FLORIDA'S Early Childhood COURT

Improving outcomes for infants and toddlers in Florida's dependency court

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Center for Prevention & Early Intervention Policy
www.cpeip.fsu.edu

In collaboration with Florida's statewide multidisciplinary team

April 2017

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Florida's Early Childhood Court

Florida has a long and impressive history of progressive model court initiatives, pioneering the nation's first drug courts and unified family courts. Likewise, Florida was the birthplace of the nation's first Early Childhood Court, the Miami Child Well-Being Court, which inspired national expansion of Zero to Three's Safe Babies Court Teams. Building upon these model programs, best practices research, and the compelling new science of adversity, Florida has embarked on a collaborative statewide Early Childhood Court initiative.

Early Childhood Court addresses child welfare cases involving children under the age of three. It is a problem-solving court – where legal, societal, and individual problems intersect. Problem-solving courts seek to address not only the legal issues but also the underlying non-legal issues that will benefit the parties and society as well.

Problem-solving courts can also be seen as differentiated court case management whereby cases are triaged based on the level of complexity of the issues, and the most complex, service-intensive cases are heard on a special docket before a specific judicial officer. This specialized docket provides greater judicial oversight through more frequent judicial reviews and a multidisciplinary team approach. The team works in a non-adversarial manner to link the parties to treatment and services, and closely monitor the participants' compliance.

The legacy of unhealed adverse childhood experiences is seen every day in dependency court, as formerly abused or neglected children are now the abusing or neglecting parent. Fortunately, this multigenerational cycle of trauma and maltreatment can be interrupted with a systemic shift toward "therapeutic jurisprudence," a reframing of the judicial system to promote a more effective approach to altering the trajectory for maltreated children and their families.

The goal of Florida's Early Childhood Court is to improve child safety and well-being, heal trauma and repair the parent/child relationship, expedite permanency, prevent recurrence of maltreatment, and stop the intergenerational cycle of abuse/neglect/violence. To that end, Florida's Early Childhood Court has 15 specific core components, described in detail throughout this document.

1. Judicial leadership
2. Trauma lens
3. Central role of infant mental health specialist & child-parent psychotherapy
4. Continuum of behavioral health services
5. Collaborative court team
6. Community coordinator
7. Cross agency training
8. Developmental support for the child
9. Parent education and support
10. Placement stability and concurrent planning
11. Monthly family team meetings
12. Parent-child contact (family time / visitation)
13. Coparenting
14. Evaluation
15. Funding and sustainability

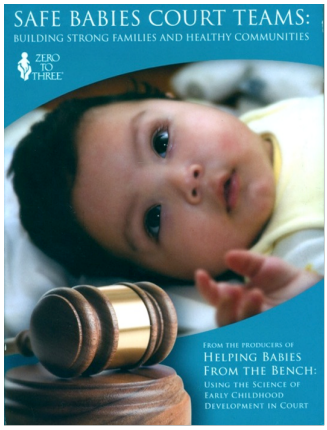
Florida's Early Childhood Court began when Florida State University's Center for Prevention and Early Intervention Policy was awarded the Early Childhood Comprehensive Systems grant on Trauma & Toxic Stress and partnered with the judicial branch's Office of Court Improvement. The grant enabled pilot Early Childhood Court teams to develop in Escambia and Pasco Counties, based on best practices learned from Miami's Child Well-Being Court Model (the first in the nation) and Zero to Three's successful Safe Babies Court Team. The purpose of the pilots was to establish an integrated system of care addressing trauma and child well-being for very young maltreated children involved with the judicial system. FSU's role was to expand awareness of trauma and toxic stress, facilitate linkages between the early childhood systems and the judiciary, and expand evidence based interventions to improve outcomes for infants, toddlers, and their families.

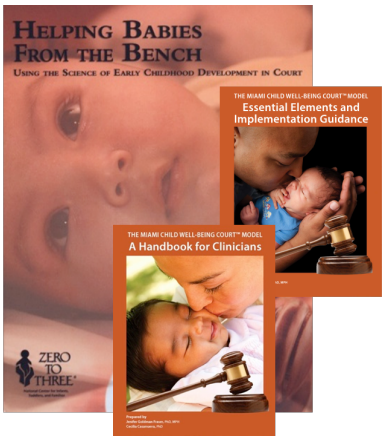
There is substantial momentum to expand Early Childhood Court throughout the state. Understanding of both the vulnerability and the opportunity for changing the developmental trajectory for maltreated children has inspired dependency judges and local coalitions in more than twenty of Florida's sixty-seven counties to begin Early Childhood Court. Most counties are in the exploration and installation stages of implementation, and several are in the initial implementation stage; all are eager to expand best practices and deeply committed to improving outcomes for young children in dependency courts.

Stages of Implementation

- **Exploration** – During the Exploration Stage, readiness is assessed by an implementation team. At the end of this stage, a decision is made to proceed with implementation of an evidence-based program.
- **Installation** – The function of the Installation Stage is to acquire or repurpose the resources needed to do the work ahead.
- **Initial Implementation** – Initial Implementation is the time when the innovation is being used for the first time.
- **Full Implementation** – Full Implementation is reached when 50% or more of the intended practitioners, staff, or team members are using an effective innovation with fidelity and good outcomes.

Source: The National Implementation Research Network, FPG Child Development Institute, University of North Carolina, Chapel Hill





Recently, Florida's Early Childhood Court Initiative has increased its capacity for expansion and implementation. On March 9, 2015, Florida's Court Improvement Program was notified that it had been chosen along with five other jurisdictions to receive a training and technical assistance grant from Zero to Three's Quality Improvement Center for Research-Based Infant-Toddler Court Teams (QIC-CT), the Center for the Study of Social Policy, the National Council of Juvenile and Family Court Judges, and RTI International. In addition to training and technical assistance for all participating Early Childhood Court sites, the grant includes an evaluation component for both process evaluation and outcome assessment, as well as the provision of a Zero to Three statewide, state-level coordinator position to be housed with the Court Improvement Program.

The goals of the QIC-CT are to: strengthen and enhance the capacity of the courts, child welfare agencies and related child serving organizations in the demonstration sites to achieve safety, permanency, and well-being for infants and toddlers in the child welfare system; and create momentum for collaborative approaches meeting the developmental needs of infants and toddlers in the child welfare system. The QIC-CT will disseminate best practices and findings from the experiences with each site, including identification of practices that are transferable to state and local child welfare systems across the United States. The demonstration sites, which were selected through a rigorous review process, include:

- The Florida Court Improvement Program, State of Florida
- New Haven/Milford Safe Babies Court Teams, Connecticut
- The Judiciary, State of Hawaii, Honolulu, Hawaii
- Polk County Safe Babies Court Team, Des Moines, Iowa
- Forrest County Safe Babies Court Team, Hattiesburg, Mississippi
- Eastern Band of Cherokee Indians, Cherokee, North Carolina

In addition, Florida's Early Childhood Court Initiative continues to be supported in the following ways:

- Florida State University's Center for Prevention and Early Intervention Policy continues to coordinate the statewide Early Childhood Court effort to link early childhood systems with the judiciary.
- The Court Improvement Program continues to provide support to the judges and serve as liaisons to the circuits for technical assistance and training needs.
- The Florida Association of Infant Mental Health and the Center for Prevention and Early Intervention Policy provide linkages with trained clinicians and state and national consultants for guidance.
- The Department of Children and Families has supported a statewide all-sites meeting to "kick-off" the state's work with Zero to Three's Quality Improvement Center for Research-Based Infant-Toddler Court Teams.
- Florida's community-based care lead agencies continue to partner with Early Childhood Court teams to identify community coordinators and Early Childhood Court resources.
- Many resources are available to guide replication of the Miami Child Well-Being Model including a book, an implementation guide, and a handbook for clinicians. Also, see the *Helpful Resources* section of this document.

Need and Opportunity for Systemic Change

ADE

Ade's parents, as adults, led troubled lives which included chronic substance abuse, suicide attempts and mental illness, and domestic violence. Her mother, as a child, was raised in an alcoholic family and was sexually abused beginning at the age of 13.

On the day after Ade was born, the Florida child abuse hotline received a report alleging that her mother tried to strangle the hospital nurse and was mentally unstable. From that day, until the day Ade was eleven months old, Ade lived with five different families in five different homes, including a shelter home, two foster homes, her parents' home, and nonrelative caregiver's home. She attended at least three different child care centers. By the time she was two, Ade had been removed from her parents' home twice and her case was heard before five different judicial officers.

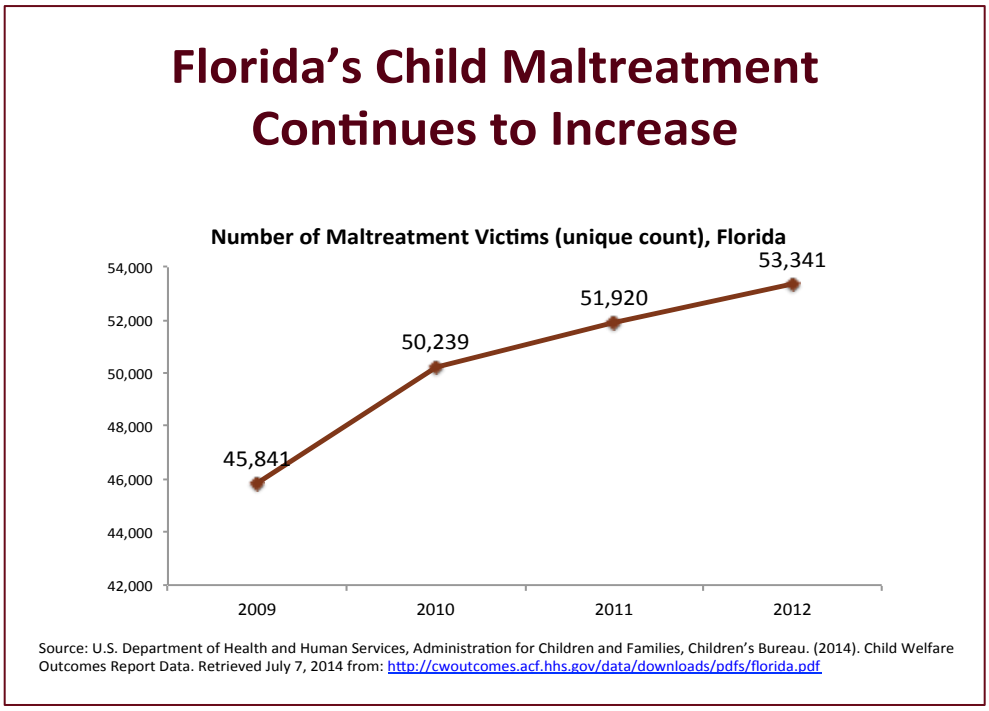
The true story of Ade illustrates the intergenerational cycle of trauma, the impact of early adversity, and the critical system reform needed to provide attachment, stability, and swift permanency for our youngest and most vulnerable abused and neglected children.

There is compelling research on the devastating consequences of early adverse experiences. The landmark Adverse Childhood Experiences (ACE) study [1] clearly illustrates that the effects of untreated early adversity exacerbate over the life cycle resulting in: learning, emotional, and behavior problems [2] during school age; unhealthy adult behaviors such as smoking and substance abuse; adult depression and anxiety; and, impairment due to mental and physical health problems. The more adverse experiences in childhood, the greater the likelihood of lifelong problems.[3]

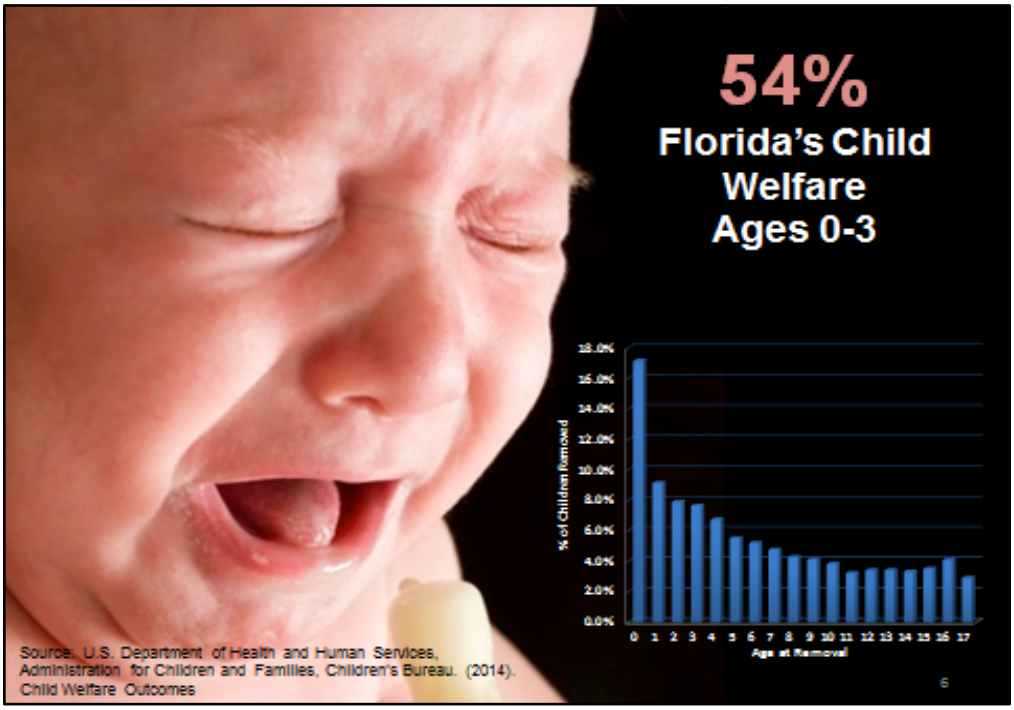
The multigenerational legacy of early adversities are seen every day in our judicial system. Critical opportunities to intervene have been missed in mitigating the toxic impact of chronic stress and trauma. Advances in the science of adversity invite us to rethink our traditional practices to achieve substantially greater outcomes than current efforts. The time has come to support fundamental shifts in policy and practice. Florida's Early Childhood Court Initiative seeks to create system change at both the state and local levels to improve the immediate and long-term well being of our most vulnerable young children and families

Need For Change

Infants and toddlers most vulnerable in child welfare. Florida's rates of child maltreatment have continued to increase from 45,841 in 2009 to 53,341 in 2012. See below.



The majority (54.3%) of children entering out-of-home care are age 5 or under; babies under age one comprise the largest group (17.8%).[4]



In January 2015, the number of active cases of infants and toddlers ages 0-3 in out of home care was 11,341.

11,342 Active Florida Cases

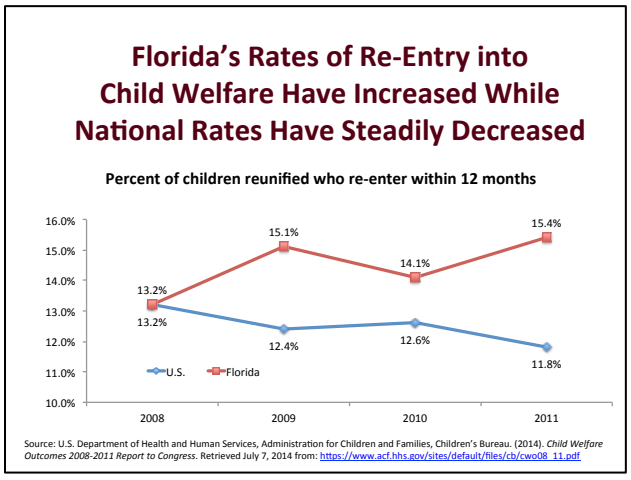
For Children Ages 0-3, as of January 2015

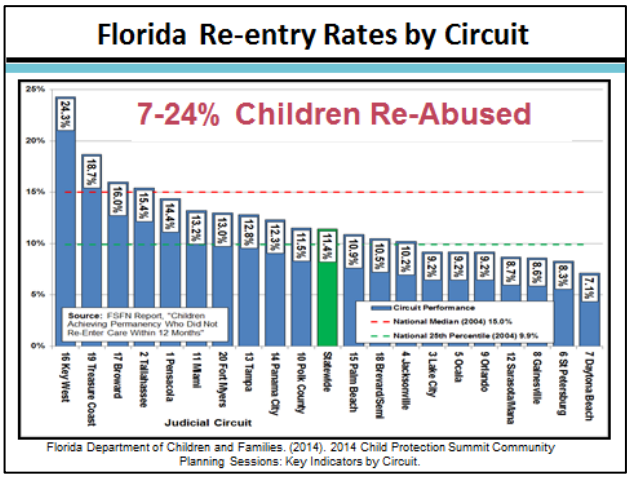
County	# Cases Ages 0-3	County	# Cases Ages 0-3	County	# Cases Ages 0-3	County	# Cases Ages 0-3
Escambia	306	Clay	110	Gilchrist	10	Jackson	35
Okaloosa	216	Duval	341	Levy	11	Washington	10
Santa Rosa	86	Nassau	23	Union	6	Palm Beach	656
Walton	42	Citrus	103	Orange	531	Monroe	45
Franklin	4	Hernando	124	Osceola	164	Broward	1,196
Gadsden	16	Lake	137	Hardee	24	Brevard	357
Jefferson	4	Marion	254	Highlands	60	Seminole	155
Leon	104	Sumter	23	Polk	391	Indian River	55
Liberty	2	Pasco	296	Miami-Dade	1,236	Martin	48
Wakulla	5	Pinellas	611	DeSoto	26	Okeechobee	29
Columbia	58	Flagler	33	Manatee	200	St. Lucie	235
Dixie	1	Putnam	14	Sarasota	185	Charlotte	93
Hamilton	10	St. Johns	57	Hillsborough	1,218	Collier	156
Lafayette	1	Volusia	362	Bay	162	Glades	2
Madison	1	Alachua	176	Calhoun	14	Hendry	28
Suwannee	15	Baker	14	Gulf	10	Lee	403
Taylor	12	Bradford	12	Holmes	14	Total	11,342

Source: The Florida Dependency Court Information System (FDCIS), 1/5/2015

Maltreatment at an early age is related to poor developmental outcomes.[5] A 2013 study by the American Academy of Pediatrics reports childhood exposure to parental violence and psychological distress is associated with delayed developmental milestones.[6] National data show 38-65% of infants and toddlers encountered by the child welfare system have delays[7] and up to 82% of maltreated infants have attachment problems.[8] Over 80% of children aging out of foster care have received a psychiatric diagnosis prior to age 18.[9] Nearly one-third of foster care alumni reported being re-traumatized while in foster care.[10]

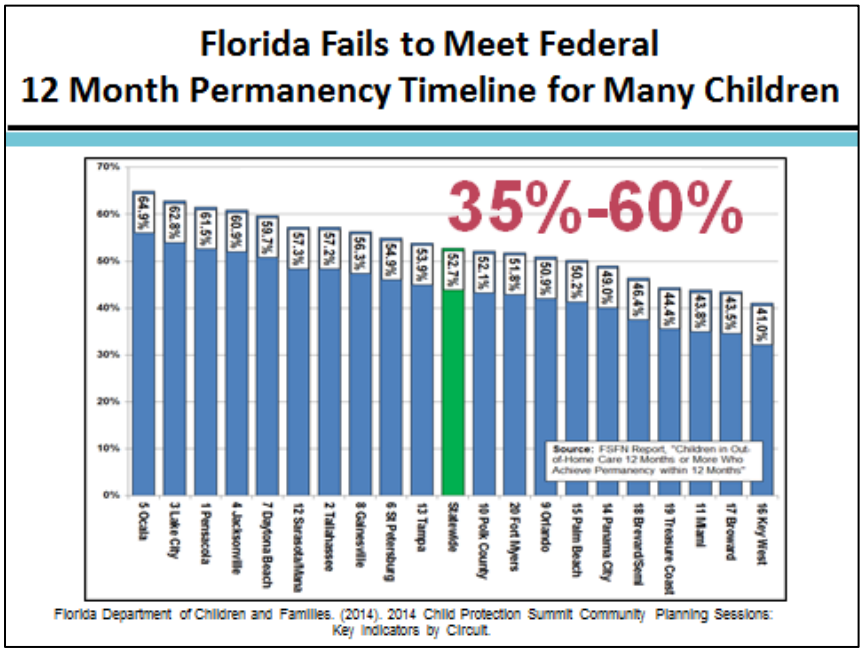
Re-abuse. Florida's rate of re-entry into child welfare has increased while national rates have steadily decreased.[11]



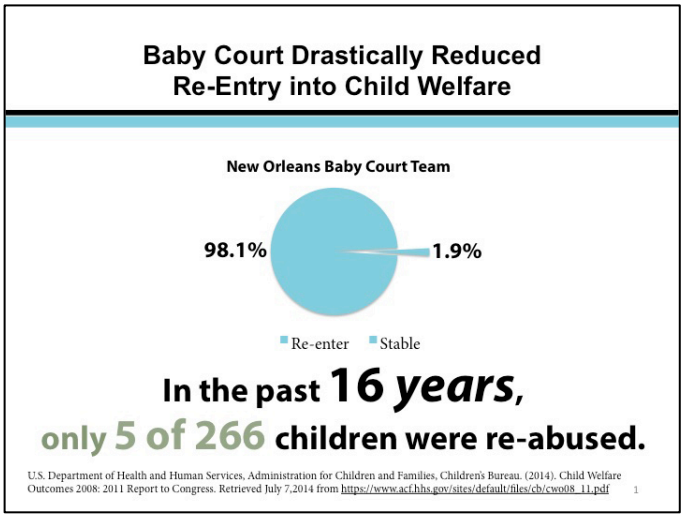


Majority of child fatalities are children under age 5. A review by Casey Family Programs of Florida's 2013 child fatalities documented that **90% of the sample of deceased children were under the age of five and 55% of deaths were of children from birth to age one**. "Parental substance abuse, chronic mental health problems and domestic violence were common factors in families of children who died due to suspected maltreatment."[12]

Permanency. Data show that many of Florida fails to meet the federal 12-month permanency timeline for many children.



Opportunity for Systemic Change

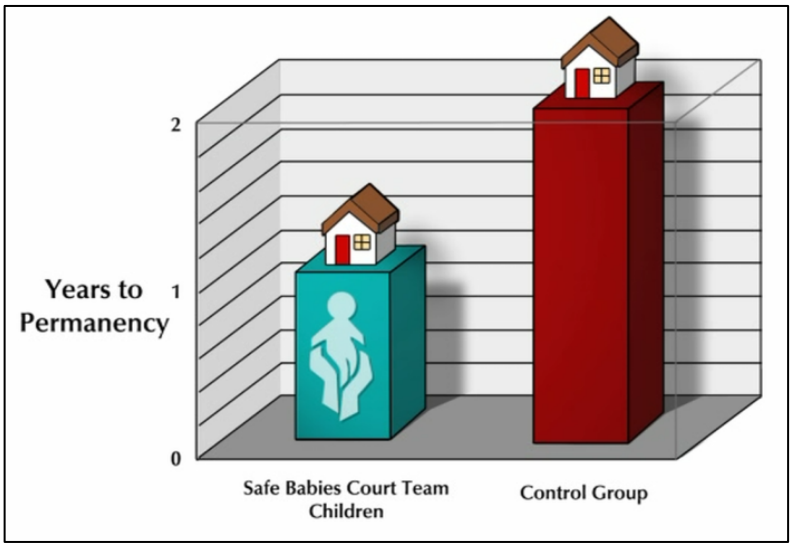


Findings from Early Childhood Court teams. Findings have shown significant improvements in decreasing time to permanency and dramatically reducing re-entry into child welfare. The New Orleans' Early Childhood Court had only 5 re-entries out of 266 children in almost 16 years, a substantial difference than Florida's current high recurrence rate of 15.1% (about 7,500 children) for just one year.[13]

Similarly, a 2009 evaluation of Safe Babies Court Teams reported that 99.05% of infants and toddlers served were protected from further maltreatment.[14]

Regarding permanency, a comparison of children served by the Safe Babies Court Teams approach (n=298) with a matched sample of children included in the National Survey of Child and Adolescent Well-Being (n=511) found that the children served by the Safe Babies Court Teams across four sites:

- reached permanency two to three times faster;
- exited the foster care system approximately one year earlier;
- were more likely to reach permanency with a member of their biological family;
- exited most frequently through reunification (38%). (Adoption was the most typical exit for the comparison group at 41%); and
- were placed with family members at higher rates (62.4% of Court Teams children versus 37.7% of the comparison group).[15]



In 2014 the Safe Babies Court Teams Project was added to the California Evidence-Based Clearinghouse for Child Welfare with a scientific rating of 3 signifying promising research evidence, high child welfare system relevance, and a child welfare outcome of permanency (http://www.cebc4cw.org/program/safe-babies-court-teams-project/). The next phase of research will examine the long-term impact of the Safe Babies Court Teams on outcomes of safety, permanency and wellbeing.

Cost effectiveness. In addition, *Economics for the Public Good* evaluated the cost effectiveness of the Safe Babies Court Teams on the basis of one positive outcome: expedited permanency.[16] Economics for the Public Good found that:

- The average direct cost is $10,000 per child, which is similar to or lower than those found in other early childhood interventions.
- Short-term savings generated by the earlier exits from foster care are estimated at an average of $7,300 per child. In other words, the Court Teams' reduced costs of foster care placements alone cover two-thirds of the average costs per child.
- The Court Teams are able to leverage substantial in-kind resources–for every grant dollar, Zero to Three has generated another dollar of in-kind support.[17]
- Children involved with ZTT Court Teams access more services than the comparison group. In particular, Court Teams' children were significantly more likely to receive a developmental screening (92% v. 25%), health care visit (94% v. 76%), and dental visit (29% v. 18%).

In summary, the Safe Baby Court Team approach offers an opportunity to substantially improve outcomes for our most vulnerable infants and toddlers in Florida's child welfare system.

Florida's Child Welfare System is Well Positioned for Innovative Approaches

Florida is well poised for success having embraced the science of adverse childhood experiences and brain development, built capacity for infant mental health services for infants and toddlers, invested in evidence-based interventions, galvanized funding, and linked early childhood systems with child welfare systems with a goal of creating a statewide system of trauma-informed Early Childhood Court teams. Florida's new partnership with QIC-CT will greatly enhance Florida's efforts to expand and sustain this initiative. In addition, all three branches of Florida government are aligned for this work.

Florida's problem-solving courts and family courts. The judicial branch has a long history of supporting problem-solving courts. Florida is home to the first problem-solving court in the country. Currently, there are over 200 problem-solving courts in Florida including, but not limited to, 102 drug courts, 21 veterans courts, and 26 mental health courts. In addition, Florida's family courts have undergone reform over the past few decades, codified in four Florida Supreme Court opinions – striving to uphold justice and accountability, while at the same time supporting healing and resilience. Most recently, one of the court's steering committees published a court tool kit regarding trauma and child development.

Florida's Department of Children and Families (DCF) and the community-based care agencies. DCF is one of the nation's first states to be granted a Title IV-E waiver to strengthen safeguards and state accountability for achieving child safety, the timely resolution of permanency, and to better address the complex needs of children and families served. The waiver requires states to be accountable for performance in achieving safety, permanency and well-being. In 2011, reauthorization of Title IV-B also required state agencies (DCF) to address trauma. DCF's Quality Parenting Initiative seeks to enhance the capacity of foster parents and biological parents to keep children safe while also support development and optimal well-being. In addition, a new practice model is being implemented statewide, which will provide assessment tools for safety, family functioning, risk, and caregiver protective capacities.

DCF contracts with grassroots coalitions called community-based care (CBCs) agencies in an innovative, privatized redesign of Florida's child welfare system. Each CBC is well integrated in its home community and seeks community alliances and local providers to ensure safety, well-being, and permanency for the vulnerable children in their care.

Florida's statutes. The 2014 legislative session brought sweeping changes to Florida's child welfare system. The legislature identified nine specific child welfare outcomes. Many of the stated outcomes directly link to the components of Early Childhood Court.

Child Protection and Child Welfare Outcomes

It is the goal of the Department to protect the best interest of children by achieving the following outcomes in conjunction with the community-based care lead agency, community-based subcontractors, and the community alliance:

1. Children are first and foremost protected from abuse and neglect.
2. Children are safely maintained in their homes, if possible and appropriate.
3. Services are provided to protect children and prevent their removal from their home.
4. Children have permanency and stability in their living arrangements.
5. Family relationships and connections are preserved for children.
6. Families have enhanced capacity to provide for their children's needs.
7. Children receive appropriate services to meet their educational needs.
8. Children receive services to meet their physical and mental health needs.
9. Children develop the capacity for independent living and competence as an adult.

Source: Florida Statutes, 409.986 (2)

In addition, the legislature included in law: "A lead agency must serve dependent children through services that are supported by research or are best child welfare practices. The agency may also provide innovative services, including, but not limited to, family-centered, cognitive-behavioral, trauma-informed interventions designed to mitigate out-of-home placements."[18]

Comprehensive Gap Analysis. In response to the Casey Family Programs review, former DCF Secretary Jacobo recommended that a comprehensive gap analysis be conducted by the CBCs with special attention to services for children with disabilities, or who live in a household where substance abuse, mental health issues, or domestic violence are suspected—key factors highlighted in the report. The gap analysis would reflect whether comprehensive, integrated, intense, and high quality programs are available for high-risk children and their families. To be effective in treating high-risk families, a continuum of evidenced-based prevention and intervention services should be available in every community to help support their safety and child-parent.

CAPTA Law Requiring Developmental Linkages for Child Welfare. The high incidence of unmet needs and the potential benefits of early intervention for children encountering the child welfare system was so compelling that the federal government enacted the Child Abuse Prevention and Treatment Act (CAPTA, 2003) to ensure better access to Part C early intervention services. All verified abuse cases of children under age 3 are required to be referred to Part C for a developmental screen. Florida's Early Intervention System under Part C of the Federal IDEA legislation is administered through the Florida Department of Health, Early Steps State Office.

Trauma Informed Care. Parents involved in the child welfare system often have histories of trauma and unfortunately their young children are also often exposed to trauma. This intergenerational transmission of adverse childhood experiences and trauma exposure can be ameliorated through the provision of appropriate trauma-focused, evidence-based services. In 2013, Florida was awarded an Early Childhood Comprehensive Systems (ECCS) grant on Trauma & Toxic Stress to FSU. To meet the requirements of the grant, the Trauma Informed Care Workgroup was formed under the Florida Children and Youth Cabinet to identify effective practices to mitigate trauma and toxic stress and determine possibilities for meaningful systemic change. A website has been created to build awareness of trauma informed systems across Florida's agencies: http://floridatrauma.org/

Florida's Title IV-E waiver requires states to be accountable for performance in child well-being, which is defined as "families having the capacity to provide for their children's needs, children having educational opportunities and achievements appropriate to their abilities, and children receiving physical and mental health services adequate to meet their needs." Reauthorization of Title IV-B also requires state agencies to address trauma. CAPTA law requires referral of all children with verified abuse to Part C for screening. The convergence of mandates illustrates that an integrated screening process for development and trauma is necessary.

Descriptions of the Early Childhood Court Team Core Components

Early Childhood Court Team Core Components

1. Judicial leadership
2. Trauma lens
3. Central role of infant mental health specialist & child-parent psychotherapy
4. Continuum of behavioral health services
5. Collaborative court team
6. Community coordinator
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11. Monthly family team meetings
12. Parent-child contact (family time / visitation)
13. Coparenting
14. Evaluation
15. Funding and sustainability

1. Judicial Leadership

Florida is nationally respected for its progressive and innovative courts, pioneering the nation's first drug courts and unified family courts. Likewise, Florida was the birthplace of the nation's first Early Childhood Court, and Judge Lederman has provided judicial leadership over the past decade in promoting systems collaboration between early childhood and the judiciary.

Judicial leadership is pivotal in facilitating changes in court procedures and improving collaboration with child welfare, community mental health, and other service providers on behalf of better outcomes for young children. Judges are the catalysts for change because of their unique position of authority in the disposition of child welfare cases. The trauma-informed judge asks "*Have I considered whether or not trauma has played a role in the parents' actions or the child's behavior*?" The judge understands that healing underlying trauma is essential for helping parents realize optimal capacity for parenting. (See Florida's Family Court Tool Kit http://www.flcourts.org/resources-and-services/court-improvement/judicial-toolkits/family-court-toolkit/)

The judge recognizes a broader version of "best interest of the child" which includes consideration of the child's attachment relationships. The judge values the infant mental health specialist and utilizes their expertise in assessing the child-parent relationship so more informed decisions about placement, visitation, reunification and permanency can be made. The judge orders child-parent psychotherapy and frequent visitation to enrich the child-parent relationship and to expedite permanency. The judge strives to stabilize the foster care placement and encourages case managers to avoid moves that may be detrimental to the child.

The judge is not a "social worker" and therefore, relies on the community coordinator and court team to determine appropriate services and create a case plan with key essential elements. The judge understands the importance of ordering evidence-based services to enhance child well-being such as high quality childcare, developmental screening and appropriate early

intervention, home visiting, parenting classes, dyadic therapies, and early childhood mental health consultation to childcare. The court sets aside a special docket for young children and schedules monthly reviews to assess progress and to identify modifications needed.

2. Trauma Lens

A core foundation of this initiative is the understanding of the impact of trauma on children and their families. Approximately 90% of children known to the foster care system have been exposed to trauma.[19] A child's experience of trauma, whether it is psychological maltreatment, neglect, exposure to violence, or physical or sexual abuse, can have broad and long-lasting adverse effects on developmental functioning, and physical, social, or emotional well-being—including a child's physiological and emotional responses; ability to think, learn, and concentrate; their impulse control, self-image, and relationships with others. Across the life span, complex trauma or exposure to multiple traumatic events can be linked to a wide range of problems, including addiction, chronic physical conditions, depression and anxiety, self-harming behaviors and other psychiatric disorders.[20] The ACE study demonstrated a correlation between long-term negative outcomes in adulthood with multiple adverse experiences that occurred in childhood.[21]

A trauma lens shifts the focus from "*what's wrong with this child or adult" to "what has happened to this child or adult.*" Challenging behaviors may be misinterpreted as simply "bad" instead of understanding these behaviors in the context of trauma and unmet emotional needs. It is critical to recognize the signs of trauma and get appropriate treatment so that healing can begin and re-traumatization can be prevented. In many families known to child welfare, the parents have had early adverse experiences and unhealed trauma and thus, the cycle continues, negatively impacting the physical and mental health of their own children. Compelling evidence shows that healing early trauma can change one's life trajectory, and that while early intervention is best, it is never too late for healing to occur. Thus, trauma screening and services should be available to both parents and children and provided by mental health specialists with trauma expertise. A website has been created to build awareness of trauma informed systems across Florida's agencies: http://floridatrauma.org/

3. Central Role of Infant Mental Health Specialist & Child-Parent Psychotherapy

One of the major differences in a traditional dependency court and the Early Childhood Court Team is the predominant role of the infant mental health (IMH) specialist in the court. The IMH specialist can assess the child-parent interactions and the parents' capacity to provide nurturing and safety; work with both parent and child for repairing the relationship; provide coaching to improve visitation; make recommendations about the feasibility of reunification; assist in the transition to permanent placement if reunification is not feasible; and help the parent adjust to the loss. The clinician provides the judge with a professional assessment of the family's ability to protect and care for the child and to ensure the child's overall well-being.

Child-Parent Psychotherapy (CPP): The predominant evidence-based intervention in both the Miami Child Well-Being Court Team and Zero to Three's Safe Babies Court Teams is Child-Parent Psychotherapy. CPP is central to the goal of repairing the child-parent relationship and healing the child's traumatic stress with a careful eye on attachment. CPP is considered a powerful therapeutic vehicle for catalyzing the parent's insight and motivation to address the problems that resulted in the child's removal from the home.[22]

The IMH clinician seeks to heal the relationship between the child and the parent by helping the parent develop a realistic assessment of the child's needs and abilities. Through the course of

treatment, the therapist helps the parent address past trauma that is impairing the parent's view of the child. CPP has demonstrated effectiveness for parents who have maltreated their young children achieve a healthy relationship, while addressing the underlying reasons for their incapacity to parent.[23] CPP can be provided in a clinical setting or in a home-based model. See the California Clearinghouse for Evidenced Based Practices for a full description of the research basis: www.cebc4cw.org/program/child-parent-psychotherapy/detailed

For most families, CPP is the vehicle for change and is initiated as soon as possible. As trauma is healed, parents have increased capacity to complete other requirements in the case plan, but most importantly, the child-parent relationship improves as the parent learns to recognize the child's cues and how to appropriately respond. Some parents may not initially be ready to participate in CPP and may require more individual treatment services or engagement in the process before intensive CPP begins; however, the intention is that every family in Early Childhood Court will receive CPP. Criteria for enrolling parents in CPP can vary by program; however, for reasons of consistency, Florida is adopting the eligibility criteria established by the Baby/Early Childhood Court Team in Escambia County (Circuit 1). The criteria are as follows:

- Family Circumstances Appropriate for the Project:
  - Parental Substance Abuse: If a caregiver is actively using or under the influence, CPP is not initiated until substance abuse treatment begins. Initial assessments can determine treatment needs and substance abuse services can be explored from the time of the child's shelter placement. In most cases, CPP services should be provided in conjunction with substance abuse treatment program for three reasons: 1) quicker engagement; 2) no lapse in visitation; and 3) CPP can act as a motivator for sobriety and catalyst for change. (Note: As part of the assessment process, consideration is given to the substance abuse history in terms of frequency, duration, and intensity of substance use/abuse).
  - Parental Mental Health Issues: If a caregiver is actively psychotic, a referral is made for mental health services first. Caregivers who carry a diagnosis of schizophrenia or bipolar disorder are engaged in individual treatment services and medication compliance is closely monitored. The key is that the caregiver is not actively psychotic, or if they truly have a serious psychiatric disorder, their condition is well managed as CPP begins.
  - Domestic Violence in the Home: Families with a domestic violence allegation are accepted into the program with consideration of no contact orders (injunctions) and the safety of the non-offending parent and children.
- Family Circumstances that are Beyond the Capacity of the Project:
  - Violence Toward the Child: CPP is not provided to caregivers if there has been an "egregious" act of violence toward the child or the parent willfully failed to protect the child (i.e. known sexual abuse of the child). This is determined by the judge based on Chapter 39 statutory parameters.

Competencies Needed: In order to provide CPP, therapists should have a strong foundation in early childhood development and infant mental health, in addition to specific training in child-parent psychotherapy. A new national CPP registry has been established that requires an 18-month combination of face-to-face training, supervision, case consultation, fidelity measures, and demonstration of competencies. Florida has built CPP expertise for over a decade and continues to expand capacity with five trainings planned in 2015 to meet the new CPP national roster criteria. CPP Trainings adhering to the national registry criteria for 2015 include: USF-St. Petersburg beginning November 2014; UWF-Pensacola beginning March 2015; FSU Harris &

SAMHSA-Jacksonville beginning May 18-20, 2015; FSU Harris-Orlando beginning July 20-22, 2015; Child First, Palm Beach beginning October 5-8, 2015. The FSU Harris IMH Training Institute will continue to facilitate trainings to expand capacity for well-trained IMH specialists with expertise in CPP and to link with the courts.

4. Continuum of Behavioral Health Services

In addition to the essential Child-Parent Psychotherapy, families involved in child welfare often need additional therapeutic interventions. Each Early Childhood Court team should work with their community to ensure a continuum of evidence based behavioral health services to address the array of trauma, mental health, substance abuse, and domestic violence issues facing families in child welfare. The intensity of the intervention should mirror the specific characteristics of the parent and child. The continuum of mental health services could include:

- Parent-Child Relationship Assessment
- Trauma Interventions
- Individual Parent Treatment for Mental Health/Substance Abuse/Domestic Violence
- Therapeutic Visitation/Visit Coaching
- Child-Parent Psychotherapy
- Family Therapy where identified child may/may not be present based on appropriateness. This work often includes significant others (parent partners, extended family members)

Parent-Child Relationship Assessment: Because young children experience the world from within the circle of their parents' arms, the ideal way to evaluate their social and emotional well-being is by assessing them in the context of their primary relationships (e.g., with birth parents and foster or kinship care providers). Relationship assessments include two primary procedures:[24]

1. Structured interactional play assessment that reveals how the caregiver behaves with the child. It measures:
   - The adult's ability to provide emotional support to the child, set limits, provide structure, and help the child learn effectively.
   - The child's ability to show affection, complies with the adult's requests, respond to the learning situation, and regulate his or her own feelings.
2. An interview with the adult to understand the adult's "working model of the child." This allows the clinical evaluator to assess the adult's ability to provide appropriate care to the child. For example, parents who abuse their children have negative perceptions of their children compared to other people's children and unrealistically high expectations for their children's behavior.[25] It explains the parent's behavior toward the child and sets the stage for a teaching intervention.

The clinician makes recommendations to the court about the types of interventions that will work best for the parent and child; the setting most conducive to their needs (home or clinic); the dosage needed.

Trauma Interventions: Many families involved in child welfare have a history of trauma, often handed down through the generations. Healing past trauma is critical to addressing the root cause of addictions, mental health problems, and other destructive means of dealing with the trauma. Identifying trauma and getting appropriate treatment (e.g., sexual abuse treatment, etc.) is essential to overall healing. Case managers could utilize tools such as the *"Child Welfare*

Trauma Referral Tool" designed to help child welfare workers make more trauma-informed decisions about the need for referral to trauma-specific and general mental health services. (Published on National Child Traumatic Stress Network: http://www.nctsn.org)

Individual Parent Treatment for Mental Health/Substance Abuse/Sexual Abuse Issues: The co-occurrence of child maltreatment, substance abuse and mental health problems is well documented**.** Substance abuse is one of the primary reasons for removal of a child from the home and placement into the child welfare system. According to Florida data for FY 2010-2011, 56% of the verified child abuse allegations had indications of substance abuse by the parents. During this same timeframe, 60% of the out-of-home placements were due to parental substance use disorders.[26] Ensuring that families receive trauma-centered treatment is key to successful parenting capacity.

Therapeutic Visitation/Visit Coaching: Visitation is an opportunity to strengthen the child-parent relationship, especially with feedback and oversight from a trained infant mental health specialist. The Early Childhood Court Team will aspire to have a therapeutic visitation coach in at least one of the 3-4 weekly visitations between the parent and child. This "Visit Coach" should be supervised by the treating Master's level infant mental health specialist. Visit Coaches can come from a range of professions including in-home service providers, graduate students (in psychology, social work, and related fields), guardian ad litem (GAL), and other case-neutral persons who are knowledgeable about child development and creating supportive environments. Visit Coaches are trained to work closely with the parents to make each visit a positive and educational experience, maximizing the parents' development of strong parenting skills in a realistic environment while strengthening the child-parent bond. Ideally, visits are held in home-like settings (foster homes, churches, community centers) that provide the opportunity for the parents to establish a relationship with neighborhood supports who will be available to them after supervised visitations end. During visits, parents can prepare a meal or snack and interact with their child in indoor and outdoor time. Engaging in these practical parenting activities—with guidance—helps parents learn how to plan ahead, multitask while supervising their child, correct mistakes, and experience increasing success with each visit. Visit coaches provide support for this by:

- Playing a supportive role before, during, and after visits.
- Helping parents prepare activities for visits that will meet their children's developmental needs.
- Helping parents plan before the visit, so that they are prepared to appropriately respond to challenging behaviors with developmentally appropriate guidance and discipline.
- Debriefing with parents after the visits to see how well they followed their plan and discuss strategies for the next visit.
- Providing a supportive environment which allows the parent to make decisions and learn in the moment as much as possible (and develop confidence in his or her parenting abilities), while ensuring that the child remains emotionally and physically safe at all times during the visit.
- Helping parents recognize and process the emotions they are experiencing (e.g. anxiety prior to the visit, sadness and anger at the end of the visit).[27]
- Bridging between birth and foster parents to build a positive relationship.

Developing the continuum of services: Community mental health agencies often provide an array of mental health services to their clients, but child-parent psychotherapy or other mental health services designed specifically for children 0-5, are rarely offered. Many therapeutic services are not yet "trauma-informed" nor do they have the capacity to meet community needs. Most communities need to develop this continuum of services. The first step is to initiate a series of meetings with service providers to learn more about what is currently available in the community and conduct a formal or informal "gap analysis." Providers should be encouraged to present information about their services at Court Team meetings and continue to participate as active members. Once these partnerships are established, the Court Team can devise a plan to develop a full continuum of infant mental health services in the community.

5. Collaborative Court Team

The Court Team represents the concerned agencies that commit to make system changes on behalf of young children in the court and work with the judge to put the Early Childhood Court Team model in place. When beginning a Court Team, a local judge and his or her counterpart at the child welfare agency convene an initial informational meeting with representatives of community stakeholders. The purpose of the meeting is to explain the need to focus on infants and toddlers, to begin to outline how the many organizations that touch the lives of these children can work together on their behalf, and the urgency of achieving permanency. The Court Team is made up of key community stakeholders involved with the court who commit to restructuring the way the community responds to the needs of maltreated infants and toddlers. Members of the team include service agencies, voluntary services such as GALs, court administration, attorneys, DCF, foster parents, court appointed social workers, children's advocacy groups, Community-Based Care agencies, children's mental health agencies, etc.

The Court Team meets monthly to learn about the services available in the community, to identify gaps in services, and to discuss issues raised by members of the Court Team related to cases they are monitoring. The Court Team should determine the community need and capacity; assess the number of children in dependency ages birth to thee or birth to five; determine exclusion criteria for participation (e.g., parent in residential care, rehabilitation or jail; parent actively using substances); identify early childhood mental health providers in area (in collaboration with FAIMH); work with the CBC and community mental health agencies to understand Medicaid reimbursement and Purchase of Services needed to engage therapists; and formalize decisions and protocols.

Membership in the Court Team should be by open invitation. It is anticipated that the diversity of agencies represented will expand over time. Members can include:

- Local leaders at government agencies serving children and adults
- Primary health care providers; Healthy Start
- Attorneys representing children, parents, and the child welfare system
- Community based care system and partners
- Court Appointed Special Advocates (CASAs) and Guardians Ad Litem (GALs)
- Mental health and infant mental health professionals
- Early intervention specialists; Early Steps
- Substance abuse treatment providers
- Dentists
- Domestic violence service providers
- Representatives from colleges and universities
- Members of foster parent organizations
- Children's advocates
- Early Head Start, early learning coalitions and child care providers
- Court Improvement Project staff
- Volunteer community leaders
- Potential funders (Community Foundations, United Way)

6. Community Coordinator

A local Community Coordinator provides child development expertise to the judge and the Court Team and takes the lead in finding needed services, qualified providers, and commensurate funding. This professional ensures court reviews are held as needed and schedules case/family review meetings on a regular basis. (See Appendix E: Community Coordinator Job Description.)

7. Cross Agency Training

Systems change is possible when all the agencies and players involved in the court team are trained in the Baby/Early Childhood Court Team model, trauma-informed care, the social-emotional needs of young children, the science of adversity, and the impact of trauma upon development and mental health. Training resources include local Florida Association of Infant Mental Health chapters, university experts, the Office of Court Improvement, local CBCs, national Zero To Three, etc. Florida State University created a Early Childhood Court Resource List, which is a web-based resource clearinghouse to assist in the implementation Early Childhood Courts (See www.cpeip.fsu.edu/CourtFour.cfm).

8. Developmental Supports for Child/Parent (Developmental Screening, Early Intervention, and Quality Child Care)

Development proceeds at a faster rate during the first five years of a child's life than at any subsequent developmental stage. This period offers great potential to establish a positive developmental trajectory, but also creates vulnerabilities for the child if their physical status, relationships, and environments do not support appropriate learning, development, and growth. These developmental years provide the foundation for later abilities and accomplishments.

Infants and toddlers in foster care are America's most vulnerable children. Children under age three constitute over one third of children entering care and they remain in care longer and return to care more frequently than other children. They are also four to five times more likely to have a developmental delay than their age peers. Thus, securing services for these children is a vital task for all those who work with young children.[28]

Children with a Fetal Alcohol Spectrum Disorder (FASD) and those children with brain injury may present significant developmental disabilities and behavioral and learning problems. Research shows that foster care children are at high risk of academic failure and are more likely than their peers to perform below grade level on tests, to repeat a grade, and to attend school infrequently.[29] They are also more likely to have behavioral problems both in and out of school. Quality early childhood experiences can mitigate educational problems by giving children the skills needed for success, increasing pre-academic performance and language abilities.

Value of High Quality Learning Environments: Florida's Rilya Wilson Act states that "children who are in the care of the state due to abuse, neglect, or abandonment are at increased risk of poor school performance and other behavioral and social problems. It is the intent that children who are currently in the care of the state be provided with an age-appropriate education program to help ameliorate the negative consequences of abuse, neglect, or abandonment."[30]

High quality childcare can significantly help address the needs of children in child welfare by enhancing development and providing nurturing and emotional support. It can also serve as a protective factor for further abuse. High quality childcare is defined by accreditation such as the National Association for the Education of Young Children (NAEYC), Quality Counts Star Rating of 3-5 stars or a score of good (5) to excellent (7) on the Infant/Toddler or Early Childhood Environment Rating Scales (ITERS or ECERS).

Children in child welfare are eligible for subsidized childcare. The Florida Office of Early Learning (OEL) administers federal and state child care funds and partners with 30 local early learning coalitions to deliver comprehensive early learning services statewide. The office oversees three programs—the School Readiness Program, the Voluntary Prekindergarten Education Program, and Child Care Resource and Referral Network. There is also a statewide Resource and Referral call number: 866-357-3239. Each area has a local Early Learning coalition charged with coordinating childcare options and hosting an office for registering children for subsidized childcare. Furthermore, every court should have contact information for their local early learning coalition.

CAPTA Law Requiring Developmental Linkages for Child Welfare. The high incidence of unmet needs and the potential benefits of early intervention for children encountering the child welfare system was so compelling that the federal government enacted the Child Abuse Prevention and Treatment Act (CAPTA) to ensure better access to Part C early intervention services. Since 2003, all verified abuse cases of children under age three are required to be referred to Part C (Early Steps) for developmental screening. If the child is found to be eligible, services must be provided. Each court should have the contact information for their local Early Steps office. [31] Questions to consider:

- Does the child appear to be achieving the key development milestones at or above age-appropriate levels?
  - Social/emotional development
  - Cognitive development
  - Physical/motor development
  - Language development
  - Self-care skills
  - School readiness skills
- If the child is in the first 36 months of life, has the child been referred to Early Steps for screening/assessment of developmental delay or disability?
- If the child is 36-60 months of age and presents with developmental delays or disabilities, is the child receiving early intervention services provided via an Individualized Family Support Plan (IFSP) or an Individual Educational Plan (IEP)? If not, why not?
- If early intervention services are provided, do the child and parents/foster parents seem to be responding to the interventions as demonstrated by improved interaction, acceptance of attempts to nurture, more spontaneous play, emergence of language, etc.?
- If the child is demonstrating developmental delay, but does not meet eligibility requirements for Part C or Part B, how will the child receive needed services to "catch up" developmentally and reduce the risk for further delay?

9. Parent Education & Supports

Many parents in the child welfare system were never adequately parented themselves and lack appropriate role models. Parent training programs provide education and practice to enhance parenting capacity and skills. These programs have been researched and ranked in the California Evidence Based Clearinghouse for Child Welfare (www.cebc4cw.org). Programs are rated as: Level 1: Well supported by research evidence; Level 2: Supported by research evidence; Level 3:

Promising practice; or NR, which is not able to be rated due to lack of evidence. Choosing parenting education programs should consider the research evidence; appropriateness of the parent education for the age of the child (i.e., ages 0-5, adolescence, all ages); and appropriateness for the target population (i.e., child welfare, children with disabilities, child with behavior challenges, etc.)

Parent "education" programs are not to be confused with parent "therapy" programs. Parenting education provides instruction about child development and positive approaches to nurturing and caring for children. Parent therapy is "therapeutic" and focused on healing trauma, addressing substance abuse and other issues that interfere with parenting capacity.

Home visiting is another valuable support for families with young children. This in-home model provides a home visitor, clinician, nurse, social worker or paraprofessional who regularly comes to the home to support parenting efforts from pregnancy to kindergarten. A variety of evidence based home visiting models exist but all basically support parents in strengthening their relationship with their child, optimizing their child's development, sharing positive parenting techniques, and developing positive social supports.[32] Home visiting programs have been shown to reduce risky behaviors (smoking, lack of prenatal care), improve birth outcomes, prevent child maltreatment, and enhancing positive parenting (i.e., reading baby's cues, reading books, alternatives to spanking) and improving school readiness. The Maternal Infant and Early Childhood Home Visiting (MIECHV) program has expanded and provides a list of evidence-based home visiting programs. (Evidence-Based Home Visiting Models–Maternal, Infant and Early Childhood Home Visiting: (http://mchb.hrsa.gov/programs/homevisiting/models.html)

10. Placement and Concurrent Planning

Any and every change in placement is a difficult adjustment for the child. Ideally, the first placement is the last placement. Changes in placement can be minimized by reaching out to extended family members prior to removal from the parents' care and by quickly identifying caregivers (kin and non-related foster parents) who would be willing to become the child's permanent family if reunification becomes impossible.

Florida law requires that every case involving a child in an out-of-home placement must be evaluated to determine if concurrent case planning is appropriate. Strategies for determining appropriateness are also outlined in rule. Since 2009, Florida's Dependency Bench Book has provided guidance in the chapter, *Concurrent Case Planning Best Practice Model*, as well chapters on related areas of placement stability and co-parenting.

It is important for all members of the court team to understand concurrent planning and to make sure that (a) case managers follow concurrent planning best practices, and (b) parents and foster parents understand it is the legal way to ensure that their child reaches a permanent home as quickly as possible.

11. Monthly Family Team Meetings to Review Open Cases

An essential component of the baby court approach is a monthly team meeting to review progress of the open cases. The team consists of the community coordinator, the biological and foster parents, and the team of service providers, guardians ad litem, child welfare staff and attorneys, and extended family members. Monthly case meetings build communication among those invested in the child's case, speed access to services, and track the family's progress (referrals made, services received, and barriers encountered). Some meetings occur during the

court hearing where the judge presides; others take place outside of the courtroom, and the judge learns about the team's recommendations during the court hearing.

12. Parent-Child Contact/Visitation

Frequent and consistent contact is essential if young children are to develop and maintain strong secure relationships with their parents. Research has shown that frequent visitation (i.e. multiple times each week) increases the likelihood of reunification, reduces the time in out-of-home care, and promotes healthy attachment.[33] Knowing this, the Babies Court Team approach strives for daily contact between parent and child, which can include face-to-face contact, telephone, or Skype interactions. The Court Team focuses attention on increasing the time children and parents spend together by expanding the opportunities for visits (e.g., doctor's appointments, screenings, and other health services) and their locations (e.g., the foster home, the birth parents' home). Because parents who abuse or neglect their children may lack positive parenting models, the Court Team has identified strategies, such as therapeutic visitation, to improve parents' ability to appropriately respond to their children's needs.

Trainings have been provided across the state to educate judges on the science of attachment and best practices regarding family time and a multidisciplinary task force was created to revise protocols for the dependency bench book called Family-Centered Practice, Family Time/Visitation Protocols, finalized 8/21/2012.

Understanding the compelling research regarding the linkage between frequent visitation and the likelihood of reunification, Florida's judges have made significant strides in increasing family time/visitation from the monthly minimum required in statute. Community partners have worked to overcome transportation barriers by providing gas cards and bus passes for parents, and worked with Florida's guardian ad litem program to change policies to permit volunteers to transport children to family time. Weekly CPP sessions also provide an opportunity for therapeutic visitation. These efforts have significantly increased the amount of family time and while daily contact is optimal, a minimum of three times a week is commonly achieved.

13. Coparenting

Most young children are coparented by multiple significant adults—mothers, fathers, step-parents, relatives, neighbors, godparents, childcare providers, and teachers. For children in foster care, foster parents fill the key role as parent to the child. The Court Team works with all of the coparents involved in the child's life, especially in efforts to find and engage fathers in the parenting process. The Court Team helps facilitate open and strong lines of communication between all important adults in the life of the child and helps them develop a connected, coordinated and attuned view of the child. This: 1) creates an environment that increases predictability, routine, and ultimately family-level security for the child; 2) decreases the child's stress when transitioning between residences and caregivers; and 3) increases the likelihood of the family's reunification.

14. Evaluation

Evaluation is essential for determining program effectiveness. In order to standardize data collection and build a database for tracking outcomes, Florida's Early Childhood Court Teams will use the Early Childhood Court Tracking System, a specialized module housed within the Florida Dependency Court Information System. CIP designed the tracking system in cooperation with the statewide Early Childhood Court leadership team and the data sub-workgroup. Version

1.0 was released in November 2014. The data elements relate directly to the core components and include data on family time, parent-child relationship assessments, developmental screenings, and CPP sessions.

Through CIP's data sharing agreement with the state child welfare agency, the tracking system also retrieves basic case information from the agency's Florida Safe Families Network. The system will monitor the following permanency and safety measures: 1) time to permanency (from removal to reunification and from removal to legal permanency – court case closure); and 2) recurrence of maltreatment. In addition, CIP is currently attempting to define well-being measures. Some of the basic data that will be captured include:

- Number of children enrolled
- Demographics of children enrolled
- Type(s) of maltreatment/reason(s) for removal
- Parent/caregiver risk factors
- Length of time in Early Childhood Court Program
- Intervention services provided (team meetings, court hearing, developmental screening, CPP, visitation, referrals)
- Number of placements and reasons for disruption
- Length of time from removal to reunification
- Length of time from removal to permanency
- Reunification/permanency type (e.g., parents, permanent guardianship, adoption)
- Number of children with another confirmed allegation within 6 months of reunification
- Other community data

Florida will participate in the national evaluation of the QIC-CT, which includes a process evaluation and short-term outcomes, with plans for study of long-term outcomes pending funding.

15. Funding and Sustainability

One of the first questions asked when communities consider creating a Baby/Early Childhood Court Team is "*How do we pay for the core components?*" Every community has unique resources such as "community foundations" or Children's Services Councils (CSCs) which have designated tax dollars devoted to children—many targeted specifically for young children. There are also consistent local and statewide funding sources for supporting Early Childhood Court. A matrix of potential funding sources that align with the core components has been created (See chart below: *At a Glance Potential Funding Sources for Early Childhood Court Services in Florida*).

Two primary funding sources are Florida's Title IV-E waiver dollars and Medicaid. Each Early Childhood Court team can partner with its child welfare community-based care agency (CBC) to utilize Title IV-E waiver dollars for supporting Early Childhood Court. Across the state, CBCs have seen the value and potential cost savings of expedited permanency and reduced reoccurrence of maltreatment and have invested. CBCs are currently underwriting the cost of the community coordinator position; expanding expertise in CPP evidence based intervention by funding training for mental health clinicians; funding infant mental health specialists' work with the court that is not billable to Medicaid; and providing other essential supports to the Early Childhood Court team.

Medicaid is also a key source of funding. Child-Parent Psychotherapy (CPP) is a Medicaid billable service in Florida under Individual/Family Therapy. Medicaid can be a funding mechanism for

developmental therapy and the array of mental health services needed for the child and family. EPSDT (Early Periodic Screening Diagnostic Treatment) is the federal mandate that requires states to provide mental health screening for all children and youth up to age 18 enrolled in Medicaid. For those children found to have a mental illness, states must provide all medically necessary services to address the child's condition. Allowable services under Florida's Medicaid Community Behavioral Health Services include assessment, treatment planning, individual or family therapy, and other more intensive treatment. Children may also qualify for:

1. Medicaid Therapeutic Behavioral On-Site (TBOS) services and Behavioral Health services.
2. Substance Abuse and Mental Health (SAMH) 100-800 funds allocated to provide non-Medicaid reimbursable wraparound services to children with mental health or behavioral health needs who are victims of abuse or neglect and in the physical custody of the Department of Children and Families, or at high risk for out-of-home placement.
3. Title IV-E Waiver and other funding sources for child welfare, which could be used flexibly to provide any of the Early Childhood Court services.
4. Early Steps (Part C of IDEA), which addresses developmental delays and provides early intervention therapies (physical, speech, occupational, infant mental health, etc.) to children birth to 36 months of age with an eligible delay or condition.

A Certified Mental Health Targeted Case Manager (TCM) could serve as the Community Coordinator since many of the functions of the Coordinator are consistent with the service description of TCM *(Florida Medicaid Mental Health Targeted Case Management Handbook,* http://www.flatherapy.com/therapy/wp-content/uploads/2010/05/CTCM-Handbook1.pdf), which is designed to:

> *"assist recipients in gaining access to needed financial and insurance benefits, employment, medical, social, education, assessment of functional abilities and needs, and other services. These supportive services include working with the recipient and the recipient's natural support system to develop and implement the recipient's service plan. They also include follow-up to determine the status of the recipient's services, and the effectiveness of activities related to the successful implementation of the service plan toward enhancing the recipient's inclusion in the community."*

Potential funders—such as United Way, Community Foundations, family foundations, etc.—are a critical part of the Community Court Team. Publix Supermarkets is an ardent supporter of early childhood issues. Every Community Court Team will need to explore, brainstorm, and seek funding in ways that sustain the important work of the Early Childhood Court Model.

The key to sustainability and ensuring continued functioning over the next decade is community support and "institutionalizing" Early Childhood Court into court administration so that as judges rotate, dockets remain stable. Strategies for state funding and legislative support have been initiated and are currently being pursued. Support for Florida's Early Childhood Courts ranges from the Florida Supreme Court, the Governor's Children and Youth Cabinet, members of the Florida legislature, child welfare leadership, and local grassroots supports. Evaluation results that document improved outcomes will further solidify the sustainability of Florida's Early Childhood Court teams statewide.

At-A-Glance Potential Funding Sources for Early Childhood Court Services in Florida

Service	Medicaid	DCF Substance Abuse and Mental Health State Funding	DCF Mental Health/ Substance Abuse Block Grant	DCF Mental Health/ Substance Abuse TANF	DCF Title IV E Waiver	Title IV- B Child Welfare Services & Promoting Safe Families
Individual and Family Therapy	**X**	**X**	**X**	**X**	**X**	
Therapist Non-Face-to-Face					**X**	
Therapeutic Visitation	**Possibly (through TBOS)[1]**	**X**			**X**	**X**
Community Coordination		**Possibly[2]**	**Possibly**	**Possibly**	**X**	**Possibly[3]**
Parenting Education/ Evidence-Based					**X**	**X**

[1] Therapeutic Behavioral Onsite Services (TBOS) is designed to provide services to the child and family to improve the child's functioning. The limitation is that the child must meet the following:

Under the age of 2 years and meets one of the following criteria:

- Exhibiting symptoms of an emotional or behavioral nature that are atypical for the recipient's age and development that interferes with social interaction and relationship development.
- Failure to thrive (due to emotional or psychosocial causes, not solely medical issues).

Under the age of 2 years and meets one of the following criteria:

- Exhibiting symptoms of an emotional or behavioral nature that are atypical for the recipient's age and development that interferes with social interaction and relationship development.
- Failure to thrive (due to emotional or psychosocial causes, not solely medical issues).

Ages 2 years through 5 years and meets both of the following criteria:

- Exhibiting symptoms of an emotional or behavioral nature that are atypical for the recipient's age and development.

Ages 2 years through 5 years and meets both of the following criteria:

- Exhibiting symptoms of an emotional or behavioral nature that are atypical for the recipient's age and development.
- Score in at least the moderate impairment range on a behavior and functional rating scale developed for the specific age group.

Services can include therapy or behavioral management services.

[2] Substance Abuse and Mental Health funds are a possibility for the Community Coordinator using the cost center "case management" if the parent meets the eligibility requirements of the funding source and the services are directly related to finding services for the family. Routine administrative work such as scheduling court appearances may not be covered. The services would have to be billed on a unit-based mechanism through a substance abuse or mental health provider.

[3] The Title-IV B Family Support Services section covers an array of services focused primarily on improving the family functioning including child and parent relationships. However, the description of services includes a flexible service.

Funding Source	Eligibility	Services Description	Entity Responsible for Managing Funds	Services Covered
Medicaid	Must meet financial eligibility for Medicaid or be in DCF out-of-home care. Services must be covered by Medicaid and be determined medically necessary.	Array of therapeutic services outlined in the *Community Behavioral Health Services Limitations and Coverage Handbook.*	The Florida selected Managed Medical Assistance (MMA) Health Plans	• Individual and Family Therapy • In-Depth Assessment • Treatment Planning • TBOS
DCF Substance Abuse and Mental Health state funding	Provide services to targeted populations: adults with mental health and/or substance use disorders in the child welfare system.	Wide array of services, however; extremely limited funds.	Managing Entities	• Individual and Family Therapy • Therapeutic Visitation
DCF Mental Health/Substance Abuse Block Grant	Services for adults and adolescents with substance use disorders and services for adults with Serious and Persistent Mental Illness and Children with Serious Emotional Disturbance.	Same array of services as available through state revenue.	Managing Entities	• Individual and Family Therapy
DCF Mental Health/Substance Abuse TANF	Provide services to adults with mental health and substance abuse disorders who are eligible for TANF Diversion funds. Generally, adults must have an income below 200% of poverty. The financial eligibility is determined through ACCESS.	Same array of services as above.	Managing Entities	• Individual and Family Therapy

Funding Source	Eligibility	Services Description	Entity Responsible for Managing Funds	Services Covered
DCF Title IV-E Waiver	Any child and family diverted from the child welfare system or served by the system either in-home or in out-of-home services.	Services that assist in preparing families for re-unification, reduce likelihood of re-abuse and neglect, address parental capacity issues, and improve child well-being.	Community-Based Care Lead Agencies	• Individual and Family Therapy • Therapist Non-Face-to-Face • Therapeutic Visitation • Community Coordination • Parenting Education/ Evidence-Based
Title IV-B Child Welfare Services and Promoting Safe Families	The Family Support Services Section is available to families served by the state's child welfare program.	Array of services to provide support to families such as parent education, structured activities to strengthen the child-parent relationship, developmental screenings, transportation, and respite care.	Community-Based Care Lead Agencies	• Therapeutic Visitation • Parenting Education/ Evidence-Based
CF Appropriation Category 100-800	Individual services for children served in the child welfare system. Treatment and supportive services are available to the child if the services are not Medicaid compensable or the child is not Medicaid eligible. The child can have a diagnosis through a V code which allows children "at risk" to be served.	Non-Medicaid reimbursable community (non-residential) treatment services identified in the child's mental health treatment or service plan. Services include areas such as: Non-traditional supports to meet treatment goals specified as part of the child's treatment or case plan including, but not limited to: • Outings • Recreational clubs • Clothing • Educational materials	Community-Based Care Lead Agency	• Individual and Family Therapy – *Only for children not covered by Medicaid*. • *Possibly*[4] Therapeutic Visitation

[4] The 100-800 funding category is designed to provide non-Medicaid compensable services to children who are Medicaid recipients or to provide therapeutic services to children who are not enrolled in Medicaid. The flexible array of services can be provided through this funding mechanism.

Funding Source	Eligibility	Services Description	Entity Responsible for Managing Funds	Services Covered
County Funding	Based upon the specific funding description from the county.	Counties' social services often fund specific services. The counties *may* be interested in providing some limited funds to address gaps in services.	Counties	• Individual and Family Therapy • Therapist Non-Face-to-Face • Therapeutic Visitation • Community Coordination • Parenting Education/ Evidence-Based[5]
Local, State or National Foundations	Based upon the specific funding description from the foundations.	There are several local, state or national foundations that *may* be willing to provide funds for start-up programs or to fill gaps in existing services.	Foundations	• Individual and Family Therapy • Therapist Non-Face-to-Face • Therapeutic Visitation • Community Coordination • Parenting Education/ Evidence-Based[6]
Children's Services Boards[7]	Based upon the specific funding description from the Children's Services Boards.	Children Services Boards *may* be willing to fund gap services not clearly mandated (to be provided by the Community-Based Care Lead Agency).	Local Children's Services Boards	

[5] Funding would be dependent upon the contract from the county. Counties may be willing to "gap fill" certain services. For example, if the CBC or ME would fund direct services of the Community Coordinator, perhaps that county would provide for the administrative type functions.

[6] Each local area may have a foundation or United Way that is committed to providing social services in that area. Also there are several state and national foundations that may have available funds. The foundations or United Way will specify what services they will cover.

[7] Children's Services Boards are in Broward, Duval, Martin, Miami-Dade, Palm Beach, Pinellas, Hillsborough, and St. Lucie Counties. Florida allows voters in an interested county to approve taxing authority for a Children's Services Council through a countywide referendum. The funds are used to provide services not covered by other funding means to children and families in the county. The Children's Services Councils are reluctant to provide services that they view as the responsibility of a government entity (children in child welfare). The array of services and targeted population is specified by the Children's Services Councils. Interested parties must apply for services through the Children's Services Council.

Steps to Starting a Early Childhood Court Team

Phase I: Commitment and Readiness

Commit

- Identify a judge who is committed to improving outcomes for young children, anchored in the knowledge and science that young children exposed to trauma need evidence-based clinical intervention, and is willing to promote the importance of infant mental health in the court.

- Initiate a meeting of key stakeholders to create a common vision and partnership with the Baby/Early Childhood Court Team. Key stakeholders at the initial meeting should include the judge, CPI (child protective investigator), OPA (operational program administrator), CBC administrator, case management provider, DCF attorney, Infant Mental Health provider, Director of CBC Alliance, providers who will serve the parents, and others the judge deems important in the initial meeting. Once commitment is obtained at this level, determine what other persons/organizations need to be included in the Court Team.

Organize

- Determine who will take the leadership role (schedule meetings, chair meetings, etc.) and who will manage fiscal accountability and data collection.

- Develop the Court Team (attorneys, Guardian ad Litem, case managers, DCF, CBC, foster parent organization, school district, Early Head Start, Early Learning Coalition, Early Steps, Healthy Start, health care providers, community mental health agencies, churches, volunteer organizations, community centers, etc.) to work with the judge to put the Baby/Early Childhood Court model in place. The Court Team provides the leadership structure and serves as the steering committee of stakeholders with a shared vision and commitment to the long-term work of systems.

- Identify and hire a Community Coordinator who is knowledgeable in early childhood issues to facilitate needed changes, coordinate case/court reviews and services, and find effective and appropriate community resources for young children and their families.

Things to *Consider*

Every community will be at a different level of "readiness" and may determine different processes, priorities, and outcomes based on their community's specific needs. It is essential to take the time to carefully consider the following issues before setting actions into motion:

Population of Focus – Will the ages be birth to three or birth to five? Training needs, competencies, expertise, community resources, etc. are different for infants and toddlers vs. four- and five-year-olds.

System Capacity – It is recommended that Community Coordinators have no more than 20 children on their caseload. How many children under age five are placed in foster care annually? How many will initially be enrolled? Should your community begin with a "pilot project" then assess and increase capacity and enrollment in phases based on increased resources?

Eligibility Criteria – How will you select the children to enroll? Things to consider include: the number of times the child has been placed in care; the likelihood of reunification; the level of

parent engagement, ability, and willingness; parental history and severity of substance abuse, mental health issues, and/or domestic violence; and termination of parental rights with siblings.

Evaluation – How will you determine if the new processes are working better? How will you know if the children and the families are better off with your new system? What constitutes success? Establish timelines for assessing effectiveness of the process (6 months or 12 months, post-permanency). Establish procedures for collecting data on children and their families after they are no longer in foster care—include obtaining their permission to do so.

Every Court Team will want to be successful. It is important to determine what "success" will look like for your community, the child, the parent(s), foster parents, and the system as a whole. Even cases that result in termination of parental rights can be successful for all parties—including the parent—if done in a compassionate, supportive manner that allows them to move forward with the skills, knowledge, and self-respect they gained through the process.

Inventory of Resources and Needs

- Florida created a tool, *Readiness/Implementation Tool for Core Components*, to help communities to gauge readiness, to inventory local services, to determine gaps, and to identify steps for implementation. See **Appendix D.**
- Review the history and outcomes for children ages birth to five for the last 12 months and assess the length of time in care, time to permanency, placement stability, and maintenance of permanency.
- Project the number of children ages birth to three or ages birth to five to determine case load and need for services.
- Assess the capacity for frequent visitation.
- Inventory the capacity for providing infant mental health services in the community; it is important to identify trained CPP therapists who are willing to participate in Baby/Early Childhood Court.
- Assess the current practices in the child welfare agency regarding placement of young children (near parents or out of county, sibling placements, visitation, transportation, concurrent placements, etc.).
- Assess the services needed and available for parents when re-unification is the goal.
- Determine the mechanisms to integrate and coordinate services and supports for the family.
- Continually assess training needs (What training is needed and by whom?).

Phase II: Implementation

Procedures & Protocols

- Work with the judge and court administrator to establish a special docket for children ages birth to five with required monthly case reviews.
- Determine team member responsibilities and capacity to meet expectations. Create a flow-chart that describes each step of the process that includes at least:
    a. Eligibility criteria
    b. Referral process
    c. Enrollment
    d. Assessments
    e. Release of information
    f. Team formation
    g. Data reporting, collection, and analysis process

- Establish a regular meeting schedule for the Court Team.

Formalize Decisions

- Once the revised procedures are in place, establish court-agency protocols for the revised procedures including:
  - Referring infants and toddlers for developmental, health and IMH assessments
  - Scheduling monthly case/family team meetings to assess family progress
  - Sharing information between service providers
  - Determining evaluation methods/time frames (Specific desired outcomes, tools used, data collected, etc., when and by whom)
- Formulate interagency agreements to specify each partner's role and fiscal responsibilities for implementation of the new model.

Training

- Provide cross-agency and community training on the social-emotional needs of young children, the science of adversity, and the impact of trauma upon development and mental health, and the Baby/Early Childhood Court model.
- Increase the training capacity for Infant Mental Health specialists.
- Train Infant Mental Health specialists in areas needed, such as Medicaid billing.
- Seek support from academic institutions to build capacity where needed, to increase providers of direct services, and to train clinicians in Child-Parent Psychotherapy.
- Determine who needs to be trained on what topics and establish a training schedule.
- Determine who will provide training on what topics and costs involved.

Phase III: Evaluation/Adaptation/Sustainability

Assessing Effectiveness

- Document agreed-upon processes and outcomes for all Baby/Early Childhood Court Team participants and families, including: 1) length of time to reunification or termination; 2) developmental status of child compared with their status at intake; 3) frequency of visitation and parent contact; and 4) placement stability. Establish benchmark dates for implementing various components of the model.
- Select or develop the tool(s) needed to collect the desired data.
- Establish dates for assessing effectiveness for both the child and family and the team and system process (e.g., 6 months, 12 months, post-permanency).
- Make changes based on the data to improve system effectiveness, child-parent well-being, and successful outcomes for both.

Funding

- Develop a budget to ensure that:
  - all children ages birth to three or ages birth to five involved in dependency court receive an appropriate assessment and services by an Infant Mental Health specialist or other qualified clinician and intervention services, as needed.
  - a CPP therapist can attend all court hearings or other meetings as necessary.
  - transportation for families to participate in frequent visitation and monthly case reviews is available.
  - appropriate training can be provided, as needed.

  - a community coordinator can be hired.
  - evaluation can be conducted.

- Explore funding sources available to the court, child welfare and community mental health agencies that can pay for needed services and supports and infrastructure.
  - Match services needed with appropriate funding sources (e.g., Child-Parent Psychotherapy is Medicaid reimbursable, subsidized childcare for children in child welfare, EPSDT for therapies, flexible Title IV-E wavier monies, 100-800 monies for at-risk children).
  - Determine billing mechanisms and who is responsible.

Sustainability

- Figure out how to sustain the Early Childhood Court Team and processes throughout changes in judicial assignments.
- All Court Team members are responsible for researching and determining resources for long-term sustainability.
- Determine an on-going training schedule to accommodate high turnover, especially in case management positions.

Summary

The Early Childhood Court Team approach has demonstrated improved outcomes for young children in the foster care system in many communities. Over 50% of Florida's children in the foster care system are under age five. Therefore, we must make every effort to decrease the length of time to permanency. It is imperative that necessary services and supports are identified early and adequately provided in order to have a significant impact. Central to those services is the use of CPP, which is known to provide the best long-term outcomes for these families. The provision of on-going services and supports to re-unified families is also paramount so there are no further incidences of maltreatment or abuse. Early Childhood Teams can be implemented in every area of the state if the will and determination exists within communities to make this a priority.

Helpful Resources

Documents

- Fraser, J.G., & Casanueva, C. (2013). *The Miami Child Well-Being Court Model: Essential elements and implementation guidance*. Available from http://www.fdlrs-um.miami.edu/wp-content/uploads/2013/08/ImplementationGuidance_01-30-13_web2_FNL.pdf
- National Child Traumatic Stress Network, The. (2013). *Bench card for the trauma-informed judge.* Available from http://nctsn.org/sites/default/files/assets/pdfs/judge_bench_cards_final.pdf
- Becker, A. *The Long Reach of Childhood Trauma*. Available from http://ctmirror.org/2015/01/20/the-long-reach-of-childhood-trauma/

Websites

- Florida's Baby Court Resource List: www.cpeip.fsu.edu/CourtFour.cfm
- California Evidence Based Clearinghouse for Child Welfare. (2013). *Information and resources for child welfare professionals.* Available from http://www.cebc4cw.org/
- Substance Abuse and Mental Health Services Administration. (2013). *National registry of evidence-based programs and practices.* Available from http://nrepp.samhsa.gov/
- Florida Association for Infant Mental Health. (2013). Available from www.faimh.org
- Florida Family Court Tool Kit: Trauma & Child Development: www.flcourts.org/resources-and-services/court-improvement/judicial-toolkits/family-court-toolkit/
- Trauma informed systems across Florida's agencies: http://floridatrauma.org/
- Georgetown's Center for Early Childhood Mental Health Consultation. (2013). *Best practice tutorial series: Module 7: Recognizing and addressing trauma in infants, young children and their families.* Available from http://www.ecmhc.org/tutorials/index.html
- Health Resources and Services Administration: Maternal and Child Health. (2013). *Maternal, Infant and Early Childhood Home Visiting (MIECHV): Evidence-based home visiting models.* Available from http://mchb.hrsa.gov/programs/homevisiting/models.html
- National Child Traumatic Stress Network. (2012). *National Child Traumatic Stress Network empirically supported treatments and promising practices.* Available from http://nctsn.org/resources/topics/treatments-that-work/promising-practices

DVD

- Zero to Three. (2012). *Helping babies from the bench: Using the science of early childhood development in court [DVD].* Washington, DC: Author.

Books

- McHale, J. & Irace, K. (2011). Coparenting in diverse family systems. In J. McHale & K. Lindahl (Eds.), *Coparenting: A conceptual and clinical examination of family systems.* Washington, DC: American Psychological Association Press (pp. 15-38).
- Tableman, B., & Paradis, N. (2008). *Courts, child welfare and infant mental health: Improving outcomes for abused/neglected infants and toddlers*. Southgate, MI: Michigan Association for Infant Mental Health.

Florida's Child Welfare System

It's not rocket science, it's much more complicated!

When you combine complex subjects like child development, psychology, addiction, domestic violence, poverty, public opinion, and the natural instincts of parenting with the host of laws, rules, and procedures designed to protect two basic rights that are in conflict (the right of children to be safe and healthy and the right of parents to their children) the results are bound to be complicated and, at times, confusing.

The purpose of this chart is to help the average person understand this system. It simplifies things for the purpose of making the basics clear. As such it is generally accurate for every case but specifically accurate for none. It is important to note that some important pieces of the system are left out at this level – Child Legal Services and Guardian Ad Litem for example – to clarify the basic process. This is child welfare for novices. A good place to start learning.

HOTLINE CALL – Each year over 250,000 calls are received by Florida's Child Abuse Hotline. About 40% of these calls are screened out by the professionals who receive them 24 hours a day, 365 days a year.

SHERIFF OR DEPT. OF CHILDREN & FAMILIES – Of the 150,000+ calls accepted by the Hotline about 25% are referred to Sheriff's investigators in the 5 counties (Broward, Pinellas, Pasco, Manatee, & Seminole) that have opted to assume this duty. The remaining 75% are referred to Dept. of Children & Families Protective Investigators.

INVESTIGATION – About 60% of calls (150,000+) to the Hotline result in an investigation. In nearly half of these investigations there is no evidence of abuse and the case is closed.

INDICATED – In about a third of the investigations (45,000+) there is some evidence of abuse however it does not meet the standard of proof set in the law to continue the investigation. In about 6,000 of these cases, where it is clear that a problem exists, a referral to the CBC Lead Agency is made for services designed to prevent future entry into the system.

CASE TRANSFER STAFFING "ENTRANCE TO SYSTEM" – When a Sheriff's Investigator or Dept. of Children & Families Protective Investigator concludes that sufficient evidence exists to open a child abuse case two things happen simultaneously (1) a case is filed in court (technically this is called filing a Dependency petition) and (2) a services case is opened by a Community Based Care (CBC) lead agency. At this point the CBC Lead Agency assumes all responsibility for the case at a staffing with the Investigator.

DIVERT TO SERVICES (CBC OR PROVIDER) – In cases where an investigation shows there is a serious problem but it does not meet the legal definition of abuse (about 15% of the "Indicated" cases) the family is referred for services to prevent almost certain entry into the system later on. Typically these are intensive in-home services to solve problems and build parenting skills before it's too late. No court case is opened.

COURT HEARINGS – Child abuse is a crime and as such all actions of the child welfare system are under the direction of the court system. America's legal system is designed to insure that anyone accused of any crime understands what they are accused of and has a fair hearing with representation. No action – placement, services, visitation, etc. – happens on any case without court oversight and approval.

Shelter Hearing – If an investigation results in a child being removed from their home the Investigator must present evidence to a judge within 24 hours that justifies this action. At that time the judge can agree that the removal is justified under the law or disagree and order the child be returned to her/his parents. Since not all cases involve children being removed there is not a Shelter Hearing in every case.

Arraignment – When a parent is accused of abuse – i.e. a Dependency petition is filed – Florida law requires that formal charges must be filed and responded to in court within specific timeframes. The hearing where this happens is the Arraignment Hearing. At this hearing the state is represented by Dept. of Children & Families Child Legal Services and the parents have an attorney. Florida law allows 28 days from the date of the Shelter Hearing for the Arraignment Hearing to be held but typically it is held much sooner than that, often within 1 week of the filing of the Dependency Petition.

Disposition – If a parent admits guilt at the Arraignment Hearing or consents to a Dependency Petition (basically a no-contest plea) a Disposition Hearing is scheduled to finalize the court orders that will spell out the conditions that the parent must comply with in order to have their children returned and end further court involvement. Florida law requires that this hearing be held within 15 days of the Arraignment Hearing if a parent consents or admits at the Arraignment Hearing.

Adjudication – If a parent enters a Not Guilty plea at Arraignment then a trial is scheduled. If the parent is found Guilty a Disposition Hearing is held (usually immediately). If the parent if found Not Guilty the case is closed.

CBC LEAD AGENCY – Florida's child welfare system is governed by the Court system and overseen by the Department of Children & Families. Actual services to abused children and their families are organized and managed by 20 not-for-profit organizations that contract with DCF for all services in a specific geographic area. This area can be as small as one county but is more typically several counties that comprise a Circuit. Lead agencies are governed by local volunteer boards of directors, have contracts that include full financial risk for all services regardless of the number of children entering the system, and may either provide services directly or subcontract certain services to other non-for-profits in the community.

PLACEMENT – When abuse is substantiated the first decision that must be made is whether or not the child is safe in her/his own home or needs to be removed to safe environment. Options for out-of-home placement are with relatives, in a licensed foster home or a licensed group home.

CASE MANAGEMENT – The heart of the child welfare system is the Case Manager. These are the front line staff who work face to face with children and families to determine their needs and what services will best meet those needs to achieve a safe family reunification. The first task of a Case Manager is preparing the preliminary case plan for submission to the Court. This involves talking to the parents, the children, relatives, caregivers, schools, community members and attorneys to determine the most appropriate course of action. Once the Court approves the case plan the Case Manager is responsible for following the progress of the child and family in monthly visits and providing updates on this progress to the Court at regular intervals. Research shows that Case Managers have the largest impact on getting positive outcomes for children in the child welfare system.

SERVICES – When a child enters the child welfare system the State legally becomes their parent and is responsible for all the things that any parent is responsible for – health, education, dentist visits, food, shelter, safety, and well-being. All needs of the child in any area are documented in the case plan and services must be arranged to meet those needs. Additionally the needs of the family in terms of returning the child home safely are documented in the case plan and again, services must be arranged to meet those needs. The two most common issues that must be addressed by families involve substance abuse and domestic violence.

COURT ORDERED CASE PLAN In the initial round of Court Hearings after a court case is opened (i.e. Dependency Petition is filed) the last one is the Disposition Hearing. This typically takes place within one month of the case first being opened. At this time the Court reviews everything that has happened – where the child lives, where the child goes to school, visitation with parents and siblings, and any services needed by the child. The Court also reviews the plan of the CBC Lead Agency to return the child to her/his parents. All of this information is in a document called the case plan. When the Court approves the case plan it becomes a formal court order that obligates both the family and the CBC Lead Agency to certain courses of action. Every case plan must have one of four legally defined case plan goals. The most typical goal is to reunify the family.

JUDICIAL REVIEW – A court review of every case is required by law at least every 6 months to determine the status of the child and compliance with the case plan. The court reviews the need for any changes to the case plan, the child's placement, and if there is a reason to change the case plan goal. This review is required for both out-of-home and in-home placements. The Judicial Review held at 11 months is called a Permanency Hearing where the court will determine the best option for the child achieving a legally permanent, nurturing family – either their own or if that is not possible another permanent family such an adoptive family, a relative, or a guardian.

EXIT FROM THE SYSTEM TO PERMANENCY – In 1997 Congress determined that abused children often spent years in the child welfare system. In response they enacted the Adoption and Safe Families Act, or ASFA, which required states to focus on returning them home as soon as safely possible or placing them with another permanent family within a year or so after a case is opened.

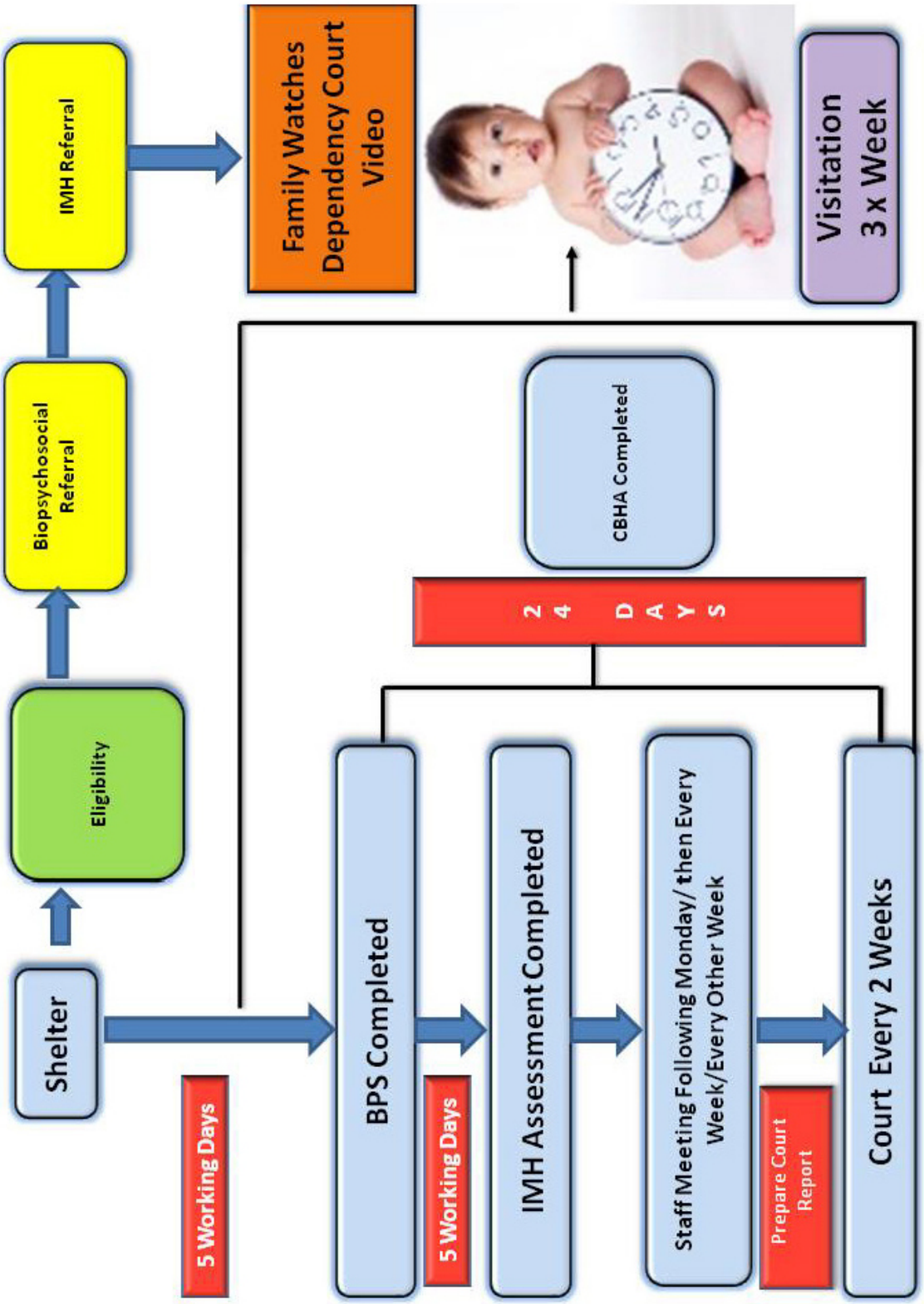
FAMILY REUNIFICATION PLAN SUCCESSFUL – When the court determines that the parents have met the obligations laid out for them in the case plan and that it is safe for the child to be returned to them the case is closed.

PERMANENT LIVING ARRANGEMENT When the court determines that a child cannot safely be returned to their home with the timeframe required by law (ASFA) and that adoption is not possible the court may consider legal guardianship as a permanency option. The guardian can be a relative, foster parent or other individual willing to provide care for the child. Guardianship gives the caregiver official, permanent custody of the child but parental rights are suspended not terminated as in adoption. Guardians have authority over decisions regarding protection, education, and care without the involvement of the child welfare system.

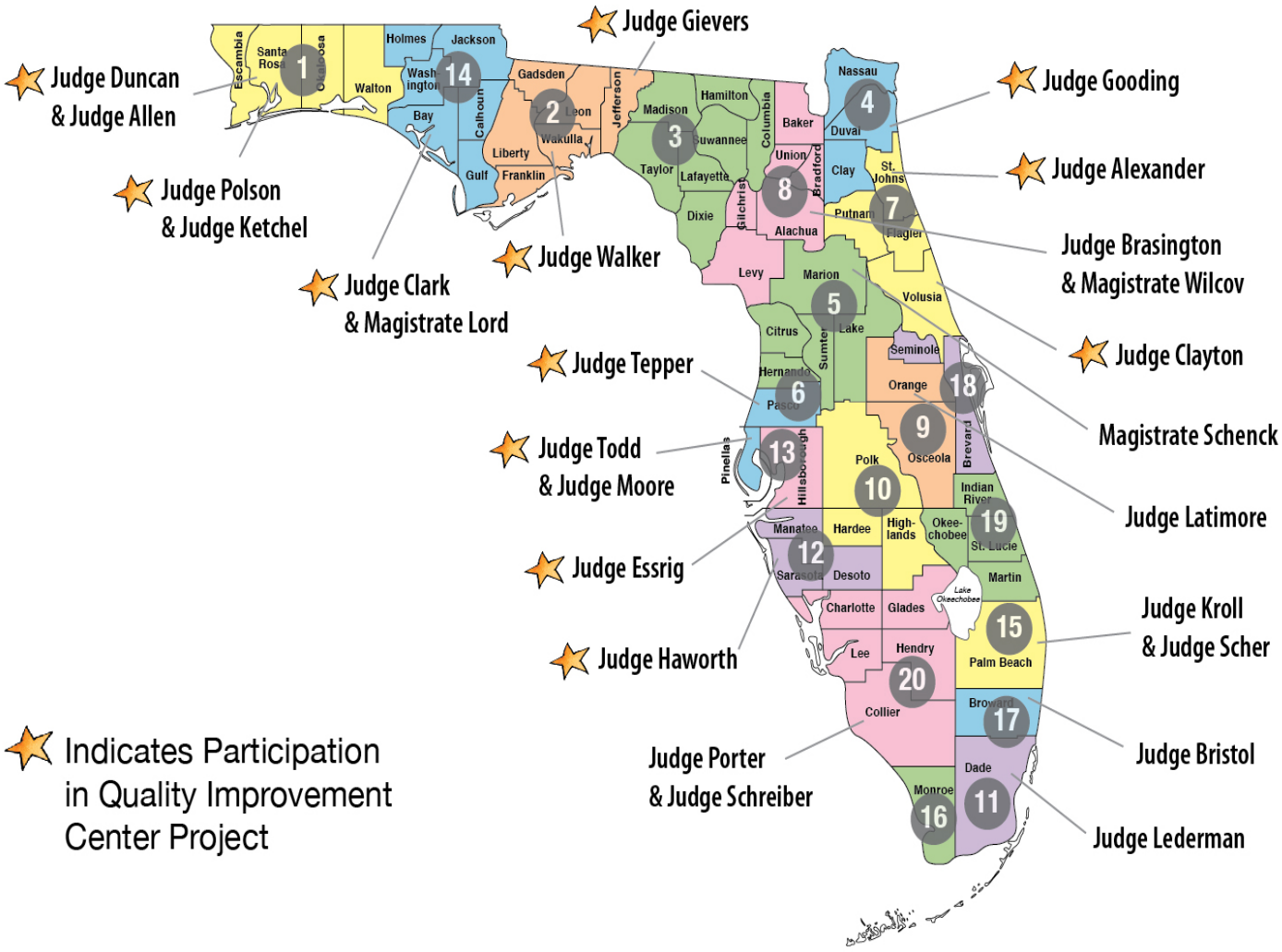
ADOPTION – When the court determines that a child in foster care will not be reunited with their parents, adoption – the legal transfer of parental rights from one parent to another – is the preferred option. In many cases relatives or their foster parents adopt these children. Florida is recognized as a national leader in adoption from foster care.

INDEPENDENT LIVING – The laws and rules of the child welfare system apply to juveniles, that is, persons under the age of 18. When the court determines that a youth in foster care who is nearing 18 will not be reunited with their parents or adopted or be placed with a guardian the permanency option for this youth is Independent Living. Federal law requires all youth in foster care who have reached their 16th birthday have "a written description of the programs and services which will help such a child prepare for the transition from foster care to independent living." Independent Living programs help youth who are aging out of the foster care system connect with services.

Appendix B: Escambia County's Early Childhood Court Flowchart



Appendix C: Florida's Existing & Potential Early Childhood Court Teams by Circuit



Appendix D: Readiness/Implementation Tool for Core Components

(Revised 4/15/15)

CORE COMP0NENTS				
1. JUDICIAL LEADERSHIP	**Not Yet Prepared**	**Moderately Prepared**	**Highly Prepared**	**Not Sure**
• *There is judicial commitment and leadership.*				
• *Judge is willing to facilitate changes in court procedure if necessary.*				
• *Judge can accommodate increased court reviews.*				
What is still needed?				
Potential Barriers?				
Action(s) Taken:				
2. TRAUMA LENS	**Not Yet Prepared**	**Moderately Prepared**	**Highly Prepared**	**Not Sure**
• *A strong knowledge base exists among all involved parties on the impact of trauma on young children.*				
• *Those most involved with the child can recognize trauma symptoms in infants and toddlers.*				
• *Case managers are currently screening for trauma.*				
What is still needed?				
Potential Barriers?				
Action(s) Taken:				
3. ROLE OF IMH SPECIALIST & CPP	**Not Yet Prepared**	**Moderately Prepared**	**Highly Prepared**	**Not Sure**
• *There trained IMH specialists in the community billing Medicaid/insurance.*				
• *There is sufficient capacity to provide as many weekly sessions as needed.*				
• *There are funding mechanisms to cover therapist's attendance at staffings and court reviews.*				
• *The role of the IMH specialist is embraced by the members of the Court Team and the importance of Child-Parent Psychotherapy (CPP) is recognized.*				
What is still needed?				
Potential Barriers?				

Action(s) Taken:

4. CONTINUUM OF BEHAVIORAL HEALTH SERVICES	**Not Yet Prepared**	**Moderately Prepared**	**Highly Prepared**	**Not Sure**
• *The initial Parent-Child Relationship assessment occurs within a two week time frame upon shelter placement.*				
• *Needed mental health, substance abuse, and/or domestic violence services for either parent is available and readily accessible.*				
• *All behavioral health providers communicate progress/concerns to one another and work in an integrated and coordinated manner.*				
What is still needed?				
Potential Barriers?				
Action(s) Taken:				

5. COLLABORATIVE COURT TEAM	**Not Yet Prepared**	**Moderately Prepared**	**Highly Prepared**	**Not Sure**
• *Integral community members and programs are identified to become part of the Baby/Early Childhood Court Team.*				
• *Members of the Baby/Early Childhood Court Team are committed to the approach.*				
• *An implementation timeline of activities is developed (who/what/when).*				
• *The Court Team has established eligibility criteria for enrollment and discharge criteria.*				
• *The Court Team has identified funding mechanisms for all aspects of the approach.*				
What is still needed?				
Potential Barriers?				
Actions(s) Taken:				

6. COMMUNITY COORDINATOR	**Not Yet Prepared**	**Moderately Prepared**	**Highly Prepared**	**Not Sure**
• *The qualifications/experience for a community coordinator is established.*				
• *The hiring/supervision of community coordinator is established.*				
• *A job description/role of the community coordinator is written.*				
• *Funding for position is solidified.*				
What is still needed?				

Potential Barriers?				
Action(s) Taken:				
7. CROSS AGENCY TRAINING	**Not Yet Prepared**	**Moderately Prepared**	**Highly Prepared**	**Not Sure**
• *Core training needs are identified (Baby/Early Childhood Court Team approach, early childhood development, IMH, trauma informed care, etc.).*				
• *A training schedule is established (who, what, when).*				
• *Responsibility for on-going training needs is established and assigned.*				
What is still needed?				
Potential Barriers?				
Action(s) Taken:				
8. DEVELOPMENTAL SUPPORTS FOR CHILD	**Not Yet Prepared**	**Moderately Prepared**	**Highly Prepared**	**Not Sure**
• *All infants / toddlers entering care are referred to Early Steps for Developmental Screening.*				
• *Appropriate services with ready access are in place for infants/toddlers showing delays?*				
• *There is sufficient community capacity to provide needed developmental therapy services (O.T., P.T., Speech, Mental Health).*				
• *All infants / toddlers in care are enrolled in high quality child care programs? (4 or higher quality rating)*				
What is still needed?				
Potential Barriers?				
Action(s) Taken:				
9. PARENT EDUCATION & SUPPORT	**Not Yet Prepared**	**Moderately Prepared**	**Highly Prepared**	**Not Sure**
• *A list of evidence-based community parent education services is available.*				
• *Parents are referred to the most appropriate parenting programs based on their issues.*				
• *Parent education services are evidence-based with evaluation methods in place.*				
• *Parents are court ordered to services if necessary not as a standard case planning practice.*				
What is still needed?				
Potential Barriers?				

Action(s) Taken:

10. PLACEMENT AND CONCURRENT PLANNING	**Not Yet Prepared**	**Moderately Prepared**	**Highly Prepared**	**Not Sure**
• *Pre-removal conferences or family group decision-making is used in the 24 hours prior to removal if feasible.*				
• *Kinship guardians are identified and supported as the preferred placement.*				
• *Concurrent planning begins immediately after an infant or toddler is removed from his/her home.*				
• *Foster parents understand concurrent planning and work with the birth parent to encourage/mentor when reunification is the goal.*				
• *Infants/toddlers are not removed from a foster placement without an emergency staffing to evaluate effect of move on the child and assess/support foster family needs to maintain placement.*				
What is still needed?				
Potential Barriers?				
Action(s) Taken:				

11. FAMILY TEAM MEETINGS	**Not Yet Prepared**	**Moderately Prepared**	**Highly Prepared**	**Not Sure**
• *All critical members of the Court Team review each case on a monthly basis to review family's progress.*				
• *Parents are key members of the team and are invited to bring other supportive family members, advocates, or friends.*				
• *The Court Team has identified a protocol for reporting/communication within the team and at team meetings.*				
• *All necessary services and supports are provided and other services and supports needed are identified and referrals made.*				
• *Court reviews are scheduled for cases exceeding goals or where goals are not being met in order to expedite permanency hearings.*				
What is still needed?				
Potential Barriers?				
Action(s) Taken:				

12. PARENT-CHILD CONTACT	Not Yet Prepared	Moderately Prepared	Highly Prepared	Not Sure
• *Parents have face-to-face visitation with their infants at a minimum of three times per week or as close to daily as possible.*				
• *Parent-child contact occurs in locations that work for the infants/toddlers and the birth and/or foster parents.*				
• *Parent involvement in normal activities (doctor's appt's., child care, weekend activities) is encouraged by all the Team.*				
• *Other mechanisms (FaceTime, Skype, phone calls) take place when face-to-face visitation is not possible.*				
What is still needed?				
Potential Barriers?				
Action(s) Taken:				

13. COPARENTING APPROACH	Not Yet Prepared	Moderately Prepared	Highly Prepared	Not Sure
• *All significant adults in child's life are engaged and involved in permanency planning and promoting child well-being.*				
• *There is special effort to engage fathers.*				
• *The IMH specialist will meet with the family members and supportive adults to develop a united and attuned plan for interaction with the child.*				
What is still needed?				
Potential Barriers?				
Action(s) Taken:				

14. EVALUATION	Not Yet Prepared	Moderately Prepared	Highly Prepared	Not Sure
• *The Court Team has identified at least three specific outcomes to achieve.*				
• *The Court Team has identified all data needed to support the outcomes.*				
• *Specific agencies/staff are identified to collect the data.*				
• *The data is analyzed, reviewed, and necessary changes made every 3 to 6 months or as needed to achieve outcomes.*				
What is still needed?				
Potential Barriers?				
Action(s) Taken:				

15. SUSTAINABILITY PLAN	Not Yet Prepared	Moderately Prepared	Highly Prepared	Not Sure
• *A sustainability plan is developed that addresses a plan for rotational judges, funding and retention of core services.*				
What is still needed?				
Potential Barriers?				
Action(s) Taken:				

Appendix E: Sample Community Coordinator Job Description

Lakeview Center
BAPTIST HEALTH CARE

Early Childhood Court Coordinator
Job Description Circuit 1, Lakeview Center

Employee Name:	Division: Families First Network Department/AU: 8010
Working Title or Position: Early Childhood Court Coordinator Specialist IV	Supervisor: Contracts and Court Services Team Manager
Classification: Exempt – Executive P-16	

Position Summary

Responsible for the coordination and oversight of FFN/LCI's Early Childhood Court (ECC) processes throughout Circuit One. Responsible for coordinating ECC to ensure quality work performance, fidelity to the model, and adherence to regulatory compliance issues across the organization.

Role Requirements (minimum qualifications required for an interview)

This position requires all of the following "Role Requirements":

- Master's degree in social work, psychology, child welfare, administration, education or related human services field with at least four (4) years experience working with children and families.
- Strong written and verbal skills required along with proficiency in Microsoft Word, Excel, and basic data collection and analysis methods.
- Experience with group dynamics and coordinating and leading groups.
- Knowledge of early childhood development, infant mental health and early intervention strategies.
- Ability to travel weekly and routinely to all four counties in Circuit One. Periodic travel out of the circuit will be required throughout the year.

Position Function (reason position exists - supports department and organizational mission)

This position is responsible for the general oversight and coordination of day to day operations of the Early Childhood Court program sites. Specifically, the position is responsible to:

1. Develop, maintain, and monitor standards of practice to ensure consistency and fidelity of the ECC model circuit-wide.
2. Coordinate circuit-wide expansion of ECC to additional jurisdictions as needed or requested.
3. Coordinate Circuit ECC Steering Committee and other related stakeholder meetings.
4. Represent Circuit One ECC on statewide and national Safe Babies Court Teams conference calls and liaison with statewide and national Baby Court representatives and entities.
5. Monitor and assist in building capacity among area clinicians in Child Parent Psychotherapy and Infant Mental Health through coordination of training with local and national experts in the field; explore training and funding opportunities.
6. Establish and maintain a list of qualified and credentialed providers of Child Parent Psychotherapy and Infant Mental Health services in Circuit One; establish and maintain documentation of qualified CPP and IMH training programs.
7. Provide staff training as necessary.
8. Create and maintain up to date ECC program documents and publications.
9. Represent ECC by participating in related committees, councils, and community meetings as appropriate.
10. Promote ECC by providing information and presentations to interested parties as requested.
11. Coordinate circuit's ECC data collection efforts and provide reports upon request.
12. Participate in quality assurance and quality improvement efforts to enhance program outcomes.
13. Troubleshoot process issues in coordination with key stakeholders.
14. Maintain positive relationships with FFN case management, providers, and other stakeholders.
15. Liaison with judiciary and court administration in relation to ECC.
16. Explore grant opportunities as appropriate to ECC and the system of care.
17. Assist with contract duties and agreements related to ECC and the system of care as needed or requested.
18. Comply with LCI safety policies/procedures.
19. Adhere to the Lakeview Standards of Performance.
20. Other duties as assigned.

Physical Requirements

- While performing the duties of this job the employee is regularly required to sit, stand, and walk; use hands to finger, handle, or feel; reach with hands and arms; talk, hear and effectively communicate with clients and co-workers. Employee will be required to sit for long periods of time. The position requires frequent travel. Vision requirements include close and distance vision.
- The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

Employee's Signed Acknowledgement Of Receipt Of Present Job Description

My signature below represents that I have read and understand my responsibilities as Early Childhood Court Coordinator and that I am able to perform the essential functions of this position. **Employee Signature**	**Date**
Supervisor Signature	**Date**

Glossary

Early Childhood Court Teams: Early Childhood Court Teams are an *approach* toward improving child and family outcomes in the dependency system for infants and toddlers. Core components have been identified from the pioneering work of the Miami Child Well-Being Court Team and Zero to Three's Safe Babies Court Teams. The Early Childhood Court Team approach works with local judges, child welfare agencies, and community organizations to create multidisciplinary teams who provide communities with services and resources that support maltreated young children, encourage evidence-based decision-making, and create systemic changes that address gaps in services. Two external evaluations of the Safe Babies Court Teams Project have been completed to date, and the findings suggest that the Court Teams approach decreases the time to permanency, reduces recurrence of maltreatment, and improves child well-being.[34] The core components of Safe Baby Court Teams include judicial leadership, the provision of CPP, frequent visitation (optimal daily contact), and monthly case reviews. Child-Parent Psychotherapy (CPP) is the predominant evidence-based intervention in both the Miami Child Well-Being Court Team and Zero to Three's Safe Babies Court Teams. "The intervention is central to the goal of repairing the parent-child relationship and healing the child's traumatic stress. CPP is considered a powerful therapeutic vehicle for catalyzing the parent's insight and motivation to address the problems that resulted in the child's removal from the home."35 See the California Evidence-Based Clearinghouse for Child Welfare for a full description of the research basis:
www.cebc4cw.org/program/child-parent-psychotherapy/detailed

Child Abuse Prevention and Treatment Act (CAPTA): CAPTA is the key federal legislation addressing child abuse and neglect. It provides federal funding to states in support of prevention, assessment, investigation, prosecution, and treatment activities and also provides grants to public agencies and nonprofit organizations, including Indian Tribes and Tribal organizations, for demonstration programs and projects. Additionally, CAPTA identifies the federal role in supporting research, evaluation, technical assistance, and data collection activities. CAPTA also sets a minimum definition of child abuse and neglect. CAPTA requires state early intervention and child welfare systems to establish coordinated procedures for the referral of substantiated cases of abused, neglected, or illegal drug-exposed infants and toddlers to Part C services. http://www.childwelfare.gov/pubs/factsheets/about.pdf

Concurrent Planning: Concurrent planning is an approach that seeks to eliminate delays in attaining permanent families for children and youth in foster care. Effective implementation requires comprehensive and early assessment. It involves identifying and working toward a child's primary permanency goal (such as reunification with the birth family) while simultaneously identifying and working on a secondary goal (such as guardianship with a relative). This practice can shorten the time to achieve permanency if efforts toward the primary goal prove unsuccessful because progress has already been made toward the secondary goal. http://www.childwelfare.gov/permanency/overview/concurrent.cfm

Dependent Child: This term is used in state statutes that deal with the care for dependent, neglected, and delinquent children. The term means dependent upon public support, that is, any child under the age of 18 who is destitute or whose home, by reason of neglect by the parents, is an unfit place for such child, or whose father, mother, guardian, or custodian does not properly provide for such a child.

Early Learning Coalitions : Housed administratively in the Department of Education, the Office of Early Learning (OEL) is the state agency responsible for administering Florida's School Readiness and Voluntary Prekindergarten programs. OEL oversees how early learning coalitions and other subcontractors use federal, state, local and private resources. The goal is for Florida's children to achieve the highest possible level of school readiness. Early learning coalitions are 501(c)3 entities that locally administer Florida's early learning programs. There are 30 early learning coalitions representing all of Florida's 67 counties. A board of directors oversees each coalition. http://www.floridaearlylearning.com/oel_resources/faq.aspx

Early Steps: This refers to Florida's Part C of the Individuals with Disabilities Education Act (IDEA). Part C is a federal program that provides funding for a statewide program of early intervention services for children from birth to 36 months who have an "established condition" or are at risk for a developmental delay. Florida's program is called Early Steps and has regions across the state to ensure that very young children's developmental needs are met through an array of services such as occupational, physical and speech therapies, counseling, nursing services, transportation, and more. Screening and evaluation is provided at no charge to families. In addition, CAPTA law requires that all children with verified maltreatment ages 0-3 must be referred to Part C for developmental screening since maltreated children are at elevated risks for developmental problems. For more information, see http://www.floridahealth.gov/alternatesites/cms-kids/families/early_steps/early_steps.html

Evidence-based Practice (EBP): The concept of "evidence-based practice" continues to evolve across disciplines. Definitions of what constitutes "evidence" have been debated, and vary from medicine to child welfare[36] and the social sciences. There is no common, widely agreed upon definition of what constitutes "evidence-based," however there are multiple registries that utilize various levels of scientific rigor to rate programs. One of the most respected registries is the California Evidence-Based Clearinghouse for Child Welfare (CEBC). CEBC staff search for all of the research evidence for a practice, and then each practice is reviewed and, if applicable, is rated on a continuum known as the Scientific Rating Scale. The scale ranges from "1–Well-Supported Research Evidence" to "5–Concerning Practice." Ratings of a 1, 2, or 3 on the scale indicate that the program has some level of comparison research evidence with good outcomes. http://www.cebc4cw.org/what-is-evidence-based-practice/

A contemporary medical definition includes: "the integration of the best research evidence with clinical expertise and patient values" which gives *equal* emphasis to: 1) the patient's situation; 2) the patient's goals, values and wishes; 3) the best available research evidence; and 4) the clinical expertise of the practitioner. The difference is that a patient may refuse interventions with strong research support due to differences in beliefs and values. Similarly, the clinician may be aware of factors in the situation (co-occurring disorders, lack of resources, lack of funding, etc.) that indicate interventions with the best research support may not be practical to offer. The clinician may also notice that the best research was done on a population different from the current client, making its relevance questionable, even though its rigor is strong. Such differences may include age, medical conditions, gender, race or culture. [37]

Florida's Guardian ad Litem (GAL) Program: A Guardian ad Litem is a trained, court-appointed volunteer who protects the child's interests upon entering the legal system and serves as the voice for abused and neglected children in dependency court. Florida has both GALs and CASAs, Court Appointed Special Advocates. http://guardianadlitem.org/honoraryGAL.asp

Healthy Start: Florida's Healthy Start began in 1991 when Governor Lawton Chiles convened a group of community leaders and challenged them to build local coalitions to reduce Florida's high infant mortality rate and provide high-quality prenatal care for mothers and health care for children. Florida has universal prenatal risk screening and infant risk screening. Services are provided through Florida's Department of Health through 33 local Healthy Start agencies across the state, with funds allocated for care coordination and outreach, breastfeeding and childbirth education, parenting education and support, smoking cessation assistance, nutritional services, counseling, psychosocial counseling, and home visits.

Infant Mental Health: "Infant mental health" is defined as the healthy social and emotional development of a child from birth to 3 years. It is a growing field of research and practice devoted to the:

- Promotion of healthy social and emotional development;
- Prevention of mental health problems; and
- Treatment of the mental health problems of very young children in the context of their families. (Zero To Three)

Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT): This is a mandatory set of services and benefits shaped to fit the standards of pediatric care and to meet the special physical, emotional, and developmental needs of low-income children under age 21 who are enrolled in Medicaid. Since one in three U.S. children under age 6 is eligible for Medicaid, EPSDT was created to ensure that they receive appropriate health, mental health, and developmental services. EPSDT encompasses: "Early" identification of problems beginning at birth; "Periodic" checking of children's health at regular intervals; "Screening" of physical, mental, developmental, behavioral, dental, hearing, vision, and other tests to detect potential problems; "Diagnostic" tests to follow up when a risk is identified; and "Treatment" provided when appropriate. All medically necessary diagnostic and treatment services within the federal definition of Medicaid must be covered, regardless of whether or not such services are otherwise covered under the state Medicaid plan for adults ages 21 and older.

Multi-disciplinary Team: An early childhood intervention team generally consists of the family or parents, teachers with early childhood education training, special education specialists, infant mental health specialists, speech and language pathologists, physical therapists, occupational therapists, and other allied health or support staff. For children in child welfare, the multi-disciplinary team can consist of the early childhood experts noted above, in addition to the caregivers/professionals most closely involved with the child's permanency and child-parent (case manager, attorney, GAL, CASA, foster parent, parent).

Trauma-Informed Approach: refers to how a program, agency, organization, or community thinks about and responds to those who have experienced or may be at risk for experiencing trauma—it refers to a change in the organizational culture. In this approach, all components of the organization incorporate a thorough understanding of the prevalence and impact of trauma, the role that trauma plays, and the complex and varied paths in which people recover and heal from trauma. A trauma-informed approach is designed to avoid re-traumatizing those who seek assistance, to focus on "safety first" and a commitment to "do no harm," and to facilitate participation and meaningful involvement of consumers and families, and trauma survivors in the planning of services and programs. A trauma approach incorporates three key elements: *realizing* the prevalence of trauma, *recognizing* signs of trauma, and *responding* with sensitivity and healing interventions.

Frequently Asked Questions (FAQs)

What is an "Early Childhood Court Team?"

Early Childhood Court Teams are an approach toward improving child and family outcomes in the dependency system for infants and toddlers. Core components have been identified from the pioneering work of the Miami Child Well-Being Team and Zero to Three's Safe Babies Court Teams. The Early Childhood Court Team approach works with local judges, child welfare agencies, and community organizations to create multidisciplinary teams who provide communities with services and resources that support maltreated young children, encourage evidence-based decision-making, and create systemic changes that address gaps in services. Two external evaluations of the Safe Babies Court Team Project have been completed to date, and the findings suggest that the Court Teams approach decreases the time to permanency, reduces recurrence of maltreatment, and improves child well being.

What is the difference between this type of case and a regular dependency case?

Many aspects of the Early Childhood Court Team differ from the more typical dependency case. The degree of judicial leadership and oversight is heightened, as well as the frequency of case and court reviews. Child and family assessment with linkages to all needed services, including Child-Parent Psychotherapy (CPP), is essential and frequently monitored. Special emphasis is placed on frequent/daily contact between parent and child with therapeutic supervision or visit coaches who can help parents learn how to better parent their child and keep them safe. On-going evaluation of the effectiveness of the approach is important to ensure necessary services, supports, and system structures/processes are adapted as needed to achieve success.

How often does the Judge need to hear these cases?

Typically, cases are heard before the judge every two weeks initially, and then monthly or as needed thereafter. The judge plays a key role in this approach—praising the parent when things are going well and firmly reminding them of possible consequences when things are not going well. Parents involved in the Safe Babies Court Teams have reported that the judge's relationship with them was a major factor in successful reunification.

How will this affect the Judge's dependency docket?

This will vary depending on the number of children enrolled in the Early Childhood Court Team. Some judges "carve out" a specific day, time, or location that is more supportive than the courtroom. Other judges hear the cases as they come up for review on the docket. Most judges involved in the Early Childhood Court Teams report they spend more time initially, but less time as the cases moved to permanency.

How many families can we serve at a time?

Each community will need to determine capacity in each of the Core Components prior to determining how many families can be served at a time. Some communities start with a small number and increase enrollment as the capacity expands. Ideally, all children birth to five years of age in foster care are enrolled in the Early Childhood Court Team approach, but again, this will depend on each community's capacity.

What are the criteria for enrollment for parents? For children?

Generally, the criteria for enrollment for both parents and the child can vary depending on the selection criteria chosen by each community. Some communities enroll all children who have a concurrent plan of reunification/permanency through adoption. Other communities enroll those parents most likely to remain engaged throughout the process and benefit from services and supports, thus achieving timely reunification.

What is the referral process?

Children can be referred to the Early Childhood Court Team at any point in the judicial process. Escambia County Early Childhood Court refers/enrolls when the child is sheltered. Other communities may decide to wait until after the initial infant mental health/family assessment to determine those most appropriate for enrollment, again based on the community's criteria. Children and parents who are referred, but not accepted, could still benefit from the infant mental health/family assessment to ensure all necessary services and supports recommended by the assessing clinician are provided. Children/families can always be re-referred in the future as circumstances change.

Why is daily parent/child contact recommended?

Frequent contact between parent and child is a key strategy for reunifying families and achieving permanency. The Early Childhood Court Team approach strives for daily parent contact. This can be in the form of face-to-face visits, phone (parent reading a bedtime story to child), Skype, or FaceTime. Ideally, face-to-face contact should occur 3 to 4 times a week. Research shows that frequent visitation/contact increases the likelihood of successful reunification, reduces time in out-of-home care, promotes healthy attachment, and reduces the negative effects of separation for the child and the parent.

V*isitation* does not adequately describe the quality and quantity of time that families need to spend together when children are removed from the home, so child welfare experts have begun using other terms, such as *family time.*

Many children in foster care come from families where the child-parent attachment is unhealthy, so visitation should be viewed as a *planned, therapeutic intervention* and the best possible opportunity to begin to heal what may be a damaged or troubled relationship. Visitation coaches can help parents learn how to effectively build relationships. Visitation is also a *diagnostic tool* to help determine if reunification is the best permanency option for the child.

How is transportation for parents and/or children provided to ensure frequent visitation?

One judge said, "where there is a will, they will find a way; if not, they can find an excuse." Each baby court team and partners must find possible solutions for their community. Ideally, parents visiting children in the foster home to minimize stress for the child or foster parents are provided transportation for these visits. Bus passes or gas cards can be provided to support travel. Arranging visits during medical appointments allows the parent to learn more about the child's medical needs. Visitation while the child is attending childcare or during therapy sessions involves the parent in the child's daily routine and their developmental progress. GALs can transport children in many communities. Some Community-Based Care programs employ a "transporter" who drive children for visits, however strangers can be stress provoking, especially for young children. Each community must find strategies that work for their specific area.

What is Child-Parent Psychotherapy (CPP)? How long is it?

Child-Parent Psychotherapy (CPP) is the predominant evidence-based intervention in both the Miami Child Well-Being Court Team and Zero to Three's Safe Babies Court Teams. CPP is considered a powerful therapeutic vehicle for catalyzing the parent's insight and motivation to address the problems that resulted in the child's removal from the home. The intervention is central to the goal of repairing the parent-child relationship and healing the child's and parents' traumatic stress. Through the course of treatment, the therapist helps the parent address the trauma in their past that is impairing the parent's view of the child. See the California Evidenced-Based Clearinghouse for Child Welfare for a full description of the research basis: www.cebc4cw.org/program/child-parent-psychotherapy/detailed

CPP requires extensive training by experienced clinicians followed by clinical case mentoring and coaching. The length of Child-Parent Psychotherapy will depend on each case and the issues that brought the child into care. More time will be required if there are multiple child mental health diagnoses or when there is also a Parent-Child Relationship Disorder. Every child involved in CPP will have a Treatment Plan that addresses the child's mental health diagnosis or emotional/behavioral issues, with specific measurable objectives. Treatment Plans are reviewed a minimum of every six months with goals and objectives evaluated. Completion is determined to be successful when the child/parent accomplish, or nearly accomplish, all set goals and objectives and no longer meet criteria for treatment. The child-parent relationship is determined to be secure and healthy.

How is Child Parent Psychotherapy (CPP) different than parenting education?

Parenting education and CPP are not synonymous. Court referred parenting is typically group based, parent focused and targets skill building. Parenting classes are designed to teach parents a model for increasing positive child-parent interaction and decreasing problematic behaviors. Parenting programs typically offer concrete ways of helping parents learn both relationship building skills and behavior management skills. Relationship building skills include praise and following a child's lead. Behavior management skills include teaching how to give good simple direct commands, how to reinforce compliance, and how to use time-outs when the child does not listen. Parenting programs are typically staffed by paraprofessionals or bachelor level providers.

In contrast, Child Parent Psychotherapy (CPP) is a therapeutic approach focused on the parent, the child and the relationship. While it can be very helpful for parents to learn skills, often the problem is not that a parent has a skills deficit but rather that they are triggered by the child's behavior. For example, when a toddler hits, a parent who has been the victim of domestic violence may respond by becoming aggressive or feeling helpless and withdrawing. Most parenting programs would not address the role that emotion regulation and trauma triggers play in the way the parent responds to the child, and this is a key focus of CPP. The master's level therapist works with the parents on accurately reading the child's cues, understanding their own cues/feelings and then shifting how they respond to their child. The goal of CPP is to support, repair and strengthen the caregiver-child relationship. CPP requires clinical skill, knowledge of child development and extensive training and skill by a mental health therapist.

Some parenting programs are "psycho-educational" which attempts to be both educational and therapeutic. Programs such as *Circle of Security* utilize attachment theory to help parents understand the underlying emotional needs in their child's challenging behaviors. Parents view

videotape of interactions with their child to begin to see their role in their children's behaviors and how their own childhood experiences impact their reactions. The goal is also to enhance the parent child relationship.

How frequently does the therapist report to the court? What will be reported to the court by the therapist?

Progress of treatment, or lack of progress, is reported to the Early Childhood Court Team and the judge at both case and court reviews or at any time the therapist deems necessary. The therapist will report the attendance of the parent in sessions, the willingness and ability of the parent to participate in treatment, the parent's ability to gain insight in the treatment process about both their child's and their own trauma, and the parent's change in attitude and behaviors related to the child-parent relationship.

What data will be collected and who will collect the data?

Every community has some mechanism(s) already in place for data collection. Each community can determine what data is necessary to show positive outcomes related to permanency and child well-being. Basic data might include:

- Number of children enrolled
- Length of time in care
- Permanency outcome (reunification, adoption)
- Pre-post child developmental outcomes
- Services recommended and provided

DCF has a fairly broad data system from which much of this data can be pulled and reviewed. Other systems/agencies may have state, local, or internal mechanisms for collecting some of the data. Each Early Childhood Court Team can assign specific data requirements for collection of data to court team members and review data at specific intervals (every six months/annually).

How are Early Childhood Court Teams funded?

- Every community will have a different array of resources.
- Every CBC has flexibility in how it uses its Title IV-E Waiver dollars, prevention funds, and general revenue funds.
- Medicaid can be a funding mechanism for developmental therapy services and the array of mental health services needed for the child and family.
- EPSDT (Early Periodic Screening Diagnostic Treatment) is the federal mandate requiring states to provide mental health screening for all children and youth up to age 18 enrolled in Medicaid.
- Allowable services under Florida's Medicaid Community Behavioral Health Services include assessment, treatment planning, individual or family therapy, and other more intensive treatment services.
- Child-Parent Psychotherapy (CPP) is a Medicaid billable service in Florida under Individual/Family therapy, which allows for a maximum of 104 quarter-hour units (26 hours), per recipient, per state fiscal year.
- Communities with Children's Services Councils (CSCs) typically have designated tax dollars devoted to children, many of them targeted specifically for young children.
- Every Community Court Team will need to explore, brainstorm, and seek funding in ways that sustain the important work of the Early Childhood Court approach.

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