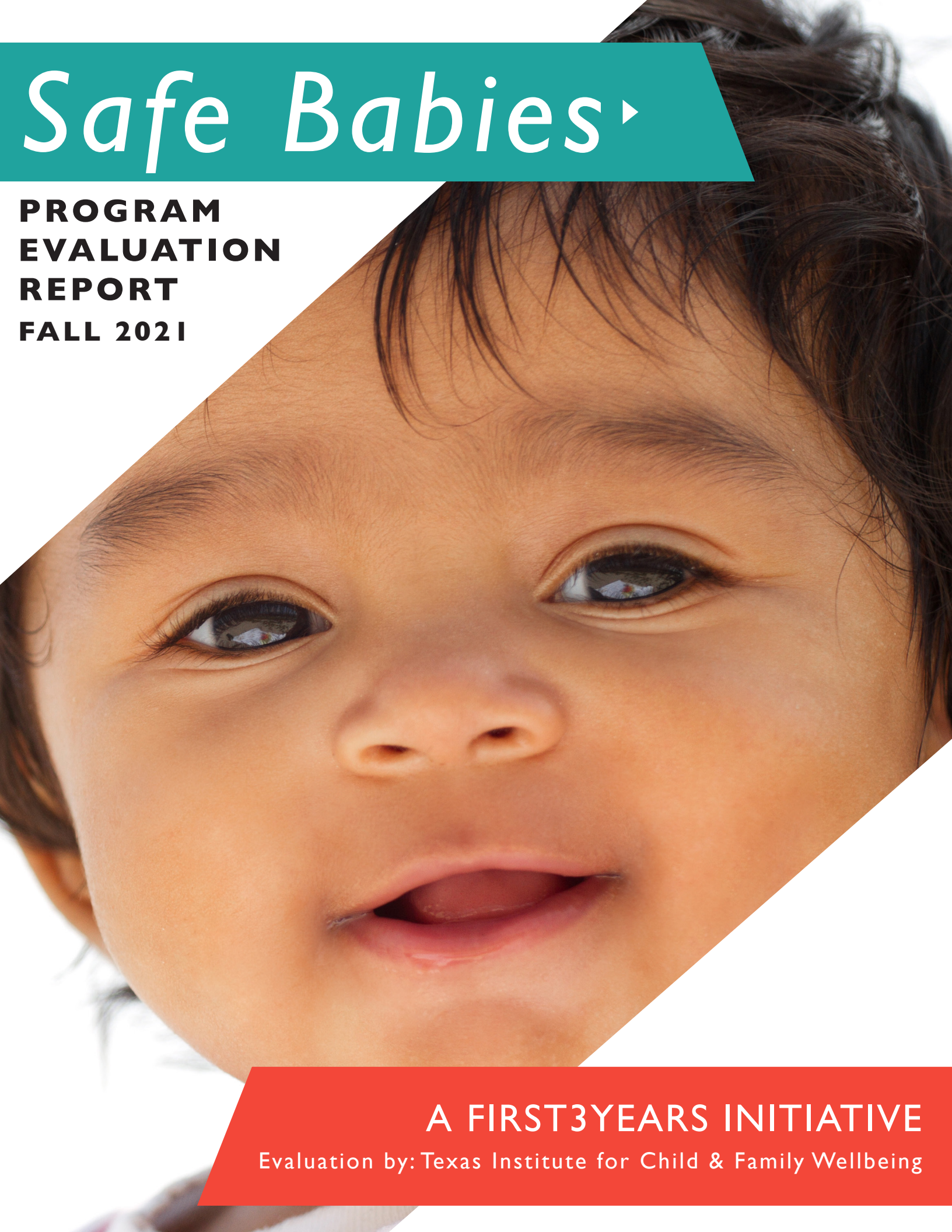
Safe Babies

PROGRAM EVALUATION REPORT

FALL 2021



A FIRST3YEARS INITIATIVE

Evaluation by: Texas Institute for Child & Family Wellbeing

SAFE BABIES PROGRAM EVALUATION REPORT

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Evaluation by:

Texas Institute for Child & Family Wellbeing

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Texas Institute for Child & Family Wellbeing
Steve Hicks School of Social Work

SAFE BABIES
A FIRST3YEARS INITIATIVE

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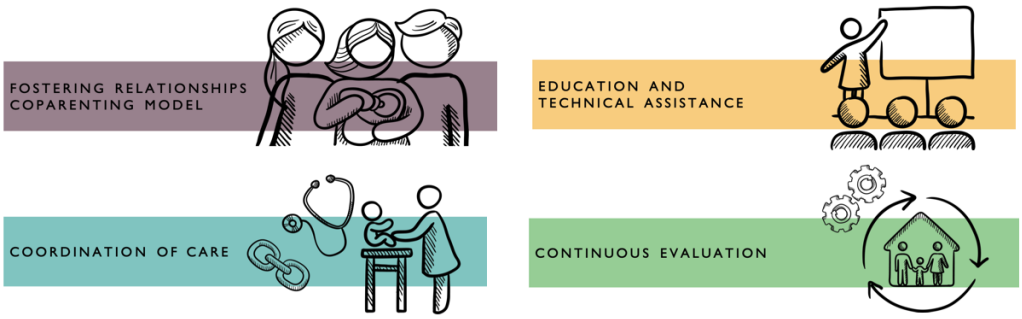
Executive Summary

The Safe Babies program, led by First3Years, collaborates with child welfare stakeholders in Tarrant, Dallas, and Harris Counties to: 1) enhance the quality of relationships between infants and toddlers and their caregivers, 2) increase awareness of and advocate for policies that support a trauma-informed approach to serving infants and toddlers in the child welfare system, and 3) train professionals in current best practices. Safe Babies aims to increase the likelihood of family reunification and ensure that services for infants and toddlers are developmentally appropriate through the delivery of four Core Components:

SAFE BABIES PROGRAM CORE COMPONENTS:



First3Years contracts with the Texas Institute for Child and Family Wellbeing to conduct a third-party evaluation of the Safe Babies program. The evaluation utilizes a mixed-methods design to examine short-term, intermediate, and long-term outcomes related to child permanence and wellbeing. Researchers use Department of Family and Protective Services (DFPS) administrative data; county-level data from Early Childhood Intervention (ECI) providers; and survey, interview, and focus group data from birth parents, caregivers, and professionals involved in Safe Babies. The report includes an analysis of the data, progress toward intended outcomes, and key takeaways and recommendations.

Note: the term "caregivers" includes both foster and kinship caregivers for the purpose of this report.

SUMMARY OF KEY FINDINGS

- Birth parents and caregivers noted Safe Babies' support for coparenting, especially in helping them build trust and communication. Professionals demonstrated an understanding of the impact of coparenting between birth parents and caregivers on a child's wellbeing.
- Professionals demonstrated a strong alliance in supporting families and an understanding of the relationship between attachment, early development, and placement.
- Birth parents, caregivers, and professionals reported that the COVID-19 pandemic posed major challenges to navigating the child welfare system, and birth parents reported that Safe Babies helped them overcome pandemic-related hurdles.
- Many professional interviewees reflected on recent changes to the historically adoption-driven narrative in the child welfare system, with more caregivers and professionals supporting family preservation or reunification when possible.
- Caregivers and professionals involved with Safe Babies generally reported positive perceptions about birth parents, with room for improvement in their perceptions of parents experiencing mental health or domestic violence issues.
- Time to permanence was significantly shorter for infants and toddlers in Safe Babies than for infants and toddlers who were not in Safe Babies.
- A higher percentage of infants and toddlers in Safe Babies returned home than infants and toddlers who were not in Safe Babies.

RECOMMENDATIONS

- Safe Babies should continue working with caregivers and professionals to cultivate more positive perceptions about birth parents. This will further reduce stigma experienced by birth parents involved in the child welfare system.
- Safe Babies should continue to align stakeholders around a culture of support for coparenting between birth parents and caregivers and for meeting the attachment and development needs of young children in foster care.
- First3Years should continue to grow the capacity of the Safe Babies program in order to serve more families in existing counties and reach families in new counties. This supports the long-term goal of achieving a more trauma-informed and developmentally appropriate response to infants, toddlers, and their families in the child welfare system.

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Introduction & Overview

BACKGROUND AND PROBLEM STATEMENT

The quality of attachment between a child and primary caregiver is a powerful predictor of the child's outcomes in life.[1] 'Attachment' is a circumscribed aspect of the caregiver-child relationship that involves making the child feel safe and protected.[2] Secure attachment describes a healthy attachment style in which the child has learned to trust their caregiver based on the caregiver's positive and consistent response to the child's needs.[3] This sense of trust provides a child with the confidence they need to explore their environment and gain a sense of self-esteem.[4]

Secure attachment with a primary caregiver ensures that the child will feel calm enough to experience healthy development of their brain and nervous system.[5] Brain development in infancy and early childhood lays the foundation for all future development.[6] A history of secure attachment and subsequent healthy child development leads to greater resilience to adversity over a lifetime.[7]

Conversely, when a child experiences neglectful or abusive caregiving, it is more likely that the child will develop an insecure attachment to the caregiver.[8] Children with insecure attachments have learned they have little ability to elicit the needed response from their caregiver through typical care-seeking behavior.[9] The absence of responsive caregiving over a prolonged period causes an increase in cortisol, the hormone responsible for preparing humans to fight or flee in response to a stressor. Continuously elevated levels of cortisol keep a child in a constant state of hyperarousal.[10] Burdened to remain vigilant to threats, the child may become less likely to develop self-regulatory functions.[11] The child may behave impulsively, inattentively, or aggressively; feel hopeless; develop a poor self-concept; and have trouble forming healthy relationships.[12]

When a child enters the child protection system, the ability of social systems to provide the types of support that the child needs influences the child's adjustment in the aftermath of child abuse and neglect.[13] The child protection system's response may remove the child from immediate danger, but must also adequately respond to the trauma the child has experienced and minimize any potential for institutional trauma. Separation from a parent is distressing for infants and young children, even if abuse or neglect has occurred.[14] Once the child enters the child welfare system, they often experience additional changes in caregivers, which undermines their capacity to form a secure attachment with a primary caregiver.[15] Young children cannot anticipate future, so disruption in caregiving for even a very short time is often stressful. The younger the child and the longer the separation or period of uncertainty, the more damaging it is to the child's wellbeing.[16] In fact, children in foster care are at a significantly higher risk of developing insecure attachments than other children.[17]

Figure 1: Summary of the Problem

BABIES CAN'T WAIT.

- Their sense of time and rate of development is vastly different from that of adults.
- 85% of core brain development happens before a child turns 3 years old. During this time, the brain is setting up processes for learning as well as stress, emotion, and change management.[18]
- National data shows that young children in foster care are more likely to experience delays in emotional, social, and cognitive development than their non-child welfare involved peers.[19]
- 82% of young children in foster care show elevated signs of stress (cortisol), which inhibits healthy brain development.[20]

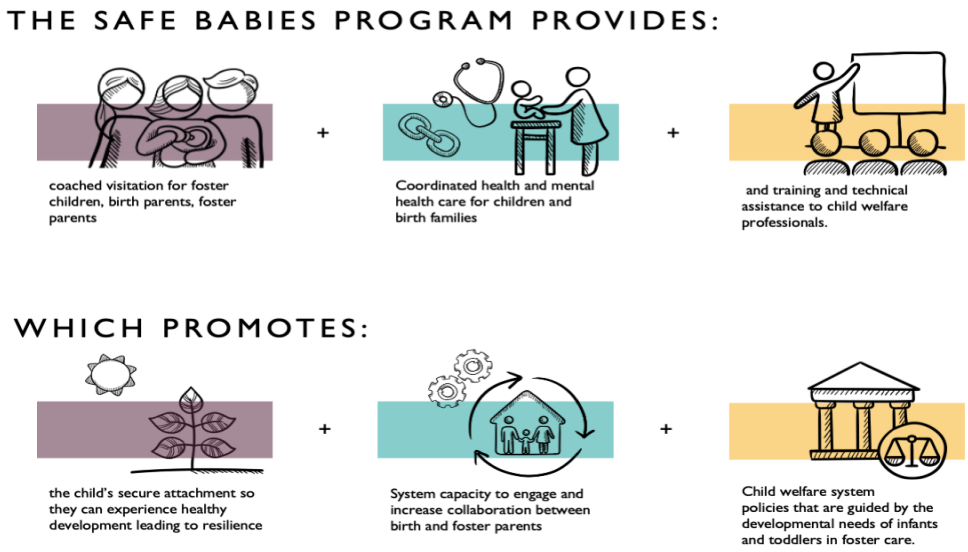
BABIES ARE THE MOST VULNERABLE.

- 34% of children in foster care in Texas are infants and toddlers (aged 0–3). Of these infants and toddlers, approximately 12% are from Tarrant County, 23% are from Dallas County, and 25% are from Harris County. [21]
- Lack of predictable experiences, such as multiple placement changes, not only disrupt healthy development but can also prevent a child from developing self-regulation and social skills.[22]
- Current child welfare and legal systems should be better supported to meet the needs of infants and toddlers, especially in preserving and repairing the parent-child relationship.

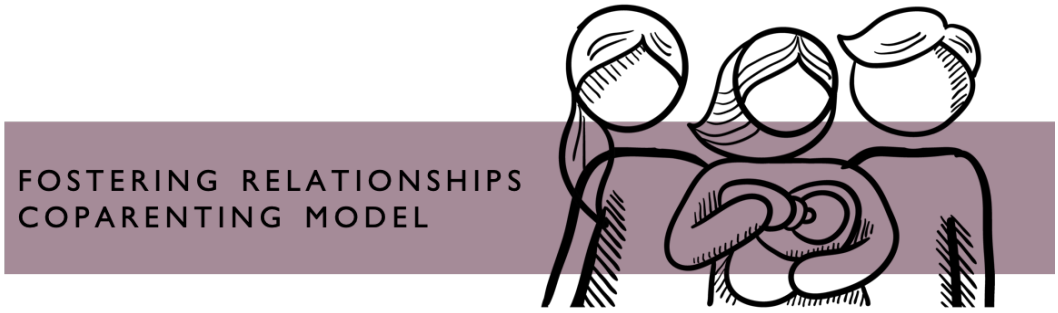
PROGRAM OVERVIEW

Safe Babies seeks to lessen the long-term impact of abuse or neglect, increase the likelihood of family reunification, and ensure that developmentally appropriate and trauma-informed policies guide the care and transitions of infants and toddlers in the child welfare system. The program works directly with birth parents and caregivers to strengthen coparenting relationships. Safe Babies also works with birth parents, caregivers, and professionals to create plans that focus on the needs of infants and toddlers, especially around transitions such as visitations, court hearings, and placement changes. Lastly, the program works with stakeholders in each county to achieve a more developmentally appropriate and trauma-informed child protection response. Anticipated results include better permanency and wellbeing outcomes for infants and toddlers in the child welfare system.

Figure 2: Overview of Safe Babies Program

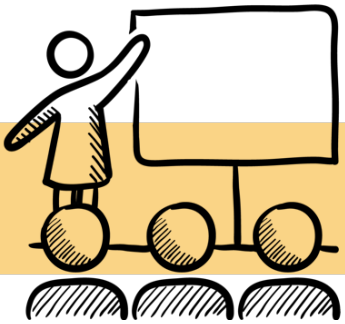


SAFE BABIES CORE COMPONENTS



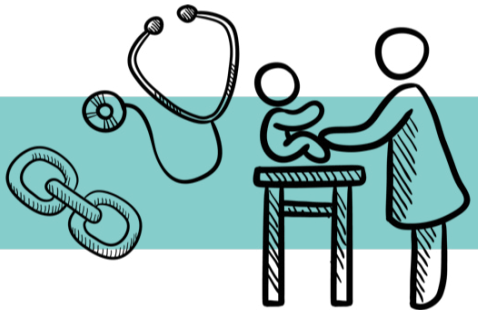
Fostering Relationships is a national coparenting model through which birth parents and caregivers are trained—in this case, by Safe Babies staff—to interact with the child and one another in ways that promote the child's secure attachment. When birth parents and caregivers work together, the child is more likely to experience a sense of calm and stability in situations often characterized by disruption. The model aims to strengthen the relationship between birth parents and caregivers, help parents and children before, during, and after visitations, and increase birth parents' and caregivers' use of the "follow the lead" technique with children. Birth parents and caregivers receive helpful, real-time guidance from the Safe Babies coordinator. This reinforces what birth parents are already doing well and increases opportunities for birth parents and caregivers to work in partnership. The Safe Babies coordinator also offers supportive contact between visits to reinforce healthy attachment behaviors among all parents and caregivers.

EDUCATION AND TECHNICAL ASSISTANCE



Safe Babies trains Child Protective Services (CPS) workers, judges, lawyers, Child Placing Agency (CPA) staff, and other child welfare professionals on the unique needs of infants and toddlers in the child welfare system. By gaining a deeper understanding of how attachment, early development, placement, and safety interrelate, people involved in the child's case will be better equipped to make decisions.

COORDINATION OF CARE

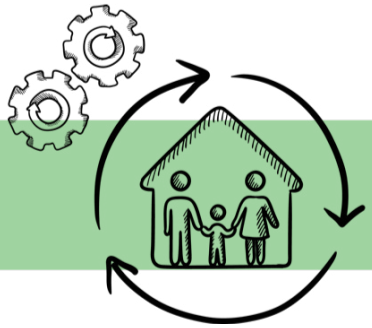


Disconnection from positive relationships and social supports, poverty, lack of parenting knowledge and modeling, and substance use and mental health issues are common barriers for birth parents in providing a stable, nurturing environments for children. Safe Babies helps coordinate services for the parent and child and keeps all parties informed to minimize case disruptions and achieve better outcomes.

Safe Babies facilitates team meetings in which birth parents, caregivers, and professionals meet at regular intervals to align around common goals and troubleshoot issues such as barriers to accessing services. These meetings provide the opportunity for better service coordination and continuity, including giving birth parents and caregivers the opportunity to provide feedback about the quality of services or additional service needs. The stakeholder committee, made up of child welfare system professionals from each county, meets to oversee program implementation and address any program issues as they arise. This committee works to ensure continuity of care within the program that is individualized based on the needs of families.

Early intervention is key to achieving the best outcomes for children with developmental delays or medical diagnoses. Safe Babies partners with Early Childhood Intervention (ECI) to ensure that all infants and toddlers in the program have access to developmental screenings and, when necessary, service referrals.

CONTINUOUS EVALUATION

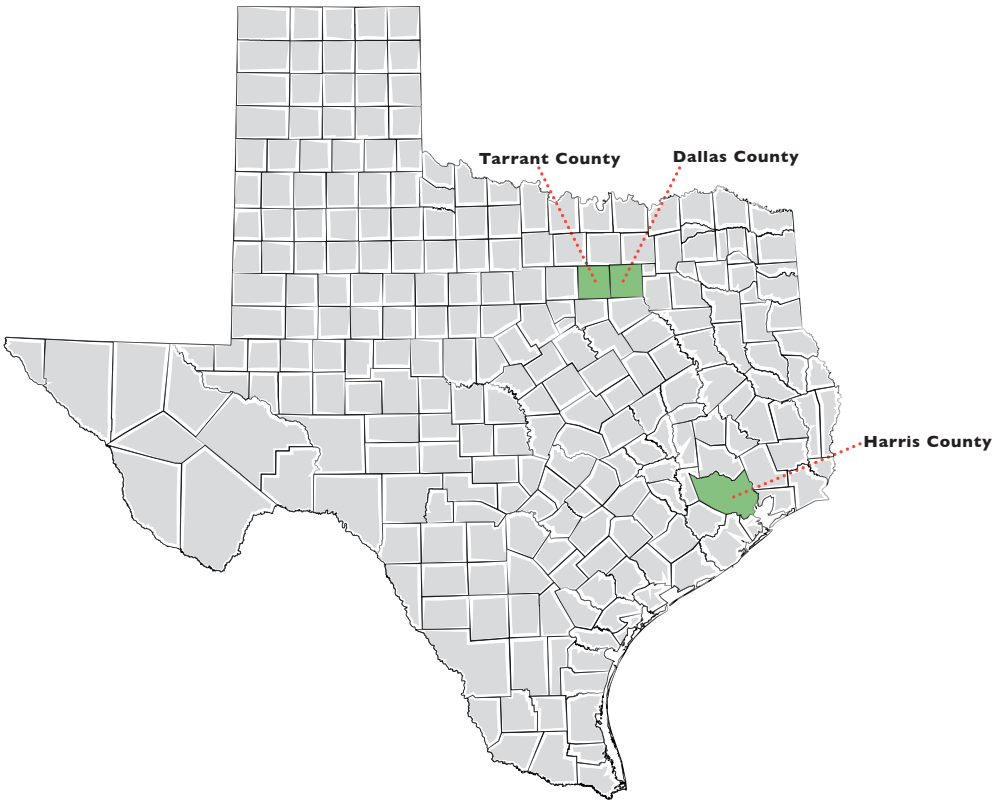


First3Years is committed to ongoing evaluation of Safe Babies and continuous quality improvements to ensure the program is successful and can be effectively replicated in other Texas communities.

GEOGRAPHIC INFORMATION

In 2015, Safe Babies first partnered with Tarrant County stakeholders and began serving families in 2016. In 2018, the program partnered with Dallas County stakeholders and began serving Dallas County families in 2019. In 2019, the program partnered with Harris County stakeholders and began serving Harris County families in 2020. This strategic expansion aligns with First3Years' greater vision to build local capacity for a more developmentally appropriate and trauma-informed response to infants and toddlers in the child welfare system.

Figure 3: Map of Safe Babies Counties



PROGRAM PARTICIPANTS

Program participants include children 0–36 months of age and their families, including birth parents, caregivers, and older siblings (ages 3+) involved in the child welfare system in Tarrant, Dallas, and Harris counties. The program is also supported by child welfare stakeholders in these counties.

BIRTH PARENTS

Birth parents are identified for potential involvement in Safe Babies by a variety of parties, including CPS investigations or conservatorship staff, attorneys, and judges. In order to be eligible, a birth parent's child must be 0–36 months of age at the time of referral (though services may continue beyond 36 months). Parents with severe aggravated assault charges within the past 5 years, perpetrators of extreme domestic violence, sexual assault, or sex trafficking, and teen parents younger than 17 are typically screened out due to the need for more intensive services. However, all referrals are considered on a case by case basis and are staffed with the Safe Babies Director with additional information from CPS staff. CPS staff, Safe Babies staff, or the birth parent's attorney invite the birth parent to participate in the program.

CAREGIVERS

CPAs identify caregivers, including foster and kinship caregivers, willing to participate in the program. Safe Babies staff trains all caregivers on the Fostering Relationships Coparenting Model. Safe Babies also uses a train-the-trainer model with CPAs so they can continue to train caregivers on the Fostering Relationships Coparenting Model. Initial training may occur before or after the child is placed with the caregiver.

STAKEHOLDERS

Safe Babies works closely with professionals at the local and state level to design, implement, and continuously operate and improve the program in each county. Program stakeholders include, but are not limited to:

- Department of Family and Protective Services (DFPS)
- Judicial support, including judges and parent and child attorneys
- Court Appointed Special Advocates (CASA)/Child Advocates Inc. (CAI)
- Early Childhood Intervention (ECI) service providers
- Child Placing Agencies (CPAs)
- Caregivers, including foster parents and kinship caregivers
- Other child and family service agencies including (but not limited to) mental health, substance use, and domestic violence service providers

PROGRAM EVALUATION OVERVIEW

EVALUATION BACKGROUND

First3Years contracts with the Texas Institute for Child & Family Wellbeing at The University of Texas at Austin, Steve Hicks School of Social Work to evaluate the Safe Babies program. The purpose of the evaluation is to determine whether children who participate in Safe Babies have improved permanency and wellbeing outcomes.

Figure 4: Evaluation Research Question

RESEARCH QUESTION

Do children who participate in the Safe Babies program have better permanence and wellbeing outcomes compared to children who do not participate in the program?

POPULATION (P), INTERVENTION (I), COMPARISON (C), OUTCOMES (O)

For the purposes of this evaluation, the target population **(P)** is infants and toddlers who were removed from their homes by CPS in Tarrant, Dallas, or Harris County due to abuse, neglect, or drug exposure at birth and who participate in the Safe Babies program **(I)**. The target population is compared **(C)** with infants and toddlers who were removed from their homes by CPS in Tarrant, Dallas, and Harris counties due to abuse, neglect, or drug exposure at birth who did *not* participate in Safe Babies. Short-term, intermediate, and long-term outcomes **(O)** related to child permanence and wellbeing are organized in Table 1 based on the program's Core Components. While some of these outcomes relate directly to the program, others relate to the broader culture change surrounding coparenting, attachment, and development that Safe Babies seeks to achieve. The Program Evaluation Findings section describes progress and areas for growth related to these outcomes, both within the program and within the broader child welfare context.

Table 1: Summary of Intended Program Outcomes

	SHORT TERM	INTERMEDIATE	LONG TERM
FOSTERING RELATIONSHIPS COPARENTING MODEL	Birth parents feel increased support. Birth parents and caregivers demonstrate sensitive parenting. Birth parents and caregivers work together collaboratively.	Children achieve permanency with families. Fewer children return to foster care.	Children increase resilience. Child welfare system grows capacity to develop collaborations between birth parents and caregivers.
EDUCATION AND TECHNICAL ASSISTANCE	Service providers demonstrate a strong alliance.	Stakeholders demonstrate increased understanding of the relationship between attachment, early childhood development, and placement.	Developmentally informed policies guide the treatment of infants and toddlers in the child welfare system.
COORDINATION OF CARE	Children's developmental needs are identified early. Birth parents and service providers strengthen partnerships. Birth parents experience less stigma around accessing services.	Children's physical and mental health improve.	

EVALUATION DESIGN AND METHODOLOGY

The evaluation utilizes a mixed-methods design to examine short-term, intermediate, and long-term outcomes. All data is de-identified before reporting and personal information is stored on a secure server.

Quantitative Data

Professional, birth parent, and caregiver surveys are collected via Qualtrics on an ongoing basis. Parent and caregiver survey respondents may opt to receive a $25 gift card via Tango.com. Professionals do not receive gift card incentives. ECI and DFPS administrative data are requested twice per year. ECI data in this report includes Tarrant and Dallas counties. Researchers plan to begin collecting ECI data from Harris County, which began serving families in October 2020, in future reports. DFPS data includes Tarrant, Dallas, and Harris counties. All quantitative data is analyzed using SPSS statistical analysis software.

Qualitative Data

Qualitative data include professional, birth parent, and caregiver interviews and focus groups. Researchers recruit professionals via Safe Babies stakeholder contact lists and birth parents and caregivers via an electronic contact form, which is completed by Safe Babies Coordinators with the verbal consent of parents at the close of each case. Parents and caregivers may opt to receive a $25 gift card and professionals do not receive incentives for participating in interviews or focus groups. Interviews and focus groups are recorded, transcribed using GMR Transcription, coded using Dedoose, and analyzed using Microsoft Excel.

COVID-19

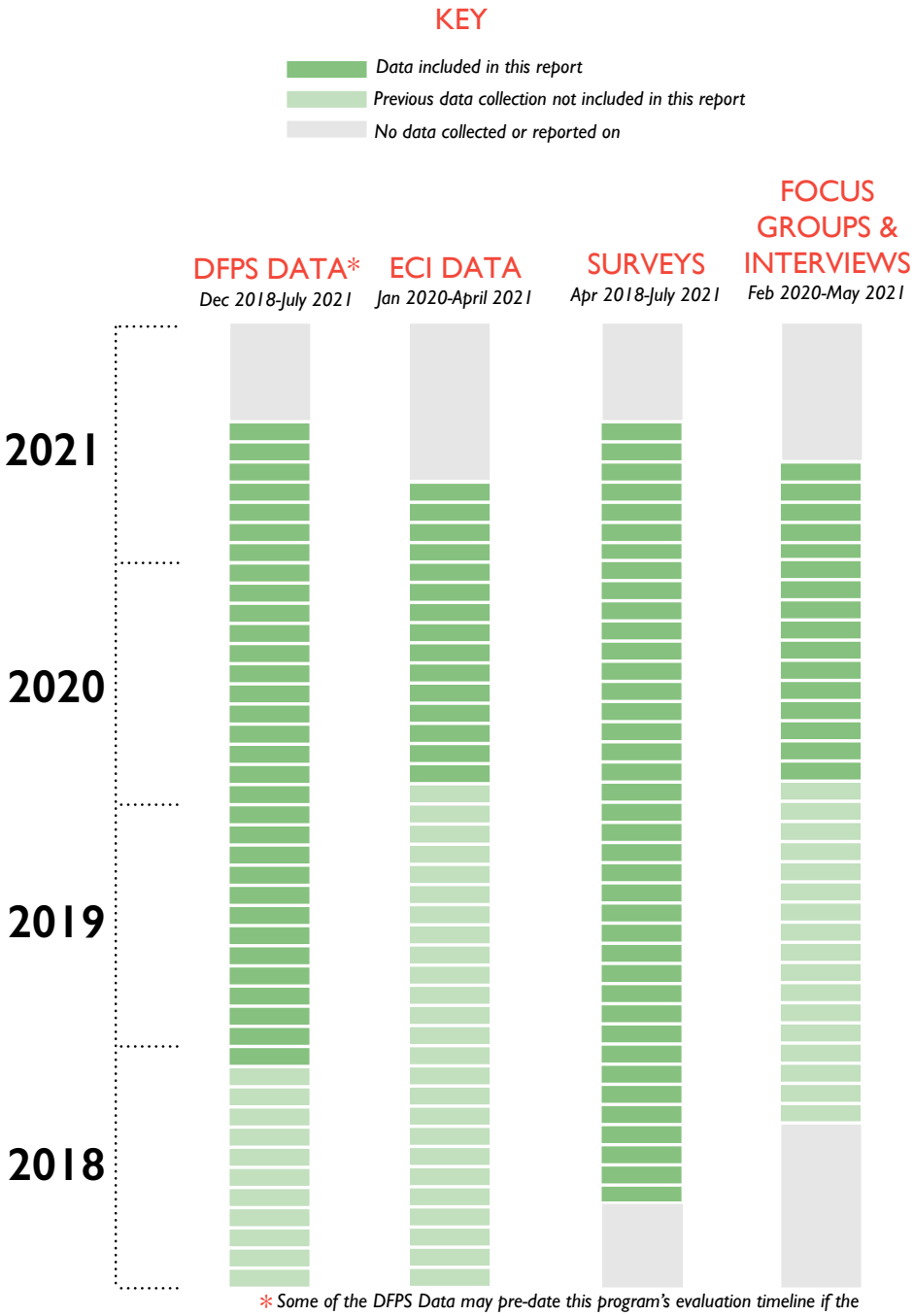
Researchers added questions related to the impact of the COVID-19 pandemic to all surveys and interview guides at the start of the pandemic. As a result, qualitative data related to COVID-19 collected from birth parents, caregivers, and professionals is included throughout the report. Additionally, researchers conducted all interviews and focus groups virtually beginning in March 2020 to accommodate the health and safety of all parties. Data collection timelines were also extended to ensure that the 2021 report could include all necessary qualitative and quantitative data.

Data Included in This Report

It is important to note the small sample sizes for individual measures or items within individual measures. Smaller sample sizes reduce the power of a study and increase the margin of error. Data can appear more skewed and it may be harder to detect a significant finding when one is there. One of the ways to evaluate data that is highly skewed or collected from a small sample size is by using non-parametric tests that do not require data to be normally distributed. Researchers analyzed data using either parametric or non-parametric tests, depending on which test was appropriate. As a result, the way scores are reported and discussed may look different depending on the type of test that was used. More information about the tests can be found in the appendix. Additionally, researchers reported on the median (the "middle" number in a sorted list of numbers) as opposed to the mean (average) for quantitative findings when the distribution of data was highly skewed. The median is preferred to other measures of central tendency (such as the mean) when data is skewed because it is more resistant to outliers.

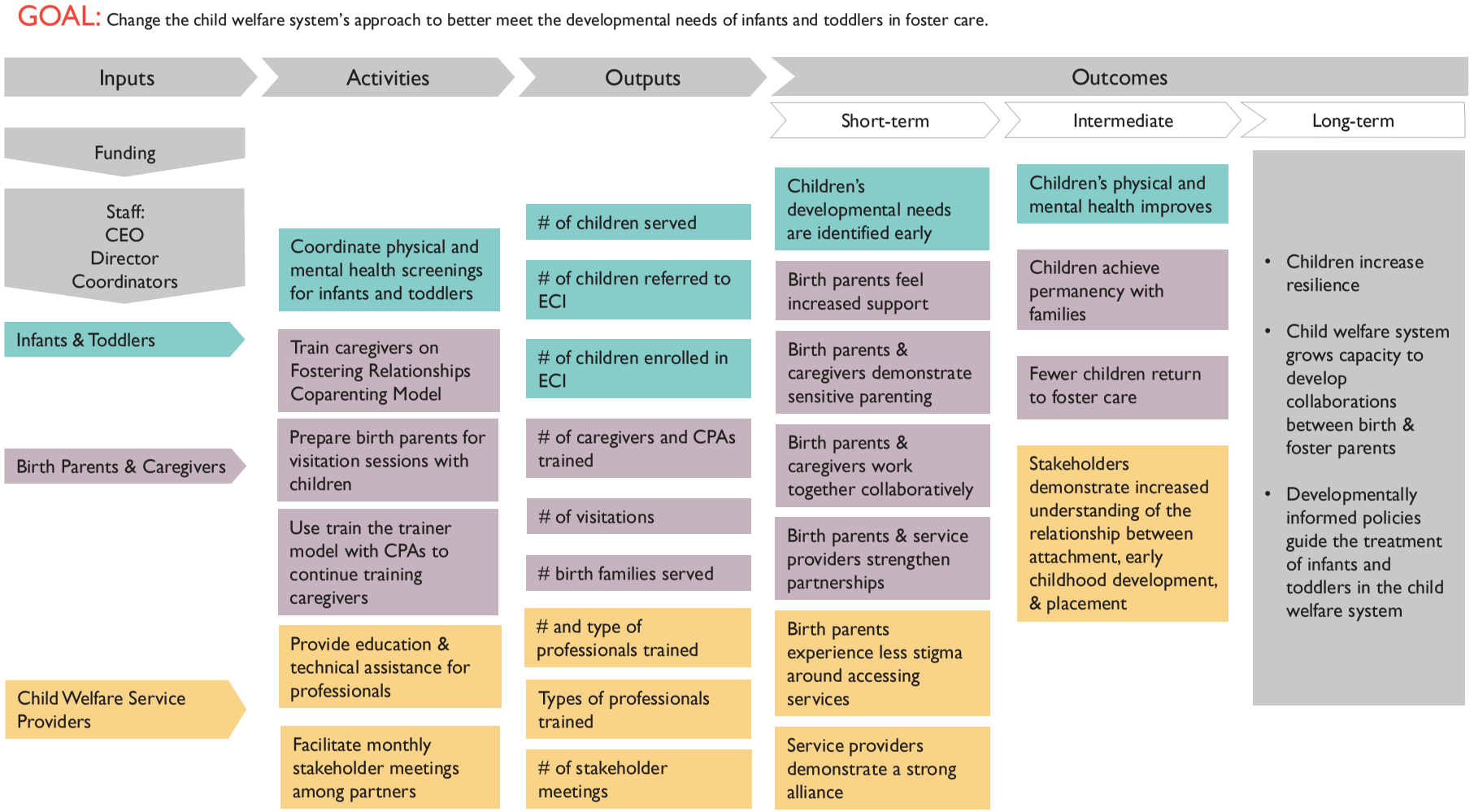
Figure 5 depicts the data collection timelines for data from all sources included in this report. Additionally, the figure shows data collection from previous reporting periods that may be referenced in this report. Data reporting timelines vary by source as program evaluation data is collected on an ongoing basis using several methods. Additionally, researchers begin collecting data from new counties as they implement the program. Some DFPS data included in this report dates back to before the start of Safe Babies implementation as some families included in the study became involved in child welfare prior to the start of the program.

Figure 5: Data Collection Timeline for Data Included in this Report



* Some of the DFPS Data may pre-date this program's evaluation timeline if the families were involved with DFPS prior to 2018.

Figure 6: Safe Babies Program Logic Model



Program Evaluation Findings

ABOUT STUDY PARTICIPANTS

Below is an overview of demographic information for children, birth parents, caregivers, and professionals in each qualitative and quantitative data set.

ADMINISTRATIVE DATA

DFPS DATA FOR SAFE BABIES & COMPARISON GROUPS

Table 2 shows child characteristics for the 103 children whose families participated in Safe Babies (intervention group) and the 8,812 children whose families did not participate in Safe Babies (comparison group).

Table 2: Child Characteristics for Safe Babies & Comparison

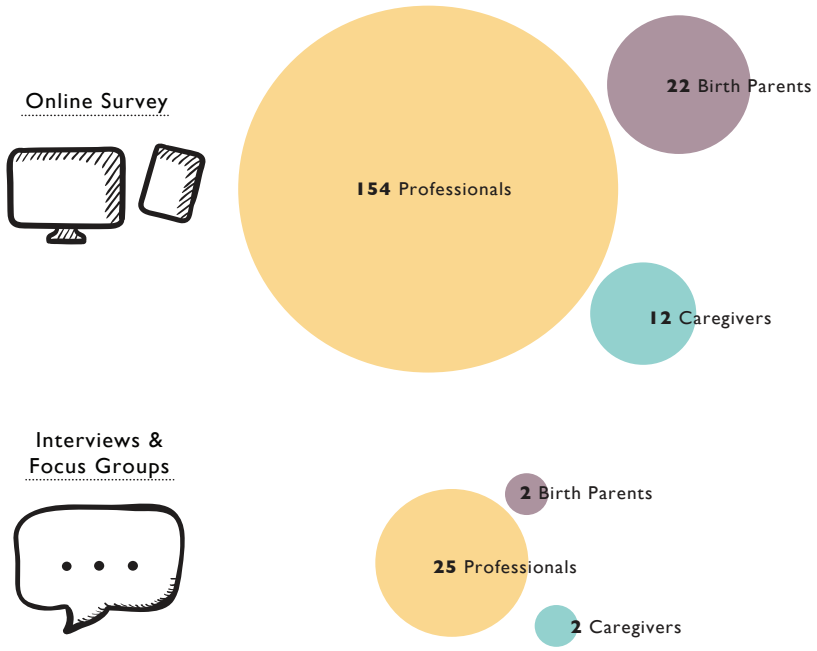
CHILD CHARACTERISTICS	SAFE BABIES	COMPARISON
TOTAL # CHILDREN	**103**	**8,812**
AVG. AGE IN MONTHS (stand. dev.)	33.72 (18.26)	48.34 (22.26)
AVG. # PLACEMENTS (stand. dev.)	2.74 (1.15)	2.90 (1.15)
GENDER		
Male	63 (61%)	4,577 (52%)
Female	40 (39%)	4,235 (48%)
RACE/ETHNICITY		
African American	30 (29%)	3,754 (43%)
Anglo	32 (31%)	1,548 (18%)
Hispanic	31 (30%)	2,824 (32%)
Other	10 (10%)	682 (8%)

EARLY CHILDHOOD INTERVENTION (ECI)

Safe Babies coordinators or CPS staff refer all infants and toddlers to ECI. Of the 29 children in Safe Babies referred to ECI in Tarrant and Dallas counties between January 2020 and April 2021, approximately 66% (n = 19) were enrolled. The remaining 34% were either not eligible to receive services, or had caregivers who declined or withdrew children from services. It should be noted that researchers only collect data from two of the three Dallas County ECI providers and do not yet collect ECI data from Harris County.

SURVEYS, INTERVIEWS & FOCUS GROUPS

Figure 7: Survey, Interview & Focus Group Participants



BIRTH PARENT SURVEY

A total of 22 birth parents completed the birth parent survey. Children of these birth parents had been in foster care for an average of 8.5 months.

CAREGIVER SURVEY

A total of 12 caregivers completed the caregiver survey. Approximately one third had been foster or kinship caregivers for less than a year while others ranged from 2–10 years.

PROFESSIONAL SURVEY

A total of 154 professionals completed the professional survey. Of the professional respondents who indicated the county in which they worked (5 declined to specify), 38% were from Tarrant County, 25% were from Dallas County, and 37% were from Harris County. Respondents included a wide array of child- and family-serving professionals with an average of 6 years' experience in their current role, 14 years' experience in child welfare, and 1.5 years' experience working with Safe Babies.

BIRTH PARENT, CAREGIVER, AND PROFESSIONAL INTERVIEWS AND FOCUS GROUPS

Researchers conducted interviews with two birth parents and two caregivers in Tarrant and Dallas counties and 25 professionals in Tarrant, Dallas and Harris counties from:

- 7 Child Placing Agencies (CPAs)
- 7 legal service entities
- 4 medical/mental health agencies
- 3 Early Childhood Intervention (ECI) agencies
- 3 Court Appointed Special Advocate (CASA) or other agencies

FOSTERING RELATIONSHIPS COPARENTING MODEL

Coparenting Outcomes

The following outcomes relate to the first Core Component of the Safe Babies Program: Fostering Relationships Coparenting Model.

SHORT-TERM OUTCOMES

BIRTH PARENTS FEEL INCREASED SUPPORT

Birth parent interviewees reported feeling supported by Safe Babies staff throughout their case and by caregivers in and outside of visitation with children. Caregiver interviewees reported feeling that Safe Babies helped them better support birth parents through training and by facilitating communication.

> *"I'm sure if I called [Safe Babies Coordinator] right now, [they] would just listen to me and give me advice. But they are not just advocates. I mean, they were sometimes my reason to keep going. Because it's a hard process to go through, especially when you feel like everything is stacked against you. And they tried to move the walls for me if I needed them to. They kind of kept my spirits alive and kept hope in me.*
>
> *– Birth Parent*

> *"[The caregiver] always had that bag packed for any situation, just in case I didn't bring anything, or he ran out, or he needed anything at all. She was always the number one backup. And during the visits—we needed a nose sucker one time. She offered to run and go get one.... She asked me if I wanted her to stay or leave. She supported me way more than I thought that she should or than I expected.*
>
> *– Birth Parent*

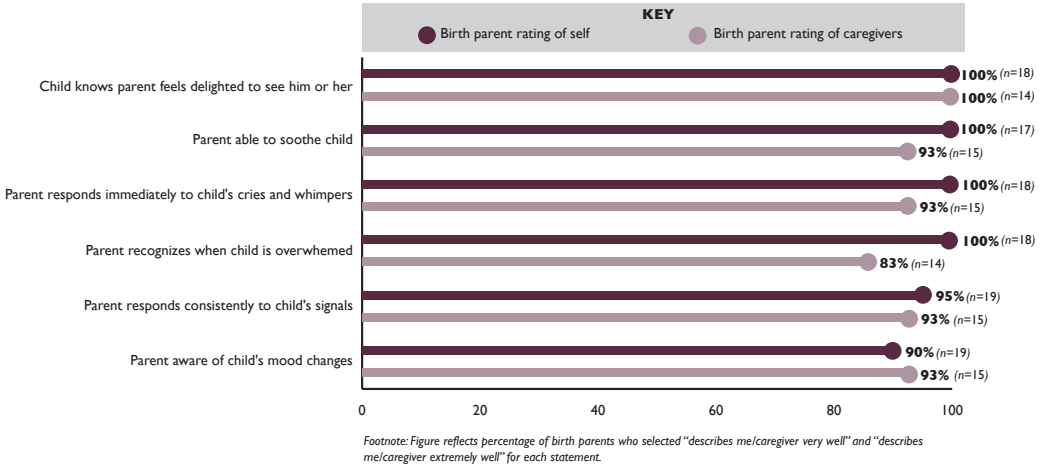
> *"Safe Babies provided some training to help us know how, as foster parents, to optimally support and interact with [his] parents, and to provide the best experience for [him] in terms of visitation and also just support for [him] when we were not at visitation. Of course, [he] was a newborn and if he had been a little bit older and been aware of the way we were speaking about his parents, he would have seen that there was no animosity and that we were very supportive of his parents. I think that much of the point of Safe Babies is to foster a bridge of coordination and support between biological parents and foster parents so that the best decisions and care can be given to the child from both ends.*
>
> *– Caregiver*

BIRTH PARENTS AND CAREGIVERS DEMONSTRATE SENSITIVE PARENTING

Birth parent survey respondents were asked how well sensitive parenting statements described them and how well they described caregivers. The percentage of birth parents who indicated that the statements described them (or caregivers) "very well" or "extremely well" are presented in Figure 8. Birth parents generally rated themselves higher than they rated caregivers, with the exception of the statement "parent is aware of child's mood changes." This finding may reflect the need to increase support for birth parents during coached visitations to help them recognize their child's mood changes (see Appendix Table 6).

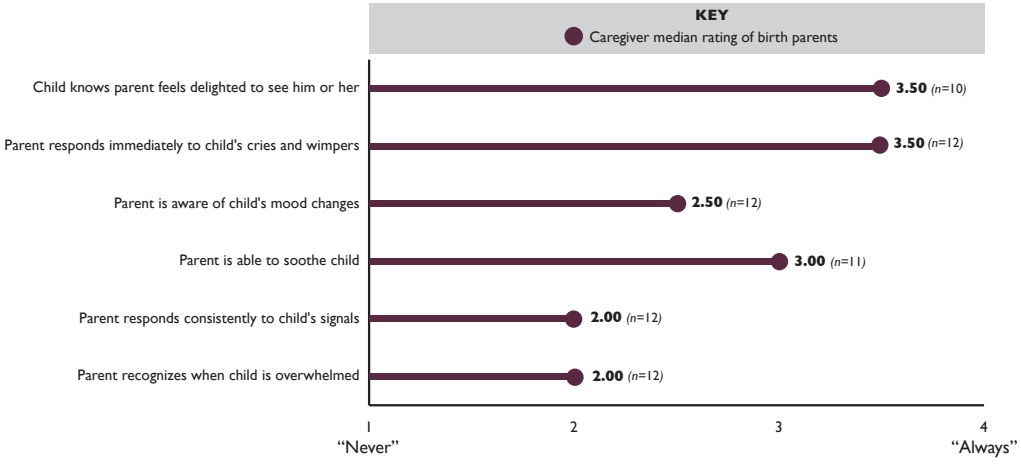
Similarly, caregiver survey respondents were asked how often birth parents engaged in sensitive parenting activities on a scale of 1 (never) to 4 (always). Figure 9 shows that caregiver median ratings of birth parents were high for "child knows parent feels delighted to see him or her" and "parent responds immediately to child's cries or whimpers" (meaning they reported birth parents did these things often). Caregiver median ratings of birth parents were low for "parent responds consistently to child's signals" and "parent recognizes when child is overwhelmed" (meaning they reported birth parents did these things less often). These topics may be worth exploring further with birth parents and caregivers (see Appendix Table 7).

Figure 8: Birth Parent Ratings of Self and Caregivers - Sensitive Parenting



Footnote: Figure reflects percentage of birth parents who selected "describes me/caregiver very well" and "describes me/caregiver extremely well" for each statement.

Figure 9: Caregiver Ratings of Birth Parents - Sensitive Parenting



Footnote: Higher ratings reflect caregiver perception that birth parents do this more often.

BIRTH PARENTS AND CAREGIVERS WORK TOGETHER COLLABORATIVELY

Birth parent and caregiver interviewees reflected on support from Safe Babies to build trust and communication between them. One birth parent and one caregiver noted being "on the same page" for the child.

> *We still are co-parenting, which is amazing. And I do have to say that Safe Babies, I feel they allowed us to get to where we are just because of [the jealousy that previously existed]. And we're on the same page... I just feel like we have a relationship that is very open and honest.*
>
> *– Birth Parent*

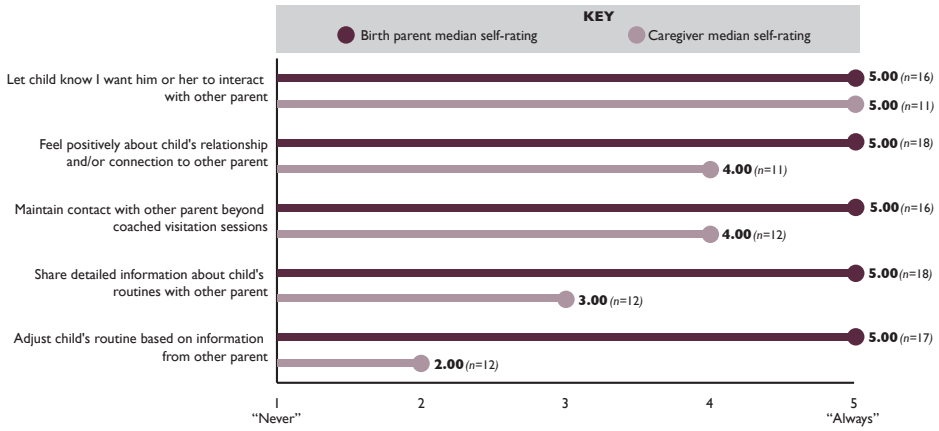
> *For [the birth parent] to still keep in touch with us and still feel like we kept [their] child safe, we attribute that a lot to Safe Babies because... [They were] actually really angry and frustrated at us, and sort of blamed us that [their] child was in care, and any little thing that happened to him it was our fault. Then when Safe Babies came along and really just smoothed over the whole process, it was just a huge transformation even with that. We've not seen that before we were involved with Safe Babies, and so that's the only thing that we can say is they gave us the pointers, and the tips, and the guidance that we needed, and they did that too for bio-parents. So, everybody is on the same page. And it just really helped the child feel so much better about these visits.*
>
> *– Caregiver*

Most professional interviewees said that coparenting relationships between birth parents and caregivers can have a huge impact on child wellbeing. Several professionals also noted the support for coparenting that Safe Babies provides.

> *I think when the adult's and children's worlds are functioning well, children function well. And this program really tends to help build a supportive community for both birth parents and foster parents to be in collaboration and cooperation with one another. I think even if it's not successful and that birth parents can't eventually reunite, I think this context of everyone trying to cooperate and trying to work together, that's when children benefit.*
>
> *– Professional*

Birth parent and caregiver survey respondents rated the extent to which they engaged in coparenting activities from 1 (never) to 5 (always). Figure 10 shows that birth parents and caregivers reflected overall collaboration in nearly every category (see Appendix Table 8). Caregiver median ratings were lower than birth parent median ratings across most categories, especially regarding whether they "share detailed information with the child's birth parents" or "adjust the child's routine based on information from the birth parent." This may indicate a need for caregivers to engage in a more reciprocal coparenting relationship with birth parents. Birth parents and caregivers had the highest median ratings regarding "letting the child know I want him or her to interact with the other parent," reinforcing the theme from interviews that birth parents and caregivers are "on the same page."

Figure 10: Birth Parent & Caregiver Self-Ratings - Coparenting Activities



Footnote: Higher ratings indicate better engagement in coparenting activities.

INTERMEDIATE OUTCOMES

CHILDREN ACHIEVE PERMANENCY WITH FAMILIES

Researchers used DFPS administrative data to compare outcomes for children in foster care whose families participated in Safe Babies (intervention group) with children in foster care whose families did not participate in Safe Babies (comparison group). Table 3 shows the exit status of children in each group as of July 2021. Table 4 shows the exit outcomes for children who exited care in each group. The proportion of children in each exit outcome category was significantly different between groups; $\chi 2(5, N = 6{,}404)=21.50$, $p=.001$ (see Appendix Table 9). Table 4 shows that, of the children that exited care, 51% of children in Safe Babies returned home compared to 27% in the comparison group.

Table 3: In Care vs Exited Care for Safe Babies & Comparison

IN CARE VS EXITED CARE	SAFE BABIES	COMPARISON
TOTAL	**103**	**8,817**
Remain in Foster Care	42 (41%)	2,474 (28%)
Exited Foster Care	61 (59%)	6,343 (72%)

Table 4: Exit Outcomes for Safe Babies & Comparison

EXIT OUTCOMES	SAFE BABIES	COMPARISON
TOTAL EXITED	**61**	**6,343**
Returned Home	31 (51%)	1,694 (27%)
Relative Adoption	3 (5%)	995 (16%)
Non-relative Adoption	12 (20%)	1,444 (23%)
Custody Given to Relatives	15 (25%)	2,142 (33%)
Other	0 (0%)	95 (2%)

Researchers also looked at the time to permanence for children who exited care. The

average time to permanence for children in Safe Babies (M=15.24 months, SD=6.64) was significantly shorter than the average time to permanence for children in the comparison group (M=18.49 months, SD= 9.77), a statistically significant difference; $t(65.23)=-5.36$, $p<.001$ (see Appendix Table 9). When looking only at children who returned home, there were no significant differences in time to permanence between groups; $t(1,723)=1.40$, $p=.161$ (see Appendix Table 9). However, findings related to family reunification and time to overall permanence are promising and should continue to be studied.

FEWER CHILDREN RETURN TO FOSTER CARE

Researchers also compared time to re-entry for those that returned to foster care between groups. There was no significant difference in the proportion of children who re-entered foster care within 6 months ($\chi 2(1,N=176)=0.81$, $p=.367$) or within 12 months ($\chi 2(1,N=176)=0.05$, $p=.830$) between groups (see Appendix Table 9). Researchers will continue to examine re-entry in future program evaluation reports.

Table 5: Return to Foster Care for Safe Babies & Comparison

TIME TO RE-ENTRY	SAFE BABIES	COMPARISON
TOTAL RE-ENTERED	**1**	**175**
Within 6 Months	0	69
Within 12 Months	1	106

LONG-TERM OUTCOMES

CHILDREN INCREASE RESILIENCE

One foster parent interviewee mentioned Safe Babies' support for children to cope during visitations and transitions. While most interviewees did not speak directly to resilience, it was often alluded to when discussing transitions and reunifications. Researchers may add a question to the interview guide that asks interviewees to speak more directly to child resilience.

> *"We've kind of been telling all of the other parents what our routine is after visits to reintroduce the child back into our home.... We've just been trying to take the pointers and the tips that we've learned from Safe Babies and apply them in cases even if it's not ones that Safe Babies is involved with. We notice a huge difference when biological parents are willing to also talk about the foster parents. We see that it makes it more comfortable for the children.*
>
> *– Caregiver*

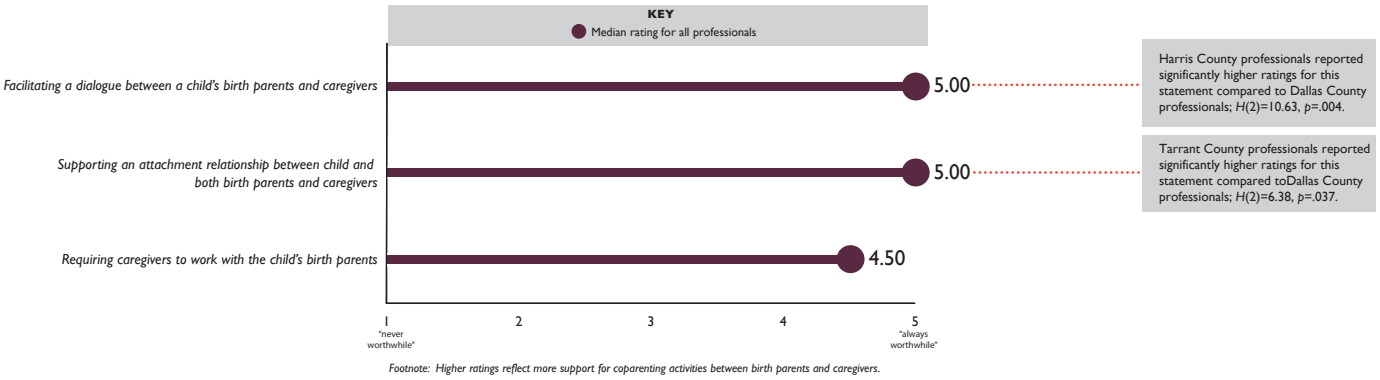
CHILD WELFARE SYSTEM GROWS CAPACITY TO DEVELOP COLLABORATIONS BETWEEN BIRTH PARENTS AND CAREGIVERS

Regarding the capacity of the child welfare system to develop collaborations between birth parents and caregivers, professionals interviewees expressed the need for changes within the system to better support a culture of collaboration.

> *I think that have the capacity to [support coparenting between birth parents and caregivers]. I don't know that they have—I don't know what the right word is, the understanding of how important it is.*
>
> *– Professional*

In parallel to interview data, professional survey respondents rated how often they felt coparenting activities between birth parents and caregivers were worthwhile on a scale from 1 (never worthwhile) to 5 (always worthwhile). The median ratings for each activity ranged from 4.5 to 5, indicating a high proportion of professionals viewed these activities as sometimes or always worthwhile (see Figure 11). When looking at responses by county, Harris County professionals rated "facilitating a dialogue between a child's birth parents and caregivers" significantly higher than Dallas County professionals ($H(2)=10.63$, $p=.004$)and Tarrant County professionals rated "supporting an attachment relationship between child and both birth parents and caregivers" significantly higher than Dallas County professionals ($H(2)=6.38$, $p=.037$). There may be a need to provide additional support for Dallas County professionals on these topics. This shared understanding and support among child welfare professionals is key to developing a culture of collaboration between birth parents and caregivers (see Appendix Tables 10, 11, and 12 for county comparisons).

Figure 11: Professional Beliefs - Birth Parent and Caregiver Coparenting



Footnote: Higher ratings reflect more support for coparenting activities between birth parents and caregivers.

One professional interviewee had the unique perspective of having worked in the child welfare system in another state. They spoke to the impact of a system that supports coparenting between birth parents and caregivers and how meaningful it is to have programs like Safe Babies working to achieve that culture in Texas.

> *From my experience, coming from [another state] to this, it seemed almost like a—something that is almost foreign, as far as, "Oh, you want me to communicate, have a relationship with the biological parents?" Speaking as a foster parent.*
>
> *– Professional*

> *I have honestly been very impressed and excited about Safe Babies coming and introducing their program to [our organization]. I think co-parenting is a huge necessity in foster care. And coming straight from [another state] to Texas, I saw shared parenting a lot with foster families and biological parents. And so, to have a service that is really dedicated to that, I thought, is great.*
>
> *– Professional*

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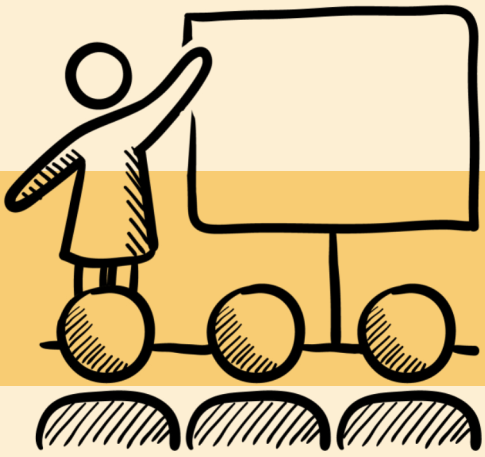
EDUCATION AND TECHNICAL ASSISTANCE



Education & Technical Assistance Outcomes

The following outcomes relate to the second core component of the Safe Babies program: Education and Technical Assistance

SHORT-TERM OUTCOMES

SERVICE PROVIDERS DEMONSTRATE STRONG ALLIANCE

Most professional interviewees reflected a strong alliance to support families. One professional said that Safe Babies provided a space for collaboration where tension and distrust typically exist. Some professionals felt it important for service providers, especially CPAs, to set the tone for caregivers to work with birth parents.

> *"[Safe Babies is] very much aligned in many ways with how we view families and child development, and I do appreciate their systemic lens around a family unit, versus this child as a isolated entity that is separate from the family unit.*
>
> *– Professional*

> *"Safe Babies is really the only place that we willingly enter a case that we know is involved in court because of all the coordination that happens through Safe Babies. Generally, we avoid these with a 10-foot pole because [it's] really is not therapeutic. It's just somebody trying to get access to information. And with Safe Babies, it really does feel like the intention is to be therapeutic.*
>
> *– Professional*

> *"I think, coming from a training perspective, you kind of set that tone, kind of create that culture within the foster parents that we bring on and what that looks like, as far as a relationship with bio parents.*
>
> *– Professional*

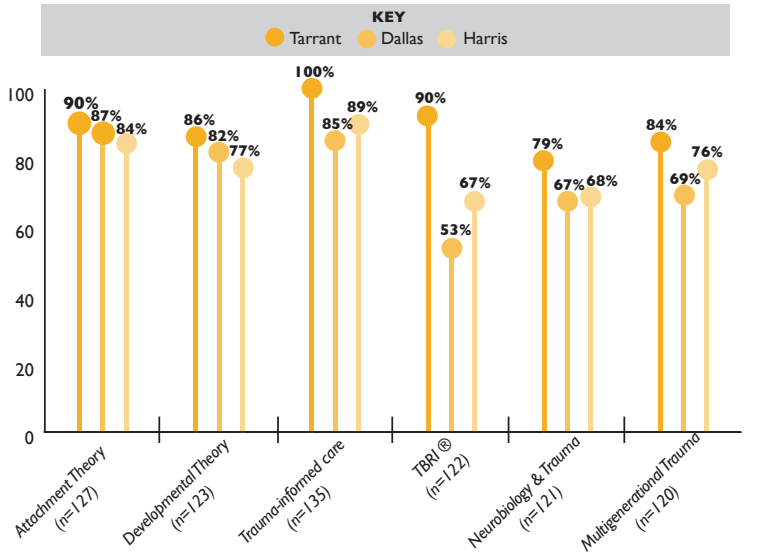
INTERMEDIATE OUTCOMES

STAKEHOLDERS DEMONSTRATE UNDERSTANDING OF RELATIONSHIP BETWEEN ATTACHMENT, DEVELOPMENT, AND PLACEMENT

Professional survey respondents indicated whether they received training on topics related to infants and toddlers in the child welfare system. Since the last reporting period, a follow-up question was added to indicate whether they received each type of training from Safe Babies. Figure 12 shows the percentage of professionals in each county that received each type of training (see Appendix Table 13). Figure 13 shows the percentage of professionals (since the follow-up item was added) who received each training from Safe Babies (see Appendix Table 14). Tarrant County, which ha the longest involvement with Safe Babies, had the highest percentage of professionals trained on each topic. Whether professionals received each training through Safe Babies varied by type of training and county. One professional interviewee tied the training and understanding of these concepts into the overall communication,

coordination, and support that Safe Babies provides.

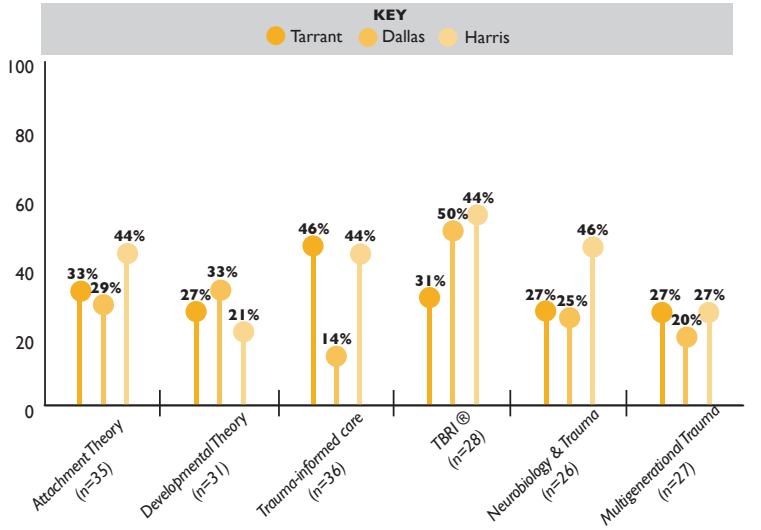
Figure 12: Professional Training by County



Tarrant county, which has had longer involvement with Safe Babies, had a higher percentage of professionals trained on each topic.

Footnote: Numbers below item labels represent the number of professionals in all counties who answered each item.

Figure 13: Professional Training from Safe Babies by County



Whether professionals recieved each type of training from Safe Babies varied by type of training and county.

Footnote: Numbers below each item label represent the number of professionals in all counties who, since the follow-up training question was added, responded to each item.

"So, communication and coordination with the Safe Babies team has always been phenomenal. They're timely. They're professional and responsive. They know their stuff, so knowledgeable in child development and family systems, and very engaged and active in the community services that [this county] has to offer as well—plugged in, as all members of their team. As far as the training, I guess that bleeds into the training, just very informed, very knowledgeable about services, how they work in [this county] and then evidence-based programming and supports to help this population as well. I've just observed that be part of all of what they do.

– Professional

In the professional survey, respondents also demonstrated their understanding of the relationship between attachment, development, and placement when rating their beliefs about birth parents on a scale from 1 (disagree) to 5 (agree). When asked if "children under three years of age can bond with multiple caregivers," the median response for each county was 5, meaning professionals across counties agreed with this statement. When asked if "infants are less affected by maltreatment than older children," the median response for each county was 1, meaning professionals across counties disagreed with this statement. Professional interviewees echoed this understanding about the relationship between attachment, early development, and placement.

> *I would especially say the model they have of involving the foster and biological families. I think it works very well to help a child develop that secure attachment in knowing that, you know, if they've been used to their biological family for a long time...then, they're removed from the home for whatever reason and maybe start developing attachment with the foster family. I think that's okay. But I think knowing that like both of those attachments are important. So it's important to foster both of those and recognize that the goal really is to hopefully reunite them with their families—permanently. [...] Because we also know it's not uncommon for the mom of a child in care to have been in foster care herself or know someone who has been involved in the system. So really working with that family to break the cycle, I think helps reduce the likelihood of generational trauma, of generational issues with attachment.*
>
> *– Professional*

LONG-TERM OUTCOMES

DEVELOPMENTALLY INFORMED POLICIES GUIDE TREATMENT OF INFANTS AND TODDLERS IN FOSTER CARE

Professional interviewees were asked whether the child welfare system currently takes into account the development and attachment needs of young children in foster care. Most professional interviewees identified this as an area for growth, especially when it came to transitions (e.g., removals, visitations, placement changes). Some indicated that the child welfare system was making strides when individual programs or professionals who understood these concepts were involved, but that in an overworked system, it is hard to find consistency. Researchers will continue to study this outcome as the program continues.

> *From I think they try to, but I think sometimes that their workload and with what they have to deal with on a day-to-day basis sometimes…makes it more difficult.*
>
> *– Professional*

> *I think certain parts of the child welfare system do a great job of recognizing trauma and attachment and stuff, but I feel like in practice, our caseworkers, and especially our CPS investigators, do not take that into account when they make removal decisions and visitation decisions and monitored return decisions.*
>
> *– Professional*

•••

COORDINATION OF CARE

Coordination of Care Outcomes

The following outcomes relate to the third Core Component of the Safe Babies program: Coordination of Care.

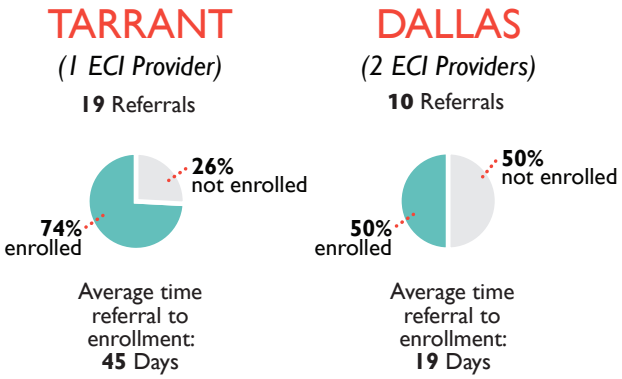
SHORT-TERM OUTCOMES

CHILDREN'S DEVELOPMENTAL NEEDS ARE IDENTIFIED EARLY

Early Childhood Intervention (ECI) provides a critical and timely intervention for infants and toddlers experiencing developmental delays or disabilities. Safe Babies cultivates a close relationship with ECI in each county to ensure children have support for their physical, emotional, and cognitive development as they create secure attachment with caregivers.

Figure 14 shows ECI referral and enrollment rates for children in Safe Babies in Tarrant and Dallas counties between January 1, 2020 and April 1, 2021 (see Appendix Table 15). The average time to enrollment for Tarrant County was 45 days, which was the same as the last reporting period. The average time to enrollment for Dallas County was 19 days. It is worth noting that this is the first report to include Dallas County ECI data and that data is only included from two out of three Dallas County ECI providers. Researchers also do not yet collect data from Harris County ECI providers.

Figure 14: ECI Enrollment for Tarrant & Dallas Counties



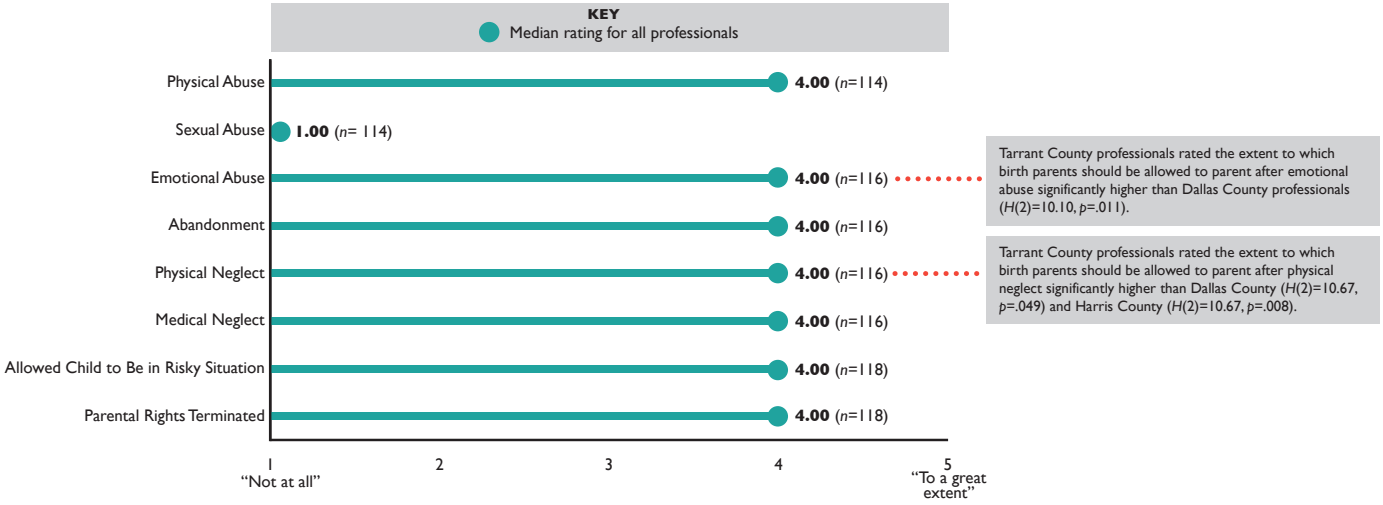
One professional interviewee expressed difficulty connecting families with ECI during the pandemic and the impact that it had on children with disabilities in foster care. As the COVID-19 pandemic continues, it will be critical to maintain quality and timely supports for children in foster care who have developmental delays or disabilities.

> *"COVID's impacted our ability to be in the homes with our little ones and families. [...] So, that's just from the ECI side. We also haven't been able to deliver the amount of services that we are accustomed to delivering. So, for babies with developmental delays and disabilities already, for whatever reason, they're getting not what we believe is enough in-service delivery the last year. As far as CPS referrals, there was a period of time where we stopped receiving CPS referrals. Now, I will say, in the last few months, that has picked up significantly. So, that's positive, but there was a period during the pandemic where it's almost like it just stopped.*
>
> *– Professional*

BIRTH PARENTS AND SERVICE PROVIDERS STRENGTHEN PARTNERSHIPS

Professional survey respondents rated the extent to which birth parents should be allowed to parent given a variety of circumstances from 1 (not at all) to 5 (to a great extent). Figure 15 shows the median responses for all counties. Professionals felt that birth parents should be allowed to parent across most items, with the exception of sexual abuse. In looking at differences between counties, Tarrant County professionals were significantly more likely to agree that birth parents should be allowed to parent in when emotional abuse had occurred than Dallas County professionals. Tarrant County professionals were also significantly more likely to agree that birth parents should be allowed to parent when physical neglect had occurred than Dallas or Harris County professionals. Tarrant County has had the longest involvement with Safe Babies, which could contribute to more supportive beliefs about birth parents. These supportive attitudes are a critical element of partnership between birth parents and service providers. (See Appendix Tables 16, 17, 18, 19 and 20 for county comparisons.)

Figure 15: Professional Beliefs - Birth Parents Parenting After Maltreatment



Footnote: Higher ratings indicate more support for birth parents being allowed to parent when abuse or neglect has occured.

Professionals across counties said that historically, the motivation for caregivers to adopt children has been strong among child welfare professionals and caregivers alike, but that this culture is changing. Professionals noted that caregivers and service providers are becoming more supportive of birth parents reunifying with their children when possible, with some attributing shift to Safe Babies.

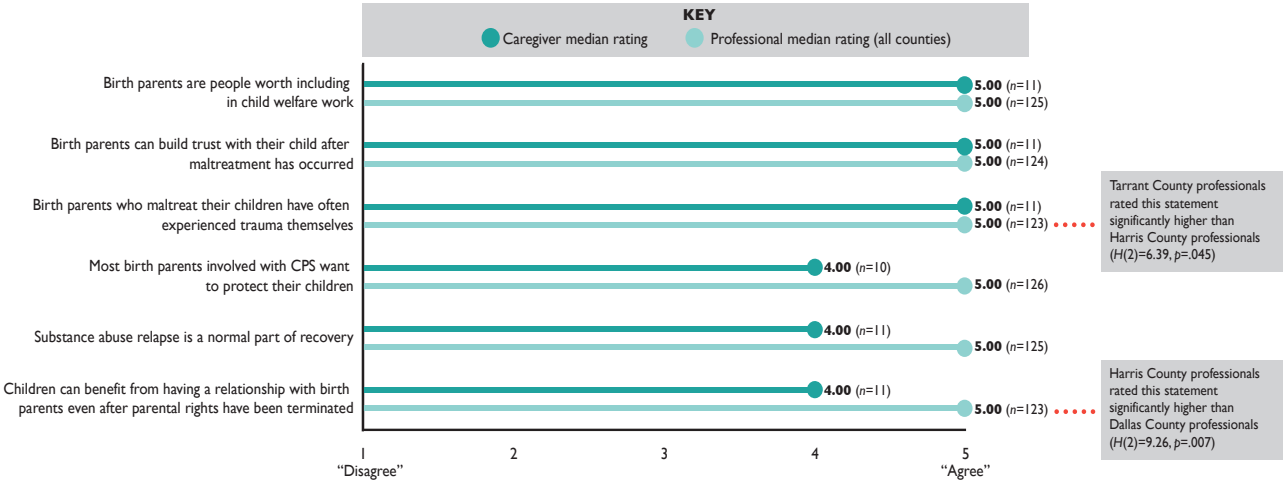
> *"I think 10 years ago, more than 10 years ago, the focus was on getting kids in adoption, and now the focus is not. The focus is getting them with family members and reunifying.*
> *– Professional*

> *"They don't seem to be adoption motivated, where a lot of placements are adoption motivated for these babies, and so, I don't wanna say that they're necessarily hoping the parents fail, but it can come across as that. With Safe Babies, it's more of just a pouring into somebody else. I'm not here trying to take your children and keep them. I want you to succeed. What can I do to help you succeed?*
> *– Professional*

BIRTH PARENTS EXPERIENCE LESS STIGMA AROUND ACCESSING SERVICES

Professional and caregiver survey respondents rated the extent to which they agreed with positive statements about birth parents from 1 (disagree) to 5 (agree). Figure 16 shows that professionals and caregivers generally agreed with positive statements about birth parents, with a higher median (more agreement with positive statements) reported for professionals than caregivers on three items. In looking at differences between counties, Tarrant County professionals rated the statement "birth parents who maltreat their children have often experienced trauma themselves" significantly higher than Harris County professionals ($H(2)=6.39$, $p=.045$). In addition to Tarrant County having the longest involvement with Safe Babies, Tarrant County survey respondents also reported the highest percentage of professionals with trauma-related training (see Figure 12). Harris County professionals rated the statement "children can benefit from having a relationship with birth parents even after parental rights have been terminated" significantly higher than Dallas County professionals ($H(2)=9.26$, $p=.007$). (See Appendix Tables 21, 22 and 23 for county comparisons).

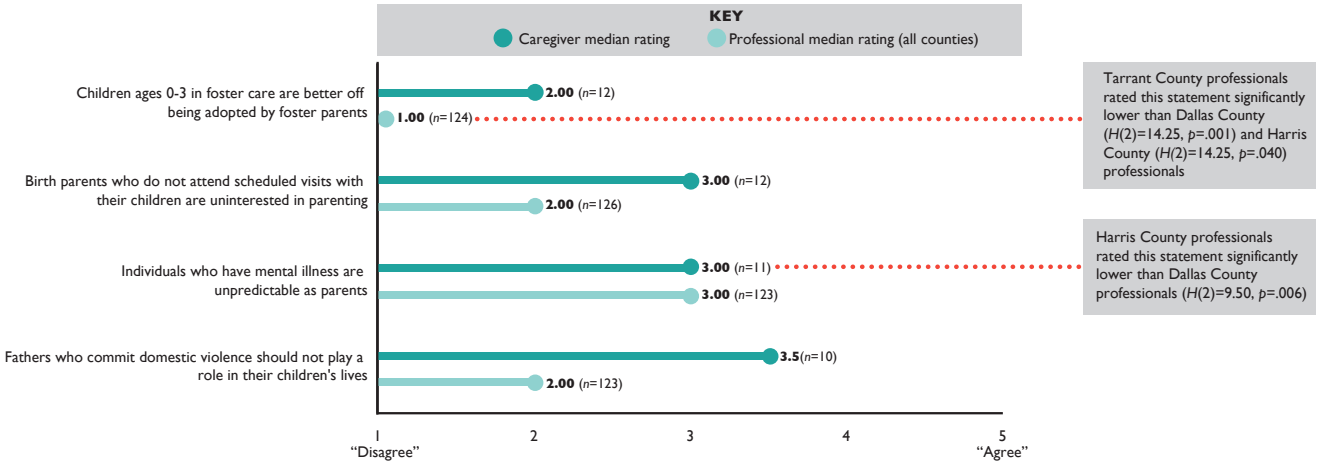
Figure 16: Caregiver & Professional Positive Beliefs About Birth Parents



Footnote: Higher ratings reflect more positive perceptions of birth parents.

Professional and caregiver survey respondents also rated the extent to which they agreed with negative statements about birth parents on the same scale. Figure 17 shows that professionals had a lower median rating (less agreement with negative statements) than caregivers across most categories, especially regarding "fathers who commit domestic violence should not be allowed to parent." Tarrant County professionals rated the statement "children ages three and younger are better off being adopted by foster parents" significantly lower than both Dallas County ($H(2)=14.25$, $p=.001$) and Harris County ($H(2)=14.25$, $p=.040$) professionals. Both professionals and caregivers had a median rating of 3 for the statement "individuals who have mental illness are unpredictable as parents" and Harris County professionals rated this statement significantly lower than Dallas County professionals ($H(2)=9.50$, $p=.006$). Professionals and caregivers may need more support in working with parents who have mental health issues and caregivers may need support to better understand domestic violence issues (see Appendix Tables 24, 25 and 26 for county comparisons).

Figure 17: Caregiver & Professional Negative Beliefs About Birth Parents



Footnote: Lower ratings reflect less negative perceptions of birth parents.

Birth parent interviewees said that Safe Babies met them where they were, helping them access whatever information or services they needed. One birth parent survey respondent echoed this support from Safe Babies when facing difficulty during the COVID-19 pandemic.

> *I wanted more contact or knowledge or information on my son in between visits. [The Safe Babies coordinator] actually initiated or helped set up an email address so that me and the foster mom could at least email. And that's kinda how it started. We started emailing every day, and she gave me updates. Safe Babies did help me out with my phone bill. They helped me get into treatment. Really, Safe Babies was the only help I was given. I mean, huge support. Anything I needed. They were right there.*
>
> *– Birth Parent*

> *COVID-19 has definitely impacted my CPS case. I didn't get to see my child for weeks, and it's been extremely hard getting a job. Safe Babies has helped me in so many ways and helped me with a lot of resources.*
>
> *– Birth Parent*

INTERMEDIATE OUTCOMES

CHILDREN'S PHYSICAL AND MENTAL HEALTH IMPROVES

Most interviewee responses related to child health and wellbeing centered around better communication between all parties because of Safe Babies, resulting in improved attachment, service coordination, and transitions (i.e. during visitations).

> *With the way that we were able to communicate, it helped [my child] in so many different ways. There was no animosity. There was no uncomfortableness. I mean, any kind of visit we had was all happy, comfortable, very welcoming. I was already informed of anything and everything before the visit, so it didn't take away from the visit. It was like I was living his life with him every day. [...] I got to spend my time with [him] knowing his quirks or having that experience and bonding with him during that time. And anything new that he did during the week or the day before, I already knew about, excited about. I think, helped him progress because it was just another constant.*
>
> *– Birth Parent*

> *He would bring stuff to us, and then we would encourage him to go bring it to mom and play with mom. And we could just see a huge transformation in the child, and then at the end of visits, there were no tears; it was a huge difference from before when he didn't have Safe Babies involved.*
>
> *– Caregiver*

> *[Safe Babies] just helps to bridge a gap between the foster parents and the biological parents, which I think is great for everybody as far as the coordination of services and communication.*
>
> *– Professional*

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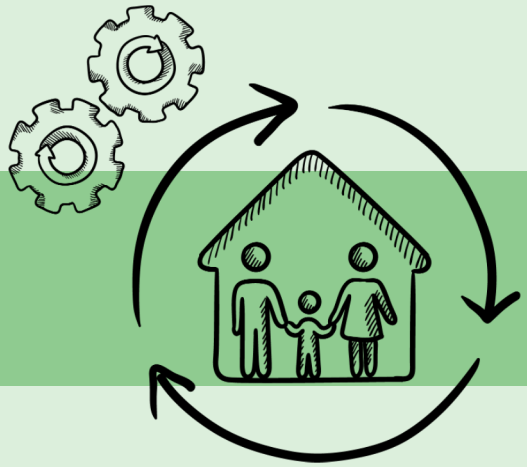
CONTINUOUS EVALUATION



Continuous Evaluation

As Safe Babies continues in each current county and expands to new counties, the need for continuous evaluation remains. First3Years is committed to ongoing evaluation of the Safe Babies program and making quality improvements to ensure the program is successful and can be effectively replicated in other Texas communities. Additionally, as the number of families and counties served continues to grow, it will take time to examine progress toward intermediate and long-term outcomes.

Utilizing quantitative and qualitative data from several different sources for this evaluation, the Texas Institute for Child and Family Wellbeing maintains a flexible plan for data collection and analysis. Figure 18 outlines the overall data collection process and Figure 19 depicts the yearly reporting structure for this ongoing evaluation.

Figure 18: Ongoing Data Collection

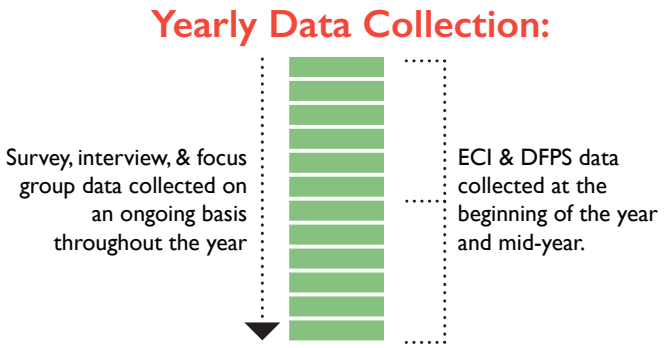
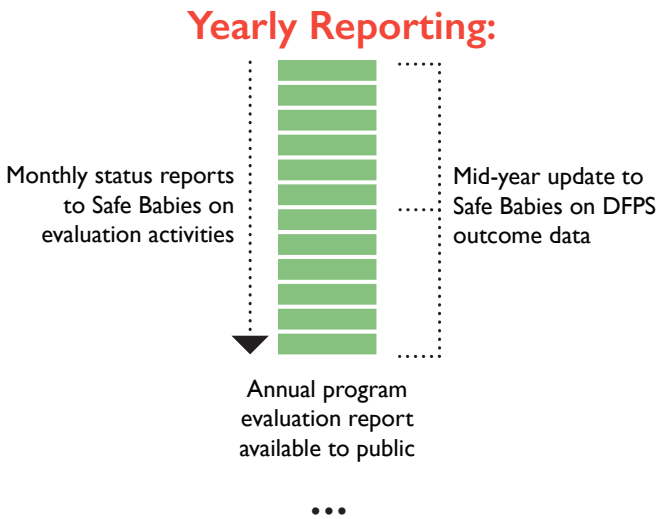


Figure 19: Reporting to Safe Babies & Public



Discussion

PROGRAM STRENGTHS AND OPPORTUNITIES

COPARENTING

Caregivers reported that training from Safe Babies helped them better support birth parents. Birth parents, in turn, indicated feeling more supported by caregivers. Additionally, professionals demonstrated an understanding of the impact that a coparenting relationship between birth parents and caregivers can have on a child's wellbeing. Opportunities for growth related to coparenting include helping caregivers engage in a more reciprocal coparenting relationship with birth parents (by seeking birth parent input). Professionals involved with Safe Babies indicated overall support for coparenting between birth parents and caregivers and expressed a need to strengthen this supportive culture within the broader child welfare system. Additionally, a higher percentage of children in Safe Babies returned home than the comparison group and time to permanence was significantly less for children compared to the comparison group. These findings are promising and should continue to be examined along with other intermediate and long-term outcomes.

EDUCATION AND TECHNICAL ASSISTANCE

Professionals demonstrated a strong alliance to support families involved in child welfare, and one indicated that Safe Babies made collaboration possible where there was typically tension or distrust between parties. Most professionals across counties indicated they had been trained on topics relevant to serving young children in foster care, though not all received this training directly from Safe Babies. As Safe Babies expands, it is promising to see this strong alliance and baseline level of training on attachment, development, and trauma across counties. Professional interviewees and survey respondents also demonstrated their understanding of the relationship between early development, attachment, and placement, with differences between counties that may be worth focusing on to further strengthen this alignment and understanding. More broadly, professionals reported that the child welfare system had room for growth in supporting the development and attachment needs of young children, especially when it came to removals, visitations, and placement changes.

COORDINATION OF CARE

Findings suggest the COVID-19 pandemic posed major difficulties for both families accessing services and the child welfare professionals serving them. Birth parents reported feeling supported by Safe Babies in navigating hurdles related to the pandemic. Professionals reflected positive perceptions about birth parents being allowed to parent after abuse or neglect had occurred, with the exception of sexual abuse, a complex topic that may need more focused attention. Professionals said the historically adoption-driven narrative in child welfare was changing to one of support for family reunification when possible. Caregivers and professionals reported positive beliefs about birth parents, understanding the benefits of supporting the parent-child relationship, that substance use disorder recovery is a process, and that birth parents have often experienced trauma themselves. Caregivers and professionals had room for improvement in their perceptions of parents with mental illness and caregivers may need more support in understanding domestic violence issues. Birth parents, caregivers, and professional interviewees echoed the sentiment that better communication between all parties leads to improved child wellbeing.

LIMITATIONS

As was previously mentioned, it is important to note the small sample sizes for data collected from individual measures or items within these measures. Smaller sample sizes reduce the power of a study and increase the margin of error. Data can appear more skewed, and it may be harder to detect significant findings. Researchers used non-parametric tests where data was highly skewed and reported on medians for most items as opposed to means (which are not as resistant to outliers). The Appendix details the type of test used for each measure or item in the report. Given that the sample sizes for individual measures or items within measures were small, researchers interpret findings with caution. Researchers expect that as the program population grows, findings will become more generalizable to the population of families involved in child welfare.

Additionally, participation in this evaluation is voluntary and the population of participants in the study may look different than parents, caregivers, and professionals who choose not to participate, which leaves the potential for response bias.

Lastly, some of the long term outcomes reflect an overall culture shift that is difficult to uniquely attribute to the Safe Babies program. However, in recognizing Safe Babies as a leader and key player within this broader culture change, researchers can continue to examine the role of the program in achieving this overall shift.

CONTINUOUS EVALUATION

Since the evaluation partnership began, an increase in the number of families served and expansion to new counties have allowed researchers to collect more data and conduct more meaningful analysis. Researchers expect this trend to continue as Safe Babies continues on this trajectory of growth. Over time, researchers will be able to more thoroughly examine progress toward long-term outcomes and an increase in the sample size of families served will result in findings that are more generalizable to the overall population of infants, toddlers, and families involved in the child welfare system.

RECOMMENDATIONS

Researchers provide the following recommendations based on evaluation findings:

1) Safe Babies should continue working with caregivers and professionals to cultivate more positive perceptions about birth parents. This will further reduce stigma experienced by birth parents involved in the child welfare system.

2) Safe Babies should continue to align stakeholders around a culture of support for coparenting between birth parents and caregivers and for meeting the attachment and development needs of young children in foster care.

3) First3Years should continue to grow the capacity of the Safe Babies program in order to serve more families in existing counties and reach families in new counties. This supports the long-term goal of achieving a more trauma-informed and developmentally appropriate response to infants, toddlers and their families in the child welfare system.

CONCLUSION

Findings show that Safe Babies is achieving short-term outcomes and making significant progress toward intermediate and long-term outcomes. Birth parents, caregivers, and professionals have a strong understanding and alignment around coparenting between birth parents and caregivers, supporting the development and attachment needs of children, and coordinating services and care that support the overall wellbeing of children.

Safe Babies is also playing a key role in the culture shift toward support for coparenting, attachment and development needs of young children, and family reunification within the broader child welfare system. These areas of focus can be difficult to achieve in the face of workload and capacity challenges, but Safe Babies and all parties who support this culture shift should continue working to achieve these changes system-wide. Not only do they have the potential to impact overall child and family wellbeing, but in theory can also alleviate system capacity issues with improved reunification and re-entry outcomes.

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Appendix

Table 6: Birth Parent Ratings of Self and Caregivers - Sensitive Parenting (Fig. 8)

SENSITIVE PARENTING STATEMENTS	DESCRIBES ME VERY OR EXTREMELY WELL		DESCRIBES CAREGIVER VERY OR EXTREMELY WELL	
	n	Freq. (%)	n	Freq. (%)
Child knows parent feels delighted to see him or her	18	18 (100%)	14	14 (100%)
Parent able to soothe child	17	17 (100%)	15	14 (93%)
Parent responds immediately to child's cries and whimpers	18	18 (100%)	15	14 (93%)
Parent recognizes when child is overwhelmed	18	18 (100%)	14	12 (86%)
Parent responds consistently to child's signals	19	18 (95%)	15	14 (93%)
Parent aware of child's mood changes	19	17 (90%)	15	93% (14)

Table 7: Caregiver Ratings of Birth Parents - Sensitive Parenting (Fig. 9)

SENSITIVE PARENTING STATEMENTS	n	MEDIAN
Child knows parent feels delighted to see him or her	10	3.50
Parent able to soothe child	11	3.00
Parent responds immediately to child's cries and whimpers	12	3.50
Parent recognizes when child is overwhelmed	12	2.00
Parent responds consistently to child's signals	12	2.00
Parent aware of child's mood changes	11	2.50

Table 8: Birth Parent and Caregiver Ratings - Coparenting Activities (Fig. 10)

COPARENTING STATEMENTS	BIRTH PARENTS		FOSTER PARENTS	
	n	Median	n	Median
Let child know I want him or her to interact with other parent	16	5.00	11	5.00
Feel positively about child's relationship and/or connection with other parent	18	5.00	11	4.00
Maintain contact with other parent beyond coached visitations	16	5.00	12	4.00
Share detailed information about child's routines with other parent	17	5.00	12	3.00
Adjust child's routine based on information from other parent	18	5.00	12	2.00

Table 9: All Outcomes for Safe Babies and Comparison (Table 5)

OUTCOME CATEGORY	TEST STATISTICS		
	Chi-Square Tests		
	Value	**df**	**Sig.**
Exit Outcomes	21.50	5	.001*
Re-Entry within 6 Months	0.812	1	.367
Re-Entry within 12 Months	0.046	1	.830
	Independent Samples T-Tests		
	t	**df**	**Asymp. Sig.**
Months to Permanence	-5.36	65.23	<.001*
Months to Return Home	1.40	1,723	.161

*Indicates results were statistically significant

Table 10: Professional Beliefs About Coparenting - Kruskal-Wallis H Tests (Fig. 11)

COPARENTING ACTIVITIES WORTH SUPPORTING	TARRANT		DALLAS		HARRIS		KRUSKAL-WALLIS TEST STATISTICS		
	n	**Mean Rank**	**n**	**Mean Rank**	**n**	**Mean Rank**	**Kruskal-Wallis H**	**df**	**Asymp. Sig.**
Facilitating dialogue between child's birth parents and caregivers	50	61.02	30	47.97	39	67.95	10.63	2	.005*
Supporting attachment relationship between child and both birth parents and caregivers	50	64.66	30	50.95	39	60.99	6.38	2	.041*
Requiring caregivers to work with the child's birth parents	50	64.38	30	52.40	39	60.63	3.09	2	.213

*Indicates results were statistically significant

Table 11: Faciliating a Dialogue Between Child's Birth Parents and Caregivers-Pairwise Comparisons of Counties (Fig. 11)

SAMPLE 1 – SAMPLE 2	TEST STAT.	STD. ERROR	STD. TEST STAT.	SIG.	ADJ. SIG.
Dallas - Tarrant	-13.05	5.86	-2.23	.026	.078
Dallas - Harris	-19.98	6.16	-3.24	.001	.004*
Tarrant - Harris	-6.93	5.42	-1.28	.201	.604

*Indicates results were statistically significant
(Each row tests null hypothesis that Sample 1 and Sample 2 distributions are the same. Asymptotic significances (2-sided tests) displayed. Significance level is .05. Significance values have been adjusted by the Bonferroni correction for multiple tests.)

Table 12: Supporting Attachment Relationship Between Child and Both Birth Parents and Caregivers - Pairwise Comparisons of Counties (Fig. 11)

SAMPLE 1 – SAMPLE 2	TEST STAT.	STD. ERROR	STD. TEST STAT.	SIG.	ADJ. SIG.
Dallas - Harris	-10.04	5.75	-1.75	.081	.243
Dallas - Tarrant	-13.71	5.47	-2.51	.012	.037*
Harris - Tarrant	3.67	5.06	0.73	.468	<.001

*Indicates results were statistically significant
(Each row tests null hypothesis that Sample 1 and Sample 2 distributions are the same. Asymptotic significances (2-sided tests) displayed. Significance level is .05. Significance values have been adjusted by the Bonferroni correction for multiple tests.)

Table 13: Professional Training by County (Fig. 12)

TYPE OF TRAINING	ALL PROFESSIONALS		TARRANT		DALLAS		HARRIS	
	n*	**Freq. (%)**	**n**	**Freq. (%)**	**n**	**Freq. (%)**	**n**	**Freq. (%)**
Attachment Theory	127	111 (87%)	52	47 (90%)	31	27 (87%)	43	36 (84%)
Developmental Theory	123	101 (82%)	50	43 (86%)	28	23 (82%)	44	34 (77%)
Trauma-informed Care	135	125 (93%)	54	54 (100%)	33	28 (85%)	47	42 (89%)
TBRI ®	122	89 (73%)	50	45 (90%)	32	17 (53%)	39	26 (67%)
Neurobiology and Trauma	121	88 (73%)	52	41 (79%)	30	20 (67%)	38	26 (68%)
Multigenerational Trauma	120	93 (78%)	49	41 (84%)	29	20 (69%)	41	31 (76%)

*One professional did not indicate the county in which they worked, so n's for each county do not total n for all professionals

Table 14: Professional Training from Safe Babies by County (Fig. 13)

TYPE OF TRAINING	ALL PROFESSIONALS		TARRANT		DALLAS		HARRIS	
	n	**Freq. (%)**	**n**	**Freq. (%)**	**n**	**Freq. (%)**	**n**	**Freq. (%)**
Attachment Theory	35	13 (37%)	12	4 (33%)	7	2 (29%)	16	7 (44%)
Developmental Theory	31	8 (26%)	11	3 (27%)	6	2 (33%)	14	3 (21%)
Trauma-informed Care	36	14 (39%)	13	6 (46%)	7	1 (14%)	16	7 (44%)
TBRI ®	28	12 (43%)	13	4 (31%)	4	2 (50%)	11	6 (55%)
Neurobiology and Trauma	26	9 (35%)	11	3 (27%)	4	1 (25%)	11	5 (46%)
Multigenerational Trauma	27	7 (26%)	11	3 (27%)	5	1 (20%)	11	3 (27%)

Table 15: ECI Enrollment for Tarrant and Dallas Counties (Fig. 14)

COUNTY	REFERRED	ENROLLED	NOT ENROLLED	AVG. DAYS TO ENROLL
Tarrant	19	14 (74%)	5 (26%)	45
Dallas	10	5 (50%)	5 (50%)	19
Combined	**29**	**19 (66%)**	**10 (34%)**	**25**

Table 16: Professional Beliefs About Allowing Birth Parent to Parent After Maltreatment - Kruskal-Wallis H Tests (Fig. 15)

MALTREATMENT CATEGORIES	TARRANT		DALLAS		HARRIS		KRUSKAL-WALLIS TEST STATISTICS		
	n	Mean Rank	n	Mean Rank	n	Mean Rank	Kruskal-Wallis H	df	Asymp. Sig.
Physical Abuse	49	65.48	27	49.09	37	51.54	7.57	2	.023*
Sexual Abuse	48	60.76	27	46.22	38	59.91	4.89	2	.087
Emotional Abuse	49	67.92	28	47.64	38	52.84	10.10	2	.006*
Abandonment	49	61.99	28	54.66	38	55.32	1.51	2	.470
Physical Neglect	49	68.46	28	51.54	38	49.28	10.67	2	.005*
Medical Neglect	49	62.27	28	55.57	38	54.29	1.95	2	.376
Allowed Child to be in Risky Situation	50	67.68	28	52.25	39	52.72	7.04	2	.030*
Parental Rights Terminated	50	65.94	28	49.21	39	57.13	5.46	2	.065

*Indicates results were statistically significant

Table 17: Physical Abuse - Pairwise Comparisons of Counties (Fig. 15)

SAMPLE 1 – SAMPLE 2	TEST STAT.	STD. ERROR	STD. TEST STAT.	SIG.	ADJ. SIG.
Dallas - Harris	-2.45	7.31	-0.34	.738	1.000
Dallas - Tarrant	-16.39	6.92	-2.37	.018	.054
Harris - Tarrant	-6.93	5.42	-1.28	.201	.604

Results were not significant once adjusted.
(Each row tests null hypothesis that Sample 1 and Sample 2 distributions are the same. Asymptotic significances (2-sided tests) displayed. Significance level is .05. Significance values have been adjusted by the Bonferroni correction for multiple tests.)

Table 18: Emotional Abuse - Pairwise Comparisons of Counties (Fig. 15)

SAMPLE 1 – SAMPLE 2	TEST STAT.	STD. ERROR	STD. TEST STAT.	SIG.	ADJ. SIG.
Dallas-Harris	-5.20	7.37	-0.71	.480	1.000
Dallas-Tarrant	-20.28	7.01	-2.89	.004	.011*
Harris -Tarrant	15.08	6.39	2.36	.018	.055

*Indicates results were statistically significant.
(Each row tests null hypothesis that Sample 1 and Sample 2 distributions are the same. Asymptotic significances (2-sided tests) displayed. Significance level is .05. Significance values have been adjusted by the Bonferroni correction for multiple tests.)

Table 19: Physical Neglect - Pairwise Comparisons of Counties (Fig. 15)

SAMPLE 1 – SAMPLE 2	TEST STAT.	STD. ERROR	STD. TEST STAT.	SIG.	ADJ. SIG.
Harris -Dallas	2.26	7.40	0.31	.760	1.000
Harris -Tarrant	19.18	6.42	2.99	.003	.008*
Dallas-Tarrant	-16.92	7.04	-2.40	.016	.049*

*Indicates results were statistically significant.
(Each row tests null hypothesis that Sample 1 and Sample 2 distributions are the same. Asymptotic significances (2-sided tests) displayed. Significance level is .05. Significance values have been adjusted by the Bonferroni correction for multiple tests.)

Table 20: Risky Situation - Pairwise Comparisons of Counties (Fig. 15)

SAMPLE 1 – SAMPLE 2	TEST STAT.	STD. ERROR	STD. TEST STAT.	SIG.	ADJ. SIG.
Dallas-Harris	-0.47	7.58	-0.06	.951	1.000
Dallas-Tarrant	-15.43	7.22	-2.14	.033	.098
Harris -Tarrant	14.96	6.53	2.29	.022	.066

Results were not significant once adjusted
(Each row tests null hypothesis that Sample 1 and Sample 2 distributions are the same. Asymptotic significances (2-sided tests) displayed. Significance level is .05. Significance values have been adjusted by the Bonferroni correction for multiple tests.)

Table 21: Professional Positive Beliefs - Kruskal-Wallis H Tests (Fig. 16)

POSITIVE STATEMENTS	TARRANT		DALLAS		HARRIS		KRUSKAL-WALLIS TEST STATISTICS		
	n	Mean Rank	n	Mean Rank	n	Mean Rank	Kruskal-Wallis H	df	Asymp. Sig.
Birth parents are people worth including in child welfare work	50	63.28	31	63.00	43	61.23	0.41	2	.814
Birth parents can build trust with their child after maltreatment has occurred	51	64.75	31	58.15	41	61.49	0.97	2	.616
Birth parents who maltreat their children have often experienced trauma themselves	48	65.75	31	63.69	43	55.17	6.39	2	.041*
Most birth parents involved with CPS want to protect their children	51	61.74	31	60.87	43	66.03	0.73	2	.686
Substance abuse relapse is a part of recovery	51	61.52	31	60.37	42	65.26	0.71	2	.703
Children can benefit from having a relationship with birth parents even after parental rights have been terminated	50	61.73	29	47.64	43	70.58	9.26	2	.010*

*Indicates results were statistically significant

Table 22: Birth Parents who Maltreat their Children Have Often Experienced Trauma Themselves - Pairwise Comparisons of Counties (Fig. 16)

SAMPLE 1 – SAMPLE 2	TEST STAT.	STD. ERROR	STD. TEST STAT.	SIG.	ADJ. SIG.
Harris -Dallas	8.52	4.88	1.75	0.08	.242
Harris -Tarrant	10.58	4.35	2.43	0.02	.045*
Dallas-Tarrant	-2.06	4.77	-0.43	0.67	1.000

*Indicates results were statistically significant.
(Each row tests null hypothesis that Sample 1 and Sample 2 distributions are the same. Asymptotic significances (2-sided tests) displayed. Significance level is .05. Significance values have been adjusted by the Bonferroni correction for multiple tests.)

Table 23: Children Can Benefit from Relationship with Birth Parents After Parental Rights Terminated - Pairwise Comparisons of Counties (Fig. 16)

SAMPLE 1 – SAMPLE 2	TEST STAT.	STD. ERROR	STD. TEST STAT.	SIG.	ADJ. SIG.
Dallas-Tarrant	-14.09	7.33	-1.92	.054	.163
Dallas-Harris	-22.94	7.54	-3.04	.002	.007*
Tarrant-Harris	-8.85	6.53	-1.36	.175	.525

*Indicates results were statistically significant.
(Each row tests null hypothesis that Sample 1 and Sample 2 distributions are the same. Asymptotic significances (2-sided tests) displayed. Significance level is .05. Significance values have been adjusted by the Bonferroni correction for multiple tests.)

Table 24: Professional Negative Beliefs - Kruskal-Wallis H Tests (Fig. 17)

NEGATIVE STATEMENTS	TARRANT		DALLAS		HARRIS		KRUSKAL-WALLIS TEST STATISTICS		
	n	Mean Rank	n	Mean Rank	n	Mean Rank	Kruskal-Wallis H	df	Asymp. Sig.
Children ages 0-3 in foster care are better off being adopted by caregivers	50	49.75	31	76.06	42	66.20	14.25	2	.001*
Birth Parents who do not attend scheduled visits with their children are uninterested in parenting	51	65.00	31	64.37	43	59.64	0.63	2	.731
Individuals who have mental illness are unpredictable as parents	50	60.49	30	76.85	42	51.74	9.26	2	.009*
Fathers who commit domestic violence should not play a role in their children's lives	49	58.30	31	58.39	42	67.54	2.12	2	.346

*Indicates results were statistically significant

Table 25: Children Ages 0-3 in Foster Care are Better of Being Adopted by Caregivers - Pairwise Comparisons of Counties (Fig. 17)

SAMPLE 1 – SAMPLE 2	TEST STAT.	STD. ERROR	STD. TEST STAT.	SIG.	ADJ. SIG.
Tarrant-Harris	-16.45	6.65	-2.48	.013	.040*
Tarrant-Dallas	26.32	7.26	3.62	<.001	.001*
Harris -Dallas	9.86	7.52	1.31	.190	.569

*Indicates results were statistically significant.
(Each row tests null hypothesis that Sample 1 and Sample 2 distributions are the same. Asymptotic significances (2-sided tests) displayed. Significance level is .05. Significance values have been adjusted by the Bonferroni correction for multiple tests.)

Table 26: Individuals with Mental Illness are Unpredictable as Parents (Fig. 17)

SAMPLE 1 – SAMPLE 2	TEST STAT.	STD. ERROR	STD. TEST STAT.	SIG.	ADJ. SIG.
Harris -Tarrant	8.75	7.16	1.22	.222	.665
Harris -Dallas	25.11	8.18	3.07	.002	.006*
Tarrant-Dallas	16.36	7.90	2.07	.038	.115

*Indicates results were statistically significant.
(Each row tests null hypothesis that Sample 1 and Sample 2 distributions are the same. Asymptotic significances (2-sided tests) displayed. Significance level is .05. Significance values have been adjusted by the Bonferroni correction for multiple tests.)

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SAFE BABIES
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