james bell associates

Evaluation of the Court Teams for Maltreated Infants and Toddlers: Final Report

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Executive Summary

A. Background

Infants and toddlers are the largest single group of children in foster care in the United States and have the highest rates of victimization across age groups (32%). [i] Following removal from their parents and placement in foster care due to maltreatment, infants typically remain in care longer than older children.[ii] Infants who enter the foster care system prior to 3 months of age spend on average 31 months or longer in care. [iii] Moreover, after placement in foster care, infants and toddlers are more likely than older children to be abused and neglected. [iv] Young children in the foster care system are highly vulnerable to the effects of multiple transitions—such as shifting among caregivers—that disrupt bonding and attachment. [v]

To address these concerns, ZERO TO THREE (ZTT), a national policy organization, developed the Court Teams for Maltreated Infants and Toddlers. In developing the Court Team approach, ZTT built upon a successful model developed by the Miami-Dade County Juvenile Court to address the needs of young children exposed to violence through the provision of court-ordered services, infant mental health interventions, and more frequent supervised visitation between very young children and parents. [vi]

The Court Team model was first implemented by the 328th District Court in Fort Bend County, Texas (TX) in October 2005. In April 2006, the Fifth District Court in Polk County, Iowa (IA) implemented the model, followed by the Youth Court in Forrest County, Mississippi (MS) in May 2006. The Child Protection Division of the Orleans Parish Juvenile Court in Louisiana (LA) implemented the Court Team model in June 2007. Between 2008 and 2009, the model was expanded to seven additional sites.

The Court Team model involves a family court Judge partnering with a child development specialist to create a multi-disciplinary team of child welfare and health professionals, child advocates and community leaders who provide services to abused and neglected infants and toddlers. The Court Team approach seeks to ensure that these vulnerable children are monitored closely while under the court's jurisdiction, receive the services they need, and achieve positive safety, permanency, and well-being outcomes. Key components of the model include ongoing training for the team about the short and long-term effects of maltreatment on very young children, monthly court hearings and case reviews, provision of child-focused services, infant mental health interventions, and evidence-based parenting education/ interventions. ZTT—the project developer—provides training for each local Court Team, ongoing supervision and support to the child development specialist who is a ZTT staff member, two meetings per year where all site teams come together, and technical assistance and resource materials to support implementation of the Court Team model

In 2006, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) at the Department of Justice awarded James Bell Associates a two-year field-initiated grant to conduct a process and outcome evaluation of the Court Team model as it was implemented in four jurisdictions: Fort Bend County, TX, Polk County, IA, Forrest County, MS, and Orleans Parish, LA.

B. About the study

The study examined the following questions:

- *To what extent is there evidence that system change is underway at each program site through implementation of the Court Team model?*
- *What is the state of knowledge among Court Team stakeholders regarding the impact of abuse and neglect on early development and the needs of maltreated infants and toddlers who come through the courts?*
- *What short-term outcomes result for infants and toddlers served by the Court Teams?*

The process evaluation examined implementation of the Court Team model at the four sites and included two rounds of site visits, interviews and focus groups with key stakeholders, court observations, and document review. As the evaluation of the Court Team model was undertaken in 2007, and the model has evolved over time, implementation of the eight core components of the "second-generation" model were examined: (1) Judicial leadership; (2) Community Coordinator; (3) Court Team; (4) Monthly case reviews; (5) Child focused services; (6) Mental health interventions; (7) Parenting education and interventions; and (8) Training and technical assistance.

The outcome evaluation utilized a single group-design that examined infants and toddlers and their presenting conditions at the time of removal from the home and their outcomes related to safety, permanency, and well-being at case closure. The sample included all children, from birth to age three, who were served by the Fort Bend, Forrest County, and Polk County Court Teams from the respective date of implementation at each site through December 31, 2008. [vii] Information was obtained on 150 families and the 186 infants and toddlers within those families. New cases that were opened after that date were not included in the analyses.

JBA received IRB approval to conduct a secondary analysis of children's data from the Court Team database maintained by the ZTT Community Coordinators. These case-level analyses identify the key characteristics of the children served, including demographics (age, gender, race/ethnicity), the presenting conditions of infants and toddlers in each jurisdiction, and reasons for removing children from the home. Placement, service utilization and visitation patterns were examined. Outcomes related to maltreatment recurrence, stability of placements, achievement of a permanent placement, and the timely permanency were determined. Outcomes were determined using the national child welfare measures for the Child and Family Services Review conducted by the Children's Bureau, Administration for Children and Families, Department of Health and Human Services and the recently developed Court Performance measures established by the Department of Justice. [viii] Collectively, these measures address infants' and toddlers' needs for protection, stability, and the sustained involvement of a nurturing caregiver.

C. Key Findings: Safety, Permanency, and Well-being of Infants and Toddlers

The infants and toddlers served by the Court Teams achieved positive safety, permanency, and well-being outcomes:

- ***Safety:*** 99.05 percent were protected from further maltreatment (N=186);

- ***Permanency:*** Of the 88 closed cases examined, 95 percent achieved permanency through reunification (46.5%), placement with a fit and willing relative (30.6%), legal guardianship (4.5%), and adoption (13.6%); and

- ***Well-being:*** 97 percent received needed services to meet identified needs, particularly for routine pediatric care and developmental screenings and services (N=186).

Additional findings regarding children's characteristics, reasons for removal from the home, placement, services, family contact, and timely permanency are:

- ***Characteristics:*** The 150 families served by the Court Teams were racially and ethnically diverse. The children were of African American (36%), Caucasian (28%), and Latino origin (16%). For nearly one fifth of the children, more than one race/ethnicity was reported (18%). Of the 186 children, more than one half of the children were infants (less than 18 months old) at the time of removal. Of these, nearly 33 percent were less than one month old and 20 percent were between 1-5 months old. Almost all (96%) of the families involved with the Court Teams met the federal definition of poverty (per the guidance provided by ZTT). [ix]

- ***Reasons for removal:*** More than 50 percent of the children were removed due to neglect and more than 25 percent were removed due to physical abuse. Other forms of maltreatment perpetrated were medical neglect (6.4%), abandonment (4.2%), psychological maltreatment (1.7%), and sexual abuse (.4%). Parental substance abuse and mental illness played a significant role in child maltreatment. In 75 percent of the cases across sites, parental use of alcohol/drugs was cited as a risk factor.

- ***Health needs at intake:*** Forty percent of the infants and toddlers had been directly exposed to parental substance abuse and this contributed to their poor health status. *In utero* or prenatal exposure to alcohol and drugs was prevalent across sites, as well, involving 49 percent of the cases. Across the sites, 25 percent of the infants were identified as substance exposed newborns.

- ***Services received to alleviate maltreatment and meet developmental needs:*** Ensuring the timely provision of physical, developmental, and mental health services to maltreated infants and toddlers is a core component of the Court Team model. All of the children had multiple needs for services at the time of removal from the home, based on the presenting conditions and type of maltreatment perpetrated. Their needs continually changed as they grew and ongoing monitoring of their developmental status was critical. By study completion, 97 percent of the identified service needs had either been fully met or were in process with progress being made. Only three percent were experiencing no progress or minimal activity. Across sites, progress was least likely to be made in the areas of parent-child psychotherapy and parent-child relationship evaluations, which is a key element of the Court Team approach to heal the parent-child bond. Lack of progress was primarily attributed to client reasons, although in some cases there was a waiting list or the service was not available in the community.

- ***Family Contact (Visitation):*** Court-ordered arrangements for parents and children were highly individualized. Family contact plans took into consideration any safety risks to the child(ren), the appropriate degree of parental contact, and availability of professional or family resources to supervise parent-child contact. Across sites, 91 percent of the initial family contact was supervised, typically by child welfare staff and relatives. At the time the case opened, family contact at least twice per week was ordered in 58 percent of the cases. Daily contact was ordered in 31 percent of the cases. By the time of case closure, family contact at least twice per week was ordered in 55 percent of the cases. Parent-child contact occurred once per week for 26 percent of the cases. The family contact plan for most children was stable throughout the case process, with 53 percent of the cases experiencing only one change or no change in the initial schedule.

- ***Foster care placements and placement stability:*** A key feature of the Court Team model is to place infants and toddlers in nurturing environments that foster stable and secure attachments with their caregivers while they are in foster care. Placement with relatives was the most frequently occurring type of placement. It accounted for 37 percent of all placement types and was fairly evenly distributed across the three sites. The child's Grandmother served as the caretaker in nearly 50 percent of these placements. More than two-thirds (67%) of the placements were stable (based on cases closed as of study end), as children had no more than two placement settings while in care for less than 12 months, between 12-24 months, and greater than 24 months.

- ***Absence of maltreatment recurrence:*** Of the 186 children under court supervision, 99.05 percent did not experience a subsequent report of substantiated maltreatment within 6 months from the initial report. There was one reported occurrence (.05%) of repeat maltreatment perpetrated. Dependency cases were re-opened on three of the 150 families (2%) due to the subsequent birth of a substance-exposed child (2 cases) and parental substance abuse and child endangerment (1 case).

- ***Achieving permanency:*** Achieving timely permanency is especially critical for the vulnerable infants and toddlers served by the Court Teams. Permanency outcomes were examined for closed cases served by the Court Team from the date of model implementation until December 31, 2008 (N=88). Of these cases, 95 percent achieved permanency through reunification (46.5%), placement with a fit and willing relative (30.6%), legal guardianship (4.5%), and adoption (13.6%). Reunification with the parent was the intended goal for 84 percent of the children for whom a goal was provided. Reunification with the parents was actually achieved for 46.5 percent of the cases. Placement with a fit and willing relative was the permanency outcome for 30.6 percent of the cases and legal guardianship was the outcome for almost 4.5 percent of the cases. Nearly fourteen percent (13.6%) of the children were freed for adoption. Five percent of the children did not achieve permanency.

- ***Timely permanency:*** Achieving permanency with the statutory timeframes of the Adoption and Safe Families Act (ASFA) of 1997 is especially critical for vulnerable infants and toddlers. The greater part of the reunification outcomes occurred within the ASFA timeframes. Of the 41 children that were reunified with parents, 59 percent were reunified with 12 months from the date that the court order was filed. More than one-third (37%) of the children were reunified between 12-18 months, and a very small percentage (5%) of reunifications occurred between 18-24 months. In the cases where parental rights were terminated, the termination occurred within

18 months of case opening. Interviews and focus groups with Court Team stakeholders indicate that lack of parental compliance with service plans or their willingness to change becomes evident early in the case given the heightened oversight afforded by the monthly hearings.

D. Implementation of the Court Team Model

Judicial leadership was fully implemented and found to be a key catalyst for the successful implementation of the Court Team model. In the courtroom, judicial leadership was demonstrated through decision-making and the quality of oversight in child maltreatment cases and ensuring that a child's best interests were served. Judicial questioning and oversight were also informed by effective practice in child welfare and the science of early child development. Notwithstanding the quality and reach of judicial leadership, successful implementation of the Court Team model depended greatly on the **Community Coordinators**. They served as a primary resource on the science of child development, monitored ZTT cases, attended court hearings, facilitated referrals and service linkages, maintained contact with all relevant parties, participated in case reviews or conferences convened by the court or the child welfare agency, and maintained a database that captured all aspects of the case.

Across the four sites, the "**Court Team**" comprised the judicial and legal community, child welfare, and service professionals for parents and children (including early intervention specialists, parenting educators, therapists, case managers, and family preservations specialists, and substance abuse counselors). This feature of the model has been fully implemented at the four sites. The composition of each Court Team has progressively expanded in each jurisdiction and change in composition is desirable. Variations in team composition across the sites reflect the resource base and existing service array in each community. Differences also speak to the presence of pre-existing collaborative efforts between the courts, child welfare, and child-focused service providers in each jurisdiction. Gaps in the composition of the Court Team were indicative of lack of resources.

Monthly oversight through court hearings and case staffings has been fully implemented at the four sites. Most stakeholders found that the monthly reviews ensured that court-ordered services for infants and toddlers were implemented quickly and that cases moved towards permanency in a timely manner. Stakeholders reported that a key benefit of the monthly hearings was that all parties in attendance had the most current information regarding the status of the case, the progress made, and the services received.

The provision of **child-focused services** to ensure the developmental, medical, and mental health needs of maltreated infants and toddlers has been fully implemented at all sites, to the extent that community resources allow. Stakeholders reported and cases level analyses confirmed that children's basic medical and developmental needs were met in each jurisdiction. The monthly hearings and reviews facilitated identification of new needs and development of plan for continuing care aligned with each child's developmental stage.

The Court Team approach emphasizes the importance of providing **mental health interventions** for maltreated children and the parent(s). However, this element of the model has not been fully implemented across sites. Three sites had well-established infant mental health providers in the community that provided parent-child attachment assessments, dyadic therapy, and family therapy. Each provider had a long-standing relationship with the court and child welfare agency and this facilitated their integration into the Court Team's approach. Two of these sites had well-established referral and treatment protocols in place that facilitated timely assessments and interventions, thus parents and children were routinely assessed and received services. Another site struggled with implementing the infant mental health component of the model due to very limited community capacity.

The Court Team model encourages the use of **evidence-based parenting education** to strengthen parenting skills, build parent-child relationship, and enhance family functioning. A variety of parenting interventions were available across the four sites, and one site used an evidence-based model (i.e., *Nurturing Parenting Program).* Stakeholders at each site expressed reservations about the quality and quantity of the parenting education services, thus this element of the model was not fully implemented as intended. However, providers made concerted efforts to tailor their interventions to address families where child maltreatment occurred, particularly to make sessions more interactive and child-focused.

Training on infant and toddler development was provided during the early implementation phase of the Court Team at each site. Site-specific trainings were organized by the Community Coordinators.

E. Changes in knowledge and practice

As a result of the trainings sponsored by ZTT, many stakeholders indicated that their awareness of the impact of child abuse and neglect on infant and toddler development had increased, as well as their awareness of the multiple needs of very young children in foster care and the need for timely responses. What is important to consider is that this knowledge did not remain static, but was shared and put into practice. Knowledge-in-action was particularly evident during the courtroom hearings, as the Judge, attorneys, child welfare workers, CASAs, and the Community Coordinator shared a common language regarding infants and toddlers' developmental needs. Courtroom testimony, questions, and exchanges focused on the short and long terms effects of injuries or substance exposure, screenings, assessments, bonding, attachment, developmental milestones, relationships and interactions with birth parents, kin, and siblings, play therapy, Early Head Start referrals, etc..

Across the Court Team sites, attorneys and guardian *ad litems* indicated that they were more knowledgeable and better able to represent very young children as a result of training and exposure to ZTT cases (e.g., understanding the effects of Shaken Baby syndrome, exposure to methamphetamine). Members of the legal community reported having a better understanding of the severity of maltreatment on child

development, the need for babies to develop healthy, secure attachments, and to be nurtured by a permanent caregiver. In this regard, they felt better able to advocate for their young clients and ensure that they were serving the child's best interests.

Participation in the monthly Court Team meetings, convened by the Judge and facilitated by the Community Coordinator, helped to increase stakeholders' knowledge of the community resources for infants and toddlers, as well as gaps in the service continuum. Stakeholders that participated in ZTT's multi-disciplinary National Training Institute, with its focus on the dissemination of knowledge pertaining to early child infant development and effective practice, reported that it was valuable experience for their professional development.

F. Recommendations

The following recommendations are made to improve the functioning of the Court Team approach as a whole, along with particular elements of the model, in recognition that a systems change process requires working at multiple levels simultaneously. The model is well-received by major stakeholders, particularly by legal representatives who are better informed to advocate for their client(s) and by providers that form a continuum of care for infants and toddlers and their parents. The perspective from child welfare is that the model sets high standards for practice and case review. However, child welfare staff are under-resourced and overwhelmed, thus there is some frustration in implementing the model, given that they value and believe in the approach.

These suggestions to ZERO TO THREE and the Court Team sites are based on the evaluation findings, stakeholder feedback, and the literature on effective strategies for building service capacity and implementing systems change in the health and human service delivery systems, particularly the courts and child welfare. [x] [xi] [xii] [xiii] [xiv] [xv] (Applicable components of the model are noted in parentheses).

1. ***Court processes***
   Consider using monthly case reviews or staffings in lieu of court hearings for cases that are progressing well and pose minimal risk as the monthly court hearing are the most resource intensive component of the model. For cases involving risk and with limited parental engagement or compliance, continue the practice of monthly hearings before the Judge *(Monthly case reviews/hearings).*

   Establish time-certain slots for hearing cases on the ZTT docket to minimize the time workers, attorneys, and services providers spend waiting for a case to be called *(Monthly case reviews/hearings; Legal representation).*

2. ***Court and child welfare collaboration and assessing fit and feasability***
   As the Courts and child welfare pursue common outcomes for children, it would be helpful for the Judges, Community Coordinators, child welfare administrators, and front-line staff to engage in constructive dialogue to ensure that policy initiatives to support infant and toddler

development and court-ordered services are aligned with the resources and capacity of the child welfare agency. While this recommendation to assess fit and feasibility is largely addressed to the family contact component of the Court Team model, which has a sound developmental rationale, it pertains more generally to ensure that policy, program, and effective practice components of the model are congruent. Based on stakeholder feedback, increased dialogue (as has occurred with the Orleans Parish Court Team) would be valuable regarding the logistical, transportation, and supervisory responsibilities associated with increased family contact, given the frequency and level of supervision that is court-ordered (i.e., parent-child visits were court-ordered to occur at least twice per week in 58 percent of the cases; daily contact was ordered in 31 percent of the cases at the time of case opening; 91 percent of the initial family contact was supervised, typically by child welfare staff and relatives). [xvi] This court and child welfare conversation between expectations and resources should also take into consideration new federal requirements for states to make reasonable efforts to provide frequent visitation or other ongoing interaction between siblings in foster care (per the recently enacted *Fostering Connections to Success and Increasing Adoptions Act, P.L. 110-351) (Judicial leadership; Family Contact).*

3. ***Formalize procedures, roles, and processes***
Implement formalized procedures so that caseworkers routinely screen and refer families for assessment and therapy—especially those with the goals of reunification—and ensure that all children are assessed (*Mental health interventions).*

For each jurisdiction, develop and share site-specific protocols or resource guides to ensure clear understanding of the Court Team process and roles across the court, child welfare, the legal community, service providers, and families to ensure clarity in the multi-disciplinary process (as done by the Polk County Court Team). Specifically, identify:

- The steps involved in working with a ZTT case from removal to closure;
- The roles and responsibilities of all parties involved in an infant and toddler case (to include the Judge, Community Coordinator, legal representatives, child welfare and service providers);
- Referral processes and information sharing procedures;
- Inter-agency reporting mechanisms;
- Permanency planning timelines;
- Court-specific policies; and
- General information about Court Team agencies and the services provided.

Include in this protocol clear policies and procedures regarding the sharing of sensitive information and requirements of the Health Insurance Portability and Accountability Act (HIPAA).

4. ***Child and parent interventions***
Invite the provider that conducts the attachment assessment to Family Team Meeting in order to share observations and interpret findings from the assessment (*Mental health interventions).*

Consider conducting a relationship assessment *prior to* making a permanent placement, or having a re-assessment of the parent-child or foster-parent-child relationship at the one year milestone (*Mental health interventions; Placement stability, Permanency planning).*

Identify parenting education interventions that focus on parents of younger children (in general) and caring for substance-exposed newborns (given their apparent prevalence in the Court Team population examined (25%)) (*Parenting education and interventions; Family contact).* [xvii][*xviii*]

Adapt parenting education sessions so that they are more individualized and tailored to each family's needs and allow for greater parent-child interaction, preferably in an in-home setting or at a family-friendly visitation center (*Parenting education and interventions).*

Establish linkages across providers working with the family, so that parenting education is aligned with mental health interventions and substance abuse treatment services (*Parenting education and interventions).*

Make greater use of therapists, parenting educators or visit coaches during family contact so that they can coach the parent in his or her interactions with the child and model appropriate behaviors (*Parenting education and interventions; Family contact).*

5. ***Community capacity building***
   Implement a peer-networking forum so that Court Team sites with fully implemented infant mental health systems and those without can learn about successful efforts and strategies to (1) build or advocate for service capacity; and (2) develop referral and treatment protocols to facilitate timely assessments and interventions.

   Support community advocacy efforts to provide a continuum of infant mental health and culturally competent, individualized parenting services, and the provision of community-based supports to support increased parent-child contact (e.g., visit coaching, visitation centers).

6. ***Monthly Court Team meetings***
   While the monthly meetings are good for informational and networking purposes, stakeholders at some sites suggested that there needs to be greater strategic focus on the content so that highly-committed but time-pressed professionals feel that it is time well-spent. Other stakeholders suggested using the monthly Court Team meetings to better effect in order to share information across providers and build relationships, especially for those that do not have frequent contact with each other or for those whom are not co-located. Dedicate time during each monthly meeting to obtain input and feedback from the Court Team members about implementation challenges and solutions and make this a standing agenda item to foster ongoing dialogue.

7. ***ZTT Training and technical assistance***
   Given that barriers to child-focused service delivery were largely systemic, it would be helpful for the national ZTT office to assist and/or support the Judges and Community Coordinators with their advocacy efforts with organizations and agencies at the local and state level to effect long-term solutions *(Technical assistance).*

   In coordination with the ZTT national office, provide in-service training on infant mental health interventions to child welfare workers *(Training).*

   Stakeholder-identified suggestions for training include fetal alcohol spectrum disorders and intermittent refresher courses on child development (to accommodate turnover in provider agencies) *(Training).*

8. ***Quality assurance and evaluation***
   Update and enhance the Court Team database *User's Guide* to ensure consistent reporting on children's status and outcomes. Provide a complete glossary to facilitate data entry.

Modify the Court Team database and improve technical guidance so that it provides needed information to support local and national reporting on children's status and outcomes and to monitor program effectiveness. Specifically, amend the database to:

- Provide a data field to identify children as American Indian or Alaskan Native to indicate tribal affiliation and cases under concurrent jurisdiction, in keeping with the provisions of the *Indian Child Welfare Act of 1978* (25 U.S.C. § 1901 et. seq.);
- Allow for identification of the primary type of maltreatment perpetrated (i.e., reason for removal) for consistency with national reporting systems;
- Allow for refinement of child maltreatment categories (i.e., reasons for removal) per state statutes to facilitate reporting within each jurisdiction;
- Provide data fields to identify a child as a substance-exposed newborn or as diagnosed with fetal alcohol syndrome; [xix]
- Provide a category to indicate "data not available" for reasons for removal and key health indicators;
- Provide a data field to identify permanent placement with the father in the Child Case Status record when termination has occurred for the mother; [xx]
- Provide a data field to identify subsidized guardianship as permanency goal or status (per the recently enacted *Fostering Connections to Success and Increasing Adoptions Act, P.L. 110-351).*
- Ensure that full permanency planning and outcome data can be entered and saved in the Child Case Status record on an ongoing basis so that a full record of information is available and reflects change over time; and
- Strengthen internal quality assurance checks to identify out-of-range and inconsistent values, dates or status.

Consider sponsoring and conducting a workload analysis to assess the time and resources spent on ZTT cases in each jurisdiction. With this information, consider whether development of a dedicated unit of social workers for ZTT cases would be a viable strategy for child welfare agencies to adopt.

9. ***Needs assessment***
Conduct annual needs assessments at each Court Team site in order to identify gaps in the service continuum and identify training needs in the community *(Child-focused services, Mental health intervention, Parenting education, Training).*

G. Stakeholder Perspectives on the Benefits of the Court Team Model

When asked about the benefits of Court Team model for children and families, stakeholders in each jurisdiction—and from multiple disciplines—provided thoughtful testimonials about the value of the approach from their perspective. [xxi] Common themes expressed across sites pertained to the value of the hard work involved in staffing infant and toddler cases; having the court, child welfare, and service providers pull together as a more cohesive team to collaborate in serving vulnerable children and families; and having multiple parties provide diligent, and caring, oversight to foster accountability.

To this end, one stakeholder in Fort Bend County, TX attributed improved outcomes for infants and toddlers to the "watchful eye of ZTT." In Orleans Parish, LA, stakeholders commented on the collective oversight role of the Court and child welfare. One noted that "all parties are involved and are very aware of

what is going on in the cases." Others observed that the Court Team process "makes the work of all parties better" and "keeps all on their toes." A stakeholder in Polk County, IA emphasized the collective import of the approach for families: "Through the oversight, interventions, and monthly support, the Court, child welfare, and service provider collaboration conveys a strong message to parents: "[This is] what I need to do in order to be a good parent and get my kids back." It's not, "We'll take the kids and get back to you." In this regard, the Court Team approach was perceived as one that emphasized healing maltreated infants and toddlers, providing services to assist troubled parents, and wrapping families in a community's support while holding parents accountable for their actions. In Forrest County, MS, one stakeholder observed, "ZTT is the trunk of the tree and the agencies are the branches . . . There are more minds wrapped around the family, resources are available. It is a better, resource-rich vehicle for helping families, with enforcement from the Judge. It is a much richer model."

H. Conclusions

Evaluation findings indicate that the Court Team for Maltreated Infants and Toddlers is a promising approach for promoting greater collaboration between the courts, child welfare, and the community to meet the needs of very young children in foster care and to realize positive safety, permanency, and well-being outcomes. For the 186 infant and toddler cases examined, key findings are that 99.05 percent were protected from further maltreatment while under court supervision, 95 percent achieved permanency, and 97 percent received needed services to meet identified needs, particularly for routine pediatric care and developmental screenings and services.

Elements of the Court Team model that were fully implemented included judicial leadership guided by knowledge of child development; the liaison role of the community coordinator to coordinate case management and ensure communication and information sharing among multiple parties; teams comprised of networked community stakeholders to provide an array of child-focused services; an emphasis on kinship care to foster placement stability; individualized, supervised family contact (visitation) to promote parent-child bonding and attachment; and high utilization of local and national training on child development sponsored by ZTT. Aspects of the model that were found to be unevenly implemented across the sites were infant mental health services and evidence-based parenting education services. A greater focus on formalizing Court Team procedures and processes in each jurisdiction is suggested, in order to institutionalize practices and foster financial and programmatic sustainability, as well as strengthening the collaboration between the courts and child welfare to effect systems change and maintain a "watchful eye" on infants and toddlers under their supervision and in their care.

Endnotes

[i] U.S. Department of Health and Human Services, Administration on Children, Youth, and Families. (2009). *Child Maltreatment 2007*. Washington, DC: U.S. Government Printing Office.

[ii] Wulczyn, F. & Hislop, K. (2002). Babies in foster care: The numbers call for attention. *ZERO TO THREE Journal*, (22) 4, 14-15.

[iii] Ibid.

[iv] Ibid.

[v] Silver, J. & Dicker, S. (2007). Mental health assessment of infants in foster care. *Child Welfare*, (22) 5, 35-55.

[vi] Lederman, C.S., Osofsky, J.D., & Katz, L. (2001). When the bough breaks the cradle will fall: Promoting the health and well-being of infants and toddlers in juvenile court. *Juvenile & Family Court Journal*, 52 (4), 33.

[vii] At the time the grant proposal was submitted in June 2006, Orleans Parish Juvenile Court had not yet implemented the Court Team model, thus it was not included in the outcome evaluation.

[viii] Flango, V. E. & Kauder, N. (2008). *Court Performance Measures in Child Abuse and Maltreatment Cases: Key Measures*. Washington, DC: Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice and Children's Bureau, U.S. Department of Health and Human Services.

[ix] According to the U.S. Department of Health and Human Services, the 2003 guideline for a four-person family was $20,650.

[x] National Child Welfare Resource Center for Organizational Improvement (Summer/Fall 2009). *Improving Child Welfare/Court Collaboration*. University of Southern Maine, Edward S. Muskie School of Public Service.

[xi] Carnochan, S., Taylor, S., Abramson-Madden, Han, M., Rashid, S.,Maney, J., *et al*. (2007). Child welfare and the Courts: An exploratory study of the relationship between two complex systems. *Journal of Public Child Welfare*, 1 (7), 117-136.

[xii] Nissen, L.B., Merrigan, D., & Kraft, M.K. (2005). Moving mountains together: Strategic community leadership and systems change. *Child Welfare*, 84 (2), 123-140.

[xiii] Abernathy, P.L. & Hall., M.A. (2009). Improving outcomes for infants and toddlers in the child welfare system. *ZERO TO THREE Journal*, 29 (26), 28-33.

[xiv] Kreger, M., Brindis, C.D., Manuel, D.M., & Sassoubre, L. (2007). Lessons learned in systems changes initiatives: Benchmarks and indicators. *American Journal of Community Psychology*, 39, 301-320.

[xv] Fixsen, D.L., Naoom, S.F., Blasé, K., Friedman, R.M., & Wallace, F. (2005). *Implementation Research: A Synthesis of the Literature.* Tampa, FL: National Implementation Research Network (FMHI Publication #231).

[xvi] Edwards, L. (2003). Judicial oversight of parental visitation in family reunification cases. *Juvenile and Family Court Journal*, 54 (3), 1.

[xvii] Burry, C.L. & Wright, L. Facilitating visitation for infants with prenatal substance exposure. *Child Welfare*, 85 (6), 899-918.

[xviii] Johnstone, T., Miller, M.K. (2008). The Court's role in promoting comprehensive justice for pregnant drug and alcohol users. *Juvenile & Family Court Journal*, 59 (3), 39.

[xix] Malbin, D.V. (2004). Fetal Alcohol Spectrum Disorder and the role of the Family Court Judge in improving outcomes for children and families. *Juvenile and Family Court Journal*, 55, 2, 53-60.

[xx] Malm, K., Murray, J. and Geen, R. (2006). *What about the Dads? Child Welfare Agencies' Efforts to Identify, Locate, and Involve Nonresident Fathers.* Washington, D.C.: The U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

[xxi] Stakeholders tended to refer to either the "Court Team" or simply "Zero To Three."

Table of Contents

Page

List of Tables

List of Figures

Appendices

Chapter I

Introduction: The Court Teams for Maltreated Infants and Toddlers

The ZERO TO THREE Court Teams for Maltreated Infants and Toddlers (Court Team) is a systems change initiative that brings together the courts, child welfare and child serving organizations to serve vulnerable children. The goal of the Court Team is to ensure that infants and toddlers are monitored closely while under the court's jurisdiction, receive the services they need, and achieve positive safety, permanency, and well-being outcomes. The Court Team model involves a family court Judge partnering with a child development specialist to create a multi-disciplinary team of child welfare and health professionals, child advocates and community leaders who advocate for and provide services to abused and neglected infants and toddlers and their families. Key components of the model include monthly court hearings and case reviews, provision of child-focused services, infant mental health interventions, and use of evidence-based parenting education/interventions. ZERO TO THREE (ZTT)—the project developer—provides training, technical assistance and resource materials on child development activities to support implementation of the Court Team model.

The model was first implemented by the 328th District Court in Fort Bend County, Texas (TX) in October 2005. In April 2006, the Fifth District Court in Polk County, Iowa (IA) implemented the model, followed by the Youth Court in Forrest County, Mississippi (MS) in May 2006. The Child Protection Division of the Orleans Parish Juvenile Court in Louisiana (LA) implemented the Court Team model in June 2007. In 2008, the Court Team model expanded to four additional sites: Family Court of the First Circuit, Honolulu, Hawaii; Unified Family Court, San Francisco, CA; Separate Juvenile Court of Douglas County in Omaha, NE; and New Haven Juvenile Court in Connecticut. In 2009, three more courts were added: the Cherokee Court in Cherokee, North Carolina; Douglas County Juvenile Court in Douglasville, Georgia; and the 10th Division Circuit Court in Little Rock, Arkansas. The evaluation focused on the four early adopting sites.

The twofold objective of the evaluation was: (1) to examine the early systems and client-level outcomes of the three Court Team projects in funded in 2005; and (2) to provide needed evaluation findings to the Office of Juvenile Justice and Delinquency Prevention (OJJDP) on the progress of systems change as reflected in utilization of services and initial outcomes related to infants and toddlers' safety, permanency, and well-being. The goals and objectives of this evaluation are congruent with the legislative goals of the 1997 Adoption and Safe Families Act to implement reforms in dependency courts, expand judicial oversight to ensure child safety and timely case processing, and attain positive outcomes for the children in

the child welfare system. [1] Findings from the federal Child and Family Services Reviews (CFSRs)—conducted by the Children's Bureau, Administration for Children and Families (ACF), U.S. Department of Health and Human Services—which monitor states' performance on key child outcomes and systemic factors, underscore the need for greater collaboration between the courts and the child welfare system in meeting the needs of all children in foster care.[2]

A. Organization of the report

Chapter I presents background information pertinent to the Court Team model, including infant and toddler maltreatment and placement in foster care, origins of the Court Team approach in the Miami-Dade Safe Start Initiative, and the legislative framework of the Adoption and Safe Families Act of 1997 which established the safety, permanency, and well-being outcomes for children. A description of the process and outcome evaluation, along with methods and data sources, is presented. This chapter concludes with a discussion of the limitations of the study. **Chapter II** begins with a brief description of each of the Court Team sites. It continues with the presentation of findings regarding implementation of the key components of the Court Team model (i.e., judicial leadership; the role of the local ZTT Community Coordinator; mobilization of Court Team community partners; institutionalization of monthly case reviews and/or hearings; coordination of child-focused services; availability and use of parent/child mental health interventions; use of evidence-based parenting education and interventions; and provision of training and technical assistance by ZTT). Facilitators and barriers to model implementation are identified. This chapter addresses changes in knowledge and practice among key stakeholders involved in infant and toddler cases, including judges, attorneys, and service providers. Integration of the Court Team model into the dependency court process in each jurisdiction is presented.

Chapter III presents key findings on the safety, permanency and well-being outcomes for infants and toddlers served by the Court Teams in Fort Bend County, TX; Forrest County, MS; and Polk County, IA. Information is presented on 150 families and the 186 infants and toddlers within those families that were served by the Court Teams through December 31, 2008. The case-level analyses identify the key characteristics of the children served, including demographics (age, gender, race/ethnicity), the presenting conditions of infants and toddlers in each jurisdiction, and reasons for removing children from the home.

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[1] Safety outcomes are that children are (1) protected from abuse and neglect; and (2) safely maintained in their homes whenever possible and appropriate. Permanency outcomes are: (1) children have permanency and stability in their living situations; and (2) the continuity of family relationships and connections is preserved for families. Outcomes related to well-being are: (1) families have enhanced capacity to provide for their children's needs; (2) children receive appropriate services to meet their educational needs; and (3) children receive adequate services to meet their physical and mental health needs.

[2] *Summary of the Results of the 2001 - 2004 Child and Family Services Reviews* (2004). Department of Health and Human Services, Administration for Children and Families, Children's Bureau. Accessed July 2009 at http://www.acf.hhs.gov/programs/cb/cwmonitoring/results.

Service utilization and visitation patterns are presented. Outcomes related to maltreatment recurrence, stability of placements, achievement of timely permanency are presented. The data are arrayed to present child-specific information, site-specific data, or cross-site analyses where appropriate and feasible. Where available, comparative information regarding children's characteristics and outcomes in each jurisdiction prior to the implementation of the Court Team model are also presented in Chapter III. Finally, **Chapter IV** provides conclusions and recommendations.

B. Background

1. Infants and Toddlers: Maltreatment compounded by placement in foster care

According to the latest national figures cited *Child Maltreatment 2007,* an estimated 794,000 children in the 50 States, the District of Columbia, and Puerto Rico were determined to be victims of abuse or neglect. [3] Children in the age group of birth to 1 year had the highest rate of victimization across age groups at 31.9 percent. Infants are the largest single group of children in foster care in the United States. Following removal from their parents and placement in foster care due to maltreatment, infants typically remain in foster care longer than older children.[4] Infants who enter the foster care system prior to 3 months of age spend on average 31 months or longer in care. [5] Moreover, after placement in foster care, infants and toddlers are more likely than older children to be abused and neglected. [6] Young children in the foster care system are highly vulnerable to the effects of multiple transitions—such as shifting among multiple caregivers—that disrupt bonding and attachment. [7] Research also has shown that unresponsive, frightening, and chaotic caregiving are associated with insecure and disorganized attachments that leave infants vulnerable and less able to self-regulate arousal and distress.[8] Chronic stress, such as that associated with maltreatment and exposure to violence, also has detrimental effects on a young child's developing brain and learning, behavior, and physical and mental health. [9] The effects of early childhood maltreatment are

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[3] U.S. Department of Health and Human Services, Administration on Children, Youth, and Families. (2009). *Child Maltreatment 2007*. Washington, D.C. U.S. Government Printing Office.

[4] Wulczyn, F. & Hislop, K. (2002). Babies in foster care: The numbers call for attention. *ZERO TO THREE Journal*, (22) 4, 14-15.

[5] Ibid..

[6] Ibid.

[7] Silver, J. & Dicker, S. (2007). Mental health assessment of infants in foster care. *Child Welfare*, (22) 5, 35-55.

[8] Sroufe, L.A., Carlson, E.A., Levy, A.K., & Egeland, B. (1999). Implications of attachment theory for developmental psychopathology. *Development and Psychopathology*, 11, 1-13.

[9] Shonkoff, J., & Phillips, D. (2000). *From Neurons to Neighborhoods: The Science of Early Childhood*

cumulative and can have life long implications if not properly addressed. There is evidence that many adolescents and young adults who first become delinquent and later develop criminal behavior were exposed early in their lives to violence, disorganized families, poor education, and limited opportunities.[10] [11] For example, one longitudinal study indicated abuse or neglect during childhood increases the likelihood of arrest as a juvenile by 59 percent.[12]

The science of early childhood and early brain development, along with empirical findings from program evaluations, reveal that nurturing relationships, developmentally-appropriate care, and intensive services for infants and toddlers can ameliorate the harmful effects of maltreatment and adverse experiences and promote better developmental outcomes.[13]

2. Origins of the Court Team Model: The Miami Safe Start Initiative

The science-based framework of early child development was the foundation for the therapeutic intervention established in the Miami-Dade County Juvenile Court by the Honorable Cindy S. Lederman, Dr. Joy Osofsky, and Dr. Lynne Katz; this model provided the inspiration for the Court Team approach. Conceived during the Miami Safe Start Initiative, an OJJDP-funded dependency court intervention program for young children exposed to violence, the Miami-Dade model assembled a court/community team that developed a shared understanding about the needs of young children in foster care. [14] Court-ordered services for infants included referrals for medical care, behavioral/developmental assessments and treatment (where needed), and more frequent supervised visitation between infants and parents. Dyadic therapy—an evidence-based, attachment-focused therapy—was implemented to nurture and strengthen the parent/child bond and to rebuild a healthy and secure attachment/relationship. Early research findings on the initiative showed substantial gains in improving social and emotional and health-related status of infants, toddlers, and their families. Of the families receiving the intervention, 58 percent of the children improved in their

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Development. Washington, DC: National Academy Press.

[10] Osofsky, J. (Ed.) 1997. *Children in a violent society*. New York: The Guilford Press.

[11] Osofsky, J. (Ed.). 2004. *Young children and trauma: Intervention and treatment.* New York: The Guildford Press.

[12] Widom, C. & Maxfield, M. 2001. An update on the "Cycle of Violence." *Research in Brief*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice.

[13] Shonkoff & Phillips (2000).

[14] Lederman, C.S., Osofsky, J.D., & Katz, L. (2001). When the bough breaks the cradle will fall: Promoting the health and well-being of infants and toddlers in juvenile court. *Juvenile & Family Court Journal*, 52 (4), 33.

developmental functioning; [15] 100 percent of infants were reunited with their families; [16] and reports of abuse and neglect were reduced from 97 percent to zero. [17]

3. The Adoption and Safe Families Act of 1997 and Permanency Planning

The Adoption and Safe Families Act (ASFA) of 1997 [18] provides the legislative framework for the work of the Court team to meet the needs of infants and toddlers. ASFA establishes the goals of safety, permanency, and well-being of children and families served by the courts and child welfare system. The legislation identified seven outcomes for children and families served by the child welfare system:

- Reduce recurrence of child abuse and/or neglect;
- Reduce the incidence of child abuse and/or neglect in foster care;
- Increase permanency for children in foster care;
- Reduce time in foster care to reunification without increasing re-entry rates;
- Reduce time in foster care to adoption;
- Increase placement stability; and
- Reduce placements of young children in group homes or institutions.

The legislation outlines the conditions under which a state should terminate parental rights and seek a permanent placement for a child, and also sets timeframes and deadlines for permanency determinations. Attainment of ASFA-mandated outcomes rests on the interdependent efforts of the child welfare system to address the multiple, and often complex, needs of children and families.

Figure I-1 (below) depicts a **"Child's Journey through the Child Welfare System"** and portrays the stages and decision points involved in the dependency court process. The model—based on federal and common state law and practice—traces the progression of a case as it moves from investigation and substantiation of alleged abuse or neglect by child protective services; to the determination by the court that abuse or neglect has occurred at the preliminary protective hearing; to the decision to remove the child; and the subsequent role of the child welfare agency and the Courts in providing ongoing oversight of the case and permanency planning.

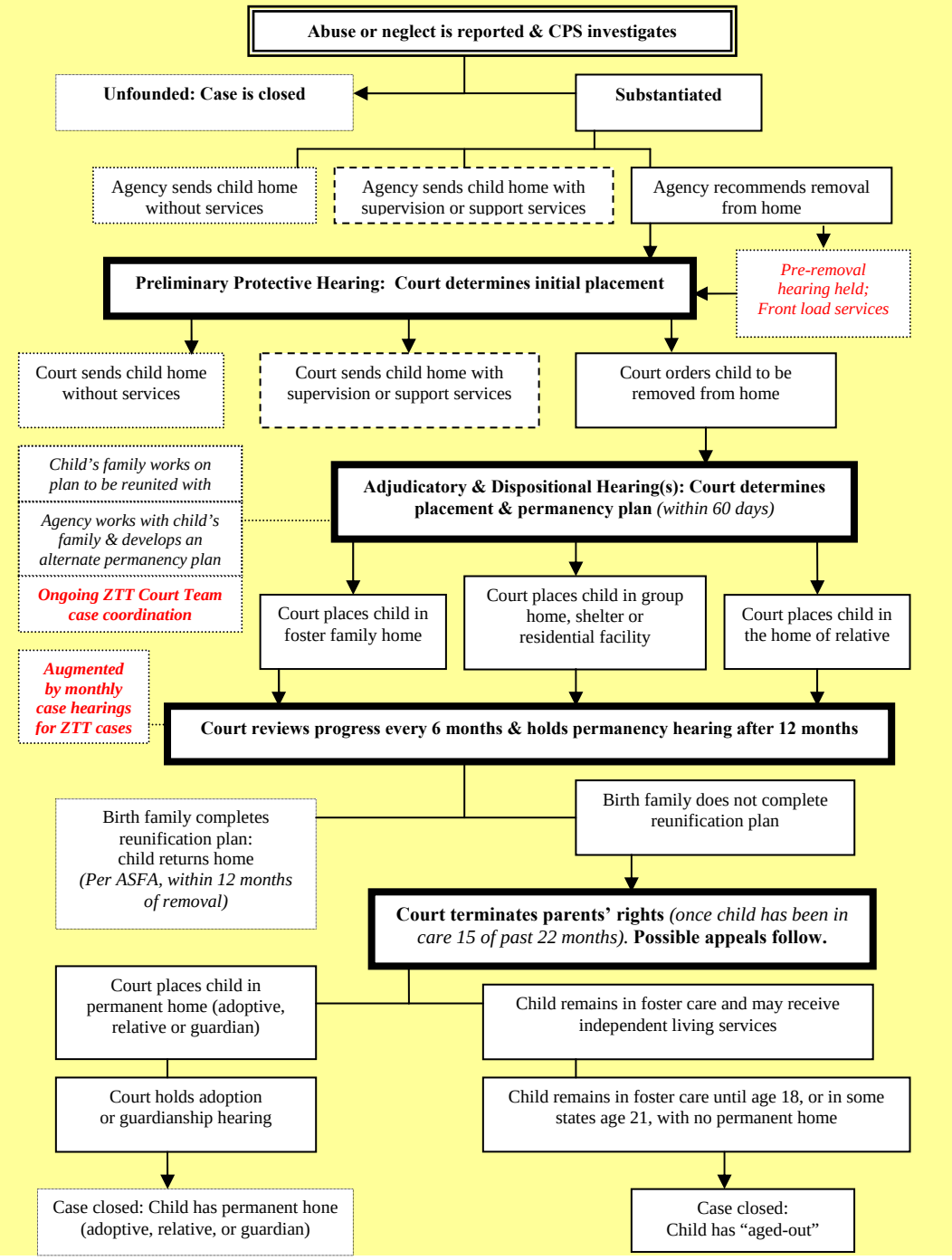
[15] Adams, S. Osofsky, J., Hammer, J., & Graham, M. (2003). *Program Evaluation Florida Infant and Young Child Mental Health Pilot Project, Year 3, Final Report*. Tallahassee, FL: Florida State University.

[16] Lederman, C. (2003). *Mental Health trends in 2003: Miami's Infant and young children's mental health program: A place where healing begins*. The National Center for State Courts.

[17] Lederman (2003).

[18] Public Law 105-89), Titles IV-B and IV-E, Section 403(b), Section 453, and Section 1130(a) of the Social Security Act.

Figure I-1. A Child's Journey through the Child Welfare System
(Adapted per the Court Team Model) [19]



[19] Adapted from Badeau, S. & Gesiriech, S. (2003). *A child's journey through the child welfare system*. Washington, DC: The Pew Commission on Children in Foster Care.

C. Evaluation Design

In 2006, OJJDP awarded James Bell Associates a two-year field-initiated grant to evaluate the Court Teams in four jurisdictions: Fort Bend County, TX; Forrest County, MS; Polk County, IA; and Orleans Parish, LA. [20] The study examined the following questions:

- To what extent is there evidence that system change is underway at each program site through implementation of the Court Team model?
- What is the state of knowledge among Court Team stakeholders regarding the impact of abuse and neglect on early development and the needs of maltreated infants and toddlers who come through the courts?
- What preliminary, or short-term, outcomes result for infants and toddlers served by the Court Teams?

The process and outcome evaluation used a mixed-methods approach and obtained data from multiple sources. Data collection activities are presented in **Table I-1. Process and Outcome Evaluation Data Collection Activities per Goals and Objectives** (below). Data collection methods and analysis procedures are detailed below.

1. Process Evaluation

a. Preliminary Activities

Upon notification of receipt of the grant funds by OJJDP in February 2007, the evaluation team initiated a number of preliminary evaluation activities. First, in April 2007, an *introductory letter* was sent to each Judge, along with a *project description*. Then, the research staff conducted a *review of program documentation* including grant applications, progress reports, implementation materials, judicial policies and procedures, and ZTT technical assistance materials A review of applicable state statutes with respect to permanency planning, state definitions of child abuse and neglect, and disclosure of child abuse and neglect records was also conducted (See Appendices X and Y). From May-July 2007, the research staff engaged each Court Team site in an *Orientation Conference Call* which included the Judge, ZTT Community Coordinator, ZTT staff, and other relevant parties. The following topics were addressed:

- Data collection activities for the process evaluation, including plans for preliminary site visit, suggestions for stakeholders to interview or hold focus groups, attending a Court Team hearing and discussing confidentiality concerns and the development of an observation protocol.

[20] Orleans Parish is included in the process evaluation. At the time the grant proposal was submitted in June 2006, Orleans Parish had not yet implemented the Court Team model, thus it was not included in the outcome evaluation.

Table I-1. Process and Outcome Evaluation Data Collection Activities per Goals and Objectives

Goal & Objectives		Process Evaluation			Outcome Evaluation	
		Document Review	Stakeholder interviews	Observations	Secondary data analysis	Case record review
Goal 1. Determine the degree to which system change is underway at each program site through implementation of the Court Team model, as assessed by a multiple case-study approach.						
1.1	To assess the extent to which the elements of Court Team model are implemented at each site.	●	●	●		
1.2	To assess the extent to which new, needed services are being court-ordered for infants and toddlers who are involved in a substantiated incident of abuse/neglect.	●	●	●	●	●
1.3	To identify the facilitators and barriers to access, coordination, utilization, and payment of assessments and services for infants and toddlers and their families and non-familial caregivers at each site	●	●			
1.4	To identify cross-site similarities and differences in Court Team implementation, operations, and systemic changes.	●	●	●		
Goal 2. Assess the state of knowledge among Court Team participants and stakeholders regarding the impact of abuse and neglect on early development and the needs of infants and toddlers in the child welfare system.						
2.1	To assess awareness among Court Team members regarding the needs of infants and toddlers in foster care and how to promote healthy outcomes that will foster child well-being.		●	●		
2.2	To assess knowledge among Court Team members and other key community stakeholders regarding the impact of abuse and neglect on infant and toddler development.		●			
2.3	To assess the degree to which judicial practice has changed for infant toddler cases as a result of the implementation of the Court Team model, such as more frequent judicial queries in adjudicating cases.		●	●	●	
2.4	To assess knowledge among Court Team members regarding community services available for maltreated infant and toddlers.	●	●	●		
Goal 3. Assess the preliminary outcomes for infants and toddlers who have been served by the Court Teams through use of a case-controlled study.						
3.1	To identify demographic characteristics and presenting conditions of children and families served by the Court Teams at each site.				●	●
3.2	To measure children's safety, permanency, and well-being outcomes (i.e., recurrence of maltreatment, rates of service utilization, frequency of visitation, stability of placements or number of placements, and time to achieve permanency (e.g., reunification, adoption).				●	●
3.3	To compare court-ordered services and supports for infants and toddlers in the Court Teams with a matched case sample of infants and toddlers served before implementation of Court Team Model. [Was 3.4] [21]				●	●

[21] Objective 3.3. was formerly Objective 3.4 in the original grant application to OJJDP. The original Objective 3.3 involved tracking and measuring adult receipt of services associated with positive family functioning and improved child safety, permanency, and well-being outcomes. However, adult outcomes were not evaluated.

- Evaluation of child outcomes, [22] including eligibility criteria, access to current and historical case data and records; and procedures and permission to access administrative data.

- Information regarding project documentation, including revised court forms to institute procedural changes.

Following the Orientation Call, a *detailed summary* was provided to each of the sites which summarized agreed-upon decisions regarding stakeholder interviews, permission from the Court to observe the court hearing, and procedures for accessing administrative data.

b. Initial Site Visits to Pilot Test Data Collection Instruments

JBA staff conducted a *preliminary round of sites visits* to the four Court Team sites between September–October 2007 to meet with stakeholders and pilot-test interview protocols, focus group guides, and observation tools. With the prior verbal permission of the presiding Judge (obtained during the Orientation Conference Call), [23] the research staff observed dependency court proceedings in each jurisdiction in order to gain familiarity with the hearing process, the role of parties in attendance, the nature of judicial inquiry in cases involving infants and toddlers, and issues related to the service needs of children and parents.

Discussions were held with relevant parties from the Court and the child welfare agency to discuss data sharing agreements and access to administrative data for the outcome evaluation. In addition, the evaluation team observed a monthly meeting of the Court Team at each site. At the conclusion of the site visits, the *data collection instruments* were refined and reviewed. *Follow-up informational interviews* were held with each Community Coordinator in July-August 2008 to obtain updated information on Court Team implementation, plan the second round of site visits, and discuss data sharing issues for the outcome evaluation.

c. On-Site Data Collection

Upon receiving Institutional Review Board (IRB) approval in October 2008, a second round of site visits was conducted in late 2008 and early 2009 by a two-person team to the four sites: Forrest County in November 2008; Fort Bend in December 2008, and Orleans Parish in January 2009. A visit was made to the Polk County site in March 2009 as part of the annual ZTT All-Sites Meeting. JBA staff conducted interviews, focus groups, and observed court hearings. Participation in the interviews and focus groups was voluntary. The IRB granted a waiver of documentation for consent for the portion of the study involving

[22] Short-term outcomes are: increased service referrals for infants and toddlers; increased visitation; stability of placements; permanency goal achievement; time to permanency; absence of maltreatment recurrence

[23] Personal communication to the Principal Investigator and research staff from the Honorable Ronald R. Pope, Judge Presiding, 328th District Court, Fort Bend County, TX (May 24, 2007); the Honorable Constance Cohen, Associate Juvenile Judge, Fifth Judicial District of Iowa (May 30, 2007); the Honorable Judge Ernestine Gray, Orleans Parish Juvenile Court, LA (July 12, 2007); and the Honorable Michael W. McPhail, Youth Court Judge, Forrest County, MS (July 18, 2007). Dates correspond to the Orientation Conference Call held with each Court Team site prior to the site visit.

interviews of Court Team members and determined that a signed consent form was not required for the research. Instead, the IRB required that a "Research Subject Information Sheet" be read or provided to all subjects at the time of initial consent. A copy is provided in **Appendix A.**

Details of the on-site data collection activities are as follows.

Interviews with stakeholders: JBA staff conducted *semi-structured interviews* with stakeholders in each jurisdiction. Each interview lasted about one hour, although the interviews with the Community Coordinator went into greater depth and lasted approximately two hours. Interviews were conducted with each Judge; ZTT Community Coordinator; the County Attorney or Prosecutor; legal representatives for parents and children; child welfare administrators; representatives of foster parent organizations and child advocacy groups; and community service providers (i.e., early childhood development specialists, pediatricians, therapists and mental health professionals, in-home service providers, Early Head Start and child care providers, parenting educators, and substance abuse treatment providers).

The interviews addressed the following topics: (1) planning; (2) implementation of the required elements of the Court Team Model; (3) modifications to the model; (4) site-specific operations (i.e., legal and judicial processes, working with ZTT/Court Team cases); [24] (5) contextual factors that facilitate or hinder model implementation; (6) service array in the community; [25](7) composition of the Court Team and inter-agency collaboration; (8) institutionalization of monthly case reviews, permanency hearings, and monthly Court Team meetings; (9) training and knowledge of infant and toddler development; and (10) perceived benefits and future goals. Interview Guides are provided in **Appendix B.**

Focus Groups: One-hour *focus groups* were held with legal representatives (i.e., attorneys or Guardians *ad litem*); supervisors and frontline workers from the child welfare agency; and Court-Appointed Special Advocates (CASAs). The focus group guides addressed: (1) the approach to handling infant and toddler cases before and after implementation of the Court Team Model; (2) changes in the assessments and services available for infants and toddlers and parents or caregivers; (3) knowledge about infant and toddler development and the impact of child abuse and neglect on these children; and (4) challenges experienced in implementing the Court Team model. The guides are provided in **Appendix C.**

Observations of Review Hearings in Family and Juvenile Court: At the discretion of each Judge, JBA staff observed dependency court hearings in order to understand changes in practice on the part of Court Team, including the Judge, attorneys, child welfare workers, and legal advocates. [26] JBA

[24] Activities related to Core Components: Questions posed by the Judge during the hearing; Increased participation by parties involved; New Court order forms or procedures; Recommendations or orders for child-focused services; Recommendations or orders for needed services for parents; Changes in visitation practices (i.e., type, duration, frequency); Changes in placement practices (e.g., kinship placements); Participation/attendance at court team meetings or monthly case reviews; Monitoring (including monthly case reviews), tracking, and reporting; Training and technical assistance.

[25] Availability of services in the community; Introduction of new services (e.g., infant-parent psychotherapy or parent-child interaction therapy); Coordination of assessment and services by the Community Coordinator; Utilization of services; Payment or reimbursement for services.

[26] Public access to Juvenile and Family Court proceedings vary. Dependency hearings are open to the public in some States and are closed in others. In all courts, however, by statute, there is judicial discretion to allow persons to attend who have an interest in the workings of the Court. This is in keeping with the position of the National Council of Juvenile and Family Court Judges, which advocates that the dependency and juvenile courtrooms should be open in order to promote accountability, to educate others about the justice system, and to encourage greater community participation. NCJFCJ 68th Annual Conference, July 17 - 20, 2005, Pittsburgh, PA, Resolution No. 9. Accessed September 2008 at http://www.ncjfcj.org/images/stories/dept/resolutions/resolution%20no.%209%20open%20hearings.pdf

staff observed all cases on the infant and toddler docket during the Fort Bend County, Forrest County, and Polk County visits. [27] A *hearing observation form* was used to document the proceedings. It is provided in **Appendix D.**

The tool was modeled on observational tools developed for evaluations of the Court Improvement Program [28] and addressed the type of hearing; the parties in attendance (noted by function, not personal name); key elements of the court proceedings (opening, court procedures), the nature of judicial inquiry; input from all parties; and findings. Specifically, the tool captured the types of inquiries made by the judge and other parties relative to the ongoing care and placement of the child, as well as addressing physical, developmental, mental health, and educational concerns. [29] The confidentiality and privacy of all parties to the case was respected as the observation form *did not collect* individually identifiable, protected health information on the child or family and complies with the privacy requirements of the *Health Insurance Portability and Accountability Act (HIPAA).* Collection of observational data was conducted with the permission of the presiding Judge and congruent with the degree of public access to the dependency hearing.

Observations of Court Team Meetings: Each Court Team site held meetings on a monthly basis that were attended by key stakeholders, including the Judge, ZTT Community Coordinator, attorneys, advocates, child welfare staff, and service providers. The monthly meetings focused on building system capacity and working through issues related to practice change. (Discussions of individual cases do *not* take place during the Court Team meetings). These meetings provide an opportunity for the stakeholders to share information. Minutes are taken during the meetings and later distributed to the Court Team members. The evaluation team attended Court Team meetings at each site.

Program documentation: On an ongoing basis, JBA staff reviewed program documentation including progress reports; implementation materials; prior evaluation reports; site-specific guidelines, protocols, and brochures; and ZTT publications and technical assistance materials.

d. Qualitative data analysis

Interview, focus group, observational data, and program documentation were analyzed using *Atlas.ti* software. Standard qualitative data analysis techniques were used: (1) initial data reduction and transformation of written field notes and transcriptions; (2) identification of higher-order categories or themes using content analysis and data displays in text or diagrammatic form; and (3) conclusion drawing and verification through cross-checking techniques to establish confidence in the validity of the findings. [30]

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[27] During the first site visits in Orleans Parish a non-ZTT case was observed. The second site visit did not coincide with the hearing schedule, thus we did not have the opportunity to observe a ZTT hearing.

[28] The observation tool is adapted from the Minnesota Children's Justice Initiative Hearing Observation Form (Phase 2) (undated) and Missouri Structured Court Observation form (undated).

[29] Questions regarding physical, developmental, mental health, educational/child care setting, and placement needs of the child are derived from Osofsky, J.O., Maze, C.L., Lederman, C.S., Grace, M. & Dicker, S. (2002). *Questions Every Judge and Lawyer Should Ask about Infants and Toddlers in the Child Welfare System.* Reno, NV: National Council of Juvenile and Family Court Judges.

[30] Miles, M. and Huberman, A. 1994. *Qualitative Data Analysis: An Expanded Sourcebook,* 2nd edition. Thousand Oaks, CA: Sage Publications.

Chapter II presents findings regarding the site-specific implementation of the model, local adaptations, and facilitators and barriers to Court Team implementation at each site and across sites.

2. Outcome Evaluation

The evaluation utilized a single group-design that examined the presenting conditions and outcomes of maltreated infants and toddlers served by the Court Teams from the time of their removal from home to case closure. The sample included all children, ages 0 to 3, who were served by the Fort Bend, Forrest County, and Polk County Court Teams from the respective date of implementation at each site through December 31, 2008. The sample size is 186.

The evaluation examined demographic characteristics of infants and toddlers in each jurisdiction, presenting conditions (i.e., reasons for removal, health indicators), process measures related to service utilization and frequency of visitation, and outcomes related to maltreatment recurrence, stability of placements, achievement of timely permanency. Collectively, these measures address infants' and toddlers' immediate needs for protection, nurturance, stability and the sustained involvement of a caregiver.

The outcome evaluation was guided by the national Child Welfare Outcomes measures and Child and Family Services Review (CFSR) indicators developed by the Administration for Children and Families. These measures are used to determine whether the children served by the nation's child welfare systems are protected from abuse and neglect; have permanency and stability in their living situations and continuity in their family relationships, and receive adequate services to meet their needs. Upon publication of the Court Performance Measures in December 2008, the outcome framework was revised to allow for reference to these measures, as appropriate. [31] **Table I-2** presents a cross-walk of the Court Team evaluation measures, child welfare outcome measures, corresponding CFSR indicators, and Court Performance measures.

a. Case-Level Data from the ZTT Court Team Database

In August 2007, ZTT implemented a web-based database to allow each jurisdiction to track parent and child characteristics, needs, services received, and permanency outcomes. [32] JBA entered into a data sharing agreement with ZTT to obtain a de-identified child-level dataset for secondary analysis. JBA received IRB approval and was granted a *Waiver of Consent and a Waiver of Authorization for Secondary Analysis of a De-Identified, Limited Data Set,* as some of the information collected by ZTT is considered Protected Health Information (PHI), as defined by the Privacy Rule (HIPAA) (See **Appendix E).**

[31] Flango, V. E. & Kauder, N. (2008). *Court Performance Measures in Child Abuse and Maltreatment Cases: Key Measures.* Washington, DC: Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice and Children's Bureau, U.S. Department of Health and Human Services.

[32] At the national level, the Court Teams data is also used for project management and quality improvement purposes. ZTT reports aggregate findings regarding inputs and short-term outcomes to its funding sponsor. *Court Teams for Maltreated Infants and Toddlers: A Guidebook for Local Teams* (May 2008).

Table I-2. Crosswalk of Child Welfare Outcome Measures, CFSR Indicators, and Court Performance Measures

Outcome	Court Team Evaluation	Child Welfare Outcome Measure	CFSR outcome & item	Court Performance Measure
Children are protected from abuse and neglect				
Absence of maltreatment recurrence	Of all infants and toddlers served by the Court Teams who were victims of substantiated maltreatment, what percentage did not have a substantiated report of maltreatment within a 6-month period?	**1.1: Absence of Maltreatment Recurrence:** Of all children who were victims of substantiated or indicated child abuse and/or neglect during the reporting period, what percentage did not have another substantiated or indicated report within a 6-month period? [33]	**Safety Outcome 1** Item 2: Repeat maltreatment	**Measure 1A: Child safety while under court supervision –** Percentage of children who are abused or neglected while under court jurisdiction
Continuity of family relationships				
Frequency of visitation	Of all infants and toddlers served by the Court Teams, what percentage was visited by parent(s): at least weekly? more than weekly? less than weekly?		**Permanency Outcome 2** Item 13: Visiting with parents and siblings	*Not applicable*
	Of all infants and toddlers served by the Court Teams, what percentage was placed in proximity to the birth parent(s) to facilitate visitation while the child was in foster care?		**Permanency Outcome 2** Item 11: Proximity of current placements	*Not applicable*
Children have permanency and stability in their living arrangements				
Stability of placements	Of all infants and toddlers served by the Court Teams, what percentage: • remained with the birth parent; • were placed with a relative; • were placed with a non-relative [34]		**Permanency Outcome 1** Item 6: Stability of foster care placement Item 15: Relative placement	*Not applicable*
	• Of all infants and toddlers served by the Court Teams, what percentage had no more than two placement settings during the following time periods: less than 12 months; 12 to 24 months; 24+ months.	**Permanency Composite 4: Placement Stability** [35] 1) Two or fewer placement settings for children in care for: • less than 12 months; • 12 to 24 months; • 24+ months.	**Permanency Outcome 1** Item 6: Stability of foster care placement	*Not applicable*

[33] This measure was changed to reflect the revised national measure per *The Data Measures, Data Composites, and National Standards to be Used in the Child and Family Services Review*, 71 Fed. Reg. 109, 32973 (June 7, 2007). The rate of maltreatment recurrence was measured in previous years.
[34] Foster/adopt home; medical foster home; therapeutic foster care; other foster parent; group home; crisis nursery; shelter; hospital; or temporary placement.
[35] Replaces **6.1: *Increase Placement Stability***

Outcome	Court Team Evaluation	Child Welfare Outcome Measure	CFSR outcome & item	Court Performance Measure
Children have permanency and stability in their living arrangements				
Time to achieve permanency	Of all infants and toddlers served by the Court Team, what percentage were • reunified with the parent? • placed with a fit and willing relative? • referred for legal guardianship • placed for adoption?	**3.1: Increase Permanency for Children in Foster Care (Exits from Foster Care):** For all children who exited the child welfare system, what percentage left either to reunification, adoption, or legal guardianship?	**Permanency Outcome 1** Item 8: Reunification with parent, guardianship or permanent placement with relative Item 9: Adoption achieved	**Measure 2A: Achievement of Child Permanency -** Percentage of children in foster care who reach legal permanency by reunification, adoption, or legal guardianship
	For infants and toddlers served by the Court Team, what was the average length of time to achieve the permanency goal of • reunification? • legal guardianship or placed with a fit and willing relative? • adoption?	**4.1: Reduce the Time in Foster Care to Reunification Without Increasing Re-entry:** Of all children who were reunified with their parents or caretakers at the time of discharge from foster care, what percentage was reunified in the following time periods? • Less than 12 months from latest removal; • At least 12 months, but less than 24; • At least 24 months, but less than 36; • At least 36 months, but less than 48; • 48 or more months. **5.1: Reduce Time in Foster Care to Adoption** As above for children who exited care to a finalized adoption.		**Measure 4A: Time to permanent placement** Average (median) time from filing of the original petition to legal permanency
Children receive adequate services to meet their physical and mental health needs & Families have enhanced capacity to provide for children's services				
Rates of service utilization	Of all infants and toddlers served by the Court Teams, what percentage received services based on needs identified at intake?		**Well-Being Outcome 1** Item 17: Needs and services of child, parents, and foster parents **Well-Being Outcome 2** Item 22: Physical health Item 23: Mental/ behavioral health needs	*Not applicable*

To populate the database, each ZTT Community Coordinator collects child- and parent-specific information data on a number of case-level indicators related to safety, placement, visitation, service needs, and developmental status. The database is populated on a monthly basis, usually following the court hearings, with information gleaned from court records, child welfare files, and service provider reports. The ZTT Community Coordinators periodically review cases to verify the quality and accuracy of client-level data. Reports are generated on key indicators for quality assurance purposes (e.g., to track whether all children are receiving required medical screening when they enter out-of-home care).

To respect the privacy and confidentiality of sensitive information concerning families and children involved in maltreatment cases, each Court Team has established protocols for tracking service referrals and utilization, changing case needs, and key milestones through the use of confidentiality releases, referral forms, and data collection procedures. [36] To facilitate information collection, each Judge has invested the respective ZTT Community Coordinator with legal authority to access and obtain confidential information regarding infant and toddler dependency cases, as described below.

- **Fort Bend County, TX:** The ZTT Community Coordinator has been appointed as a Guardian *ad litem* (GAL) for all infant and toddler cases heard by the 328th District Court. This appointment authorizes access to all child and parent records. As the GAL, the ZTT Community Coordinator is notified of all hearings and receives copies of all documents. The GAL is listed on all court documents, including original affidavit for removals, orders, mediated settlements, permanency planning reports and medical summaries. The GAL receives monthly copies of all CASA reports. Although the ZTT Community Coordinator serves as the GAL for the child age 0-3 and his/her siblings, only data relevant to the ZTT case is entered in the ZTT database.

- **Forrest County, MS:** The ZTT Community Coordinator has been appointed a "Designee" by the Judge of the Forrest County Youth Court. In this capacity, the ZTT Community Coordinator has access to court records maintained by the Youth Court Administrator and obtains copies of all documents and reports from the child welfare agency and service providers. Information from these data sources is abstracted and entered in the ZTT database for case-tracking purposes. The ZTT Community Coordinator does not have direct access to case files from the Department of Human Services.

- **Polk County, IA:** Via court order, the Presiding Judge of the Fifth District Court has granted the ZTT Community Coordinator access to court files and documents submitted to the court by child protective services and social service providers. The ZTT Community Coordinator is co-located at the Department of Human Services (DHS) and has direct access to DHS case

[36] *Court Teams for Maltreated Infants and Toddlers: A Guidebook for Local Teams* (May 2008).

files. Throughout the life of the case, the ZTT Community Coordinator collects information regarding the child(ren) and parent from multiple providers. [37]

The data residing in the Court Teams database is similar to administrative data that is regularly collected by child welfare agencies on such variables as reason for removal, characteristics of children in care, placement type and duration, and exit status. JBA did not have access to the parental information in the data base, other than a list containing a family identifier, the number of children involved in the case, and the dates of case opening, closure, and re-opening. JBA obtained three de-identified data extracts between September 2008 and June 2009 that contained child-specific variables, as detailed below.

Case Status: Data elements pertaining to case status largely focus on key milestones related to a dependency case and the ASFA timeline. The ***case open date*** reflects the date that the case was officially opened as a Court case. The ***case close date*** indicates the date that the case was officially closed by the court system and permanency was achieved (e.g., reunification, adoption, guardianship). The ***date of initial court order*** indicates that a judicial determination has been made that it is contrary to the welfare of child to remain in the home. The ***date of removal*** refers to the date that the child was removed from the parent or guardian. The ***ASFA one year marker*** is a system-generated timeline that indicates whether the case is approaching this critical milestone (as measured by the number of days that remain) or whether it has passed.

Child Demographics: Data elements pertaining to child demographics are ***age, gender, race/ethnicity, primary language, number of siblings***, and ***other children removed***. Additional indicators describe family characteristics, i.e., whether the ***family meets federal definition of poverty*** [38] and whether the ***father's name is on the birth certificate***. [39]

Reasons for Removal: The Court Teams database captures data related to the type of maltreatment perpetrated on the child under the category of "Reasons for Removal" (i.e., the reason a child was removed from the home). Seven types of maltreatment are captured: ***abandonment; medical neglect; neglect; physical abuse; sexual abuse; psychological maltreatment; and other abuse.*** Parental risk factors identified are ***use of alcohol/drugs factor in removal*** and ***mental illness a factor in removal***. These terms are similar to those found under the category "Reason for Agency Involvement" in the Onsite Review Instrument used for data collection during the federal Child and Family Services Review: Physical abuse; sexual abuse; emotional maltreatment; neglect (not including medical neglect; abandonment; mental/physical health of parent; mental/physical health of child; substance abuse by parent(s); child's behavior;

[37] Parental participation in the Court Team is voluntary. During the adjudication hearing, the ZTT Community Coordinator obtains informed consent from the parents whose children are in temporary DHS custody to participate in the Court Team and to collect information. At this time, necessary releases for services and cross-agency collaboration are obtained.

[38] ZTT provided guidance for the poverty measure using the 2003 U.S. Department of Health and Human Services guideline set at $20,650 for a four-person family.

[39] While legal and biological paternity is established by the presence of the father's name on the birth certificate, it is also a valued indicator of social fatherhood or the "enactment of rights and duties associated with men's status as fathers." Cited in Waller, M.R. (2002). *My Baby's Father: Unmarried Parents and Paternal Responsibility*. Ithaca and London: Cornell University Press.

substance abuse by child; domestic violence in child's home; child in juvenile justice system; and other (e.g., parent incarcerated). [40]

Key Health Indicators at Intake: The database maintains an inventory of each child's presenting condition at the time of case opening (also referred to as "intake"). The indicators are***: Premature Birth; low birth weight; small for gestational age; medically fragile; physical disability; and failure to thrive.*** While these indicators typically describe the child's health status, they may also be related to the type of maltreatment suffered or reason for removal from the home (e.g., failure to thrive and neglect). Additional indicators refer to parental behaviors that impact child maltreatment. ***Exposure to parental substance abuse*** refers to a child being present when a parent is abusing alcohol or drugs or under the influence of drugs. [41] ***Exposure in utero to smoking, alcohol/drugs, or domestic violence*** captures information related to the biological effects of prenatal drug exposure and postnatal home environment, both of which influence child development and vulnerability. Descriptive information is provided with respect to health needs at intake (e.g., cocaine positive at birth, born at 32 weeks).

Placement: The Court Teams database tracks the stability and setting of the child's placement while in out-of-home care. This includes: ***Type of placement; placement with relatives; the presence of the birthparent in home with the child; the location of the placement;*** [42] ***and the distance of the placement from the primary biological parent.*** [43] Placement types include remaining with the birth parent; relative placement; non-relative placement; foster/adopt home; medical foster home; therapeutic foster care; other foster parent; group home; crisis nursery; shelter; hospital; or temporary placement.

Service Needs and Usage: The database tracks services which the judge orders for the child (***Court Ordered Service)*** and whether services have been received (***Monthly Service Detail***). Service categories are: ***dental care; developmental screening; Early Intervention Early Head Start/Head Start; family counseling; full developmental assessment; hearing services; IFSP developed; immunizations; infant mental health services; other early childhood education; parent-child psychotherapy; parent-child relationship evaluation; primary health care visit; psychological evaluation; specialist health care visit;*** and ***vision services.***

Visitation: The Court Team database captures information related to the Judge's orders regarding visitation and the frequency with which it occurs. This includes ***type of visitation; frequency of visitation;*** and ***actual visitation received.*** Dates are provided regarding changes to the type or frequency of the visitation, as ***ordered by the Judge.***

Permanency Planning: Data elements pertaining to permanency planning and outcomes comprise the (1) ***primary permanency goal*** (i.e., reunification with parent; place child with a fit

[40] CFSR Onsite Review Instrument (March 2008). OMB Control No: 0970-0214. Expiration date: 1/31/2010

[41] Per Iowa statute, the intent to manufacture methamphetamine in the presence of a child is considered "abuse." The statute reads: That the person responsible for the care of a child has, in the presence of the child, manufactured a dangerous substance or possesses a product containing ephedrine, its salts, optical isomers, salts of optical isomers, or pseudoephedrine, its salts, optical isomers, or salts of optical isomers, with the intent to use the product as a precursor or an intermediary to a dangerous substance (Ann. Stat. § 232.68).

[42] The site of the child's placement status is further described as in county of residence; out of county of residence; or out of state.

[43] This is expressed as 0-10 miles; 10-30 miles; 31-60 miles; and over 60 miles.

and living relative; refer child for legal guardianship; place child for adoption; other); (2) ***concurrent plan goal*** (as above, to include termination of parental rights (TPR)); and (3) ***case outcome*** (as above). As permanency planning is driven by the ASFA timeline and legal mandates, the month/day/year of ***court hearings*** are captured in the database, along with the identification of the hearing type (i.e., Initial protective hearing; Adjudicatory; Dispositional; File TPR petition; Permanency; Review; Status; Informal (Court Team Monthly Reviews); Termination; and Post Termination). Dates related to achievement of permanency include the ***determination date for child permanency*** and the ***date the child was placed with or living with a parent; a relative with legal custody; or an adoptive parent.***

b. Administrative data for comparative purposes

In the grant application, JBA had originally proposed conducting a quasi-experimental evaluation using historical comparison groups to compare the outcome of infants and toddlers served in each jurisdiction prior to the implementation of the Court Team model. Although we had intended to develop a matched sample of infant and toddlers based on comparable characteristics, there were not a sufficient number of cases served by each jurisdiction to allow for matching on discrete variables. [44] Additional challenges in developing the comparison groups included limited access to child welfare administrative data, uneven quality of historical data, and limited resources to examine paper-based case files.

However, the evaluation team was successful in obtaining comparable descriptive data and aggregate outcome data for infants and toddlers served in each jurisdiction comparisons prior to implementation of the Court Team model, as presented in Chapter III. Administrative data was obtained from the following sources:

- **Fort Bend County, TX:** Administrative data from the Child Advocates of Fort Bend County program was used to describe the characteristics and outcomes for 95 infants and toddlers served by the 328th and 387th District Courts prior to implementation of the model in October 2005.

- **Forrest County, MS:** Under the auspices of the Judge and Court Clerk, case reviews were conducted of 30 cases served by the Youth Court between January 2004 and January 2006, prior to Court Team implementation. Court case files were provided by the Youth Court and abstracted on-site. Additional case information was abstracted from case records on-site at the Forrest County Department of Human Services. Printouts of data pages from the Mississippi Automated Child Welfare Information System (MACWIS) were provided. JBA staff entered these data into an Excel spreadsheet.

- **Polk County, IA:** A de-identified Adoption and Foster Care Analysis and Reporting System (AFCARS) dataset was obtained from the Iowa Department of Human Services. The sample of 60 infants and toddlers resided in Polk County, IA and were served by the Fifth Judicial District from March 2000 through April 2006.

[44] Additional challenges in developing a comparison group included limitations on access to court or child welfare data and differences in the quality of historical data.

c. Quantitative data analysis

Cleaned ZTT Court Team data tables were uploaded into SAS software for programming and analysis. The data included family detail, child background, reasons removed, child placement status, child service needs, monthly service detail, immunizations, visitation, child case status, and additional notes. Frequencies and percentages were obtained for the key variables noted above and are arrayed in tables in Chapter III. Details of the data analysis are contained in Chapter 3. Medians were calculated to estimate time to permanency. Cross-tabulations and significance tests were conducted where applicable and are noted in Chapter III.

D. Limitations of the Study

There are three limitations that need to be acknowledged regarding the present study. The first limitation concerns external validity and the inability to generalize these research findings to infants and toddlers in other dependency courts, given the small sample size overall (N=186). The small sample size at each site (i.e., 86, 50, 50) also limited site-specific analyses.

Second, information on parents is limited to their parental rights status at case closure (i.e., rights retained, relinquished, or terminated). This information was obtained from the child case status records. We recognize that parental history, engagement with social services, and compliance with treatment plans are major determinants of child outcomes. However, the evaluation team did not have access to parental information recorded in the Court Team database. Parent data included detailed information on demographics, background (i.e., history of alcohol/drug abuse, mental health issues, domestic violence issues, prior experience with child welfare or juvenile justice, teen pregnancy, and adult incarceration); maltreatment allegations since the family entered the ZTT program; identification of court-ordered services and referrals, and service utilization (e.g., intensive case management, parent education, family counseling, psychological or psychiatric evaluation, mental health screening or counseling, anger management, parent/child evaluation and psychotherapy, substance abuse screening, inpatient/outpatient substance abuse treatment (with children), etc.).

Permission to access these data for analysis would have involved tracking, locating, and obtaining informed consent directly from parents to participate in the study and to analyze this information; this was beyond the scope of the evaluation. However, we did observe some parents during the court hearings, and heard directly about their progress, struggles, and outcomes (both positive and negative). Where feasible and appropriate, [45] future studies should examine parental data as well as include parents as key

[45] Involving parents may be problematic and discouraged by their counsel in the event that a criminal investigation regarding child maltreatment is underway.

informants in qualitative data collection in order to more fully understand the complex factors and relationships that contribute to children's safety, permanency, and well-being outcomes.

Third, there were limitations with the database utilized for tracking children's progress. Development of the database occurred in conjunction with implementation of the Court Team model. Some changes were made to the database structure throughout the implementation period as needs were identified by the sites. Although a User Guide had been issued, it was not consistently updated to reflect changes. Definitions of variables were not consistently employed across sites (e.g., recording whether services were needed; identifying health needs at intake).

All sites reported difficulty tracking their cases using the database and indicated that they used external databases to manage case activity. Due to resource limitations, system upgrades that might have prevented some of these challenges were delayed. Certain modules prevented users from saving data unless all fields had been entered; thus dummy data were entered as placeholders in order to save interim case information (e.g., a fictitious and out-of-range date). Sites reported that data entered were not always reflected in the data tables or reports generated (e.g. dates of most recent visitation). Indeed, data cleaning revealed areas of missing data (e.g., demographics, dates of service utilization) and internal inconsistencies within or across tables (e.g., child outcome status did not correspond with parental rights status). The evaluation team ran logic checks and produced case-specific reports indicating where sites needed to enter or revise data. Inconsistencies were identified and corrected prior to conducting the analyses.

Chapter II

Implementation of the Court Team Model

In each jurisdiction, the Court Team seeks to restructure the way in which the community—including the courts, child welfare agencies, child development clinicians and practitioners—responds to the needs of the maltreated infants and toddlers. Through judicial leadership, case management, and community collaboration, the Court Teams seek to promote the coordination of existing child-focused services and resources to provide intensive interventions for very young children; this represents a collective effort to strengthen the systems' capacity to address the needs of this highly vulnerable population and to improve safety, permanency, and well-being outcomes.

This chapter examines the implementation of the Court Team model at four sites: the 328th District Court in Fort Bend County, TX (October 2005); the Fifth District Court in Polk County, IA (April 2006); the Youth Court in Forrest County, MS (May 2006); and the Child Protection Division of the Orleans Parish Juvenile Court, LA (June 2007). Given that the Court Team sites began implementing the model at different times, the evaluation team collected both prospective and retrospective information to capture key activities, contextual factors, and adaptations that were responsive to local needs and conditions. [46] The evaluation team examined:

- Implementation of the key components of the Court Team model at each site, including judicial leadership; the role of the local ZTT Community Coordinator; mobilization of Court Team community partners; institutionalization of monthly case reviews and/or hearings; coordination of child-focused services; availability and use of parent/child mental health interventions; use of evidence-based parenting education and interventions; and provision of training and technical assistance by ZTT;

- Services provided to infants and toddlers including delivery of early childhood intervention screenings and evaluation; Part C services (e.g., family training, counseling, home visits, and other services authorized by the Individuals with Disabilities Act amendments of 2004 and the Child Abuse and Prevention Treatment Act amendments of 2003); and physical and mental health care;

- Facilitators and barriers to model implementation;

- Changes in knowledge and practices among key stakeholders involved in infant and toddler cases, including judges, attorneys, and service providers;

- Integration of the Court Team model into the Dependency Court process.

[46] Mowbray, C.T., & Herman, S.E. (1991). Using multiple sites in mental health evaluations: Focus on program theory and implementation issues. In R.S. Turpin, & J.M. Sinacore (Eds.), *Multisite Evaluations, New Directions for Program Evaluation* 50, 45-58.

The chapter begins with a brief description of each Court Team site, including demographics, the background and tenure of the Presiding Judge and Community Coordinator and key contextual information about each jurisdiction (e.g., child welfare lawsuit, designation as a Model Court, impact of Hurricane Katrina). Next, the chapter presents a cross-site summary regarding the implementation status of eight core components of the Court Team model. This presentation is followed by identification of common facilitators and barriers that impacted implementation at the Court Team sites. Changes in Court Team stakeholders' knowledge and practice—based on learning about the impact of abuse and neglect on early development and the needs of infants and toddlers in the child welfare system—are examined. The chapter concludes with a comparative examination of the integration of the Court Team process into the dependency court proceedings in each jurisdiction.

A. Description of the Four Court Teams Sites

1. Fort Bend County, TX

Fort Bend County, TX is one of the wealthier counties surrounding Houston. Median household income is $77,016 for the 532,000 residents.[47] Between 2000 and 2008 the county's population increased by 50 percent. [48] The poverty rate is 8 percent [49] and is half the rate of neighboring Harris County (16%).[50] Children under five account for 7 percent of the Fort Bend County population.[51] Fort Bend is becoming a more racially diverse county. Almost two-thirds of Fort Bend County residents are Caucasian (62%) and one-fifth are African American (20.9).[52] The county also includes a sizeable minority of Spanish speaking residents.[53] Children in foster care are monitored by Child Protective Services (CPS), the state's child welfare agency, and by the 328th District Court. The Judge is an elected official and has served on the 328th District since 2003, having been an attorney in private practice prior to election. When the Court Team came into being, the state was attempting to privatize child welfare services under

[47] U.S. Census Bureau (September 4, 2009). *Fort Bend County QuickFacts.* Accessed October 2009 from http://quickfacts.census.gov/qfd/states/48/48157.html.
[48] Ibid.

[49] Ibid.

[50] Ibid.

[51] Ibid.

[52] Ibid.

[53] Liberman, M. (August 27, 2006). *Language Log: Spanish in the states.* Accessed October 2009 from http://itre.cis.upenn.edu/~myl/languagelog/archives/003510.html.

Senate Bill 6.[54] This created job insecurity among CPS employees that continued until the state abandoned Senate Bill 6 in 2007. The Fort Bend County Community Coordinator had been working in human services in the County for 17 years as a clinician and administrator prior to assuming the ZTT position in July 2005. The Court Team model was implemented in Fort Bend County in October 2005.[xxii]

2. Forrest County, MS

Forrest County, MS, which includes the city of Hattiesburg, sits near the Gulf Coast. Hattiesburg accounts for 60 percent [55] of the county's 79,425 residents.[56] Almost eight percent (7.7%) of the residents are children under the age of five. The median household income is $32,589 for the county as a whole. The poverty rate is 25 percent. Almost all residents are Caucasian white (62%) or African-American (35%).[57] The Forrest County Youth Court hears all juvenile delinquency and child dependency cases. Trial court judges stand for election every four years. The Presiding Judge previously served as a city court judge and an assistant district attorney. The ZTT Community Coordinator had worked for the Forrest County Department of Human Services (DHS) for more than 25 years and then assumed the ZTT position. The Community Coordinator began in the position three months after Hurricane Katrina devastated the Gulf Coast. In 2004, the Mississippi DHS, Department of Human Services (DHS), which administers the state's child welfare services, was sued by Children's Rights and co-counsel on behalf of some 3,500 foster children under the agency's care and protection. The state and Children's Rights negotiated a settlement in the *Olivia Y. v. Barbour* case which was approved by the federal judge in January 2008.[58] During this period, the University of Southern Mississippi, School of Social Work became actively involved in Forrest County DHS management. In 2008, the Forrest County Youth Court was selected to participate in the National Council of Juvenile and Family Court Judges (NCJFCJ) Model Courts Program. [59] Court Team model was implemented in Fort Bend County in May 2006.

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[54] Hagert, C., McCown, F.S., Roper, T., Castro, E.D.L., Habibi, S. (August 2008). *Drawing the Line between Public and Private Responsibility in Child Welfare: The Texas Debate*. Austin, TX: Center for Public Policy Priorities. Accessed October 2009 from http://www.cppp.org/files/4/CPSreportweb.pdf.

[55] U.S. Census Bureau. (September 4, 2009). *Hattiesburg (city) QuickFacts*. Accessed October 2009 from http://quickfacts.census.gov/qfd/states/28/2831020.html.

[56] U.S. Census Bureau. (September 4, 2009). *Forrest County QuickFacts*. Accessed October 2009 from http://quickfacts.census.gov/qfd/states/28/28035.html.

[57] Ibid.

[58] Children's Rights. (June 8, 2009). *After Slow Start, Court-Ordered Child Welfare Reforms Underway in Mississippi*. Accessed October 2009 from http://www.childrensrights.org/news-events/press/after-slow-start-court-ordered-child-welfare-reforms-underway-in-mississippi/.

[59] Permanency Planning for Children Department. (2009). *Victim Act Model Court Sites*. Accessed October 2009 from http://www.ncjfcj.org/content/blogcategory/112/151/.

3. Orleans Parish, LA

Orleans Parish, LA, which includes the City of New Orleans, is estimated to have had 311,850 people living within its boundaries in 2008, of whom 6 percent are children under five. Between 2000 and 2006 the total population of New Orleans declined by more than 50 percent, largely due to the devastation wrought by Hurricane Katrina. The population of Orleans Parish is African-American (62%) and Caucasian (34%). Only 8 percent of the residents speak a language other than English at home. Median household income in 2007 was estimated at $37,348. Almost 22 percent of the population fell below the poverty line.[60] The state child welfare agency is the Office of Community Services, and much like every service provider in Louisiana, has faced extreme challenges since Hurricane Katrina. The Judge implementing the Court Teams program is one of two judges hearing juvenile delinquency and child maltreatment cases for Orleans Parish. The Judge was first elected to the Orleans Parish Juvenile Court in 1984 to fill an unexpired term and has been re-elected three times. [61] The Judge serves as the Lead Judge for the Model Court and has served in that role since 1999, when NCJFCJ selected the Orleans Parish Juvenile Court to participate.[62] The Community Coordinator brings 18 years of professional experience in court administration, juvenile justice, adult protection and child welfare to the position with the Orleans Parish Court Team. Court Team model was implemented in Fort Bend County in June 2007.

4. Polk County, IA

Polk County, IA includes Des Moines, Iowa's state capital. Des Moines residents account for 46 percent [63] of Polk County's 425,000 residents. [64] The median household income is $54,377. Children under five make up 8 percent of the county's total population. The poverty rate is 9 percent. [65] Children in foster care are monitored by the state Department of Human Services (DHS) and the Polk County Juvenile Court. The Judge is one of five Juvenile Court judges handling child maltreatment cases in the

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[60] *Orleans Parish QuickFacts.*

[61] Hudson, L. (2006). *Court Teams for Maltreated Infants and Toddlers Project Congressional Briefing Speaker Biographie*s. Washington, DC: ZERO TO THREE.

[62] Permanency Planning for Children Department (2009). *Victim Act Model Court Profiles: New Orleans, Louisiana*. Accessed October 2009 from http://www.ncjfcj.org/images/stories/dept/ppcd/pdf/StatusReport2006/neworleansprofile.pdf.

[63] U.S. Census Bureau. (September 4, 2009). *Des Moines (city*) QuickFacts. Accessed October 2009 from http://quickfacts.census.gov/qfd/states/19/1921000.html.

[64] U.S. Census Bureau. (September 4, 2009). *Polk County QuickFacts*. Accessed October 2009 from http://quickfacts.census.gov/qfd/states/19/19153.html.

[65] Ibid.

Fifth Judicial District. Prior to appointment to the bench in 1994, the Judge served in private practice, prosecution, and as an adjunct law professor. [66] NCJFCJ selected the Polk County Juvenile Court as a Model Court in 2005 and the Judge leads this effort. [67] The Model Court Project offered the Des Moines judges access to cutting edge research and best practices that laid a foundation of collaboration with community partners that the Court Team used as a foundation for its efforts on behalf of infants and toddlers. The ZTT Community Coordinator previously provided in-home therapy, skill development, and supervision services to families and children birth to eighteen years of age. Court Team model was implemented in Polk County in April 2006.

B. Implementation of the Court Team Model: Cross-site summary

The guiding principles of the Court Team have evolved since the model was first developed and implemented in 2005. The original model focused on eight key elements: (1) a Judge as the catalyst for systems change; (2) a local Community Coordinator to serve as a resource for child development expertise for the court; (3) a "Court Team" composed of key community stakeholders dedicated to serving vulnerable children; (4) monthly case reviews to assess the progress of each case; (5) use of new forms to court-order service referrals for infants and toddlers; (6) provision of training and technical assistance by ZTT to court personnel and community service providers on infant and toddler development, dyadic therapy, parenting interventions, services available in the community, and child trauma; (7) community capacity to refer parents to mental health assessments and treatment, such as dyadic therapy; and (8) dissemination of resource materials developed by ZTT (e.g., *Babies from the Bench)*. Over time, the model was refined as ZTT and the Court Team sites examined their accomplishments and challenges experienced during the early implementation process.

The next iteration of the model, issued in 2007, retained the focus on judicial leadership, the role of the Community Coordinator, collaboration among key community stakeholders, and monthly reviews of infant and toddler cases to assess progress. The emphasis on utilization of new court order forms was eliminated. The revised model placed much greater emphasis on the provision of mental health assessments and treatment for parents in order to heal their relationship with their children. [68] The revised model also emphasized the incorporation of child-focused services—developmental, medical, and mental

[66] Iowa Judicial Branch. (2009). *District Courts: District Five Judges and Magistrates*. Accessed October 2009 from http://www.iowacourts.gov/District_Courts/District_Five/Judges_and_Magistrates/.

[67] Permanency Planning for Children Department (2009). *Victim Act Model Court Profiles: Des Moines, Iowa*. Accessed October 2009 from http://www.ncjfcj.org/images/stories/dept/ppcd/pdf/StatusReport2006/desmoinesprofile.pdf.

[68] Specifically, the language changed from "will have the capacity" to "must have the capacity."

health—into the case plan document. Parenting education and interventions were also emphasized, with a clear preference for research-based programs that included observations of parent child interactions before and after delivery of the curriculum. Delivery of training and technical assistance, dissemination of resource materials, and evaluation were broadly integrated into "national activities" led by ZTT.

As of this writing, the model has 11 components and continues to evolve as the operations of the Court Teams have matured, child welfare practice has evolved, and community collaboration has increased. [69] Most significantly, changes to the core model are informed by emerging evidence about what works for vulnerable children and families. In this regard, frequent and consistent parent-child contact (i.e., visitation) has been added as a core component of the model. The repertoire of mental health interventions utilized by the Court Teams has expanded to include a continuum of services: an assessment of the parent-child relationship, use of evidence-based parenting programs, use of visit coaching to foster positive parent-children contacts, use of psycho-educational parenting interventions, and child-parent psychotherapy. Further refinements to the model include targeting infants and toddlers in out-of-home care, emphasis on placement stability and concurrent planning, and use of family team meetings to assess progress (and held in or out of court). Training and technical assistance now includes dissemination of resource materials. The emphasis on evaluation addresses information collected on knowledge enhancement, collaboration, and services to children and families and use of this information for quality improvement purposes.

The evaluation of the Court Team model was undertaken in 2007; thus, implementation of the eight core components of the "second-generation" model is examined below: (1) Judicial leadership; (2) Community Coordinator; (3) Court Team; (4) Monthly case reviews; (5) Child focused services; (6) Mental health interventions; (7) Parenting education and interventions; and (8) Training and technical assistance. Brief summaries of the implementation highlights of each aspect of the Court Team model are provided, noting site-specific adaptations of the model in relation to community strengths and challenges. A general assessment of the implementation status is provided (i.e., fully implemented, not fully-implemented) based on stakeholder perceptions, along with specific challenges experienced and suggestions for improvement.

[69] *Court Team Project Core Components* accessed September 2009 at http://www.zerotothree.org/site/DocServer/Court_Teams_Core_Components.pdf?docID=6904

1. Judicial leadership – Fully implemented

Judicial leadership is the key driver for the successful implementation of the Court Team model and the meeting the needs of maltreated infants and toddlers. The reach of judicial leadership was exhibited in three interconnected domains: in the courtroom, in the child welfare system, and in the community. With regard to judicial leadership in the court and child welfare system, all of the Judges took an active role in leading system reform efforts through the establishment of a specialized docket to address infant and toddler cases (referred to as the ZTT docket in some jurisdictions). A composite portrait of the Court Team judge, drawn from stakeholder comments across the four sites, is one that "cares about children and their outcomes;" "insists on high standards (of practice);" "is adamant that children in custody receive the best services;" "facilitates change;" "reinforces the importance of the accountability to the child by the family, worker, prosecutor, provider, etc.;" and "is supportive of the team working through its process. " The Judges acknowledged their indebtedness to the Miami-Dade model, their belief in the Court Team approach, the value of making an investment in it, and working through any challenges.

In the courtroom, judicial leadership was demonstrated through decision-making and the quality of oversight in child maltreatment cases. One stakeholder summed this up as the Judge is the "change agent and decision maker." While much of this active oversight role was informed by the legislative mandate of the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) and strengthened by the ASFA of 1997, judicial oversight was also informed by current knowledge about best practice in child welfare. Speaking to the judge's role in the dependency process, one Judge remarked, "We have this window of opportunity to undo the damage caused by abuse and neglect." The "window of opportunity" opened each month during the hearings. To this end, judicial oversight consisted of attending to the child's continued safety, weighing placement options, addressing efforts to locate relatives and other placement resources, ordering the scope and frequency of family contact (visitation) and sibling access, approving permanency plans, and overseeing reasonable efforts towards timely permanency and adhering to required permanency timelines and hearing schedules. During the courtroom observations, the study team observed the Judges address these multiple facets of the dependency cases on the ZTT docket. This involved hearing testimony and questioning parties to the case regarding the service needs of child, the time for completion of assessments and treatment, additional services that were needed or recommended, and services to be provided by prior to next hearing. While such questions fall within the guidelines established by the National Council of Juvenile and Family Court Judges, judicial questioning was informed also by the Judges' knowledge of infant and toddler development.[70] Questions such as "Where

[70] Osofsky, Maze, Lederman, Grace, & Dicker, 2002.

are we with Paul's developmental screening?" or "How is Simone's relationship with Mom?" or "Have you looked into whether [this] provider has an open slot for Inez?" were heard. [71] In this regard, the Judges augmented their oversight role to include the dissemination and utilization of the science of early childhood development (e.g., achieving developmental milestones, attachment and bonding, early learning and child care).

During the hearings, the Judges focused on the safety and well-being of the child in his or her current placement. In assessing factors regarding the child's "best interest" Judges discussed and weighed placement options, family contact schedules, and the changing physical, developmental, and mental health of the child, as well as child care and/or educational needs. [72] Similar attention was given to the child's parent, and is well-captured by one stakeholder's comment that implementation of the Court Team model enabled a "strong commitment to protecting children while giving the families resources" to ensure that "reasonable efforts" were made in the case. [73] In this regard, judicial questioning during the hearings addressed a range of needs, services, and supports for families: child care, child support, domestic violence counseling and/or treatment, education, employment, housing, mental health assessment and/or intervention, parent/child therapy, parenting classes, paternity, physical health exams, social supports, substance abuse testing and/or treatment, TANF or emergency assistance, transportation, and visitation. With regard to 'front-loading' services, one Judge observed that "more work early in the case means less work in the long run."

Judges engaged in dialogue with parents to obtain their perspective on various issues. At times, the Judge would praise parents' efforts to address their issues and "get their children back." One Judge noted that this strategy of positive reinforcement "means a lot when it's coming from the Judge." Another noted that it was important to "involve parents in the program" and "to get parents to recognize that the Court Team is invested in them and to not give up." However, the Judges also questioned or challenged parents' commitment to themselves and their children. They openly admonished them for their lack of progress, and made very clear the probable consequences of inaction: a limited prospect for timely reunification with one's child, the potential loss of parental rights.

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[71] Children's names are fictitious.

[72] *Determining the Best Interests of the Child: Summary of State Laws* (April 2008). Accessed October 2009 from www.childwelfare.gov/systemwide/laws_policies/statutes/best_interest.cfm.

[73] State child welfare systems are required to demonstrate that "reasonable efforts" have been made to (1) maintain a child in his/her family and prevent unnecessary removal, as long as the child's safety is not endangered; (2) safely reunify a child with his/her family in situations where removal becomes necessary; and (3) create timely alternative permanency plans for the child when reunification is not possible. States are not required to make efforts to prevent removal or reunify a child with his/her birthparents in certain circumstances, including: (1) when the parent has been convicted of murdering or felony assault of the child or a sibling; (2) when parental rights have been terminated for sibling(s) of the child; or (3) the child has been the victim of serious physical abuse. *Determining the Best Interests of the Child: Summary of State Laws* (April 2008). Accessed October 2009 from www.childwelfare.gov/systemwide/laws_policies/statutes/best_interest.cfm.

The message conveyed from the bench was that all parties to the case were accountable. One stakeholder described the Judge's decision-making and oversight role as "stepping back and seeing how to lift all boats: It means dealing with all systems players, being respectful of all roles, and enhancing their ability to do their part [role] correctly." Other stakeholders observed that the Judges established an open and respectful forum for discussing issues relevant to the case. They fostered dialogue among parties that had either shared or divergent perspectives on the issues at hand: child welfare, attorneys, CASAs, parents, families, and the Community Coordinator. As one Judge noted, "The Court Team model is open to a different way of handling cases that is more inclusive and less adversarial." While, at times, issues were contested by legal representatives for children or parents, these exchanges occurred in the context of collaborative problem-solving process, such as whether there had been a *truly* diligent search for a putative father or whether the family contact plan should be changed based on conflicting perceptions of parental engagement with the child or progress with services. One stakeholder captured the inner workings of the Court Team model and the role of the Judge as the "change agent" in this complex dynamic:

> ZTT is similar to drug courts and mental health courts, where the leadership comes from the bench. But ZTT is more complex than the drug court because it engages many people who have never worked together before. There are challenges working as a team but we've surpassed most major obstacles through the Judge, who cuts through a lot of nonsense in court: communication issues, the length of time the system usually takes, bureaucracy, scheduling problems regarding access to services. The Judge and service providers hold clients accountable.

In the family-centered, but no-nonsense environment of the courtroom (i.e., "the Judge calls the shots"), the monthly hearings resulted in a set of court-ordered directives and action steps—mostly directed to the child welfare workers who were managing the case plan—to address continuing or newly-identified needs of the child and the family with a strict timeline for completion. Some stakeholders lamented that the Judge did not understand "practical constraints," and stated that "everyone may not always agree with the Judge's decision." However, stakeholders acknowledged that the "Judge is concerned with doing what is right for the children."

Away from the bench, each Judge's leadership extended into the community. [74] This was demonstrated over time, beginning with the planning phase for implementation of the Court Team when the Judges convened planning meetings, articulated his or her vision, invited community members to contribute their expertise and participate as a part of a network of support services. Judges remarked that

[74] In July 2006, the National Council of Juvenile and Family Law Judges (NCJFCJ) adopted a resolution regarding judicial leadership in juvenile and family courts. This resolution "encourages judges to be leaders and to take action" – recognizing a judge's unique role in motivating change. "Because judges see cases from all perspectives, they can often provide a clear vision of how the child welfare system needs to be improved."

community outreach was an extension of their role as a juvenile and family court judge and acknowledged having "a certain influence" to bring all the necessary stakeholders to the table. While recognizing the authority of the office, stakeholders consistently commented on their respect for the Judge as a leader in the community and for his or her personal characteristics (e.g., caring, fairness, passion, diplomacy, and thinking outside the box) that were demonstrated in the courtroom. Leadership in the community continued as the Judges convened the monthly meetings of the Court Team that were organized by the Community Coordinator (but which excluded any *ex parte* communications regarding specific cases). Stakeholders affirmed that the Judges fostered collaborative relationships with agencies and stakeholders. Judges also made efforts to educate the legal community and the legislature regarding the needs of infants and toddlers in the child welfare system and to bring needed services to their communities. As one Judge noted, "It is [my] responsibility to bring a new awareness to all participants about the critical needs of young children."

2. Local Community Coordinator - Fully implemented

Building awareness of the needs of vulnerable infants and toddlers was shared with the Community Coordinator, who worked in partnership with the court and in collaboration with local child-serving organizations on behalf of infants and toddlers. When describing their role and responsibilities with the Court Team, the Community Coordinators emphasized that their work involved building relationships with families, service professionals, and community members. In this regard, they placed great emphasis on open communication and accessibility. Their role in cases under court supervision was multi-faceted and they engaged in similar case-related activities across the sites. The Community Coordinators served as a primary resource on the science of child development, monitored ZTT cases, attended court hearings, facilitated referrals and service linkages, maintained contact with all relevant parties, and participated in case reviews or conferences convened by the court or the child welfare agency. Each Community Coordinator performed a quasi-case management role and was actively involved in ensuring that the needs of the infants and toddlers under court supervision were met. This was made evident during the hearings observed by the study team: As a matter of practice, the Judges requested each Community Coordinator to provide comments or raise concerns about the progress of the case based on her expertise and informed opinion (e.g., the quality of the parent-child bond during supervised family contact, recommendations for treatment or intervention, service barriers to address). At two sites, the Community Coordinator also served as an extension of the court with legal authority to serve as guardian *ad litem* or Designee (Fort Bend County, TX; Forrest County, MS).

Discussions with the Judges revealed that the Community Coordinator played a central role in the implementation and success of the Court Team model at each of the four sites. One Judge observed simply that the Community Coordinator "is the program." Another Judge noted that the Community

Coordinator is "the one who gets everything moving" while another Judge characterized the contribution of the Community Coordinator as the one who "ensures that problems are resolved." Yet another Judge observed that the Community Coordinator "carries the message to the community, but also brings stakeholders in to the table."

Indeed, stakeholders concurred that the Community Coordinators contributed greatly to the functioning of the Court Team, both in the courtroom and in the community. "Always there, always advocating" and "having a heart for the case" captures the essence of the Community Coordinators' approach. Stakeholders also remarked on the community-building skills that the Community Coordinators demonstrated in fulfilling the demands of their role: being knowledgeable, accessible, resourceful, and able to build and sustain relationships.

Moving beyond the courtroom, each Community Coordinator was actively engaged in shaping local community resources and networks into a coherent team to work on behalf of maltreated infants and toddlers. They worked with local providers to expand the types of services available and create linkages. One Community Coordinator noted, "I use my past professional experience and connections—calling one person, getting names, calling other people. I ask them: 'What do you think you have that could enhance services for infants and toddlers?' I help the providers reach the families and I help the providers reach each other." Two Community Coordinators advocated at the state and local level to increase awareness of the underserved infant and toddler population, address gaps, and secure needed services in their communities.

Given their prior professional experience in serving children and families, the Community Coordinators were well-grounded in their approach to coordination and collaboration. They understood the pressures and constraints that child welfare staff and service providers—with high caseloads and limited resources—faced. In their intermediary role, the Community Coordinators stated that they were mindful of maintaining clear boundaries with workers or providers, yet they also lent support where needed. As one Community Coordinator noted, "I can't take the lead [on a case], but I can walk with them."

Each Community Coordinator served as a "bridge" or liaison across the court, the child welfare agency, and provider network. In this regard, they facilitated ongoing communication and coordination across the Court Team members. A stakeholder observed that the Community Coordinator is "the glue that holds the team together." In addition, they routinely shared information and resources provided by the ZTT national office. Each Community Coordinator organized monthly meetings of the Court Team members to address topics of concern, facilitate networking, and contribute resources. In this regard, the Community Coordinator sought out and invited guest speakers to these gatherings to disseminate information in an effort to build capacity and shared knowledge across the team.

3. Teams comprised of key community stakeholders - Fully implemented

Across the four sites, the Court Team comprised the judicial and legal community, child welfare, and service professionals for parents and children (including early intervention specialists, parenting educators, therapists, case managers, and family preservation specialists, and substance abuse counselors). What members of the Court Team shared was "an interest in serving infants and toddlers."

This feature of the Court Team model has been fully implemented at the four sites. Variations in team composition across the sites reflect the resource base and existing service array in each community (e.g., Fort Bend, TX, Polk County, IA, and Orleans Parish, LA have a CASA program while Forrest County, MS does not; Polk County has an active Visiting Nurse program). Differences also speak to the presence of pre-existing collaborative efforts between the courts, child welfare, and child-focused service providers in each jurisdiction, such as children's mental health services (Polk County, IA; Orleans Parish, MS) or pediatric clinics (Forrest County, MS; Orleans Parish, LA).

In each jurisdiction, stakeholders noted that the Judge's personal invitation to get involved, along with his or her standing in the community, fostered participation in the Court Team. Stakeholders also noted that the Community Coordinators proactively recruited participation in the Court Team, by coordinating the pre-existing service array, tapping into professional relationships and networks, and actively targeting key providers and agencies in each locale.

Stakeholders remarked that participation in the Court Team united health and human service providers that had, at times, operated somewhat independently of the other. Effective coordination of efforts across Court Team members was also attributed to a heightened awareness of the science of early childhood development and the importance of meeting infants and toddlers' needs promptly.

The composition of each Court Team has progressively expanded in each jurisdiction and change in composition is desirable. As one stakeholder aptly noted, "The team is constantly evolving." Some Court Team members were more directly involved with each other by managing cases, representing or providing services to parents and children. However, as one stakeholder observed, "Everybody has a job to do." Other members of the network play a more tangential role and are still building relationships. Some stakeholders noted that the degree of active engagement varied, particularly across the provider network. Gaps in the composition of the Court Team were indicative of lack of engagement or resources (e.g., infant mental health, early learning).

Through their participation in the Court Team, stakeholders reported that they enjoyed more frequent communication with each other and have obtained greater understanding of the families that they mutually serve. Stakeholders noted that attendance at the monthly Court Team meeting was beneficial, if time-consuming. The monthly gatherings fostered camaraderie, built common knowledge about community resources through information sharing and presentations, and facilitated initial referrals and

ongoing communication by building face-to-face relationships across the Court Team. As one stakeholder noted, "You make a contact with someone and build a relationship. If you have an agenda or see a problem [the Court Team meeting] is a good place to take it."

Various stakeholders suggested that the monthly Court Team meetings could be used to better effect to share information across providers and build relationships, especially for those that do not have frequent contact with each other or for those whom are not co-located. It was also suggested that the monthly meetings could serve as a forum to obtain input and feedback from the Court Team members about implementation challenges and solutions.

4. Monthly case reviews (hearings) - Fully implemented

Monthly oversight of infant and toddler case has been fully implemented at the four sites. Three Courts hold monthly "ZTT" hearings for a specialized docket of infant and toddler dependency cases (Fort Bend County, TX; Forrest County, MS, and Orleans Parish, LA). One Court conducts hearings every 60-90 days and conducts a monthly case review (Polk County, IA).

Most stakeholders affirmed that the monthly hearings were a critical component of the model, as they ensured that court-ordered services were implemented quickly and that cases moved towards permanency in a timely manner. Across sites, conduct of the hearings varied as a matter of judicial style, courtroom procedures, and legal representation of parties. At the conclusion of the hearing it is common practice for the Judge to ask the ZTT Community Coordinator to provide comments or recommendations regarding any aspect of the case. [75]

With regard to the benefits of conducting a monthly hearing, stakeholders reported that all parties observed first-hand whether children's needs are being met and whether parents are making progress with their service plans and commitments. As one stakeholder aptly noted, "You can attain little goals in 30 days." Stakeholders affirmed that the monthly hearings kept parents, attorneys, case workers, and providers "on track." The hearings "put everybody in the same place to work things out" and to address issues of concern (e.g., barriers to service delivery, disagreements that required resolution). Another stakeholder stated, "If there's a problem with the case, you fix it at the monthly hearing, rather than three months later."

An additional benefit of the monthly hearings was that all parties in attendance had the most current information regarding the status of the case, the progress made, and the services received. Case progress was consistently documented and workers were up-to-date on the status of their clients. For service providers, being present in the courtroom facilitated the triangulation of self-report information, client observations, and first-hand information from the Judge and attorneys. Participation in

[75] Three of the four Court Teams also conduct monthly case reviews attended by members of the court, attorneys, and child welfare staff.

monthly hearings also fostered understanding of the case from multiple perspectives. Being present in court to observe the full docket of cases gave attorneys, workers, and service providers exposure to other cases and they learned from each other. Stakeholders observed that there is "more work and more time" involved with the infant and toddler cases, but there is also "greater involvement and intensity" with these cases than others.

While acknowledging that reviewing cases on a monthly basis has many benefits, stakeholders observed that the hearings are a resource intensive effort in terms of cost and time. The frequency of the hearings and the degree of preparation required created a significant strain on many parties to the case, particularly for child welfare workers who spoke of having high caseloads and limited time. Although monthly hearings were seen as beneficial, some stakeholders perceived them as burdensome due to their frequency and the amount of preparation required for each one. A number of stakeholders noted that most cases progressed very little within the span of one month, making both monthly progress reports and hearings unnecessary.

Many stakeholders supported the idea of implementing monthly reviews—instead of monthly hearings—for cases that were progressing well. For those cases where risk was present and parental compliance was an issue, stakeholders concurred that cases should be heard monthly before the judge. In some jurisdictions, stakeholders also noted that the hearings would be more cost-effective and time efficient if the cases were scheduled during a time-certain slot. At one site, it was suggested that the hearings could be managed better by coordinating efforts between the attorneys and county attorney's office so that service professionals would not have to spend an inordinate amount of time waiting for a case to be called.

5. Child-focused services - Fully implemented

The provision of developmental, medical, and mental health services for maltreated infants and toddlers to ensure their well-being is an essential component of the Court Team approach. Stakeholders reported and case-level analyses confirmed that children's basic medical and developmental needs were met in each jurisdiction. Infants and toddlers' immediate needs were assessed at intake (i.e., the pre-removal or shelter hearing) to address their presenting condition (e.g., substance exposed newborn, physical trauma, poor nutritional status). A plan for continuing care that was aligned with each child's developmental stage was put in place; the child's status was reviewed at the monthly hearings and the plan was changed as needed. As one stakeholder noted, "Service needs change with the assessment; this is not a cookie-cutter approach."

The service array differed markedly across sites. Forrest Count, MS and Polk County, IA both had significant resources to draw upon in the community. Fort Bend County, TX had fewer resources and a shifting provider base due to changes in child welfare contracting and privatization efforts. Orleans

Parish, LA had lost a significant number of health and human service providers following Hurricane Katrina, but some of these services had slowly begun to return.

Despite these differences, all sites had access to primary health care physicians that accepted Medicaid reimbursement; this ensured that children received routine physical exams and scheduled immunizations. [76] Two of the sites had a dedicated pediatrician as part of the Court Team to provide children with continuous primary care and to provide a medical home (Forrest County, MS; Orleans Parish, LA). At one site, a pediatrician—an expert on neonatal exposure to methamphetamine—from a regional child protection center assessed all drug-exposed children (Polk County, IA). [77]

All sites worked with a Part C Early Intervention provider that screened infants and toddlers for developmental delays and provided early intervention services (i.e., occupational, physical, and speech therapy). The Community Coordinators established relationships with the Part C providers to facilitate referrals and helped to institute a routine process between the provider and the child welfare agency. Being part of the Court Team helped pediatricians and early intervention specialists to work closely together to address the needs of children. One early intervention provider summed up this symbiotic relationship by noting, "Our job is to work with the pediatrician on medical matters and provide developmental supports."

Some aspects of the Court Team's approach on providing developmentally-appropriate services were already part of the child protection protocol (e.g., early intervention services, medical care, immunizations), yet the Court Team brought providers together in a more focused manner to care for infants and toddlers. Across sites, many stakeholders noted that they had worked with the court and child welfare agency prior to the implementation of the Court Team but had done so rather independently of each other. Relationships, communication, and coordination had improved following implementation of the Court Team model. Stakeholders noted that the Community Coordinator was integral to building relationships across providers. These efforts helped ensure that infants and toddlers could receive services without being placed on a wait list.

Stakeholder-identified barriers to service delivery were largely systemic. This included limited availability in the community (i.e., "services are in short supply"), waiting lists for services (e.g., early childhood education), and delays in accessing services (e.g., due to difficulties in obtaining Medicaid cards for children).

[76] Stakeholders expressed concerns about the length of time it takes to obtain Medicaid cards for children as this delays access to needed services.

[77] *In utero* meth exposure results in overstimulation and disrupted sleep cycles among infants and hyperactivity and attention-deficit disorder among meth-exposed school children.

6. Mental health interventions - Not fully implemented across sites

The Court Team approach emphasizes the importance of providing mental health interventions for both maltreated children and the parent(s). Guidance provided by ZTT emphasized that the level of intervention was dependent on the parent-child relationship, the nature of maltreatment, and the underlying familial reasons that precipitated abusive or neglectful behavior. Stakeholders across the sites reported that the findings from parent-child relationship assessments were valuable in making case plans. These findings informed approaches to parenting education, the degree of visitation or family contact, and the need for parent-child psychotherapy. As one stakeholder observed, "The idea of parent/child attachment has been a huge shift - it drives everything we do." Discussions with stakeholders affirmed the benefit of conducting parent-child relationship assessments at the opening of the case to inform specific interventions. Some stakeholders also indicated that infant and toddler cases would benefit from having a relationship assessment *prior to* making a permanent placement, or having a re-assessment of the parent-child or foster-parent-child relationship at the one year milestone.

Three sites had well-established infant mental health providers in the community that provided parent-child attachment assessments, dyadic therapy, and family therapy (Forrest County, MS; Orleans Parish, LA; Polk County, IA). Each provider had a long-standing relationship with the court and child welfare agency and this facilitated their integration into the Court Team's approach. These sites also benefitted from onsite training, follow-up, and clinical supervision in dyadic therapy that was provided by the nationally-recognized child psychologist that developed the Miami-Dade approach.

Two of these sites had well-established referral and treatment protocols in place that facilitated timely assessments and interventions. Parents and children were routinely assessed and received services. One site was in the process of refining its approach to screening and referral. Each site is briefly discussed below.

In Orleans Parish, the infant mental health team predated the implementation of the Court Team model, having been founded in 1998. Certain elements of the model were already well-established practices at this site, including collaboration among the infant mental health team, the court, and child welfare, an increased emphasis on parent-child visitation, and development of a support network for the family. Child welfare caseworkers work with families to determine the need for relationship-based evaluations with all caregivers and make a referral to the provider, which has a contract with the agency. Following an intensive observation with the caregivers and child, and development of an assessment report, weekly treatment is provided for the duration of the case. A team approach is used, such that multiple clinicians may work with various family members and foster parents to provide dyadic therapy or individualized counseling services. Cases are staffed with the provider, child welfare workers, attorneys, CASAs, and the Community Coordinator. Stakeholders suggested that the child welfare

agency consider returning to the earlier practice of having a dedicated unit and team of case workers focus on these cases, given that "ZTT" cases were time consuming and resource intensive.

Similarly, in Polk County, IA provision of infant mental health services pre-dated the implementation of the Court Team. The provider has adjusted its protocols and practice to facilitate the expedited timeframes for ZTT cases. The Community Coordinator identifies family risk factors when the child is removed (using a form developed by the provider) and makes referrals for attachment assessments, particularly for cases involving domestic violence and substance abuse. The assessment employs a battery of measures and a series of observations of parent-child interactions. In less than three weeks, the provider conducts the observations and prepares a recommendation to the Court that is ready for the next hearing. The report is shared with the parent(s), caseworker, attorneys, GAL, and Judge. [78] In some cases, dyadic therapy is recommended, typically with a parent education component. Other interventions recommended include substance abuse treatment and parenting education or marriage counseling, depending on the presenting conditions of the case. Services are Medicaid-reimbursable.

In Forrest County, MS, child welfare caseworkers and the Community Coordinator make the decision regarding which cases would be best served by dyadic therapy or other mental health services (e.g., if an infant is placed with the father). Other factors that are considered include the likelihood of reunification, whether the parent is actively using drugs, and if family preservations services are available. The case worker initiates the referral to the two mental health providers serving the region. (One of the therapists was trained and supervised by the model developer). Dyadic therapy is provided for the duration of the case. As not all children have been assessed, stakeholders at the Forrest County site indicated that more formalized procedure needed to be put in place so that caseworkers would routinely screen and refer families for assessment and therapy—especially those with the goals of reunification—and that all children would be assessed. In addition, an in-service training on dyadic therapy for caseworkers was suggested.

In contrast to the other Court Team sites, the Fort Bend County, TX site struggled with implementing the infant mental health component of the model. Stakeholders expressed concern about maintaining the integrity of the whole Court Team model without implementing this vital component and noted two key barriers. First, the organization that was designated to serve in this capacity focused on parent-child interaction therapy, not dyadic therapy as prescribed by the model, and did not work with infants and toddlers. Second, there were limited therapists and providers in the community to conduct parent-child relationship assessments and provide therapy. Stakeholders noted that there were not mental

[78] Stakeholders observed that it would be valuable for the provider who conducted the attachment assessment to be invited to the first Family Team Meeting in order to share observations and interpret findings from the assessment. However, this may not be possible as parents decide who attends the Family Team Meetings.

health providers available for parents and even less for children. [79] The Community Coordinator, with the Judge's backing, advocated at the state and local level for greater infant mental health services in Fort Bend throughout the period of implementation. [80] Towards the end of the study period, the Community Coordinator had successfully arranged for a recognized expert in infant mental health to provide training and to assist with community capacity-building. Fort Bend County's experience underscores the fact that a systems change process requires patience and a commitment to working at multiple levels to expand a community's service array.

However, the experience of Orleans Parish demonstrates just how quickly a natural disaster can destroy a community's health and human service infrastructure and inflict mental health trauma on children and families. [81] Although the infant mental health team remained stable, stakeholders reported that Orleans Parish faced a critical shortage of mental health providers for parents and children in the aftermath of Hurricane Katrina. In addition, many experienced caseworkers who had been part of the original infant mental health team left the area. Although some service providers had since returned, mental health services still remained scarce. Stakeholders reported that local mental health providers and therapists were needed to conduct assessment and provide tailored, individualized interventions for parents and children, particularly given the co-occurrence of mental health disorders with child maltreatment and the continued vulnerability of families in the post-Katrina environment.

With regard to the provision of mental health services for children and parents, stakeholders across the four sites identified a number of challenges, including a low reimbursement rates for therapists, delays in sending and receiving referrals and reports (e.g., parent psychological evaluations), difficulty in obtaining timely appointments, and decreases in Medicaid reimbursements rates.

7. Evidence-based parenting education: Not fully implemented across sites

Another key element of the Court Team approach was the provision of parent education to strengthen the parent-child relationship and enhance family functioning. ZTT encouraged the use of evidence-based parenting education programs that had demonstrated effectiveness with diverse groups.

[79] The Fort Bend County, TX site implemented on-site substance abuse screening of parents at the Courthouse during the emergency hearing in order to facilitate uptake of treatment services and development of the family's case plan.

[80] Lack of mental health assessments and services for infants and toddlers, along with lack of qualified infant mental health specialists were cited as the two most common service deficits identified by Judges in a 2008 National Council of Juvenile and Family Court Judges. Cited in Abernathy, P.L. & Hall, M.A. (2009). Improving outcomes for infants and toddlers in the child welfare system. *ZERO TO THREE Journal*, 29 (26), 28-33.

[81] Osofsky, J., Ososfky, H., & Harris, W. (2007). Katrina's children: Social policy considerations for children in disasters. *Social Policy Report*, 21 (1), 3-18.

A variety of parenting interventions were available across the four sites. As with the child-focused services and mental health services, the availability of parenting programs depended on the community context and service array. At three sites, the providers had pre-existing service contracts in place with the child welfare agency and their involvement with the Court Team was an extension of this arrangement (Forrest County, MS; Orleans Parish, LA; Polk County, IA). At one site, the provider received referrals from the child welfare agency and worked with families that requested services independently (Fort Bend County, TX). At each site, the Community Coordinator worked closely with the child welfare agency and the provider to ensure that parenting education services were received.

Given pre-existing arrangements, individual providers had some discretion about the type of parenting interventions in use and relied on those which resulted in desired outcomes and improvements for participants. Thus, the Court Teams largely worked within the parameters of parenting education curricula in use by the providers. The curricula focused on nurturing, communication, listening, attending to the child's needs and help-seeking behaviors, appropriate expectations, decision-making, and appropriate discipline methods. Successful delivery of the curriculum depended on the level of parent engagement and commitment. A provider observed that a parent's commitment to skill-building and behavior change was essential to meeting case plan goals and possible reunification with one's child(ren): "When parents are educated on how to use their strengths, they either want to do it or they don't."

Providers made concerted efforts to tailor their interventions to the needs of the families with infants and toddlers in foster care. Fort Bend County, TX had parenting classes available through a local provider and a regional child and family services organization. Bilingual services were available through the parenting program. In Forrest County, MS parenting classes and a fatherhood program were available through a local agency. The *Active Parenting* and *Positive Parenting* curricula were used. The Court Team recently introduced an early childhood dance therapy for parents and children, known as the *Rainbow Dance*. In Orleans Parish, LA both in-home and center-based parenting programs were available to families in the "ZTT program." A fatherhood initiative that helped fathers with children recover from Hurricane Katrina recently became involved with the Court Team. Polk County, IA had a number of parenting initiatives in place that collaborated with the Court Team, including in-home family preservation services with a parenting component, a *Parent as Partners* program, a fatherhood initiative, and parenting sessions for caring for drug-exposed infants and toddlers.

The case of Orleans Parish offers a telling example of the adaptation of an evidence-based parenting model to work with Court Team and the families served. The Judge invited the provider to be part of the Court Team and the provider also works closely with the child welfare agency (which supports the use of evidence-based parenting interventions). The provider used the *Nurturing Parenting Program* (NPP), developed by Dr. Stephen Bavolek, which is designed for families at risk for abuse and neglect

and seeks to stop inter-generational child abuse. The NPP has been found to yield significant pre-post changes in parenting attitudes and child rearing practices, as well as increased family cohesion, expressiveness, and independence. The target population is parents *and* their children between the ages of 1-18 years. Key program goals are building nurturing parenting skills and reducing repeat maltreatment. NPP requires interaction with the child during the classes and also has an in-home component so that the provider can observe the parent and child together. Group-based sessions are held for 2-3 hours once per week for 12-45 weeks. The program addresses parenting skills, self nurturing activities, and home practice exercises. The NPP has been adapted for Hmong, Latino, and African American families.

Some challenges in implementing an evidence-based parenting program are to ensure that the model is appropriate for the target population, the intervention is implemented with fidelity, and any adaptations are carefully thought through. Indeed, in working with vulnerable families in Orleans Parish, the parent educator found that elements of the program were not conducive. To this end, the provider worked with the program developer to lobby the state child welfare office to increase the provision of in-home services. The provider also found that many parents were functionally illiterate and worked with the developer to revise materials to accommodate the parents' literacy levels.

Across sites, a number of stakeholders felt that it would be helpful to have a series of parenting classes dedicated to parents of younger children. In addition, many children in the ZTT program were substance-exposed newborns whose parents could benefit from classes that were tailored to the specific developmental challenges that they faced.

With regard to site-specific challenges, stakeholders in Polk County, IA did not express any concerns about the parenting interventions in place. In Forrest County, MS stakeholders expressed concern that county budget cuts had shortened the length of the parent intervention from three months to five weeks. To compensate for the abbreviated sessions, the provider scheduled at least two individual sessions for the parent. The provider observed that the longer duration of services enabled parents to reach goals and to have longer-term support. Stakeholders in Fort Bend County, TX expressed concerns that the parenting sessions were classroom-based and non-interactive. While classroom or group training could serve as a base, stakeholders in Fort Bend felt strongly that parenting interventions should be individualized and held in conjunction with home-based visits or at a visitation center. In addition, stakeholders emphasized the importance of establishing linkages across providers working with the family, so that mental health, parenting, and/or substance abuse treatment services were better coordinated. Some suggested an approach where a therapist or parenting educator could coach the parent

in his or her interactions with the child and model appropriate behaviors. [82] Fort Bend stakeholders stressed the need for culturally competent parenting interventions for Spanish-speaking parents.

8. Training and technical assistance – Fully implemented

Training was provided at each site as the Court Team was implemented. The ZTT national office organized site visits to the Miami-Dade County Juvenile Court for the Judges and Community Coordinators to observe the model in practice and to confer with the Presiding Judge. As part of a ZTT's peer networking strategy, each Community Coordinator also visited another Court Team site to learn about implementation efforts. During the early implementation phase, each Community Coordinator organized a community-wide training event on infant and toddler development, dyadic therapy, and the Court Team model. Additional trainings were held to address topics that would benefit Court Team members at all sites. Across sites, stakeholders noted that the training on family contact (i.e., parent/child visitation) by a nationally-recognized expert was especially informative.

Site-specific trainings were also organized by each ZTT Community Coordinator and an open invitation was extended to the community. Topics focused on community-driven issues and needs (e.g., children of substance abusing parents, effects of methamphetamine use, family contact). Community Coordinators routinely shared new information with Court Team members, either through mass emails or at the monthly Court Team meetings. ZTT-sponsored trainings served to orient Court Team members, and prospective members to the model, and helped members obtain a better understanding of parents and children's needs. One stakeholder observed that "exposure and learning more helped build commitment" to implementing the model.

ZTT sponsors a *National Training Institute*, which is an annual conference dedicated to promoting the health and development of infants and toddlers which brings together scientists, practitioners, and policymakers. Each year, the Judge and Community Coordinator from each site attended. This small delegation has increased to include Court Team members, such as child welfare staff (who noted that their participation has helped to transfer knowledge to other staff).

Most stakeholders did not report any challenges in applying new information learned from ZTT trainings. Members of the legal community reported the knowledge of infant and toddler development increased their capacity to represent their clients, both parents and children. Some stakeholders observed that limited resources or services sometimes made it difficult to put new knowledge into practice. In this regard, child welfare workers expressed concern that it was sometimes challenging to meet the Court Team's expectations regarding implementing effective practices (such as increased family contact).

Stakeholders welcomed opportunities for cross-disciplinary trainings and noted that more information and training on infant and toddler development is always needed. Some suggestions for

[82] Beyer, M. (2004). Visit Coaching. New York: Administration for Children's Services.

training mentioned were fetal alcohol spectrum disorders and intermittent refresher courses on child development (to accommodate turnover in provider agencies). Stakeholders reported that they also had multiple opportunities for training in the community and that experts were available to provide additional training.

C. Facilitators and barriers to model implementation

Stakeholders across sites identified facilitators to implementation of the Court Team model. A key facilitator was that stakeholders—representing multiple disciplinary perspectives (judicial, legal, clinical health, and social work)—shared a common commitment to addressing the issues presented by each family and maintained a focus on the best interests of the child. That the locus of administration for the "ZTT program" was the juvenile and family courts sent a strong message that gave the approach legitimacy and increased accountability. Another facilitator was that the Community Coordinator had the flexibility and independence to work across parties. This facilitated the transfer of knowledge and creation of new relationships that expanded the network of services available to very young children and their families. The presence of a pre-existing service continuum and known providers in the community helped greatly, as this infrastructure and professional capacity facilitated the initial reception to and ongoing implementation of the Court Team model. Use of a strengths-based approach in delivering services gave providers a common language and orientation to meeting the needs of infants and toddlers, assisting troubled parents, and healing families. Strong working relationships between providers, both old and new, along with an appreciation of the need to coordinate efforts for optimal and timely service delivery, played a significant role in implementation the model.

However, discussions with stakeholders revealed that each jurisdiction faced challenges in implementing the Court Team model, notwithstanding the strong interest and commitment to the approach. As noted previously regarding child-focused, mental health, and parenting education services, limited service array in the community posed significant challenges. Two of the sites had a less resource-rich service array in place (Fort Bend County, TX; Orleans Parish, LA) than the other two sites (Forrest County, MS; Polk County, IA), thus not all needed services were available. Lack of transportation was a considerable challenge for the Fort Bend County, TX site and affected many aspects of meeting the goals of the case plan, such as the regularity of parent-child visitation, keeping appointments, and getting to court on time. The Judge and Community Coordinator persistently advocated for additional resources.

While there was shared commitment to meeting childrens' needs and helping families through the Court Team approach, there was also shared recognition that child welfare workers often shouldered much of this burden and had limited resources to do so. Across the sites, child welfare workers attested to

the fact that ZTT cases "take a lot of time" and involve "a lot of work" given the heightened focus on family contact, intensive services, monthly staffing and hearings, and preparing reports for court based on the input of multiple providers. There was a pragmatic recognition among workers that they could only do so much, and much relief in being able to say so openly during stakeholder discussions. As one worker remarked, "There's consequences if we do not provide services as ordered: contempt, lack of reasonable efforts, facing disciplinary action. The concept is good but there is a strain and burden associated with it. There is already a strain on agency resources." At another site, a supervisor echoed this concern, "[child welfare] is getting pinned for the lack of implementation of parts of the model, when they aren't able to meet all the program's requirements due to limited resources." A concern expressed by some child welfare staff was that Court Team policies and practices were put in place by judicial decree and not through a stakeholder process. A worker summed up this tension by exclaiming, "The Judge doesn't care about obstacles. The Judge just wants it done."

Child welfare staff also spoke to the strain they encountered in achieving the court's mandate regarding high standards of care. At three of the sites (Fort Bend County, TX; Forrest County, MS; Orleans Parish, LA) this tension surfaced mostly around the issue of family contact (visitation) which simultaneously brought to bear the science of early childhood development, judicial oversight, effective social work practice, and real-world resource constraints. [83] Workers fully understood the developmental importance of infant-parent attachment and bonding, along with the need for increased family contact, and they described their commitment to ensuring that visitation occurred by working after hours or on weekends and travelling out of the county. Despite their efforts to meet the demands of a ZTT case, however, some workers stated that they often did not feel appreciated by the courts for their efforts or were not recognized when their efforts resulted in case progress. Indeed, some workers described leaving court feeling demoralized. With regard to the heavy caseloads and the intensive nature of working on the infant and toddler cases, a worker lamented, "The only way we could do more is if there were less children." In contrast to workers at the other sites, Polk County, IA workers felt less defensive; they did not feel that "the entire case weighed on their shoulders" but that it was more of a "team effort."

D. Changes in knowledge and practices among key stakeholders

As a result of the trainings sponsored by ZTT, many stakeholders indicated that their awareness of the impact of child abuse and neglect on infant and toddler development had increased, as well as their awareness of the multiple needs of very young children in foster care and the need for timely responses. What is important to consider is that this knowledge did not remain static, but was shared and put into action. Service providers that worked directly with children and parents noted that they shared what they

[83] The Polk County, IA site had implemented a visitation policy through the Model Court initiative.

had learned about infant and toddler development with their colleagues; this new knowledge informed their practice. Knowledge-in-action was particularly evident during the courtroom hearings, as the Judge, attorneys, child welfare workers, CASAs, and the Community Coordinator shared a common language regarding infants and toddlers' developmental needs. Courtroom testimony, questions, and exchanges focused on the short and long term effects of injuries or substance exposure, screenings, assessments, bonding, attachment, developmental milestones, relationships and interactions with birth parents, kin, and siblings, play therapy, Early Head Start referrals, etc..

Across the Court Team sites, attorneys and Guardian *ad litems* indicated that they were more knowledgeable and better able to represent very young children as a result of training and exposure to ZTT cases (e.g., understanding the effects of Shaken Baby syndrome, exposure to methamphetamine). Members of the legal community reported having a better understanding of the severity of maltreatment on child development, the need for babies to develop healthy, secure attachments and to be nurtured by a permanent caregiver. In this regard, they felt better able to advocate for their young clients and ensure that they were serving the child's best interests.

Participation in the monthly Court Team meetings, convened by the Judge and facilitated by the Community Coordinator, helped to increase stakeholders' knowledge of the community resources for infants and toddlers, as well as gaps in the service continuum. Stakeholders that participated in ZTT's multi-disciplinary *National Training Institute*, with its focus on the dissemination of knowledge pertaining to early child infant development and effective practice, reported that it was valuable experience for their professional development.

E. Integration of the Court Team model into the Dependency Court process

ASFA requires that the status of each child in foster care be reviewed at least every 6 months by either a court or through administrative review (42 U.S.C.A. § 675 (5)(B)). A permanency planning hearing must be held within 12 months after the date the child entered foster care and every 12 months thereafter (42 U.S.C.A § 675 (5)(C). A series of court hearings are used to review the status of each case and determine the permanent placement of children who have been placed in out-of-home care. If a determination is made by the Court that "reasonable efforts" to reunite the child with a parent are not required, then a permanency hearing must be held within 30 days; this typically occurs because grounds exist for termination of parental rights. Statutes in most States and territories are consistent with ASFA's requirements. The following determinations are made at hearings:

- Whether the child's current placement is safe and appropriate for the child's needs;
- Whether the case plan developed by the State agency is appropriately addressing the service needs of the child and family;

- The extent of compliance with the case plan;
- The progress that has been made in correcting the conditions that led to the child's placement in care;
- Whether the State child welfare agency has made reasonable efforts to provide the services that meet the needs of the family; and
- Development of a permanency plan that includes the desired permanency goal and the timeframe for achieving that goal.

While Courts are statutorily required to conduct hearings every six months, under the Court Team model each jurisdiction has elected to conduct hearings on a monthly basis for infant and toddler cases. Following is a brief description of the dependency Court proceedings in each jurisdiction, focusing on the schedule of Court Team hearings for infant and toddler cases, persons entitled to attend the hearings, determinations made at the hearings, and permanency options for children per each state's statutory requirements. The four sites are presented in the order in which they were implemented. Information for each jurisdiction is provided per the relevant statute. This information is also provided in **Appendix C.** Court Hearings for the Permanent Placement of Children: Summary of State Laws.

1. Fort Bend County, TX

The 328th District Court in Fort Bend County, TX serves all cases involving children age 0-3 (and their siblings), thus this court operates with a "specialized docket." [84] The Court conducts monthly hearings on each infant and toddler case, which exceeds the six-month timeframe established by statute (Tex. Fam. Code Ann. § 263.201; 263.304; 263.305; 262.2015).

Parties in attendance include the Judge, Court staff, the child welfare worker and supervisor from the Department of Family and Protective Services, parents and child(ren), the managing conservator or guardian of the child(ren), attorneys *ad litem* for the child(ren), [85] parent attorneys, the CASA and CASA

[84] Specialized dockets are also referred to as "problem-solving courts" that have been established to deal with problems that may benefit from focused and sustained attention. Examples of specialized dockets are drug treatment courts, community courts, domestic violence courts, mental health courts, and adoption courts (Casey, P.M. & Rottman, D.B. (2003). *Problem-Solving Courts: Models and Trends.* Williamsburg, VA: National Center for State Courts).

[85] Attorney *ad litem* means an attorney who provides legal services to a person, including a child, and who owes to the person the duties of undivided loyalty, confidentiality, and competent representation (Tex. Fam. Code Ann. § 107.001(2).By law, in Texas all children must have legal representation by an attorney *ad litem* who is appointed by the Court to advocate the child's wishes, even if those wishes are contrary to the State's position or the parents (Tex. Fam. Code Ann. § 107.003). The Court appoints a local attorney who is compensated by the county. In a suit filed by a governmental entity requesting termination of the parent-child relationship or to be named conservator of a child, the court shall appoint an attorney *ad litem* to represent the interests of the child immediately after the filing, but before the full adversary hearing, to ensure adequate representation of the child (Tex. Fam. Code Ann. § 107.012). Legislation signed into law by the Governor (effective September 1, 2005) requires all attorneys *ad litem* in termination and conservatorship suits filed by the Department of Family and Protective Services (DFPS) to have completed three hours of continuing legal education training relating to child advocacy.

Supervisor, [86] and the ZTT Community Coordinator (Tex. Fam. Code Ann. § 263.301; 263.302). The ZTT Community Coordinator is appointed as a Guardian *ad litem*. [87] Per the above-cited statute, the child shall attend the hearing. Effective June 2007, children over the age of four are required to attend each permanency hearing unless the Court specifically excuses the child's attendance (Tex. Fam. Code Ann. § 263.302). The Court shall consult with the child in a developmentally appropriate manner regarding the child's permanency plan, if the child is four years of age or older and if the court determines it is in the best interest of the child. Failure by the child to attend a hearing does not affect the validity of an order rendered at the hearing. The Presiding Judge of the 328th District Court has exercised judicial discretion on this requirement and does not allow young children in the courtroom (Personal communication, October 10, 2007).

Determinations relative to infants and toddlers that are made at the hearing include: compliance with the service plan; need for substitute care; appropriateness of the current placement; need for additional services; extent of progress made to mitigate the causes of child maltreatment; and a determination of reasonable efforts regarding the permanency plan (Tex. Fam. Code Ann. § 263.306). The ZTT Community Coordinator leads mediations or monthly case reviews to augment the monthly hearing.

Hearings are open to the public unless the Judge finds good cause to require closure (Tex. Fam. Code Ann. § 54.08 (1999)). However, if a child is under age 14 at the time of the hearing, the court shall close the hearing to the public unless the court finds that the interests of the child or the interests of the public would be better served by opening the hearing to the public.

A case is terminated within 12 months of the case opening when the Court dismisses the case or issues final orders returning the child to a parent (reunification); granting a managing conservatorship to a relative or another person; granting a managing conservatorship to the Department of Protective and Regulatory Services (DPRS) with or without terminating parental rights; [88] or terminating parental rights and appointing a relative, other suitable person or DPRS as managing conservator of the child (Tex. Fam. Code Ann. § 263.306). All of these outcomes are considered permanency, including permanent managing

[86] In Fort Bend County, a CASA is appointed for each child.

[87] Guardian ad litem (GAL) means a person appointed to represent the best interests of a child. The term includes: a volunteer advocate appointed under Subchapter C; a professional, other than an attorney, who holds a relevant professional license and whose training relates to the determination of a child's best interests; an adult having the competence, training, and expertise determined by the court to be sufficient to represent the best interests of the child; or an attorney *ad litem* appointed to serve in the dual role. (Tex. Fam. Code Ann. § 107.001 (2) (5)). GALs are appointed in cases where there has been an allegation of child abuse, child neglect, PINS, juvenile delinquency, or dependency. In these situations, the guardian *ad litem* is charged to represent the best interests of the minor child which can differ from the position of the state or government agency as well as the interest of the parent or guardian.

[88] Managing Conservator may be a court-appointed parent, another competent adult, or an agency appointed by the court to provide the place where the minor will live and receive daily care.

conservatorship (PMC) awarded to the State, which is intended only for medically fragile children or youth in need of specialized care (e.g., youth with psychiatric needs). The court is required to hold permanency reviews every six months as long as the child remains in PMC.

2. Forrest County, MS

All cases involving children age 0-3 on the Youth Court's docket are automatically designated as a ZTT case in Forrest County, MS. [89] The Youth Court conducts monthly hearings on each infant and toddler case; this exceeds the every six month case review timeframe as required by the statute (Miss. Code Ann. § 43-15-13).

Parties in attendance include the Judge, Court staff (i.e., Clerk, Bailiff), the County Prosecuting Attorney, child welfare worker and supervisor from the Department of Human Services, parents and child(ren), the guardian of the child(ren) or foster parent(s), grandparents, Guardian *ad litem*, [90] parent attorneys, service providers, and the ZTT Community Coordinator. [91] The ZTT Community Coordinator is appointed as a Designee. [92] In this capacity, the Community Coordinator is vested with full authority to: (1) perform a duty in a manner in which the Youth Court has exclusive original jurisdiction; (2) issue a verbal or written custody order to a law enforcement office or the Department of Human Services, Child of Family Services; and (3) authorize a child's confinement and/or release from the Forrest County Juvenile Detention Center (Miss. Code Ann. § 43-21-105 (c).

The Mississippi Code of 1772 is silent regarding the presence of children in the court during the hearing. However, the Presiding Judge prefers that the child come to court in order to assess the child's status and quality of care (Personal communication, October 30, 2007). Members of the public are excluded from juvenile hearings unless they have a direct interest in the in the case or the work of the Court (Miss. Code Ann. § 43-21-259 (1998); § 43-21-261 (1998).

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[89] The Youth Court is a division of a Family Court, County Court, or Chancery Court (Miss. Code. Ann § 43-21-107).

[90] In every case involving an abused or neglected child which results in a judicial proceeding, a guardian *ad litem* shall be appointed to represent the child in such proceedings (Miss. Code. Ann § 43-23-15). The guardian *ad litem* shall be appointed by the court when custody is ordered or at the first judicial hearing regarding the case, whichever occurs first. The guardian *ad litem* shall investigate, make recommendations to the court or enter reports as necessary to hold paramount the child's best interest (Miss. Code. Ann § 43-21-121). The court may appoint either a suitable attorney or a suitable layman as guardian *ad litem.* In cases where the court appoints a layman as guardian *ad litem*, the court shall also appoint an attorney to represent the child. In order to be eligible for an appointment as a guardian *ad litem*, such attorney or lay person must have received child protection and juvenile justice training provided by or approved by the Mississippi Judicial College within the year immediately preceding such appointment.

[91] Forrest County, MS does not have a CASA program.

[92] Designee means any person that the judge appoints to perform a duty which this chapter requires to be done by the judge or his designee. The judge may not appoint a person who is involved in law enforcement to be his designee (Miss. Code. Ann § 43-21-105 (c).

Determinations relative to infants and toddlers that are made at the hearing include: extent of care and support provided by the parents while the child is in temporary custody; extent of communication with the child by parents or guardian; degree of compliance by the agency and the parents with the case plan; methods of achieving the permanency goal and plans for establishing a permanent home for the child; and services offered and/or utilized to facilitate the child's permanency plan (Miss. Code Ann. § 43-15-13). The youth court is authorized to seek the "cooperation of all societies, organizations or agencies having for their object the protection or aid of children" and which facilitates the work of the Court Team to provide coordinated services to the child and family (Miss. Code Ann. § 43-21-127).

Monthly case staffings are led by the ZTT Community Coordinator in consultation with members of the Court Team (e.g., child welfare workers, early childhood specialists, parenting educators, infant mental health specialists, etc.). The Judge recuses himself from these staffings, as discussions of individual cases outside the courtroom is prohibited and would be a violation of judicial ethics (Personal communication, October 28, 2007).

Permanency options for the child are: return to the parent (reunification); adoption; placement with a relative; another safe and adequate placement for a child who cannot return home or be placed for adoption (Miss. Code Ann. § 43-15-13).

3. Polk County, IA

The Juvenile Court is part of the Fifth District Court of Iowa and its jurisdiction includes dependency, delinquency, termination of parental rights, involuntary juvenile commitments, and adoption. There are two Associates Judges presiding in Juvenile Court. Although both Courtrooms hear cases involving children age 0-3, only one Court participates in the Court Team initiative and coordinates with the ZTT Community Coordinator.

Infant and toddler cases are monitored on a monthly basis by the Court Team. The monthly reviews include other judges; [93] pediatricians; child welfare workers; attorneys representing children, parents, and the child welfare system; CASAs; GALs; mental health professionals; substance abuse treatment providers; representatives of foster parent organizations and children's advocacy groups; Early Head Start and child care providers.

Formal review hearings on the case status and progress are held every 60-90 days with the Presiding Judge. Additional reviews are scheduled according to the needs of the case. Parties in attendance at the review hearings include the Judge, Court staff, the County Attorney, the child welfare worker and supervisor from the Department of Human Services, the child's parent(s), guardian, custodian, or Guardian *ad litem* (Iowa Ann. Stat. § 232.91). Other parties in attendance include parent attorney(s),

[93] The Presiding Judge does not participate in monthly case staffings as this would constitute an *ex-parte* communication concerning a pending or impending proceeding and is a violation of judicial ethics.

the CASA, and the ZTT Community Coordinator. A Guardian *ad litem* is assigned to every case. The ZTT Coordinator is not appointed as a GAL but has access to information in the court order as well as the child welfare records.

Determinations relative to infants and toddlers that are made at the review hearing are: whether services have been offered to the family to correct the situation that led to the child's removal from home; whether the services provided are sufficient and if additional services are needed to facilitate reunification; whether the best interests of the child are being served; and whether reasonable progress is being made to achieve the permanency goal (Iowa Ann. Stat. § 232.104.(2)).

Permanency options for the child are: Return to the parent; termination of parental rights and adoption of the child; transfer of custody from one parent to another parent; guardianship; transfer of custody to a suitable person; and another planned, permanent living arrangement when there is a compelling reason that another permanent placement is not in the child's best interest (Iowa Ann. Stat. § 232.104(2)).

With respect to infants and toddlers and the grounds for termination of parental rights (TPR), the Court may order TPR if it finds that all of the following have occurred (Iowa Ann. Stat. § 232.116): (1) the child is three years of age or younger; (2) the child has been adjudicated a child in need of assistance; (3) the child has been removed from the physical custody of the child's parents for at least six months of the last twelve months, or for the last six consecutive months and any trial period at home has been less than thirty days; and (4) there is clear and convincing evidence that the child cannot be returned to the custody of the child's parents.

4. Orleans Parish, LA

The Orleans Parish Juvenile Court is a District Court with specialized jurisdiction and handles all juvenile matters, including delinquency cases, juvenile status offenses, Child in Need of Care proceedings, child support claims, adoptions, voluntary transfers of custody, termination of parental rights, and juvenile traffic tickets. There are presently six Judges presiding in the Juvenile Court. Two judges hear Child In Need of Care cases. The ZTT Community Coordinator works with the one of the judges regarding cases involving infants and toddlers. Determinations as to whether a child age a 0-3 child should enter the ZTT program is done on a case-by-case basis.

Monthly case staffings (reviews) for infant and toddler cases are led by the ZTT Community Coordinator. Monthly review hearings are held in court. Parties in attendance include the Judge, Court staff (i.e., Clerk, Court Manager), the District Attorney, the Bureau of General Counsel (representing the

Office of Community Services (OCS)), [94] child welfare worker from OCS, parents and child(ren), the guardian of the child(ren), foster or adoptive parent(s), grandparents or relatives caring for the child, the child's attorney,[95] and parent attorneys [96] (La. Stat. Ann. ch. C, Art. § 708). The ZTT Community Coordinator and a Liaison from OCS attend the hearings. A CASA volunteer is appointed to provide independent, factual information to the court regarding the children and cases to which they are assigned and advise and assist the court in its determination of the best interest of the children involved.; advocate on behalf of the child(ren); and monitor proceedings in cases (La. Stat. Ann. ch. C, Art. § 424.3).

Prior to the commencement of the hearing, the court determines whether it is in the child's best interest for the child to remain in the courtroom during the testimony of the witnesses (La. Stat. Ann. ch. C, Art. § 708). Hearings related to Child in Need of Care proceedings, adoptions, voluntary transfers of custody, and termination of parental rights are not open to the public (La. Stat. Ann. ch. C, Art. § 407 (1998). However, the Court may admit any other person to a juvenile proceeding "who has a proper interest in the proceedings or the work of the court."

Determinations relative to infants and toddlers that are made at the review hearing are: continuing necessity and appropriateness of the placement; extent of compliance with the case plan; extent of progress toward correcting the circumstances necessitating placement in foster care; likely date by which the child may be returned to the home or placed for adoption or guardianship; and whether the department (OCS) has made reasonable efforts to reunify the family or to finalize the child's placement (LA. Stat. Ann. Ch. Code Art. § 690; 702). Permanency options for the child in the following priorities of placement are: return to the parent; adoption; placement with a legal guardian; placement in the legal custody of a relative; and placement in the least restrictive, most family-like alternative permanent living arrangement (LA. Stat. Ann. Ch. Code Art. § 702). Returning a child to the legal custody of the parents must occur within a specified time period consistent with the child's age and need for a safe and permanent home. In order for reunification to remain as the permanent plan for the child, the parent must be in compliance with the case plan and making significant measurable progress toward achieving its goals and correcting the conditions requiring the child to be in care.

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[94] The District Attorney's Office represents the state from the beginning of the case through disposition. The OCS Bureau of General Counsel represents the case after disposition, for all reviews, and in termination of parental rights cases.

[95] Per the Louisiana's Children's Code (Article 607 A), every child in a neglect and abuse case must be represented by legal counsel. Children are represented by private lawyers appointed by the court or lawyers from the Legal Aid Bureau, Loyola Law Clinic, The Pro Bono Project or the Tulane Law Clinic. Guardians *ad litem* are not appointed.

[96] Indigent parents are entitled to legal representation and are represented by the Orleans Parish Indigent Defense Program.

Chapter III

Key Characteristics and Outcomes of Infants and Toddlers Served by the Court Teams

Introduction

This section presents key findings on the characteristics and safety, permanency and well-being outcomes for infants and toddlers served by the Court Teams in Fort Bend County, TX; Forrest County, MS; and Polk County, IA. The outcome evaluation was guided by the national Child Welfare Outcomes measures developed by the Administration for Children and Families. These measures are used to determine whether children served by the nation's child welfare systems are protected from abuse and neglect; have permanency and stability in their living situations and continuity in their family relationships; and receive adequate services to meet their needs. The outcome framework was revised slightly to reference the *Court Performance Measures in Child Abuse and Neglect Cases* released in December 2008 by the Department of Justice.

Information is presented on 150 families and the 186 infants and toddlers within those families that were served by the Court Teams through December 31, 2008. New cases that were opened after that date were not included in the analyses. The case-level analyses identify the key characteristics of the children served, including demographics (age, gender, race/ethnicity), the presenting conditions of infants and toddlers in each jurisdiction, and reasons for removing children from the home. Placement, service utilization and (family contact) visitation patterns were examined. Outcomes related to maltreatment recurrence, stability of placements, achievement of permanency, and timeliness in obtaining the permanency goal were examined. Collectively, these measures address infants' and toddlers' immediate needs for protection, nurturance, stability and the sustained involvement of a caregiver. The data are arrayed to present child-specific information, site-specific data, or cross-site analyses where appropriate and feasible. Information on the Court Team database tables and variables used in the analyses is provided in **Appendix H**.

A. Key Characteristics

1. Case Status of Families Served by the Court Team

Table III-A1 presents the status of open and closed cases by family. Fort Bend County, TX, which began implementation of the model in October 2005, served 72 families. Cases for 56 families (75%) have been closed.[97] Forrest County, MS began implementation in May 2006. During this time, 41

[97] Families can have multiple children in the court system; case closure is based on the family, not the individual child.

families were served and 15 family cases (35%) were closed. The Polk County, IA site began implementation in April 2006 and served 36 families, of which 20 family cases (55%) were closed. Across the three sites, cases were re-opened for three families during the course of the study; of those three, two remain open while the other was closed.

Table III-A1. Status of Open/Closed Cases by Family

	All Sites		***Fort Bend County, TX***		***Forrest County, MS***		***Polk County, IA***	
As of December 31, 2008	**N=150**	**%**	**N=72**	**%**	**N=41**	**%**	**N=36**	**%**
Closed cases	91	60.6	56	77.7	15	35.7	20	55.6
Open cases	59	39.3	16	22.2	27	64.3	16	44.4
Reopened cases	3	100%	1	33.0	2	66.0	-	-

Source: ZERO TO THREE Court Team database (2009)

2. Infant and Toddler Characteristics

Information pertaining to the key characteristics of the children served by the Court Teams is provided in **Table III-A2a**. Among the 186 children, 97 were male and 89 were female. The Fort Bend County, TX Court Team served 86 infants and toddlers. Both the Forrest County, MS and Polk County, IA sites served 50 children each.

Across all sites, more than one half of the children were infants (less than 18 months old) at the time of removal. Of these, nearly 33 percent were less than one month old and 20 percent were between 1-5 months old. [98] Children between the ages of 6-18 months represented 23 percent of all cases. Toddlers between the ages of 19-36 months represented 22 percent of the Court Team cases. Although the cross-site differences were not statistically significant, cases in the Forrest County, MS Court Team were more likely to involve removal close to birth, with 46 percent of the children removed at less than one month old, compared to 27 percent in Polk County, IA and 28 percent in Fort Bend, TX.

[98] According to *Child Maltreatment 2007*, an estimated 794,000 children in the 50 States, the District of Columbia, and Puerto Rico were determined to be victims of abuse or neglect. Children in the age group of birth to 1 year had the highest rate of victimization across age groups at 31.9 percent.

Table III-A2a. Characteristics of Infants and Toddlers served by the Court Teams

	All Sites		***Fort Bend County, TX***		***Forrest County, MS***		***Polk County, IA***	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Number of Children	186	100.0	86	100.0	50	100.0	50	100.0
Gender								
Male	97	52.2	46	53.5	25	50.0	26	48.0
Female	89	47.9	40	46.5	25	50.0	24	52.0
Age [a]								
< 1 month	60	32.4	24	27.9	23	46.0	13	26.5
1-5 months	39	21.1	21	24.4	10	20.0	8	16.3
6-11 months	23	12.4	10	11.6	5	10.0	8	16.3
12-18 months	22	11.9	10	11.6	4	8.0	8	16.3
19-36 months	41	22.1	21	24.4	8	16.0	12	24.5
Race/Ethnicity [b 99]								
African American	67	36.0	34	39.5	29	58.0	4	8.0
Caucasian	53	28.5	14	16.3	15	30.0	24	48.0
Latino/a	31	16.7	30	34.8	-	-	1	2.0
Native American [c]	-	-	-	-	-	-	-	-
More than one R/E reported	35	18.8	8	9.3	6	12.0	21	42.0
Language spoken in home [d]								
English	162	87.1	63	73.3	49	98.0	50	100.0
Spanish	24	12.9	23	26.7	1	2.0	-	-
Other	-	-	-	-	-	-	-	-
Family meets federal definition of poverty [e]								
Yes	178	96.2	83	96.5	48	96.0	47	95.9
No	7	3.8	3	3.5	2	4.0	2	4.1
Father's name is on the birth certificate [f]								
Yes	105	58.3	50	61.7	13	26.0	42	85.7
No	75	41.7	31	38.3	37	74.0	7	14.3

Source: ZERO TO THREE Court Team database (2009)

Notes:
[a] Missing data = 1
[b] Missing data = 3
[c] Not reported
[d] Missing data = 3
[e] Missing data = 4
[f] Missing data = 9

[99] Chi-Square =83.9 p<0.0001

As shown in the table, most of the children were African American (36%) or Caucasian (28%). For nearly one fifth of the children, more than one race/ethnicity was reported (18%). There were significant differences in race/ethnicity across the sites (Chi-Square =83.9, p<0.0001). The majority of children in Fort Bend County, TX and Forrest County, MS were African-American (39% and 58%, respectively). Although the highest proportion of children in Polk County, IA were Caucasian (48%) there was a substantial number of children with more than one race/ethnicity reported (42%). [100] Latino/a children accounted for one-third (34%) of all children at the Fort Bend County, TX site and in one-quarter of their homes, Spanish was the primary language spoken.

Almost all (96%) of the families involved with the Court Team were low-income and met the federal definition of poverty per the guidance provided by ZTT. [101] With regard to paternity, the father's name was on the child's birth certificate in 58 percent of the cases. However, this varied across sites. In Polk County, IA, 85 percent of the fathers were identified; 61 percent in Fort Bend County, TX; and 26 percent in Forrest County, MS.

As shown in **Table III-A2b,** 25 percent of the infants and toddlers served by the Court Team were the only child in the family. Thirty percent had one sibling, 20 percent had two siblings, and 25 percent had 3 or more siblings. Of the 186 children, 19 percent (n=35) had siblings that were previously removed by child welfare and 5 percent (n=9) had siblings that were removed by other means (unspecified).

Table III-A2b. Number of Siblings and Removal Status

	All sites		***Removal Status of Siblings***		
Number of siblings with mother:	**N=184**	**%**	***Not removed***	***Removed through child welfare***	***Removed through other means***
0	45	24.4	45 [a]	0	0
1	54	29.3	42	11	1
2	38	20.6	30	5	3
3	22	11.9	15	5	2
4	12	6.5	6	6	0
5	4	2.2	1	2	1
6	4	2.2	3	1	0
7	5	2.7	0	4	1

Source: ZERO TO THREE Court Team database (2009)
[a] Missing data = 2

[100] Two children were Native American but were not so identified in the database.

[101] According to the U.S. Department of Health and Human Services, the 2003 guideline for a four-person family was $20,650.

3. Reasons for Removal

The federal Child Abuse Prevention and Treatment Act (CAPTA) (42 U.S.C.A. §5106g), as amended by the Keeping Children and Families Safe Act of 2003, defines child abuse and neglect as, at minimum: Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or An act or failure to act which presents an imminent risk of serious harm. [102] Within the minimum standards set by CAPTA, each State is responsible for providing its own definitions of child abuse and neglect. Most States recognize four major types of maltreatment: neglect, physical abuse, sexual abuse, and emotional abuse. However, there are differences in how neglect and physical abuse are defined across states, as noted in the **Definitions of Child Abuse and Neglect: Summary of State Laws** provided in **Appendix F.** It is important to consider these differences when interpreting the findings regarding the reasons for removal of children served by the Court Teams.

The definition of neglect in Texas, Mississippi, and Iowa addresses failure to provide a child with adequate food, shelter, clothing, or other care necessary, as well as lack of supervision. In Texas and Mississippi the definition includes medical neglect. In Iowa, neglect includes manufacture of a dangerous substance or possession of a product containing ephedrine, which is used to produce methamphetamine. [103] With regard to physical abuse, the three states generally characterize abuse as non-accidental physical injury or maltreatment that results in substantial harm. In Texas, however, the definition of abuse includes the use by a person of a controlled substance that results in physical, mental, or emotional injury to child. [104] Both Texas and Mississippi exempt corporal punishment from the definition of physical abuse.

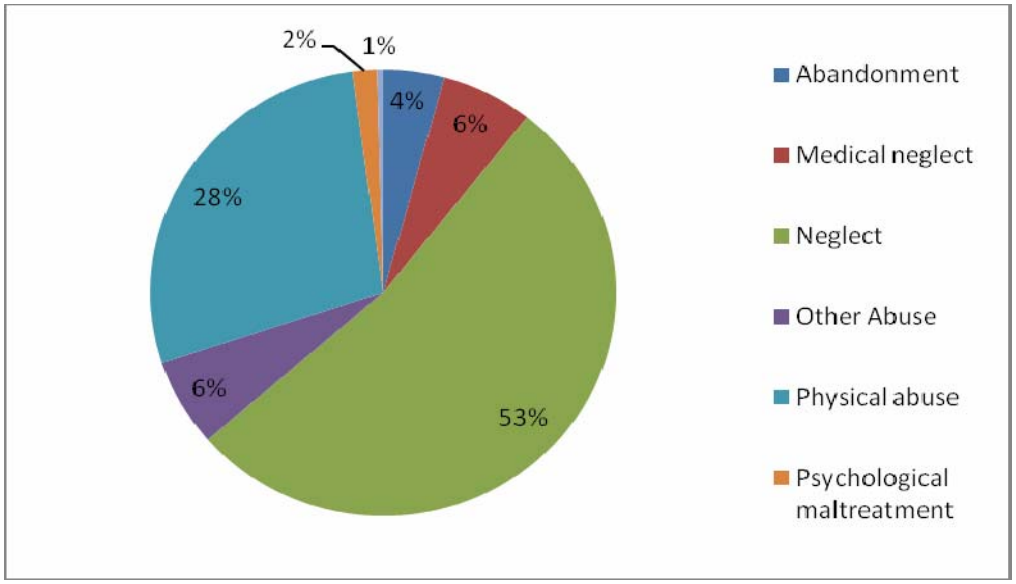
[102] Child Welfare Information Gateway. (April 2008). *What Is Child Abuse and Neglect?* Accessed September 2008 at www.childwelfare.gov/pubs/factsheets/whatiscan.cfm.

[103] Per Iowa statute, the manufacture of methamphetamine constitutes child abuse: "That the person responsible for the care of a child has, in the presence of the child, manufactured a dangerous substance or possesses a product containing ephedrine, its salts, optical isomers, salts of optical isomers, or pseudoephedrine, its salts, optical isomers, or salts of optical isomers, with the intent to use the product as a precursor or an intermediary to a dangerous substance (Ann. Stat. § 232.68).

[104] In Texas, "the current use by a person of a controlled substance, in a manner or to the extent that the use results in physical, mental, or emotional injury to a child" is considered physical abuse (Fam.Code § 261.001).

Based on the substantiated findings of child maltreatment, each Court Team identifies the type(s) of maltreatment perpetrated against the child. [105] The "reasons for removal" in the Court Team database are: physical abuse, neglect, medical neglect, sexual abuse, psychological maltreatment, abandonment; and other abuse. [106] Parental use of alcohol/drugs or mental illness were also identified, as these are risk factors associated with court and child welfare involvement with the family. [107] **Figure III-1** present the forms of maltreatment perpetrated against the infants and toddlers that were removed from their homes from the time of Court Team implementation at each site through December 31, 2008.

Figure III-1. Maltreatment of Infants and Toddlers: All cases across sites



Across the sites, more than 50 percent of the children where removed due to neglect and more than 25 percent were removed due to physical abuse. Other forms of maltreatment perpetrated were medical neglect (6.4%), abandonment (4.2%), psychological maltreatment (1.7%), and sexual abuse

[105] The Court Teams database does not identify a primary reason for removal or form of maltreatment perpetrated. Multiple reasons can be identified. Parental substance abuse and mental illness as risk factors are also identified.

[106] Physical abuse, neglect, medical neglect, sexual abuse, psychological maltreatment, and other abuse are the maltreatment types captured in the National Child Abuse and Neglect Data System (NCANDS) and reported annually by the Administration for Children and Families in *Child Maltreatment.*

[107] These terms are similar to those found under the category "Reason for Agency Involvement" in the Onsite Review Instrument used for data collection during the federal Child and Family Services Review: Physical abuse; sexual abuse; emotional maltreatment; neglect (not including medical neglect; medical neglect; abandonment; mental/physical health of parent; mental/physical health of child; substance abuse by parent(s); child's behavior; substance abuse by child; domestic violence in child's home; child in juvenile justice system; and other (e.g., parent incarcerated). [CFSR Onsite Review Instrument (March 2008). OMB Control No: 0970-0214. Expiration date: 1/31/2010]

(.4%). "Other abuse" was a form of maltreatment noted in 6 percent of the cases, although the reason was not disclosed.

As shown in **Table III-A3a**, site-specific analyses indicate that children were removed from the home in each jurisdiction for different reasons. In Fort Bend County, TX, child maltreatment primarily involved physical abuse (51%), neglect (27%), and medical neglect (10%). Nearly all of the infants and toddlers were removed from the home in Forrest County, MS for neglect (92.5%); a small number of cases involved medical neglect (3.7%) and abandonment (3.7%). In Polk County, IA, child neglect was the reason for removal in 74 percent of the cases. Children were removed due to other forms of abuse (14%), psychological maltreatment (5.3%), abandonment (3.5%), and physical abuse (3.5%).

Table III-A3a. Reasons for Removal: All children

N=186	***All Sites***		***Fort Bend County, TX***		***Forrest County, MS***		***Polk County, IA***	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Abandonment	10	4.2	5	4.0	2	3.7	2	3.5
Medical neglect	15	6.4	13	10.4	2	3.7	-	-
Neglect	125	52.9	34	27.2	49	92.5	42	73.68
Other Abuse	15	6.4	7	5.6	-	-	8	14.0
Physical abuse	66	27.9	64	51.2	-	-	2	3.5
Psychological maltreatment	4	1.7	1	0.8	-	-	3	5.3
Sexual abuse	1	.4	1	0.8	-	-	-	-

Source: ZERO TO THREE Court Team database (2009)
Note: Cases may involve multiple reasons for removal. No information was available for "Other Abuse" cases.

Parental substance abuse and mental illness played a significant role in child maltreatment, as seen in **Table III-A3b.** In 75 percent of the cases across sites, parental use of alcohol/drugs was cited as a risk factor. Nearly all of the cases (86 percent) in Polk County, IA involved parental substance abuse. Seventy-four percent of the cases in Forrest County, MS and 68 percent of the cases in Fort Bend County, TX involved parental substance abuse. Mental illness was a risk factor in 17 percent of the cases across the sites. However, parental mental illness was present in 32 percent of the cases in Forrest County, MS and 18 percent of the cases in Polk County, IA. Only 8 percent of the cases in Fort Bend County, TX involved parental mental illness.

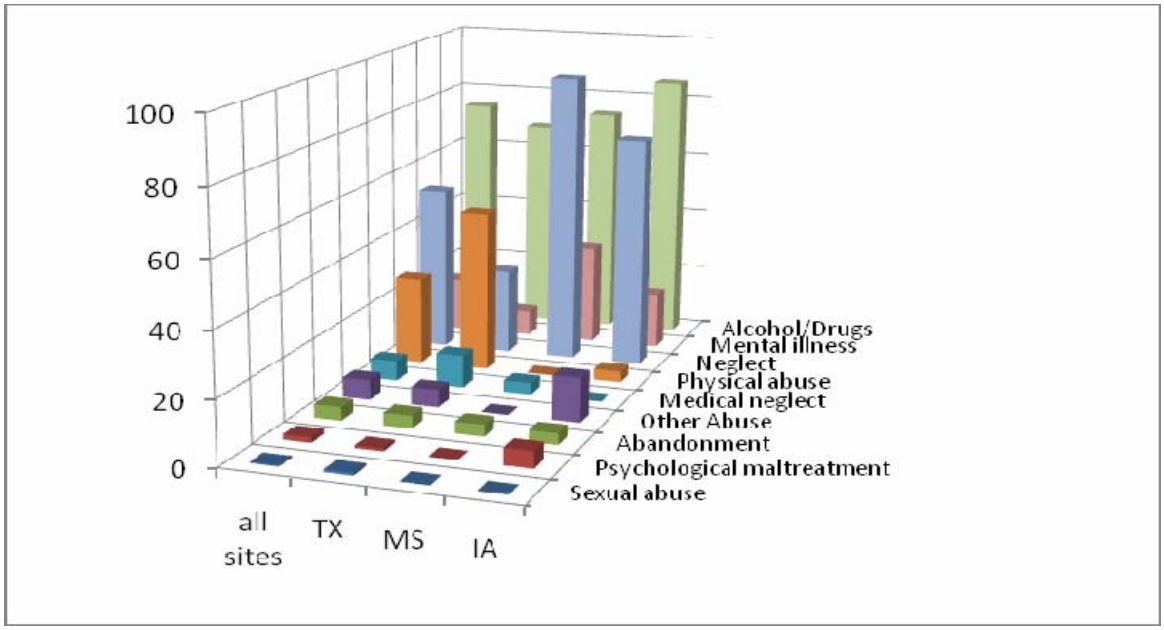
Table III-A3b. Parental Risk Factors Cited as Reasons for Removal

N=186	*All Sites*		*Fort Bend County, TX*		*Forrest County, MS*		*Polk County, IA*	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Alcohol/Drugs	139	74.7	59	68.6	37	74.0	43	86.0
Mental illness	32	17.2	7	8.1	16	32.0	9	18.0

Source: ZERO TO THREE Court Team database (2009)

As shown in the tables, and displayed graphically in **Figure III-2** (below), two major trends were identified across sites for the population of infants and toddlers served by the Court Teams. *Neglect* was the most prevalent form of maltreatment reported across sites, involving more than 50 percent of cases overall. There were cross-site differences noted, with Forrest County, MS site reporting neglect in 92.5 percent of the cases. In contrast, three-fourths (74%) of the cases in Polk County, IA and less than one-third (27%) of the cases in Fort Bend County, TX involved neglect. *Alcohol or drug use by a parent* was reported for 75 percent of the cases overall as a risk factor in the removal of the child from the home. As noted above, this was a consistent factor across all sites.

Figure III-2. Reasons for Removal and Risk Factors



Physical abuse predominated as the reason for removal in Fort Bend County, TX involving 51 percent of the 86 cases. However, this figure also includes cases involving parental use of controlled substance (per the state definition of physical abuse). As learned from an analysis of brief case notations,

at least 10 infants and toddlers were the victims of severe trauma, to include injuries consistent with Shaken Baby Syndrome (i.e., subdural hematomas, intracranial bleeds, retinal hemorrhages, and rib or multiple long bone fractures) and skull fractures, broken bones, lacerations, and bruising resulting from physical violence (e.g., being thrown in the crib, being stepped on). *Mental illness* was a cited as factor in removals for 32 percent of the cases in Forrest County, MS and in 18 percent of the cases in Polk County, IA; Fort Bend County, TX reported that 8 percent of the cases involved mental illness. [108]

Analysis of the co-occurrence of reasons for removal and risk factors indicates that neglect in conjunction with alcohol/drug use was the most frequent set of reasons for removal (83 co-occurrences). Physical abuse and alcohol/drug use was next most frequent (43 co-occurrences). Mental illness and neglect co-occurred 26 times as did mental illness and alcohol/drug use. Physical abuse and neglect co-occurred 18 times. These patterns of co-occurrence were similar across the sites.

4. Key Health Indicators at Case Opening

Child maltreatment signals a substantial risk to the development of very young children and their physical, socio-emotional, behavioral, developmental, and environmental functioning. The Court Teams staff maintain an inventory of each child's presenting condition at the time of case opening. These are*: premature birth; low birth weight; small for gestational age; medically fragile; physical disability; and failure to thrive.* While these indicators describe the child's health status, they are also related to the type of maltreatment suffered or reason for removal from the home (e.g., failure to thrive and neglect). An accumulation of risk factors is detrimental and children experiencing both neglect and failure to thrive may be at risk for deficits in cognitive functioning. [109] Descriptive information is provided for some children regarding health status at intake (e.g., cocaine positive at birth, born at 32 weeks). These health indicators and characteristics establish a baseline measure of maltreated children's status and informs the provision of services to meet their needs while under the court's jurisdiction.

Additional indicators refer to parental behaviors that played a role in child maltreatment. A child's prenatal exposure and postnatal home environment are noted through indicators related to *exposure in utero to smoking, alcohol/drugs, or domestic violence.* Although prenatal substance exposure can leave children vulnerable to a number of developmental problems, many of these problems are treatable and can be addressed with a variety of interventions. *Exposure to parental substance abuse* refers to a child being present when a parent is abusing alcohol or drugs or under the influence of drugs.

[108] The study team did not have access to parent information, thus we were not able to learn more about particular diagnoses in relation to child maltreatment.

[109] Mackner, L.M., Starr, R.H. & Black, M.M. (1997). The cumulative effect of neglect and failure to thrive on cognitive functioning. *Child Abuse and Neglect*, 21 (7), 691-700.

Parental substance use is a well-documented risk for child maltreatment. [110] It is a predictor of repeat maltreatment, [111] poor developmental outcomes, [112] and delays in permanency outcomes. [113] As seen in **Table III-A4**, the most significant risks to infant and toddler health were posed by parental substance abuse. Across all sites, forty percent of the children were directly exposed to parental substance abuse. More than 70 percent of the cases in Polk County, IA involved substance abuse, typically the use of methamphetamine. [114] In Forrest County, MS and Fort Bend County, TX, exposure to parental substance abuse was a factor in approximately 30 percent of the cases.

In utero or prenatal exposure to alcohol and drugs was prevalent across sites, as well, involving 49 percent of the cases. [115] This was most pronounced at the Forrest County, MS site, where 72 percent of the cases involved *in utero* exposure. Notably, a number of the Forrest County, MS children experienced premature births (18%), had low birth weights (24%), and were small for their gestational age (22%). Across sites, 36 percent of the infants and toddlers were exposed to parental smoking (most significantly for 77 percent of the children at the Polk County, IA site and for 48 percent of the Forrest County children). Nearly one-half of the children at the Polk County, IA were exposed *in utero* to domestic violence (48.9%). This occurred on a lesser scale at the other sites (i.e., 10 % for Forrest County, MS and 5% for Fort Bend County, TX).

[110] Young, N.K., Boles, S.M., Otero, C. (2007). Parental substance use disorders and child maltreatment: overlap, gaps, and opportunities. *Child Maltreatment*, 12 (2),137-49.

[111] Wolock I. & Magura, S. 1996. Parental substance abuse as a predictor of child maltreatment re-reports. *Child Abuse and Neglect*, December 20 (12), 1183-93.

[112] Institute for Social and Economic Development. *Developmental Needs of Children Investigated by Child Protective Services* (April 2008). Prepared for the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

[113] Smith, D.K., Johnson, A.J., Pears, K.C., Fisher, P.A., & DeGarmo, D.S. (2007). Child maltreatment and foster care: Unpacking the effects of prenatal and postnatal parental substance use. *Child Maltreatment*, 12 (2): 150-160.

[114] Per the Iowa statute, intent to manufacture methamphetamine in the presence of a child is considered "abuse." The statute reads as such: That the person responsible for the care of a child has, in the presence of the child, manufactured a dangerous substance or possesses a product containing ephedrine, its salts, optical isomers, salts of optical isomers, or pseudoephedrine, its salts, optical isomers, or salts of optical isomers, with the intent to use the product as a precursor or an intermediary to a dangerous substance **(**Ann. Stat. § 232.68).

[115] Kim, J., & Krall, J. (2006). *Literature Review: Effects of Prenatal Substance Exposure on Infant and Early Childhood Outcomes*. Berkeley, CA: National Abandoned Infants Assistance Resource Center, University of California at Berkeley.

Table III-A4. Key Health Indicators at Case Opening

N = 186	*All Sites*		*Fort Bend County, TX*		*Forrest County, MS*		*Polk County, IA*	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Premature birth	21	11.3	10	11.6	9	18.0	2	4.0
Low birth weight	30	16.1	10	11.6	12	24.0	8	16.0
Small for gestational age	16	8.6	2	2.3	11	22.0	3	6.0
Medically fragile	6	3.2	3	3.5	1	2.0	2	4.0
Physical disability	4	2.2	3	3.5	1	2.0	-	-
Failure to thrive	5	2.7	4	4.7	1	2.0	-	-
Exposure to parental substance abuse	75	40.3	24	27.9	15	30.0	36	72.0
In utero exposure to:								
Smoking	67	36.2	5	5.8	24	48.0	38	77.8
Alcohol and drugs	92	49.7	36	41.9	36	72.0	20	40.8
Domestic violence	33	17.8	4	4.7	5	10.0	24	49.0
Substance exposed newborn (SENs)	47	25.1	23	26.7	22	44.0	2	4.1

Source: ZERO TO THREE Court Team database (2009)

The federal CAPTA reauthorization of 2003 requires that state child welfare agencies be notified of newborns affected by substance abuse and to develop a plan of care. Although the extent of prenatal exposure to substance abuse was identified, this information did not translate directly into knowing how many of the children were classified as substance-exposed newborns (SEN) (i.e., children who test positively at birth for alcohol or controlled substances) and the degree to which the Court's intervention to protect the child was contingent on SEN status. [116] [117](This status was not directly discernable from the analysis of reasons for removal either). While the Court Teams database lacks a discrete indicator to designate a child as a SEN, analysis of the child's date of birth, date of removal and court order, and health information provided sufficient information to indicate this status. Using these criteria, twenty-five percent of the infants were identified as SENs (n=47) across the sites. [118] More than 40 percent of the

[116] Sagatun-Edwards, I, & Saylor, C. (2000). Drug-exposed infant cases in juvenile court: Risk factors and court outcomes. *Child Abuse and Neglect*, 24 (7), 925-37.

[117] According to the National AIA Resource Center (September 2006 Issue Brief) testing and screening practices to determine prenatal use of illegal substances are determined locally by hospitals, clinics, and health centers. Some hospitals practice universal testing of all newborns to eliminate bias and differential treatment and increase identification. However, this practice raises concerns about women's rights to privacy and confidentiality, as well as the patient-provider trust relationship. Most hospitals use targeted testing based on identification of risk factors and rely on a doctor's discretion. Yet, this practice introduces bias and may inhibit identification of affected cases. Several states, including Iowa, require health practitioners to administer toxicology tests if prenatal use of illegal substances is suspected.

[118] The definition of neglect per the state of Iowa includes "the presence of an illegal drug in a child's body as a direct and foreseeable consequence of the acts or omissions of the person responsible for the care of the child" (Ann. Stat. § 232.68). Texas and Mississippi do not include prenatal substance exposure in the state's definition of neglect.

Forrest County, MS children were identified as SENs (n=22). Of these, 14 infants tested positive for cocaine, seven tested positive for marijuana, and one tested positive for both. In thirteen of these cases, siblings had previously been removed from the home by child protective services. Among the Fort Bend County, TX children, 26 percent were identified as SENS (n=23). Twenty-one children tested positive for cocaine. Of these, seven children had siblings who had been previously removed via child welfare. Two SENs (4%) were identified for the Polk County, IA site (i.e., methamphetamine positive, cocaine positive).

While few in number (n=6), children identified as "medically fragile" were especially vulnerable. A Caucasian female—born prematurely, low birth weight, small for gestational age—was removed at birth due to *in utero* exposure to alcohol/drugs and smoking. An African-American male—premature, low birth weight, small for gestational age, *in utero* exposure to alcohol/drugs—was diagnosed with failure to thrive at 6 weeks when his heart slowed and he stopped breathing. A Latino male—removed for medical neglect as a toddler, not walking or talking at two years of age—was diagnosed with a physical disability.

B. Placement, Family Contact (Visitation), and Service Utilization

1. Placement Types and Location

A key feature of the Court Team model is to place infants and toddlers in nurturing environments that foster stable and secure attachments with their caregivers while they are in foster care. **Figure III-3** presents information regarding the type of placements for the 184 infants and toddlers under court supervision for whom data were available. [119] Definitions of the placement types per the ZTT guidance are provided in **Appendix I**. As shown in the pie chart, placement with relatives was the most frequently occurring type of placement and accounted for 39 percent of all placements. [120] However, this is closely followed by placement in a foster/adopt home, which represented 37 percent of all placements. [121]

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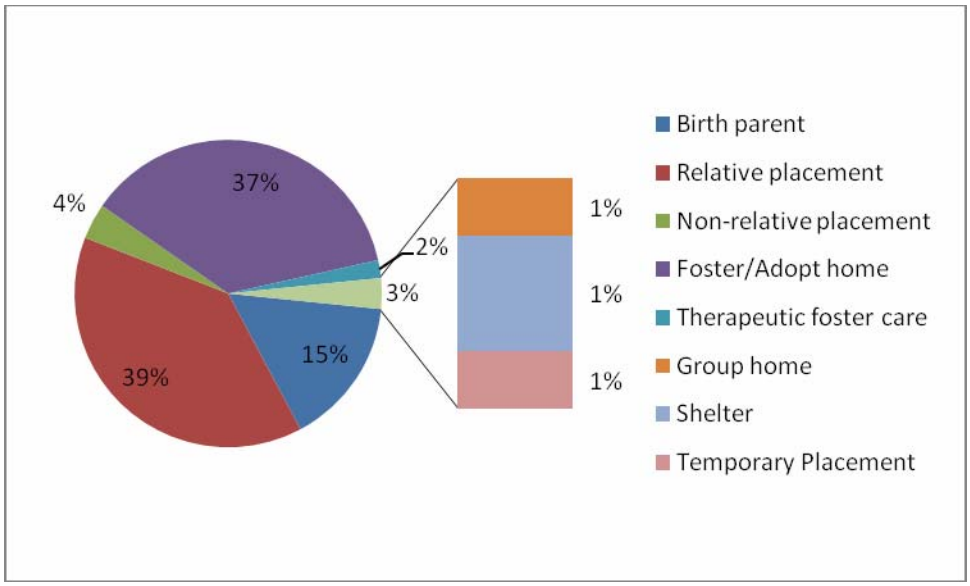
[119] Most cases had more than one placement; the percentages are based on the total number of placements.

[120] In Texas, placement preference is given first to the non-custodial parent and then to relatives. At the first status hearing, judges are required to make sure that child protective services (CPS) has gotten all available information to locate relatives (Tex. Fam. Code § 263.202(a)(2). At each permanency hearing, judges are required to evaluate CPS efforts to identify relatives with whom a child can be placed (Tex. Fam. Code § 263.306(a)(6). In Mississippi, the Department of Human Services is required by law to give placement priority to kin within the third degree when seeking an out-of-home placement for a child (Ann. Code § 43-15-13). In Iowa, a stepparent or a relative within the fourth degree of relation may assume custody of a minor child (Ann. Code §§ 600A.4, 232.102).

[121] The category of foster/adopt and other foster parent were combined for purposes of analysis. Per Texas Department of Family and Protective Services (DFPS) policy on Foster and Adoptive Home Development, "foster parents who are also interested in adopting children in DFPS managing conservatorship may also become approved as an adoptive home." A distinction is made between foster homes (i.e., private home that provides 24-hour care for children in the managing conservatorship of DFPS) and foster/adopt homes (i.e., private home that provides 24-hour care for children in the managing conservatorship of DFPS and is

Placement with the birth parent accounted for 15 percent of placements across sites, whereas placement with a non-relative (i.e., friends or fictive kin) occurred in 4 percent of the placements. Therapeutic group homes, group homes, shelters, and temporary placements accounted for 5 percent of placements overall.[122]

Figure III-3. Types of Placement



Source: ZERO TO THREE Court Team database (2009)
Note: Percentages differ slightly from Table III B1a due to rounding.

As shown in **Table III-B1a,** placement with a relative was prevalent across sites. In Fort Bend County, TX 43 percent of placements were with a relative. Similarly, 38 percent of the placements in Polk County, IA were with a relative, as were 30 percent of the placements in Forrest County, MS. Stakeholders noted that placements with relatives maintained family connections for the child and facilitated greater parent-child contact as kin supervised the visits (thus lessening some of the burden placed on child welfare or in-home workers to supervise all family contact). Stakeholders noted that kinship placements also provided a "buffer" in cases involving parental substance abuse, given the potential for relapse during the recovery process.

Site-specific differences were seen in other types of placements. For example, nearly one-half (48.9%) of the placements in Forrest County, MS were in foster/adopt homes, as were 41 percent in Fort Bend County, TX. However, in Polk County, IA this accounted for only 7 percent of the placement

additionally studied and approved to adopt). There were only 7 placements in foster/adopt homes in the Fort Bend County sample.

[122] The ZTT Court Team database includes "hospital" in the list of placement types. For purposes of this analysis, however, hospital stays were not included in order to conform to the types of placements used in the CFSR onsite review instrument (July 2008). However, there are 15 instances of hospitalization noted for 11 children. Two children were hospitalized more than once.

types. Differences across sites emerged most distinctly with regard to placement with the birth parent. Although remaining with the birth parent accounted for 15 percent of all placements overall, most (60%) of these placements were in the Polk County, IA site. Remaining with the birth parent was a placement option for less than ten percent of the placements noted in Fort Bend County, TX (8%) and Forrest County, MS (7%). There was also greater reliance on the use of non-relative placements in the Polk County, IA site (9%) than in the other sites (i.e., 5% in Fort Bend County, TX and none in and Forrest County, MS).

Table III-B1a. Type of Placement: All children

N=372	***All Sites***		***Fort Bend County, TX***		***Forrest County, MS***		***Polk County, IA***	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Birth parent	58	15.6	16	8.9	7	7.4	35	35.4
Relative placement	144	38.7	78	43.4	28	29.8	38	38.4
Non-relative placement	14	3.7	5	2.8	-	-	9	9.1
Foster/Adopt home	137	36.8	74	41.3	3	48.9	17	17.2
Medical foster home	-	-	-	-	-	-	-	-
Therapeutic foster care	7	1.9	3	1.7	4	4.3	-	-
Group home	3	0.8	1	0.5	2	2.1	-	-
Crisis nursery		-	-	-	-	-	-	-
Shelter	6	1.6	-	-	6	6.4	-	-
Temporary Placement	3	0.8	2	1.1	1	1.1	-	-

Source: ZERO TO THREE Court Team database (2009)

Other differences were seen across sites with respect to the types of placements used or available and children's needs. The Polk County, IA site utilized only four types of placements for children under court supervision: relative placement, birth parent, foster/adopt home, and non-relative placement. While the Forrest County, MS and Fort Bend County, TX sites also employed such placement strategies, children were placed in therapeutic foster care, group homes, and temporary placements. Only the Forrest County, MS site placed infants and toddlers in emergency shelters; this occurred in cases where both the child and his/her teen mother were in state custody. No infants or toddlers were placed in crisis nurseries or in medical foster homes at any of the sites.

Analysis of the location of all placements indicates that most infants and toddlers were kept close to their homes. As seen in **Table III-B1b**, the majority of placements were within the county where the family resided (75%). This occurred in 85 percent of the Polk County, IA placements, 75 percent of the Fort Bend County, TX placements, and in 65 percent of the Forrest County, MS placements. For two sites, this analysis includes 14 instances were a child had a temporary stay in the hospital. Eight instances of hospitalization occurred out-of-county.

Table III-B1b. Location of Placements: All Children and All Types

N=386	*All Sites*		*Fort Bend County, TX*		*Forrest County, MS*		*Polk County, IA*	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
In county	288	74.6	142	74.4	62	64.6	84	84.9
Out of county	95	24.6	48	25.1	34	35.4	13	13.1
Out of State	3	0.7	1	0.5	-	-	2	2.0
Total	*386*	*100*	*207*	*100*	*96*	*100*	*99*	*100*

Source: ZERO TO THREE Court Team database (2009)

The Court Team model places particular emphasis on reaching out to extended family members prior to the removal of a child from the home. Kinship care was a key placement option for the infants and toddlers overseen by the Court Teams. As shown in **Table III-B1c**, examination of the 152 relative placements indicates that the child's Grandmother served as the caretaker in nearly 50 percent of these placements across the sites. Site-specific differences reveal patterns of kinship care that are likely due to the demographic and cultural characteristics of each community. For example, the child's Aunt served as the caregiver in 35 percent of the relative placements in Fort Bend County, TX. At the Forrest County, MS site, a range of male kin—uncle, grandfather, or brother—provided care. In Polk County, IA site, friends and neighbors provided care to infants and toddlers. Many stakeholders welcomed seeing children placed in kinship care to help families stay together and to facilitate the parent-child relationship. However, a few stakeholders thought that foster care would be preferable as they believed that some children were placed in dysfunctional family environments.

Table III-B1c. Placement with Relatives

	All Sites	
Of all children placed with relative caregiver or non-relative caregiver, percentage placed with:	**N=141**	**%**
Aunt	38	27.0
Brother	1	1.0
Cousin	4	3.0
Grandfather	6	4.3
Grandmother	75	53.2
Great Aunt	8	5.7
Great Uncle	3	2.1
Sister	1	1.0
Uncle	5	3.6

Source: ZERO TO THREE Court Team database (2009)
Missing data =3

2. Family Contact (Visitation) [123]

Meaningful parent-child contact is a key element of the Court Team approach and is grounded in the principles of early childhood development. As noted in the Court Team Guidebook, "frequent and consistent contact is essential for young children to develop and maintain strong secure relationships with parents." [124] With regard to child permanency outcomes, frequent parent-child contact is linked to increased reunification and reduction in time spent in out-of-home care. [125] More frequent family contact and placement stability increases the likelihood of a child's reunification within 12 months of removal from the home, as mandated by ASFA.[126]

Table III-B2a presents information on the type of family contact that was ordered by the court at the time the family contact or visitation plan was first developed (e.g., at the pre-removal hearing or formalized at the adjudication/disposition hearing). [127] These data reflect a snapshot of the court-ordered plans for the family and includes 186 children with open and closed cases. Across the three sites, 91 percent of initial contact was supervised, typically by CPS staff and relatives. A small percentage (6%) of contact was unsupervised. Information on supervision was not provided for a fraction of the cases (2%).

Table III-B2a. Type of Family Contact Ordered at Case Initiation

	All Sites	
	N=186	**%**
Supervised	169	90.9
Unsupervised	12	6.5
Unable to determine	4	2.2
None - Parents incarcerated	1	0.5

Source: ZERO TO THREE Court Team database (2009)

As presented in **Table III-B2b,** by the last month of recorded contacts, 75 percent of the family contact between parents and children was still supervised. The proportion of unsupervised family contact increased to 19 percent. For a small percentage of cases no family contact occurred at all. This was due

[123] The Court Teams database tracks the type and frequency of visitation. The term "family contact" is used in this report for consistency with current ZTT practice and teachings regarding visitation.

[124] ZERO TO THREE. (November 2008). *Court Team for Maltreated Infants and Toddlers: Guidebook for Local Teams.* Washington, DC.

[125] Smariga, M. (2007). *Visitation with infants and toddlers in foster care: What Judges and Attorneys Need to Know*. Washington, DC: American Bar Association Center on Children and the Law and ZERO TO THREE Policy Center.

[126] Potter, C.C., and Klein-Rothschild, S. 2002. Getting home on time: Predicting timely permanency for young children. *Child Welfare*, 81 (2), 123-150.

[127] This practice varies by jurisdiction. A family contact plan can be established at the pre-removal or shelter hearing and finalized at the disposition hearing.

to suspended visits or no contact due to a parent gone missing, parental incarceration, residence in an inpatient treatment facility, or a court-order forbidding contact with the child.

Table III-B2b. Type of Family Contact by Last Month of Recorded Contact

	All Sites	
	N=186	**%**
Supervised	141	75.8
Unsupervised	36	19.4
Other	9	4.8

Source: ZERO TO THREE Court Team database (2009)

The frequency of family contact at case initiation is presented in **Table III-B2c.** [128] A key finding is that the frequency of contact between parents and children was highly individualized to address the needs of the case. Daily contact was ordered in 31 percent of the cases. Parent-child contact from 3-6 times per week was ordered in 14 percent of the cases; contact at least twice per week was ordered for 13 percent of the cases. Thus, family contact at least twice per week was ordered in 58 percent of the cases. One-third of the infants and toddlers were scheduled to have contact once per week with a parent.

Table III-B2c. Frequency of Family Contact Ordered at Case Initiation

	All Sites	
	N=186	**%**
Once a week	62	33.3
Twice a week	25	13.4
Other	99	53.2
Daily (to include liberal)	*36*	
Daily - child placed with parent	-	
In home	*18*	
In rehabilitation facility	*2*	
In foster care	*1*	
3-6 times per week	*26*	
Every other week	*1*	
Mother & father have separate schedules	*4*	
No family contact		
Parent(s) incarcerated	*1*	
Parent is missing	*1*	
Other	*1*	
Unable to determine	*3*	
Not noted	*5*	

Source: ZERO TO THREE Court Team database (2009)

However, this aggregate view masks the multiple permutations of family contact by type and frequency. Descriptive data reveal detailed arrangements that were tailored to address safety risks to the

[128] The Court Teams database captures three types of family contact: once a week, twice a week, and other.

child, the degree of parental access, the scope of supervision, and availability of professionals or family members to supervise family contact. Examples of some patterns that were sustained over time include:

- Father has unlimited supervised family contact.
- Mother meets with siblings and child once a week.
- Mother has daily supervised contact with relative.
- Relative supervises additional contact. Mother takes care of bed time routines and feedings.
- Mother has supervised family contact once per week by a professional and liberal family contact with relative.
- Parents have daily contact and cook, feed children, bathe them, and put them to bed.
- Mother has unlimited unsupervised contact. Father has unsupervised contact during scheduled weekend hours.

As presented in **Table III-B2d,** by the time of the last month of recorded visits, the contact patterns had shifted and foreshadowed permanency outcomes related to reunification or terminations. For 31 percent of the children, family contact occurred on a daily basis, either because the parent had "liberal" access to the child (16%) or because the parent and child were placed together (16%), mostly in the home. In 13 percent of the cases, family contact occurred between 3-6 times per week and twice-weekly contact occurred in 11 percent of the cases. By the time of case closure, family contact at least twice per week was ordered in 55 percent of the cases. Parent-child contact occurred once per week for 26 percent of the cases.

Table III-B2d. Frequency of Contact by Last Month of Recorded Contact

	All Sites	
	N=186	**%**
Once a week	49	26.3
Twice a week	21	11.3
Other	116	62.4
Daily (to include liberal)	*30*	
Daily- child placed with parent		
In home	*24*	
In rehabilitation facility	*3*	
In foster care	*2*	
3-6 times per week	*24*	
Weekends only	*2*	
Mother & father have separate schedules	*8*	
No family contact		
No contact ordered by judge	*3*	
Parent(s) incarcerated	*2*	
Parent in rehabilitation	*1*	
Parent is missing	*1*	
Other	*3*	
Unable to determine	*8*	
Not noted	*4*	

Source: ZERO TO THREE Court Team database (2009)

The family contact plan for most children was stable throughout the case process, with 53 percent of the cases experiencing only one change or no change in the initial schedule, as shown in **Table III-B2e** (below). Forrest County, MS had few schedule changes, with 70 percent of the family contact plans remaining as originally ordered and 25 percent changing only once. At the Polk County, IA site, 46 percent of the family contact plans remained as originally ordered; an equal proportion changed between 2-3 times. However, Fort Bend County, TX reported extensive changes in the family contact plans.

Stakeholders reported that changes in the frequency and type of family contact were related to safety concerns posed by lack of parental progress or non-compliance with service plans. For example, parent-child contact gradually increased over time. The frequency remained constant until the parent became non-compliant with court-ordered substance abuse treatment. The frequency of family contact was then reduced and supervision increased until the parent completed treatment.

Table III-B2e. Number of Changes in Family Contact by Site

	All Sites		***Fort Bend County, TX***		***Forrest County, MS***		***Polk County, IA***	
Number of family contact schedules:	**N=186**	**%**	**N=94**	**%**	**N=51**	**%**	**N=41**	**%**
1	62	33.3	7	7.5	36	70.6	19	46.3
2	37	19.9	13	13.8	13	24.6	11	26.8
3	20	10.8	10	10.6	2	3.9	8	19.5
4	12	6.5	9	9.6	-	-	3	7.3
5	8	4.3	8	8.5	-	-	-	-
6	11	5.9	11	11.7	-	-	-	-
7	11	5.9	11	11.7	-	-	-	-
8	8	4.3	8	8.5	-	-	-	-
9	1	0.5	1	1.1	-	-	-	-
10	7	3.8	7	7.5	-	-	-	-
Greater than 10	9	4.8	9	9.6	-	-	-	-

Source: ZERO TO THREE Court Team database (2009)

Adhering to the scheduled family contact plan posed considerable resource and logistical challenges, particularly for the child welfare workers who were obligated to arrange, transport, supervise, and document the visits. This often involved coordinating visits with siblings who were placed in different locations. Each jurisdiction, however, made concerted efforts to secure additional supports to assist with increased family contacts, given limited resources. Notably, through local philanthropic and volunteer efforts, a "Visitation Center" was established in a two-story house in a residential neighborhood in Polk County, IA to provide a home-like atmosphere for parents and children to engage in everyday activities (e.g., feeding, bathing, reading to a child) and therapeutic interventions (e.g., parent child play

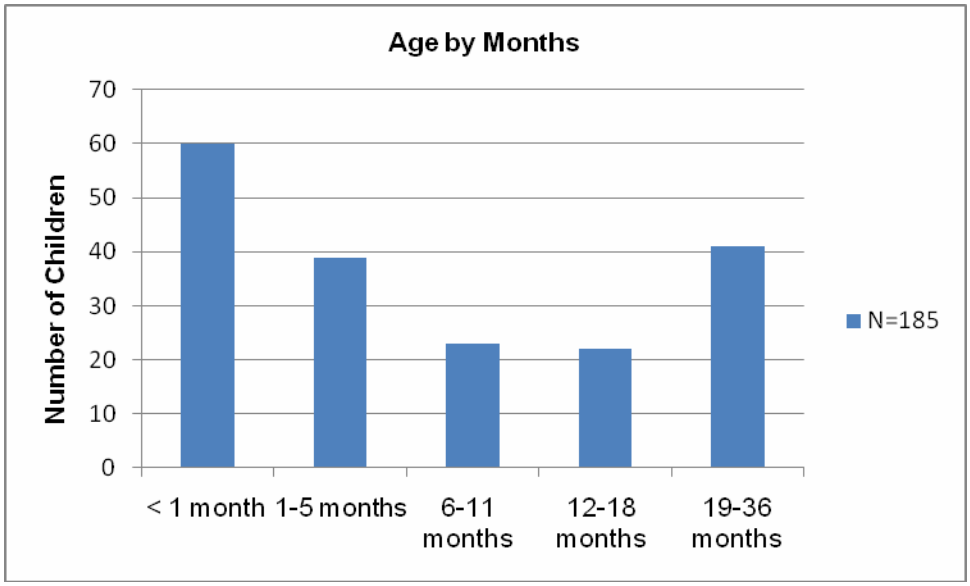
therapy, visit coaching). In Polk County, IA the court had developed *Parent Child Visitation Guidelines* for families and visits were also supervised by auxiliary staff that provided in-home services. In Orleans Parish, LA worked with the child welfare agency to secure a van and dedicated driver for transportation to visits, as well as dedicated staff for supervision. Fort Bend County, TX had a visit coach on staff at the child welfare agency. However, this single resource was insufficient to meet the demand. Stakeholders at this site advocated for greater supports and the Community Coordinator secured a grant through a foundation to provide family contact resources (e.g., fund transportation, rent space for visits).

Discussions with stakeholders revealed distinctly different orientations to family contact, however. The judiciary and members of the legal community perceived family contact as a fundamental right of the parent and child whereas some members of the child welfare community tended to perceive family contact as a reward or incentive for parental compliance with service plans. This difference in perspective offers an opportunity for the courts and child welfare to build greater awareness and consensus building on the value of family contact, as well as to engage stakeholders in discussions regarding resource constraints and reasonable efforts.

3. Service Utilization

More than half of the children served by the Court Teams were newborns and infants (n=99), as seen in **Figure III-4.** Nearly one-quarter of the children were between the ages of 6-12 months (n=45) and one-fifth were toddlers (n=41).

Figure III-4. Infants and Toddlers Served by Court Teams: Age by Months



Missing = 1

Each grouping corresponds to a distinct period of early childhood growth and learning in terms of motor, cognitive, and social-emotional development, as well as language acquisition. These vulnerable infants and toddlers were in need of multiple services, screenings, and interventions to mitigate the harm of maltreatment [129] and to ensure that they achieved age-appropriate developmental milestones. However, many young children in foster care do not receive basic health care, such as immunizations, dental services, hearing and vision screening, or testing for exposure to lead and communicable diseases. [130]

The provision of child-focused services is a core component of the Court Team model. Responding to the needs of maltreated infants and toddlers is the impetus for increased community collaboration and the inclusion of pediatricians, early intervention specialists, dentists, and therapists as key members of the Court Team. As stated in the Court Team Guidebook (2008: 7):

> Comprehensive developmental, medical and mental health services are incorporated into the case plan document to ensure that the children's well being is given primary consideration in the resolution of the case. Because maltreated children are so likely to experience developmental delays and medical problems, it is critical to find them a medical home with consistent primary caregiving by a pediatrician who comes to know the child and family. Services provided by the pediatrician should include a screening for symptoms of developmental delay at each visit. This screening should focus on all domains of development (cognitive, language, gross and fine motor, social, and emotional). In addition, all children should receive a screening for developmental delays conducted by the local agency responsible for complying with Part C of the Individuals with Disabilities Education Act. [131]

The provision of infant mental health services is another core component of the Court Team model. As noted in the *Court Team Guidebook* (2008: 8-10), "[c]hildren who have been traumatized by their parents' care may need mental health services. Parents who are maltreating their children need some level of intervention to help them overcome the reasons for their neglectful or abusive behavior. The intensity of the intervention should mirror the specific characteristics of the parent and child." A clinical assessment of the parent-child relationship is recommended, upon which a clinician may make recommendations to the Court about the types of interventions that would be suitable for the parent and

[129] Institute for Social and Economic Development. *Developmental Needs of Children Investigated by Child Protective Services* (April 2008). Prepared for the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

[130] Stahmer, A.C., Leslie, L.K., Hurlburt, M., Barth, R.P., Webb, M.B., Landsverk, J., & Zhang, J. (2005). Developmental and behavioral needs and service use for young children in child welfare. *Pediatrics*, 116 (4), 891-900. Grove Village, IL: American Academy of Pediatrics.

[131] The reauthorization of CAPTA—with the enactment of the Keeping Children and Families Safe Act of 2003 (P.L. 108-36)—required States to develop "provisions and procedures for referral of a child under age 3 who is involved in a substantiated case of child abuse or neglect to early intervention services funded under Part C of the Individuals with Disabilities Education Improvement Act" (§ 106(b)(2)(A)(xxi)). Child Welfare Information Gateway. (2007). *Addressing the Needs of Young Children in Child Welfare: Part C –Early Intervention Services.* Accessed September 2008 at www.childwelfare.gov/pubs/partc.cfm

child, such as evidence-based parenting education programs for maltreating parents; visit coaching; [132] psycho-educational parenting intervention; [133] and child-parent psychotherapy. [134]

The Court Teams database tracks children's service needs in 22 areas that encompasses physical care; immunizations; hearing, vision, and developmental screenings; infant mental health; and early learning. Each month following the court hearings, the Community Coordinators noted the degree to which each child's service needs had been met (i.e., fully met, progress being made, no/minimal progress) and identified new needs (next scheduled round of immunizations, etc). For those services involving parents, such as parent/child relationship evaluations or psychotherapy, reasons for delays or non-utilization are noted (e.g., parent needs to complete treatment first, parent refuses to participate, parent is hospitalized or incarcerated).

Table III- B3a. Service Needs in Progress: All Cases

	All Sites	
Infant/Toddler Service Need	**N**	**%**
Dental care	69	7.9
Developmental screening	90	10.3
Early Intervention (EI) - Occupational therapy	19	2.2
EI - Other	16	1.8
EI - Physical therapy	26	3.0
EI - Speech therapy	27	3.1
Early Head Start/Head Start	12	1.4
Family counseling	9	1.0
Full developmental assessment	119	13.6
Hearing Services	8	0.9
Individual Family Service Plan developed	48	5.5
Immunizations	73	8.3
Infant mental health services	4	0.5
Other	15	1.7
Other early childhood education	56	6.4
Parent-child psychotherapy	23	2.6
Parent-child relationship evaluation	48	5.5
Primary health care visit	152	17.4
Psychological evaluation	4	0.5
Specialist health care visit	50	5.7
Vision services	7	0.8

Source: ZERO TO THREE Court Team database (2009)

[132] Beyer, M. (2008). Visit Coaching: Building on family strengths to meet children's needs. *Juvenile & Family Court Journal*, 59 (1). Reno, NV: National Council of Juvenile and Family Court Judges.

[133] Cicchetti, D., Rogosch, F.A., Toth, S.L. (2006). Fostering secure attachment in infants in maltreating families through preventive interventions. *Development and Psychopathology*, 18, 623-649. London: Cambridge University Press.

[134] Lieberman, A. F. & Van Horn, P. (2006). Assessment and Treatment of Young Children Exposed to Traumatic Events. In J. Osofsky (Ed.), *Young Children and Trauma: Intervention and Treatment.* New York: Guilford Press.

Table III-B3a (above) provides the total number of services identified as a need for the 186 infants and toddlers. Most children had multiple needs. The Court Team sites were successful in fulfilling the mandate to provide medical and developmental services. Infants and toddlers needs were consistently identified across the sites. The largest percentage of cases (82%) required a primary health care visit. Both the Forrest County, MS and Polk County, IA sites had a dedicated pediatrician as a member of the Court Team; referrals were accepted for any child that did not have a medical home. More than 25 percent of the children received specialized health care, ranging from neurological examinations for brain injuries (Fort Bend County, TX and Forrest County, MS) to visiting nurse services for periodic check-ins on health status (Polk County, IA).

Each of the three sites site had a Part C provider on the Court Team. A full developmental assessment was required for 64 percent of cases overall; developmental screenings were required for nearly 50 percent of cases. An Individual Family Service Plan (IFSP) was developed for 25 percent of the children.

With regard to parent-child mental health needs, 31 percent of the cases had been referred for parent-child relationship evaluation and 13 percent referred for psychotherapy. As shown in **Table III-B3b,** the majority of these cases were at the Polk County, IA site where a state-accredited community mental health center was a central part of the Court Team. Seventy-six percent (n=38) of the parent-child dyads were referred for a relationship evaluation (e.g., attachment assessment). For 71 percent of those cases, the service plan was achieved or progress was being made. At least 20 percent of the Polk County, IA cases involved a referral for parent-child psychotherapy; known progress was being made in the majority of the cases. At the Forrest County, MS site, 22 percent of the cases were referred to a regional mental health care provider for parent-child relationship evaluations and they were successfully engaged in psychotherapy. Despite the limited array of child therapists and organizations that offered infant mental health services in the area, the Fort Bend County, TX site referred a small percentage of cases (9.3%) for parent-child relationship evaluations; progress was being for those cases referred to parent-child psychotherapy.

Table III-B3b. Parent-Child Relationship Evaluation and Psychotherapy: Referrals and Utilization

	All Sites		*Fort Bend County, TX*		*Forrest County, MS*		*Polk County, IA*	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
	186	**-**	**86**	**-**	**50**	**-**	**50**	**-**
Parent-child relationship evaluation								
Referrals noted	57	31	8	9.3	11	22	38	76
Service utilization							[a]	
Service plan achieved or progress being made			3	-	11	-	27	-
No/minimal progress			5 [b c]	-			1 [b]	-
Parent-child psychotherapy								
Referrals noted	24	13	3	3.5	11	22	10 [d]	20
Service utilization								
Service plan achieved or progress being made			3	-	11	-	10	-
No/minimal progress							2 [b]	-

Source: ZERO TO THREE Court Team database (2009)

Notes: Referral information is derived from the Child Service Needs table. Service utilization data is derived from the Monthly Service Progress table. Using the Child IDs, information on identified service needs from the Child Service Needs table was matched to the service status noted on the Monthly Service Progress table.

[a] = Ten cases noted in the Child Service Needs table do not appear in the Monthly Service Progress table. In some cases the service process was interrupted due to parental incarceration or hospitalization.
[b] = Client reason
[c] = Service not available
[d] = Missing data = 2

Across the sites, less frequently utilized services include most of the mental health services, such as family counseling (5%), [135] psychological evaluation (2%), and infant mental health (2%) for play therapy or psychiatry.

Across all service needs, and accounting for multiple iterations of the same need (e.g., recurring need for immunizations), 63 percent of the needs had been fully met, and 34 percent were in process with progress being made. Only three percent were experiencing no progress or minimal activity. Services that were noted as not available due to wait lists include Early Head Start at the Polk County, IA site and developmental screenings at the Fort Bend County, TX site. There was no wait list reported for services at the Forrest County, MS site.

Monthly progress was least likely to be made in the areas of parent-child psychotherapy (28% with no/minimal progress) and parent-child relationship evaluations (26% with no/minimal progress).

[135] The use of family counseling may be underreported as this service is also captured in the parent section of the database as it is often a court-ordered service for the parent.

Lack of progress was primarily attributed to client reasons, although in some cases there was a waiting list or the service was not available in the area.

C. Safety and Permanency Outcomes

1. Absence of Maltreatment Recurrence

Ensuring child safety is a key goal of the child welfare system and the dependency court. Maltreatment recurrence, also referred to as repeat maltreatment or re-victimization, is defined as the second, third, fourth, or subsequent time that a child has been found to be a victim of maltreatment. [136] Maltreatment recurrence is addressed by both the Child and Family Services Review (CFSR) and the Court Performance measures. However, it is phrased differently as the former measures the absence of maltreatment and the latter measures its presence. The CFSR measure—*Absence of Maltreatment Recurrence*—addresses the percent of child who *did not* experience another incident of maltreatment within a six-month period. The national standard for this measure is 94.6 percent. [137] [138] Court Performance measure 1A—*Child Safety While Under Court Jurisdiction*—addresses the percentage of children who were abused or neglected while under court supervision (from case opening to case closure) within a given year (a recurrence rate has not been established). [139]

There are a number of factors that influence repeat maltreatment. Studies addressing child-level factors associated with maltreatment recurrence find that younger children [140] and children with health problems or developmental delays [141] are more likely to experience repeat maltreatment. Family-related factors that contribute to maltreatment recurrence include poverty, little or no income, inadequate housing

[136] Fluke, J.D., Shusterman, G.R., Hollinshead, D., & Yuan, Y.T. (2005). *Rereporting and Recurrence of Child Maltreatment: Findings from NCANDS.* Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

[137] The Data Measures, Data Composites, and National Standards to be Used in the Child and Family Services Reviews, 71 Fed. Reg. 109, 32973 (June 7, 2007).

[138] Item 2 of the CFSR operationalizes repeat maltreatment as a substantiated or indicated report of maltreatment within a 6-month period for any child in the family involved with child welfare.

[139] Flango & Kauder, 2008, 6-7.

[140] Drake, B., Johnson-Reid, M., Way, I. & Chung, S. (2003). Substantiation and recividism. *Child Maltreatment* 8 (4), 248-260; Lipien, L. & Forthofer, M.S. (2004). An event history analysis of recurrent child maltreatment reports in Florida. *Child Abuse and Neglect* 28, 947-966; Marshall, D.B. & English, D.J. (1999). Survival analysis of risk factors for recividism in child abuse and neglect. *Child Maltreatment* 4 (4), 287-296. Fuller, T.L., Wells, S.J., & Cotton, E.E. (2001). Predictors of maltreatment recurrence at two milestones in the life of a case. *Children and Youth Services Review*, 25 (7), 49-78.

[141] Depanfilis, D. & Zuravin, S.J. (2002). The effect of services on the recurrence of maltreatment. *Child Abuse and Neglect* 26, 187-205; Marshall & English, 1999.

[142] and family composition (e.g., cases involving multiple children as victims). [143] Caregiver risks factors, such as substance abuse, criminal history, domestic violence, or caregiver history of abuse and neglect increase the likelihood of maltreatment recurrence. [144]

Given these factors, the infant and toddlers served by the Court Team were at risk of subsequent victimization due to their age, family poverty, and caregiver substance abuse. [145] Of the 186 children under court supervision, 99.05 percent did not experience a subsequent report of substantiated maltreatment within 6 months from the initial report. There was one reported occurrence (.05%) of repeat maltreatment perpetrated. This involved a case in Fort Bend County, TX. [146]

The families served by the Court Teams were vulnerable to incidents of repeat maltreatment given the presence of multiple risk factors, particularly caregiver substance abuse. As shown in **Table III-C1,** dependency cases were re-opened on two families in Forrest County MS, and one family in Polk County, IA. The reasons for re-opening were parental substance abuse and child endangerment (one case) and the subsequent birth of a substance-exposed child in the family (two cases).

Table III-C1. Cases Re-opened on a Court Team Family

	All Sites		***Fort Bend County, TX***		***Forrest County, MS***		***Polk County, IA***	
Cases re-opened on a family:	**N = 150**	**%**	**N =72**	**%**	**N = 42**	**%**	**N = 36**	**%**
- Within 6 months	0	0	0	0	0	0	0	0
- Later than 6 months from case opening	3	2.0	0	0	2	4.7	1	2.7

Source: ZERO TO THREE Court Team database (2009)

2. Placement Stability

Research has demonstrated a strong association between frequent placement moves in foster care and poor outcomes. For example, one recent study found that children in foster care experience

[142] Jones, L. (1998). The social and family correlates of successful reunification of children in foster care. *Children and Youth Family Services Review*, 20 (4), 305-323.

[143] Marshall & English, 1999.

[144] Fuller, T.L., & Wells, S.J. (2003). Predicting maltreatment recurrence among CPS cases with alcohol and other drug involvement. *Children and Youth Services Review*, 25 (7), 553-569; Marshall & English, 1999; Depanfilis & Zuravin, 2002.

[145] Connell, C.M., Bergeron, N., Katz, K.H., Saunders, L., & Tebes, J.K. (2007). Re-referral to child protective services: The influence of child, family, and case characteristics on risk status. *Child Abuse and Neglect*, 31 (5), 573-88.

[146] Disclosure of any further information about the case would compromise the privacy of the family. The study team learned about this occurrence of repeat maltreatment during the on-site interviews (December 2008). The child section of the Court Team database did not reflect this information. Supplemental allegations are only noted in the parent section of the database and the study team did not have access to these data.

placement instability unrelated to their baseline problems, and this instability has a significant impact on their behavioral well-being. [147] Additionally, children who had more than one placement move during their first year were more likely to experience placement instability in long-term out-of-home care. [148] Multiple placements also negatively impact a child's attachment to primary caregivers and can compromise secure attachments as an early developmental milestone. [149] Such findings support interventions designed to promote placement stability as a means to improve outcomes for children upon entry into care.

Table III-C2a. Number of Placements: All Sites

	All sites	
Number of placements for open & closed cases	**N=184**	**%**
1	71	38.6
2	62	33.7
3	28	15.2
4	14	7.6
5	6	3.2
6	-	-
7	1	.5
8	1	.5
11	1	.5

Source: ZERO TO THREE Court Team database (2009)
Missing data = 2

Table III-C2a (above) presents the number of placements for 184 infants and toddlers served by the Court Teams. Across the sites, nearly 40 percent of the children had one placement from the time of case opening to the time of case closure. One-third of the children had two placements during this time. However, 25 percent of the children had between 3-5 placements over the life of the case. Three children had seven or more placements. [150]

To determine placement stability, the number of placements and length of time under court supervision was examined for a subset of 88 cases using the time parameters for the *Child Welfare*

[147] Rubin, D.M., O'Reilly, A., Luan. X., Localio, A. (2007). The impact of placement stability on behavioral well-being for children in foster care. *Pediatrics*, 119 (2), 336-344.

[148] Webster, D., Barth, R. P., & Needell, B. (2000). Placement stability for children in out-of-home care: A longitudinal analysis. *Child Welfare*, 79 (5), 14-32.

[149] Wulczyn, F., Cogan, J.P. & Harden, B.J. (2002) *Placement stability and movement trajectories.* Chicago: University of Chicago, Chapin Hall Center for Children**.**

[150] For one of these children, this included four consecutive stays in hospital. Another child was placed in a group home, a shelter, with a foster parent, and with a relative. One child was placed with a relative, non-relative, a foster parent and the birth parent.

Outcome Permanency Composite 4: Placement Stability measure. [151] Closed cases for which there were valid case opening, closure, and placement change dates were considered. The average number of days under court supervision for these 88 cases was slightly more than one year or 374 days (SD=151.34), with the number of days ranging from 56 to 898 days.

As presented in **Table III-C2b**, the children are grouped according to their length of time under court supervision and the number of placements they had during this time. For 35 of the 48 children under court supervision for less than 12 months, 73 percent had two or fewer placement settings. For 22 of the 38 children under court supervision between 12-24 months, 58 percent had two or fewer placements. There were only two children under court supervision for more than 24 months and both had only one placement.

Table III-C2b. Number of Placements by Time in Care: All Sites

N =88	***Across all sites***					
	Less than 12 months		***Between 12-24 months***		***More than 24 months***	
Number of placements for closed cases only:	**N=48**	**% 54.5**	**N=38**	**% 43.1**	**N=2**	**% 2.3**
1	14	15.9	9	10.2	2	2.3
2	21	23.8	13	14.7	-	-
3	4	4.5	9	10.2	-	-
4	7	7.9	3	3.4	-	-
5	1	1.1	3	3.4	-	-
6	-	-	-	-	-	-
7	-	-	-	-	-	-
8	1	1.1		-	-	-

Source: ZERO TO THREE Court Team database (2009)

Further analysis was conducted on these 88 closed cases. A key finding is that more than two-thirds (67%) of the placements were stable. One third (33%) of the placements were not stable as children experienced more than 2 placements during their time in care. Chi square tests were conducted to determine if there was a relationship between placement stability/instability *and* (1) case characteristics; (2) site; and (3) being in kinship care. Across sites, the stability of placements did not differ by selected demographic characteristics (race/ethnicity (Chi Square = 0.21, p=0.9761); by site (Chi Square = 0.95, p=0.6228); or by whether the child was placed with relatives during the initial placement (Chi Square = 1.65, p=0.1992). [152]

[151] In the original proposal to OJJDP, the Child Welfare Outcome measure 6.1 Increase placement stability was proposed. However, as the composite measure was introduced by ACF during the course of this study, this newer measure is used.
[152] Additional demographic characteristics that were analyzed included the number of siblings with this mother, the number of children previously removed, health needs at intake (i.e., medically fragile, disabled, failure to thrive). However, the cell sizes were too small for Chi Square to be a valid test.

3. Permanency Planning

Permanency planning is the legal process through which children under the court's supervision secure a permanent relationship and a home with nurturing caregivers. The Adoption and Safe Families Act (ASFA) of 1997 requires permanency plans for children in foster care, sets time limits for the creation of a permanency plan, and requires that a permanency planning hearing be held within 12 months of the child's first entering care. Legal permanency options include return to parent, adoption, placement with a fit and willing relative (kinship care), legal guardianship, and another planned permanent living arrangement. Through use of concurrent planning, alternative permanency options are identified and explored in the event that the desired goal proves unrealistic or is not in the child's best interests. [153]

Table III-C3a presents the primary permanency goal for a subset of infant and toddlers (149/186) for whom complete permanency data were available. Although sites noted permanency goals were available for 100 percent of the children, database limitations restricted proper data entry, thus 149 cases were examined. [154] Of these, 148 children had a primary permanency goal identified, and of those, one case was noted as "inconclusive."

Table III-C3a. Child Primary Permanency Goal

	All Sites		***Fort Bend County, TX***		***Forrest County, MS***		***Polk County, IA***	
	N=149	**%**	**N =65**	**%**	**N=50**	**%**	**N=34**	**%**
Reunification with parent	125	83.4	44	67.7	47	94.0	34	100.0
Place with fit and willing relative	15	10.1	15	23.1	-	-	-	-
Refer child for legal guardianship	2	1.3	-	-	2	4.0	-	-
Place child for adoption	6	4.0	6	9.2	-	-	-	-
Other: Inconclusive	1	0.7	-	-	1	2.0	-	-

Source: ZERO TO THREE Court Team database (2009)

Stakeholders indicated that permanency goals are identified at case initiation but are subject to change over the life of the case. Reunification with the parent was the intended goal for 84 percent of the

[153] State statutes vary in their degree of specificity in defining the criteria for determining the child's best interest. Some states provide detailed checklists to guide decision-making whereas other states express guiding principles. Wayne, R.H. (2008). The Best Interest of the child: A silent standard—will you hear it when you know it? *Journal of Public Child Welfare*, 2, 1 33-49.

[154] The Child Case Status section records the following information: Primary permanency goal, concurrent plan, parental rights outcome, child permanency outcome, determination date for child permanency, data child place with parent, relative with legal custody, or adoptive parent. ZTT staff reported that the primary and concurrent planning information cannot be saved independent of the outcome information, thus leading to variations in the timing of the data entry and use of "Other" as a placeholder.

children for whom a goal was provided. This was the primary goal for 100 percent of the children in the Polk County, IA site, for 94 percent of the children at the Forrest County, MS site, and for 68 percent of the children at the Fort Bend County, TX site. Other goals varied across sites. For example, placement with a fit and willing relative was the primary permanency goal for nearly 25% of the children at the Fort Bend County, TX site. However, it was never identified as a primary permanency goal for the Forrest County, MS and Polk County, IA sites. Adoption was identified as the permanency goal for 9% percent of the children at the Fort Bend County, TX site whereas it was not identified as the primary permanency goal at the other sites.

Concurrent planning involves working towards the permanency goal while at the same time developing an alternative permanent plan. Through concurrent planning, potential caregivers and alternate permanency options are identified in the event that reunification with the birth parent may not be possible or is not in the child's best interests. [155] This typically involves family centered casework and legal strategies aimed at achieving timely reunification while establishing a viable permanency plan if reunification is not realistic.

Table III-C3b. Child Concurrent Plan Goal

	All Sites		***Fort Bend County, TX***		***Forrest County, MS***		***Polk County, IA***	
	N=149	**%**	**N=65**	**%**	**N=50**	**%**	**N=34**	**%**
Reunification with parent	11	7.4	7	10.8	3	6.0	1	2.9
Place with fit and willing relative	102	68.5	36	55.4	43	86.0	23	67.7
Refer child for legal guardianship	2	1.3	-	-	2	4.0	-	-
Place child for adoption	27	18.1	18	27.7	1	2.0	8	23.5
Other: Inconclusive	1	-	-	-	1	2.0	-	-
Other: Not specified	6	4.7	4	6.2	-	-	2	5.9

Source: ZERO TO THREE Court Team database (2009)

As shown in **Table III-C3b,** approximately 95 percent of the children had a concurrent plan; 5 percent did not have a concurrent goal noted in the database. Placement with a fit and willing relative was the concurrent plan goal for nearly 70 percent of the cases across sites. This was most prevalent at the Forest County, MS site, as 86 percent of the cases had kinship care as the concurrent goal. To a lesser extent, placement with a fit and willing relative was the concurrent plan in the Forrest County, MS, and Fort Bend County, TX sites, accounting for 68 percent and 55 percent of the goals, respectively.

[155] National Resource Center for Foster Care and Permanency Planning. *Understanding and Using Concurrent Planning to Achieve Permanency for Children and Youth.* ABA Conference, June 6, 2002, Best Practices to Implement ASFA: Creative Strategies for Practitioners.

Adoption was identified as the concurrent goal for nearly a quarter of the children at the Fort Bend County, TX (28%) and Polk County, IA (24%) sites whereas it was reported for only 2 percent of the cases in the Forrest County, MS site. Reunification with the parent was the concurrent plan for 10 percent of the cases in Fort Bend County, TX, 6 percent of the cases in Forrest County, MS, and in 3 percent of the cases in Polk County, IA. Some of these concurrent plans involved reunification with the non-custodial parent. The concurrent plan for one child was noted as "Inconclusive." No further information was available for six cases with the goal noted as "Other."

4. Achieving Permanency

Along with securing the safety and well-being of children in the child welfare system, the goal of the ASFA of 1997 is to secure timely permanent placement outcomes for children. The following sections address the achievement of permanency for infants and toddlers served by the Court Teams and the timeliness of these outcomes per statutory guidelines.

a. Case Closure

The majority of the 186 cases reviewed (59%) are closed across the sites. However, the percentage of closed cases varied markedly by site, with Fort Bend County, TX demonstrating the highest percentage of closures (77%) and Forrest County, MS, the lowest (32%). Polk County, IA has closed slightly more than half of their cases. By law, the 329th District Court in Fort Bend County is required to issue a Dismissal Order within 365 days of the adversary hearing or "mediation" and close the case (Tex. Fam. Code Ann. § 263.306). Variation in the start-up date of the model across the three sites also accounts for differences in the number of cases closed (i.e., Fort Bend County, TX in October 2005; Polk County, IA in April 2006; and Forrest County, MS in May 2006).

Table III-C4a. Case Status as of December 31, 2008

	All Sites		***Fort Bend County, TX***		***Forrest County, MS***		***Polk County, IA***	
	N=186	**%**	**N=65**	**%**	**N=50**	**%**	**N=50**	**%**
Closed	109	58.6	66	76.7	16	32.0	27	54.0
Open	75	40.3	26	23.6	32	68.0	23	46.0

Source: ZERO TO THREE Court Team database (2009)

As noted previously, cases were re-opened on two families at the Forrest County, MS site and one family at the Polk County, IA site.

b. Permanency Outcomes

To examine the permanency outcomes of infants and toddlers under court supervision, analyses were conducted to determine what percentage of infants and toddlers served by the Court Team were

reunified with the parent, placed with a fit and willing relative, referred for legal guardianship, or placed for adoption. The analogous Child Welfare Outcome measure—*Increase Permanency for Children in Foster Care (Exits from Foster Care)*—calculates the percentage of children who exited the child welfare system to reunification, adoption, or legal guardianship. Similarly, the analogous Court Performance Measure—*2A: Achievement of Child Permanency*—calculates the percentage of children in foster care who reach legal permanency by reunification, adoption, or legal guardianship. Per the Court Performance definition, legal permanency is achieved when a "permanent and secure legal relationship" has been established "between the adult caregiver and the child." [156] Legal permanency for a child is not achieved through "another planned living arrangement" (APPLA). This refers to a case plan designation for children in out-of-home care for whom there is no goal for placement with a legal permanent family and there is sufficient reason to exclude all other goals. [157] The analyses used the more stringent criteria presented by the Court Performance measure.

Figure III-5. Achievement and Non-Achievement of Permanency

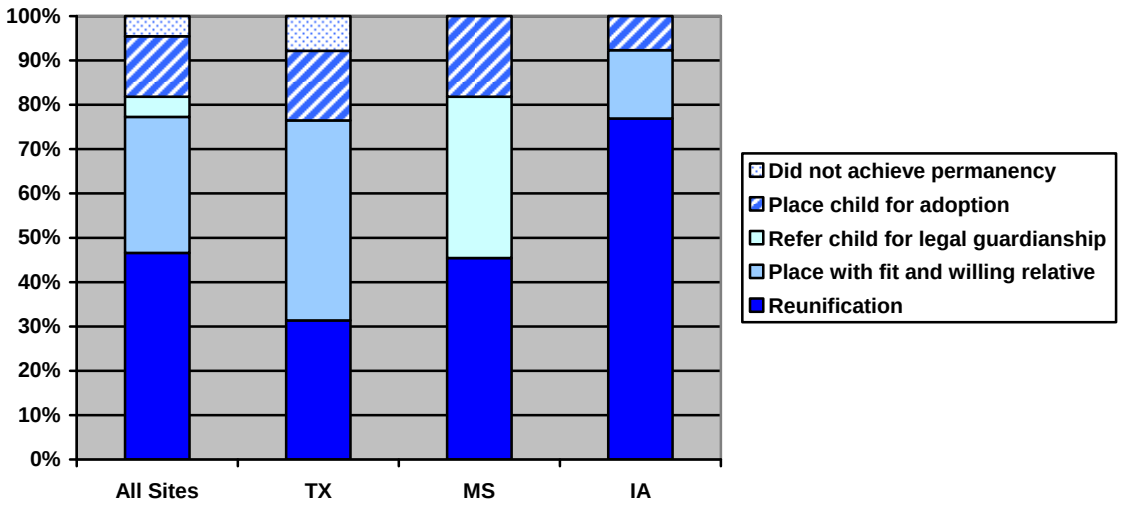


Figure III-5 presents the permanency outcomes for closed cases served by the Court Team from the date of implementation of the model at each site until December 31, 2008 (N=88). [158] Across all sites, permanency was achieved in 95 percent of the closed cases. Nearly forty-seven percent of the children

[156] Flango & Kauder, 2008, 16-17.

[157] Renne, J. (2002). Reasonable efforts to finalize a permanency plan for "Another Planned Permanent Living Arrangement." *American Bar Association Child Law Practice*, 21 (1), 38-42.

[158] The Court Teams database captures reunification with the parent, placement with a fit and willing relative, guardianship, and adoption but not APPLA.

were reunified with the parent, 31 percent were placed with a fit and willing relative, and 14 percent were freed for adoption. [159] However, using the standard applied by the *Court Performance measure 2A*, nearly five percent of the children did not achieve permanency. Sadly, two medically fragile children died while in custody despite the therapeutic care and medical oversight that were put in place through court and child welfare intervention. Continued custody of two children remained with the child welfare agency.

Table III-C4b1 presents the permanency outcomes for the 88 closed cases across sites and for cases at each site. At the Fort Bend County, TX site 47 children, or 92 percent, have achieved permanency. Of these, 49 percent were placed in the custody of a relative, 34 percent were reunified with the parent, and 17 percent were freed for adoption. Twenty-six children at the Polk County, IA site have achieved permanency; this represents 100 percent of the closed cases. The majority were reunified with their parents (77%). Custody to a relative occurred in 15 percent of the cases and freeing the child for adoption occurred in 8 percent of the cases. At the Forrest County, MS site, 11 children have achieved permanency to date. Reunification with the parent occurred in 45 percent of the cases; 36 percent of the children were referred for legal guardianship with a relative. A small number of children were freed for adoption (18%).

Table III-C4b1. Reasons for Achievement and Non-Achievement of Permanency

	All Sites		***Fort Bend County, TX***		***Forrest County, MS***		***Polk County, IA***	
	N=88	**%**	**N=51**	**%**	**N=11**	**%**	**N=26**	**%**
Achieved permanency								
Reunification	41	46.5	16	31.4	5	45.5	20	76.9
Place with fit & willing relative	27	30.6	23	45.1	-	-	4	15.4
Refer child for legal guardianship	4	4.5	-	-	4	36.4	-	-
Place child for adoption	12	13.6	8	15.7	2	18.2	2	7.7
Did not achieve permanency	2	2.2	2	3.9	-	-	-	-
Deceased	2	2.2	2	3.9				

Source: ZERO TO THREE Court Team database (2009)

Site-specific differences in outcomes must take into consideration some variation in the statutory permanency options that pertain in the states of Texas, Mississippi, and Iowa. [160] As shown in **Table III-C4b2,** common permanency options across the statutes are return to the parent and adoption. However,

[159] Due to rounding up, the percentages quoted do not correspond exactly with percentages noted in Table III-C4b1.

[160] See **Appendix G** for further detail regarding each State's permanency options and the conduct of hearings.

there are differences in the terminology used to describe legal custody and the relationship between a child and a non-parental caregiver, such as a relative, as well as substantive differences regarding the retention, relinquishment, or termination of parental rights when a child is in kinship care.

Table III-C4b2. Legal Permanency Options

Texas	***Mississippi***	***Iowa***
Fam. Code § 263.306 • Return to the parent • Adoption • Placement in a permanent managing conservatorship	**Ann. Code § 43-15-13** • Return to the parent • Adoption • Placement with a relative • Another safe and adequate placement for a child who cannot return home or be placed for adoption	**Ann. Stat. § 232.104(2)** • Return to the parent • Termination of parental rights and adoption of the child • Transfer of custody from one parent to another parent • Guardianship • Transfer of custody to a suitable person • Another planned, permanent living arrangement when there is a compelling reason that another permanent • Placement is not in the child's best interest

In Texas, when a child is taken into custody, the Department of Family and Protective Services (DFPS) is appointed as the "temporary managing conservator." The Court has four child custody options to consider for the Dismissal or Final Order at the conclusion of the 365 day-Conservatorship timeline:

1. Dismiss DFPS's managing conservatorship and return the child to a parent;
2. Transfer managing conservatorship from DFPS to a relative or other suitable person (i.e., grant Permanent Managing Conservatorship (PMC) to a relative);
3. Terminate parental rights and appoint DFPS, a relative, or other suitable person as PMC;
4. Appoint DFPS as permanent managing conservator without terminating parental rights (TPR). [161]

Reunification with the parent, PMC with a relative, and adoption represent achievement of permanency; awarding PMC to the Department without TPR does not. Awarding "PMC" to a relative may occur without termination of parental rights; the birth parent may continue to have contact with the child as determined by the court order. [162] As seen in **Table III-C4b1** (above), at the Fort Bend County, TX site,

[161] Texas Department of Family and Protective Services: 6230 Selecting a Conservatorship Option. Accessed July 2009 at http://www.dfps.state.tx.us/handbooks/CPS/Files/CPS_pg_6230.jsp.

[162] Texas Department of Family and Protective Services: Adoption of Permanent Managing Conservatorship. Accessed July 2009 at http://www.dfps.state.tx.us/Child_Protection/Adoption/pmc.asp. The PMC can petition the court to issue additional orders as

49 percent (n=23) of the children were placed in the custody of a relative. Of these children, 12 parents retained parental rights, 7 parents relinquished paternal rights, and rights were terminated for 7 parents.

In Mississippi, durable legal custody of the child can transfer from the parent to a relative. Per the Mississippi Code of 1972 (as amended) "durable legal custody" refers to "the legal status created by a court order which gives the durable legal custodian the responsibilities of physical possession of the child and the duty to provide him with care, nurture, welfare, food, shelter, education and reasonable medical care. All these duties as enumerated are subject to the residual rights and responsibilities of the natural parent(s) or guardian(s) of the child or children." [163] A child has to live with the relative for a period of one year in order for that relative to obtain durable legal custody. [164] (While synonymous with legal guardianship, this status does not connote subsidized guardianship as this does not exist in Mississippi). As shown in **Table III-C4b1** (above), 36 percent of the children who have achieved permanency at the Forrest County, MS site were referred for legal guardianship with a relative; in these cases the parents retained their rights.

Per the Iowa statute, guardianship establishes a legal relationship between a child and an adult caregiver, but it does not end the legal relationship between the child and the child's biological parents. A guardian provides for the child's including shelter, education, and medical care, although the biological parents are still legally required to provide financial support for the child (Ann. Stat. § 232.104(2)). Custody to a relative occurred in 15 percent of the cases at the Polk County, IA site, as seen in **Table III-C4b1** (above). In these four cases, parental rights were terminated. There is no further information available as to whether these cases involved "guardianship" or were designated as "transfer of custody" to a suitable person per the statute.

5. Achieving Timely Permanency

a. Time to Permanent Placement

Building upon the ASFA mandate and the urgent need to provide infants and toddlers with a safe, stable, and permanent home, the Court Teams emphasize achieving permanency in a timely manner and ensuring that this relation will be sustained. [165] To determine whether this goal was met, analyses were conducted with 77 closed cases for which dates were available to determine the length of time taken to

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needed with regard to the birth family. The family and child may apply for benefits to obtain Medicaid coverage for the child. The family must meet eligibility criteria to receive any other benefits to which they may be entitled such as Food Stamps and TANF. The PMC is responsible for enforcing and attempting to collect child support if the parents are ordered to pay, which may require hiring an attorney and petitioning the court. Foster care payments end after PMC is awarded.

[163] SEC. 43-21-105. Definitions. Accessed July 2009 at http://www.mscode.com/free/statutes/43/021/0105.htm

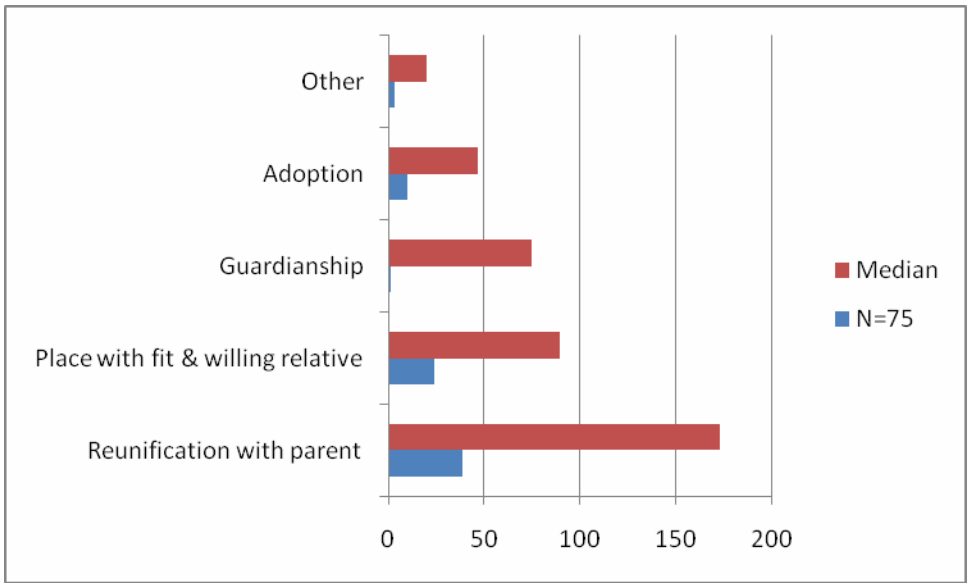
[164] HB 1072 43-21-151 and 43-21-609 MS Code of 1972 SB 2856 Section 43-21-105 MS Code of 1972.

[165] Edwards, L. (2007). Achieving timely permanency in child protections courts: The importance of frontloading the court process. *Juvenile and Family Court Journal,* 58 (2), 1.

achieve this milestone, using the parameters provided by Court Performance measure 4A—*Time to Permanent Placement* (i.e., date the petition was filed to the date that the child was placed in a permanent home). The Court Team database variables used in the analysis were the date on which the court order was signed and the date that the child was placed with a parent, relative, or adoptive parent.

Figure III-6 presents the median number of days to achieve permanent placements across the three sites. The median length of number of days to achieve reunification for 39 cases was 173 days or about six months from the date the petition was filed. Placement with a fit and welling relative occurred in 89 days or within three months for 24 cases. Placements for adoption occurred fairly quickly, within 46.5 days or 1 ½ months, for the 8 cases examined. Notably, the permanent placements for reunification and placement with relatives are occurring well-within the ASFA timeframes of one year.

Figure III-6. Median Days from Petition to Permanent Placement: All Sites



Source: ZERO TO THREE Court Team database (2009)

Site-specific differences are noted in **Table III-C5a.** For example, the median number of days for permanent placement with a parent ranged from 103 days in Forrest County, MS to 232 days in Polk County, IA. The median number of days for permanent placement with a relative ranged from 89 days in Fort Bend County, TX to 122 days in Polk County, IA. This suggests that the Court Teams are making concerted efforts to identify relative caregivers for infants and toddlers and to maintain family connections.

Table III-C5a. Median Days from Petition to Permanent Placement [166]

	All Sites		***Fort Bend County, TX***		***Forrest County, MS***		***Polk County, IA***	
	N=75	**Median**	**N=44**	**Median**	**N=5**	**Median**	**N=26**	**Median**
Reunification with parent	39	173	15	156	4	103	20	232
Place with fit & willing relative	24	89.5	20	89.5	-	-	4	122.5
Guardianship	1	75	-	-	1	75	-	-
Adoption	8	46.5	6	84	-	-	2	31
Other	3	20	3	20				

Source: ZERO TO THREE Court Team database (2009)

b. Achieving Permanency within Statutory Timeframes

Table III-C5b1 presents findings regarding the achievement of a permanent within the statutory ASFA timeframes. A key finding is that more than 50 percent of the infants and toddlers served by the Court Teams achieved a permanent placement within 12 months of case opening. Forty percent of the children achieved permanency within 12-18 months. A very small percentage (4%) of the children achieved permanency between 18-24 months. Permanency was achieved in more than 24 months for only one case.

The greater part of the reunification outcomes occurred within the ASFA timeframes. Of the 41 children that were reunified with parents, 59 percent were reunified with 12 months from the date that the court order was filed. More than two-thirds (37%) of the children were reunified between 12-18 months, and a very small percentage (5%) of reunifications occurred between 18-24 months. Notably, in Fort Bend County, TX, 69 percent of the infants and toddlers were reunified within 12 months.

For comparative purposes across sites, the category of Legal Guardianship and Placement with Fit and Willing Relative were combined. Across the sites, 48 percent of the cases achieved permanency in less than 12 months and an equal proportion did so within 12-18 months. The majority of the cases that achieved this permanency outcome were from the Fort Bend County, TX site. Nearly sixty percent of the children achieved this outcome within 12 months.

[166] Based on Court Performance Measure 4A: Time to Permanent Placement (Flango & Kauder 2008, 16-17). Corresponding variables in the Court Team database are the date court order was signed, date child placed with or living with parent, date child placed with relative with legal custody, and date child placed with adoptive parent.

Table III-C5b1. Time to Permanency [167]

	All Sites		*Fort Bend County, TX*		*Forrest County, MS*		*Polk County, IA*	
	N=84	**%**	**N=47**	**%**	**N=11**	**%**	**N=26**	**%**
Time to Reunification [a]	41						[a]	
Less than 12 months	24	58.5	11	68.8	2	40.0	11	55.0
Between 12-18 months	15	36.6	5	31.3	1	20.0	9	45.0
Between 18-24 months	2	4.3	-	-	2	40.0	-	-
More than 24 months	-	-	-	-	-	-	-	-
Time to Legal Guardianship[b c] **or Placement with Relative**								
Less than 12 months	15	48.4	13	56.5	1	25.0	1	25.0
Between 12-18 months	15	48.4	9	39.1	3	75.0	3	75.0
Between 18-24 months	1	3.2	1	4.4	-	-	-	-
More than 24 months	-	-	-	-	-	-	-	-
Time to Adoption [d]								
Less than 12 months	7	58.3	5	62.5	-	-	2	100.0
Between 12-18 months	5	41.7	3	37.5	2	100.0	-	-
Between 18-24 months	-	-	-	-	-	-	-	-
More than 24 months	-	-	-	-	-	-	-	-

Source: ZERO TO THREE Court Team database (2009)
[a] Missing data = 4
[c] Only the Forrest County site used legal guardianship as a permanency goal

Across sites, twelve infants and toddlers were freed for adoption. In 50 percent of the cases, this outcome was achieved in less than 12 months. Children were freed for adoption between 12-18 months in 40 percent of the cases. Only one case extended beyond 24 months. These findings suggest that there is early movement toward relinquishment and termination of parental rights.

Indeed, for 85 percent of the cases where parental rights were terminated, the termination appears to have occurred within 18 months of case opening, as shown in **Table III- C5b2**. [168] For the majority of these cases, the original permanency goal was reunification with the parent. Yet in at least half of these cases the concurrent plan was "place child for adoption." In some cases, parental rights were terminated and the child was placed with a relative. These patterns suggest that there is a concerted effort

[167] Based on Court Performance Measure 4A: Time to Permanent Placement (Flango & Kauder 2008, 16-17). Corresponding variables in the Court Team database to calculate this measure are the date the initial court order was signed, the date of determination of child permanency, and the child permanency outcome.

[168] The Court Team database variables used in the analysis were the date on which the court order was signed and the date of the determination of child permanency as a proxy for the date the TPR was finalized. The study team did not have access to parent data to determine the actual date of TPR. The Court Performance Measure 4I: Time to Termination of Parental Rights calculates the time to TPR using the date of the original petition and the date the TPR was finalized (Flango & Kauder, 2008, 22-23).

made to work with the parent(s) but also an early recognition that reunification may not be in the best interests of the child, thus adoption or kinship care was pursued.

Table III-C5b2. Time to Termination of Parental Rights [169]

N=15	*Fort Bend County, TX*		*Forrest County, MS*		*Polk County, IA*	
	N=7	**%**	**N=2**	**%**	**N=6**	**%**
Less than 12 months	4	57.1	2	100.0	1	16.7
Between 12-18 months	1	14.3	-	-	5	83.3
Between 18-24 months	1	14.3	-	-	-	-
More than 24 months	1	14.3	-	-	-	-

Source: ZERO TO THREE Court Teams database (2009)

Interviews and focus groups with Court Team stakeholders support this thesis, as they observed that parental compliance with service plans or their willingness to change becomes evident early in the case given the heightened oversight afforded by the monthly hearings and reviews. In Fort Bend County, TX, stakeholders noted that in cases involving possessory conservatorship (where there is placement with kin without TPR) and in cases where TPR has occurred and a child has been adopted by a relative, the birth parent has contact with the child through visitation and maintains a connection. One stakeholder referred to the terms of this legal relationship as "an agreement of the heart."

D. Pre- and Post-Implementation Observations Across Court Team Sites

This section presents descriptive comparative information regarding each jurisdiction—Fort Bend County, TX; Forrest County, MS; and Polk County, IA—prior to the implementation of the Court Team model. To the extent possible, comparable case-level information was obtained in order to discern differences regarding infants and toddlers under court supervision. The following topics are addressed: Infants and Toddler Characteristics; Reasons for Removal; Maltreatment Recurrence; Placement Type, Location, and Number; Achieving Permanency; and Time to Permanency. Not all information was available for each site. Data sources are: *Child Advocates of Fort Bend County (2000-2005); Forrest County Youth Court & Department of Human Services (July 2002-May 2006); and Iowa Department of Human Services, AFCARS file (March 2000-July 2005).* Comparable cross-site information was not available regarding health indicators at case opening; placement stability; and family contact (visitation.).

1. Infant and Toddler Characteristics

Table III-D1 presents basic demographic characteristics of the infants and toddlers under court supervision in each of the Court Team sites prior to implementation of the model. Among the 185 children across the three jurisdictions, 94 were male and 91 were female.

Between 2000-2005, there were 95 infants and toddlers under court supervision in the 328th and 387th District Courts in Fort Bend County, TX. In Forrest County, MS, 30 infants and toddlers were under supervision of the Youth Court during the years 2002-2006. Sixty infants and toddlers from Polk County were under court supervision in the Fifth Judicial District in Polk County, IA from 2000-2005.

In Fort Bend County, TX 44 percent of the infants and toddlers under court supervision were African-American, 32 percent were of Latino origin, and 22 percent were Caucasian. In Forrest County, MS, 70 percent of the children were African-American and 30 percent were Caucasian. In Polk County, IA, 60 percent of the children were Caucasian, 33 percent were African-American, 3 percent were Native American, and 2 percent were Asian Pacific.

Table III-D1. Characteristics: Pre-Court Team Population

	Fort Bend County, TX		***Forrest County, MS***		***Polk County, IA***	
	N	**%**	**N**	**%**	**N**	**%**
Number of Children	95	-	30	-	60	-
Male	46	48	11	-	37	62
Female	49	52	19	-	23	38
Race/Ethnicity						
African American	42	44	21	70	20	33
Caucasian	21	22	9	30	36	60
Latino/a	30	32				
Native American					2	3
Asian Pacific					1	2
Hawaiian Islander						
More than one R/E reported	2	2				
Missing						

Sources:
Child Advocates of Fort Bend County (2000-2005)
Forrest County Youth Court & Department of Human Services (July 2002-May 2006)
Iowa Department of Human Services, AFCARS file (March 2000-July 2005)

2. Reason for Removal

Table III D-2 displays information regarding the reasons infants and toddlers were removed from their homes prior to Court Team implementation. In Fort Bend County, TX, physical abuse was a factor in 47 percent of cases. Safety risks to child well-being were a factor in removal in 33 percent of cases, followed by exposure to alcohol or drugs and neglect, which were each a factor in 8 percent of cases. Abandonment and medical neglect were cited as reasons for removal in Fort Bend County for 4 percent and 3 percent of cases, respectively. In Fort Bend County, TX, there appears to be an increase in cases involving neglect (cf. Table III-A3a.).

Neglect was the predominant reason for removal in cases in Forrest County, MS, and was involved in 90 percent of cases. Exposure to alcohol or drugs was also involved in 40 percent of cases in Forrest County, MS. Forrest County, MS saw an increase in cases involving alcohol/drugs and mental illness (cf. Table III-A3b).

Table III D-2. Reasons for Removal: Pre-Court Team Population

	Fort Bend County, TX		***Forrest County, MS***		***Polk County, IA***	
	N=95	**%**	**N=30**	**%**	**N=60**	**%**
Abandonment	4	4			2	3
Alcohol/Drugs			12	40	39	65
Medical neglect	2	3	-	-	NA	-
Mental illness	-	-	2	0.6	NA	-
Neglect	8	8	27	90	17	28
Neglect with drugs	5	5			-	-
Physical abuse	45	47	2	0.6	8	13
Psychological maltreatment	-	-			-	-
Sexual abuse	-	-			2	3
Other						
- Drug exposure [a]						
- Risk	31	33				
- Death of parent			1		-	-
- Incarceration of parent			3		5	8
- Caretaker unable to cope					8	13
- Inadequate housing						
- Sibling risk			5		-	-
- Child of minor in agency custody						

Sources:
Child Advocates of Fort Bend County (2000-2005)
Forrest County Youth Court & Department of Human Services (July 2002-May 2006)
Iowa Department of Human Services, AFCARS file (March 2000-July 2005)

The majority of cases in Polk County, IA cited exposure to alcohol or drugs (65%) as a reason for removal. Other prevalent reasons for removal at this site were neglect (28.3%), physical abuse (13.3%), and caretaker's inability to cope (13.3%). Less prevalent reasons for removal in Polk County, IA were incarceration of parent (8.3%), sexual abuse (3.3%), and abandonment (3.3%). Polk County, IA had a substantial increase in cases involving neglect, although this could also involve parental substance abuse (cf. Table III-A3a).

3. Placements: Type, Location, and Number

The information presented in **Table III-D3a** shows the types of placements for a sample of infants and toddlers prior to implementation of the Court Team.

Table III-D3a. Type of Placement: Pre-Court Team Population

N=186	*Fort Bend County, TX*		*Forrest County, MS*		*Polk County, IA*	
	N=95	%	N=30 [a]	%	N=60	%
Birth parent	7	7	1	3	-	-
Relative placement	31	33	5	17	-	-
Nonrelative placement	-	-	-	-	-	-
Foster home	57	60	14	48	5	8
Foster/Adopt home	-	-	2	7	29	48
Medical foster home	-	-	-	-	-	-
Therapeutic foster care	-	-	3	10	-	-
Other foster parent	-	-	-	-	-	-
Group home	-	-	-	-	-	-
Crisis nursery	-	-	-	-	-	-
Shelter	-	-	3	10	-	-
Hospital	-	-	1	3	-	-
Temporary Placement	-	-	-	-	-	-
Trial home visit	-	-	-	-	26	43

[a] *= Missing = 1*
Sources:
Child Advocates of Fort Bend County (2000-2005)
Forrest County Youth Court & Department of Human Services (July 2002-May 2006)
Iowa Department of Human Services, AFCARS file (March 2000-July 2005)

In Fort Bend County, TX, nearly two-thirds of the infants and toddlers were placed in foster homes (60%) and one-third were placed with relatives (33%). Following implementation it appears that relative placements increased (from 33% to 43%) and the use of foster/adopt homes decreased (from 60% to 41%) (cf. Table III-B21a). There were no placements with birth parents prior to implementation of the Court Team. However, following implementation nearly 9 percent of the infants and toddlers were placed with the birth parent.

In Forrest County, MS, children were placed in foster/adopt homes in equal proportion during both periods (48 % prior; 49% post) (cf. Table III-B21a). Prior to implementation, 17 percent of the children were placed with relatives, whereas nearly 30 percent were placed with kin when the Court Team model was implemented. Ten percent of the children were placed in shelters in the pre-implementation period and 6 percent were placed during implementation.

In Polk County, IA, prior to implementation, most placements were in foster/adopt homes (48%) or trial home visits (43%). Following implementation of the Court Team model, most placements were with the birth parent (35%) or relative (38%) (cf. Table III-B21a). Placements in foster/adopt homes accounted for only 17 percent of the placement types during Court Team implementation.

As seen in **Table III-D3b,** prior to Court Team implementation in Forrest County, MS, nearly three-fourths of the placements were out-of-county (73%) and only one-fourth were in the county. Following implementation, this trend reversed: nearly three-fourths were in-county and one-fourth were out-of-county (cf. Table III-B1b). Comparable county-level data were not available for Fort Bend County, TX and Polk County, IA.

Table III-D3b. Location of Placements: Pre-Court Team Population

	Fort Bend County, TX		***Forrest County, MS***		***Polk County, IA***	
	N=95	**%**	**N=30**	**%**	**N=60**	**%**
In county	-	-	8	27	-	-
Out of county	-	-	22	73	-	-
In state	-	-	30	100	60	100
Out of state	-	-	-	-	-	-

Sources:
Forrest County Youth Court & Department of Human Services (July 2002-May 2006)
Iowa Department of Human Services, AFCARS file (March 2000-July 2005)

A cross-site analysis was conducted regarding the number of placements for the aggregate Court Team population (cf. Table III-C2a). However, site-specific data are presented in **Table III-D3c.**

In Fort Bend County, TX, 87 percent of the infants and toddlers served prior to Court Team implementation had only one placement, as did 55 percent of the children in Forrest County, MS. More than 40 percent of the infants and toddlers in Polk County, IA had two placements, 37 percent had one placement, and 17 percent had three placements.

Table III-D3c. Number of placements: Pre-Court Team Population

N=186	*Fort Bend County, TX*		*Forrest County, MS*		*Polk County, IA*	
	N	**%**	**N**	**%**	**N**	**%**
	N=95	**%**	**N=30** [a]	**%**	**N=60**	**%**
1	83	87	16	55	22	37
2	8	8	4	14	25	42
3	2	2	3	10	10	17
4	2	2	2	7	2	3
5	-	-	2	7	-	-
6	-	-	1	3	-	-
7	-	-	-	-	-	-
8	-	-	-	-	1	**2**
9	-	-	-	-	-	-
> 10	-	-	1	3	-	-

[a] *= Missing = 1*
Sources:
Child Advocates of Fort Bend County (2000-2005)
Forrest County Youth Court & Department of Human Services (July 2002-May 2006)
Iowa Department of Human Services, AFCARS file (March 2000-July 2005)

A separate analysis for the Fort Bend County, TX site regarding placement stability indicates that nearly 13 percent of infants and toddlers under court supervision had no more than two placements within 12 months of removal from the home and nearly 88 percent had no more than two placements between 12-24 months from removal *(Child Advocates of Fort Bend County (2000-2005).*

4. Absence of Maltreatment Recurrence

Prior to implementation of the Court Team model, 97 percent (92/95) of infants and toddlers under court supervision in Fort Bend County, TX did not experience a subsequent report of maltreatment within six months of case opening *(Child Advocates of Fort Bend County (2000-2005).* One hundred percent of the infants and toddlers did not experience a subsequent report of maltreatment within six months of case opening in Forrest County, MS prior to implementation (*Forrest County Youth Court & Department of Human Services (July 2002-May 2006).* Comparable data were not available for Polk County, IA.

5. Achieving Permanency

Table III-D5 displays information regarding the reasons for achievement of permanency, as well as information regarding the number of children that did not achieve permanency. Of all infants and toddlers served by the 328th and 387th District Court, Fort Bend County, TX a total of 98 percent of children in the pre-Court Team group achieved permanency. Among these children, 57 percent were adopted, 41 percent were reunified with their birth parent, and 2 percent were placed with a relative. In contrast, during Court Team implementation, 16 percent were adopted, 31 percent were reunified with the parents, and 45 percent were placed with a fit and willing relative (cf. Table III-C4b1). Permanency planning data were not available for Fort Bend County, TX.

Prior to Court Team implementation in Forrest County, MS, permanency was achieved for 90 percent of the children under court supervision. Within this group of children, 41 percent were reunified with their birth parent, 28 percent were adopted, and 21 percent were referred for legal guardianship. Following implementation, all children achieved permanency: 46 percent were reunified with their birth parent, 36 percent were referred for legal guardianship, and 18 percent were adopted (cf. Table III-C4b1).

Prior to implementation in Polk County, IA, the primary permanency goal for most children was adoption (48%). Post-implementation, however, 100 percent of the primary permanency goals were for reunification with the birth parent. During the pre-implementation period, 100 percent of children in the comparison group in Polk County, IA achieved permanency: 50 percent of the infants and toddlers were reunified, 48 percent were adopted, and 2 percent were placed with a relative as a legal guardian. In contrast, during the implementation period, 77 percent of the children were reunified with the parent and only 8 percent were adopted (cf. Table III-C4b1).

Table III-D5. Reasons for Achievement & Non-Achievement of Permanency

	Fort Bend County, TX		***Forrest County, MS***		***Polk County, IA***	
	N=95	**%**	**N=30**	**%**	**N=60**	**%**
Achieved permanency						
Reunification	38	40.9	12	41.4	30	50.0
Place with fit & willing relative	2	2.2			1	1.7
Guardianship			6	20.7		
Adoption	53	57.0	8	27.6	29	48.3
Did not achieve permanency	2	2.0	3	10.3	0	0

Sources:

Child Advocates of Fort Bend County (2000-2005)
Forrest County Youth Court & Department of Human Services (July 2002-May 2006)
Iowa Department of Human Services, AFCARS file (March 2000-July 2005)

6. Time to Permanency

As shown in **Table III-D6,** prior to implementation of the Court Team model, 62 percent of the children in Fort Bend County, TX achieved reunification in less than 12 months. This rate increased slightly during the period of implementation, as 69 percent were reunified in less than 12 months (cf. Table III-C5b1). During both periods, 31 percent of the children were reunified within 12-18 months. Prior to implementation of the Court Team, 100 percent of the placements with a relative or legal guardian were achieved in less than 12 months as were the adoptions. Following Court Team implementation, the percentage decreased to 56.5 percent and 62.5 percent, respectively.

Data were not available for Forrest County, MS.

In Polk County, IA, 47 percent of the infants and toddlers under court supervision were reunified within 12 months, 37 percent within 12-18 months, and 17 percent between 18-24 months. Seventy three percent of the children achieved the goal of adoptions within 12-24 months and 28 percent achieved this goal in more than 24 months. Following implementation of the Court Team model in Polk County, IA, permanency was achieved sooner in cases of reunification, relative placement, and adoption. Permanency was achieved in all cases within 18 months (cf. Table III-C5b1).

Table III-D6. Time to Permanency

	Fort Bend County, TX		***Forrest County, MS***		***Polk County, IA***	
	N=95	**%**			**N=60**	**%**
Time to Reunification						
Less than 12 months		62			14	47
Between 12-18 months		31			11	37
Between 18-24 months		7			5	17
More than 24 months		0			0	0
Time to Legal Guardianship or Placement with Fit & Willing Relative						
Less than 12 months		100			0	0
Between 12-18 months		0			0	0
Between 18-24 months		0			0	0
More than 24 months		0			1	100
Time to Adoption						
Less than 12 months		100			0	0
Between 12-18 months		0			13	45
Between 18-24 months		0			8	28
More than 24 months		0			8	28

Sources:
Child Advocates of Fort Bend County (2000-2005)
Iowa Department of Human Services, AFCARS file (March 2000-July 2005)

Chapter IV

Conclusions and Recommendations

This chapter summarizes the key findings regarding the characteristics and outcomes of the infant and toddler served by the Court Teams and performance against national child welfare measures. Brief summaries of the implementation status of the interrelated aspects of the Court Team model across the four sites are provided. This is followed by recommendations to strengthen the model, improve implementation, and foster sustainability. The chapter concludes with stakeholders' thoughts on the benefits of the model for serving maltreated infants and toddlers under court supervision.

A. Key Findings

The infants and toddlers served by the Court Teams achieved positive safety, permanency, and well-being outcomes:

- ***Safety:*** 99.05 percent were protected from further maltreatment (N=186);
- ***Permanency:*** Of the 88 closed cases examined, 95 percent achieved permanency through reunification (46.5%), placement with a fit and willing relative (30.6%), legal guardianship (4.5%), and adoption (13.6%); and
- ***Well-being:*** 97 percent received needed services to meet identified needs, particularly for routine pediatric care and developmental screenings and services (N=186).

Analysis of the case-level data for 186 infants and toddlers served by the Fort Bend County, TX, Forrest County, MS, and Polk County, IA Court Teams (with cases closed as of December 2008) was informed by the national Child Welfare Outcomes measures and Child and Family Services Review (CFSR) indicators developed by the Administration for Children and Families. These measures are used to determine whether the children served by the nation's child welfare systems and under court supervision are protected from abuse and neglect; have permanency and stability in their living situations and continuity in their family relationships, and receive adequate services to meet their needs. Upon publication of the Court Performance Measures by the Department of Justice in December 2008, the outcome framework was revised to reference these measures, as appropriate.

Additional findings with regard to children's characteristics, reasons for removal from the home, placement, services and family contract are detailed below.

- ***Reasons for removal:*** More than 50 percent of the children were removed due to neglect and more than 25 percent were removed due to physical abuse. Other forms of maltreatment perpetrated were medical neglect (6.4%), abandonment (4.2%), psychological maltreatment (1.7%), and sexual abuse (.4%). Parental substance abuse and mental illness played a significant role in child maltreatment. In 75 percent of the cases across sites, parental use of alcohol/drugs was cited as a risk factor.

- ***Health needs at intake:*** Forty percent of the infants and toddlers had been directly exposed to parental substance abuse and this contributed to their poor health status. *In utero* or prenatal exposure to alcohol and drugs was prevalent across sites, as well, involving 49 percent of the cases. Across the sites, 25 percent of the infants were identified as substance exposed newborns.

- ***Services received to alleviate maltreatment and meet developmental needs:*** Ensuring the timely provision of physical, developmental, and mental health services to maltreated infants and toddlers is a core component of the Court Team model. All of the children had multiple needs for services at the time of removal from the home, based on the presenting conditions and type of maltreatment perpetrated. Their needs continually changed as they grew and ongoing monitoring of their developmental status was critical. By study completion, 97 percent of the identified service needs had either been fully met or were in process with progress being made. Only three percent were experiencing no progress or minimal activity. Across sites, progress was least likely to be made in the areas of parent-child psychotherapy and parent-child relationship evaluations, which is a key element of the Court Team approach to heal the parent-child bond. Lack of progress was primarily attributed to client reasons, although in some cases there was a waiting list or the service was not available in the community.

- ***Family Contact (Visitation):*** Court-ordered arrangements for parents and children were highly individualized. Family contact plans took into consideration any safety risks to the child(ren), the appropriate degree of parental contact, and availability of professional or family resources to supervise parent-child contact. Across sites, 91 percent of the initial family contact was supervised, typically by child welfare staff and relatives. *At the time the case opened, family contact at least twice per week was ordered in 58 percent of the cases. Daily contact was ordered in 31 percent of the cases.* By the time of case closure, family contact at least twice per week was ordered in 55 percent of the cases. Parent-child contact occurred once per week for 26 percent of the cases. The family contact plan for most children was stable throughout the case process, with 53 percent of the cases experiencing only one change or no change in the initial schedule.

- ***Foster care placements and placement stability:*** A key feature of the Court Team model is to place infants and toddlers in nurturing environments that foster stable and secure attachments with their caregivers while they are in foster care. Placement with relatives was the most frequently occurring type of placement. It accounted for 37 percent of all placement types and was fairly evenly distributed across the three sites. The child's Grandmother served as the caretaker in nearly 50 percent of these placements. More than two-thirds (67%) of the placements were stable (based on cases closed as of study end), as children had no more than two placement settings while in care for less than 12 months, between 12-24 months, and greater than 24 months.

- ***Absence of maltreatment recurrence:*** Of the 186 children under court supervision, 99.05 percent did not experience a subsequent report of substantiated maltreatment within 6 months from the initial report. There was one reported occurrence (.05%) of repeat maltreatment perpetrated. Dependency cases were re-opened on three of the 150 families (2%) due to the subsequent birth of a substance-exposed child (2 cases) and parental substance abuse and child endangerment (1 case).

- ***Achieving permanency:*** Achieving timely permanency is especially critical for the vulnerable infants and toddlers served by the Court Teams. Permanency outcomes were examined for closed cases served by the Court Team from the date of model implementation until December 31, 2008 (N=88). Of these cases, 95 percent achieved permanency through reunification (46.5%), placement with a fit and willing relative (30.6%), legal guardianship (4.5%), and adoption (13.6%). Reunification with the parent was the intended goal for 84 percent of the children for whom a goal was provided. Reunification with the parents was actually achieved for 46.5 percent of the cases. Placement with a fit and willing relative was the permanency outcome for 30.6 percent of the cases and legal guardianship was the outcome for almost 4.5 percent of the cases. Nearly fourteen percent (13.6%) of the children were freed for adoption. Five percent of the children did not achieve permanency.

- ***Timely permanency:*** Achieving permanency with the statutory timeframes of the Adoption and Safe Families Act (ASFA) of 1997 is especially critical for vulnerable infants and toddlers. The greater part of the reunification outcomes occurred within the ASFA timeframes. Of the 41 children that were reunified with parents, 59 percent were reunified with 12 months from the date that the court order was filed. More than one-third (37%) of the children were reunified between 12-18 months, and a very small percentage (5%) of reunifications occurred between 18-24 months. In the cases where parental rights were terminated, the termination occurred within 18 months of case opening. Interviews and focus groups with Court Team stakeholders indicate that lack of parental compliance with service plans or their willingness to change becomes evident early in the case given the heightened oversight afforded by the monthly hearings.

B. Implementation of the Court Team Model

The guiding principles of the Court Team for Maltreated Infants and Toddlers have evolved since the model was first developed and implemented in 2005. As the evaluation of the Court Team model was undertaken in 2007, implementation of the eight core components of the "second-generation" model were examined: (1) Judicial leadership; (2) Community Coordinator; (3) Court Team; (4) Monthly case reviews; (5) Child focused services; (6) Mental health interventions; (7) Parenting education and interventions; and (8) Training and technical assistance.

Judicial leadership was fully implemented and found to be a key catalyst for the successful implementation of the Court Team model. In the courtroom, judicial leadership was demonstrated through decision-making and the quality of oversight in child maltreatment cases and ensuring that a child's best interests were served. Judicial questioning and oversight were also informed by effective practice in child welfare and the science of early child development. In this regard, the Judges augmented their oversight role to include dissemination and utilization of knowledge. Judges were instrumental in promoting a high level of accountability among those charged with providing care and services to a child—workers, attorneys, services providers, and family members. Judges were also credited with establishing an open and respectful forum for discussing issues relevant to the case and fostering dialogue among parties. Judicial leadership extended into the community through involvement with planning and ongoing implementation or refinement of the model at each site, and by convening monthly meetings of

the Court Team. Judges also made efforts to educate the legal community and the legislature regarding the needs of infants and toddlers in the child welfare system and to bring needed services to their communities

Notwithstanding the quality and reach of judicial leadership, successful implementation of the Court Team model depended greatly on the **Community Coordinators**. They served as a primary resource on the science of child development, monitored ZTT cases, attended court hearings, facilitated referrals and service linkages, maintained contact with all relevant parties, participated in case reviews or conferences convened by the court or the child welfare agency, and maintained a database that captured all aspects of the case. Each Community Coordinator performed a quasi-case management role and was actively involved in ensuring that the needs of the infants and toddlers under court supervision were met. "Always there, always advocating" and "having a heart for the case" captured the essence of the Community Coordinators' approach. Each Community Coordinator was actively engaged in shaping local community resources and networks into a coherent team to work on behalf of maltreated infants and toddlers. They worked with local providers to expand the types of services available and create linkages; they advocated at the state level when necessary. The Community Coordinators served as a "bridge" across the court, the child welfare agency, and the provider network. In this regard, they facilitated ongoing communication and coordination across the Court Team.

Across the four sites, the "**Court Team**" comprised the judicial and legal community, child welfare, and service professionals for parents and children (including early intervention specialists, parenting educators, therapists, case managers, and family preservation specialists, and substance abuse counselors). This feature of the model has been fully implemented at the four sites. Stakeholders noted that the Judge's personal invitation to get involved or the Community Coordinator's recruitment efforts fostered participation in the Court Team. The composition of each Court Team has progressively expanded in each jurisdiction and change in composition is desirable. Variations in team composition across the sites reflect the resource base and existing service array in each community. Differences also speak to the presence of pre-existing collaborative efforts between the courts, child welfare, and child-focused service providers in each jurisdiction. Gaps in the composition of the Court Team were indicative of lack of engagement or resources. Stakeholders remarked that participation in the Court Team united health and human service providers that had, at times, operated somewhat independently of the other. Effective coordination of efforts across Court Team members was also attributed to a heightened awareness of the science of early childhood development and the importance of meeting infants and toddlers' needs promptly.

Monthly oversight through court hearings and case staffings has been fully implemented at the four sites. Most stakeholders found that the monthly reviews ensured that court-ordered services for

infants and toddlers were implemented quickly and that cases moved towards permanency in a timely manner. Stakeholders reported that a key benefit of the monthly hearings was that all parties in attendance had the most current information regarding the status of the case, the progress made, and the services received. Case progress was consistently documented and workers were up-to-date on the status of their clients. For service providers, being present in the courtroom facilitated the triangulation of self-report information, client observations, and first-hand information from the judge and attorneys. Participation in monthly hearings also fostered understanding of the case from multiple perspectives. Being present in court to observe the full docket of cases gave attorneys, workers, and service providers exposure to other cases and they learned from each other. Thus, participation in the hearing or staffings facilitated ongoing knowledge development and the reproduction of effective judicial, legal, and child welfare practice.

The provision of **child-focused services** to ensure the developmental, medical, and mental health needs of maltreated infants and toddlers has been fully implemented at all sites, to the extent that community resources allow. Stakeholders reported and case-level analyses confirmed that children's basic medical and developmental needs were met in each jurisdiction. The monthly hearings and reviews facilitated identification of new needs and development of plans for continuing care aligned with each child's developmental stage. All sites had access to primary health care physicians that accepted Medicaid reimbursement; this ensured that children received routine physical exams and scheduled immunizations. All sites worked with a Part C Early Intervention provider that screened infants and toddlers for developmental delays and provided early intervention services (i.e., occupational, physical, and speech therapy). The Community Coordinators established relationships with the Part C providers to facilitate referrals and helped to institute a routine process between the provider and the child welfare agency. Being part of the Court Team helped pediatricians and early intervention specialists to work closely together to address the needs of children. Some aspects of the Court Team's approach on providing developmentally-appropriate services were already part of the child protection protocol (e.g., early intervention services, medical care, immunizations), yet the Court Team brought providers together in a more focused manner to care for infants and toddlers.

The Court Team approach emphasizes the importance of providing **mental health interventions** for maltreated children and the parent(s). However, this element of the model has not been fully implemented across sites. Three sites had well-established infant mental health providers in the community that provided parent-child attachment assessments, dyadic therapy, and family therapy. Each provider had a long-standing relationship with the court and child welfare agency and this facilitated their integration into the Court Team's approach. These sites also benefited from onsite training, follow-up, and clinical supervision in dyadic therapy that was provided by the nationally-recognized child

psychologist that developed the therapeutic intervention for the Miami-Dade model. Two of these sites had well-established referral and treatment protocols in place that facilitated timely assessments and interventions, thus parents and children were routinely assessed and received services. One site was in the process of refining its approach to screening and referral. Another site struggled with implementing the infant mental health component of the model and stakeholders noted two key systemic barriers: (1) the organization that was designated to serve in this capacity focused did not provide dyadic therapy (as prescribed by the model, and did not work with infants and toddlers; and (2) there were limited therapists and providers in the community to conduct parent-child relationship assessments and provide therapy.

The Court Team model encourages the use of **evidence-based parenting education** to strengthen parenting skills, build parent-child relationship, and enhance family functioning. A variety of parenting interventions were available across the four sites, and one site used an evidence-based model (i.e., *Nurturing Parenting Program)*. This component was not fully-implemented as intended. Stakeholders at each site expressed reservations about the quality and quantity of the parenting education services, thus this element of the model was not fully implemented as intended. As with the child-focused services and mental health services, the availability of parenting programs depended on the community context and service array. Individual providers had some discretion about the type of parenting interventions in use and relied on those which resulted in desired outcomes and improvements for participants. Site-specific examples include in-home parenting services, fatherhood initiatives, *Active Parenting, Positive Parenting,* and *Parent as Partners* programs. Each Court Teams largely worked within the parameters of parenting education curricula in use by the providers. The curricula focused on nurturing, communication, listening, attending to the child's needs and help-seeking behaviors, appropriate expectations, decision-making, and appropriate discipline methods. Providers made concerted efforts to tailor their interventions to the needs of the families with infants and toddlers in foster care.

Training was provided during the early implementation phase of the Court Team at each site and this element of the model was fully implemented. This included site visits to the Miami-Dade County Juvenile Court for the Judges and Community Coordinators to observe the model in practice and to confer with the Presiding Judge. Each Community Coordinator also visited another Court Team site to learn about implementation efforts. During the early implementation phase, each Community Coordinator organized a community-wide training event on infant and toddler development, dyadic therapy, and the Court Team model. Across sites, stakeholders noted that the training on family contact (i.e., parent/child visitation) by a nationally-recognized expert was especially informative. Site-specific trainings were also organized by each ZTT Community Coordinator and an open invitation was extended to the community. Topics focused on community-driven issues and needs (e.g., children of substance abusing parents, effects of methamphetamine use, family contact). Community Coordinators routinely shared new

information with Court Team members, either through mass emails or at the monthly Court Team meetings. ZTT-sponsored trainings served to orient Court Team members, and prospective members to the model, and helped members obtain a better understanding of parents' and children's needs. One stakeholder observed that "exposure and learning helped build commitment" to implementing the model.

The Court Team model provides an integrated cross-systems approach to address the needs of maltreated infants and toddlers under court supervision. [170] In leading this effort, the juvenile and family courts have taken a primary role in ensuring that infants and toddlers are protected from harm, well-served, and achieve timely permanency in a stable, nurturing home. [171] While judicial leadership provides the vision and moral authority behind this initiative, the active efforts of the Community Coordinator demonstrates another level of leadership that is integral to the successful implementation of the model. The Community Coordinators fostered increased coordination and communication across individuals from child welfare, the legal community, early intervention, health, mental health, and preventive services. These individuals, as part of the Court Team, each performed a distinct role through their active engagement in casework, representation, or service delivery. In this regard, implementation of the Court Team model is vested in the expertise and practice, leadership capacities, and social capital of a network of individuals within each community.

The Court Team model exhibits many of the features that are associated with successful drug courts for substance-abusing adults. This includes treating the family as a unit (but with a focus on the parent-child dyad), addressing unique familial needs from a multi-disciplinary perspective, providing intensive monitoring of case plans and compliance, making use of information derived from multiple sources to inform decision making, coordinating services and communication among various agencies, institutionalizing referral processes (i.e., for early intervention services), and formal interagency collaboration. [172]

C. Recommendations

The following recommendations are made to improve the functioning of the Court Team approach as a whole, along with particular elements of the model, in recognition that a systems change process requires working at multiple levels simultaneously. The model is well-received by major stakeholders, particularly by legal representatives who are better informed to advocate for their client(s)

[170] Harbison, E., Parnes, J., & Macomber, J. (2007). *Vulnerable Infants and Toddlers in Four Service Systems.* Washington, DC: Urban Institute.

[171] Jones-Harden, B. (2007). *Infants in the Child Welfare System.* Washington, DC: ZERO TO THREE.

[172] Dice, J.L., Clauseem, A.H., Katz, L.F., & Cohen, J.B. (2004). Parenting in Dependency Drug Court. *Juvenile and Family Court Journal, 55,* 1-10.

and by providers that form a continuum of care for infants and toddlers and their parents. The perspective from child welfare is that the model sets high standards for practice and case review. Child welfare staff value and believe in the approach, but they are under-resourced and overwhelmed, thus there is some frustration in implementing the model.

These suggestions to ZERO TO THREE and the Court Team sites are based on the evaluation findings, stakeholder feedback, and the literature on effective strategies for building service capacity and implementing systems change in the health and human service delivery systems, particularly the courts and child welfare. [173] [174] [175] [176] [177] (Applicable components of the model are noted in parentheses).

1. ***Court processes***
   Consider using monthly case reviews or staffings in lieu of court hearings for cases that are progressing well and pose minimal risk as the monthly court hearing are the most resource intensive component of the model. For cases involving risk and with limited parental engagement or compliance, continue the practice of monthly hearings before the Judge *(Monthly case reviews/hearings).*

   Establish time-certain slots for hearing cases on the ZTT docket to minimize the time workers, attorneys, and services providers spend waiting for a case to be called *(Monthly case reviews/hearings; Legal representation).*

2. ***Court and child welfare collaboration and assessing fit and feasibility***
   As the Courts and child welfare pursue common outcomes for children, it would be helpful for the Judges, Community Coordinators, child welfare administrators, and front-line staff to engage in constructive dialogue to ensure that policy initiatives to support infant and toddler development and court-ordered services are aligned with the resources and capacity of the child welfare agency. [178] While this recommendation to assess fit and feasibility is largely addressed to the family contact component of the Court Team model, which has a sound developmental rationale, it pertains more generally to ensure that policy, program, and effective practice components of the model are congruent. Based on stakeholder feedback, increased dialogue (as has occurred with the Orleans Parish Court Team) would be valuable regarding the logistical, transportation, and supervisory responsibilities associated with

[173] National Child Welfare Resource Center for Organizational Improvement (Summer/Fall 2009). *Improving Child Welfare/Court Collaboration*. University of Southern Maine, Edward S. Muskie School of Public Service.

[174] Carnochan, S., Taylor, S., Abramson-Madden, Han, M., Rashid, S., Maney, J., *et al*. (2007). Child welfare and the Courts: An exploratory study of the relationship between two complex systems. *Journal of Public Child Welfare*, 1 (7), 117-136.

[175] Nissen, L.B., Merrigan, D., & Kraft, M.K. (2005). Moving mountains together: Strategic community leadership and systems change. *Child Welfare*, 84, 2, 123-140.

[176] Kreger, M., Brindis, C.D., Manuel, D.M., & Sassoubre, L. (2007). Lessons learned in systems changes initiatives: Benchmarks and indicators. *American Journal of Community Psychology*, 39, 301-320.

[177] Fixsen, D.L., Naoom, S.F., Blasé, K., Friedman, R.M., & Wallace, F. (2005). *Implementation Research: A Synthesis of the Literature.* Tampa, FL: National Implementation Research Network (FMHI Publication #231).

[178] Limited control over the kinds of services the child welfare system provides to parents was cited as a barrier by 57 percent of Judges responding to 2008 survey administered by the National Council of Juvenile and Family Court Judges (Abernathy & Hall, 2009).

increased family contact, given the frequency and level of supervision that is court-ordered (i.e., parent-child visits were court-ordered to occur at least twice per week in 58 percent of the cases; daily contact was ordered in 31 percent of the cases at the time of case opening; 91 percent of the initial family contact was supervised, typically by child welfare staff and relatives). [179] This court and child welfare conversation between expectations and resources should also take into consideration new federal requirements for states to make reasonable efforts to provide frequent visitation or other ongoing interaction between siblings in foster care (per the recently enacted *Fostering Connections to Success and Increasing Adoptions Act, P.L. 110-351) (Judicial leadership; Family Contact).*

3. *Formalize procedures, roles, and processes*

Implement formalized procedures so that caseworkers routinely screen and refer families for assessment and therapy—especially those with the goals of reunification—and ensure that all children are assessed (*Mental health interventions).*

For each jurisdiction, develop and share site-specific protocols or resource guides to ensure clear understanding of the Court Team process and roles across the court, child welfare, the legal community, service providers, and families to ensure clarity in the multi-disciplinary process (as done by the Polk County Court Team). Specifically, identify:

- The steps involved in working with a ZTT case from removal to closure;
- The roles and responsibilities of all parties involved in an infant and toddler case (to include the Judge, Community Coordinator, legal representatives, child welfare and service providers);
- Referral processes and information sharing procedures;
- Inter-agency reporting mechanisms;
- Permanency planning timelines;
- Court-specific policies; and
- General information about Court Team agencies and the services provided.

Include in this protocol clear policies and procedures regarding the sharing of sensitive information and requirements of the Health Insurance Portability and Accountability Act (HIPAA).

4. *Child and parent interventions*

Invite the provider that conducts the attachment assessment to Family Team Meeting in order to share observations and interpret findings from the assessment (*Mental health interventions).*

Consider conducting a relationship assessment *prior to* making a permanent placement, or having a re-assessment of the parent-child or foster parent-child relationship at the one year milestone (*Mental health interventions; Placement stability, Permanency planning).*

Identify parenting education interventions that focus on parents of younger children (in general) and caring for substance-exposed newborns (given their apparent prevalence in the Court Team population examined (25%)) (*Parenting education and interventions; Family contact).* [180] *181*

[179] Edwards, L. (2003). Judicial oversight of parental visitation in family reunification cases. *Juvenile and Family Court Journal,* 54 (3), 1.

[180] Burry, C.L. & Wright, L. Facilitating visitation for infants with prenatal substance exposure. *Child Welfare,* 85 (6), 899-918.

Adapt parenting education sessions so that they are more individualized and tailored to each family's needs and allow for greater parent-child interaction, preferably in an in-home setting or at a family-friendly visitation center (*Parenting education and interventions).*

Establish linkages across providers working with the family, so that parenting education is aligned with mental health interventions and substance abuse treatment services (*Parenting education and interventions).*

Make greater use of therapists, parenting educators or visit coaches during family contact so that they can coach the parent in his or her interactions with the child and model appropriate behaviors (*Parenting education and interventions; Family contact).*

5. ***Community capacity building***
Implement a peer-networking forum so that Court Team sites with fully implemented infant mental health systems and those without can learn about successful efforts and strategies to (1) build or advocate for service capacity; and (2) develop referral and treatment protocols to facilitate timely assessments and interventions.

Support community advocacy efforts to provide a continuum of infant mental health and culturally competent, individualized parenting services, and the provision of community-based supports to support increased parent-child contact (e.g., visit coaching, visitation centers).

6. ***Monthly Court Team meetings***
While the monthly meetings are good for informational and networking purposes, stakeholders at some sites suggested that there needs to be greater strategic focus on the content so that highly-committed but time-pressed professionals feel that it is time well spent. Other stakeholders suggested using the monthly Court Team meetings to better effect in order to share information across providers and build relationships, especially for those that do not have frequent contact with each other or for those whom are not co-located. Dedicate time during each monthly meeting to obtain input and feedback from the Court Team members about implementation challenges and solutions and make this a standing agenda item to foster ongoing dialogue.

7. ***ZTT Training and technical assistance***
Given that barriers to child-focused service delivery were largely systemic, it would be helpful for the national ZTT office to assist and/or support the Judges and Community Coordinators with their advocacy efforts with organizations and agencies at the local and state level to effect long-term solutions *(Technical assistance).*

In coordination with the ZTT national office, provide in-service training on infant mental health interventions to child welfare workers *(Training).*

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[181] Johnstone, T., Miller, M.K. (2008). The Court's role in promoting comprehensive justice for pregnant drug and alcohol users. *Juvenile & Family Court Journal,* 59 (3), 39.

Stakeholder-identified suggestions for training include fetal alcohol spectrum disorders and intermittent refresher courses on child development (to accommodate turnover in provider agencies) *(Training).*

8. ***Quality assurance and evaluation***

Update and enhance the Court Team database *User's Guide* to ensure consistent reporting on children's status and outcomes. Provide a complete glossary to facilitate data entry.

Modify the Court Team database and improve technical guidance so that it provides needed information to support local and national reporting on children's status and outcomes and to monitor program effectiveness. Specifically, amend the database to:

- Provide a data field to identify children as American Indian or Alaskan Native to indicate tribal affiliation and cases under concurrent jurisdiction, in keeping with the provisions of the *Indian Child Welfare Act of 1978* (25 U.S.C. § 1901 et. seq.);
- Allow for identification of the primary type of maltreatment perpetrated (i.e., reason for removal) for consistency with national reporting systems;
- Allow for refinement of child maltreatment (i.e., reasons for removal) categories per state statutes to facilitate reporting within each jurisdiction;
- Provide data fields to identify a child as a substance-exposed newborn or as diagnosed with fetal alcohol syndrome; [182]
- Provide a category to indicate "data not available" for reasons for removal and key health indicators;
- Provide a data field to identify permanent placement with the father in the Child Case Status record when termination has occurred for the mother; [183]
- Provide a data field to identify subsidized guardianship as permanency goal or status (per the recently enacted *Fostering Connections to Success and Increasing Adoptions Act, P.L. 110-351).*
- Ensure that full permanency planning and outcome data can be entered and saved in the Child Case Status record on an ongoing basis so that a full record of information is available and reflects change over time; and
- Strengthen internal quality assurance checks to identify out-of-range and inconsistent values, dates or status.

Consider sponsoring and conducting a workload analysis to assess the time and resources spent on ZTT cases in each jurisdiction. With this information, consider whether development of a dedicated unit of social workers for ZTT cases would be a viable strategy for child welfare agencies to adopt.

9. ***Needs assessment***

Conduct annual needs assessments at each Court Team site in order to identify gaps in the service continuum and identify training needs in the community *(Child-focused services, Mental health intervention, Parenting education, Training).*

[182] Malbin, D.V. (2004). Fetal Alcohol Spectrum Disorder and the role of the Family Court Judge in improving outcomes for children and families. *Juvenile and Family Court Journal* (Spring), 53-60.

[183] Malm, K., Murray, J. and Geen, R. (2006). *What about the Dads? Child Welfare Agencies' Efforts to Identify, Locate, and Involve Nonresident Fathers*. Washington, D.C.: The U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

D. Stakeholder Perspectives on the Benefits of the Court Team Model

When asked about the benefits of Court Team model for children and families, stakeholders in each jurisdiction—and from multiple disciplines—provided thoughtful testimonials about the value of the approach from their perspective. [184] Common themes expressed across sites pertained to the value of the hard work involved in staffing infant and toddler cases; having the court, child welfare, and service providers pull together as a more cohesive team to collaborate in serving vulnerable children and families; and having multiple parties provide diligent, and caring, oversight to foster accountability.

a. Fort Bend County, TX

Stakeholders in Fort Bend County remarked on the benefits to vulnerable children and the oversight role of the Court and the Court Team. One stakeholder noted that "it's nice to see a change for children through ZTT before they enter "the system." Another stated, "We don't want ZTT to stop! It needs to continue. It provides benefits for the future and that is so crucial for these babies." One stakeholder commented on the importance of permanency for infants and toddlers, "We originally thought the goal of the Court Team was to move children through the system as fast as possible and to achieve reunification. Now we realize it's the best outcome for the child – permanency." One stakeholder attributed the positive outcomes of the infants and toddlers under court supervision to the "watchful eye of ZTT." A provider that worked closely with parents and children noted that the "court has a heart."

b. Forrest County, MS

Stakeholders in Forrest County, MS reflected on the difference in the way cases involving infants and toddlers were handled before the Court Team model was implemented and what has changed. They were particularly "mindful that the child is first." Many voices offered their assessment of the pre-Court Team environment. Weaving together their comments, stakeholders remarked: "Before, 0-3 children in the foster care system were not given a lot of individualized attention. They were languishing . . . It was crisis-oriented. There was no proactive work done, no participation from community partners . . . There has been a 180 degree turnaround!" [185] Reflecting on the Court Team implementation, stakeholders noted: "Now, there is an organized and streamlined process. There is more communication and greater cohesiveness. Key professionals are working on behalf of families. There is more support: "This family is going to get the help they need." They are not likely to fall through the cracks. . . . It is a collaborative effort, everyone is helping everyone else. There is a team. There is more support for families . . . We have a sense of sharing clients. It's *our* client and we all pull together . . . ZTT is the trunk of the tree and the agencies are the branches . . . There are more minds wrapped around the family, resources are

[184] Stakeholders tended to refer to either the "Court Team" or simply "Zero To Three."

[185] ". . ." indicate that the following statement is from another stakeholder.

available. It is a better, resource-rich vehicle for helping families, with enforcement from the Judge. It is a much richer model . . . The model helps me do what I want to do as a social worker, it makes me work harder and takes more time but it is worth it for the children to get them what they need." Finally, one stakeholder observed that there are "common expectations regarding practice. ZTT raises all boats insofar as practice is considered."

c. Orleans Parish, LA

In Orleans Parish, stakeholders commented on the collective oversight role of the Court Team and the benefit of intensive services and supports to families. One stakeholder noted that "all parties are involved and are very aware of what is going on in the cases." Others observed that the Court Team process "makes the work of all parties better" and "keeps all on their toes." A child welfare worker seconded these opinions, saying "It's great to have others look at the case. It great to have another eye to make sure that the case plan is followed." Another worker noted, "I have looked at ZTT cases versus the other section cases. It takes more work and time, but there are benefits to the clients and the process is evident. Referrals are always made, we get attorneys, and we get information—this doesn't always happen with cases in the other sections." One stakeholder noted that "families are getting good care" through the Court Team. Another remarked on the value of the Court Team in drawing together social service providers: "We learned a lot about the services that are available for children post-Katrina and how each one is different." With regard to the benefits to families, one stakeholder commented that the Court Team model appears to provide a sense of "stability" for troubled families, stating, "This may be the first time that these families have known expectations. You step up when you know you have the Judge looking over your shoulder. I have heard this from families." Another stakeholder observed, "Being a part of this community and the child welfare system, I have first hand knowledge of the benefits of the program. I hope it stays because of the benefits to the children and families. "

d. Polk County, IA

Stakeholders in Polk County, IA focused on the benefits of a collective approach to working with families and with each other. As participation in ZTT is voluntary, one legal representative stated, "I explain to parents that this is a family-friendly program." One stakeholder remarked, "The Court Team expectation is that we go out and try harder to work with parents. It involves a greater time investment." Another noted that "there's more alignment with Mom and Dad" about how to address the issues of the case. A child welfare staff echoed these statements but also spoke to the collective import of the approach for families: "Through the oversight, interventions, and monthly support, the Court, child welfare, and service provider collaboration conveys a strong message to parents: "[This is] what I need to do in order to be a good parent and get my kids back." It's not, "We'll take the kids and get back to you." Speaking to the Court Team process in contrast with other dependency cases, one stakeholder observed

"Court Team cases go smoother. There is a cohesive team and they are engaged in the process." In ZTT cases, all of the parties are aware of what's going on." With regard to court and child welfare collaboration, a stakeholder remarked, "The benefit [of the Court Team] is that we coordinate and collaborate and problem solve. We learn from and respect each others' roles: the attorneys, the judge, the social workers." Another observed that the "Model Court initiative set the tone for the Court Team implementation and collaboration." Finally, a stakeholder noted that "from a judicial and child welfare perspective, 'reasonable efforts' are in place via the systems efforts, via the Court Team."

E. Conclusions

Evaluation findings indicate that the Court Team for Maltreated Infants and Toddlers is a promising approach for promoting greater collaboration between the courts, child welfare, and the community to meet the needs of very young children in foster care and to realize positive safety, permanency, and well-being outcomes. For the infant and toddler cases examined, key findings are that 99.05 percent were protected from further maltreatment while under court supervision (N=186), 95 percent achieved permanency (for those with closed cases, N=88), and 97 percent received needed services to meet identified needs, particularly for routine pediatric care and developmental screenings and services (N=186).

Elements of the Court Team model that were fully implemented included judicial leadership guided by knowledge of child development; the liaison role of the Community Coordinator to coordinate case management and ensure communication and information sharing among multiple parties; teams comprised of networked community stakeholders to provide an array of child-focused services; an emphasis on kinship care to foster placement stability; individualized, supervised family contact (visitation) to promote parent-child bonding and attachment; and high utilization of local and national training on child development sponsored by ZTT. Aspects of the model that were found to be unevenly implemented across the sites were infant mental health services and evidence-based parenting education services. A greater focus on formalizing Court Team procedures and processes in each jurisdiction is suggested, in order to institutionalize practice and foster financial and programmatic sustainability, as well as strengthening the collaboration between the courts and child welfare to effect systems change and maintain a "watchful eye" on infants and toddlers under their supervision and in their care.

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Appendix A

Research Subject Information Sheet

RESEARCH SUBJECT INFORMATION SHEET

TITLE:	EVALUATION OF COURT TEAMS FOR MALTREATED INFANTS AND TODDLERS PROJECT
PROTOCOL NO.:	None WIRB Protocol #20081747
SPONSOR:	Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, Department of Justice Washington, DC United States
INVESTIGATOR:	James DeSantis, Ph.D. Suite 1500 1001 19th Street North Arlington, Virginia 22209 United States
SITE(S):	James Bell Associates Suite 1500 1001 19th Street North Arlington, Virginia 22209 United States
STUDY-RELATED PHONE NUMBER(S):	James DeSantis, Ph.D. 703-528-3230
SUB-INVESTIGATOR(S):	Carol Hafford, Ph.D. 703-528-3230
Study ID	_____

This information sheet may contain words that you do not understand. Please ask the study staff to explain any words or information that you do not clearly understand. You may have a copy of this information sheet to think about before making your decision.

PURPOSE OF THE STUDY

The twofold objective of the evaluation is: (1) to examine the early systems- and client-level outcomes of the Court Team projects; and (2) to provide needed evaluation findings to OJJDP on the progress of systems change as reflected in utilization of services and short-term outcomes, such as family reunification and reducing the recurrence of child maltreatment.

PROCEDURES

A total of approximately 80 subjects at four Court Team sites will be asked to participate in this study. You will be one of approximately 20 subjects to be asked to participate at this location.

- **Study participants:** Judge; Community Coordinator; County Attorney/Prosecutor; legal representatives for parents and children; Court-Appointed Special Advocates (CASAs); child welfare administrators, supervisors and frontline workers; and community service providers such as early childhood development specialists, pediatricians, therapists, in-home service providers, parenting educators, and substance abuse treatment providers that are directly involved in the implementation of the Court Team model.

- **Duration of the study:** The study lasts for approximately six months.

- **Research procedures:** As part of the research, the study staff will conduct site visits with each Court Team. The purpose of the site visits is to collect information on the planning and implementation phases of the project in order to understand how the Court Team model is being implemented across the sites, including any adaptations that have been made locally and challenges that have been experienced in implementing the model. During the site visit, the study staff will conduct in-person interviews or focus groups with each study participant, using a semi-structured interview protocol or focus group guide, respectively. Interviews will last about 1-2 hours. Telephone interviews may be substituted for the in-person interviews.

POTENTIAL RISK AND DISCOMFORT
There are no risks to you for participating in this study.

BENEFITS
There is no direct benefit to you from your participation in the study. Your participation will help us understand whether the court team model is effective.

SUBJECT COSTS AND PAYMENT FOR PARTICIPATION
There is no cost to you for your participation in the study. You will not be paid to be in the study.

ALTERNATIVE
Your alternative is to not participate in this study

PRIVACY AND CONFIDENTIALITY
The interview protocol collects the following personally identifiable information: name, title or position, and place of employment. No further personally identifiable information will be collected from you.

All interview and focus group responses are confidential. Your name and other personally identifiable information will be removed from interview transcripts to protect your anonymity. The dependency court or agency where the Court Team model is being implemented will not learn about your responses and will not see the completed interview form. Your name will not be used in any printed or published materials that result from this study.

Information from this study will be given to the sponsor. "Sponsor" includes any persons or companies which are contracted by the sponsor to have access to the research information during and after the study.

Research records which identify you will be looked at and/or copied for research or regulatory purposes by:

- the sponsor;
- Department of Justice; and
- the Western Institutional Review Board® (WIRB®).

Absolute confidentiality cannot be guaranteed because of the need to give information to these parties. The results of this research study may be presented at meetings or in publications. Your identity will not be disclosed in those presentations.

VOLUNTARY PARTICIPATION

Your participation in this study is voluntary. Refusing to participate will involve no penalty or loss of benefits to which you are entitled. You may decide not to participate, or you may leave the study at any time. Please contact the study staff if you decide to stop participating in this study.

If you are employed by the Court Team, your decision to not participate in the study, or a decision on your part to withdraw from the study, will have no effect whatsoever on your employment status.

Your participation in this study may be stopped at any time by the study staff or the sponsor without your consent.

SOURCE OF FUNDING FOR THE STUDY

James Bell Associates received a grant through the U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention to conduct this evaluation.

QUESTIONS

If you have any questions about this study or your participation in this study, please contact the Principal Investigator, Dr. James DeSantis, or the Study Coordinator, Dr. Carol Hafford, at:

James Bell Associates
1001 19th Street North, Suite 1500
Arlington, VA 22209
800-546-3230 or 703-528-3230

If you have questions about your rights as a research subject, or if problems arise which you do not feel you can discuss with the study staff, please contact:

Western Institutional Review Board® (WIRB®)
3535 Seventh Avenue, SW
Olympia, Washington 98502
800-562-4789 or 360-252-2500
Email: ClientServices@wirb.com.

If you agree to be in this study, you will receive a copy of this information sheet for your records.

Appendix B

Interview Guides

Judge

Community Coordinator

Legal Representation

Child Welfare Agency

Court Team Partners/Service Providers

Court Team Judge

The purpose of the interview is to obtain information from the Judge regarding the implementation and progress of the Court Team in each jurisdiction. The following topics are addressed: (A) Background; (B) Court Team planning; (C) Implementation of the Core Components; (D) Site-specific operations;(E) Training and technical assistance; (F) Perceived benefits and future goals. All background information relevant to these topics will be consulted prior to the site visit or telephone interview.

Directions to Interviewer: Inform the interviewee that all information is confidential and will not be shared with other members of the Court Team. Information will be aggregated for analysis and reporting purposes.

Court Team		**Study ID**	
Interviewed by		**Date**	

A. Background

1. Please briefly tell us about yourself and your background. How long have you served as a juvenile/family court judge?

2. Can you tell us why a Court Team was needed in this community? *Probe for local need/problem that impacts maltreated infants and toddlers*

3. What is your long-term vision for the Court Team model?

4. Who was responsible for deciding to implement the Court Team model in this jurisdiction?

5. What, if any, data were collected to establish the need for the intervention(s)?

6. Were other programs or models considered? If so, which ones?

B. Planning Phase

1. When did planning take place?

2. What was your role during the planning process?

3. Who else was involved in the planning process?
   Probe: Judicial staff? Legal community? Public child welfare agency staff? Service providers? Community members? External consultants? ZTT Community Coordinator?

4. What issues were addressed?

5. What kinds of activities were conducted during the Planning Phase?

6. What information did the Court receive from the ZERO TO THREE national office during the planning process?

7. Were any new policies or procedures developed by the Court during the planning phase?

8. Were any challenges encountered during the planning phase? If so, what were the challenges and what strategies were used to try to resolve the challenges?

C. Court Team Implementation **Objective 1.1**

We would like to ask you some questions about implementing the core components of the Court Team model.

1. First, judicial leadership is a primary component on the Court Team model. Can you tell us what this means to you? [186]

[186] Establishing standards of practice for courts, court staff, and attorneys; encouraging multi-disciplinary training for judges and lawyers; participating in data collection and analysis; assessing court resources, including training and workloads; ensuring competent and adequately trained representation by attorneys; participating in multi-

2. Did you receive definitions from ZERO TO THREE about the core components of the model or was interpretation of some/all of the components left up to the Court Team site? [187]

3. Have all core components been fully implemented?

4. In terms of implementing the core components, what has gone well?

5. Have there been any challenges in implementing the core components? If so, please describe.

6. Are there any factors that have played a role in either helping or hindering implementation of the Court Team model?

Probe: State policies or initiatives; Relationship with Child Protective Services; Funding; Local issues (e.g., shortage of foster homes, culturally appropriate services, meth use and need for substance abuse services)

D. Site-Specific Operations **Objective 1.1, 1.2, 1.3, 2.3**

1. What is the Court's annual caseload: # of abuse-neglect [or dependency] petitions, # of TPRs, # of adoptions, etc.?

2. What are the eligibility criteria for participation in the Court Team in [name of jurisdiction]?
Probe: Age of children, parental capacity, etc.

3. Have the eligibility criteria changed over time?

4. What is the maximum number of ZTT cases that the Court Team can serve each month? _____

a. How many cases are currently being served? _____
b. If less than anticipated, what factors impact the ability to meet this target?
c. What percentage of children between the ages of 0-3 that come before the Court are served by the Court Team project?

5. How were infants and toddlers served by the Court prior to implementation of the Court Team model?

6. What is different now in the way that you approach infant and toddler cases?
Probe: Types of questions asked during the hearing, treatment of parties, involving fathers, referrals for developmental services or screenings, use of court orders, expectations of community partners, focus on parent-child relationship, frequency of planned visitation; type of

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disciplinary groups; engaging in collaborative efforts; speaking, writing, lecturing, and participating in activities etc. regarding child welfare law, the legal system, and other child welfare issues; reporting to the county administrators office about the needs of the system; and reports to the state legislature about the needs of the system.

[187] As of most recent ZERO TO THREE Impact Statement: Judicial Leadership, local Community Coordinator, Court Team community partners, monthly reviews, child-focused services, mental health interventions, evidence-based parenting education and interventions, national activities (i.e., training and technical assistance, resource materials, evaluation).

visitation; what counts as visitation; monitoring of parental compliance with the case plan, recognizing parental efforts, limiting placement changes, etc.

7. Has the Court developed new orders, forms, procedures (including hearings) to address infant/toddler cases?

8. In what ways does the Community Coordinator contribute to the functioning of the Court Team in [name of jurisdiction]?

Probe: Child development expertise for the court; Prior relationships with community partners (e.g., child welfare, providers); Bringing in new partners; Coordination of services and resources in support of infants and toddlers; Broadening the range of services available to children and parents; Involving extended family in planning for child. .

9. Are there key priorities for the Court Team model in this jurisdiction (e.g., meaningful visitation, father involvement, needed services)? [Note: This question addresses local adaptations to the model]

- If so, what are they?
- Have any activities been added to the Court Team model to address the priority/these priorities?

10. Have you noticed any changes in the way that attorneys or case workers or parents approach a case since the Court Team model was implemented? What have you observed?

11. Who are the members of the Court Team?

a. Has the composition changed over time?
b. Who would you consider to be active members?

1. Does the Court hold monthly Court Team meetings? Is there a consistency in attendance?

13. What do monthly Court Team meetings contribute to the functioning of the Court Team in [name of jurisdiction]?

14. Did you encounter any challenges in collaborating with the community members?

- If so, explain.
- How did you address this/these barrier(s)?
  Probe: Stakeholder involvement and commitment? Sufficient referrals? Access to services? Coordination of services? Utilization of services? Payment for assessments? Monitoring?

Additional interventions

15. To your knowledge, does the Court or child welfare agency offer any other services/interventions to the target population that may impact case level findings of an outcome study (e.g., mediation, pre-hearing conferences, family group decision making)?

E. Training and Technical Assistance — Objective 2.1, 2.2

Training and knowledge of infant and toddler development

1. What training opportunities have been offered by ZERO TO THREE's national office regarding the early development and needs of infants and toddlers?

- Effect of maltreatment on early development?
- Strategies to improve child well-being?
- Other?

2. Has knowledge of infant and toddler development changed your practice? If so, how? Can you give us an example?

3. Have you experienced any challenges in applying the new information that you have learned?

4. What other kinds of training do you participate in?

5. What training opportunities have been offered in the community?

Technical assistance

6. Did the Court receive any technical assistance for Court Team implementation?

7. Has the Court made policy or practice changes based on the technical assistance provided by ZERO TO THREE?

8. Is there any other training or technical assistance that you think might be helpful?

9. Do you seek advice from or confer with other Juvenile or Family Court Judges who are implementing another Court Team project? If so, what kinds of topics are addressed?

F. Perceived benefits and future goals

1. In your opinion, what have been some of the key benefits for children and families served through the Court Team?

2. Have you observed any effects on the other children in the family as a result of using this approach?

3. What are the goals for the Court Team in the coming year? Are there any planned changes to the Court Team model in the next year?

4. Is there anything else that you would like to add?

Court Team Community Coordinator

The purpose of the interview is to obtain information from the Community Coordinator regarding the implementation and progress of the Court Team model in each jurisdiction. The following topics are addressed: (A) Background; (B) Court Team planning; (C) Implementation of the Core Components; (D) Site-specific operations;(E) Training and technical assistance; (F) Perceived benefits and future goals. All background information relevant to these topics will be consulted prior to the site visit or telephone interview.

Directions to Interviewer: Inform the interviewee that all information is confidential and will not be shared with other members of the Court Team. Information will be aggregated for analysis and reporting purposes. Use skip patterns as noted.

Court Team		**Study ID**	
Interviewed by		**Date**	

A. Background

1. Please briefly tell us about yourself and your background.

   a. What is your professional background?
   b. How long have you served as the Community Coordinator in [name of jurisdiction?]

B. Court Team Planning

The purpose of this section is to understand the decision making and planning process behind implementation of the Court Team model.

Choosing the Court Team Model

1. In your opinion, why was a Court Team needed in this community?
   Probe for local need/problem that impacts infants and toddlers

2. Who was responsible for deciding to implement the Court Team model in this jurisdiction?

Planning Phase

3. Were you involved in the planning process?
   If no skip to question10 below beginning with To your knowledge."

   If yes:

   a. *When did planning take place?*
   b. What was your role during the planning process?

4. Who else was involved in the planning process?
   Probe: Judicial leadership? Legal community? Public child welfare agency staff? Service providers? Community members? External consultants?

5. What issues were addressed?

6. What kinds of activities were conducted during the Planning Phase?

7. What information did the Court receive from the ZERO TO THREE national office during the planning process?

8. To your knowledge, were any challenges encountered during the planning phase?

   a. If so, what were the challenges?
   b. How were these challenges resolved?

9. Were any new policies or procedures developed by the Court during the planning phase?

C. Implementation of the Core Components of the Court Team Model

Objective 1.1

Note to Interviewer: Repeat the following set of questions for each item in the table below. Provide the interviewee with a copy of this page for reference. Begin by saying "I am going to go through each of the Core Components of the Court Team model and ask the same set of questions. Let's begin."

	Definition/Guidance			**Implementation**		
Core Component	***Did [you/the Court] receive a definition/guidance regarding this component? If interpretation of a component was left up to each Court Team site, then probe for comments or concerns.***			***Has the component been fully implemented? Can you identify any factors that have helped to implement this component? Have there been any challenges in implementing this component? Do you have any concerns or comments regarding this component?***		
	Yes	**No/Not Sure**	**Comment or Concern**	**Yes**	**No/Not Fully**	**Comment or Concern**
Judicial leadership						
Local Community Coordinator						
Teams comprised of key community stakeholders						
Monthly case reviews						
Child-focused services						
Mental health interventions						
Evidence-based parenting education and interventions						
National Activities (i.e., training, TA, resource materials, evaluation)						

D. Site-Specific Operations — Objective 1.1, 1.2, 1.3, 2.3

Eligibility criteria and cases served

1. What are the eligibility criteria for participation in the Court Team in [name of jurisdiction]?
   Probe: Age of children, parental capacity, etc.
   - Have the eligibility criteria changed over time? If so, how and why was this necessary?

2. What is the maximum number of cases that the Court Team can serve each month? _____
   a. How many cases are currently being served? _____
   b. If less than anticipated, what factors impact the ability to meet this target?
   c. What percentage of children between the ages of 0-3 that come before the Court are served by the Court Team project?

Case processing

3. Please describe the flow of a case through the Court Team process.
   Probe for the following elements:
   - *Identification of an infant/toddler case and by whom*
   - *Notification to the Community Coordinator and by whom (e.g., CPS intake worker, county attorney, judge's case manager?)*
   - *Custody hearing at which the cases is referred to ZTT*
   - *Parties involved*
   - *Community Coordinators next steps (e.g., contact with, coordination with, referrals to , etc).*
   - *Timeline for development of child welfare agency case plan and/or family conference*
   - *Initiation of the monthly case review*
   - *Frequency of court hearings*

4. Have you experienced any challenges with this process?

5. How does this process differ from previous dependency court or child welfare practice?

6. Has the court developed new orders, forms or procedures to address infant/toddler cases?

7. Has the child welfare agency provided resources to support the Court Team (e.g., liaison)? If so, please describe.

8. Have you noticed any changes in the way that attorneys or case workers or parents approach a case since the Court Team model was implemented? What have you observed?

Roles and collaboration

9. What does your role as Community Coordinator consist of? [188] Please describe your activities.

[188] ZERO TO THREE Year 1 Report (June 27 2007) detailed multiple roles of the Community Coordinator: Working with the Judge; Working with ZTT; Linking with providers in the local system; Court Team facilitator; Information sharing; Event planner and host; Working with cases; Attend hearings and monitor cases.

10. What is your relationship to the ZERO TO THREE national office?

11. Have you experienced any challenges with respect to your role?
Probe: Working with the Judge? Being supervised by national staff?

12 Judicial leadership is a primary component of the Court Team model. Can you tell us what this means to you? Can you give us an example? [189]

13. Who are the members of the Court Team?
a. Has the composition of the Court Team changed over time? If so, how?
b. Who would you consider to be active members?

14. Who are the key providers with whom the Court Team works (e.g., EHS, pediatrician, parenting educators, substance abuse service providers)?
a. As the Community Coordinator, did you recruit any providers to collaborate with the Court Team?
b. Or were the providers already part of the process?
c. Have you worked with local providers to expand the types of services available for infants and toddlers? If so, explain.

15. Did you encounter any challenges in collaborating with the service providers?
Probe: Stakeholder involvement and commitment? Sufficient referrals? Access to services? Coordination of services? Utilization of services? Payment for assessments? Monitoring?

a. If so, explain.
b. How did you address this/these barrier(s)?

Monthly Case Reviews

16. We would like to ask you some questions about the monthly case reviews.

a. Where is it held?
b. When is it held?
c. How long does it last?
d. Who attends? Is there a consistency in attendance?
e. What is the purpose of the review?
f. As the Community Coordinator, what is your role during the review?
g. What typically happens during the meetings?

17. What do the reviews contribute to the functioning of the Court Team?

18. Have you experienced any challenges in conducting the monthly case reviews?

[189] Establishing standards of practice for courts, court staff, and attorneys; encouraging multi-disciplinary training for judges and lawyers; participating in data collection and analysis; assessing court resources, including training and workloads; ensuring competent and adequately trained representation by attorneys; participating in multi-disciplinary groups; engaging in collaborative efforts; speaking, writing, lecturing, and participating in activities etc. regarding child welfare law, the legal system, and other child welfare issues; reporting to the county administrators office about the needs of the system; and reports to the state legislature about the needs of the system.

Court Team meetings

19. Does the Court hold monthly Court Team meetings?
    a. Where is the meeting held?
    b. When is it held?
    c. How long does it last?
    d. Who attends? Is there a consistency in attendance?
    e. Who leads the meeting?
    f. What is the purpose of the monthly Court Team meetings?
    g. What typically happens during the meetings?

20. What do the meetings contribute to the functioning of the Court Team?

21. Have you experienced any challenges regarding the monthly Court Team meetings?

22. What kinds of activities do you take part in with other Court Team members in order to maintain communication and collaboration (e.g., family team meetings, trainings, discussions, phone calls, emails, key contact or liaison, co-location)?

Changes or Modifications to Court Team Model

23. Are there key priorities for the Court Team model in this jurisdiction (e.g., meaningful visitation, father involvement, needed services)? [Note: This question addresses local adaptations to the model]
    a. If so, what are they?
    b. Have any activities been added to the Court Team model to address the priority/these priorities?

24. Did the [name of Court] consult with ZERO TO THREE national office for advice about modifying the Court Team model in this jurisdiction? If yes, what did they suggest?

25. How much flexibility have you been given by ZERO TO THREE national office to modify the Court Team model? Which components could be modified and which were non-negotiable?

26. Did you get input from other external sources about possible ways to modify the model? If so, who provided the input, and what did they suggest?

Additional interventions

27. To your knowledge, does the Court or child welfare agency offer any other services/interventions to the target population that may impact case level findings of an outcome study (e.g., mediation, pre-hearing conferences, family group decision making)?

Contextual factors

28. Are there any factors that have played a role in either helping or hindering implementation of the Court Team model?

    Probe: State policies or initiatives; Relationship with Child Protective Services; Funding; Local issues (e.g., shortage of foster homes, culturally appropriate services, substance abuse and need for substance abuse services)

Funding

29. How is the Court Team funded? Identify funding sources and amounts (currently and over time).

E. Training and Technical Assistance — Objective 2.1, 2.2

Training and knowledge of infant and toddler development

1. Have you received training from the ZERO TO THREE national office regarding the early development and needs of infants and toddlers? If yes,
   a. What types of training did you participate in?
   b. What topics were covered?
   c. Who provided the training?
   d. Did anyone else participate in the training?
   e. How long was the training?
   f. Where did the training(s) occur?

2. Has knowledge of infant and toddler development changed your practice? If so, how? Can you give us an example?

3. Have you experienced any challenges in applying the new information that you have learned?

4. Do you provide training for the Court Team members? If so, on what topics?

5. Are there opportunities for ongoing training for you and the Court Team?

Technical assistance (TA)

6. Does the [name of jurisdiction] receive TA from the ZERO TO THREE national office for Court Team implementation?
   a. In what areas?
   b. Is TA currently being provided? By whom?
   c. What methods are used to provide TA (e.g., site visits, phone calls, cross-site calls, emails, annual meetings)?
   d. Are there any unmet needs?
   e. Are there any topics that you would have liked more TA from the ZERO TO THREE national office?
   f. Has [name of jurisdiction] made policy or practice changes based on the TA provided by the ZERO TO THREE national office?

7. Do you seek advice from or confer with other Community Coordinators who are implementing a Court Team? If so, what kinds of topics are addressed?

8. Have you requested or received TA from another source? If so, for what reason?

F. Perceived benefits and future goals

1. In your opinion, what have been some of the key benefits for children and families served through the Court Team?

2. What are the goals for the Court Team in the coming year? Are there any planned changes to the Court Team model in the next year?

Legal Representation

The purpose of the interview is to obtain information from Attorneys that work with the Court to provide services to maltreated infants and toddlers or their parents. The following topics are addressed: (A) Background; (B) Court Team Planning; (C) Working with Court Team cases; (D) Collaboration; (E) Training and technical assistance; and (F) Benefits, changes, and goals. All background information relevant to these topics will be consulted prior to the site visit or telephone interview.

Directions to Interviewer: Inform the interviewee that all information is confidential and will not be shared with other members of the Court Team. Information will be aggregated for analysis and reporting purposes. Use skip patterns as noted.

Court Team		**Study ID**	
Interviewed by		**Date**	

An important part of this study is to understand the services that are available to children and families through the Court Team. We would like to ask you some questions about you or your agency's collaboration and service provision with the Court Team in [name of jurisdiction].

A. Background

1. What is the name of your organization/firm?

2. How many years have you been practicing as an Attorney? As an Attorney Ad litem?

3. Do you represent children and/or parents in dependency court?

4. Have you worked with the Court or the child welfare agency prior to the implementation of the Court Team model? If so, how?

5. In your opinion, what was the reason for implementing the Court Team for Maltreated Infants and Toddlers in this community?

B. Court Team Planning

1. How were you/was the firm/organization invited to participate in the Court Team initiative?

2. Were you involved in the planning for the Court Team project? YES NO
   If no, skip to the next section.
   If yes, continue with the questions below.

3. Who else was involved in the planning process?
   Probe: Judicial leadership? Legal community? Public child welfare agency staff? Service providers? Community members? External consultants? Community Coordinator?

4. What issues were addressed?

5. What kinds of activities were conducted during the Planning Phase?

6. To your knowledge, what information did you receive from ZERO TO THREE during the planning process?

7. Were any new policies or procedures developed by the Court during the planning phase?

8. Were any challenges encountered during the planning phase? If so, what were the challenges and what strategies were used to try to resolve the challenges?

C. Working with the Court Team cases

Objective 1.1, 1.2, 1.3, 2.3

We would like to have a better understanding of how cases involving maltreated infants and toddlers are treated by the Court Team, so we will ask some question about the process involved.

Representation

1. Please describe the system of legal representation for children in **[name of jurisdiction].**
   a. When and how are representatives appointed?
   b. What is their role (best interest? speak for child's wishes? other?)?
   c. What are their qualifications (attorneys, lay volunteers, paid volunteers)?
   d. What, if any training are they required to receive for a ZTT case?
   e. Are their caseloads capped at a maximum number?

2. Does the court **[name of jurisdiction]** use CASA volunteers?
   a. When and why are they appointed?
   b. What is their role in a ZTT case?
   c. What are their qualifications?
   d. What are their caseloads?

3. Please describe the system of representation for parents in **[name of jurisdiction].**
   a. When and how are representatives appointed?
   b. Is there separate representation for each parent?
   c. Are there requirements for defense attorneys who take these cases? Training?
   d. How are defense attorneys compensated?
   e. Are there maximum caseloads?

Court Hearings

4. Please name the sequence of hearings for child protection cases and the frequency in this jurisdiction.

HEARING TYPE *	FREQUENCY	PURPOSE
Emergency Removal, Temporary Custody, Shelter Care		
Pre-Trial Conference; Adversarial		
Adjudication		
Disposition		
Review; Status; Informational (TX)		
Permanency		
Dismissal or Final Order (TX)		
TPR Trial		
Ongoing Placement Review		
Other *(Describe)*		

* Hearings names and types will vary by State

5. How many children/parents has your firm/organization represented through the Court Team? _____

6. Is participation in the ZTT Court Team for Maltreated Infants and Toddlers mandatory for parents?
   YES NO

7. How receptive are parents to participating in the ZTT Court Team pilot?

8. How often do you meet with your client?

9. Please tell about the hearings.
   - What typically occurs during each hearing? *(Note in "Purpose" and use blank page opposite)*
   - What is your role during the hearings?
   - How often are *review hearings* conducted for ZTT cases?
   - What is the statutory timeframe for permanency review hearings?
   - Are concurrent plans developed? Are there any challenges associated with this?
   - If a case reaches TPR, does it remain in this court/on the ZTT docket? If not, does it go to another court?

10. Do the monthly review hearings contribute to the progress of ZTT cases? If so, how?

11. Do you and other members of the Court Team meet to review the case outside of the hearing?
    YES NO

12. If yes, who are the Court Team members that you meet with on each case (e.g., DHS, parent, foster parent, Community Coordinator?)

13. Have you and your client experienced any success or challenges regarding the progress of cases?

14. Do child maltreatment cases involving parental substance abuse pose any particular challenges?

15. What was the typical approach to handling infant and toddler cases prior to implementation of the Court Team Model?
    What is different now?
    Probe for Activities related to Core Components [190]

16. Have you experienced any challenges with regard to meeting the Adoption and Safe Families Act of 1997 (ASFA) timeframes for reunification or TPR?
    Probe:
    - *Reunification within 12 months from date of removal?*
    - *Adherence to the "15 of 22 months" provision to initiate TPR?*
    - *Provision to bypass reunification efforts ("fast track") in extraordinarily high risk situations*

[190] Activities related to Core Components: Questions posed by the Judge during the hearing; Increased participation by parties involved; New Court order forms or procedures; Recommendations or orders for child-focused services; Recommendations or orders for needed services for parents; Changes in visitation practices (i.e., type, duration, frequency); Changes in placement practices (e.g., kinship placements); Participation/attendance at court team meetings or monthly case reviews; Monitoring (including monthly case reviews), tracking, and reporting; Training and technical assistance.

Monthly Case Reviews

17. We would like to ask you some questions about the monthly case reviews. Do you participate in this process?

    h. Where is it held?
    i. When is it held?
    j. How long does it last?
    k. Do you or another legal representative attend?
    l. Who else attends? Is there a consistency in attendance?
    m. What is the purpose of the review?
    n. What is your role during the review?
    o. What typically happens during the meetings?

18. What do the reviews contribute to the functioning of the Court Team?

19. Have you experienced any challenges in participating in the monthly case reviews?

20. Is participation in monthly case reviews a change from previous practice?

Additional interventions

21. To your knowledge, does the Court or child welfare agency offer any other services/interventions to the target population that may impact case level findings of an outcome study (e.g., mediation, pre-hearing conferences, family group decision making)?

D. Collaboration — Objective 1.3

1. Does your agency have a formalized collaborative arrangement in place with the Court Team or the child welfare agency?
   Probe: Formal agreement or informal working arrangement?
   a. How long has this arrangement been in place?
   b. Has this arrangement changed over time? If so, how?

2. Did you encounter any challenges in collaborating with the Court Team?
   - If so, explain.
   - How did you address this/these barrier(s)?
     Probe: Stakeholder involvement and commitment? Sufficient referrals? Access to services? Coordination of services? Utilization of services? Payment for assessments? Monitoring?

3. What kinds of activities do you take part in with other Court Team members in order to maintain communication and collaboration (e.g., family team meetings, trainings, discussions, phone calls, emails, key contact or liaison, co-location)?

E. Training and Technical Assistance **Objective 2.1, 2.2**

Training and knowledge of infant and toddler development

1. Have you received training from the ZERO TO THREE national office or via the Community Coordinator regarding the early development and needs of infants and toddlers? If yes,
   a. What types of training did you participate in?
   b. *Probe: Effect of maltreatment on early development; Strategies to improve child well-being?*
   c. What topics were covered?
   d. Who provided the training?
   e. Did anyone else participate in the training?
   f. How long was the training session(s)?
   g. Where did the training(s) occur?

2. Has knowledge of infant and toddler development changed your practice? If so, how? Can you give us an example?

3. Have you experienced any challenges in applying the new information that you have learned?

4. Does your firm/organization provide training for the Court Team members? If so, on what topics?

5. Are there opportunities for ongoing training for you and the Court Team in the community?

Technical assistance and Information

6. To your knowledge, did your firm/organization receive any technical assistance or information from ZERO TO THREE for Court Team implementation?

   a. If so, in what area?
   b. Has your firm/organization made policy or practice changes based on the technical assistance or information provided [by ZERO TO THREE?]

7. Are there any areas where you would have liked technical assistance or information from [ZERO TO THREE? Other?]

8. Do you seek advice from or confer with other providers who are part of the Court Team? If so, what kinds of topics are addressed?

F. Benefits, changes, and future goals

1. Has participation with the Court Team changed any aspect of the firm/organization‘s policies, procedures, or practices? If so, explain.

2. In your opinion, what have been some of the key benefits for children and families served through the Court Team?

3. Are you aware of any goals for the Court Team in the coming year? If so, what are they?

4. Is there anything else that you would like to add?

Child Welfare

The purpose of the interview is to obtain information from the Child Welfare staff regarding the implementation and progress of the Court Team in each jurisdiction. The following topics are addressed:

(A) Background; (B) Court Team planning; (C) Implementation of the Core Components; (D) Site-specific operations;(E) Training and technical assistance; (F) Perceived benefits and future goals. All background information relevant to these topics will be consulted prior to the site visit or telephone interview.

Directions to Interviewer: Inform the interviewee that all information is confidential and will not be shared with other members of the Court Team. Information will be aggregated for analysis and reporting purposes.

Court Team		**Study ID**	
Interviewed by		**Date**	

An important part of this study is to understand the services that are available to children and families through the Court Team. We would like to ask you some questions about the agency's collaboration and service provision with the Court Team in [name of jurisdiction]. First we would like to get an overview of your organization.

A. Background

1. What is the name of your agency or organization?

2. How long has it been in existence? What is its history?

3. What are the range of services and programs provided?

4. What is the agency or organization's service area?

5. How many staff provide services?

6. In your opinion, what was the reason for implementing the Court Team for Maltreated Infants and Toddlers in this community?

B. Court Team Planning

1. Were you involved in the planning for the Court Team project?
   If no, skip to the next section.
   If yes, continue with the set of questions.

2. Who else was involved in the planning process?
   Probe: Judicial leadership? Legal community? Public child welfare agency staff? Service providers? Community members? External consultants?

3. What issues were addressed?

4. What kinds of activities were conducted during the Planning Phase?

5. To your knowledge, what guidance, if any, did the Court receive from ZERO TO THREE during the planning process?

6. Where any new policies or procedures developed by the Court during the planning phase?

7. Were any challenges encountered during the planning phase? If so, what were the challenges and what strategies were used to try to resolve the challenges?

C. Court Team Implementation **Objective 1.1**

We would like to ask you some question about implementing the core components of the Court Team model.

1. First, judicial leadership is a primary component on the Court Team model. Can you tell us what this means to you?

2. Did you receive definitions from ZERO TO THREE about the core components of the model or was interpretation of some/all of the components left up to the Court Team site? [191]

3. Have all core components been fully implemented?

4. In terms of implementing the core components, what has gone well?

5. Have there been any challenges in implementing the core components? If so, please describe.

6. Are there any factors that have played a role in either helping or hindering implementation of the Court Team model?

Probe: State policies or initiatives; Relationship with Child Protective Services; Funding; Local issues (e.g., shortage of foster homes, culturally appropriate services, meth use and need for substance abuse services)

D. Site-Specific Operations **Objective 1.1, 1.2, 1.3, 2.3**

1. What are the eligibility criteria for participation in the Court Team in [name of jurisdiction]?

Probe: Age of children, parental capacity, etc.

2. Have the eligibility criteria changed over time?

3. Can you describe the flow of a case through the Court Team process? [192]
   - At what point is an infant/toddler case identified? Or referred to the Court Team?
   - When is the first review of the case scheduled? Who attends?
   - What kinds of services or screening are immediately referred?
   - What are the next steps in the process?
   - Have you experienced any challenges with this process?

4. Can you tell us what was the typical approach to handling infants and toddler cases prior to implementation of the Court Team model? What is different now?

Probe: Types of questions asked during the hearing, treatment of parties, involving fathers, referrals for developmental services or screenings, use of court orders, expectations of community partners, focus on parent-child relationship, frequency of planned visitation; monitoring of parental compliance with the case plan, recognizing parental efforts, etc.

5. Has the agency developed new policies, practices, or procedures to address infant/toddler cases?

6. In what ways does the Community Coordinator contribute to the functioning of the Court Team in [name of jurisdiction]?

Probe: Child development expertise for the court; Relationships with community partners (e.g., child welfare, providers); Coordination of services and resources in support of infants and toddlers.

7. Have you noticed any changes in the way that attorneys or case workers or parents approach a case since the Court Team model was implemented? What have you observed?

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[191] As of most recent ZERO TO THREE Impact Statement: Judicial Leadership, local Community Coordinator, Court Team community partners, monthly reviews, child-focused services, mental health interventions, parenting education and interventions, national activities (i.e., training and technical assistance, resource materials, evaluation).

[192] Will vary across sites.

8. Are there key priorities for the Court Team model in this jurisdiction (e.g., meaningful visitation, father involvement, needed services)? [Note: This question addresses local adaptations to the model]

- If so, what are they?
- Have any activities been added to the Court Team model to address the priority/these priorities?

9. Do you [or other child welfare staff] participate in monthly Court Team meetings?

10. What do monthly case review/hearings contribute to the functioning of the Court Team in [name of jurisdiction]?

11. Did you encounter any challenges in collaborating with the community members? If so, explain. How did you address this/these barrier(s)?

Probe: Stakeholder involvement and commitment? Sufficient referrals? Access to services? Coordination of services? Utilization of services? Payment for assessments? Monitoring?

E. Training and Technical Assistance — Objective 2.1, 2.2

Training and knowledge of infant and toddler development

1. Have you been involved in any training provided by ZERO TO THREE regarding the early development and needs of infants and toddlers? If so, on what topics:
    - Effect of maltreatment on early development?
    - Strategies to improve child well-being?

2. Has knowledge of infant and toddler development changed your practice? If so, how?

3. Have you experienced any challenges in applying the new information that you have learned?

4. What other kinds of training do you participate in?

Technical assistance

5. Did the Court receive any technical assistance for Court Team implementation?

6. Has the Court made policy or practice changes based on the technical assistance provided by ZERO TO THREE?

7. Is there any other training or technical assistance that you think might be helpful?

8. Do you seek advice from or confer with other Judges who are implementing another Court Team project? If so, what kinds of topics are addressed?

F. Perceived benefits and future goals

1. In your opinion, what have been some of the key benefits for children and families served through the Court Team?
2. What are the goals for the Court Team in the coming year? Are there any planned changes to the Court Team model in the next year?

3. Is there anything else that you would like to add?

Court Team Partners

The purpose of the interview is to obtain information from Community Stakeholders (e.g., Child Welfare, Service Providers) that work with the Court to provide services to maltreated infants and toddlers or their parents. The following topics are addressed: (A) Agency context; (B) Court Team Planning; (C) Working with Court Team cases; (D) Collaboration; (E) Training and technical assistance; and (F) Benefits, changes, and goals. All background information relevant to these topics will be consulted prior to the site visit or telephone interview.

Directions to Interviewer: Inform the interviewee that all information is confidential and will not be shared with other members of the Court Team. Information will be aggregated for analysis and reporting purposes. Use skip patterns as noted.

Court Team		**Study ID**	
Interviewed by		**Date**	

An important part of this study is to understand the services that are available to children and families through the Court Team. We would like to ask you some questions about the agency's collaboration and service provision with the Court Team in [name of jurisdiction]. First we would like to get an overview of your organization.

A. Background

1. What is the name of your agency or organization?

2. How long has it been in existence? What is its history?

3. What are the range of services and programs provided? **(List services)**
   Note to Interview: The response may segue to Q3 in C. Service Provision.

4. What is the agency or organization's service area?

5. How many staff provide services?

B. Court Team Planning

1. How was the agency invited to participate in the Court Team initiative?

2. Were you involved in the planning for the Court Team project? YES NO
   If no, skip to the next section.
   If yes, continue with the questions below.

3. Who else was involved in the planning process?
   Probe: Judicial leadership? Legal community? Public child welfare agency staff? Service providers? Community members? External consultants? Community Coordinator?

4. What issues were addressed?

5. What kinds of activities were conducted during the Planning Phase?

6. To your knowledge, what information did you receive from ZERO TO THREE during the planning process?

7. Were any new policies or procedures developed by the Court during the planning phase?

8. Were any challenges encountered during the planning phase? If so, what were the challenges and what strategies were used to try to resolve the challenges?

C. Working with the Court Team cases **Objective 1.1, 1.2, 1.3, 2.3**

We would like to have a better understanding of how cases involving maltreated infants and toddlers are treated by the Court Team, so we will ask some question about the process involved.

Service Provision

1. In your opinion, what was the reason for implementing the Court Team for Maltreated Infants and Toddlers in this community?

2. Please describe how you or the agency gets notified and involved in a Court Team case.
   Probe: Through referrals? Through court-order? Can families self-refer?

3. Who are the Court Team members that you work with on each case (e.g., DHS, foster parent, Community Coordinator?)

4. Do you subcontract out or internally refer any services? If so,
   a. To whom?
   b. For what types of services?

5. How many children and/or families has your agency/ organization served through the Court Team?

Monthly Case Reviews

6. We would like to ask you some questions about the monthly case reviews.
   a. Where is it held?
   b. When is it held?
   c. How long does it last?
   d. Do you or another agency representative attend?
   e. Who else attends? Is there a consistency in attendance?
   f. What is the purpose of the review?
   g. What is your role during the review?
   h. What typically happens during the meetings?

7. What do the reviews contribute to the functioning of the Court Team?

8. Have you experienced any challenges in participating in the monthly case reviews?

9. Is participation in monthly case reviews a change from previous practice?

Court Hearings

10. Do you or another member of the agency attend court hearings? If so,
    a. What is your role?
    b. Are you subpoenaed?

11. What was the typical approach to handling infant and toddler cases during a hearing prior to the Court Team Model?

12. What is different now? *Probe for Core Components* [193]
    a. Can you tell us about the Judge's approach to handling infant and toddler cases? Would you provide some examples?
    b. What are his/her expectations for service providers who are part of the Court Team?

Additional interventions

[193] Questions posed by the Judge during the hearing; Increased participation by parties involved; New Court order forms or procedures; Recommendations or orders for developmental services for children; Recommendations or orders for needed services for parents; Visitation practices; Placement practices (e.g., kinship placements); Participation/attendance at court team meetings or monthly case reviews; Monitoring (including monthly case reviews), tracking, and reporting; Training and technical assistance.

13. To your knowledge, does the Court or child welfare agency offer any other services/interventions to the target population that may impact case level findings of an outcome study (e.g., mediation, pre-hearing conferences, family group decision making)?

D. Collaboration — Objective 1.3

1. Does your agency have a formalized collaborative arrangement in place with the Court Team or the child welfare agency?
   Probe: Formal agreement or informal working arrangement?
   a. How long has this arrangement been in place?
   b. Has this arrangement changed over time? If so, how?

2. Did you encounter any challenges in collaborating with the Court Team?
   a. If so, explain.
   b. How did you address this/these barrier(s)?
   Probe: Stakeholder involvement and commitment? Sufficient referrals? Access to services? Coordination of services? Utilization of services? Payment for assessments? Monitoring?

3. What kinds of activities do you take part in with other Court Team members in order to maintain communication and collaboration (e.g., family team meetings, trainings, discussions, phone calls, emails, key contact or liaison, co-location)?

E. Training and Technical Assistance — Objective 2.1, 2.2

Training and knowledge of infant and toddler development

1. Have you received training from the ZERO TO THREE national office or via the Community Coordinator regarding the early development and needs of infants and toddlers? If yes,
   a. What types of training did you participate in?
   b. *Probe: Effect of maltreatment on early development; Strategies to improve child well-being?*
   c. What topics were covered?
   d. Who provided the training?
   e. Did anyone else participate in the training?
   f. How long was the training session(s)?
   g. Where did the training(s) occur?

2. Has knowledge of infant and toddler development changed your practice? If so, how? Can you give us an example?

3. Have you experienced any challenges in applying the new information that you have learned?

4. Does your organization provide training for the Court Team members? If so, on what topics?

5. Are there opportunities for ongoing training for you and the Court Team in the community?

Technical assistance and information

6. To your knowledge, did your agency receive any technical assistance or information from ZERO TO THREE for Court Team implementation?
   a. If so, in what area?
   b. Has your agency made policy or practice changes based on the technical assistance or information provided [by ZERO TO THREE?]

7. Are there any areas where you would have liked technical assistance or information from [ZERO TO THREE? Other?]

8. Do you seek advice from or confer with other providers who are part of the Court Team? If so, what kinds of topics are addressed?

F. Benefits, changes, and future goals

1. Has participation with the Court Team changed any aspect of the agency's policies, procedures, or practices? If so, explain.

2. In your opinion, what have been some of the key benefits for children and families served through the Court Team?

3. Are you aware of any goals for the Court Team in the coming year? If so, what are they?

4. Is there anything else that you would like to add?

Appendix C

Focus Group guide

Focus Group Questions

Note: To be used for Court-Appointed Special Advocates, child welfare workers and/or supervisors, representatives of foster parent organizations, attorneys for parents and children.

Evaluation questions

- *Goal 1:* To what extent is system change underway at each program site through implementation of the Court Team model? Objectives 1.1-1.3

- *Goal 2:* What is the state of knowledge among Court Team stakeholders regarding the impact of abuse and neglect on early development and the needs of maltreated infants and toddlers who come through the Court? Objectives 2.1-2.4

Discussion

1. Tell us your name and how long you have been a member of the Court Team in [name of jurisdiction].

2. What was the typical approach to handling infant and toddler cases prior to the Court Team Model? What is different now? Would you provide some examples? Does anyone have other comments or views on this topic? *Probe for activities related to Core Components: Questions posed by the Judge during the hearing; Increased participation by parties involved; New Court order forms or procedures; Recommendations or orders for child-focused services; Recommendations or orders for needed services for parents; Changes in visitation practices (i.e., type, duration, frequency); Changes in placement practices (e.g., kinship placements); Participation/attendance at court team meetings or monthly case reviews; Monitoring (including monthly case reviews), tracking, and reporting; Training and technical assistance.* Objective 1.1, Implementation of eight Core Components

3. Have changes taken place regarding assessments and services available for infants and toddlers? What kinds of changes? Does anyone have other comments or views on this topic? *Probe for assessments/services: Introduction of new services (e.g., infant-parent psychotherapy or parent-child interaction therapy); Coordination of assessment and services by the Community Coordinator; Utilization of services; Payment or reimbursement for services.* Objective 2.4.

4. Have changes taken place regarding assessments and services available for parents or caregivers? What kinds of changes? Does anyone have other comments or views on this topic? *Probe for assessments/services (as above).* Objective 2.4

5. In general, how knowledgeable do you think you were before the Court Team project about infant and toddler development and the impact of child abuse and neglect on these children? Is your knowledge any different now? If so, how? What helped you become more informed? *Probe for training, TA, and use of resource material* Objective 2.1; 2.2

6. Do you think this community has experienced any challenges in making the Court Team model work here? Objective 1.3

Appendix D

Court Team Hearing Observation Form

COURT TEAM SITE: _____ **OBSERVER:** _____

COURT TEAM FOR MALTREATED INFANTS AND TODDLERS HEARING OBSERVATION FORM [194]

JUDGE: _____ **HEARING DATE:** _____/_____/_____

HEARING TYPE [195]	*(Check one)*
Emergency Removal, Temporary Custody, Shelter Care	
Pre-Trial Conference; Adversarial	
Adjudication	
Disposition	
Review; Status; Informational (TX)	
Permanency	
Dismissal or Final Order (TX)	
TPR Trial	
Ongoing Placement Review	
Other *(Describe)*	

TIME
Start time: _____ am/pm
End time: _____ am/pm
Total time: _____

_____ Closed hearing
_____ Open to public

HEARING CONTINUANCE

Was the hearing continued? *(Circle one)* YES NO
If YES, the basis for continuance?
If YES, to what date or within what timeframe? *(Circle one)*

Within 2 weeks	Within 1 month	Within 2 months	Within 3 months	Other *(Describe)*

AUDIENCE

Were there people in the audience: YES NO

If YES, did judge ask audience members to identify themselves: YES NO

INDIVIDUALS AT HEARING (Circle or list all that apply)

Court	Judge	Community Coordinator (aka GAL)	Court Reporter	Bailiff
Child protection	County/Prosecuting Attorney	CPS Supervisor	CPS Case worker	CPS Investigator
Parent/Guardian	Mother	Father #1 Father #2	Legal Guardian	Caregiver (foster parent, relative)
Legal Representation	Mother Attorney ad litem *Court-Appointed? YES/NO*	Father(s) Attorney ad litem *Court-Appointed? YES/NO*	Child(ren) Attorney ad litem	Child(ren) Guardian ad litem and/or CASA
Service Providers *(Identify)*				
Other	Translator	Tribal Representative		

[194] This observation tool is adapted from the Minnesota Children's Justice Initiative Hearing Observation Form (Phase 2) (undated) and Missouri Structured Court Observation form (undated).
[195] Hearing names and types will vary by State.

	COURT PROCEEDINGS *(For each question, check the specific action(s) observed)*	YES	NOT DISCUSSED/ OBSERVED	NOT APPLICABLE
OPENING				
	Introduced all parties and attorneys?			
	Determined whether parents had counsel, whether counsel was present, or if necessary advised the parents of their right to counsel? [Will vary across sites]			
	Determined that all necessary parties were present or had been served?			
	If any of the parties were not present or not served, attempted to determine reason?			
	Instructed [name of agency] to continue, if necessary, efforts to notify non-custodial parent(s) and putative father(s)?			
	Explained the purpose of the hearing?			
PROCEDURES				
	Were the proceedings sound recorded or captured by a court reporter?			
	Did any of following call witnesses/ present evidence/ cross examine witnesses (i.e., Judge, County Attorney, Parent or Child Attorney(s), GAL, CASA)? *(circle all that apply)*			
	Did the following testify or make oral statements to the court (i.e., Parent, CPS Supervisor, CPS Caseworker, CASA, Caregiver, Service Provider, ZTT Community Coordinator, Other)? *(circle all that apply)*			
JUDICIAL INQUIRY/FINDINGS				
	Discussed **placement issues,** including continuing need for placement and/or placement alternatives (including discussions regarding placement with relatives) and timetable for reunification?			
	Discussed **parent/child visitation issues**, including type of visitation (e.g., supervised or unsupervised), frequency and duration of visitation, and who will transport parents/children to and from visitation?			
	Discussed **efforts to locate relatives** to serve as placement options or to serve as a family resource?			

COURT PROCEEDINGS *(For each question, check the specific action(s) observed)*	YES	NOT DISCUSSED/ OBSERVED	NOT APPLICABLE
RE THE CHILD: [196] Discussed **service needs of child,** time for completion of assessments and treatment (if any), additional services needed/recommended, and **services to be provided by social services agency to the child** prior to next hearing:			
PHYSICAL HEALTH			
• Has the child received a comprehensive health assessment since entering foster care?			
• Are the child's immunizations complete and up-to-date for his or her age?			
• Has the child received a hearing and vision screen?			
• Has the child received regular dental services?			
• Has the child been screened for communicable diseases?			
• Does the child have a "medical home" where he or she can receive coordinated, comprehensive, continuous care?			
DEVELOPMENTAL HEALTH			
• Has the child received a developmental evaluation by a provider with experience in child development?			
• Are the child and his or her family receiving the necessary early intervention services (e.g., speech therapy, occupational therapy, educational interventions, and family support)?			
MENTAL HEALTH			
• Has the child received a mental health screening, assessment, or evaluation?			
• Has the child received necessary infant mental health services?			
EDUCATIONAL/CHILD CARE SETTING			
• Is the child enrolled in a high-quality early childhood program?			
• Is the early child hood program knowledgeable about the needs of the children in the child welfare systems?			
PLACEMENT			
• Is the child placed with caregivers knowledgeable about the social and emotional needs of infants and toddlers in out-of-home placement, especially young children who have been abused, exposed to violence, or neglected?			
• Do the caregivers have access to information and support related to the child's unique needs?			
• Are the foster parents able to identify problem behaviors in the child and seek appropriate services?			
• Are all efforts being made to keep the child in one consistent placement?			
• Approved, modified, or rejected the case plan and ordered any further examinations, evaluations, or • services that are needed in order to address the needs of the child?			

[196] Questions regarding physical, developmental, mental health, educational/child care setting, and placement needs of the child are derived from *Questions Every Judge and Lawyer Should Ask about Infants and Toddlers in the Child Welfare System* (2002), published by the National Council of Juvenile and Family Court Judges, Reno, Nevada.

COURT PROCEEDINGS *(For each question, check specific action(s) observed)*	YES	NOT DISCUSSED/ OBSERVED	NOT APPLICABLE

RE THE PARENT(S): Discussed **case plan compliance** including**, service needs of parents,** time for completion of assessments and treatment (if any), what parents have accomplished and have yet to accomplish, additional services needed/recommended, resolution of insurance issues (if any), and **services to be provided by social services agency to parents** prior to next hearing. *(Check areas addressed below)*

NOTES	SERVICES AND SUPPORTS	MO	FA	MO	FA	MO	FA
	Child care						
	Child support						
	Domestic violence counseling and/or treatment						
	Education						
	Employment						
	Housing						
	Mental health assessment and/or intervention						
	Parent/child therapy						
	Parenting classes						
	Paternity						
	Physical health exams						
	Social supports						
	Substance abuse testing and/or treatment						
	TANF or emergency assistance						
	Transportation						
	Visitation						
	Other:						
	Other:						

INPUT			
Did the court ask any of the following if they had questions/comments/recommendations (i.e., Parents, Parents' attorneys, GAL, CASA, CPS Supervisor, CPS Caseworker, Caregiver, Service provider, ZTT Community Coordinator, Other?) (*Circle all that apply)*			
CLOSING			
Established date and time of the next hearing before all parties left the court? Type of Hearing:			
Stated findings, decision, and order on record?			
Distributed court orders to all participants before they left the courthouse?			
COMMENTS			

Appendix E

Waiver of Consent and a Waiver of Authorization for Secondary Analysis of a De-Identified, Limited Data Set

WIRB®
WESTERN INSTITUTIONAL REVIEW BOARD®
3535 SEVENTH AVENUE, SW • OLYMPIA, WA 98502-5010
P.O. BOX 12029 • OLYMPIA, WA 98508-2029
(360) 252-2500 • 1-800-562-4789 • FAX (360) 252-2498

October 29, 2008

James DeSantis, Ph.D.
James Bell Associates
1001 19th Street North, Suite 1500
Arlington, Virginia 22209

Dear Dr. DeSantis:

SUBJECT: APPROVAL OF RESEARCH; WAIVER OF CONSENT AND WAIVER OF AUTHORIZATION GRANTED; WAIVER OF DOCUMENTATION OF CONSENT GRANTED; SUBJECT INFORMATION SHEET APPROVED
Sponsor: Office of Justice and Juvenile Delinquency Prevention
WIRB Pr. No.: 20081747 WIRB Study No.: 1102762

Protocol Title: EVALUATION OF COURT TEAMS FOR MALTREATED INFANTS AND TODDLERS PROJECT

At the meeting of October 24, 2008, Western Institutional Review Board (WIRB) reviewed your submission for the above-referenced research. The purpose of this letter is to inform you of the decision of the Board.

The Board voted to **approve** the above-referenced research study. Please note that this letter is supplemental to the WIRB Certificate of Approval for this study.

Waiver of Consent and Waiver of Authorization for Secondary Analysis of a De-Identified, Limited Data Set

WIRB determined that documentation received from you regarding the portion of this research involving a secondary analysis of a de-identified, limited data set pertaining to maltreated infants and toddlers that are under the Court's jurisdiction satisfies the three requirements for a waiver of authorization. These requirements are:

1. The use or disclosure of the PHI involves no more than minimal risk to the individuals, based on the following elements:

    a. An adequate plan to protect identifiers from improper use and disclosure;
    b. An adequate plan to destroy the identifiers at the earliest opportunity consistent with conduct of the research (unless there is a health or research justification for retaining the identifiers, or such retention is otherwise required by law); and
    c. Adequate written assurances that the PHI will not be reused or redisclosed to any other person or entity, except as required by law, for authorized oversight of the research project, or for other research for which the use or disclosure of PHI would be permitted by HIPAA.

2. The research could not be practicably conducted without access to and use of the PHI; and

3. The research could not practicably be conducted without the waiver.

The Board determined that a waiver of authorization for use of the following protected health information is needed and approved for the following purpose:

Data regarding children's health and well-being that have been captured in the Court Teams database and will be de-identified.

The Board also **determined** that this study qualifies for a waiver of consent under 45 CFR 46.116(d), which states:

(1) The research involves no more than minimal risk to the subjects;
(2) The waiver or alteration will not adversely affect the rights and welfare of the subjects;
(3) The research could not practicably be carried out without the waiver or alteration; and
(4) Whenever appropriate, the subjects will be provided with additional pertinent information after participation.

Waiver of Documentation of Consent and Subject Information Sheet

The Board **granted a waiver of documentation of consent** for the portion of the study involving interviews of Court Team Members. The Board determined that all of the required elements for a waiver of documentation of consent were satisfied, and as such, a signed consent form is not required for this research. In granting this waiver of documentation of consent, the Board requires that the submitted document entitled "Research Subject Information Sheet," be read or provided to all subjects at the time of initial consent.

Federal regulation 45 CFR § 46.117(c) explains the requirements for a waiver of documentation of consent. The regulation states "an IRB may waive the requirement for the investigator to obtain a signed consent form if it finds that the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside the research context. In cases where the documentation requirement is waived, the IRB may require the investigator to provide subjects with a written statement regarding the research."

You may address the Board in person or in writing regarding its action. If you wish to address the Board in person or if you have questions, please contact WIRB Regulatory Analyst, J. Claire Brown, J.D., at 360-252-2851, or e-mail RegulatoryAffairs@wirb.com.

Sincerely,

Theodore D. Schultz, J.D.
Chairman

TDS:JCB:jca
W:\Documents\Correspondence\Waiver \DeSantis 20081747
cc: Carol Hafford, Ph.D., James Bell Associates
Jeffrey Gersh, Office of Justice and Juvenile Delinquency Prevention
Dr. Richard W. Seaman, WIRB Panel Six Chair
Study File; Protocol File

Appendix F

Definitions of Child Abuse and Neglect:
Summary of State Laws

Definitions of Child Abuse and Neglect: Summary of State Laws [197]

328th District Court, Fort Bend County, TX	Youth Court Forrest County, MS	Fifth Judicial District of Iowa Polk County	Juvenile Court, Orleans Parish, LA
Neglect			
Fam. Code § 261.001 *Neglect* includes the following acts or omissions by a person: • Placing a child in or failing to remove a child from a situation that a reasonable person would realize requires judgment or actions beyond the child's level of maturity, physical condition, or mental abilities and that results in bodily injury or a substantial risk of immediate harm to the child • Failing to seek, obtain, or follow through with medical care for a child, with the failure resulting in or presenting a substantial risk of death, disfigurement, or bodily injury, or with the failure resulting in an observable and material impairment to the growth, development, or functioning of the child • The failure to provide a child with food, clothing, or shelter necessary to sustain the life or health of the child, excluding failure caused primarily by financial inability, unless relief services had been offered and refused • Placing a child in or failing to remove the child from a situation in which the child would be exposed to a substantial risk of sexual conduct harmful to the child • Placing a child in or failing to remove the child from a situation in which the child would be exposed to acts or omissions that constitute sexual abuse • The failure by the person responsible for a child's care, custody, or welfare to permit the child to return to the child's home without arranging for the necessary care for the child after the child has been absent from the home for any reason, including having been in residential placement or having run away	**Ann. Code § 43-21-105** *Neglected child* means a child: • Whose parent, guardian, custodian, or any person responsible for his or her care or support neglects or refuses, when able so to do, to provide for him or her proper and necessary care or support, education as required by law, or medical, surgical, or other care necessary for his or her well-being • Who is otherwise without proper care, custody, supervision, or support • Who, for any reason, lacks the special care made necessary for him or her by reason of his or her mental condition, whether said mental condition be mentally retarded or mentally ill • Who, for any reason, lacks the care necessary for his or her health, morals, or well-being **Citation: Ann. Code § 43-21-105** **Exceptions:** A parent who withholds medical treatment from any child who in good faith is under treatment by spiritual means alone through prayer in accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practitioner thereof shall not, for that reason alone, be considered to be neglectful.	**Ann. Stat. § 232.68** *Child abuse* or *abuse* means: • The failure on the part of a person responsible for the care of a child to provide for the adequate food, shelter, clothing, or other care necessary for the child's health and welfare when financially able to do so or when offered financial or other reasonable means to do so • The presence of an illegal drug in a child's body as a direct and foreseeable consequence of the acts or omissions of the person responsible for the care of the child • That the person responsible for the care of a child has, in the presence of the child, manufactured a dangerous substance or possesses a product containing ephedrine, its salts, optical isomers, salts of optical isomers, or pseudoephedrine, its salts, optical isomers, or salts of optical isomers, with the intent to use the product as a precursor or an intermediary to a dangerous substance • Cohabitation with a person listed on the sex offender registry	**Ch. Code art. 603** *Neglect* means the refusal or unreasonable failure of a parent or caretaker to supply the child with necessary food, clothing, shelter, care, treatment, or counseling for any injury, illness, or condition of the child, as a result of which the child's physical, mental, or emotional health and safety is substantially threatened or impaired. Neglect includes prenatal neglect. *Prenatal neglect* means the unlawful use by a mother during pregnancy of a controlled dangerous substance that results in symptoms of withdrawal in the infant or the presence of a controlled substance in the infant's body. **Exceptions** **Ch. Code art. 603** The inability of a parent or caretaker to provide for a child due to inadequate financial resources shall not, for that reason alone, be considered neglect. Whenever, in lieu of medical care, a child is being provided treatment in accordance with the tenets of a well-recognized religious method of healing that has a reasonable, proven record of success, the child shall not, for that reason alone, be considered to be neglected or maltreated. Nothing in this section shall prohibit the court from ordering medical services for the child when there is substantial risk of harm to the child's health or welfare.

[197] Summarized from *Definitions of Child Abuse and Neglect: Summary of State Laws.* Accessed September 5, 2008 http://www.childwelfare.gov/systemwide/laws_policies/state/index.cfm?event=stateStatutes.processSearch.

328th District Court, Fort Bend County, TX	Youth Court Forrest County, MS	Fifth Judicial District of Iowa Polk County	Juvenile Court, Orleans Parish, LA
Physical Abuse			
Fam. Code § 261.001 *Abuse* includes the following acts or omissions by a person: • Physical injury that results in substantial harm to the child or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident or reasonable discipline by a parent, guardian, or conservator that does not expose the child to a substantial risk of harm • Failure to make a reasonable effort to prevent an action by another person that results in physical injury or substantial harm to the child • The current use by a person of a controlled substance, in a manner or to the extent that the use results in physical, mental, or emotional injury to a child • Causing, expressly permitting, or encouraging a child to use a controlled substance **Citation: Fam. Code § 261.001** **Exceptions:** Abuse does not include reasonable discipline by a parent that does not expose the child to substantial risk of harm.	**Ann. Code § 43-21-105** *Abused child* means a child whose parent, guardian, custodian, or any person responsible for his or her care or support, whether legally obligated to do so or not, has caused or allowed to be caused upon the child nonaccidental physical injury or other maltreatment. **Ann. Code § 43-21-105** **Exceptions:** Physical discipline, including spanking, performed on a child by a parent, guardian, or custodian in a reasonable manner shall not be deemed abuse under this section.	**Ann. Stat. § 232.68** *Child abuse* or *abuse* means any nonaccidental physical injury, or injury that is at variance with the history given of it, suffered by a child as the result of acts or omissions of a person responsible for the care of the child.	**Ch. Code art. 603** *Abuse* means any one of the following acts that seriously endanger the physical, mental, or emotional health and safety of the child: • The infliction, attempted infliction, or, as a result of inadequate supervision, the allowance of the infliction or attempted infliction of physical or mental injury upon the child by a parent or any other person • The exploitation or overwork of a child by a parent or any other person • *Crime against the child* includes homicide, battery, assault, kidnapping, or cruelty to juveniles.
Sexual Abuse			
Fam. Code § 261.001 *Abuse* includes the following acts or omissions by a person: • Sexual conduct harmful to a child's mental, emotional, or physical welfare, including conduct that constitutes the offense of indecency with a child, sexual assault, or aggravated sexual assault • Failure to make a reasonable effort to prevent sexual conduct harmful to a child • Compelling or encouraging the child to engage in sexual conduct • Causing, permitting, encouraging, engaging in, or allowing the photographing, filming, or depicting of the child if the person knew or should have known that the resulting photograph, film, or depiction of the child is obscene or pornographic • Causing, permitting, encouraging, engaging in, or allowing a sexual performance by a child	**Ann. Code § 43-21-105** *Abused child* includes sexual abuse or sexual exploitation. *Sexual abuse* means obscene or pornographic photographing, filming, or depiction of children for commercial purposes, or the rape, molestation, incest, prostitution, or other such forms of sexual exploitation of children under circumstances that indicate that the child's health or welfare is harmed or threatened.	**Ann. Stat. § 232.68** *Child abuse* or *abuse* means: • The commission of a sexual offense with or to a child • Allowing, permitting, or encouraging the child to engage in prostitution • The commission of bestiality in the presence of a minor by a person who resides in a home with a child, as a result of the acts or omissions of a person responsible for the care of the child	**Ch. Code art. 603** *Abuse* includes any one of the following acts that seriously endanger the physical, mental, or emotional health of the child: • The involvement of the child in any sexual act with a parent or any other person • The aiding or toleration by the parent or caretaker of the child's sexual involvement with any other person • The aiding or toleration by the parent of the child's involvement in pornographic displays • Any other involvement of a child in sexual activity constituting a crime under the laws of the State

			Child pornography means visual depiction of a child engaged in actual or simulated sexual intercourse, deviate sexual intercourse, sexual bestiality, masturbation, sadomasochistic abuse, or lewd exhibition of the genitals. *Crime against a child* includes rape, sexual battery, incest, carnal knowledge of a juvenile, indecent behavior with a juvenile, pornography involving juveniles, or molestation of a juvenile.
Emotional Abuse			
Fam. Code § 261.001 *Abuse* includes the following acts or omissions by a person: • Mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning • Causing or permitting the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment in the child's growth, development, or psychological functioning	**Ann. Code § 43-21-105** *Abused child* includes emotional abuse or mental injury.	**Ann. Stat. § 232.68** *Child abuse* or *abuse* means any mental injury to a child's intellectual or psychological capacity as evidenced by an observable and substantial impairment in the child's ability to function within the child's normal range of performance and behavior as the result of the acts or omissions of a person responsible for the care of the child, if the impairment is diagnosed and confirmed by a licensed physician or qualified mental health professional.	**Ch. Code art. 603** *Abuse* includes any act that seriously endangers the mental or emotional health of the child or inflicts mental injury.
Abandonment			
Fam. Code § 261.001 *Neglect* includes the leaving of a child in a situation where the child would be exposed to a substantial risk of physical or mental harm, without arranging for necessary care for the child, and the demonstration of intent not to return by a parent, guardian, or conservator of the child.	This issue is not addressed in the statute.	This issue is not addressed in the statute.	**Ch. Code art. 603** *Crime against the child* includes criminal abandonment of a child.

Appendix G

Court Hearings for the Permanent Placement of Children: Summary of State Laws

Court Hearings for the Permanent Placement of Children: Summary of State Laws

328th District Court, Fort Bend County, TX	Youth Court Forrest County, MS	Fifth Judicial District of Iowa Polk County
Permanency Options		
Fam. Code § 263.306 • Return to the parent • Adoption • Placement in a permanent managing conservatorship	**Ann. Code § 43-15-13** The following permanency options may be considered: • Return to the parent • Adoption • Placement with a relative • Another safe and adequate placement for a child who cannot return home or be placed for adoption	**Ann. Stat. § 232.104(2)** The court may consider the following permanency options: • Return to the parent • Termination of parental rights and adoption of the child • Transfer of custody from one parent to another parent • Guardianship • Transfer of custody to a suitable person • Another planned, permanent living arrangement when there is a compelling reason that another permanent • placement is not in the child's best interest
Schedule of Hearings		
Fam. Code §§ 263.201; 263,304; 263.305; 262.2015 A status hearing shall be held no later than 60 days after the child is placed to review the child's status and service plan. A permanency hearing shall be held: • No later than 180 days after the child is placed and subsequent hearings no later than 120 days thereafter • Within 30 days of a finding that reasonable efforts are not required	**Ann. Code § 43-15-13** An administrative review shall be completed on each child within the first 3 months and a foster care review once every 6 months after the child's initial 48-hour shelter hearing.	**Ann. Stat. § 232.104** A permanency hearing shall be held: • Within 12 months of the date the child was removed from the home • Within 30 days in a case where the reasonable efforts requirement has been waived
Persons Entitled to Attend Hearings		
Fam. Code §§ 263.301; 263.302 Notice of the permanency hearing shall be provided to: • The department • The foster parent, preadoptive parent, relative providing care, or the director of the group home where the child resides • Each parent of the child • The managing conservator or guardian of the child • An attorney *ad litem* • A volunteer advocate • Any other person or agency named by the court to have an interest • The child shall attend each permanency hearing unless the court specifically excuses the child's attendance.	**Ann. Code § 43-15-13** The following persons may be present at the hearing: • The parent • The foster parent • The grandparents • The guardian *ad litem* • Representatives of any private care agency that has cared for the child • The family protection worker or family protection specialist assigned to the case	**Ann. Stat. § 232.91** Any hearings or proceedings shall not take place without the presence of the child's parent, guardian, custodian, or guardian *ad litem.* A parent without custody may petition the court to be made a party to the proceedings. An agency, facility, institution, or person, including a foster parent or an individual providing preadoptive care, may petition the court to be made a party to the proceedings.

328th District Court, Fort Bend County, TX	Youth Court Forrest County, MS	Fifth Judicial District of Iowa Polk County
Determinations Made at Hearings		
Fam. Code § 263.306 At each permanency hearing the court shall determine: • The parties' compliance with temporary orders and the service plan • Whether the child continues to need substitute care • Whether the child's current placement is appropriate for meeting the child's needs • Whether other plans or services are needed to meet the child's special needs or circumstances • If the child is placed in institutional care, whether efforts have been made to ensure placement of the child in the least restrictive environment consistent with the best interest and special needs of the child • If the child is 16 or older, what services are needed to assist the child in making the transition from substitute care to independent living • The extent of progress that has been made toward alleviating or mitigating the causes necessitating the placement of the child in foster care • Whether the department has made reasonable efforts to finalize the permanency plan that is in effect for the child	**Ann. Code § 43-15-13** The review shall include at a minimum an evaluation of the child based on the following: • The extent of the care and support provided by the parents while the child is in temporary custody • The extent of communication with the child by parents or guardian • The degree of compliance by the agency and the parents with the social service plan established • The methods of achieving the goal and the plan establishing a permanent home for the child • Social services offered and/or utilized to facilitate plans for establishing a permanent home for the child	**Ann. Stat. § 232.104** At each hearing, the court shall determine: • Whether services have been offered to the family to correct the situation that led to the child's removal from home • The sufficiency of the services being provided and whether additional services are needed to facilitate the safe return of the child to the child's home • Whether the best interests of the child are being served • Whether reasonable progress is being made to achieve the permanency goal

Appendix H

Court Team Database Tables and Variables Used in the Analyses

Court Team Database Tables and Variables Used in the Analyses

Table		Court Team Database Table	Variables	N =	All-Sites	Site-Specific
III-A1	Status of Open/Closed Cases by Family	Family Detail Child Case Status	- Site - Family ID - Case Status - Case Open Date - Case Close Date - Case Reopen Date - Number of Children Involved in Case - Child ID	N = 150 All families and all children	Yes	Yes
III-A2a	Characteristics of Infants & Toddlers served by the Court Teams	Child Background	- Site - Child ID - Date Of Birth - Race - Gender - Primary Language at Home (If other, please describe) - Family Meets Federal Definition of Poverty - Father's Name is on Birth Certificate	N=186	Yes	Yes
III-A2b	Number of Siblings and Removal Status	Child Background	- Site - Child ID - Number of Siblings with this Mother - Other Children Previously Removed	N=186	Yes	Yes
III-A3a	Reasons for Removal: All Children	Reasons Removed	- Site - Child ID - Abandonment - Alcohol/Drugs a factor in removal - Medical neglect - Mental illness a factor in removal - Neglect - Other abuse - Physical abuse - Psychological maltreatment - Sexual Abuse	N=186	Yes	Yes
III-A3b	Parental Risk Factors cited as Reasons for Removal	Reasons Removed	- Site - Child ID - Alcohol/Drugs a factor in removal - Mental illness a factor in removal	N=186	Yes	Yes
III-A4	Key Health Indicators at Case Opening	Child Background	- Site - Child ID - Health Needs At Intake - Premature Birth - Low Birth Weight - Small for Gestational Age	N=186	Yes	Yes

Table		Court Team Database Table	Variables	N =	All-Sites	Site-Specific
			- Medically Fragile - Physical Disability - Failure to Thrive - Exposure to Parental o Substance Abuse o Smoking o Domestic Violence			
III-B1a	Type of Placement: All children	Child Placement	- Site - Child ID - Start Date - End Date - Type (Birth parent; Relative placement; Nonrelative placement; Foster Adopt home; Medical foster home; Therapeutic foster care; Other foster parent; Group home; Crisis nursery; Shelter; Hospital; Temporary Placement)	N=372 All placements excluding hospital	Yes	Yes
III-B1b	Location of Placements: All children and all types	Child Placement	- Site - Child ID - Location	N=386 all placements types	Yes	Yes
III-B1c	Placement with Relatives	Child Placement	- Site - Child ID - With Who? - Birthparent in home with child?	N=141	Yes	No
III-B2a	Type of Family Contact Ordered at Case Initiation	Visitation	- Site - Child ID (Multiple records per child) - Type of Visitation o Supervised o Unsupervised o Other	N=186	Yes	No
III-B2b	Type of Family Contact by Last Month of Recorded Visit	Visitation	- Site - Child ID (Multiple records per child) - Frequency of Visitation o Once a Week o Twice a Week o Other - Notes	N=186	Yes	No
III-B2c	Frequency of Family Contact Ordered at Case Initiation	Visitation	- Site - Child ID (Multiple records per child) - Frequency of Visitation o Once a Week o Twice a Week o Other - Notes	N=186	Yes	No

Table		Court Team Database Table	Variables	N =	All-Sites	Site-Specific

III-B2d	Frequency of Family Contact by Last Month of Recorded Visit	Visitation	- Site
			- Child ID (Multiple records per child)
			- Frequency of Visitation
			  o Once a Week
			  o Twice a Week
			  o Other
			- Notes
				N=186	Yes	No

III-B2e	Number of Changes in Family Contact by Site	Visitation	- Site
			- Child ID (Multiple records per child)
			- Frequency of Visitation
			  o Once a Week
			  o Twice a Week
			  o Other
				N=186	Yes	Yes

III-B3a	Service Needs in Progress: All cases	Monthly Service Progress	- Site
			- Child ID (Multiple records per child)
			- Year
			- Month
			- Service Need (Dental care; developmental screening; Early Intervention Early Head Start/Head Start; family counseling; full developmental assessment; hearing services; IFSP developed; immunizations; infant mental health services; other early childhood education; parent-child psychotherapy; parent-child relationship evaluation; primary health care visit; psychological evaluation; specialist health care visit; and vision services).
			- Status
			  o Service plan achieved for this service
			  o Making progress on this service
			  o No/minimal progress on this service
			- If Minimal Progress: Main Reason Why?
				Varies by service need	Yes	No

III-B3b	Parent-Child Relationship Evaluation and Psychotherapy: Referrals and Utilization	Monthly Service Progress	- Site - Child ID (Multiple records per child) - Year - Month - Service Need (parent-child psychotherapy; parent-child relationship evaluation) - Status - If Minimal Progress: Main Reason Why?	N=186	Yes	Yes

Table		Court Team Database Table	Variables	N =	All-Sites	Site-Specific
III-C1	Cases Re-opened on a Court Team Family	Family Detail Child Case Status	- Site - Family ID - Case Status - Site - Child ID - Case Open Date - Case Close Date - Case Re-open Date	N=150	Yes	Yes
III-C2a	Number of Placements: All sites	Placement	- Site - Child ID (Multiple records per child) - Start Date - End Date - Type (Birth parent; Relative placement; Nonrelative placement; Foster Adopt home; Medical foster home; Therapeutic foster care; Other foster parent; Group home; Crisis nursery; Shelter; ~~Hospital~~; Temporary Placement)	N=184	Yes	No
III-C2b	Number of Placements by Time in Care: All sites	Child Case Status Placement	- Site - Child ID - Case Open Date - Case Close Date - Site - Child ID (Multiple records per child) - Start Date - End Date - Type (Birth parent; Relative placement; Nonrelative placement; Foster Adopt home; Medical foster home; Therapeutic foster care; Other foster parent; Group home; Crisis nursery; Shelter; Hospital; Temporary Placement)	N=88 closed cases only	Yes	No
III-C3a	Child Primary Permanency Goal	Child Case Status	- Site - Child ID - Primary Permanency Goal	N=149 (for whom complete permanency data were available)	Yes	Yes
III-C3b	Child Concurrent Plan Goal	Child Case Status	- Site - Child ID - Concurrent Plan	N=149 (for whom complete permanency data were available)	Yes	Yes

Table		Court Team Database Table	Variables	N =	All-Sites	Site-Specific
III-C4a	Case Status as of December 31, 2008	Child Case Status	- Site - Child ID - Case Open Date - Case Close Date	N=186	Yes	Yes
III-C4b1	Achievement and Non-achievement of Permanency	Child Case Status	- Site - Child ID - Outcome: Child Permanency	N=88 (closed cases as of December 2008)	Yes	Yes
III-C5a	Median Days from Petition to Permanent Placement	Child Background Child Case Status	- Site - Child ID - Date of Court Order - Site - Child ID - Outcome: Child Permanency - Date Child Placed o with or Living with Parent o with Relative with Legal Custody o with Adoptive Parent - Notes	N=77 (closed cases as of December 2008)	Yes	Yes
III-C5c	Time to Permanency	Child Background Child Case Status	- Site - Child ID - Date of Court Order - Site - Child ID - Outcome: Child Permanency - Date of Determination of Child Permanency	N=84	Yes	Yes
III-12b	Time to Termination of Parental Rights	Child Background Child Case Status	- Site - Child ID - Date of Court Order - Site - Child ID - Outcome: Parental Rights - Date of Determination of Child Permanency - Notes	N=15	Yes	Yes

Appendix I

Placement types

ZERO TO THREE Court Teams for Maltreated Infants and Toddlers: Database Users' Guide

Placement types, as noted in the ZERO TO THREE Court Teams for Maltreated Infants and Toddlers *Database Users' Guide:*

Relative placement: A relative is a person connected to the child by blood, such as parents, siblings, and grandparents. *(Source: Child Maltreatment 2004)*

Nonrelative placement: A friend is a nonrelative acquainted with the child, the parent, or caregiver. *(Source: Child Maltreatment 2004)*

Foster adopt home: A foster parent is an individual licensed to provide a home for orphaned, abused, neglected, delinquent, or disabled children, usually with the approval of the government or a social service agency. *(Source: 2004 Child Maltreatment).* A foster/adopt parent is ready to adopt the child if not reunited.

Medical foster care: A description of two medical foster care programs: 1) Serve children of all ages with severe and chronic medical conditions such as cerebral palsy, HIV/AIDS, congenital heart disease, cancer, hydrocephalus, seizure disorders, diabetes, and Down's Syndrome. Specially recruited and medically trained foster parents who are required to participate in ongoing training and support groups care for the children. Staff are available to assist foster parents 24 hours a day…..*(source: Children's Aid Society)* 2) The Medical Foster Care (MFC) Program allows a foster child with a chronic medical condition to grow and develop in a family setting in a state licensed foster home. Medical foster parents are trained and certified as Medicaid providers of personal care services for these children….services include a 24-hour call in system for medical support to the medical foster parents. The MFC nurse and social worker provide support and coordinate care for the children with hospitals, equipment providers, therapists, health facilities, schools, foster care staff and families…. *(source: Children's Medical Services)*

Therapeutic foster care: *Therapeutic foster care*, also known as therapy foster care, cluster therapeutic foster care and family-based treatment is provided as an alternative to incarceration, hospitalization, or other forms of group and residential treatment for adolescents with a history of chronic antisocial behavior, delinquency, or emotional disturbance. It is also used to advance multiple public health goals among a number of populations. Participants are placed for several months in foster families (one or two participants per family) who are specially trained and compensated for their work. During the program, participants are provided a structured environment where they are rewarded for positive social behavior and penalized for disruptive and aggressive behavior. Therapeutic foster care also separates program juveniles from their delinquent peers and provides close supervision at school as well as home. *(The Guide to Community Preventive Services, sponsored by CDC)*

Other foster parent: A foster parent is an individual licensed to provide a home for orphaned, abused, neglected, delinquent, or disabled children, usually with the approval of the government or a social service agency. *(Source: 2004 Child Maltreatment)* This category would include a non-relative foster parent who is <u>not</u> in a position to adopt the child if parental rights are terminated.

Group home (or residential care): A nonfamilial 24-hour care facility that may be supervised by the State Agency or governed privately. *(Source: 2004 Child Maltreatment).*

Crisis Nursery: An emergency facility designed to prevent the occurrence of abuse or neglect by assuming immediate child care responsibility to alleviate stress on caretakers who are experiencing a crisis. (*Source: Ohio Department of Job and Family Services*).

Shelter: Emergency shelter means any facility, the primary purpose of which is to provide temporary or transitional shelter for the homeless in general or for specific populations of the homeless. *(Source: U.S. Department of Housing and Urban Development).*