

# Practice & Policy Brief



## Healing the Youngest Children:

Model Court-Community Partnerships

March 2007

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**About the ABA's Improving Understanding of Maternal and Child Health Project:** This project seeks to enable legal professionals to improve the health outcomes for vulnerable young children who are involved in the legal and judicial systems. It will develop new materials and provide training and technical assistance to improve child health-related knowledge and skills of attorneys and judges who handle cases involving young children.

**About the ZERO TO THREE Policy Center:** The ZERO TO THREE Policy Center is a research-based, nonpartisan program at ZERO TO THREE that brings the voice of babies and toddlers to public policy at the federal, state, and community levels by translating scientific research into language that is accessible to policymakers, cultivating leadership in states and communities, and studying and sharing promising state and community strategies.

**About the ABA Center on Children and the Law:** The ABA Center on Children and the Law, a program of the Young Lawyers Division, aims to improve children's lives through advances in law, justice, knowledge, practice, and public policy. Its areas of expertise include child abuse and neglect, child welfare and protective services system enhancement, foster care, family preservation, termination of parental rights, parental substance abuse, child and adolescent health, and domestic violence.

Photos by EyeWire

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## Introduction

Very young children in the child welfare system are at great risk for long-term harm because their brains are developing more rapidly than at any other time in their lives. By age three, a baby's brain is 85 percent of its adult size.<sup>1</sup> The brain is laying down the pathways that will ultimately govern the child's reactions to events—long after he or she becomes an adult.

Early relationships provide the foundation that determines whether a baby's brain is hard-wired for social and emotional well-being or isolation and failure. Stress and trauma alter brain development and how chronically neglected children view the world. Maltreated babies are at great risk for future school failure, juvenile justice system involvement, and other poor developmental outcomes.<sup>2</sup>

Overall, the younger the child, the greater the child victimization rate:

- Among all children found to be abused or neglected in 2004, 10.3 percent were less than one year of age and 29.4 percent were ages birth to three years.<sup>3</sup>
- In 2005, 15 percent of children who entered foster care were less than one year old, and 33 percent were ages zero to three.<sup>4</sup>
- As a group, infants and toddlers are 32 percent more likely to be placed in foster care than children ages 4 to 11.<sup>5</sup>

Infants also stay in foster care longer than older children:<sup>6</sup>

- Half the babies who enter foster care before they are three months old spend 31 months or longer in placement.<sup>7</sup>
- One-third of all infants discharged from foster care reenter the child welfare system.<sup>8</sup>

The relationships between young children and their neglectful or abusive parents have been damaged by the events that brought them to the child welfare system. The science of early childhood is shaping effective approaches for healing those relationships and getting young children and their families back on track. Using scientific knowledge, legal professionals in the child welfare system can make informed decisions and advocate for programs and policies that protect and promote permanency for the youngest children in care.<sup>9</sup>

Research shows<sup>10</sup> that achieving permanency and stability in the living arrangements of children in foster care correlates with:

- *Caseworker consistency*: A single change in social worker decreases the chances of permanency within 12 months by 52 percent.
- *Fewer placements*: Each additional placement during the first year decreases the chances of achieving permanency by 32 percent.
- *More frequent parental visitation*: Each additional day per week triples the odds that permanency will be achieved within a year.
- *Concurrent planning*: When reunification and another permanency goal are pursued from the outset, children reach permanency faster.

## From Neurons to Neighborhoods

In 2000, the National Research Council and the Institute of Medicine published *From Neurons to Neighborhoods: The Science of Early Childhood Development*, which provides scientific evidence to support focused interest on infants and toddlers. Among its findings are the following:

- From birth to age 5, children rapidly develop foundational capabilities on which subsequent development builds. In addition to their remarkable linguistic and cognitive gains, they exhibit dramatic progress in their emotional, social, regulatory, and moral capacities. All of these critical dimensions of early development are intertwined, and each requires focused attention.
  - Striking disparities in what children know and can do are evident well before they enter kindergarten. These differences are strongly associated with social and economic circumstances, and they are predictive of subsequent academic performance. Redressing these disparities is critical, both for the children whose
- life opportunities are at stake and for a society whose goals demand that children be prepared to begin school, achieve academic success, and ultimately sustain economic independence and engage constructively with others as adult citizens.
- Early child development can be seriously compromised by social, regulatory, and emotional impairments. Indeed, young children are capable of deep and lasting sadness, grief, and disorganization in response to trauma, loss, and early personal rejection.<sup>1</sup>

<sup>1</sup>Shonkoff, Jack P. and Deborah A. Phillips, eds. *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Washington, DC: National Academies Press, 2000, 5.

This brief describes four model court-community partnerships that apply research to court practices to improve outcomes for maltreated infants, toddlers, and their families.

- *Court Teams for Maltreated Infants and Toddlers*, based on the groundwork of the Miami-Dade County Juvenile Court, and functioning in Fort Bend County, Texas; Des Moines, Iowa; Hattiesburg, Mississippi; Orleans Parish, Louisiana; and Allegheny County, Pennsylvania
- *Babies Can't Wait*, a project of the New York State Permanent Judicial Commission on Justice for Children, begun in the Bronx and later expanded statewide
- *Best for Babies*, first convened by Prevent Child Abuse Arizona, and serving Yavapai County, Arizona
- *Zero to Three Family Drug Treatment Court*, a family drug treatment court that focuses on children ages three and younger in Omaha, Nebraska

The four models share 13 components that fuel their success:

*Systems Change*

1. Judge as leader and catalyst
2. Dedicated local staff with child development expertise to work with the judge
3. Court-community team
4. Attorneys who know about the needs of very young children

*Focus on Services for Very Young Children*

5. Research-based interventions
6. Access to early intervention (EI) services (See page 20, for information about EI screening and services mandated under Part C of the Individuals with Disabilities Education Act.)
7. Mental health services for children and parents

*Procedural Enhancements*

8. Frequent case monitoring and tracking
9. Child-focused court-ordered services
10. Ongoing training and technical assistance
11. Resources for professionals and parents

*Sustainability Efforts*

12. Funding
13. Program evaluation

Part I describes each model and includes a sample case showing how each project operates. Part II focuses on the 13 common components and how each model applies them. In addition, it features practice tips for attorneys and judges interested in implementing a court-community partnership focused on infants and toddlers in the child welfare system. These tips focus on core elements of such partnerships.



## Part I: The Models

### Court Teams for Maltreated Infants and Toddlers

**Fort Bend County, Texas; Des Moines, Iowa; Hattiesburg, Mississippi;  
Orleans Parish, Louisiana; and Allegheny County, Pennsylvania**

The goals of the Court Teams for Maltreated Infants and Toddlers are to (1) improve outcomes for maltreated infants and toddlers, (2) reduce the recurrence of abuse and neglect, and (3) change the court's culture to focus on the needs of infants and toddlers.

The Court Teams project has its roots in Miami, Florida, in the courtroom of Judge Cindy Lederman. Her mission was to break the cycle of intergenerational violence and heal children and families. Recognizing her docket included second and third generations of abusive and neglectful parents, she partnered with Dr. Joy Osofsky, professor of pediatrics and psychiatry at Louisiana State University Health Sciences Center, to develop new strategies to evaluate and heal troubled parent-child relationships. The partnership expanded to the University of Miami's Linda Ray Intervention Center, and the project obtained financial support as one of the Safe Start sites funded by the Office of Juvenile Justice and Delinquency Prevention and as part of a Florida Department of Children and Families' Young Child Mental Health Pilot Project. Success with these seminal projects laid the groundwork in Miami to develop the Court Teams project.

Working with the Miami Court Team, ZERO TO THREE developed a project to work with juvenile and family court judges to improve the health and well-being of the youngest victims of abuse and neglect. ZERO TO THREE identified judges for its Court Teams for Maltreated Infants and Toddlers and designed a two-phase process to be implemented in juvenile and family courts in five communities.

- *Phase 1.* Develop a partnership between a judge and a local community coordinator to establish a court-community team composed of key child-serving stakeholders, build knowledge and raise awareness of the needs of young children in foster care, and complete a community needs assessment that identifies available services and gaps.
- *Phase 2.* Provide additional services for babies, starting with court-ordered referrals for health and dental care, quality child care, behavioral and developmental assessments, therapeutic services, and frequent visits with parents.

Local statistics supported the need for the project in each jurisdiction. For example, in 2004, children ages three and younger accounted for 21 percent of Iowa's child population but more than 34 percent of the victims of maltreatment, a discrepancy that highlights the special vulnerability of the youngest children."

#### Sample Case<sup>12</sup>

*Case Facts.* It was late, and six-month-old Becky was crying again. Jane had only been back at work a few weeks and was having difficulty balancing family responsibilities and her job. Sleep deprivation was making her resent Becky's late-night demands. Standing by the crib, she patted Becky's back, trying to get her to sleep. When the crying did not stop, Jane picked her up, rigid with anger. Becky, sensing her mother's agitation, got more upset. Finally, Jane couldn't stand it and threw Becky into her crib. Becky's head hit the crib before she landed on her back. Jane, now remorseful and frightened, picked Becky up and gently rocked her until she fell asleep.

The next day, Jane took Becky to the pediatrician to ask about a fever Becky had developed and bruising on her back. A CAT scan showed a fractured skull and hemorrhaging, and the doctor noted lacerations on both sides of Becky's tongue. Police investigated and a few weeks later Jane admitted throwing Becky into the crib. Child protective services (CPS) promptly removed Becky from her parents' care.



*Intervention.* Before the first court hearing, the family appeared at mediation with a private attorney. A CPS investigator, county attorney, and the Court Team community coordinator, a child development expert, attended the meeting. Although the community coordinator tried explaining the family reunification process, the parents and their attorney were angry, defiant, and reluctant to agree to any intervention.

The Court Team judge heard the case two weeks later. Knowledgeable about babies' needs, he explained the goal of the court's intervention was to help the family achieve reunification. He made it clear that the parents would have a chance to resolve the issues that brought their child into the child welfare system and that he, the attorneys, caseworker, and agency representatives would work with them to resolve the underlying complaint. He introduced the Court Team members who would work with the parents and explained the court appointed special advocate's (CASA's) role in monitoring Becky's well-being. He told the parents that they would meet monthly with the team to review their progress. Using a form developed by the Court Team, he ordered a developmental evaluation of Becky, follow-up pediatric visits to monitor Becky's head injury, and a dental consult. He also ordered psychological evaluations for the parents, counseling, parenting skills training, a substance abuse evaluation, and anger management classes. Becky went to live with Jane's mother. Initially, the judge ordered supervised visitation in the family home for four hours daily—much longer and more frequent than typical visits because babies need more time with their parents to promote strong relationships.

Both parents complied with the court orders. Every 30 days, the judge held a review hearing with the parents, Jane's mother, and the Court Team, where the parents and the service providers reported on their successes. Jane's mother and the CASA described the parents' visits with Becky and Jane's improving ability to respond appropriately to her baby's fussy moods.

*Outcome.* The baby's evaluation showed she was developmentally on target. Medical follow-up showed her skull fracture was healing and the hemorrhaging and tongue lacerations had resolved. The parents' substance abuse evaluation found no addiction problem. The counseling helped Jane and her husband develop a better partnership for parenting tasks. After four months, visits were expanded to six hours every day and unsupervised overnight visits on the weekend. The community coordinator described the court hearings as therapeutic for the parents.

Five months after Becky's removal, the family was reunified. At a hearing a month after reunification, things were going well at home, and Jane was happy and coping well with her parenting. The family remains under court supervision. The court order includes unannounced visits by Becky's CASA and the CPS caseworker and continuing services. The Court Team will continue to monitor the case every 30 days. After six months, the case will be dismissed if no new CPS allegations are brought and the family continues to use the services and supports provided.

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## Babies Can't Wait

### New York, New York

Babies Can't Wait (BCW) is a project of the New York State Permanent Judicial Commission on Justice for Children.<sup>13</sup> BCW identifies, documents, and tracks infants in family court; provides for their special health and developmental needs; and promotes permanency.<sup>14</sup> BCW projects are underway in New York City; Erie County, New York (includes Buffalo); Monroe County, New York (includes Rochester); and Philadelphia, Pennsylvania.<sup>15</sup>

The BCW projects in these communities are improving the response to infants and toddlers in the child welfare system through three major tasks: (1) providing training on infant health and development to those working in the court and child welfare systems, (2) creating a judge's bench card for infants that addresses the special developmental and medical needs of infants, and (3) working with the child welfare agency to improve how cases involving infants are handled.<sup>16</sup> In addition, the BCW process includes the following five components to improve health outcomes for infants in foster care:

1. Identify and convene local stakeholders.
2. Provide judicial leadership.
3. Build knowledge and offer accessible ways to share that knowledge.
4. Create a favorable climate for collaborative problem solving.
5. Collect data that will help drive program design and training content, and shape service plans and court orders.<sup>17</sup>

### Sample Case<sup>18</sup>

*Case Facts.* Born prematurely at 27 weeks' gestation, Jamal weighed one pound, 12 ounces, and tested positive for cocaine. At the time of his birth, his three older siblings were all in foster care. His mother walked out of the hospital shortly after his birth. Jamal remained in the hospital for three months with no visitors. During his hospital stay, he was treated for a heart defect and retinopathy. At his three-month birthday, he had gained sufficient weight for discharge.

*Intervention.* Jamal was taken directly from the hospital into foster care. His case was assigned to the Brooklyn Family Court. Before the first hearing, the BCW early childhood specialist reviewed the case and shared potential questions and concerns with the judge. The judge ordered:

- an investigation into why the child had not been placed in care during his hospital stay
- appointment of a CASA to find answers to the infant checklist questions (see page 18) and ensure Jamal was referred to early intervention (EI) services
- a diligent search for the baby's mother, which ended several weeks later when she was found murdered

Efforts to locate Jamal's father were unsuccessful. Jamal was assigned to a foster care agency specializing in medically fragile children, and the agency placed him with a foster mother with experience caring for such children.

Jamal's CASA worked to answer the checklist questions. She learned that Jamal had many complicated health issues and was on three medications. The CASA urged Jamal's caseworker to make a referral for an EI screening. When she received the screening results, the CASA learned that Jamal had been found ineligible for services because he met the developmental milestones expected at his age. Because the early childhood specialist knew that developmental delays often do not emerge until babies are 9 to 12 months, she and the CASA pressed for rescreening.

Thirty days after the initial hearing, the early childhood specialist met with Jamal's CASA to review the case. The CASA reported that family resources did not exist for the baby but he was doing well in his foster home. He required laser surgery, which was performed successfully. Over the months preceding the six-month permanency hearing, the CASA and early childhood specialist met monthly to review Jamal's case. As a result of their persistent efforts, Jamal was finally found eligible for EI services.

At the permanency hearing, the judge reviewed the CASA's report, which was organized around the BCW infant checklist questions and detailed Jamal's well-being. He was visiting the pediatrician once a month. Soon he would receive physical therapy and other EI services in his foster home. The judge asked about changing Jamal's goal to adoption and learned that his foster mother wanted to adopt him. The judge ordered continuing services, including CASA monitoring. She changed Jamal's permanency goal to adoption and ordered the adoption process to begin.

*Outcome.* At age one, Jamal had another permanency hearing. He weighed 12 pounds and was gaining weight. His heart and eye problems were being monitored monthly, and he was receiving physical and speech therapy. Jamal continued to do well in his foster home. All the paperwork necessary to begin the adoption process had been filed, and the judge expected the adoption to be finalized soon.

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## Best for Babies

### Yavapai County, Arizona

Children ages three and younger represent approximately 23 percent of Arizona's child population, but they account for 39 percent of the substantiated reports of child abuse and neglect.<sup>19</sup> This special vulnerability galvanized support for Best for Babies (B4B). Like the other models described in this brief, the people who brought B4B to life knew one another and had worked together for many years. They developed a Yavapai County checklist of essential services for the community's most vulnerable children, delineating the responsibilities of the CPS caseworker; foster parents; West Yavapai Guidance Clinic, a nonprofit provider of mental health services for children and adults; and "Systems of Support," a team process developed to help parents in recovery accomplish their case plans for reunification. Their checklist, based on *Questions Every Judge and Lawyer Should Ask About Infants and Toddlers in the Child Welfare System*,<sup>20</sup> was implemented in October 2004 as part of the 30-day records review.

The B4B project works to: (1) convert the B4B checklist from a snapshot in time to a guide for ongoing services, (2) develop a cadre of CASA volunteers to oversee case coordination and collaboration, and (3) enhance case coordination and collaboration among all service providers working with babies and their families.

### Sample Case<sup>21</sup>

*Case Facts.* The Prescott Police Department got a call about gunfire at a home in an area known for methamphetamine labs. Entering a dilapidated trailer with their guns drawn, the officers found a young woman lying in her own blood on the kitchen floor. Standing over her was a man waving a gun and shouting at her to "get up." He was so enraged that he didn't notice the police until they snapped cuffs on him. After locking him securely in the back seat of their squad car, they returned to the crime scene. The trailer was unbearably hot. A range of smells assaulted the officers as they explored the trailer. They almost missed the baby lying among dirty bedclothes at the far end of the trailer. They immediately called CPS to come get the baby.

CPS deposited 15-month-old Margaret in an emergency foster home with Mrs. Ortiz. The baby was grossly underweight, did not walk or talk, and was listless and unresponsive. Five days later, a preliminary protective hearing was scheduled. Before the hearing, the CASA coordinator, Margaret's attorney, her father's attorney, the CPS attorney, the CPS caseworker, the B4B coordinator, a representative from the behavioral health department, and Mrs. Ortiz met to discuss the status of the case.

*Intervention.* The case plan was clear. CPS would request termination of parental rights and adoption. Services requested for Margaret were less clear. The CPS caseworker reported that Margaret had seen a pediatrician, was diagnosed with failure-to-thrive, and would be receiving follow-up hospital services. Further discussion, initiated by the B4B coordinator, revealed that the hospital had no outreach services for children with failure-to-thrive. In reality, referrals to assess Margaret had been made automatically to community health services, the Arizona Early Intervention Program (AzEIP), and the behavioral health program, but none of these agencies knew about the others' involvement. The group reviewed the B4B services checklist to verify that all required services were being ordered for Margaret.

At the preliminary hearing, the judge ordered a behavioral health assessment designed for children under six years old, developmental screening, dental referral, nutritional and health screening, and a search for suitable relatives. The CPS attorney signed the information releases that would allow medical providers to release Margaret's records to the B4B team. With this information in hand, all service providers would be able to share and coordinate assessment and treatment information.

After the meeting, the B4B coordinator called Yavapai County Community Health Services, AzEIP, and the behavioral health provider assigned to assess Margaret to arrange a coordinated assessment. Agency evaluators held joint sessions with Margaret. Building on their areas of expertise, the team gained a complete picture of the baby's status and challenges. The evaluation verified that Margaret was quite developmentally delayed. All three agencies agreed to provide in-home services collaboratively every two weeks.

Although organizing the joint intervention required effort, everyone involved agreed it enhanced the services offered. Mrs. Ortiz felt supported by the treatment team, and the behavioral health therapist was able to allay her fears that Margaret was "damaged." The treatment team included Mrs. Ortiz in their work with Margaret, explaining how they were helping Margaret meet her developmental milestones.

Meanwhile, the CASA volunteer visited Mrs. Ortiz and Margaret weekly. She observed them during daily routines and playtime and complimented Mrs. Ortiz on how she cared for the child. At the monthly Child and Family Team meetings and in court reports, the CASA described Margaret's progress in Mrs. Ortiz's care.

CPS had placed Margaret with Mrs. Ortiz on an emergency basis and planned to move her to a long-term foster placement once they found a suitable home. By the end of the first month, Margaret had gained three pounds, had started crawling and walking, and had learned to feed herself with both hands. She began to bond with Mrs. Ortiz. If Mrs. Ortiz left the room, Margaret immediately became fussy. In time, Margaret began tolerating brief separations before crying. The treatment team noted the growing affection between foster mother and toddler, ascribing much of their success in treatment to the secure emotional base Mrs. Ortiz was providing for Margaret.

*Outcome.* The treatment team reported on Margaret's attachment to Mrs. Ortiz and advocated that the child remain in her care. Armed with data about why Margaret should not be moved, the CPS worker advocated keeping Margaret with Mrs. Ortiz. Ultimately, Margaret's permanency goal was changed to adoption by Mrs. Ortiz.

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## Zero to Three Family Drug Treatment Court Omaha, Nebraska

The Zero to Three Family Drug Treatment Court (FDTC) serves Douglas County, Nebraska, which includes the city of Omaha. Of the county's 1,198 children in out-of-home care for abuse and/or neglect in February 2006, 34 percent were under age six.<sup>22</sup> Twenty-five percent of these young children had been in more than three foster care placements, and 5 percent had been in seven or more placements. In a 2004 sample of infants and toddlers reviewed by the Foster Care Review Board, substance abuse was an issue for 64 percent of the parents.<sup>23</sup>

The FDTC team became part of the national drug court movement but with a unique focus on families with children between birth and three years. Borrowing from the best practices of the National Council of Juvenile and Family Court Judges Model Court jurisdictions that have convened drug courts, they focused on babies.<sup>24</sup> Sobriety was a key component, but clean drug tests were not sufficient to guarantee a parent could safely care for a young child. The team created a five-phase program that encourages parents to visit their children regularly, progressing quickly to unsupervised contact if they remain sober and improve their parenting skills. A part-time coordinator was hired with a grant from the Nebraska State Patrol.

While a clean drug test demonstrates a parent's sobriety, it is more difficult for a judge to learn if an individual's parenting skills are improving. FDTC Judge Douglas F. Johnson worked with early childhood development specialists to develop questions that would allow him to assess the parent-child relationship. At each court hearing, he asks parents to tell him something specific about their relationship with their child (e.g., their bedtime routine). Depending on the child's age, he asks if the parent sings to the child or reads to her. Although parents are proud of staying sober, their progress as parents is what clearly matters most to them. According to Judge Johnson, "Parents light up when they're talking about something they find so intimate and special."

### Sample Case<sup>25</sup>

*Case Facts.* When Delphine came to FDTC, she was 19 years old. Her mother had introduced her to methamphetamines (meth) when she was 13. At 15, she became pregnant with Devon. Between trying to care for Devon and her meth habit, she had little time for school. Her habit grew so out of control that one day she didn't notice when three-year-old Devon wandered out of their apartment and onto a busy street. Luckily someone picked him up before he got hurt, but the Department of Health and Human Services (HHS) removed him from her custody.

*Intervention.* On Delphine's first day in court, her lawyer explained the FDTC program to her. The lawyer told her that she would have to admit her substance abuse and plead to the allegations of physical and medical neglect of Devon if she was going to be accepted in the FDTC. At the family conference before her first hearing, the facilitator made sure that Delphine understood she could lose custody of Devon forever. Not wanting that to happen, Delphine decided to go forward with the FDTC program.



Delphine, with help from her lawyer and her Aunt Joan (the only family member she wanted to include in the case planning), completed the application. After a substance abuse evaluation, a psychological assessment, and a criminal records background check, she met with the FDTC coordinator for an interview and orientation to make sure that she understood the program requirements and was motivated and willing to participate. Delphine was admitted to phase 1 of the FDTC. The judge explained that federal laws protected Devon from spending his childhood waiting for her to get sober. If Delphine failed, Devon would be freed for adoption. Other FDTC team members explained the phases of the program and her responsibilities. She met several other program participants and listened while the FDTC team talked with them about their progress.

Delphine moved in with her Aunt Joan and began outpatient substance abuse counseling and daily visits with Devon in his foster home. At weekly court appearances, she answered the judge's questions about her visits with Devon, smiling as she told him about the hugs he gave her when she arrived or how he splashed her when she helped him with his bath. She told the FDTC team that Mrs. Thompson, the foster mother, was “really nice.” Delphine appreciated her willingness to answer Delphine's many questions about what Devon did when she wasn't there. Mrs. Thompson encouraged Delphine to attend Devon's medical appointments and developmental screening. At each court hearing, Delphine was congratulated for her success and received a small gift for herself or Devon.

At seven weeks, Delphine received a medallion and certificate for completing all phase 1 requirements. She knew phase 2 would be hard, but she was determined to develop the required educational and job plan and to continue to improve her parenting. She met with the HHS social worker to talk about getting her GED. She had never really considered what kind of work she might do. She remembered that she had liked to cook when she wasn't high, so she began to consider culinary school. She continued attending Narcotics Anonymous (NA) meetings, and her drug screening continued to prove she was staying clean. For Delphine, the best part of phase 2 was that she was allowed to take Devon for walks in Mrs. Thompson's neighborhood. She told the judge that they had found a playground two blocks away where they enjoyed playing kickball together.

Ten weeks passed. As Delphine was completing phase 2, she and Devon began visiting a mental health clinician who observed them together to see if Devon would be safe with Delphine. The FDTC team told Delphine that this evaluation process would take about six weeks to complete and, at the end, she and Devon might be referred to parent-child counseling.

### **Zero to Three Family Drug Treatment Court**

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As she entered phase 3, Delphine took a part-time bakery job in addition to her daily visits with Devon and her GED classes. She was tired and sometimes felt cranky, and dealing with customers at the bakery tested her patience. She was holding it together though, feeling supported by her court appearances, now down to every three weeks. She had almost completed phase 3 and hoped to move to phase 4.

However, a relapse brought her back to court the following week, where a positive drug screen was the topic of discussion. The judge told her that she would have to begin residential substance abuse treatment that day. Delphine broke down sobbing. Another client put his arm around her and told her that it was the best thing for her. Delphine straightened up and nodded to the judge in acceptance.

Devon continued to live with Mrs. Thompson. When Delphine was discharged from the treatment facility, the FDTC team found her a room at a three-quarter house (similar to a halfway house without adult supervision), where she continued to build on her sobriety. With the support and supervision of the FDTC, she was able to increase her visits with Devon and he now spends three nights each week with her. At her most recent court appearance, she talked about having meth out of her system. “I have to tell you something,” she said. “I feel like I can really think. It feels like my brain is working for the first time ever.”

*Outcome.* If she continues to make progress, Delphine will start phase 4 soon. The FDTC team will help her secure housing. She will be expected to have a job, regularly attend NA meetings, and take part in parenting classes. In addition, she and Devon will participate in child-parent psychotherapy to help her understand how her own childhood has affected her parenting and to help her read Devon's cues and understand what he needs to grow up healthy and happy.

## Part II: Common Components and Practice Tips

Although each project differs, they all share three core beliefs.

1. Relationships are key to changing systems and practices. Success hinges on relationships between the judge and the other project members; the judge and clients; clients and their service providers; parents' and children's service providers; and, most importantly, between the parents and their children.
2. Interventions informed by the science of early childhood development lead to better outcomes for children and their families.
3. Communication and collaboration among project team members and the family lead to service plans that address the specific needs of young children and their families. Because relationships take time to develop, it is important to have a long-term view and to continue with the intervention, despite setbacks.

In addition, the projects share the 13 common components discussed below. Advocates interested in bringing these projects to their communities or adapting elements of them should refer to the practice tips. These tips emphasize the practical steps that the model court-community programs took to implement each component.

### Judge as Leader and Catalyst

#### PRACTICE TIP

- ✓ Identify a strong, proactive judge to lead the court's efforts to focus on very young children.

The 1997 Adoption and Safe Families Act gives judges responsibility for ensuring the safety and well-being of the children whose families come before them. Judges play a critical role marshaling community services and assistance on behalf of young children and families. The judge has a unique ability to encourage action among public and private child-serving agencies. The National Council of Juvenile and Family Court Judges' *Resource Guidelines: Improving Court Practice in Child Abuse & Neglect Cases*, endorsed by the American Bar Association and the Conference of Chief Justices, promote a leadership role by judges in policy development, community education, and service advocacy for children and families.<sup>26</sup>

Each model depends on strong judicial leadership for a collaborative process that draws on the strengths of all participants. Although judges are not always the catalyst, as was the case initially with Best for Babies, their leadership is critical to the successful initiatives profiled here.

### Dedicated Local Staff with Child Development Expertise to Work with the Judge

#### PRACTICE TIP

- ✓ Hire an expert in early childhood development or children's mental health to work with the judge and other team members to address the needs of maltreated young children.

## Ten Key Facts about the Healthy Development of Infants and Toddlers<sup>1</sup>

“The introduction of the science of infant mental health demands that judges become familiar with early childhood development so that the court can translate and interpret the information it receives not only from the infant mental health specialist but also from the case-workers, case managers, parents, and others.”<sup>2</sup>

1. Between birth and three years old, the brain cell connections that govern sight, hearing, and language are mapped out. External stimulation (positive and negative) has major influence over everything the brain regulates, including memory, emotions, and learning.<sup>3</sup>
2. From the first days of life, infants remember what has happened in their lives. So-called perceptual memory links growing babies to sights and smells that can trigger intense psychological and physiological responses.
3. From smiles to averted gazes and yawns, babies are trying to communicate their needs and feelings to us.<sup>4</sup>
4. It is now possible to identify signs of depression and other psychological disorders in babies as young as three months.<sup>5</sup>
5. From birth, babies feel empathy toward other babies in distress.<sup>6</sup>
6. Low birth weight and prematurity lead to developmental challenges for infants and put them at greater risk for a range of medical problems. Forty percent of babies involved with the foster care system were born low birth weight or premature or both. More than half of these children suffer from serious health problems, including elevated lead blood-levels and chronic diseases such as asthma.<sup>7</sup> These conditions make these children more challenging to care for, helping to explain the finding that disabled children are almost twice as likely to be abused as other children.<sup>8</sup>
7. Developmental delays, if not diagnosed early, can compromise the early learning that is required for successful school performance. Half of all foster children (roughly 4 1/2 times the rate in the general population) have developmental delays.<sup>9</sup>
8. Flying below the radar screen is fetal alcohol spectrum disorder (FASD), a physical dis-

ability whose primary symptoms (poor judgment, slow developmental pace, impulsivity, difficulty learning from experience) are often misdiagnosed as oppositional defiant disorder, conduct disorder, attention deficit disorder, or emotional disturbance. The brain damage is caused by alcohol and drugs that pass the placental barrier during pregnancy. It cannot be cured but, with correct diagnosis and treatment, accommodations can be made to allow people with FASD to lead productive lives.<sup>10</sup>

9. The single most important predictor of a child's healthy growth and development is the attachment he or she forms with a consistent, loving caregiver. A secure emotional bond with a loving caregiver helps infants believe they are worthwhile and enables them to nurture themselves, care for those around them, and be motivated to learn about their world. Conversely, inconsistent, neglectful, or abusive parenting will make a child grow up believing the world is painful and he or she is unworthy of care.
10. Babies grieve when their caregivers disappear.

<sup>1</sup>Adapted from Youcha, Vicky. “Ten Key Facts about the Healthy Development of Infants and Toddlers and Recommendations to Help Babies in the Foster Care System Thrive.” *The Judges' Page Newsletter*, October 2005. November 6, 2006, <[http://www.nationalcasa.org/download/Judges\\_Page/0510\\_child\\_development\\_and\\_parenting\\_issue\\_0036.pdf](http://www.nationalcasa.org/download/Judges_Page/0510_child_development_and_parenting_issue_0036.pdf)>. Reprinted with permission from the National CASA Association.

<sup>2</sup>Lillas, Constance M., Lester Langer, and Monica Drinane. “Addressing Infant and Toddler Issues in the Juvenile Court: Challenges for the 21st Century.” *Juvenile and Family Court Journal* 55(2), 2004, 89.

<sup>3</sup>Kotulak, Ronald. *Inside the Brain: Revolutionary Discoveries of How the Mind Works*. Kansas City, MO: Andrews McMeel Publishing, 1997, 7-17.

<sup>4</sup>Lillas et al., 2004, 85-87.

<sup>5</sup>Wingert, P. and M. Brant. “Reading Your Baby's Mind: New Research on Infants Finally Begins to Answer the Question: What's Going on in There?” *Newsweek*, August 15, 2005, 35.

<sup>6</sup>Ibid.

<sup>7</sup>Halfon, N., A. Mendonca, and G. Berkowitz. “Health Status of Children in Foster Care: The Experience of the Center for the Vulnerable Child.” *Archives of Pediatric and Adolescent Medicine* 149(4), 1995, 386-391.

<sup>8</sup>Prevent Child Abuse America. *Fact Sheet: Maltreatment of Children with Disabilities*. May 28, 2006, <<http://member.preventchildabuse.org/site/DocServer/maltreatment.pdf?docID=124>>.

<sup>9</sup>Osofsky, Joy, Candice Maze, Cindy Lederman, Martha Grace, and Sheryl Dicker. “Questions Every Judge and Lawyer Should Ask About Infants and Toddlers in the Child Welfare System.” *Juvenile and Family Court Journal* 55(2), 2004, 47.

<sup>10</sup>Malbin, D.V. “Fetal Alcohol Spectrum Disorder (FASD) and the Role of Family Court Judges in Improving Outcomes for Children and Families.” *Juvenile and Family Court Journal* 55(2), 2004, 53-63.

A partnership between the judge and a child development/mental health expert joins two distinct disciplines to improve outcomes for young children. The child development expert helps the judge and the other partners understand the needs of young children and how judicial decisions affect their well-being.

The judge needs a partner who can spend time coordinating the team's work. In each model, one person leads the project team, coordinates existing services and resources, and builds community capacity to support infants and toddlers in the court system. The partnerships have taken different forms. For example,

- The Court Teams for Maltreated Infants and Toddlers community coordinators, hired in each community for their child development expertise and knowledge about local services, promote systems change and ensure that case management for each child takes place. Community coordinators across the sites range from half-time to full-time status, depending upon local funding.
- The Zero to Three Family Drug Treatment Court coordinator works with the judge to manage the court docket, tracking families through the stages of the FDTC protocol.
- In 2004, the New York State Permanent Judicial Commission on Justice for Children hired an early childhood specialist to work in all five New York City boroughs to establish the BCW project in other courts, coordinate training, and review individual cases. Without the early childhood specialist, the BCW project in Queens would not have launched.

### **Court-Community Team**

#### **PRACTICE TIPS**

- ✓ Establish a multidisciplinary team or advisory committee that includes representatives from every discipline that works with very young children in the child welfare system.
- ✓ Conduct a community needs assessment. Review sample cases involving very young children in foster care to develop a baseline profile to inform the team's work. Identify significant gaps in community services (e.g., services for parents with co-occurring mental health and substance abuse disorders) and work with public officials to remedy these gaps.
- ✓ Develop a project plan.
- ✓ Bring key players in a case together before the first hearing. This should include biological family and foster parents; the CPS worker assigned to the case; attorneys for the parents, child(ren), and CPS; representatives of the medical and behavioral health service providers responsible for the developmental assessments the child(ren) will need; and a facilitator. At this meeting, discuss the family's strengths and challenges and jointly develop a case plan to present to the judge.
- ✓ Collaborate across disciplines by offering multidisciplinary training, expanding the advisory committee to include new stakeholders, and encouraging service providers to participate at child and family team meetings, conferences, and court hearings.
- ✓ Identify staff to coordinate the project and keep the process moving (such as a community coordinator).
- ✓ Agree on how decisions will be made and how to resolve conflicts and reach consensus among team members. Decisions can be made by voting or letting the judge decide.
- ✓ Connect team members with their counterparts involved in successful court-community partnerships in other communities.



Known across the models as the Think Tank (B4B), Advisory Committee (BCW), FDTC Team (Omaha), or Court Teams for Maltreated Infants and Toddlers, the court-community teams include members who commit to restructuring the community's response to maltreated infants and toddlers. The makeup of project teams varies, but typically includes:

- Judges
- Community health care providers
- Child welfare workers including high-level representatives of the child welfare agency
- Attorneys representing children, parents, and the child welfare agency
- CASAs
- Guardians ad litem
- Mental health professionals
- Substance abuse treatment providers
- Representatives of foster parent organizations and children's advocacy groups
- Early Head Start and child care providers
- Local and state government officials
- State Court Improvement Project staff

The judge convenes the team early in the process of developing the model. As the project grows, the team must remain open to new members.<sup>27</sup> The inclusive, democratic nature of the team encourages strong contributions from each member. The sense that “the whole is greater than the sum of its parts” is expressed in each model.

In Yavapai County, the first few meetings of the team—the Think Tank—were convened by the executive director of Prevent Child Abuse Arizona. “My agency began hosting a monthly think tank to which anyone with an interest in the service system was invited. It was over lunch, brown bag, informal, and fortunately we had good relationships with several people in public health nursing, the court, child welfare, and child protective services so the group began to grow and be regularly attended. Everyone pitched in to inform everyone of what their agency's current role was with infants and toddlers, and gradually we began to recognize there was an impressive knowledge base in our community about infant mental health.”<sup>28</sup>

Involving the local child welfare agency is critical to the success of each model, and the agency should be a primary partner on the team. The goal is to mobilize existing community resources to partner with CPS in protecting very young children and promoting permanency.<sup>29</sup>

In Des Moines, the Department of Human Services (DHS), actively represented on the project team, launched a therapeutic visitation protocol to increase safe interaction between foster children and their birth parents. The court team grant provided a full-day training entitled “Separation and Attachment: The Need for Expedited Permanency” for two DHS supervisors implementing the visitation project.

In New York City, the New York State Permanent Judicial Commission on Justice for Children briefed the commissioner of the Administration for Children's Services (ACS) on BCW. The commissioner embraced the initiative, established a BCW working group, and collaborated with the commission to provide related training for ACS caseworkers. As a result, ACS has developed new policies and practices concerning concurrent planning, identification of infants' needs, infant visitation, and referral to EI services.

Each community has unique services, service gaps, and barriers. The project team, through regular meetings and case reviews, learns more about available community services and better links those services together. They identify service gaps and develop strategies to fill them.



As part of this process, the team should develop a project plan. In the Bronx, the project plan included: (1) providing training for all court and child welfare personnel on the health and development of babies at a convenient time and location; (2) developing an information tracking tool that court and child welfare professionals use in all infant cases; and (3) working to change child welfare and court practice.

The teams can also learn from other successful court-community partnerships. In Omaha, for example, the judge responded to team members' doubts about the FDTC approach by connecting them with their colleagues in other courts where the approach is working.

### **Attorneys Who Know about the Needs of Very Young Children**

#### **PRACTICE TIPS**

- ✓ Train attorneys representing children, parents, and the child welfare agency on the special needs of very young children in the child welfare system, including developmental issues, emotional and attachment issues, medical issues, and community resources.
- ✓ Attorneys representing parents, children, and child welfare agencies should promptly request a range of services for their clients.
- ✓ Children's attorneys should make special efforts to regularly see the infants and toddlers they represent.

Although attorneys for children, parents, and the child welfare agency have different roles to play in child abuse and neglect litigation, they all should be aware of the special needs of maltreated babies and toddlers. They also should be aware how these special needs can guide their requests for services and supports on behalf of their respective clients, especially when advocating referral of young children for screening and evaluation for EI services under Part C of the Individuals with Disabilities Education Act.

All four models in this brief aim to ensure that attorneys recognize the importance of the parent-infant bond and become knowledgeable about the programs and services that can help strengthen that critical relationship. They are also learning about the profound impact of maltreatment on the developing brain and about the services available to mitigate such effects. Armed with this special knowledge, attorneys can better understand the role they can play in a court-community collaborative approach.

Cases involving very young children call for early, intensive services; frequent court review; and frequent visitation. The parent's involvement in the child's medical and developmental care can help develop appropriate parenting skills and speed reunification if safety is no longer a concern.

Attorneys in child dependency cases should follow all relevant practice standards,<sup>30</sup> but some standards are particularly important in cases involving very young children. Because very young children cannot speak for themselves, they, more than any other population, depend on those who speak for them to represent their interests. Guardians ad litem, CASAs, and children's attorneys must recognize that regular visits, even with nonverbal children, will provide invaluable information about an infant's or toddler's well-being and development. Child development experts can provide guidance on how to observe a baby's behavior and identify concerns. The checklist on page 18 can be a starting resource.

## Infant Checklist

### Question One: What are the medical needs of this infant?

#### *The Medical Checklist*

- What health problems and risks are identified in the infant's birth and medical records (e.g., low birth weight, prematurity, prenatal exposure to toxic substances)?
- Does the infant have a medical home?
- Are the infant's immunizations complete and up-to-date?

#### *Common Medical Diagnoses Seen in Infants in Foster Care*

- Fetal alcohol syndrome
- Congenital infections (e.g., HIV, hepatitis, syphilis)
- Growth failure, failure to thrive
- Shaken baby syndrome
- Lead poisoning
- Respiratory illness
- Hearing and vision problems

### Question Two: What are the developmental needs of this infant?

#### *The Developmental Checklist*

- What are the infant's risks for developmental delay or disability?
- Has the infant had a developmental screening/assessment?
- Has the infant been referred to the Early Intervention Program?

#### *Developmental Red Flags*

- Premature birth
- Low birth weight
- Abuse or neglect
- Prenatal exposure to substance abuse

### Question Three: What are the attachment and emotional needs of this infant?

#### *The Emotional Health Checklist*

- Has the infant had a mental health assessment?
- Does the infant exhibit any red flags for emotional health problems?
- Has the infant demonstrated attachment to a caregiver?
- Has concurrent planning been initiated?

#### *Emotional Health Red Flags*

- Chronic sleeping or feeding disturbances
- Excessive fussiness
- Incessant crying with little ability to be consoled
- Multiple foster care placements
- Failure to thrive

### Question Four: What challenges does this caregiver face that could impact his or her capacity to parent this infant?

#### *The Caregiver Capacity Checklist*

- What are the specific challenges faced by the caregiver in caring for this infant (e.g., addiction to drugs and/or alcohol, mental illness, cognitive limitations)?
- What are the learning requirements for caregivers to meet the infant's needs?
- What are specific illustrations of this caregiver's ability to meet the infant's needs?

#### *Caregiver Capacity Red Flags*

- Noncompliance with the infant's scheduled health appointments and medication or therapeutic regimens
- Caregiver substance abuse and noncompliance with psychiatric treatment and medications
- Confirmed instances of child abuse or neglect
- Incomplete immunizations and a child's poor growth or arrested development

### Question Five: What resources are available to enhance this infant's healthy development and prospects for permanency?

#### *The Resource Checklist*

- Does the infant have Medicaid or other health insurance?
- Is the infant receiving services under the Early Intervention Program?
- Have the infant and caregiver been referred to Early Head Start or another quality early childhood program?

Adapted with permission from Dicker, Sheryl and Elysa Gordon. *Ensuring the Healthy Development of Infants in Foster Care: A Guide for Judges, Advocates and Child Welfare Professionals*. Washington, DC: ZERO TO THREE; White Plains, NY: New York State Permanent Judicial Commission on Justice for Children, 2004. *Ensuring the Healthy Development of Infants in Foster Care* was written as an accompaniment to and contains adaptations and excerpts from New York State Permanent Judicial Commission on Justice for Children. *Ensuring the Healthy Development of Foster Children: A Guide for Judges, Advocates and Child Welfare Professionals*. White Plains, NY: New York State Permanent Judicial Commission on Justice for Children, 1999.

## Research-based Interventions

### PRACTICE TIP

- ✓ Develop tools to allow the court and child welfare staff to respond knowledgeably to the medical and developmental needs of babies and promote permanency.

The National Research Council and the Institute of Medicine's *From Neurons to Neighborhoods*, a synthesis of current scientific knowledge of child development from birth to age five, calls on the nation to thoroughly reassess policies that affect young children and increase its investment in their well-being (see page 2).<sup>31</sup> National data unequivocally show the needs of young children in the child welfare system are not being met<sup>32</sup> and provide a backdrop for what is happening at the local level. Project team members must recognize the need to change the way that cases involving maltreated infants and toddlers are handled in their community and collect data to support a new approach.

For example, in each New York court implementing BCW, the first major activity is reviewing court petitions filed on behalf of babies. In the Bronx, fewer than 20 percent of the court files documented court orders for health services or knowledge about the babies' health and development.<sup>33</sup> These findings highlighted gaps in services needed by infants and made a powerful case for BCW. BCW developed tools to allow the court, attorneys, and child welfare staff to respond to the medical and developmental needs of babies and promote permanency. These tools include *Ensuring the Healthy Development of Foster Children: A Guide for Judges, Advocates and Child Welfare Professionals*<sup>34</sup> and a laminated, one-page checklist entitled "Ensuring the Healthy Development of Infants in Foster Care."

## Access to Early Intervention Services

### PRACTICE TIPS

- ✓ Educate all court team members about Part C of the Individuals with Disabilities Act, which specifies that maltreated infants and toddlers are eligible for screening and services for developmental delays.
- ✓ Develop and implement policies to ensure all infants and toddlers in the child welfare system are referred for Part C services.

Part C of the Individuals with Disabilities Education Act (Public Law 105-17) states that maltreated infants and toddlers are eligible for screening and services for developmental delays. (See page 20 for more information.) In addition, the 2003 amendments to the Child Abuse Prevention and Treatment Act (Public Law 108-36) require states to refer maltreated children under age three to EI services funded under Part C. However, children in the child welfare system are not routinely referred for Part C screening and evaluation for several reasons:

- Attorneys and judges are not aware of Part C.
- States are slow to develop implementation policies because costs are attached.
- Federal regulations have been slow to arrive.

## Part C of the Individuals with Disabilities Education Act

Congress established the Part C Program under the Individuals with Disabilities Education Act (IDEA) in 1986 to address what they believed to be an “urgent and substantial need.” The purpose of Part C is to:

- enhance the development of infants and toddlers with disabilities,
- reduce education costs by reducing the need for special education through early intervention services,
- minimize the likelihood of institutionalization, and
- enhance the capacity of families to meet their children's needs.

Amendments to the Child Abuse and Prevention Treatment Act (CAPTA) in 2003 require states to develop procedures to ensure that all children under age three who are involved in a substantiated incident of abuse or neglect are referred to Part C services.

The IDEA amendments of 2004 require Part C services for all children under age three who have been maltreated or exposed to prenatal substance

use or domestic violence. This legislation opened a window of opportunity for getting developmental assessments and treatment for infants and toddlers who have been abused or neglected. However, although “Part C” is a federal requirement, many states and local jurisdictions are not yet aware of the Part C program in their states.

For eligible children, Part C services include the following:<sup>1</sup>

- Family training, counseling, and home visits
- Nursing, health, and nutrition services
- Service coordination
- Medical services for diagnostic or evaluation purposes
- Occupational and physical therapy
- Psychological and social work services
- Vision, orientation, and mobility services
- Speech-language pathology services
- Transportation services
- Age-appropriate special education instruction

<sup>1</sup>Santucci, R., E. Grindstaff, P. DiBattista, and J. Barker. *Special Education: Grant Programs Designed to Serve Children Ages 0-5*. Washington, DC: U.S. General Accounting Office, 2002, 8. May 28, 2006 <<http://www.gao.gov/new.items/d02394.pdf>>.



Each model program is investigating how to develop and implement policies to ensure all infants and toddlers in the child welfare system are referred for Part C services. Such policies would link eligible children with a service coordinator to help these children access other community services. For instance, the Court Teams project has made referrals to Part C a priority. In its first year, 77 percent of the children enrolled in the project had received a Part C screening and 53 percent were receiving services.<sup>35</sup>

## **Mental Health Services for Children and Parents**

### **PRACTICE TIP**

- ✓ Develop the community's capacity to offer mental health interventions to parents and young children together.

Babies who are harmed in their relationships with their parents can sometimes be healed with appropriate mental health intervention. Child-parent psychotherapy improves the relationship by increasing parents' responsiveness and sensitivity to their baby and creating strategies for parents to respond to their children's cues in ways that support their development. This model also addresses parents' unmet emotional needs that impair their ability to meet their babies' needs.<sup>36</sup> (See page 22 for a more detailed explanation.) Because child-parent psychotherapy shows promising early outcomes for safe reunification, developing the capacity to offer it is a goal of Court Teams for Maltreated Infants and Toddlers, B4B, and the FDTC.

No state is meeting the federal criteria for providing mental health services to young children in foster care.<sup>37</sup> One reason is the scarcity of mental health clinicians trained to work with children under age six. To address this issue, the Des Moines Court Team brought in a nationally recognized child development expert to train local mental health professionals to provide child-parent psychotherapy. Another barrier is lack of funding. Medicaid policy in many states does not specifically cover child-parent psychotherapy. The Court Teams project is investigating state Medicaid policies to see whether rule changes are required to cover child-parent psychotherapy. Another possible funding source is the Victims of Crime Act (VOCA), which covers therapeutic services for victims of crime. Child maltreatment involving legal sanctions or the presence of domestic violence can be considered a crime as defined by VOCA.

## Child-Parent Dyadic Psychotherapy: The Treatment Model

### *Background*

Based on Selma Fraiberg's work with disturbed mothers and their babies in the 1970s, this intervention focuses jointly on the parent and infant. It helps parents read, interpret, and respond to their infants' and toddlers' cues. A therapist encourages parents to express their emotions in the context of the parent-child relationship.

### *Treatment in Action: Miami Juvenile Court*

In Miami, the juvenile court makes referrals to child-parent dyadic psychotherapy. Children and parents who are referred receive intervention weekly for a minimum of 25 weeks. Case management is an important component of the Florida model. The therapist participates in clinical and case management activities. He or she links the mother with the case manager in the community child welfare agency and supports the agency in child-focused decision making. The therapist and caseworker help parents find and access services and supports that they and their babies need, such as speech and language therapy, occupational therapy, and help with housing and employment. By entering into a positive, consistent relationship, the parent starts healing negative experiences with attachment figures during childhood.

### *Promising Outcomes*

Preliminary outcomes of the child-parent psychotherapy interventions with case management in Miami include:

- marked improvement in parent-child interaction,
- a high rate of permanency, and
- no recurrence of abuse or neglect.

A total of 39 parent-child pairs completed the 25-week intervention and the post-treatment assessment when the initial data was analyzed in 2003. Results showed that parents and children displayed:

- increased sensitivity, including behavioral and emotional responsiveness to enhance the child's development,
- positive self-esteem, and
- readiness to learn.

Significantly, over the three years of the study, there were no further substantiated reports of abuse or neglect and all children achieved permanent placements.<sup>1</sup>

<sup>1</sup>Osofsky, J.D., et al. (in press). "The Development and Evaluation of the Intervention Model for the Florida Infant Mental Health Pilot Program." *Infant Mental Health Journal*, 2006.



## Frequent Case Monitoring and Tracking

### PRACTICE TIPS

- ✓ Establish a monthly case review process that informs the judge about each family's progress.
- ✓ Hold regular meetings of all individuals and organizations delivering court-mandated services to infants and toddlers to review case progress.
- ✓ Identify a group whose members take responsibility for following individual cases (e.g., CASAs).

Recognizing that very brief time periods are an eternity to a baby, each court-community partnership has shortened the long gaps between case plan review hearings. This monitoring process helps prevent very young children from falling through the cracks in the child welfare system and ensures the services they receive are effective and age-appropriate.

In some models, the case review occurs as part of a court hearing with the judge. In other models, the team meets separately without the judge to prepare for court. In New York's BCW project, the court closely monitors the case with judicial review every 60 days and review by the early childhood specialist every 30 days. In Omaha's FDTC, parents appear in court weekly during the first of five recovery phases. As parents move into new phases, their required court appearances decrease. Court Teams for Maltreated Infants and Toddlers meet monthly to review case progress. The community coordinator, CPS caseworker, and service providers discuss problems the children and parents are experiencing and together devise solutions.

Several communities rely on CASA volunteers to play a central coordinating role. In New York City's BCW project, the judge appoints a CASA for every baby as soon as the court case is opened. The CASA provides critical information to the court including answers to the commission's checklist questions (see page 18), tracks referrals for services (particularly EI services), and meets at least monthly with the caseworker to review the case. In Yavapai County, CASAs assigned to serve babies have been trained to write court reports documenting the quality of parent-child interaction during supervised visitation. Their reports help the judge make permanency decisions.

## Child-Focused Court-Ordered Services

### PRACTICE TIPS

- ✓ Incorporate child-focused services into existing case plans.
- ✓ Implement concurrent planning from the outset.
- ✓ Ensure the case plan provides frequent, regular visits between parent and child.
- ✓ If limited access to transportation creates a challenge for parents to visit their children, consider strategies to help parents overcome this barrier (such as recruiting volunteers to transport parents and children to visits or providing bus tokens and gas cards).
- ✓ Develop a shared understanding of what babies need to thrive and create a tool (e.g., a checklist or court order form) to ensure all necessary services are ordered for every baby.
- ✓ Coordinate medical, developmental, and behavioral assessments of the child so service providers share information and develop a unified treatment plan that meets the child's needs.
- ✓ Involve the child's family and foster parents in treatment.
- ✓ Order evidence-based services for children and families.

Each project focuses on court-ordered services for the child as well as the parent. Children's medical and mental health interventions are incorporated into the plan for resolving the family's child welfare system involvement.

*Health and mental health services.* The B4B team developed a checklist addressing health issues for young children for Yavapai County. The checklist was based on the “Checklist for the Healthy Development of Children in Foster Care” (see page 18), developed by the New York State Permanent Judicial Commission on Justice for Children, and *Questions Every Judge and Lawyer Should Ask About Infants and Toddlers in the Child Welfare System*.<sup>38</sup> The checklist is organized according to the team member responsible for each component (e.g., foster parents are responsible for scheduling appointments for medical examinations).

*Visitation.* Court orders and case plans should promote permanency. Frequent, regular visits are key, as research shows that increasing the number of visits per week improves the likelihood of achieving permanent placement within 12 months.<sup>39</sup> Brief weekly visits do not repair and build the strong, positive parent-child relationships necessary for the healthy development of infants and toddlers or increase the parents' capacity to appropriately care for their young children. All the projects emphasize frequent, meaningful visitation. For example, the Court Teams for Maltreated Infants and Toddlers offer team members a day-long training on using visitation to promote permanent placement.

Some communities train and support foster parents to be resources for family visitation. In some communities, parents are encouraged to have daily visits and foster parents provide transportation and support. Mentor foster parents supervise the visits in their homes so that birth parents can be involved in daily routines such as meals, bathing, and bedtime. Another option is therapeutic visitation, in which a licensed mental health clinician supervises parent-child contact, teaching the parent how to nurture his or her child, appropriately guide the child's behavior, and care for the child's special medical or developmental conditions.

*Concurrent planning.* Concurrent planning should be implemented at the outset of the case. If possible, the child should be placed in what could become a new permanent home in the event the biological parent is unable to provide a safe home.

*Evidence-based services.* The court should order evidence-based services. For example, parenting skills programs are easy to find but, for the most part, are not supported by research documenting their effectiveness. In Miami, the Court Team judge orders parents to participate in only those parenting skills programs that meet certain standards of effectiveness.

*Coordinated assessments/services.* Finally, it is important to coordinate assessments and services for infants and toddlers. Often very young children in foster care are scheduled for multiple appointments at different agencies to complete health, mental health, and developmental assessments. Lack of coordination among agencies delays or prevents the delivery of appropriate services. In Yavapai County, parents are asked to sign a series of releases so the court, CPS, CASAs, EI program, and other service providers can share information about the child's health. To handle multiple evaluations, project teams might establish a centralized assessment center where infants receive health, mental health, and developmental evaluations. This strategy would allow prompt sharing of information and coordinated services.

## **Ongoing Training and Technical Assistance**

### **PRACTICE TIPS**

- ✓ Build knowledge about the impact of abuse and neglect on early development by providing training opportunities for project team members and other legal and child-serving professionals working with young children and families.
- ✓ Educate foster parents to help birth parents gain good parenting skills.

To fulfill their leadership and oversight roles in cases involving infants and toddlers, project team members must keep abreast of recent scientific advances in infant/toddler development and apply those findings when reviewing individual cases. Each model has taken a different approach to bring this information to their communities. For instance, Court Teams for Maltreated Infants and Toddlers provide staff and consultants training on topics such as therapy to help parents respond to their children's social and emotional needs, general infant and toddler development, children and trauma, and family contact for young children in foster care.

BCW teams receive an initial five-part training from local experts covering medical, developmental, and emotional and attachment issues for infants. They learn about community resources, particularly EI and Early Head Start, and discuss an actual case with experts, a judge, attorneys, and a CASA volunteer. This initial training is followed by ongoing lunchtime booster sessions in which experts respond to questions from judges, attorneys, and CASAs.

## Resources for Professionals and Parents

### PRACTICE TIP

- ✓ Develop and share resource materials to guide project team members, birth parents, and foster parents.

Written materials are important teaching tools for the project teams. Each project has developed publications and training guides to support their efforts and has shared them widely. For example, parents in Omaha receive a detailed participant manual for the FDTC, detailing the court's expectations for their behavior and the phases of the program. In New York, BCW's "Checklist for the Healthy Development of Children in Foster Care" is being widely distributed within the courts and other organizations.

## Funding

### PRACTICE TIPS

- ✓ Find funding to hire an expert in early childhood development or children's mental health who will work with the judge to address the needs of young children in child maltreatment cases.
- ✓ Seek in-kind donations from court team members to help implement and sustain the effort.

Every model has struggled to secure funding. Local commitment to the project has permitted them to accomplish much of the initial community organizing phase with few financial resources. In each model, every team member is donating time and personal resources. The local coordinator and project evaluation require funding, however. Funding for the various models comes from state Court Improvement Projects, state and federal grants, and private foundations. For example, ZERO TO THREE obtained funding for the Court Teams project through federal grants. In New York, the Permanent Judicial Commission on Justice for Children hired an early childhood specialist for phase 2 of BCW in Queens and Brooklyn. The Omaha court secured a small grant from the Nebraska State Patrol to hire a FDTC coordinator.

## Program Evaluation

### PRACTICE TIPS

- ✓ Evaluate program progress. Define current benchmarks that the court team wants to improve (e.g., number of months from placement to permanency, number of placements while in foster care, services ordered for children and services received). Keep records and timelines about cases handled by the court team.
- ✓ Analyze and address barriers to achieving desired outcomes so the evaluation process helps the team improve over time.

Ongoing program evaluation helps projects determine how well they are succeeding and position themselves to meet funding criteria at local, state, and federal levels. The model projects have based their data collection on the primary problems they identified during their planning phase. This has helped to define realistic expectations for data collection and useful information at each assessment point.

The BCW project collected data about infants before working at each court. This allowed the project to measure progress. For example, in Brooklyn, research in 2003 revealed that court records contained no information on the children's health or developmental status. In 2005, after the BCW project was fully implemented, medical information and referrals to EI services were found in 100 percent of the court files and 67 percent of the infants were found eligible for early intervention.

The Court Teams for Maltreated Infants and Toddlers project began its evaluation by developing a logic model and an assessment of expected outcomes. As a cross-site project, the evaluation will use statistical analysis to assess the project as a whole, as well as results in each site. The evaluator is working with each site to develop a logic model, detailing activities and intended outcomes. All projects will have a core set of activities and outcomes, with individual activities as appropriate. This approach will streamline the evaluation, allowing for the use of the same data collection instruments in each site.<sup>40</sup>





## Conclusion

By focusing on the developmental needs of very young children, the four court-community models seek to improve outcomes for children now and as they grow up. What makes these programs special is collaborative judicial leadership, committed colleagues in all child and family-serving disciplines, and a willingness to expand their knowledge and try new approaches to old problems. They have turned their despair over the families who come before them into strategies for healing them. As Judge Johnson of Omaha commented, “It’s about the kids. People talk about parents getting their children back. But really, this is about the children getting their parents back.”<sup>41</sup>

## Notes

<sup>1</sup>Dekaban, Anatole S. and Doris Sadowsky. "Changes in Brain Weights during the Span of Human Life: Relation of Brain Weights to Body Heights and Body Weights." *Annals of Neurology* 4, October 1978, 345-356.

<sup>2</sup>Widom, Cathy S. and Michael G. Maxfield. "An Update on the 'Cycle of Violence.'" Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, 2001. November 6, 2006, <<http://www.ncjrs.gov/pdffiles1/nij/184894.pdf>>.

<sup>3</sup>U.S. Department of Health and Human Services, Administration on Children, Youth and Families. *Child Maltreatment 2004*. Washington, DC: U.S. Government Printing Office, 2006, table 3-10.

<sup>4</sup>U.S. Department of Health and Human Services, Administration on Children, Youth and Families, Children's Bureau. *The Adoption and Foster Care Analysis and Reporting System (AFCARS) Report: Preliminary FY 2005 Estimates as of September 2006*. Washington, DC: U.S. Department of Health and Human Services, 2006. October 20, 2006 <[www.acf.hhs.gov/programs/cb](http://www.acf.hhs.gov/programs/cb)>.

<sup>5</sup>U.S. Department of Health and Human Services. *Child Maltreatment 2004*, 62.

<sup>6</sup>Wulczyn, Fred and Kristin Brunner Hislop. "Babies in Foster Care: The Numbers Call for Attention." *ZERO TO THREE Journal* 22(4), 2002, 14-15.

<sup>7</sup>Ibid.

<sup>8</sup>Wulczyn, Fred and Kristin Brunner Hislop. *The Placement of Infants in Foster Care*. Chicago: University of Chicago, Chapin Hall Center for Children, 2000.

<sup>9</sup>The National Council of Juvenile and Family Court Judges has developed many publications setting forth judicial leadership principles, including its seminal work, *Resource Guidelines: Improving Court Practice in Child Abuse & Neglect Cases*. Reno, NV: National Council of Juvenile and Family Court Judges, 1995.

<sup>10</sup>National Clearinghouse on Child Abuse and Neglect Information. *Concurrent Planning: What the Evidence Shows*. Washington, DC: U.S. Department of Health and Human Services, 2005, 3.

<sup>11</sup>U.S. Department of Health and Human Services. *Child Maltreatment 2004*, table 3-9.

<sup>12</sup>In all case scenarios, names of individuals and some case facts have been changed to protect the confidentiality of the children, their families, and their foster families.

<sup>13</sup>The commission was established in 1988 to "address the problems of children whose lives and life chances are shaped by New York State's courts." New York State Permanent Judicial Commission on Justice for Children. *Accomplishments: 15 Year Report*. White Plains, NY: New York State Permanent Judicial Commission on Justice for Children, 2006, 39.

<sup>14</sup>Ibid., 32.

<sup>15</sup>The Robert Wood Johnson Foundation funded Babies Can't Wait from March 2001 to December 2002 with a \$48,500 grant. The federal Court Improvement Project has provided additional support. See Robert Wood Johnson Foundation. "Babies Can't Wait: Focusing on Infant Health Needs in Bronx Family Court." October 23, 2006, <<http://www.rwjf.org/portfolios/resources/grantsreport.jsp?filename=041717.htm&iaid=144&gsa=1#contents>>.

<sup>16</sup>Dicker, Sheryl and Elysa Gordon. "Building Bridges in Foster Care: The Babies Can't Wait Initiative." *Juvenile and Family Court Journal* 55(2), 2004, 33.

<sup>17</sup>Ibid., 32.

<sup>18</sup>Sheryl Dicker, "Jamal's Story," personal communication with Lucy Hudson, August 14, 2006.

<sup>19</sup>U.S. Department of Health and Human Services. *Child Maltreatment 2004*, Table 3-9.

<sup>20</sup>Osofsky, Joy, Candice Maze, Cindy Lederman, Martha Grace, and Sheryl Dicker. *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, 2002.

<sup>21</sup>Sally Campbell, personal communication with Lucy Hudson, July 13, 2006.

<sup>22</sup>Nebraska Foster Care Review Board Tracking System. "Fact Sheet on Children in Out-of-Home Care Who Are Adjudicated (3a) Abuse/Neglect." February 22, 2006. <[http://www.fcrb.state.ne.us/content/content/content/Feb\\_2006\\_Statistics](http://www.fcrb.state.ne.us/content/content/content/Feb_2006_Statistics)>.

<sup>23</sup>Nebraska Foster Care Review Board. "Children Age 0-3 and Parental Substance Abuse." February 2006. Available from Lucy Hudson at Zero to Three, E-mail: [lhudson@zerotothree.org](mailto:lhudson@zerotothree.org)

<sup>24</sup>For information on family drug treatment courts, see Edwards, Leonard P. and James A. Ray. "Judicial Perspectives on Family Drug Treatment Courts." *Juvenile and Family Court Journal* 56(3), 2005, 1-27; Robert V. Wolf. "Fixing Families: The Story of the Manhattan Family Treatment Court." *Journal of the Center for Families, Children and the Courts* 2, 2000, 5-21.

<sup>25</sup>Lou Shilton, personal communication with Lucy Hudson, July 13, 2006.

<sup>26</sup>National Council of Juvenile and Family Court Judges, *Resource Guidelines*, 18.

<sup>27</sup>In Yavapai County, the Think Tank relocated its meetings three times because of the growing number of people attending.

<sup>28</sup>Becky Ruffner, personal communication with Lucy Hudson, May 11, 2006.

<sup>29</sup>Schene, Patricia A. "Past, Present, and Future Roles of Child Protective Services." *The Future of Children* 8(1), 1998, 23-38. May 28, 2006, <[http://www.futureofchildren.org/usr\\_doc/vol8no1ART2.pdf](http://www.futureofchildren.org/usr_doc/vol8no1ART2.pdf)>.

<sup>30</sup>The American Bar Association has approved practice standards for lawyers involved in child dependency and custody litigation in various capacities. These include *Standards of Practice for Lawyers Representing Parents in Abuse and Neglect Cases* (2006); *Standards of Practice for Lawyers Representing Children in Abuse and Neglect Cases* (1996); *Standards of Practice for Lawyers Representing Child Welfare Agencies* (2004); and *Standards of Practice for Lawyers Representing Children in Custody Cases* (2003). All the standards focus on improving representation of parties so that children and families are better served by the legal system. They promote quality representation and uniformity of practice throughout the country. These standards are available at <<http://www.abanet.org/child/resources.shtml>>.

<sup>31</sup>Shonkoff, Jack P. and Deborah A. Phillips, eds. *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Washington, DC: National Academies Press, 2000.

<sup>32</sup>U.S. Department of Health and Human Services. *Child Maltreatment 2004*.

<sup>33</sup>Sheryl Dicker, personal communication with Lucy Hudson, July 11, 2006.

<sup>34</sup>New York State Permanent Judicial Commission on Justice for Children. *Ensuring the Healthy Development of Foster Children: A Guide for Judges, Advocates and Child Welfare Professionals*. White Plains, NY: New York State Permanent Judicial Commission on Justice for Children, 1999.

<sup>35</sup>McCombs, Kimberly. "Evaluation Summary: Advisory Committee." Unpublished draft, August 1, 2006.

<sup>36</sup>Lederman, Cindy S. and Joy D. Osofsky. "Infant Mental Health Interventions in Juvenile Court: Ameliorating the Effects of Maltreatment and Deprivation." *Psychology, Public Policy, and Law* 10(1-2), 2004, 162-177.

<sup>37</sup>U.S. Department of Health and Human Services, Administration on Children, Youth and Families, Children's Bureau. *Summary of the Findings of the 2001-2004 Child and Family Services Review*. Washington, DC: U.S. Department of Health and Human Services, 2005. May 29, 2006, <<http://www.acf.hhs.gov/programs/cb/cwmonitoring/results/genfindings04/genfindings04.pdf>>.

<sup>38</sup>Osofsky et al., 2002.

<sup>39</sup>National Clearinghouse on Child Abuse and Neglect Information. *Concurrent Planning: What the Evidence Shows*. Washington, DC: U.S. Department of Health and Human Services, 2005, 3.

<sup>40</sup>McCombs, August 1, 2006.

<sup>41</sup>Nygren, J. "Drug Court Grads Show Appreciation." *Omaha World-Herald*, March 1, 2006.



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