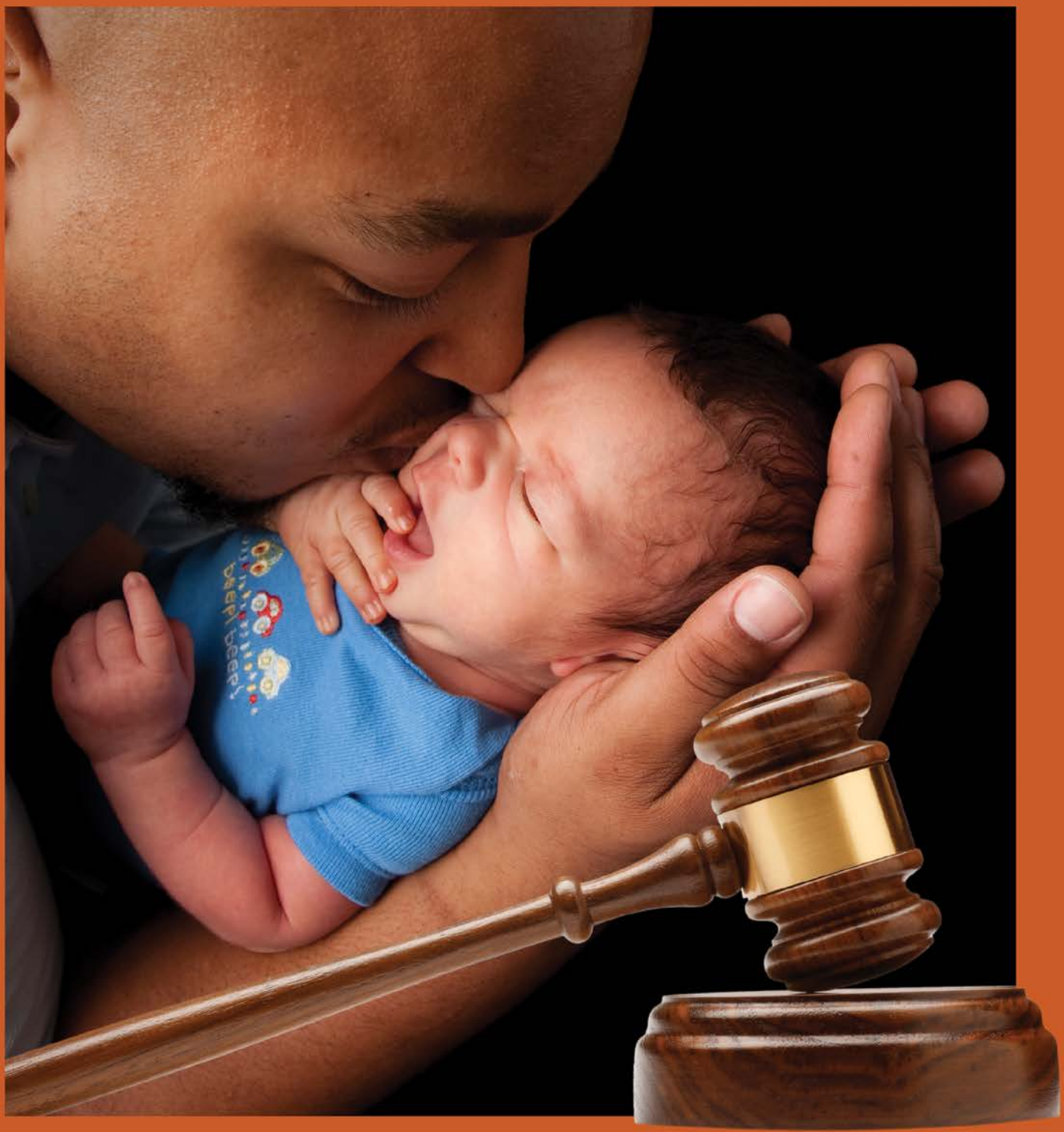
THE MIAMI CHILD WELL-BEING COURT™ MODEL

Essential Elements and Implementation Guidance



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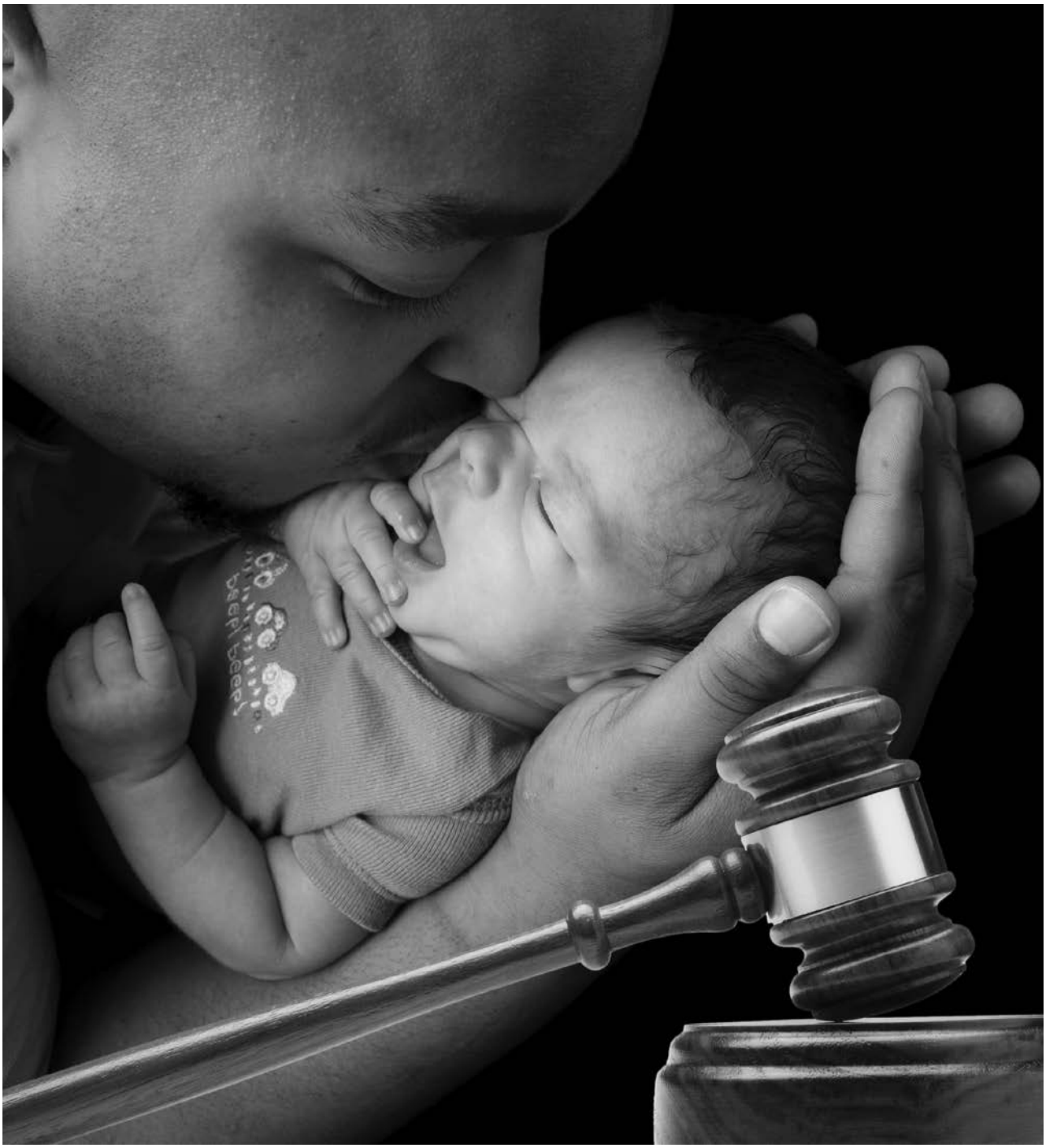

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The Miami Child Well-Being Court™ (CWBC) Model evolved out of a unique collaboration among a judge, a psychologist, and an early interventionist/education expert: Judge Cindy Lederman, Miami-Dade Juvenile Court (11th Judicial Circuit, state of Florida); Dr. Joy Osofsky, Louisiana State University Health Sciences Center; and Dr. Lynne Katz, University of Miami, Linda Ray Intervention Center.

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For further information as to how your site can partner with the Miami CWBC team for training, coaching, and implementation activities, contact Lynne Katz to schedule an initial consultation.

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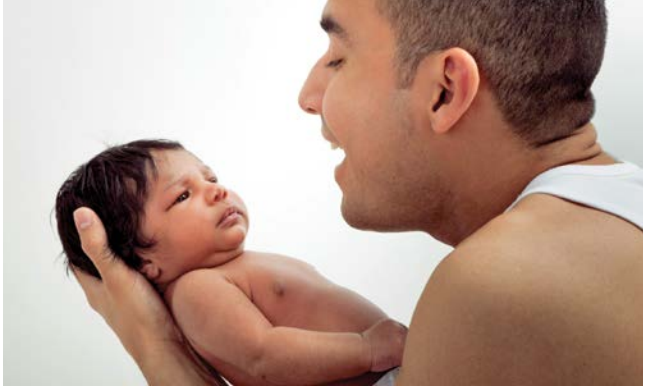


Each year in the United States, millions of young children and families become involved with the child welfare system (CWS) and the court for reasons of abuse, neglect, and other risks that jeopardize the child's safety and well-being.[1] Such adverse early life experiences are known to be powerful predictors of myriad long-term negative effects, including later emotional and behavioral disturbances, substance abuse, high-risk sexual behaviors, aggression and violent crime, and dysfunctional parenting.[2-9] The accumulation of problems across the lifespan has ties to the absence of safe, predictable, nurturing parenting in early childhood. Consistently sensitive care that provides infants, toddlers, and young children with a sense of safety, trust, and meaning in the world is a fundamental and inviolable developmental need. When this basic building block of human development is disrupted, the child's developmental trajectory can become derailed. Unfortunately, our primary system-level intervention—namely, foster care—runs the risk of further jeopardizing the child's fragile emotional state by separating him or her from the biological parent, siblings, and other important family figures. Moreover, the child's journey in foster care too often results in chronic placement instability, with the youngest children entering care at the highest rate and at highest risk for placement changes.[10] Multiple changes in caregivers, and the accompanying experience of repeated separation and attachment loss, can compound the toxic effects of the harmful experiences that resulted in child protective services (CPS) involvement in the first place.[11]

Traditional court processes focus on ensuring safety and permanency for young children, following the Adoption and Safe Families Act (ASFA, Public Law 105-89) guidelines. ASFA's goal is to reach permanency within a short timeline that accounts for the developmental characteristics of very young children and their needs for a safe and stable placement. However, traditional courts pay scant attention to the mental health and developmental needs of very young children related to their maltreatment and other harmful experiences and disruption in the caregiving environment. This approach is due, in part, to limited knowledge among professionals involved with the court about the development and mental health needs of very young children. It is often assumed that very young children are "fine" as long as they are safe, well-fed, and not abused or neglected by their caregivers. Emotional problems that manifest themselves in infancy and early childhood, such as eating, sleeping, and behavioral dysregulation, are far more subtle than the notorious behavioral and mental health problems of older children and youth in foster care (e.g., early pregnancy, delinquency, aggressive behaviors, depression, suicidality).

> "The terms coined by legal scholars to describe the transformation of the role of the judge to mentor and advisor personally involved in the case include therapeutic jurisprudence, solution-focused judging, and problem-solving courts. The judge practicing this expanded role of the court must know much more than the law. Therapeutic, solution-focused, problem-solving judging involves individualized attention, accountability, enhanced information, community involvement and collaboration. Thus the judge has a greater involvement and responsibility in each case… and the judging is much more difficult. These processes, I would argue, are the hallmarks of a well-functioning juvenile court."
>
> —Judge Cindy Lederman, Miami-Dade Juvenile Court

There are, however, numerous jurisdictions across the country vigorously engaged in court improvement initiatives to better meet the developmental and emotional needs of young children in foster care or at risk of removal from the home. Among these efforts is a court innovation that developed in Miami-Dade, Florida, over the course of more than a decade. Referred to herein as the Miami Child Well-Being Court™ (CWBC),

it is widely recognized as one of the country's flagship court improvement efforts with roots in the National Council for Juvenile and Family Court Judges and Office of Juvenile Justice and Delinquency Prevention Model Courts Project. The Miami CWBC was groundbreaking in the leadership of a judge who insisted that the court process should be informed by the science of early childhood development and who required the court to engage in intensive efforts to heal the child and—as possible—the parent-child relationship. As with the problem-solving approach of drug and mental health courts, such leadership represented a paradigm shift away from the traditional adversarial culture of the court for one in which judges "trade their typical role of objective referee for one of mentor and advisor" and instead mobilize the court to be "the catalyst and overseer of the healing process."[12] Over time, the Miami CWBC galvanized the long-term commitment and shared vision of decision-makers across the judiciary, child welfare, child mental health, and other child- and family-serving systems in Miami-Dade to create meaningful, lasting change for court-involved children and families.

The Miami CWBC™ model is anchored by three essential principles:

- The needs of vulnerable children involved in dependency court will be best served through a problem-solving court approach led by a science-informed judge. This approach is realized through a court team that is committed to collaboration in the interest of the child's safety and emotional well-being. In addition to the judge, the court team includes the attorney representing the parent, the attorney for the state, the guardian ad litem (GAL) or court-appointed special advocate (CASA), child's attorney, or both; and the child welfare caseworker.
- Young children exposed to maltreatment and other harmful experiences need evidence-based clinical intervention to restore their sense of safety and trust and ameliorate early emotional and behavioral problems. Such intervention must address the child-caregiver relationship and have the potential to catalyze the parent's insight to address the risks to the child's safety and well-being. The intervention employed in the Miami CWBC is Child-Parent Psychotherapy (CPP),[13, 14] applied to the context of court-ordered treatment.[15;a]
- The judicial decision-making process is improved when ongoing assessment of the child-parent relationship, the parent's ability to protect and care for the child, and the child's well-being is provided by the treating clinician. This is best accomplished by involving the clinician on the court team to collaborate with the other parties usually involved in court proceedings. This unusual role for the clinician in the court process is actively supported by the judge.

Across the years, numerous communities across the country and around the globe have contacted the Miami team, seeking to understand the model and learn how to put it into place. In 2009, in the context of a translational research project, the opportunity arose to study the essential elements of the model and to develop dissemination strategies to support adoption of the model in new jurisdictions. The project was supported by a grant from the National Center for Injury Prevention and Control at the Centers for Disease Control and Prevention and carried out by a multisite consortium: the originating model court team in Miami; community stakeholders in Detroit, Michigan, and Tallahassee, Florida, seeking to develop court improvement projects consonant with the Miami model; and research partners at RTI International.

This technical assistance brief is the product of a unique synergy that developed through the collaborative study of implementation processes across the originating Miami site and adopting sites. It is informed by the array of guidance in the field on dependency court best practices, infant mental health and early childhood development, implementation science, evidence-based intervention, and system integration. It is intended to serve as an introductory guide for communities seeking an overview of the Miami CWBC™ model and a roadmap of key steps to take in support of implementation, maintenance, and sustainability of the model. Our aim was to strike a balance of detail and usability for community stakeholders seeking to come away with a clear working idea of the model and concrete steps to move forward.

The first section describes practice changes essential to the model for front-line professionals working

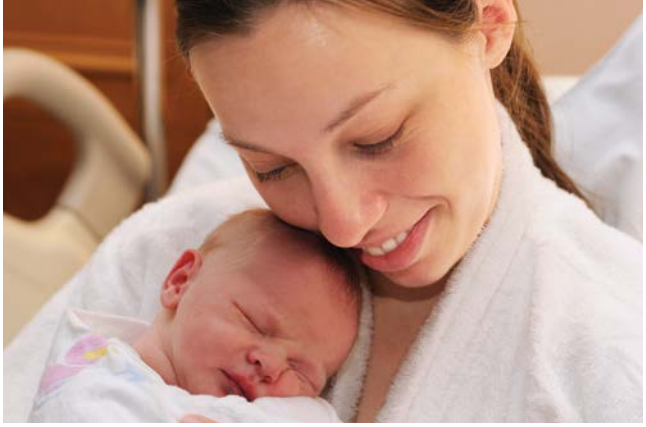
[a] Modifications to CPP are described in detail in a companion resource to this implementation guide, *The Miami Child Well-Being Court Model: A Handbook for Clinicians.*

with children and families involved with dependency court. These practice changes, or behavioral anchors, were identified through qualitative study of the dissemination and implementation processes necessary for successful uptake of the model, including court observations at the originating and adopting sites; key informant interviews with stakeholders across the various systems involved with the court project at the project sites; and close documentation of all training, coaching, and implementation activities. This section is supported by a set of tools that can be used by professionals individually as self-assessment tools to monitor areas of progress and challenge in adopting the model (see Appendix A). Section 2 presents an overview of key steps to take and areas to address in planning and carrying out implementation of the model. Sample forms and reports appear in Appendix B.

This technical assistance brief is designed to be used as a companion to two other, more in-depth resources that are part of the *Miami Child Well-Being Court™ Dissemination Toolkit:*[b] (1) *Child-Centered Practices for the Courtroom & Community: A Guide to Working Effectively with Young Children and Their Families in the Child Welfare System*,[12] offering comprehensive and practical guidance for legal, child welfare, and mental health professionals; and (2) *The Miami Child Well-Being Court™ Model: A Handbook for Clinicians*, which provides in-depth guidance to clinicians seeking to stretch their practice as a member of a CWBC team.

[b] Available from http://www.lindaraycenter.miami.edu/Home.html.

1 Behavioral Practice Changes



The implementation of a court change similar to the Miami CWBC requires both extensive collaboration among professionals from different systems and changes in professional practice for those directly working in the court. Specifically, the attorney representing the parents, the attorney for the state, the GAL or CASA, and the child welfare caseworker function as a team with a shared understanding that the caregiver-child relationship is the crucible of child well-being.[c] A CWBC depends on the leadership of a judge informed by the science of early childhood development, who requires the court to engage in intensive efforts to heal the child physically and emotionally, and on the openness and flexibility of the front-line professionals to change their everyday, familiar practices in the interest of collaborative case planning. The new practices for each member of the court team are described below.

The Judge

In a traditional court, the judge

- hears witnesses that are offered by the parties;
- expects that the caseworker or family will decide when to bring young children to the court;
- seeks evidence of compliance with services;
- assumes that the services provided to the family are helpful;
- assumes that developmental screenings, evaluations, and interventions needed by the young child will be obtained by the CWS;
- works to solve barriers and challenges during the court process;
- may accept agreements made by the parties without further inquiry; and
- bases decisions primarily on the attorneys' presentations and the written reports submitted.

In a CWBC, therapeutic jurisprudence drives every aspect of the judge's practice on the bench. This means approaching each case with sensitivity to the child's needs as relates to the experience of maltreatment and other potentially traumatic experiences (e.g., separation from caregivers, exposure to domestic violence). A healing courtroom process depends on a less adversarial and more supportive atmosphere that is sensitive to the parent's struggles and to the delicate nature of the relationship between the parent and the clinician. That is, the goal is to support the therapeutic work of the parent and child.[16,17] In court-ordered treatment, this relationship between the clinician and his client hangs in the balance. A parent who feels exposed or betrayed by a clinician during a discussion in the courtroom can disengage from treatment, thus losing crucial time and ground on the healing trajectory.

In this regard, the judge uses each hearing as a teaching opportunity for the team as well as for the parents or caregivers in the room. The judge maintains a focus on the individual child rather than on a "case," emphasizing that decisions are being made on the basis of meaningful clinical assessment acquired through the provision of evidence-based interventions. Specifically, the judge engages in numerous practices seldom seen in traditional court:

- She clearly states her expectations that the parties and clinical partners will coordinate their efforts and diligently work to build consensus about barriers and issues of contention before coming to court.
- He requires that attorneys directly address the judge and not each other; he states on the record the collective objective to work toward safe and lasting permanency and the child's well-being.

[c] Throughout this guide, we use the words "parent" and "parents" interchangeably. An illustration mentioning the mother is not meant to exclude the father (or vice versa); the use of "his" or "her" for anyone involved should be read inclusively. The term "caseworker" refers to the front-line practitioner (usually a social worker by training) assigned to the case by the CWS.

- She specifically requests that the child be brought to all court sessions, if appropriate, to see the child and keep the hearing centered on him. If the child is not in court, the judge asks why and specifically requests that the child be brought to court at the next hearing.
- He engages all parties, professionals, and participants during the court process by encouraging their active participation in the court proceeding and seeking information from all of them, including the treating clinician, throughout the court proceeding.
- She asks foster parents, the caseworker, and relatives specific questions about how the child is doing physically, developmentally, and emotionally and about what observations they have about the child-parent relationship (see *Questions Every Judge and Lawyer Should Ask About Infants and Toddlers in the Child Welfare System*).[18]
- He inquires about the quality of the services being provided and actively requires evidence-based services.
- She makes all necessary orders to have a complete description based on assessments of the physical, mental, and developmental needs of the child.
- He speaks directly with the parents and caregivers to ask about their insight and understanding about what the child needs to heal and thrive and about the case plan and their responsibilities. He encourages the parents regarding areas where improvement is needed. He reviews agreements being offered to be sure the parents and caregivers understand what is being agreed upon and what its implications are.

Even with these extensive practice changes, perhaps the greatest difference between the Miami CWBC™ model and traditional court is the way the treating clinician is integrated into the court process. Rather than providing ad hoc testimony, the treating clinician submits a status report at each hearing. The report, which is submitted in both written and oral form, is based on developmental screenings, assessments, clinical impressions, or some combination of these. It addresses five areas central to determining the family's progress toward meeting the goals of the case plan:

- the status of the child's developmental functioning and the extent to which his developmental needs are being met through referral and support services in the case plan;
- the status of therapeutic treatment—the parent's degree of compliance with and engagement in treatment, the quality of the parent-child relationship (preferably assessed in a structured way), the parent's insight into the allegation of removal, and the parent's strengths in reference to treatment goals;
- the status of parental and other risk factors and safety issues and how these risks, if left untreated, will affect the parent-child relationship, the child's safety, and the child's well-being;
- information regarding developmentally appropriate concurrent planning (i.e., planning for guardianship if the case moves to termination of parental rights); and
- ongoing concerns and corresponding recommendations regarding current or needed services or treatments to support the parent, the parent-child relationship, and the young child's developmental needs.

In summary, the judge seeks as much information as possible and inquires regarding the elements of all agreements and reasons for conclusions before reaching his own conclusions.

The Early Childhood Mental Health Specialist (Clinical Provider)

In the traditional court, a clinician working with the child, parent, or both has limited, if any, direct involvement in dependency court proceedings. The clinician is seen only infrequently in the courtroom, if ever. Usually, the clinician provides a report to the court or a party upon request, keeping all clinical information confidential, and reports in general terms on compliance with services and client progress.

In a CWBC, the clinician is a core member of the team of professionals working with the family. As such, she proactively shares information with the other professionals on the team. She also discusses with the parent—before she submits her written report to all parties and the hearing is held—what will be said in the report. Additionally, the clinician is a featured and active participant in the court proceeding, providing relevant clinical information during the hearing about the progress in reducing risk of harm for the child. In her oral report to court, the clinician references the written report and takes care to disclose information to the judge in a way

that minimizes harm to the therapeutic relationship with the parent, recognizing that the parent may need a post-hearing session to process testimony. The clinician provides recommendations for quality services and interventions that will best support the parent, the parent-child relationship, and the young child's developmental needs.

It is critical that the clinicians participating in a CWBC receive training on the dependency court process and legal terminology so that the clinical recommendations are developed and advocated for in the context of the legal proceeding. It is equally important that the clinician explain clinical terms during the proceeding, use more general language, or both so that all parties can understand his testimony. In this way, the proceeding becomes a teaching opportunity for all involved, from the judge to the parent. The central areas of practice change for clinicians involved in a CWBC are twofold:

- The clinician prepares the client for court, discusses what will be reported, and processes the client's reactions before going to court.
- The clinician incorporates the court process into the psychotherapeutic work by verbally and nonverbally supporting the parent in court and by helping the parent appropriately manage disappointment, anger, and sadness experienced during and after the court proceeding.

Without doubt, a CWBC represents major changes to and challenges in the clinical arena—in terms of both clinical practice and administrative supports. The administrative challenges include finding the resources and creating staffing structures that allow sufficient time and resources for

- knowledge-building activities,
- smaller caseloads,
- the many out-of-session (i.e., unbillable) activities involved in participating in a court team (staffings, hearings), and
- specialized clinical supervision to support high-quality clinical care with complex cases and address secondary trauma (the vicarious stress associated with helping a usually traumatized parent or child).

These administrative and structural components essential to implementing a CWBC must be worked out in the planning phase by decision-makers within and across the child- and family-serving systems that are leading and directing the court improvement initiative (see 2. Implementation Steps). To assist with planning, we have developed a detailed handbook for the integration of clinicians into the court's work. Intended as a companion to this introductory overview of a CWBC, *The Miami CWBC™ Model: A Handbook for Clinicians* provides specific, in-depth guidance and strategies regarding changes in clinical practice essential to help all participants in a CWBC initiative with implementation.

The Child Welfare Caseworker

In a traditional court, the caseworker for the child welfare agency

- has limited involvement in the court process;
- either never addresses the judge or does so only through the agency attorney;
- before court, requests a report from services providers to present to the judge at the hearing;
- responds to the report's recommendations and concerns after the hearing is completed; and
- has limited familiarity with, and does not discuss in court, services available to support child mental health, the parent-child relationship, and healthy early childhood development (such as early intervention services).

In a CWBC, the caseworker's role has many dimensions. The caseworker engages collaboratively with the court team to ensure that the child's emotional well-being is as central as risk and safety issues in his case management. He prioritizes understanding and incorporating the family's perspective, with the goal of enhancing the overall functioning of the entire family unit. Toward this end, he must become knowledgeable about specific community resources that are available to address the unique needs of the child and parent and to promote the child's health and well-being, and he must have a good sense of the quality of those resources. Examples of such resources are evidence-based parenting programs, trauma-focused treatment programs, and accredited early care and education programs. In court, the caseworker speaks directly to the judge (with support from the agency attorney, as needed) to explain how he will work with the parent to access the necessary early intervention or clinical services, and he takes all necessary steps to ensure the timely provision of services.

To work effectively in implementing court changes, it is critical that participating caseworkers receive targeted training about the child's developmental needs and the impact on well-being associated with abuse, neglect, and separation from the caregiver. Caseworkers participating in a court team will need time to develop a collaborative relationship with the clinician, regularly discussing the status, concerns, and needs of the children and their parents and substitute caregivers. When clinicians receive the court referral for psychotherapeutic services, the caseworker routinely provides the dependency petition and other legal documents to the clinician. She reviews them with the clinician, explaining the risk and safety concerns and supporting the clinician's learning process related to the legal requirements on providing critical information and evidence to the CWS.

The case manager should be an active member of the court initiative and fully aware of the time and the kinds of supports the caseworker will need to be effective in her role on the court team. For example, the manager should actively seek to develop and advance the caseworker's skills, be knowledgeable about and support the caseworker's participation in the court team, address secondary trauma, and identify possible biases that may be affecting the caseworker's handling of cases. The case manager will be instrumental in helping the caseworker to obtain salient information and evidence from the clinician and to incorporate the clinician's input into her decision-making and practice.

The key areas of practice change for the caseworker translate into the following specific actions:

- visiting the child in more than one of his living environments every 30 days;
- maintaining frequent contact with the child's parents and regularly, actively engaging the parents, clinicians, substitute caregivers, and family supports for comprehensive service planning;
- participating regularly in case plan conferences and meetings or staffings with the court team;
- convening telephone or in-person meetings with the clinician between hearings regarding progress of, and additional interventions or supports for, the parent, young child, or both;
- taking concrete steps to implement the clinician's recommendations, and addressing case-related barriers and concerns with the clinician (once consensus has been reached on the case plan and services needs of parent and child); and
- being prepared to discuss how the clinician's input informed his practice and what concrete steps have been taken to implement the clinical recommendations and address barriers or concerns.

The Parent's Attorney

In traditional court, the attorney representing the parent

- does the talking in court and directs clients not to talk, irrespective of the issue at hand;
- focuses on protecting the parent's rights and winning the case;
- cross-examines clinicians and challenges any negative statements made about the parent; and
- focuses on minimizing the number of tasks (including therapeutic services) the parent has to do in his case plan and limiting the tasks to the issue that brought the young child into the system.

In a CWBC, the parent's attorney is focused not only on protecting the parent's rights but also advocates for what the parent needs to achieve his short-term and long-term goals. She attempts to ensure that the parent's needs are met through a less adversarial problem-solving process. A collaborative working relationship between the parent's attorney and the clinician is essential to this process—and this relationship depends on the attorney's having an understanding of the child's developmental needs and the impact on the child's well-being associated with abuse, neglect, and separation from the caregiver. Toward this end, the parent's attorney participates actively in knowledge-building activities about the needs of very young children and their parents (training sessions, reading). With this foundational knowledge in place, the attorney can effectively collaborate with the clinician with the shared goal of improving the parent-child relationship. Thus, questions to the clinician during hearings are geared not toward cross-examination but toward promoting the parent's right to additional supportive services and ensuring a better understanding of the parent's treatment plan.

In a CWBC, the parent's attorney collaborates and communicates regularly with the caseworker, agency attorney, or both regarding concerns about service provision, child placement, and visitation between hearings. In this way, the team can come together before court to solve problems and prepare the recommendations that will be presented to the judge.

Taken together, these activities represent numerous new practices for the parent's attorney:

- meeting and communicating regularly with the client well before court proceedings, providing the client with contact information in writing, and establishing a message system that allows regular attorney-client contact;
- communicating regularly with the clinician to request information pertinent to the client about treatment, insights gained about allegation, progress, and concerns before the court hearing;
- participating regularly in case plan conferences and meetings with the client to help her understand the short-term and long-term legal implications of agreements made or issues discussed;
- acting in a culturally competent manner, in all communication and contact, with regard to the socioeconomic position of the parent throughout all aspects of representation;
- identifying and discussing the client's parenting strengths and challenges as well as current or potential sources of support; counseling the client about the service plan (case plan), the goals of dyadic psychotherapy, and the long-term impact that services can have in the client's life; and stressing the opportunity to resolve chronic problems that put the client's child at risk of re-entry to the CWS;
- providing the client with copies of all petitions, court orders, service plans, and other relevant case documents, including reports regarding the child, except when expressly prohibited from doing so by law, rule, or court order;
- advocating for the client's goals and empowering the client to direct the representation and make informed decisions based on thorough counsel, and working with the client to develop a case timeline and tickler system;
- educating the client about the court process and the proper way to interact with the judge and parties, asking him if there is anything he would like to directly tell the judge or if he'd prefer for the attorney to speak on his behalf, and assisting him during court when he is speaking to the judge;
- advocating for high-quality, evidence-based services and interventions that are linked to the reason for the dependency as well as to long-term stability and high quality of the relationship of the parent and child; and
- requesting information from services providers regarding the quality and effectiveness of their services for the client.

The Agency Attorney

In a traditional court, the attorney representing the state child welfare agency

- speaks for the caseworker during the hearing and does all of the speaking on behalf of the state;
- approaches the court proceeding as adversarial—the state is "against" the parents; and
- views herself as being in charge of the case and case information and focuses solely on timeliness and compliance throughout the legal process.

In a CWBC, the agency attorney collaborates with the other parties on the court team to ensure that the court is apprised not only of compliance but also of any additional services required to achieve lasting permanency and ongoing well-being for the child. The agency attorney works collaboratively with all parties to facilitate the flow of information from the caseworker to the court and to ensure that the court has the relevant information about services provided to the child and parents as well as additional needs and supports required. The agency attorney focuses on timeliness and compliance in addition to providing accurate and updated information regarding the parents' progress toward reunification. She is aware of barriers the parents face that could prevent them from participating in the proposed case plan (e.g., inability to read, language barriers) and has counseled the agency accordingly.

An essential new dimension of the agency attorney's role is to empower the caseworker with the knowledge and support to be an active member

of the court team. This is accomplished by being available to the caseworker before court to explain, in clear language, what is expected to happen before, during, and after each hearing.

As with the parent's attorney, it is essential that the agency attorney come to the table with an understanding about the child's developmental needs and the impact associated with abuse, neglect, and separation from the caregiver. This understanding can be attained through targeted training. With a foundational understanding in place, the agency attorney will be more likely to invest the time to support the caseworker's collaborative efforts as a member of the court team and to prioritize her own active involvement on the team. Such involvement will necessitate the following new practices:

- explaining to the caseworker legal issues related to individual cases;
- reviewing individual cases with the caseworker and allowing sufficient time to answer his questions;
- assisting and providing guidance to the caseworker during the hearing, as needed, to support a problem-solving approach during court proceedings;
- communicating, through in-person meetings and telephone calls, with the other professionals and parties in a case;
- sharing relevant information from the case file with other parties and the clinician in the case, when appropriate;
- monitoring progress and assessing and addressing legal barriers to safety, permanency, and well-being (e.g., unresolved paternity issues);
- informing all parties and professionals of policy or protocol issues within the agency that are barriers to full implementation of the case plan or, conversely, that provide additional support and opportunities for the child and family; and
- participating in major case meetings as needed to provide advice—particularly for a meeting in which a major decision on legal steps or strategies will be decided.

The Guardian ad Litem, Court-Appointed Special Advocate, or Child's Attorney

In a traditional court, the child advocate

- argues for what he thinks is best for the child;
- considers the young child's attendance in court to be unnecessary because the young child cannot understand the proceedings;
- focuses only on the child and views the child's needs and interests as independent from the parents' interests; and
- appears in court only when specific issues about the child will be addressed and frequently goes along with the other parties' positions, waits for another party to file a motion, or both.

In a CWBC, the child advocate grounds his arguments in a firm understanding of the child's fundamental need for a predictable and nurturing caregiving environment; the trauma for the child of being separated from her primary caregiver and family; and the impact that abuse, neglect, exposure to domestic violence, and removal from the home have on the child's behavior. Thus, the child advocate maintains a central focus on the child's relationship with one or more of her primary caregivers and considers those relationships at the core of the child well-being. As it is for the other professionals on the court team, targeted training is imperative. The child advocate should also know about federal entitlements and community services that will support the child's needs. The child advocate should develop a relationship with the child through regular interactions and visitation and observe how the child interacts with substitute caregivers, parents, siblings, and extended family. The child advocate then brings his knowledge of and observations about the child's circumstances and needs to the court team to collaborate with the other professionals to assess and develop a position (e.g., regarding the quality and quantity of parental and sibling visitation that the child needs). Specific guidance can be found in a technical assistance brief produced by the American Bar Association's Center on Children and the Law: *Advocating for Very Young Children in Dependency Proceedings: The Hallmarks of Effective, Ethical Representation*.[19]

The following practices allow the child advocate to fully represent the child's emotional and developmental needs in the CWBC process:

- becoming familiar with the child's history, including prenatal care, medical and dental care, immunizations and health screenings, quality of primary relationships, primary caregivers, the child's siblings, family and family friend connections, child care or other early care environment thus far, and familiar comforting items;
- appearing in court for all hearings in the case and on behalf of the child at all meetings and staffings;
- ensuring that arrangements are made to bring the child to court regularly, as appropriate;
- advocating for evidence-based services and effective supports that will help the young child and her family achieve the safety, permanency, and well-being goals;
- assessing regularly whether the services for the child and her family are meeting their needs;
- serving as the bridge between services providers, caseworkers, and the court, seeking remedies and obtaining entitlements as needed;
- assessing progress to support permanency for the child, always mindful of the time frame;
- raising the issue of concurrent planning at all meetings and staffings;
- if placement changes are unavoidable, ensuring that transitions are thoughtful and well-planned; and
- making the point to discuss the child's well-being and speak for the young child in court.

2 Implementation Steps

Establishing the Leadership and Management Structure

The implementation of a CWBC is first and foremost dependent on the leadership of a judge who forms a coalition of cross-systems partners—a steering committee—with a shared vision for and commitment to the long-term work of systems change. These partners must represent the key child- and family-serving system stakeholders in the community who are willing to commit time, energy, and enthusiasm for what can be painstaking and incremental work. Systems that should be represented are administrators and decision-makers from the local CWS unit or area office, the parents' bar, the attorney general's office, child advocates (GAL or CASA representatives), and community mental health providers. Other relevant partners may include leaders from local early intervention, early education and care (including Early Head Start), domestic violence, and substance abuse treatment programs; health care providers; foster parent organizations; and children's advocacy groups. It will be strategic to also include a researcher from a local university (e.g., a school of public health, social work, or medicine [e.g., psychiatry; pediatrics]) who can facilitate and lead evaluation activities for the initiative. Those who serve on the leadership team should be well-informed and savvy about the internal and external social and political context within which a CWBC is being implemented (e.g., relevant local, state, and national leadership changes; funding opportunities and changes; economic and political pressures or avenues).

Core members of the steering committee will serve as a leadership team to plan for and oversee the initiative throughout all phases of implementation (exploration, initial implementation, full implementation, maintenance, and sustainability). The leadership team includes the judge and other members of the steering committee directly responsible for overseeing implementation of the model, as well as supervisors and representative front-line professionals serving on the court team. A powerful way to characterize the leadership team is as a community of purpose committed to the long-term and complex collaborative endeavor of building court improvement. It is important that the judge set a productive and welcoming tone for these meetings, one of patience, flexibility, respect, and active listening. An atmosphere that feels hierarchical or one in which members jockey for power or become defensive will undermine the collaborative process. When there is confusion or distraction, the judge can be instrumental in inspiring consensus, regularly referencing the vision, goals, and innovation of the approach. He or she keeps the work relevant and meaningful by referencing progress made toward attaining goals and the positive impact the collaborative work is having on outcomes for very young children and their parents.

The leadership team will benefit from participants who possess the following attributes:

- Ability to see their own system from a macro and micro perspective
- Openness and collaborative style
- Comfort working outside of traditional boundaries
- Openness to innovation
- Belief in the model
- Willingness to concede control when appropriate
- Strengths-based orientation toward families

The members of the leadership team—and the steering committee—must be in it for the long haul—aware that the process will require at least 5 years for sufficient planning, initial implementation, and preliminary evaluation. Ideally, the steering committee meets at least monthly, and the leadership team meets more frequently, through the initial 1–2 years of planning. Early in the process, to lay the foundation for informed planning and decision-making, the leadership team seeks out and

participates in knowledge-building activities about the needs of very young children, child maltreatment and trauma, and evidence-based interventions.

It will be helpful to create a position at one of the partnering agencies for a program manager or coordinator. This professional, who may be responsible directly to the judge or be an employee of the child welfare agency or a community mental health organization, can be responsible for documenting and managing committee communications; scheduling meetings (steering committee, leadership team); scheduling and providing administrative support for trainings, including arranging for continuing education credits; and assisting with other coordination activities. The program manager role may also provide more expansive administrative and functional support to the operations of the court team in such areas as screening for eligible families, assisting with resource advocacy for families, assisting with grant proposals, and managing program implementation and outcome data.

The rest of this section describes the specific areas that will require attention on the part of the leadership team and steering committee, and provides helpful links to the many resources that exist to support court improvement work in the area of child abuse and neglect.

Promoting Visibility and Engaging in Policy Advocacy

An early and ongoing priority is to engage vigorously in relationship-building work that promotes a policy climate—at both the state and local levels—that will support integration of child well-being–informed perspectives and practices into the systems serving court-involved children and families.[23] Key leaders to engage include the chief judge, child welfare and other agency directors, leaders in the state bar, and other professional organization directors. These early relationships will generate the advocacy, visibility, and (optimally) funding to support sustainability of a CWBC and—ultimately—to catalyze broader impact[24] through diffusion of the CWBC to other jurisdictions and population targets (e.g., institutionalizing training of new judges to the CWBC docket, expanding CWBC dockets, expanding the target population to include older children and youth). In advocating for a CWBC, it is important to emphasize that the Miami CWBC™ model encompasses—and enhances—the best-practice principles defined in *Building a Better Court: Measuring and Improving Court Performance and Judicial Workload in Child Abuse and Neglect Cases*, a guide and toolkit from the National Council of Juvenile and Family Court Judges and two partner organizations.

Funding

A major organizational barrier that applies to all front-line professionals involved in a court team is financial pressure around productivity, case load, and time frames. Addressing funding issues, as they play out within each of the different systems involved in the CWBC model, is fundamental to successful implementation of the model. This will involve creativity in maximizing available federal, state, and private funding sources and engaging in policy-level advocacy, such as working with public funders to adjust requirements to allow sufficient time for front-line staff to engage in training and supervision and to carry out the time-intensive collaborative work across systems. From a sustainability perspective, the costs associated with the model are ideally covered by court, agency, or other resources, although time-limited grants will likely be necessary at the outset. A memorandum of agreement between the court and the child welfare and community mental health agencies can specify what each has agreed to in this joint enterprise, and it can identify roles and responsibilities (a safeguard against discontinuance when judges and agency directors change). Outside funding can support these activities. Potential linkages with the state's Court Improvement Program (CIP) activities should be explored. Since FY 2001, the Administration for Children & Families Children's Bureau has provided CIP funding to all eligible states (50 states, the District of Columbia, and Puerto Rico) to conduct assessments of their foster care and adoption laws and judicial processes and to develop and implement a plan for system improvement. Funding also includes improvements that the highest courts deem necessary to provide for the safety, well-being, and permanence of children in foster care and to implement a corrective action plan in response to findings identified in a child and family services review of the state's CWS. Private local and state foundations interested in maltreated children and vulnerable populations should also be explored, as well as national organizations such as the Annie E. Casey Foundation, Casey Family Programs, and the Doris Duke Charitable Foundation.

Building the Early Childhood Mental Health Workforce

One of the most challenging aspects of the Miami CWBC™ model is increasing the capacity of communities to provide evidence-based psychotherapeutic services to children and families participating in a CWBC. Thus, a first step for the steering committee is to assess the availability of evidence-based treatment providers in the community. This can be accomplished through an environmental scan.[25]

In the Miami CWBC™ model, the intervention is CPP, a relational treatment for children ages birth to 5 years and their caregivers.[15] CPP has been studied in several randomized controlled trials, one with a sustained effect of 6 months.[26-33] In the Miami model, the relational focus of CPP is central to the goal of repairing the parent-child relationship and healing the child's traumatic stress. CPP is considered a powerful therapeutic vehicle for catalyzing the parent's insight and motivation to address the problems that resulted in involvement with the CWS and the child's removal from the home.

A number of registries or research reviews are available describing evidence-based or evidence-supported parenting interventions, child trauma treatment, and foster care enhancements for court-involved children and families. The following are highly relevant resources for selecting a clinical intervention.

- The California Evidence-based Clearinghouse for Child Welfare: http://www.cebc4cw.org
- National Child Traumatic Stress Network Empirically Supported Treatments and Promising Practices: http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices
- Closing the Quality Chasm in Child Abuse Treatment: Identifying and Disseminating Best Practices. The Findings of the Kauffman Best Practices Project to Help Children Heal from the Effects of Child Abuse: http://www.chadwickcenter.org/Documents/Kaufman%20Report/ChildHosp-NCTAbrochure.pdf
- Child Exposure to Trauma: Comparative Effectiveness of Interventions Addressing Maltreatment. Prepared by the RTI-UNC Evidence-based Practice Center for the Agency for Healthcare Research and Quality (www.effectivehealthcare.ahrq.gov/reports/final.cfm). Guides for patients, clinicians, and policymakers are forthcoming and will be available at http://effectivehealthcare.ahrq.gov/index.cfm/research-summaries-for-consumers-cliniciansand-policymakers/ and the full report at http://effectivehealthcare.ahrq.gov/ehc/products/298/846/Child-Maltreatment_ProtocolAmendment_20120112.pdf.[34]

In assessing the landscape of services and exploring which evidence-supported interventions are available or need to be implemented, it will be helpful to explore resources available through to the National Implementation Research Network (NIRN). Based at the University of North Carolina at Chapel Hill, NIRN is a group of researchers specializing in implementation science and its application to various child- and family-serving systems. NIRN has provided targeted support to child welfare agencies in instituting and sustaining systemic changes through implementation-informed processes. See http://nirn.fpg.unc.edu/project-portfolio#childwelfare for a description of NIRN child welfare projects to date.

Selecting the Court Team

Professionals identified to serve on the court team will need certain qualities, listed below. Selection is probably best accomplished through a formal interviewing process.

All members of a court team should have

- genuine enthusiasm for and commitment to the court model and a strong desire for the model to succeed;
- a desire for lifelong learning, improving their practice, and learning new skills;
- patience for listening to and learning from others;
- openness to adapting to a nontraditional court and rethinking core aspects of their professional practices and training;
- respect for and willingness to work with professionals from different disciplines;
- established expertise in their discipline;
- capacity to see the big picture and appreciate the benefits of cross-systems work; and
- strong oral and written communication skills.

Specific disciplines call for certain additional qualities that will support collaborative work and success of the model:

- Attorneys and advocates—expertise or a stated interest in child well-being and mental health; humility
- Clinicians—comfort going to court or experience presenting in court and a stated interest in the court and child welfare systems
- Caseworkers—experience with concurrent planning and working with complex cases that involve young children and mental health services; approaching their work with families using a strengths-based lens

At the same time that front-line professionals are selected and trained, and cross-disciplinary activities are planned to foster dialogue and learning, front-line professionals should be offered a trial period to see if they are a good fit for the model. Those who do not feel comfortable with the CWBC must have an opportunity to decline participation, even if they were originally highly enthusiastic about participating in a CWBC.

Work with children who have been abused and neglected attracts professionals who tend to be highly altruistic, with passion for their work and the genuine desire to help improve the lives of vulnerable children. However, the work is very taxing. Highly capable professionals from all systems burn out, producing turnover at all levels. Contingency plans should be developed for ongoing selection and training of front-line professionals to either replace those leaving or offer a respite to members of the team by reducing the number of children and families they are involved with in the CWBC.

When the time comes to identify a new judge to preside over the CWBC or to work with a new judge assigned to the special docket, a procedure should be in place to help orient him or her to the focus on healing the child-parent relationship and adopting new practices in line with a CWBC (e.g., incorporating the clinical perspective in court, protecting the time needed for effective intervention).

Training

Activities that build knowledge about the needs of young children in the CWS are essential to implementation. A vital area for the steering committee and leadership team will be to prioritize and plan both training and administrative supports for the changes in professional practice essential to a CWBC. At the outset, an orientation is needed for each system involved in the court improvement effort—judicial, legal, child welfare, and child mental health—on the essential elements of a CWBC. The originating Miami court team is available for consultation in planning and also available to lead this training. This introductory training should ideally take place at a community-wide meeting in which all relevant stakeholders are invited to learn about the initiative. Once initial implementation of the CWBC is in place, the leadership will need to turn its attention to planning and facilitating ongoing training and education opportunities that reinforce the new practices of the court team. Ideally, ongoing training to support the practice changes essential to a CWBC (e.g., the shift away from a cross-examination questioning style by the lawyers on the team to protect the therapeutic relationship) should include the opportunity to exercise new skills in a mock court. Clinicians, in particular, benefit from opportunities to engage in mock questioning exercises with attorneys. Practicing new skills in the safe environment of a training exercise such as a mock court is an important way to learn and become more confident. Though a mock court can be convened without the judge's participation, the exercise is most powerful when the judge is there to ask "real" questions and offer targeted, off-the-record feedback to the other members of the team.

Professionals selected from each discipline to be the front-liners working for the CWBC should be offered the opportunity to attend relevant state and national training sessions. As the CWBC is implemented, each new group of professionals should go through a period of training and orientation before engaging fully with the CWBC. Informal lunch-and-learn sessions and in-service training days facilitated by legal, child welfare, and child mental health professionals and other experts in the community are another important training activity. These sessions can reinforce and further develop each team member's understanding of other professions' practices.

Additionally, it will be important to carve out protected time and space—respite sessions—for the front-line professionals on the court team to come together to refresh their commitment to the hard work and incremental (indeed, sometimes invisible) progress of systems change. These gatherings will also offer a place to discuss and vent about challenges and obstacles; reenergize their shared vision for abused and neglected children; brainstorm about ways to facilitate their collaboration; and troubleshoot procedures related to hearings, staffings, and cross-systems communication. This will help to build and strengthen the cross-systems relationships and address the problems of burnout and turnover that affect services providers working with challenging families in increasingly underresourced systems.

The National Child Traumatic Stress Network (NCTSN) has a wealth of materials that can be incorporated into any community's training plan. One particularly important resource is the widely used and publicly available *Child Welfare Trauma Training Toolkit*, 3rd edition (2013), a set of materials and step-by-step guidance for training professionals across the child- and family-service systems about child traumatic stress. The toolkit was designed to teach basic knowledge, skills, and values about working with children who are in the CWS or who have experienced traumatic stress. It provides an excellent foundation for child welfare caseworkers, supervisors, and administrators in creating trauma-informed child welfare practice. Additionally, the NCTSN has developed a set of multimedia presentations from the Learning Center for Child and Adolescent Trauma Service's system speaker series and a service system brief on the topic of judges and child trauma and ways to work with the National Council of Juvenile and Family Court Judges to promote education on child trauma. These and other helpful resources are available at http://www.nctsn.org/resources/topics/creating-trauma-informed-systems.

Another key resource for training is the Administration for Children and Families Children's Bureau, which provides an expansive training and technical assistance (T&TA) network to build the capacity of state, local, tribal, and other publicly administered or publicly supported child welfare agencies and family and juvenile courts (http://www.acf.hhs.gov/programs/cb/programs_fund/state_tribal/ct_imprv.htm). Among the many different T&TA centers, the National Child Welfare Resource Center for Legal and Judicial Issues (NRCLJI) and the National Child Welfare Resource Center for Organizational Improvement (NRCOI) provide specialized training, consultation, and supportive materials for communities engaged in court and system improvement efforts. For example, the NRCLJI offers T&TA on

- improving legal representation, specific to parent, child, and agency representation;
- understanding and following federal laws;
- adhering to legal ethics;
- planning strategically for courts;
- improving court procedure and practice; and
- collaborating between agencies, courts, and other key stakeholders.

The NRCLJI is a collaborative entity representing the American Bar Association's Center on Children and the Law, the National Council of Juvenile and Family Court Judges, and the National Center for State Courts. Each of these entities offers a wealth of technical assistance materials to support systems change and practice improvement in serving the needs of children involved with protective services and the court.

A comprehensive list of suggested training areas for professionals participating in a CWBC court team is provided in Appendix C.

Determining Procedures and Protocols

Several procedures will need to be hammered out before implementation of a CWBC can begin. Release forms will be needed to exchange information essential for communication among members of the CWBC and to protect confidentiality. Release forms developed for the CWBC must adhere to federal and state laws, specifying what information will be released to whom. An example of release forms is provided in Appendix B-1. Examples of a memorandum of agreement between the mental health agency and the CWS is provided in Appendix B-2, while Appendix B-3 provides a service guide describing infant mental health services for maltreated children. If the implementation of the CWBC has a research component, an example of a research data combination form is provided in Appendix B-4.

A second procedural issue to define during the planning phase is adherence to conditions of participation—whether to reward adherence and how to sanction nonadherence. Rewards and sanctions should be imposed with great care and with much input from the clinical partners. Many parents in the CWS have never had an appropriate parental role model; a comment from the judge, who acts as a parental authority figure, can help them find the motivation needed to change and work to develop better parenting skills and repair the relationship with their children. For example, the judge can have available inexpensive age-appropriate toys and children's books to give the parent. This simple act can be a powerful reinforcement for the parent, in terms of his efforts to both adopt more positive parenting behaviors and maintain or increase his engagement in the clinical work.

A third protocol issue is the task of identifying the target population and determining eligibility criteria. Clinical eligibility criteria should be well defined and developed with an understanding of treatment capacity in the community to provide child welfare-informed services and supports as well as evidence-based intervention to children and families. For example, in Miami the target population is children birth to 6 years old who have been removed from their homes and adjudicated dependent (wards of the court). Caregivers must be able to engage in treatment, so parents who have severe mental health or substance abuse problems are not eligible. Another eligibility criterion that may be appropriate for a new CWBC is limiting the population to parents with only one or two children, so as to work with parents who are younger and more amenable to intervention. An example of the Miami CWBC referral eligibility checklist for CPP is provided in Appendix B-5.

Finally, another critical protocol to establish during the planning phase pertains to informed consent procedures. Implementation of the CWBC will require the development of documents to be signed by the parents, lawyers, and guardians of minor parents about participation in the CWBC. Parents' participation in CWBC is voluntary. Front-line professionals working in the CWBC should ensure that parents' choices are informed, both before and during the program; that the parents fully understand the requirements of participation before agreeing to participate in a CWBC; and that they are provided legal counsel to inform this decision and subsequent decisions about program involvement. The clinical information that will be presented during the hearing, and their confidentiality rights, should be clearly explained to parents before they agree to participate in a CWBC. The informed consent should describe how the CWBC adheres to federal and state laws that protect the confidentiality of medical, mental health, and substance abuse treatment records. The terms of participation should be individualized to each parent-child pair and should be put in writing before the parent's decision to enter the program. The terms of participation will likely require adherence to a treatment plan that will be developed after engagement with the CWBC, and parents should be made aware of the consequences of noncompliance with this plan. An example of such agreements for parents participating in a CWBC with an evaluation research component is provided in Appendix B-6.

Evaluating

Evaluation is a key driver of effective implementation. Indicators of progress (e.g., number of children screened, assessed, and provided intervention) and outcomes (safety, permanency, and child well-being) will need to be selected and ongoing monitoring of them institutionalized. The National Center for State Courts Dependency Court Resource Guide provides guidance for selecting court improvement outcomes (http://www.ncsc.org/Topics/Children-Families-and-Elders/Dependency-Court/Resource-Guide.aspx). Two of these resources, available from the National Resource Center for Child Welfare Data & Technology, are the recently released issue paper (http://icmelearning.com/well-being-event/docs/Well-Being-Measures-Courts-Children.pdf) and proposed list of measures (http://www.icmelearning.com/well-being-event/docs/Well-Being-Measures.pdf) for evaluating child well-being outcomes for courts.

At a minimum, information is needed about indicated or substantiated reports and re-reports of maltreatment, which is part of the data collected from states for the *Child and Family Services Reviews* (CFSRs). CFSR Safety Outcome 1 (*children are, first and foremost, protected from abuse and neglect*) relates to recurrence of maltreatment, defined as the second, third, or subsequent time that a child has been found to be a victim of maltreatment (substantiated or indicated) within a 6-month period after a prior determination that a child was

victimized. The most recent CFSR data, from the 2007–2009 period, show that in 2009 the median recurrence across states was 5.6%.[35] As recurrence is very low during the first 6 months after a report to CWS, it is more meaningful to look at re-reports across a longer period of time. The committee will need to determine the periodicity of court reviews beyond the 6-month time point that aligns with the CFSR data.

An additional approach for assessing the impact of the CWBC is to conduct a review of court records for cases with similar demographics for a period preceding the installation of the new court. The goal is to estimate rates of re-reports for child abuse and neglect when the court was doing "business as usual" compared with rates after the CWBC was implemented. Ideally, this retrospective review should span 3 or more years of court records before implementation of the new CWBC, as that time frame will allow for data to be collected for long follow-up periods. The target population criteria set for eligibility to participate in the new CWBC should be used to identify previous cases with similar characteristics. In the area of permanency, the records review should collect information related to each placement of the child, including the type of placement (in home with biological parents, or out-of home placement: formal kin care, informal kin care, foster care) and final permanency status (reunified, adopted, guardianship, or discharged to relative). An example of a court records review form is provided in Appendix B-7. An example of a clinical records review form is provided in Appendix B-8.

In addition to comparing safety and permanency outcomes in your jurisdiction to CFSR data, it is important to refer to the annual *Child Maltreatment Report*. This report is based on the National Child Abuse and Neglect Data System (NCANDS), which collects case-level data on all children who received a CPS agency response in the form of an investigation. Case-level data include information about the characteristics of reports of abuse and neglect, the children involved, the types of maltreatment that are alleged, the dispositions of the CPS responses, the risk factors of the child and the caregivers, the services that are provided, and the perpetrators. The child maltreatment reports are available on the Children's Bureau Web site at www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment. Another important source for comparative data on foster care placement and permanency is available from the Adoption and Foster Care Analysis and Reporting System (AFCARS). AFCARS collects case-level data from states on all children who received a CWS agency response and are placed out of home. The AFCARS data set includes cumulative data on each child's removal and placement history, as well as detailed information on the child's current placement. AFCARS reports are available at http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/afcars.

Child well-being is more difficult to measure and has yet to be well defined and measured nationally for children involved with CWS in the United States. Currently, it is generally understood to refer to child mental and behavioral health (e.g., traumatic stress and other mental health symptoms; aggressive behavior) and to the child's healthy development (e.g., cognitive, physical). However, it is important also to assess other outcomes that are associated with resilience. These outcomes include the quality of the child's attachment relationships (for young children) and positive changes in caregiver nurturing behavior, attitudes toward the child, and the use of developmentally appropriate and positive discipline strategies.

Currently, there is no standard across states of how to measure well-being; as a consequence there is no equivalent in this area to NCANDS and AFCARS. The only nationally representative data with indicators of child well-being is the National Survey of Child and Adolescent Well-Being (NSCAW). NSCAW is a longitudinal study intended to answer a range of fundamental questions about the functioning, service needs, and service use of children who come in contact with the CWS. With two cohorts, each of approximately 6,000 children, the data sets are being used by researchers to identify comparison groups for studies that have only an intervention group of maltreated children. NSCAW allows comparing outcomes in all three areas (safety, permanency, and well-being), but to make comparisons in the area of well-being would require that the same well-being instruments used in NSCAW be used to assess children in the CWBC. Given that state-of-the-art instrumentation is used for NSCAW, the field is currently discussing using NSCAW as a standard model to assess well-being in maltreated children.

Information about NSCAW and the instrumentation used in the study is available at http://www.acf.hhs.gov/programs/opre/research/project/national-survey-of-child-and-adolescent-well-being-nscaw.

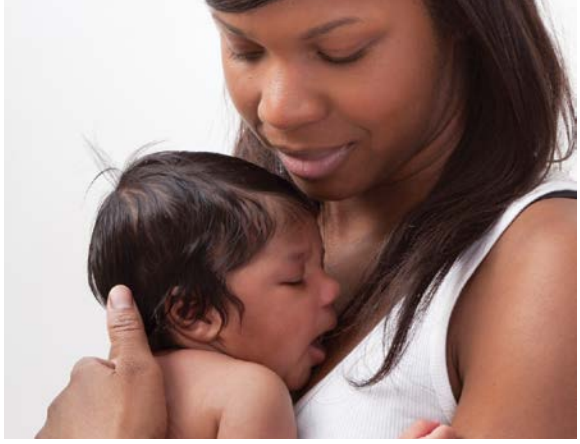
Once outcomes have been selected, an evaluation plan will need to be developed and carried out. As mentioned previously, partnering with a researcher from day one creates a seamless pathway through the data planning process. This university partner should have expertise in conducting assessments and research with child welfare populations. Most university faculties are familiar with NCANDS, AFCARS, and NSCAW and can help identify measures that would allow making comparisons at the state and national level in the areas of permanency, safety, and well-being.

For example, one of the sites involved in the Miami CWBC Initiative (Detroit) is entering a new phase of implementation of a CWBC and evaluation supported by funding from a local foundation, a team of university evaluators will be routinely conducting assessments of children and caregivers being seen in the specialized court docket. This will yield objective and unbiased evaluation of each child and family for program evaluation purposes. It will also provide the judge and front-line professionals the most reliable information about changes before and after clinical intervention to inform the court team's and the judge's decision-making. This approach also protects the therapeutic alliance between the clinician and the parent, as the clinician will not have to present assessments—often negative—in court. On the other hand, if the changes after therapy are positive, a third party provides the certainty to all other professionals involved that those outcomes are not the result of a positive relationship between the clinician and her client that may have biased the clinician's assessment of the parent.

Performance measures and outcome data will be essential for the CWBC sustainability. Because sustaining a CWBC without funding is difficult, long-term funding sources to support the evaluation need to be identified and cultivated early in the planning phase. A clear articulation of what the CWBC plans to accomplish, and how the evaluation will provide that information, will strengthen applications for long-term funding from public and private sources. Compiling empirical evidence of program successes builds visibility. Findings can be presented to the community at large. Key county officials, state legislators, foundation program officers, mental health officials, and the media can be invited to learn about a CWBC and how it has changed outcomes for vulnerable children in your community.

A final note about evaluation: keep in mind that the impact of a CWBC will increase as it becomes increasingly established and routinized. Thus, it is important to identify realistic, measurable improvement goals and time frames for gauging outcomes. A major consideration is that reunification for families participating in the specialized docket cannot be a stand-alone goal. For many cases, a positive outcome will be decreasing the time to a positive placement (adoption by a relative), in combination with the parent reaching the goal of insight that, at this time in her life, she cannot effectively protect the child. In this way, the parent-child attachment relationship may be healed and even sustained in a way that can be positive for both the parent and child. The goal, ultimately, is to repair and set the child on a healthy developmental course—either with the parent in a safe, stable, and nurturing relationship or as a loving presence in the child's heart and mind.

3 Conclusion



The CWS and the judicial system are in a critical position to help young maltreated children and their families. In order to heal and prevent further damage, it is critical to develop mechanisms by which young children can be identified as being in acute need of services. Early identification and referral to evidence-based psychotherapeutic parent-child interventions is a crucial mean for promoting caregiving and healing the effects of maltreatment. With appropriate early intervention, parents can gain pivotal insights about their children's needs and behaviors, and their capacity for mutual joy and protection of the child can be restored.

A CWBC provides a problem-solving alternative to the traditional court approach wherein the needs of young children too often slip through the cracks. A CWBC expects that all involved work together as a team on the case. This means that the team members communicate frequently, prepare for hearings collaboratively, keep one another as informed as possible about new developments that arise, and endeavor to work toward shared goals and objectives that keep the child's needs foremost.

The collaborative, less confrontational approach represents a shift from the clinician as the on-call expert to help with urgent decisions to an integrated part of the family's support system. In the CWBC model, the clinician's perspective is deemed fundamental in the courtroom, continuously bridging the many different perspectives in the courtroom, across the entire trajectory of the case, to maintain the focus on the child. As a regular participant in hearings, the clinician adds timely, cumulative knowledge about the family. This approach improves the collective certainty regarding decisions that are made and maintains the focus on the child's needs and the parent-child relationship. This scenario is never perfect, but it is a benchmark toward which the CWBC team aims. The judge ensures a less adversarial climate by providing sufficient opportunity for all parties to present issues, stating on the record the collective objective to work toward safe and lasting permanency and well-being for young maltreated children. The judge clearly states her expectations that the parties and clinical partners will coordinate their efforts and diligently work to build consensus around barriers and issues of contention prior to coming to court. Thus, caseworkers and attorneys representing the parents, the child, and the CWS system develop a working relationship with the clinician and understand that he is a neutral professional dedicated to supporting and enhancing the parent-child relationship. Questions to the clinician during hearings are geared at promoting the parent's right to additional supportive services and ensuring a better understanding of the parent's treatment plan. Critically, the attorneys advocate for high-quality, evidence-based services, and interventions that are linked to the reason for the dependency as well as to long-term stability and quality of the relationship of the parent and child.

As a systems-change initiative, a CWBC demands both time and commitment to the long-term work of building trusting relationships across complex systems and traditionally independent disciplines. It moves attorneys out of their adversarial comfort zone. It expands the caseworker's vigilant perspective on safety and protection with attention to the complex picture of young children's emotional needs in the context of the caregiver-child relationship. It brings the clinician and the clinical perspective into the courtroom, as a regular and active voice in the dependency court proceedings and lens on progress in the parent-child relationship.

These behavioral practice changes present the opportunity for real and lasting change, as the front-line professionals working with children and families in the dependency court work together to heal the parent-child relationship and promote meaningful well-being of the young child. It is our hope that a CWBC, as described in these pages, can move forward, jurisdiction by jurisdiction, to make meaningful change in the emotional lives of young children and their families' capacity to care for them.

References

1. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. *Child maltreatment 2010*. 2011; Available from http://www.acf.hhs.gov/programs/cb/stats_research/index.htm#can.
2. Cicchetti, D.V. and S. Toth. *A developmental psychopathology perspective on child abuse and neglect*. Journal of the American Academy of Child and Adolescent Psychiatry, 1995. **34**: p. 541-565.
3. Djedda, C., et al. *Child abuse: Current problems and key public health challenges*. Social Science and Medicine, 2000. **51**: p. 905-915.
4. dos Reis, S., et al. *Antipsychotic treatment among youth in foster care*. Pediatrics, 2011. 128(6): p. e1459-66.
5. Egeland, B., et al. *The long-term consequences of maltreatment in the early years: A developmental pathway model to antisocial behavior*. Children's Services: Social Policy, Research and Practice, 2002. 5: p. 249-260.
6. Kim, J. and D. Cicchetti. *Longitudinal trajectories of self-system processes and depressive symptoms among maltreated and nonmaltreated children*. Child Development, 2006. **77**(3): p. 624-639.
7. MacMillan, H.L., et al. *Childhood abuse and lifetime psychopathology in a community sample*. American Journal of Psychiatry, 2001. **158**: p. 1878-1883.
8. Widom, C.S., K. DuMont, and S.J. Czaja. *A prospective investigation of major depressive disorder and comorbidity in abused and neglected children grown up*. Archives of General Psychiatry, 2007. **64**(1): p. 49-56.
9. Widom, C.S., N.R. Marmorstein, and H.R. White. *Childhood victimization and illicit drug use in middle adulthood*. Psychology of Addictive Behaviors, 2006. 20(4): p. 394-403.
10. National Survey of Child and Adolescent Well-being. *Instability and early life changes among children in the child welfare system (NSCAW Research Brief No. 18)*. (n.d.); Available from http://www.acf.hhs.gov/sites/default/files/opre/early_life.pdf.
11. Smyke, A.T., et al. *Placement in Foster Care Enhances Quality of Attachment Among Young Institutionalized Children*. Child Development, 2010. **81**(1): p. 212-223.
12. Katz, L., C. Lederman, and J. Osofsky. *Child-centered practices for the courtroom and community: a guide to working effectively with young children and their families in the child welfare system*. Baltimore, MD: Brookes Publishing, Inc; 2010.
13. Lieberman, A.F. and P. Van Horn. *Don't hit my mommy!: a manual for child-parent psychotherapy with young witnesses of family violence* 2005, Washington, DC: Zero to Three Press.
14. Lieberman, A.F. and P. Van Horn. *Psychotherapy with infants and young children: repairing the effects of stress and trauma on early attachment*. New York, NY: Guildford Press; 2008.
15. Osofsky, J.D., et al. *The development and evaluation of the intervention model for the Florida infant mental health pilot program*. Infant Mental Health Journal, 2007. **28**(3): p. 259-280.
16. Petrila, J. *The effectiveness of the Broward mental health court: An evaluation*. 2002 March, 2009]; Available from http://www.fmhi.usf.edu/institute/pubs/newsletters/policybriefs/issue016.pdf.
17. Council of State Governments. *A Guide to Mental Health Court Design and Implementation* 2005 June 2008]; Available from http://consensusproject.org/mhcp/Guide-MHC-Design.pdf.

18. Osofsky, J.D., et al. *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.

19. Maze, C.L. *Advocating for very young children in dependency proceedings: The hallmarks of effective, ethical representation*. 2010; Available from http://www.americanbar.org/content/dam/aba/migrated/child/PublicDocuments/ethicalrep_final_10_10.authcheckdam.pdf.

20. Eoyang, G.H. Be a STAR: *A tool to assess and maintain effective collaborations*. 2006; Available from www.hsdinstitute.org/books-resources/online-learning-and-products/tools.html.

21. Mattessich, P., M. Murray-Close, and B. Monsey. *Collaboration:* What makes it work (2nd ed.). 2001; Available from http://wilderresearch.org/tools/cfi/index.php.

22. U.S. Department of Health and Human Services, Administration on Children, Youth and Families, Children's Bureau, *How are we doing? A self-assessment tool for partnerships*, in *The Childcare Partnership Project*. 1998: Washington, DC.

23. National Center for Child Traumatic Stress. *NCCTS leadership: Trauma-informed systems*, 2009, November, Los Angeles, CA: National Child Traumatic Stress Network.

24. Center on the Developing Child, Harvard University. *An Ecology of Innovation*. Available from http://developingchild.harvard.edu/topics/innovation/.

25. Champnoise, C. *Workforce planning tool kit: Environmental scan and SWOT analysis (Cornerstones for Kids series)*. 2007; Available from http://www.cps.ca.gov/WorkforcePlanning/documents/toolkitEnvScanSWOT.pdf.

26. Lieberman, A.F., D.R. Weston, and J.H. Pawl. *Preventive intervention and outcome with anxiously attached dads.* Child Development, 1991. **62**(1): p. 199-209.

27. Cicchetti, D.V., S.L. Toth, and F.A. Rogosch. *The efficacy of toddler-parent psychotherapy to increase attachment security in offspring of depressed mothers*. Attachment and Human Development, 1999. **1**: p. 34-66.

28. Cicchetti, D.V., F.A. Rogosch, and S.L. Toth. *The efficacy of toddler-parent psychotherapy for fostering cognitive development in offspring of depressed mothers*. Journal of Abnormal Child Psychology, 2000. **28**(2): p. 135-148.

29. Toth, S.L., et al. *The relative efficacy of two interventions in altering maltreated preschool children's representational models: Implications for attachment theory*. Development and Psychopathology, 2002. **14**(4): p. 877-908.

30. Lieberman, A.F., P. Van Horn, and C.G. Ippen. *Toward evidence-based treatment: Child-parent psychotherapy with preschoolers exposed to marital violence*. Journal of the American Academy of Child and Adolescent Psychiatry, 2005. **44**(12): p. 1241-1248.

31. Cicchetti, D.V., F.A. Rogosch, and S.L. Toth. *Fostering secure attachment in infants in maltreating families through preventive interventions*. Development and Psychopathology, 2006. **18**(3): p. 623-649.

32. Lieberman, A.F., C.G. Ippen, and P. Van Horn. *Child-parent psychotherapy: 6-Month follow-up of a randomized controlled trial*. Journal of the American Academy of Child and Adolescent Psychiatry, 2006. **45**(8): p. 913-918.

33. Toth, S.L., et al. *The efficacy of toddler-parent psychotherapy to reorganize attachment in the young offspring of mothers with major depressive disorder:* A randomized preventive trial. Journal of Consulting and Clinical Psychology, 2006. **74**(6): p. 1006-1016.

34. Goldman Fraser J, Lloyd SW, Murphy RA, Crowson, MM, Casanueva, C, Zolotar, A, et al. *Child exposure to trauma: Comparative effectiveness of interventions addressing maltreatment.* Comparative Effectiveness Review No. 89. (Prepared by the RTI-UNC Evidence-based Practice Center under Contract No. 290 2007 10056 I.) AHRQ Publication No. 13-EHC002. Rockville, MD: Agency for Healthcare Research and Quality; February 2013.

35. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. *Child welfare outcomes 2006–2006. Report to Congress. Safety, permanency, well-being*. 2010 [cited 2012 June 27]; Available from http://www.acf.hhs.gov/programs/cb/pubs/cwo06-09/cwo06-09.pdf.

Appendix A

Self-Assessment Tools

Appendix A. CWBC Observation Tool

Case ID _____ Date _____ Court _____

MIAMI CHILD WELL-BEING COURT™ OBSERVATION TOOL

Today's Date:	Observer:
Judge:	Start time:
Type of Hearing: ☐ Preliminary ☐ Review ☐ Adjudicatory ☐ Permanency ☐ Disposition ☐ Other:	End time: Total:

A. Parties/Participants Present

Did this party attend the hearing?

Mother	☐ No	☐ Yes
Father	☐ No	☐ Yes
Child	☐ No	☐ Yes
Caseworker	☐ No	☐ Yes
GAL/CASA	☐ No	☐ Yes

Did the following participants attend the hearing?

Clinician	☐ No	☐ Yes
Child's current caregiver	☐ No	☐ Yes
Service provider ( )	☐ No	☐ Yes
Service provider ( )	☐ No	☐ Yes
Service provider ( )	☐ No	☐ Yes

B. Collaborative Atmosphere

The group climate is collegial and welcoming (i.e., the atmosphere is not tense and contentious; there is an atmosphere of respect and a positive affect).
☐ No ☐ Yes

C. Overall Impressions/Notes

In-Court Behaviors Demonstrating the Miami Child Well-Being Court™ Model

A. The Judge

Did the judge…

1. Actively engage all parties, professionals, and participants during the court process by encouraging them to actively participate in the court proceeding ☐ No ☐ Yes
2. Specifically ask the clinician to describe the strengths and challenges of the work with the parent and child and to describe relevant clinical and developmental needs of the child and parent ☐ No ☐ Yes
3. Speak directly to the parent, offer encouragement to him or her, and acknowledge areas where improvement is needed ☐ No ☐ Yes
4. Seek information from parents and caregivers regarding their needs and what the child needs to heal and thrive ☐ No ☐ Yes
5. Inquire about the quality of the services being provided and request evidence-based services when available ☐ No ☐ Yes
6. Inquire about developmental screenings, evaluations, or interventions provided for or needed by the young child and make all necessary orders ☐ No ☐ Yes
7. Use the hearing as a teaching opportunity ☐ No ☐ Yes
8. Ensure a less adversarial climate by providing sufficient opportunity for all parties to present issues, requiring that attorneys directly address the judge and not each other, and stating on the record the collective objective to work toward safe and lasting permanency and well-being ☐ No ☐ Yes
9. Ask parents directly whether they understand the contents of the case plan, their responsibilities, and the responsibilities of the agency ☐ No ☐ Yes
10. If an agreement was being offered, review the agreement and ask the parents whether they understand the agreement and its implications ☐ No ☐ Yes
11. Specifically ask parents, foster parents, caseworker, and relatives targeted questions about how the child is doing physically, developmentally, and emotionally (using *Questions Every Judge & Lawyer Should Ask*) ☐ No ☐ Yes
12. If the child is not in court, inquire as to the reason and specifically request that the child be brought to court at the next hearing, if appropriate, to see the child and keep the hearing centered on him or her ☐ No ☐ Yes

Notes/Comments

B. The Clinician

Did the clinician…

1. Describe progress in reducing risk of harm for the child, including the quality of the parent-child relationship, parental risk factors and how they affect child safety, the parent's level of engagement, and progress in treatment ☐ No ☐ Yes
2. Present the extent to which the child's developmental needs are being met by services required by the case plan ☐ No ☐ Yes
3. Describe the parent's strengths and insight gained about the allegation, the child's needs, and their relationship ☐ No ☐ Yes
4. Reference her report during the hearing ☐ No ☐ Yes
5. Disclose information as appropriate to the judge in a way that would minimize harm to the therapeutic relationship (a post-hearing session may be needed to process testimony) ☐ No ☐ Yes
6. Provide recommendations for high-quality services and interventions that will best support the parent, the parent-child relationship, and the young child's developmental needs ☐ No ☐ Yes
7. Verbally and nonverbally support the parent in court and help the parent appropriately manage disappointment, anger, and sadness experienced during and after the court proceeding ☐ No ☐ Yes
8. Explain clinical terms during the proceeding or use more general language so that all parties and participants could understand so that the proceeding became a teaching opportunity for all involved from the judge to the parent ☐ No ☐ Yes

Notes/Comments

The Miami Child Well-Being Court™ Model evolved out of a unique collaboration among a judge, a psychologist, and an early interventionist/education expert: Judge Cindy Lederman, Miami-Dade Juvenile Court (11th Judicial Circuit, state of Florida); Dr. Joy Osofsky, Louisiana State University Health Sciences Center; and Dr. Lynne Katz, University of Miami, Linda Ray Intervention Center. This tool was supported by a generous grant from the National Center for Injury Prevention and Control at the Centers for Disease Control and Prevention (No. 1R18 CE001714-01) to Dr. Jenifer Goldman Fraser (PI), Child Witness to Violence Project, Boston Medical Center; Cecilia Casanueva (Co-I), RTI International; and Dr. Katz (Co-PI).

Appendix A. CWBC Observation Tool (continued)

Case ID _____ Date _____ Court _____

C. The Child Welfare Agency Representative or Caseworker

Did the caseworker…

1. Discuss how the clinician's input has informed his practice ☐ No ☐ Yes
2. Describe what concrete steps have been taken to implement the clinical recommendations and address barriers or concerns (if a motion must be filed to accomplish this, the caseworker will have met previously with the agency attorney) ☐ No ☐ Yes
3. Explain how a particular service or intervention for the child or parent-child dyad will support the health and well-being of the child as well as the overall permanency plan ☐ No ☐ Yes
4. Explain how she will work with the parent to effectively access the necessary early intervention or clinical services ☐ No ☐ Yes
5. Speak directly to the judge, seeking support from the attorney and therapist as needed ☐ No ☐ Yes

Notes/Comments

D. The Attorney for the Parent

Did the parent's attorney…

1. Assist the client during court when the parent was speaking to the judge ☐ No ☐ Yes
2. Advocate for what the parent needs to achieve his or her short-term and long-term goals ☐ No ☐ Yes
3. Ask questions of the clinician geared toward promoting the parent's right to additional supportive services ☐ No ☐ Yes
4. Advocate for high-quality, evidence-based services and interventions that are linked to the reason for the dependency as well as to long-term stability for the parent and child ☐ No ☐ Yes

Notes/Comments

E. The Attorney for the Agency

Did the agency attorney…

1. Allow the caseworker to directly speak to/testify before the judge if caseworker wanted to do so ☐ No ☐ Yes
2. Assist and provide guidance to the caseworker as needed during the hearing ☐ No ☐ Yes
3. Approach the court proceeding as a collaborative process ☐ No ☐ Yes
4. Facilitate the flow of information from the caseworker to the court and other parties to ensure that the court has the relevant information about services provided to the child and parents as well as additional needs and supports required ☐ No ☐ Yes
5. Focus on timeliness and compliance in addition to providing accurate and timely information regarding the parents' progress towards reunification ☐ No ☐ Yes
6. Ensure that the court is apprised not only of compliance but also of any additional services required to achieve lasting permanency and ongoing well-being for the child ☐ No ☐ Yes

Notes/Comments

F. The Child's Attorney, Court-Appointed Special Advocate, or Guardian ad Litem

Did the child's attorney, CASA, or GAL…	**Attorney**	**CASA/GAL**
1. Request or facilitate the child's court attendance in accordance with the young child's developmental needs and daily schedule	☐ No ☐ Yes	☐ No ☐ Yes
2. Use a child development framework that grounds arguments on behalf of the young child in the science of early child development and attachment theory in the context of objective information about the child	☐ No ☐ Yes	☐ No ☐ Yes
3. Proactively make recommendations and argue independently on behalf of the young child and, even when in agreement with the other parties about a particular course of action, make a point of discussing the child's well-being and best interests and speak for the young child in court	☐ No ☐ Yes	☐ No ☐ Yes
4. Focus on the young child in the context of his relationship with one or more of his primary caregivers	☐ No ☐ Yes	☐ No ☐ Yes
5. Advocate for evidence-based services and effective supports that will help the young child and her family achieve stated permanency and well-being goals	☐ No ☐ Yes	☐ No ☐ Yes

Notes/Comments

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Appendix A. Safety, Permanency, and Well-Being Indicators (supplement to the Observation Tool)

Case ID _____ Date _____ Court _____

MIAMI CHILD WELL-BEING COURT™ OBSERVATION TOOL[1]

Safety, Permanency, and Well-Being Indicators

A. SAFETY: Did the following issues come up during the hearing?

A1: Where the child is placed AND the appropriateness of the current placement[2] ☐ **No** ☐ **Yes**
A2: Whether the caregiver has been provided information specifically related to the child's unique needs ☐ **No** ☐ **Yes**
A3: Whether the caregiver has been provided support specifically related to the child's unique needs ☐ **No** ☐ **Yes**
A4: *Discussion of agency efforts to assess child safety and address identified risks [CFSR Safety 2: Item 4; TK 1A]* ☐ **No** ☐ **Yes**
A5: If safety threats have been identified, whether the child is vulnerable to these threats (are there sufficient protective capacities?) (*Child Safety: A Guide for Judges and Attorneys* [ABA NRCLJI][3]) ☐ **No** ☐ **Yes**
A6: Whether services or supports that can be put in place today would allow the child to safely remain in the home ☐ **No** ☐ **Yes**
A7: If child is not placed with a parent, whether there is a safety reason for not placing the child with a noncustodial parent able and willing to care for the child ☐ **No** ☐ **Yes**
A8: If the child is in foster care and it is not safe to return to the parents, whether there is a relative able and willing to care for the child ☐ **No** ☐ **Yes**

B. PERMANENCY: Did the following issues come up in the hearing?

B1: Whether frequent and consistent parental visitation that is developmentally appropriate for the child is in place or planned ☐ **No** ☐ **Yes**
B2: Whether visitation with siblings is in place or planned, if children are separated ☐ **No** ☐ **Yes**
B3: *Placement changes. If placement change, reasons for change; were changes in child's best interest [Perm 1: Item 6; TK 2C]* ☐ **No** ☐ **Yes**
B4: Importance and status of concurrent case planning ☐ **No** ☐ **Yes**
B5: If child is in out-of-home licensed care (foster care), whether co-parenting strategies are being used ☐ **No** ☐ **Yes**
B6: *Whether permanency goal has been selected [CFSR Perm. 1: Item 7; TK 2C]* ☐ **No** ☐ **Yes**
B7: Parental progress toward permanency goal ☐ **No** ☐ **Yes**
B8: *Efforts made by the agency to support achievement of the permanency goal [CFSR Perm 1: Item 8/9; TK 2A]* ☐ **No** ☐ **Yes**

C. CHILD WELL-BEING: Did the following issues come up during the hearing?

C1: Comprehensive health assessment ☐ **No** ☐ **Yes**
C2: Medical home ☐ **No** ☐ **Yes**
C3: Parent participation in treatment planning ☐ **No** ☐ **Yes**
C4: Immunizations ☐ **No** ☐ **Yes**
C5: Hearing screen ☐ **No** ☐ **Yes**
C6: Vision screen ☐ **No** ☐ **Yes**
C7: Lead exposure screen ☐ **No** ☐ **Yes**
C8: Dental services (if 1 or older) ☐ **No** ☐ **Yes**
C9: Communicable diseases screen ☐ **No** ☐ **Yes**
C10: Developmental evaluation by provider with experience in child development (Part C eval) ☐ **No** ☐ **Yes**
C11: Early intervention services (Part C) ☐ **No** ☐ **Yes**
C12: Infant mental health services/dyadic ☐ **No** ☐ **Yes**
C13: Early childhood program knowledgeable about the needs of CWS children (e.g., specialized Early Head Start) ☐ **No** ☐ **Yes**
C14: Other:

D. PARENTAL WELL-BEING: Did the following issues come up during the hearing?

D1: Home visiting program ☐ **No** ☐ **Yes**
D2: Parenting skills training ☐ **No** ☐ **Yes**
D3: Substance abuse services ☐ **No** ☐ **Yes**
D4: Mental health services ☐ **No** ☐ **Yes**
D5: Domestic violence services ☐ **No** ☐ **Yes**
D6: Trauma-related clinical services ☐ **No** ☐ **Yes**
D7: Vocational rehabilitative services ☐ **No** ☐ **Yes**
D8: Psychiatric care ☐ **No** ☐ **Yes**
D9: Other:

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[1] This tool is intended to be used in conjunction with the accompanying Miami CWBC™ Court Observation Tool checklist derived from available court practice benchmarks (e.g., *NCJFCJ Resource Guidelines for Improving Court Practice in Child Abuse & Neglect Cases*).

[2] Items in italics are from Flango, V. E., & Kauder, N. (2008). *Toolkit for court performance measures in child abuse and neglect cases.* Retrieved from https://www.ncjrs.gov/pdffiles1/ojjdp/223567.pdf. Items from CFSRs and Child Safety Guide are identified with [square brackets].

[3] Lund, T.R. and J. Renne. *Child safety: A guide for judges and attorneys*. 2009; Available from http://nrccps.org/documents/2009/pdf/The_Guide.pdf.

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Case ID _____ Date _____ Court _____

MIAMI CHILD WELL-BEING COURT™ OBSERVATION TOOL CHECKLIST

A. Before the Hearing

1. Group climate tense and contentious	☐ No	☐ Yes
2. Clinicians/services providers separated/alone	☐ No	☐ Yes
3. Group climate collegial and welcoming	☐ No	☐ Yes
4. Atmosphere of respect and positive affect	☐ No	☐ Yes
5. Attorneys, caseworker, clinicians know each other	☐ No	☐ Yes
6. Professionals approach and talk with each other	☐ No	☐ Yes
7. Issues discussed by clinician with others:		
8. Safety concerns	☐ No	☐ Yes
9. Risk issues	☐ No	☐ Yes
10. Relationship compliance	☐ No	☐ Yes
11. Developmental issues	☐ No	☐ Yes
12. Services needs	☐ No	☐ Yes
13. Case plan	☐ No	☐ Yes
14. Narrative to be presented based on report	☐ No	☐ Yes

B. Did the Judge…

1. Actively engage all parties	☐ No	☐ Yes
2. Ask clinician questions for narrative	☐ No	☐ Yes
3. Speak directly to the parent	☐ No	☐ Yes
4. Seek information on parent insight	☐ No	☐ Yes
5. Require evidence on services	☐ No	☐ Yes
6. Inquire about developmental evaluations	☐ No	☐ Yes
7. Expect team coordinated efforts	☐ No	☐ Yes
8. Inquire as to the elements of all agreements	☐ No	☐ Yes
9. Question caregivers about how the child is doing	☐ No	☐ Yes
10. Request child be brought to court	☐ No	☐ Yes

C. Did the Clinician…

1. Describe parent's insight gained about the allegation and child's needs	☐ No	☐ Yes
2. Discuss progress in reducing risk of harm	☐ No	☐ Yes
3. Say if developmental needs are being met by services	☐ No	☐ Yes
4. Detail parent's level of engagement and progress in treatment	☐ No	☐ Yes
5. List parental risk factors and how they impact child safety	☐ No	☐ Yes
6. Submit report discussed with parent before court	☐ No	☐ Yes
7. Reference his or her report during the hearing	☐ No	☐ Yes
8. Disclose information minimizing harm to relationship	☐ No	☐ Yes
9. Recommend quality services	☐ No	☐ Yes
10. Support the parent during court	☐ No	☐ Yes
11. Understand court process	☐ No	☐ Yes
12. Place recommendations in the context of the legal process	☐ No	☐ Yes
13. Explain clinical terms or teaching opportunity	☐ No	☐ Yes

D. Did the Caseworker…

1. Discuss how clinician informed caseworker's practice	☐ No	☐ Yes
2. Take steps to implement clinical recommendations	☐ No	☐ Yes
3. Describe how service will support child and plan	☐ No	☐ Yes
4. Tell how he or she will work with parent to access early intervention/infant mental health services	☐ No	☐ Yes
5. Speak to the judge w/support of lawyer, infant mental health specialist	☐ No	☐ Yes

E. Did the Attorney for the Parent…

1. Assist parent in speaking to the judge	☐ No	☐ Yes
2. Advocate for parent's needs to achieve goals	☐ No	☐ Yes
3. Promote parent's right to additional services	☐ No	☐ Yes
4. Advocate for high-quality, evidence-based services	☐ No	☐ Yes

F. Did the Attorney for the Agency…

1. Allow caseworker to speak to/testify	☐ No	☐ Yes
2. Assist/guide caseworker at hearing	☐ No	☐ Yes
3. Approach proceeding as collaborative process	☐ No	☐ Yes
4. Facilitate flow of need/services information	☐ No	☐ Yes
5. Focus on timeliness, compliance, progress toward reunification	☐ No	☐ Yes
6. Apprise on additional services to achieve permanency and child well-being	☐ No	☐ Yes

G. Did the Child's Attorney…

1. Request/facilitate child's court attendance	☐ No	☐ Yes
2. Use "child development" framework	☐ No	☐ Yes
3. Discuss the child's well-being and best interests and speak for the young child	☐ No	☐ Yes
4. Focus on the young child in the context of his or her relationship with caregivers	☐ No	☐ Yes
5. Advocate for evidence-based services and effective supports to achieve permanency and well-being	☐ No	☐ Yes

H. Comments

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Clinician:_____ Reporting Period (mm/yy):____/____ Case ID: _____

MIAMI CHILD WELL-BEING COURT™ CLINICIAN SELF-ASSESSMENT TOOL

Items A–N identify core practice areas and specific behavioral anchors for the clinical role in the Miami court model.

For each area, (1) check "No" or "Yes" to indicate whether or not the practice area was relevant to your court cases during the last month and (2) if applicable, identify the descriptions that best capture your activities. Ideally this form is completed with your supervisor.

Were questions A–N (below) completed with input from a supervisor? ☐ **No** ☐ **Yes**

A. Collection of All Referral and Eligibility Criteria Documentation From Caseworker

Did collection of documentation begin? ☐ **No** ☐ **Yes** ☐ **N/A for ongoing clients**

If "Yes," please mark all that apply:

1. Talked with caseworker to request all materials needed for intake ☐ **No** ☐ **Yes**
2. Collected or received all documentation (see last line below with list of forms) from caseworker ☐ **No** ☐ **Yes**
3. Once the case is assigned, talked with other professionals to collect collateral information emphasizing risk and safety issues ☐ **No** ☐ **Yes**
4. Collected some documents to begin the intake process but more needed ☐ **No** ☐ **Yes**
5. Collected all documents to begin the intake process, including therapeutic treatment referral form, eligibility form, verified petition for dependency or shelter petition (dependency petition), adjudicatory order, and any documentation on risk and safety ☐ **No** ☐ **Yes**

B. Child-Parent Assessment

Did child-parent assessment begin? ☐ **No** ☐ **Yes** ☐ **N/A for ongoing clients**

If "Yes," please mark all that apply:

1. Completed a few portions of an assessment but not all elements have been completed to date (see last line) ☐ **No** ☐ **Yes**
2. Partial completion of assessment, some documents outstanding ☐ **No** ☐ **Yes**
3. Completed all components of the assessment: Individual sessions with parent, including clinical observations of the child-parent relationship, child's caregiver home visit, parent home visit, child care visit/observation, review of verified petition for dependency, review of risk and safety issues, review of case plan and service provider reports (collateral information from all providers) provided by caseworker ☐ **No** ☐ **Yes**

C. Parent-Child Assessment Report

Did work on the parent-child report begin? ☐ **No** ☐ **Yes** ☐ **N/A for ongoing clients**

If "Yes," please mark all that apply:

1. Completed a report but not with the elements listed in the last line* Please list main areas: ☐ **No** ☐ **Yes**
2. Completed portions of a report, but not all elements listed below have been completed to date* ☐ **No** ☐ **Yes**
3. Completed a report during this period with all relevant documentation* ☐ **No** ☐ **Yes**

*A completed report includes all of the following that are relevant to this case: reason for referral; review of dependency petition (allegations of removal); summary of risk and safety issues; background information; family history/psychosocial history (including history of domestic violence and history of sexual abuse); substance abuse history; mental health history; employment history; legal history; placement history of child; collateral reports of child's functioning; developmental and medical history of child; observations/assessments (developmental screening tool; clinical observations of child-parent and child-caregiver interactions); conclusion (clinical interpretation of all information gathered, including strengths and areas of needed intervention and parental risk factors; diagnostic impression [DC 0-3 R]); and recommendations for parent, child, and relationship that address all risk factors).

D. Collaboration With Other Professionals

Were collaborative activities conducted during this period with any court professionals or service providers related with court case? ☐ **No** ☐ **Yes** ☐ **N/A for ongoing clients**

If "Yes," please mark all that apply:

1. Made several calls to contact caseworkers and expect to have calls or staffings in the following days ☐ **No** ☐ **Yes**
2. a) Discussed with caseworker gathering of collateral information, including risk and safety issues; b) provided information about client to identify other services needs; c) reviewed parent and child needs (substance abuse program; domestic violence program; psychiatrist; individual clinician; parenting facilitator; physical, occupational, and speech therapists; teachers; child's caregiver); d) reviewed case plan; and e) discussed narrative (based on report) to be presented at next court hearing and recommendations of services in reference to parent or child treatment needs ☐ **No** ☐ **Yes**
3. Met to discuss case and court presentation with at least one of the lawyers and caseworkers in the case covering issues in previous line ☐ **No** ☐ **Yes**
4. Staffing with caseworkers, parent's attorney, child's attorney, CWS attorney; GAL/CASA covering issues in previous line ☐ **No** ☐ **Yes**

E. Building Support System for Parent

Did you assist the client in contacting any individual to create or strengthen the support system for parent and child during this period? ☐ **No** ☐ **Yes**

If "Yes," please mark all that apply:

1. Worked with parent to brainstorm and process support systems and to define the extent and strength of the support that can be provided by the identified persons ☐ **No** ☐ **Yes**
2. Followed up with parent on progress in creating support system ☐ **No** ☐ **Yes**
3. Supported parent to invite person to session, and defined in advance the types of support needed and frequency of provision of support ☐ **No** ☐ **Yes**
4. Had session with parent and person; supported parent to discuss and make agreements on needed support ☐ **No** ☐ **Yes**

F. Clinical Status Reports

Was a status report submitted? ☐ **No** ☐ **Yes**

If "Yes," please mark all that apply:

1. A status report was prepared, including all components described in last line, but clinician was not able to attend court hearing; clinician's contact information was provided and clinician was available by phone ☐ **No** ☐ **Yes**
2. Completed a report for in-person court testimony with issues other than those described in last line ☐ **No** ☐ **Yes**
3. Completed report for in-person court testimony, including narrative answering core questions: a) How is the child doing; b) How is the child functioning in his or her environment; c) How is the child developing; d) How is the therapeutic process going; and e) What is the status of the parent's insight into the allegations of removal? ☐ **No** ☐ **Yes**
4. Completed report to be presented in person at court that includes all of the following as relevant to this case: status of therapeutic treatment, including the quality of the parent-child relationship, status of insight into the allegations of removal, parent's degree of compliance, status of risk factors, status of child's developmental functioning and extent to which the developmental needs of the child are being met through the referral and support services of the case plan, information on how developmentally appropriate concurrent planning is being maintained, recommendations that address current interventions needed ☐ **No** ☐ **Yes**

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Clinician Self-Assessment Tool *(continued)*

Clinician:_____ Reporting Period (mm/yy):____/____ Case ID: _____

G. Protecting Therapeutic Relationship: Preparation for Court Hearing

Did you participate in a hearing during this period? ☐ **No** ☐ **Yes**

If "Yes," please mark all that apply:

1. Had a hearing but there was no preparation of client for hearing ☐ **No** ☐ **Yes**
2. Had a hearing at short notice and only some elements of preparation were completed as listed below ☐ **No** ☐ **Yes**
3. In preparation for hearing, a session was conducted, without the child present if information was inappropriate to discuss in front of child, that a) reminded parent that clinicians are required to inform the judge of their client's status in therapeutic treatment; b) shared critical aspects of what was to be reported in court, with emphasis on risk and safety issues; and c) provided opportunities for client to ask questions to ensure that the parent understands the reporting process and the implications of what will be reported by the clinician ☐ **No** ☐ **Yes**

H. Participation in Dependency Court Hearing

What type of hearing did you attend on this case? Type:

1. Attended hearing and was available to provide testimony but was not questioned ☐ **No** ☐ **Yes**
2. Provided verbal report on case status but not as described in next line ☐ **No** ☐ **Yes**
3. Provided verbal report of status of therapeutic treatment, including the quality of the parent-child relationship; status of insight into the allegations of removal; parent's degree of compliance; status of risk factors; safety issues; status of child's developmental functioning and extent to which the developmental needs of the child are being met through the referral and support services of the case plan; information on how developmentally appropriate concurrent planning is being maintained; recommendations that address current interventions needed ☐ **No** ☐ **Yes**
4. Before case was called, found opportunity to have discussion with caseworkers, GAL/CASA, and lawyers to review status of case and what will be stated in court related to safety and risk issues ☐ **No** ☐ **Yes**
5. Provided written report before hearing to caseworker within the time frame of your jurisdiction, to include with the judicial review ☐ **No** ☐ **Yes**

I. Protecting Therapeutic Relationship: Processing After Court Hearing

Did you process the court experience with your client in a post-hearing session? ☐ **No** ☐ **Yes** ☐ **N/A (not necessary—if, for example, parent had a positive experience)**

1. Processed court experience 1:1 with client immediately after the hearing and later during a post-hearing therapy session with the goal of helping parent understand what took place in the courtroom ☐ **No** ☐ **Yes**
2. Helped the parent cope with his or her own emotions after the hearing ☐ **No** ☐ **Yes**
3. Let the client talk about the court experience and answered any questions ☐ **No** ☐ **Yes**
4. Helped client elaborate negative feelings in a therapeutic manner, allowed and encouraged the parent to discuss his or her emotions, and focused therapeutic work in re-establishing trust and therapeutic alliance with parent ☐ **No** ☐ **Yes**

J. Adjustment of Therapeutic Timeline

Has any formal adjustment been made of therapeutic timeline to coincide with ASFA timelines? ☐ **No** ☐ **Yes** ☐ **N/A (e.g., still early in process)**

If "Yes," please mark all that apply:

1. Therapeutic timeline was adjusted to reflect Adoptions and Safe Families Act (ASFA) Regulations ☐ **No** ☐ **Yes**
2. Therapeutic timeline adjusted for ASFA was discussed with client to provide realistic timelines for treatment completion ☐ **No** ☐ **Yes**
3. Changes made in frequency of sessions with client to incorporate hearing decisions and ASFA timelines ☐ **No** ☐ **Yes**
4. Made referrals for services to encourage progress within ASFA timelines ☐ **No** ☐ **Yes**
5. If client requires continued treatment beyond the 6-month supervision by the court after reunification, a report is provided to the court to continue working with parent and child ☐ **No** ☐ **Yes**

K. Participation in Dependency Staffings, Planning Meetings, Family Group Conferencing Meetings, and Formal Mediations

Did you attend any meetings on this case? ☐ **No** ☐ **Yes**

If "Yes," please mark all that apply:

1. Participated in one or more with other court professionals (Identify which type:) ☐ **No** ☐ **Yes**
2. Requested one or more of the above, with all parties as needed to address concerns ☐ **No** ☐ **Yes**
3. Before the meeting, staffing, or mediation, discussed with some members of the team risk and safety concerns/issues to be covered in meeting ☐ **No** ☐ **Yes**
4. Created a plan that involved parent involvement in these activities ☐ **No** ☐ **Yes**

L. Termination of Parental Rights Trial—Witness Testimony

Were you issued a subpoena to testify at a TPR trial for this case? ☐ **No** ☐ **Yes** ☐ **N/A**

If "Yes," please mark all that apply:

1. Subpoenaed. Reviewed initial assessment, all status reports, and progress notes to prepare for trial testimony ☐ **No** ☐ **Yes**
2. Contacted attorney who issued the subpoena to review information associated with parental risk factors ☐ **No** ☐ **Yes**
3. Prepared personal dossier experience information to be accepted as an expert witness at trial ☐ **No** ☐ **Yes**
4. Spoke to all parties involved in the case in reference to therapeutic treatment history and concerns related to child safety or plan for advocacy for the parents ☐ **No** ☐ **Yes**

M. Discharge Summary

Was a discharge summary needed? ☐ **No** ☐ **Yes** ☐ **N/A**

If "Yes," please mark all that apply:

1. Case was closed but no treatment discharge summary has been prepared for caseworker ☐ **No** ☐ **Yes**
2. Completed a partial report but missing some data for sections described in next line ☐ **No** ☐ **Yes**
3. a) Completed report that includes all of the following: treatment, pending concerns (if any), summary of recommendations (if any), and status of risk and safety issues and b) followed your agency's protocol for post-treatment support/resource to client ☐ **No** ☐ **Yes**

N. Reflective Supervision of Court Case

Did you have supervision last month? ☐ **No** ☐ **Yes** ☐ **Group/Peer supervision**

If "Yes," please mark all that apply:

1. Clinician brought assessment instruments and progress notes to supervision or group/peer for review of court case and signature. Review included quality of the parent-child relationship, risk factors, safety, dependency petition, other legal and collateral documents ☐ **No** ☐ **Yes**
2. Clinician described court-related process and reflected with supervisor or group/peer about legal implications affecting client progress or therapeutic relationship and clinical meaning of client behavior ☐ **No** ☐ **Yes**
3. Clinician and supervisor or group/peer reflected on a) clinician's responses to caregiver or child and b) treatment goals for the parent-child dyad ☐ **No** ☐ **Yes**
4. Clinician and supervisor or group/peer reflected on clinician's emotional experience with court process ☐ **No** ☐ **Yes**
5. Clinician and supervisor or group/peer reflected on parallel timelines and activities in court process, therapy, and supervision ☐ **No** ☐ **Yes**

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Case ID _____ Date _____ Court _____

MIAMI CHILD WELL-BEING™ OUT-OF-COURT JUDGE SELF-ASSESSMENT TOOL

Out-of-Court Behaviors Demonstrating Use of the Miami Child Well-Being Court™ Model

Today's Date:	Judge:	Court:

During the past month, how would you rate yourself in the following areas across all of your cases involved in the project?
1 (not at all) 2 (sometimes) 3 (often) 4 (frequently) 5 (all of the time)

	Score (1 to 5)	Related Training Needed at Your Site
1. Inspired consensus by regularly communicating the vision for the work and referencing the vision when there appeared to be confusion about it or distraction from it.		
2. Kept the purpose, goals, and approach relevant and meaningful by referencing progress made toward attaining these goals and the positive impact the collaborative work is having on outcomes for very young children and their parents.		
3. Conducted effective and meaningful meetings by encouraging participation at all levels of skill and knowledge; supported open dialogue and discussion.		
4. Used effective communication and interaction skills in both group and individual settings to discuss barriers and strategize about solutions.		
5. Was aware of and informed by internal and external social and political context within which the model is being implemented (e.g., leadership changes, funding opportunities/challenges, economic and political pressures or avenues).		
6. Demonstrated patience and flexibility with people and processes during collaborative or team meetings.		
7. Held regular (at least monthly) meetings with all involved in implementing the model.		
8. Met individually, as needed, with system leaders from across systems (child welfare agency, mental health, service providers, case management [if separate from child welfare agency]).		
9. Participated in knowledge-building activities about the needs of very young children and their parents, such as additional training, reading, etc.		
10. Requested assistance or further explanation from the local leadership team when next steps or processes were not clear.		
11. Supervised the status of plans and calendar of next activities to implement and sustain the model.		

Notes/Comments

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Case ID _____ Date _____ Court _____

MIAMI CHILD WELL-BEING™ OUT-OF-COURT ATTORNEY FOR THE STATE AGENCY SELF-ASSESSMENT TOOL

Out-of-Court Behaviors Demonstrating Use of the Miami Child Well-Being Court™ Model

Today's Date:	Attorney for the State Agency:	Court:

During the past month, how would you rate yourself in the following areas across all of your cases involved in the project?
1 (not at all) 2 (sometimes) 3 (often) 4 (frequently) 5 (all of the time)

	Score (1 to 5)	Related Training Needed at Your Site
A. Provided Support to the Caseworker		
1. Provided counsel to the caseworker about all legal matters related to individual cases as well as policy issues.		
2. Spent sufficient time with caseworker to prepare individual cases and answer questions.		
3. Explained to the caseworker, in clear language, what is expected to happen before, during, and after each hearing.		
B. Collaborated and Communicated With System Partners		
4. Cooperated and communicated through in-person meetings and telephone calls; when appropriate, periodically and regularly monitored the case with other involved professionals and parties, including the caseworker, parents' attorneys, child's attorney or CASA, and the clinician.		
5. Shared relevant information from the case file with other parties and the clinician in the case, when appropriate.		
6. Attended major case staffings—those in which the attorney or caseworker believed the attorney was needed to provide advice or in which a major decision on legal steps or strategies was to be decided.		
C. Monitored Progress and Adhered to Timelines		
7. Monitored the case and ensured that timelines were being adhered to.		
8. Monitored progress and assessed and addressed legal barriers to safety, permanency, and well-being (i.e., unresolved paternity issues).		
9. Was aware of barriers the parents had that would prevent them from participating in the proposed case plan (e.g., inability to read, language barriers) and counseled the agency accordingly.		
10. Proactively informed case participants of policy or protocol issues within the agency that were barriers to full implementation of the case plan or, conversely, that provided additional support and opportunities for the child and family.		
Notes/Comments		

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Case ID _____ Date _____ Court _____

MIAMI CHILD WELL-BEING™ OUT-OF-COURT ATTORNEY FOR THE PARENT SELF-ASSESSMENT TOOL

Out-of-Court Behaviors Demonstrating Use of the Miami Child Well-Being Court™ Model

Today's Date:	Attorney for the Parent:	Court:

During the past month, how would you rate yourself in the following areas across all of your cases involved in the project?
1 (not at all) 2 (sometimes) 3 (often) 4 (frequently) 5 (all of the time)

	Score (1 to 5)	Related Training Needed at Your Site
A. Developed a Relationship With the Client		
1. Advocated for the client's goals and empowered the client to direct the representation and make informed decisions based on thorough counsel.		
2. Provided the client with contact information in writing and established a message system that allowed regular attorney-client contact.		
3. Met and communicated regularly with the client well before court proceedings.		
4. Counseled the client about the service plan (case plan), goals of the therapeutic intervention, and the long-term impact that services can have in the client's life, stressing the opportunity to resolve chronic problems that put the client's child at risk of re-entry.		
5. Worked with the client to develop a case timeline and tickler system.		
6. Provided the client with copies of all petitions, court orders, service plans, and other relevant case documents, including reports regarding the child except when expressly prohibited by law, rule, or court order.		
7. Acted in a culturally competent manner and with regard to the socioeconomic position of the parent throughout all aspects of representation.		
8. Identified and discussed the client's parenting strengths and challenges as well as current or potential sources of support.		
B. Collaborated and Communicated With System Partners		
9. Communicated regularly with caseworker, agency attorney, or both regarding concerns about service provision, child placement, visitation, etc. before court hearing whenever possible.		
10. Communicated regularly with the clinician to request information pertinent to your client about treatment, insight gained about allegation, progress, and concerns before the court hearing.		
11. Requested information from services providers regarding the quality and effectiveness of their services for the client.		
C. Attended Non-Court Meetings With Client		
12. As necessary, attended case plan conferences, meetings, or staffings with client to help him understand the short-term and long-term legal implications of agreements made or issues discussed and to advocate for meaningful, effective supports and services.		
13. Attempted to ensure that client's needs were met through a less adversarial, problem-solving process.		
14. Represented and advocated for client in alternative dispute resolution (ADR) processes.		
D. Showed Understanding of the Needs of Very Young Children and Their Parents		
15. Engaged in at least one knowledge-building activity about the needs of very young children and their parents, such as additional training, reading, etc. (Please specify.)		

Notes/Comments

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Case ID _____ Date _____ Court _____

MIAMI CHILD WELL-BEING™ OUT-OF-COURT CHILD'S ADVOCATE SELF-ASSESSMENT TOOL

Out-of-Court Behaviors Demonstrating Use of the Miami Child Well-Being Court™ Model

Today's Date:	Child's Advocate:	Court:

During the past month, how would you rate yourself in the following areas across all of your cases involved in the project?
1 (not at all) 2 (sometimes) 3 (often) 4 (frequently) 5 (all of the time)

	Score (1 to 5)	Related Training Needed at Your Site
1. Became familiar with the child's history: prenatal care, early medical and dental care, immunizations and health screenings, quality of primary relationships, primary caregivers, the child's siblings, family and family friend connections, child care/early care environment thus far, familiar comforting items, etc.[1]		
2. Developed a relationship with the child through regular interactions and visitation.[2]		
3. Observed how the child interacted with substitute caregivers, parents, siblings, and extended family.		
4. Became familiar with developmental milestones and with federal entitlements and community services that will support the child's needs.		
5. Ensured that arrangements were made to bring the child to court regularly.		
6. Consulted professionals, clinician, and caseworker in developing a position.		
7. Raised the issue of concurrent planning at all meetings and staffing.		
8. Focused on quality and quantity of parental and sibling visitation.		
9. Was mindful of required time frames and proactively assessed progress being made to support permanency for the child.		
10. Ensured that transitions were thoughtful and well planned.		
11. Appeared on behalf of the child at all meetings and staffings.		
12. Assessed whether the services for the child and her family were specifically tailored to meet their needs.		
13. Went beyond dependency court to seek remedies and obtain entitlements.		
14. Served as a bridge between services providers, case managers, and the court.		
Notes/Comments		

[1] Maze, C.L. *Advocating for very young children in dependency proceedings: The hallmarks of effective, ethical representation*. 2010; Available from http://www.americanbar.org/content/dam/aba/migrated/child/PublicDocuments/ethicalrep_final_10_10.authcheckdam.pdf, p. 9.
[2] Ibid., pp. 10, 12-13.

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Case ID _____ Date _____ Court _____

MIAMI CHILD WELL-BEING™ OUT-OF-COURT CASEWORKER SELF-ASSESSMENT TOOL

Out-of-Court Behaviors Demonstrating Use of the Miami Child Well-Being Court™ Model

Today's Date:	Caseworker:	Court:

During the past month, how would you rate yourself in the following areas across all of your cases involved in the project?
1 (not at all) 2 (sometimes) 3 (often) 4 (frequently) 5 (all of the time)

	Score (1 to 5)	Related Training Needed at Your Site
1. Discussed the status, concerns, and needs of the children and their parents and substitute caregivers with the clinician.		
2. Provided dependency petition and other legal documents to the clinician, taking the time to review them with the clinician and to explain the risk and safety concerns.		
3. Incorporated the clinician's input into decision-making and practice.		
4. Supported clinician's learning process related to legal requirements on providing critical information and evidence to CWS.		
5. Took concrete steps to implement the clinician's recommendations when consensus had been reached.		
6. Addressed case-related barriers and concerns with the clinician.		
7. Worked diligently with the parent to effectively access the necessary early intervention services for the child (if applicable) and took all necessary steps to ensure the timely provision of services.		
8. Searched for and identified a high-quality or evidence-based service or intervention for the child, parent-child dyad, or both that promoted the child's health and well-being (e.g., evidence-based parenting program, accredited early care and education program).		
9. Visited the child in more than one of his or her living environments every 30 days.		
10. Maintained frequent contact with the child's parents.		
11. Actively and regularly engaged the parents, clinicians, substitute caregivers, and family supports for comprehensive service planning, with the goals of understanding and incorporating the family's perspective and enhancing the overall functioning of the entire family unit.		
12. Engaged in at least one knowledge-building activity about the needs of very young children and their parents, such as additional training, reading, etc. (Please specify: .)		

Notes/Comments

The Miami Child Well-Being Court™ Model evolved out of a unique collaboration among a judge, a psychologist, and an early interventionist/education expert: Judge Cindy Lederman, Miami-Dade Juvenile Court (11th Judicial Circuit, state of Florida); Dr. Joy Osofsky, Louisiana State University Health Sciences Center; and Dr. Lynne Katz, University of Miami, Linda Ray Intervention Center. This tool was supported by a generous grant from the National Center for Injury Prevention and Control at the Centers for Disease Control and Prevention (No. 1R18 CE001714-01) to Dr. Jenifer Goldman Fraser (PI), Child Witness to Violence Project, Boston Medical Center; Cecilia Casanueva (Co-I), RTI International; and Dr. Katz (Co-PI).

Case ID _____ Date _____ Court _____

MIAMI CHILD WELL-BEING™ OUT-OF-COURT CHILD WELFARE SUPERVISOR SELF-ASSESSMENT TOOL

Out-of-Court Behaviors Demonstrating Use of the Miami Child Well-Being Court™ Model

Today's Date:	Child Welfare Supervisor:	Court:

During the past month, how would you rate yourself in the following areas across all of your cases involved in the project?
1 (not at all) 2 (sometimes) 3 (often) 4 (frequently) 5 (all of the time)

	Score (1 to 5)	Related Training Needed at Your Site
1. Actively developed and advanced their caseworkers' skills to ensure quality service to their clients. (Please specify:_____)		
2. Regularly engaged in one-to-one supervision sessions that allowed the caseworker to express concerns, vicarious trauma, and possible biases impacting social work.		
3. Engaged in at least one knowledge-building activity about the needs of very young children and their parents, such as additional training, reading, etc.		
4. Supported the investment of time and effort by the caseworker to develop a collaborative relationship with the clinician.		
5. Helped the caseworker balance the need to receive critical information collected by the clinician with supporting the clinician's learning process about what critical information and evidence should be provided to CWS.		

Notes/Comments

The Miami Child Well-Being Court™ Model evolved out of a unique collaboration among a judge, a psychologist, and an early interventionist/education expert: Judge Cindy Lederman, Miami-Dade Juvenile Court (11th Judicial Circuit, state of Florida); Dr. Joy Osofsky, Louisiana State University Health Sciences Center; and Dr. Lynne Katz, University of Miami, Linda Ray Intervention Center. This tool was supported by a generous grant from the National Center for Injury Prevention and Control at the Centers for Disease Control and Prevention (No. 1R18 CE001714-01) to Dr. Jenifer Goldman Fraser (PI), Child Witness to Violence Project, Boston Medical Center; Cecilia Casanueva (Co-I), RTI International; and Dr. Katz (Co-PI).

Appendix B

Sample Forms

the CHILDREN'S Center
79 W. Alexandrine
Detroit, MI 48201
(313) 831-5535

AUTHORIZATION TO REQUEST/ RELEASE AND FACSIMILE INFORMATION

Client's Name: _____ Case #: _____ DOB: _____
SS#: _____ Program: _____

I, _____ hereby authorize The Children's Center staff to:

[ ] **Release Information**
[ ] **Obtain Information**

In accordance with Title 42 of the Code of Federal Regulations (CFR) Part II, [ ] I DO authorize [ ] I DO NOT authorize the release of records regarding drug/alcohol abuse.

In accordance with Act No. 174, Section 5(13), [ ] I DO authorize [ ] I DO NOT authorize the release of records regarding HIV-Infection, AIDS-Related Complex (ARC), Acquired Immunodeficiency Syndrome (AIDS), TB and/or other Communicable Diseases.

1. Name and Address to whom the information is to be disclosed/obtained:

_____

_____

2. The purpose and need for such disclosure/attainment:_____

_____

Information requested: (Please use initials to show selection of item(s) listed below).

_____Discharge Summary
_____Psychiatric Summary
_____Psychological Evaluation
_____Individual Treatment Plan
_____Physician's Recommendation
_____Laboratory Reports
_____Verbal clarification on information
_____Other (Must be specific)_____

_____Social History
_____Educational Evaluation
_____Behavioral/Academic Performance
_____Current Medical Dx.
_____Recent Physical Exam
_____Reason for contact with your agency

The client may revoke this authorization at any time. If not previously revoked, this consent will expire upon the below stated condition(s):

_____
Date, Event, or Condition for Expiration

If none is specified, this release will automatically expire 90 days from the date of the client's signature. This authorization is valid only for the information, agencies, and person cited above. **ANY FURTHER DISCLOSURE OF THIS INFORMATION IS NOT PERMITTED WITHOUT SPECIFIC AUTHORIZATION TO DO SO.** I hereby agree to hold The Children's Center harmless from any actions against them for alleged invasion of privacy, libel, or slander arising from disclosure of such information.

_____
Client's Signature Date Witnessed by Date

_____
Parent/Guardian Relationship to Client Date

This information release authorization form has been prepared in compliance with Title 42 of the Code of Federal Regulations, Part II; in accordance with the authority specified in Public Act 50 of 1973; and in compliance with Section 74B, Act 258, 1974, Michigan Mental Health Code. The Children's Center reserves the right to charge a fee for processing and copying records.
Form #8
12/03/tm

Memorandum of Understanding
Wayne County Baby Court Demonstration Project

I. Statement of Purpose

The purpose of this Memorandum of Understanding is to specify that the herein listed agencies participate in a collaborative relationship to benefit the 0 to 3 population of Wayne County, Michigan involved with the 3rd Circuit Family Division, Juvenile Section Court. This collaboration is based on a common belief that children age 0 to 3 require a unique approach to adjudication and special consideration and services. It will include cooperation from the following agencies, which collectively form the Wayne County Baby Court (WCBC) Demonstration Project:

- Third Judicial Circuit Court Juvenile Division
- Detroit-Wayne County Community Mental Health Agency
- Michigan Department of Human Services- Wayne County
- Wayne County Community Partners

The purpose of the WCBC is to improve the approach to adjudicating cases involving infants and toddlers through therapeutic jurisprudence. This is consistent with the growing movement across the county to partner the courts with Community Mental Health and Child Welfare services to meet the needs of children in a collaborative and expedited fashion. A demonstration grant has been established in Wayne County, Michigan to incorporate a specialty Baby Court docket to provide necessary attention to the vulnerable 0 to 3 population.

Wayne County Baby Court according to the Center of Disease Control (CDC) Grant will implement an evidence based intervention model for intervention and treatment that potentially could be replicated at other sites. (See CDC Grant titled 'Translating Child-Parent Psychotherapy into the Juvenile and Family Court System)

Collaborative outcomes include:

A. Expeditious permanency placements will increase.

B. The occurrence and reoccurrence of abuse and neglect among infants and toddlers will be reduced.

C. Infant developmental functioning will be enhanced while in care.

D. The parent/child relationship will improve and child permanency is achieved.

E. A model for intervention and treatment that can potentially be replicated at different sites.

F. The components of a quality infant mental health intervention model and its effectiveness will be documented.

II. Partner Responsibilities and Commitments

Collaborating Agency Responsibilities:

A. **Governance**- Participate in the Steering Committee meetings or appoint a temporary designee with decision making authority to represent the partner agency.

B. **Policy**- Make interagency efforts to facilitate practices, policies, and procedures that are consistent with the Baby Court program guidelines.

C. **Service Delivery**- Facilitate the transfer of the maximum level of appropriate services available through partner agencies as needed for each client.

D. **Timeliness**- Provide services in a timely manner with an emphasis on meeting client needs while preventing the misuse of available resources caused by a lack of collaboration.

E. **Coordinate**- Work as a collaborative team to reduce redundancy of services with all other necessary treatment agencies.

F. **Sustainability**- Contribute to as an agency and take an active roll in pursuing options that will increase sustainability of the Baby Court.

G. **Evaluation and Documentation**- All participating agencies will contribute to and participate to their fullest extent possible to the evaluation and documentation of the Baby Court process by Merrill Palmer Institute in conjunction with Research Triangle Institute (RTI).

Third Circuit Court

A. Provide judicial leadership for the Baby Court process.

B. Enforce all local, state and federal laws regarding child protective proceedings.

C. Determine and order appropriate services for children 0-3 and their birth parent(s).

D. Monitor and react to cases in a manner consistent with required mandates and the unique needs of each case.

E. Mediate disputes among partners to resolve issues in a timely and proactive manner.

F. Coordinate other services to be determined to support the recovery of the family unit.

Wayne County Department of Human Services

A. Identify and refer appropriate cases to the Baby Court when a child aged 0-3 is involved with the court as a result of abuse or neglect.

B. Convene collaborative permanency planning case conferences (PPC) at appropriate intervals during the life of the case.

C. Provide concurrent case planning for child to achieve expedited permanency and options for alternative placement.

D. Provide case management services, collaborate with infant mental health services and participate in all court hearings.

E. Facilitate birth parent visitation on an appropriate basis sufficient and/or as ordered by the court to facilitate and support parent/child attachment.

F. Provide support to the foster and/or adoptive family to ensure full participation in permanency plan.

G. Coordinate other services as ordered and needed to support the reunification of the family unit.

Detroit-Wayne County Community Mental Health Agency

The Community Mental Health Providers will:

A. Conduct assessments and provide reports (both verbal & written) and make recommendations to the court.

B. Attend all court hearings

C. Intervene therapeutically with an array of mental health services for parent(s) and their children as needed according to proposed treatment plans.

D. Deliver Infant Mental Health services to provide intensive didactic therapy and model effective interactions between parent(s) and their children.

E. Infant Mental Health will participate in baby court permanency planning case conferences.

F. Coordinate other services as ordered or needed to support the recovery of the family unit.

Baby Court Steering Committee

A. Will engage community partners in the participation of stakeholders where appropriate. The community partners will include but are not limited to: Wayne County Department of Human Services (WCDHS), Detroit Wayne County Community Mental Health Agency (D-WCCMHA), Attorneys for Parents, the child and DHS, Housing, & Parent Representatives.

B. Work with outside consultants relative to the Demonstration Project's evaluation.

III. Governance

The Baby Court project will be led by The Honorable Judge Judy Hartsfield in collaboration with the Baby Court Steering Committee which includes the Third Judicial Circuit Court of Michigan, the Wayne County Department of Human Services, the Detroit-Wayne County Community Mental Health Agency, and Community Partner Agencies. Steering Committee Meetings will take place on a monthly basis or as needed on a case by case basis. Subcommittees will be formed on a volunteer basis to address specific tasks or concerns as they arise and report back to the Steering Committee with feedback. All decisions will be made by a majority vote by the Steering Committee.

IV. Assurances and Termination

A. No person on group shall be denied services on the basis of age, sex, race, creed, color, national origin, political beliefs, marital status, handicap, or socioeconomic status.

B. The use or disclosure of information concerning service applicants or recipients obtained in connection with the performance of this collaborative agreement shall be restricted to purposes directly connected with the administration of the programs and the CDC Grant implemented by this agreement or as otherwise by law.

C. Proposed amendments to this memorandum must be presented for discussion and are subject to a vote or written approval by all partners.

D. Each party may terminate this Memorandum of Understanding at any time by giving thirty day prior notice to the other participants.

E. This Memorandum of Understanding contains all the terms and conditions agreed upon by all parties. No other understanding, oral or otherwise, regarding the subject matter of the Memorandum of Understanding shall be deemed or exist to bind any of the participants.

Detroit-Wayne County Community Mental Health Agency (D-WCCMHA)

INFANT MENTAL HEALTH QUICK SERVICE GUIDE

Infant Mental Health (IMH) is a therapeutic model that takes place over time. The goal of this model is to build nurturing, consistent, and reliable environments for young children. Essentially, helping young children feel physically safe and emotionally secure. Basic skill building is a byproduct of the model, not a primary intended outcome.

An Infant Mental Health Specialist provides a unique resource to child welfare and to the court with a caseload of infants/ toddlers. The IMH Specialist works with families to:

Conduct Assessments that comprises:

A thorough and ongoing developmental and behavioral assessment of the infant/toddler, including careful observation of the infant/toddler with the biological parent, foster parent, child care provider, and siblings.

The use of assessment tools- Ages & Stages Questionnaire (ASQ) and Devereux Early Childhood Assessment (DECA).

The capacities of the various caregivers to nurture the infant/toddler.

A functional description of interactions between the infant/toddler and the parent, and the extent to which the pair now have, or have the capacity for developing, a relationship that will foster the infant/toddler's development.

Provide Intervention that involves:

Infant-Parent Therapy

Building and Demonstrating a Relationship

Emotional Support

Developmental Guidance/Parenting Education

Concrete Assistance

Voice the Needs of the Infant and Family

Make recommendations about the feasibility of reunification for this parent and infant/toddler.

If reunification is appropriate, the IMH specialist will make recommendations on the components of a service plan that will avoid overwhelming the parent and the infant/toddler with multiple services. In addition, the IMH specialist with work with the parent and infant/toddler toward reunification.

Stabilize the placement of the infant/toddler in foster care by working with the foster parent and the infant/toddler.

If the court terminates, or the parent releases, parental rights, the IMH specialist will assist in the transition to a permanent placement.

Provide court reports of case activity and updates.

Standards of Contact

The infant mental health specialist meets with the parent and the infant/toddler a **minimum of 4 hours per month** in sessions that can be counted as visitation time. Actual frequency of contact is determined by the individual service plan. The role of the IMH specialist is not to supervise visits.

Why should I grant permission for my study data to be combined with other data?

All of the information we have collected from or about you and your child during the study interviews can be even more valuable to our researchers if it can be combined with other information on you and your child that we obtain from sources outside this interview. These sources might include driver's license records, school records, mental health services records, juvenile justice records, and other types of records - information that exists now, as well as information in the future.

The interviews conducted with you, your child, as well as those with their caseworkers and teachers, provide in-depth information about your child's and family's characteristics and experiences. Data collected and maintained by the CPS and other child and family service agencies provide an additional and valuable informative component to our study. Data to be collected from CPS and other local agencies will include information about children's placements in foster care and adoptive homes, brief information about any subsequent reports, and information about any services that your child or family may receive. They will also give us information about the agency, such as their budget, staff size, and staff training requirements. We will put these data on the file with that we collect during our interview with you. The data file will not identity you, your child, or your family. The agencies providing data will not receive any information that you provide during the interview, and will not know whether or not you chose to participate in the study.

How will the data be combined and who will it be released to?

The information we obtain from these sources will be combined with the information you give us in this survey and made available to our researchers on a very restricted basis. There is a defined plan to protect the information that will be made available to our researchers. Before releasing data to researchers, we would require that they complete an application for receiving the data. Applications will be reviewed and either approved or denied by a committee whose job it is to protect the rights of people like you who participate in research studies. This application review process is designed to provide protection to participants. In all instances, the information will be given only to people who can show that they have a good reason to use the information, will only be used for reports, and neither your name nor your child's will appear in any of these reports.

What are the risks and benefits associated with granting permission for this request?

The only risk you are taking by allowing your study data to be combined with other information is the small risk that some people who do research and get your information might not follow the rules we set for using your information. There are also no direct benefits for allowing your or your child's study information to be combined with other types of information. Your decision with regard to this request will not affect any services you or your child may be receiving now or in the future. By answering "yes", you are giving permission for all of your and your child's study information we have ever collected in our interviews to be used in the future for other important research studies that may be approved. However, your permission for combining your child's information only applies until the time your child becomes an adult (usually at age 18). At that time, we will not combine your child's information until we have your child's direct approval to do that.

What are my rights with regard to this request?

You have the right to refuse this request, just as you may any request made by the study team. However, we hope you will give us your permission to use your and your child's data in this way. If in the future should you decide that you no longer want your or your child's information combined with other records, you should _____ or our Office of Human Research Protections at _____

Check one box.

☐ Yes, I consent to having all of my family's information ever provided to be added in the future to information in other important research studies.

☐ No, I do not want any of my study information ever provided to be added to other information.

Printed Name of Child _____

Printed Name of Current Caregiver _____

Signature of Current Caregiver _____

Date _____

UNIVERSITY OF Miami

Linda Ray Intervention Center

Please fax to 305-325-1151

Eligibility Criterion for Dyadic Therapy and Viable Waitlist Status

To: _____ _____ _____ _____
Agency Case Worker Supervisor Date

A referral has been made for: _____ on _____
Child's name Date referral received

In order to be eligible to participate in dyadic therapy, the following items must be in place for this client: (C.W. please circle Yes/No and initial)

1. **Parent is compliant with all services mandated by case plan. (eg. Mental health services, substance abuse treatment, anger control, domestic violence)**
   Yes/ No _____ C.W. LRIC confirmation at time of follow-up Yes/No _____(date and initials)

2. **Visitation is in place and parent is in compliance.**
   Yes/ No/ NA child resides with parent _____ C.W. LRIC confirmation at time of follow-up Yes/No _____(date and initials)

3. **Case Worker confirms that transportation for child to participate is in place.**
   Yes/ No _____ C.W. LRIC confirmation at time of follow-up Yes/No _____(date and initials)

4. **Child is between the ages of 6 and 48 months.**
   Yes/ No _____ C.W. LRIC confirmation at time of follow-up Yes/No _____(date and initials)

Please be advised that your client will not be placed on our waitlist or given a start date until this form has been returned to the LRIC Case Manager and all items are confirmed.

_____ _____ _____
Case Worker's signature **Supervisor's signature** **Date**

LRIC Availability:
A. Slot ready assuming all necessary documents have been received _____
B. Waitlist with anticipated start date:_____ _____
C. No slots available; send referral to another agency _____

LRIC Follow Up:
Agency CW/Supervisor must respond via phone/email/fax/mail with updated information by_____ otherwise client will be removed from waitlist and a new referral will be required.

Appendix B-6. Research Subject Information and Consent Form Counseling Pilot Program

TITLE: Counseling Pilot Programs

PROTOCOL NO.:

SPONSOR:

INVESTIGATOR:

SITE(S):

PHONE NUMBER(S):

This consent form may contain words that you do not understand. Please ask the study director or the study staff to explain any words or information that you do not clearly understand. You may take home an unsigned copy of this consent form to think about or discuss with family or friends before making your decision.

Introduction

You and your child (age 6 months–48 months old) are being asked to take part in a research study for families with young children who are in the dependency system. The research study will be located at _____. If you agree to sign up for the research study, 1 hour per week for 25 weeks, you will learn about play activities specific to your child's needs, how to handle your child's behavior, and what to expect from your child at different ages.

Before you decide to take part in this research study, you should know the advantages and disadvantages. If you agree to take part in this research study, you will be asked to sign this consent form. A study staff member of the program will be available to answer your questions.

Purpose

This research study is for children 6 months–48 months old, and their mothers, fathers, and other primary caregivers. The purpose of this part of the research study is to provide a program that helps you understand the thinking, language, and physical and social/emotional development of your child and helps you and your child build a positive relationship.

You are being asked to give your permission for the research study staff to share information about how you are doing in the program with the study staff from the Center, your caseworker, our program collaborators, and you and your family. We will also be asking for your feedback in order to see if you like the program and if it helps you build a positive relationship with your child. If you decide to sign up for the research study, you and your child will have the chance to participate in the 25-week program. We will give you feedback and the chance to ask questions at each of the 25 weekly sessions you have with the XX Center's licensed counselors.

Procedures

As part of this research study, you will be asked questions at an interview before you start the program about your parenting skills, and questions about how you feel you and your child are

progressing. We will ask questions again about how you like the program when you are halfway through, and again after you complete the program, to see if the program improved how you feel and how much you and your child's relationship has developed. We will also observe how your child plays, using activities developed for measuring progress in young children.

Your counselors will summarize your opinions at the beginning of the program, midway through the program, and at the end of the sessions. Your caseworker will want to learn about your strengths and what areas you and your child will need to work on. Your caseworker will monitor these progress reports as you move through the program. Information about attendance and what you are learning is discussed at the weekly or monthly monitoring meetings with your caseworkers and the mental health counselors you are working with.

Your caseworker will report information about how you are progressing at your court hearings, specifically your attendance, how much you have learned about parenting, and how you are communicating and playing with your child. You will have the opportunity to talk about how the program is or isn't working for you and your child and to talk about what you are learning with your caseworker. You can invite your counselor to go with you to help you describe how you are doing in the program and to report your attendance. Your counselor cannot report what you do or say at each session or the conversations you have at those sessions unless you say you have harmed or want to harm yourself, your child, or someone else.

The research study will give the court a summary of the observations of your interactions with your child in the assessments, and reports of your child's developmental progress over time. There is no information about your psychological status or diagnosis in this report and no information from your midway interview. At the end of the research study, your counselor will report your attendance, your progress in relating to your child over the course of the program, and any recommendations for additional services, if needed. Our program collaborators may also review your progress to determine if, overall, the program is meeting the needs of families. Your name or your child's name will not be used in these program evaluations.

Possible Risks

You may feel uncomfortable or embarrassed in answering questions about your child, your family, or your previous criminal and/or mental health history during your interviews. You may choose not to answer any question or ask that the questions be stopped at any time. You and your child may withdraw without any risks from this research study program as long as you choose another program which is approved by your case worker and your lawyer.

If you decide not to participate or you decide to withdraw from the research study and you do not choose another program which is approved by your counselor and/or your lawyer, you can face risks and consequences for not meeting your case plan requirement for completing a parenting program.

New Findings

You will be told about any new information that might change your decision to be in this study.

Benefits

Your relationship with your child may improve as a result of your participation in this research program; however, this cannot be guaranteed.

Costs

This research study counseling program is free.

Payment

You will not be paid to be in the research study.

Right to Withdraw from the Study

Your participation in this study is voluntary. You may decide not to participate or you may leave the study at any time. Your lawyer can help you decide what to do. If you decide not to participate in the research study counseling program, you will need to choose another program which is approved by your counselor and/or your lawyer.

You and your child's participation in this study may be stopped at any time without your consent.

Confidentiality

Your records will be kept confidential to the extent permitted by law. The only exception is if information is revealed concerning harm to yourself or others, child and/or elder abuse and/or neglect, or other forms of abuse that are required by law to be reported to the appropriate authorities. Authorized University of XX employees or other agents who will be bound by the same provision of confidentiality may review your records for audit purposes only. If we write about this program in a publication, or talk about it at a conference or in staff training activities, we won't use your name. If you would like to participate in a conference presentation or staff training to talk about how the program has worked for you, you may volunteer to do so.

You and your child will be videotaped playing together at the beginning of the program, midway through the program, and at the end of the program as part of the research study. If you choose not to do the videotaping, we will give a written report about how you and your child are doing from our direct observations.

The counselor will also ask to videotape your weekly sessions to show you the things you have learned to do with your child and the things you still need to learn. The videotapes of the weekly sessions will not be shown to anyone outside of the research study without your specific permission. You may ask that the videotaping be stopped at any time during a session, even after permission has been given. You will still be allowed to continue in the research study even if you don't want the weekly sessions to be videotaped. If you consent to have your videotape shown to our research staff, we may review your tapes without your name on them, at the beginning and end of the program, to see overall what children and families learned from the program and what changes we can make, if necessary, to make the program better.

This information will also be shared with the sponsors of this study and with persons working with the sponsor to oversee the study. The investigators and their assistants will consider your records confidential to the extent permitted by law. The U.S Department of Health and Human Services (DHHS) may request to review and obtain copies of your records. Your records may also be reviewed for audit purposes by authorized university or other agents who will be bound by the same provisions of confidentiality.

The results of this research study may be presented at meetings or in publications. Your and your child's identity will not be disclosed in those presentations.

QUESTIONS

Please feel free to ask questions at any time. You may contact Dr. ____, the Project Director at the Center, during the day at _____, evenings and weekends if you have questions or concerns about the research study.

If you have any questions about your rights as a subject in the counseling pilot program, you may contact the University of XX Subjects Research Office at _____.

Do not sign this consent form unless you have had a chance to ask questions and have received satisfactory

answers to all of your questions.

If you agree to be in this study, you will receive a copy of this signed and dated consent form.

Videotape Consent:

I give permission to the Center project study staff to videotape me and my child for the purpose of assessment and treatment.

☐ Yes ☐ No

I give permission to the Center project study staff to videotape me and my child for the purpose of research.

☐ Yes ☐ No

I give permission to the Center project study staff to show videos of me and my child to staff at other counseling pilot programs for the purpose of training therapists how to do this kind of treatment.

☐ Yes ☐ No

Consent Signatures

I have read the information in this consent form (or it has been read to me). My questions have been answered and I have agreed to take part in this research study with my child.

Consent Signature:

_____

Date Signature of Subject (18 years and older)

_____

Date Signature of Subject (17 years and younger)

_____

Date Signature of Legally Authorized Representative (when applicable)

_____

Authority of Subject's Legally Authorized Representative or Relationship to Subject

_____

Date Signature of Person Conducting Informed Consent Discussion

Court Records Review

Reviewer's name: _____

Date of review: _____

Identifying Case Information

Case number: _____

Multiple children

☐ Yes #_____ (complete a separate review for each child in age range)

☐ No

Child DOB (MM/YY): _____

Mother DOB (MM/YY): _____

Date petition was filed with the court (MM/DD/YY) _____

Is this a CWBC case?

☐ No, case seen prior to CWBC implementation

☐ No, case seen after CWBC implementation

☐ Yes

Maternal Background Information

Mother's age (years) when petition was filed _____

Is mother a former TCW?

☐ No ☐ Yes

☐ Information not available

Is mother a current TCW?

☐ No ☐ Yes

☐ Information not available

Does mother have history of delinquency?

☐ No ☐ Yes

☐ Information not available

Documentation available of mother's history of prior involvement with DHS (as to this child/other children noted in the court file):

☐ Dependency petition

☐ Judicial review

☐ Other: _____

Prior involvement with dependency court?

☐ Yes

☐ No

Number of referrals on the mother (substantiated and not substantiated):

_____

Dates _____

Number of substantiated referrals on the mother:

_____

Dates _____

☐ Information not available

The Petition

Nature of allegation that brought mother and infant into court (check all that apply):

☐ Physical abuse

☐ Neglect (failure to provide)

☐ Neglect (failure to supervise)

☐ Sexual abuse

☐ Domestic violence

☐ Prenatal exposure

☐ Parental substance abuse

Perpetrator (check all that apply):

☐ Biological mother

☐ Biological father

☐ Non-parental adult

Describe _____

Status of original petition (legal status):

☐ Case dismissed

☐ Pending adjudication

Date of placement: _____

- ☐ Child placed in home with mother
- ☐ Child placed in home with father
- ☐ Unlicensed relative caregiver
- ☐ Unlicensed non-kin caregiver
- ☐ Licensed kin caregiver
- ☐ Licensed non-kin caregiver/foster care
- ☐ Group home
- ☐ Other: _____

☐ Working on case plan

Date of placement: _____

- ☐ Child placed in home with mother
- ☐ Child placed in home with father
- ☐ Unlicensed relative caregiver
- ☐ Unlicensed non-kin caregiver
- ☐ Licensed kin caregiver
- ☐ Licensed non-kin caregiver/foster care
- ☐ Group home
- ☐ Other: _____

☐ Closed _____ (date) _____

- ☐ Child returned home—court no longer involved (ASFA—reunification)
- ☐ Termination of parental rights
  - ☐ Adoption placement identified (ASFA—Adoption)
  - ☐ Child living in pre-adoptive home (ASFA—Adoption)
  - ☐ No adoptive home identified
  - ☐ Placement with a fit and willing relative
  - ☐ Permanent guardianship

Date of permanency hearing _____

Details While Case Was Under Court Jurisdiction

Child placement during court supervision:

☐ Child placed in home (date _____)

☐ Child placed in foster care (date _____)

☐ Child placed with relative (date _____)

Were there subsequent referrals (substantiated and not substantiated)?

_____

Date _____

Number of substantiated referrals:

_____

Date _____

☐ Information not available

Was there a subsequent petition to the court for this child?

☐ No

☐ Yes

☐ Date petition was filed with the court

(MM/DD/YY) _____

- ☐ Allegation
  - ☐ Physical abuse
  - ☐ Neglect (failure to provide)
  - ☐ Neglect (failure to supervise)
  - ☐ Sexual abuse
  - ☐ Domestic violence
  - ☐ Substance abuse
- ☐ Outcome
  - ☐ Substantiated
  - ☐ Non-substantiated

☐ Change in placement?

- ☐ No
- ☐ Yes, child is now placed with (see above for list of categories)
  - ☐ Biological parent
  - ☐ Foster parent
  - ☐ Relative placement

Perpetrator (check all that apply):

☐ Biological mother

☐ Biological father

☐ Non-parental adult

Describe _____

Services ordered for parent (to determine if services were received, review status reports across the entire review period):

☐ IMH

Received?

- ☐ No
- ☐ Yes

Dates _____
(from month/year to month/year)

☐ Individual psychotherapy

Received?

- ☐ No
- ☐ Yes

Dates _____
(from month/year to month/year)

☐ Substance abuse counseling

Received?

- ☐ No
- ☐ Yes

Dates _____
(from month/year to month/year)

☐ Educational Assistance

Received?

☐ No

☐ Yes

Dates _____
(from month/year to month/year)

☐ Housing

Received?

☐ No

☐ Yes

Services ordered for child

☐ Developmental assessment

Received?

☐ No

☐ Yes

☐ Speech/language

Received

☐ No

☐ Yes

☐ PT or OT

Received?

☐ No

☐ Yes

☐ Medical referral

Received?

☐ No

☐ Yes

Clinical Records Review Form: Data to Be Obtained From Counseling Services Case Records

VARIABLE	DATA SOURCE AND CODES
	Intake Form: Background Information
Child gender	Sex of the child (F/M)
Child age	DOB: Age in months
Child race/ethnicity	Race/ethnicity of the child Responses 1 = Caucasian 2 = African-American 3 = Hispanic 4 = Asian/Pacific Islander 5 = Bi-racial 6 = Other
Child type of maltreatment	Has the child been abused (emotionally, physically, sexually)? Responses 1 = Physical injury 2 = Sexual maltreatment 3 = Mental injury 4 = Substance abuse 5 = Lack of supervision 6 = Environmental neglect 7 = Lack of health care 8 = Threatened harm 9 = Special conditions 10 = Failure to protect 11 = Abandonment 12 = Neglect 13 = Domestic violence
Placement history	Has the child ever been placed out of the home? Placement 1 Reason 1 = Child at high risk of maltreatment recurrence 2 = Level of harm to child high 3 = Original caregiver unable to protect child 4 = Original caregiver has mental health problems 5 = Original caregiver has substance abuse problems 6 = Original caregiver has cognitive impairments 7 = Original caregiver has physical impairments 8 = Original caregiver arrested/jail 9 = Domestic violence in household
Mother years of education	Last grade completed: 1 = 0–7th grade 2 = 8th grade 3 = 9th, 10th, or 11th grade 4 = 12th grade or GED 5 = Some college 6 = Vocational training 7 = Completed college 8 = Education beyond college

Clinical Records Review Form: Data to Be Obtained From Counseling Services Case Records *continued*

VARIABLE	DATA SOURCE AND CODES
Mother race/ethnicity	Responses: 1 = Caucasian 2 = African-American 3 = Hispanic 4 = Asian/Pacific Islander 5 = Bi-racial 6 = Other
Monthly family income	What is the monthly net income of the parent (after tax)? Responses: 1 = less than $5,000 annually 2 = $5,000 to less than $10,000 annually 3 = $10,000 to less than $15,000 annually 4 = $15,000 to less than $20,000 annually 5 = $20,000 to less than $25,000 annually 6 = $25,000 to less than $30,000 annually 7 = $30,000 to less than $35,000 annually 8 = $35,000 to less than $40,000 annually 9 = $40,000 to less than $45,000 annually 10 = $45,000 to less than $50,000 annually 11 = $50,000 to less than $60,000 annually 12 = $60,000 to less than $70,000 annually 13 = $70,000 to less than $100,000 annually 14 = over $100,000
Public assistance	Y/N
Maternal childhood trauma history	—Was the parent removed from her mother/father? —If yes, what were the allegations against her mother/father? Responses: 1 = Physical injury 2 = Sexual maltreatment 3 = Mental injury 4 = Substance abuse 5 = Lack of supervision 6 = Environmental neglect 7 = Lack of health care 8 = Threatened harm 9 = Special conditions 10 = Failure to protect 11 = Death 12 = Abandonment 13 = Neglect 14 = Domestic violence

Clinical Records Review Form: Data to Be Obtained From Counseling Services Case Records *continued*

VARIABLE	DATA SOURCE AND CODES
Marital status	What is the marital status of the parent? Responses: 1 = Married 2 = Separated 3 = Divorced 4 = Widowed 5 = Never Married
Biological caregiver age	Mother's or father's age
Parent other treatments	—Parent(s) in treatment: Y/N —Type of treatment Responses: 1 = Substance abuse program 2 = Domestic violence program 3 = Psychiatrist 4 = Individual therapist 5 = Parenting program 6 = Anger management program 7 = Other
Parent mental health problems	Does the child's parent suffer from mental illness or substance abuse? **If yes, please indicate whether the problem is for the mother or father:** Responses: 1 = Alcoholism 2 = Drug problem 3 = Depression 4 = Anxiety 5 = Schizophrenia 6 = Bipolar disorder 7 = Unknown 8 = Other disorder Has the parent(s) seen anyone for mental health/substance abuse intervention?
Domestic violence	Is there history of domestic violence in parent's childhood or past/current relationships?
Caregiver receiving CPP	—Parent in treatment —Relationship of informant to child Responses: 1 = Mother 2 = Father 3 = Grandparent 4 = Relative 5 = Family friend 6 = Foster parent 7 = Other

Pre-Post Treatment Summary Form

VARIABLE	DATA SOURCE AND CODES
Therapeutic goals reached	Responses: 1 = Yes 2 = No
Judge	1 = Judge L_____ 2 = Judge C_____ (please add categories as necessary for other judges)
Pre-treatment: **Original allegation that brought the child into the dependency system**	Responses: 1 = Physical injury 2 = Sexual maltreatment 3 = Mental injury 4 = Substance abuse 5 = Lack of supervision 6 = Environmental neglect 7 = Lack of health care 8 = Threatened harm 9 = Special conditions 10 = Failure to protect 11 = Death 12 = Abandonment 13 = Neglect 14 = Domestic violence
Alleged perpetrator	Responses: 1. Mother (biological) 2. Father (biological) 3. Stepmother 4. Stepfather 5. Mother's partner 6. Father's partner 7. Adoptive mother 8. Adoptive father 9. Siblings 10. Aunt 11. Uncle 12. Great aunt 13. Great uncle 14. Maternal grandmother 15. Maternal grandfather 16. Paternal grandmother 17. Paternal grandfather 18. Great grandmother 19. Great grandfather 20. Other blood relative 21. Other non-relative
Placement pre-treatment	Responses: 1. Mother (biological) 2. Father (biological) 3. Stepmother 4. Stepfather 5. Mother's partner 6. Father's partner 7. Adoptive mother 8. Adoptive father 9. Siblings 10. Aunt 11. Uncle 12. Great aunt 13. Great uncle 14. Maternal grandmother 15. Maternal grandfather 16. Paternal grandmother 17. Paternal grandfather 18. Great grandmother 19. Great grandfather 20. Other blood relative 21. Other non-relative

Pre-Post Treatment Summary Form *continued*

VARIABLE	DATA SOURCE AND CODES
Clinical diagnosis:	Responses:
Alcoholism	1 = Yes 2 = No
Alcoholism Axis I	1 = Yes 2 = No
Referred for alcoholism	1 = Yes 2 = No
Drug problem	1 = Yes 2 = No
Drug problem Axis I	1 = Yes 2 = No
Referred for drug problem	1 = Yes 2 = No
Depression	1 = Yes 2 = No
Depression problem Axis I	1 = Yes 2 = No
Referred for depression	1 = Yes 2 = No
Anxiety	1 = Yes 2 = No
Anxiety problem Axis I	1 = Yes 2 = No
Referred for anxiety	1 = Yes 2 = No
Schizophrenia	1 = Yes 2 = No
Schizophrenia problem Axis I	1 = Yes 2 = No
Referred for schizophrenia	1 = Yes 2 = No
Bipolar disorder	1 = Yes 2 = No
Bipolar problem Axis I	1 = Yes 2 = No
Referred for bipolar	1 = Yes 2 = No
Other disorder	1 = Yes 2 = No
Problem Axis I	1 = Yes 2 = No
Referred for other disorder	1 = Yes 2 = No
Victim of intimate partner violence	1 = Yes 2 = No
Referred for intimate partner violence	1 = Yes 2 = No
Other stressors	1 = Yes 2 = No
Referred for other stressors	1 = Yes 2 = No
Post-treatment:	
Treatment intensity (Child-Parent Psychotherapy)	Responses: # of sessions
Additional abuse reports during treatment	Responses: 1 = Yes 2 = No
Type of maltreatment	Responses: 1 = Physical injury 2 = Sexual maltreatment 3 = Mental injury 4 = Substance abuse 5 = Lack of supervision 6 = Environmental neglect 7 = Lack of health care 8 = Threatened harm 9 = Special conditions 10 = Failure to protect 11 = Death 12 = Abandonment 13 = Neglect 14 = Domestic violence

Pre-Post Treatment Summary Form *continued*

VARIABLE	DATA SOURCE AND CODES	
Alleged perpetrator	Responses:	
	1. Mother (biological)	2. Father (biological)
	3. Stepmother	4. Stepfather
	5. Mother's partner	6. Father's partner
	7. Adoptive mother	8. Adoptive father
	9. Siblings	
	10. Aunt	11. Uncle
	12. Great aunt	13. Great uncle
	14. Maternal grandmother	15. Maternal grandfather
	16. Paternal grandmother	17. Paternal grandfather
	18. Great grandmother	19. Great grandfather
	20. Other blood relative	21. Other non-relative
Clinical diagnosis:	Responses:	
Alcoholism	1 = Yes	2 = No
Alcoholism Axis I	1 = Yes	2 = No
Received treatment for alcoholism	1 = Yes	2 = No
Drug problem	1 = Yes	2 = No
Drug problem Axis I	1 = Yes	2 = No
Received treatment for drug problem	1 = Yes	2 = No
Depression	1 = Yes	2 = No
Depression problem Axis I	1 = Yes	2 = No
Received treatment for depression	1 = Yes	2 = No
Anxiety	1 = Yes	2 = No
Anxiety problem Axis I	1 = Yes	2 = No
Received treatment for anxiety	1 = Yes	2 = No
Schizophrenia	1 = Yes	2 = No
Schizophrenia problem Axis I	1 = Yes	2 = No
Received treatment for schizophrenia	1 = Yes	2 = No
Bipolar disorder	1 = Yes	2 = No
Bipolar problem Axis I	1 = Yes	2 = No
Received treatment for bipolar	1 = Yes	2 = No
Other disorder	1 = Yes	2 = No
Problem Axis I	1 = Yes	2 = No
Received treatment for other disorder	1 = Yes	2 = No
Victim of intimate partner violence	1 = Yes	2 = No
Received treatment for intimate partner violence	1 = Yes	2 = No
Other stressors	1 = Yes	2 = No
Received treatment for other stressors	1 = Yes	2 = No
Was the child reunified with the parent during/post treatment	1 = Yes	2 = No
If not reunified, status of continuous contact with child	1 = Yes	2 = No

Pre-Post Treatment Summary Form *continued*

VARIABLE	DATA SOURCE AND CODES
With whom child living at treatment closure	Responses: 1. Mother (biological) 2. Father (biological) 3. Stepmother 4. Stepfather 5. Mother's partner 6. Father's partner 7. Adoptive mother 8. Adoptive father 9. Siblings 10. Aunt 11. Uncle 12. Great aunt 13. Great uncle 14. Maternal grandmother 15. Maternal grandfather 16. Paternal grandmother 17. Paternal grandfather 18. Great grandmother 19. Great grandfather 20. Other blood relative 21. Other non-relative
Pre-treatment & post-treatment **Participant in Crowell evaluation (child and __)**	Responses: 1 = Mother 2 = Father 3 = Grandparent 4 = Relative 5 = Family friend 6 = Foster parent 7 = Other
Free play	
Parent scales	
1. Positive affect	Score (from 1 to 5)
Comment = (please enter comments verbatim as a different variable)	
2. Withdrawn/depressed	Score (from 1 to 5)
Comment = (please enter comments verbatim as a different variable)	
3. Irritability	Score (from 1 to 5)
Comment = (please enter comments verbatim as a different variable)	
4. Intrusiveness	Score (from 1 to 5)
Comment = (please enter comments verbatim as a different variable)	
5. Behavioral responsiveness	Score (from 1 to 5)
Comment = (please enter comments verbatim as a different variable)	
6. Emotional responsiveness	Score (from 1 to 5)
Comment = (please enter comments verbatim as a different variable)	

Clinical Assessment Form (Crowell)

VARIABLE	DATA SOURCE AND CODES
Child scales	
7. Positive affect	Score (from 1 to 5)
Comment = (please enter comments verbatim as a different variable)	
8. Withdrawn	Score (from 1 to 5)
Comment = (please enter comments verbatim as a different variable)	
9. Anxious/fearful	Score (from 1 to 5)
Comment = (please enter comments verbatim as a different variable)	
10. Irritability	Score (from 1 to 5)
Comment = (please enter comments verbatim as a different variable)	
11. Noncompliance	Score (from 1 to 5)
Comment = (please enter comments verbatim as a different variable)	
12. Aggression toward parent	Score (from 1 to 5)
Comment = (please enter comments verbatim as a different variable)	
13. Enthusiasm	Score (from 1 to 5)
Comment = (please enter comments verbatim as a different variable)	
Reunion	
14. Parent emotional/behavioral responsiveness	Score (from 1 to 5)
Comment = (please enter comments verbatim as a different variable)	
15. Child emotional/behavioral responsiveness	Score (from 1 to 5)
Comment = (please enter comments verbatim as a different variable)	
Cleanup tasks	
Parent scales	
16. Positive affect	Score (from 1 to 5)
Comment = (please enter comments verbatim as a different variable)	
17. Withdrawn/depressed	Score (from 1 to 5)
Comment = (please enter comments verbatim as a different variable)	
18. Irritability	Score (from 1 to 5)
Comment = (please enter comments verbatim as a different variable)	
19. Intrusiveness	Score (from 1 to 5)
Comment = (please enter comments verbatim as a different variable)	

Clinical Assessment Form (Crowell) *continued*

VARIABLE	DATA SOURCE AND CODES
20. Behavioral C	Score (from 1 to 5)
Comment = (please enter comments verbatim as a different variable)	
21. Emotional responsiveness	Score (from 1 to 5)
Comment = (please enter comments verbatim as a different variable)	
22. Positive discipline	Score (from 1 to 5)
Comment = (please enter comments verbatim as a different variable)	
23. Negative discipline	Score (from 1 to 5)
Comment = (please enter comments verbatim as a different variable)	
Child scales	
24. Positive affect	Score (from 1 to 5)
Comment = (please enter comments verbatim as a different variable)	
25. Withdrawn	Score (from 1 to 5)
Comment = (please enter comments verbatim as a different variable)	
26. Anxious/fearful	Score (from 1 to 5)
Comment = (please enter comments verbatim as a different variable)	
27. Irritability	Score (from 1 to 5)
Comment = (please enter comments verbatim as a different variable)	
28. Noncompliance	Score (from 1 to 5)
Comment = (please enter comments verbatim as a different variable)	
29. Aggression toward parent	Score (from 1 to 5)
Comment = (please enter comments verbatim as a different variable)	
30. Enthusiasm	Score (from 1 to 5)
Comment = (please enter comments verbatim as a different variable)	
31. Persistence with task	Score (from 1 to 5)
Comment = (please enter comments verbatim as a different variable)	

Clinical Assessment Form (Crowell)

VARIABLE	DATA SOURCE AND CODES
Pre- and post-treatment:	
Caregiver variables	
Free play	
Positive affect	Score (from 1 to 5 if provided by Louisiana; 1 to 7 if provided by Wayne: 1 = poor, 2 = mediocre, 3 = fair, 4 = moderate, 5 = good, 6 = outstanding, 7 = excellent
Withdrawn/depressed	Score (from 1 to 7)
Irritability/anger/hostility	Score (from 1 to 7)

Objective Crowell Ratings

VARIABLE	DATA SOURCE AND CODES
Cleanup	
Positive affect	Score (from 1 to 7
Withdrawn/depressed	Score (from 1 to 7)
Irritability/anger/hostility	Score (from 1 to 7)
Positive discipline	Score (from 1 to 5 if provided by Louisiana; 1 to 3 if provided by Wayne; (1 = low, 2 = Medium, 3 = High)
Negative discipline	Score (from 1 to 5 if provided by Louisiana; 1 to 3 if provided by Wayne; (1 = low, 2 = Medium, 3 = High)
Bubbles	
Positive affect	Score (from 1 to 5 if provided by Louisiana; 1 to 7 if provided by Wayne)
Withdrawn/depressed	Score (from 1 to 7)
Irritability/anger/hostility	Score (from 1 to 7)
Task 1	
Behavioral responsiveness	Score (from 1 to 7)
Emotional responsiveness	Score (from 1 to 7)
Positive affect	Score (from 1 to 7
Withdrawn/depressed	Score (from 1 to 7)
Irritability/anger/hostility	Score (from 1 to 7)
Task 2	
Behavioral responsiveness	Score (from 1 to 7)
Emotional responsiveness	Score (from 1 to 7)
Positive affect	Score (from 1 to 7
Withdrawn/depressed	Score (from 1 to 7)
Irritability/anger/hostility	Score (from 1 to 7)
Task 3	
Behavioral responsiveness	Score (from 1 to 7)
Emotional responsiveness	Score (from 1 to 7)
Positive affect	Score (from 1 to 7
Withdrawn/depressed	Score (from 1 to 7)
Irritability/anger/hostility	Score (from 1 to 7)

Clinical Assessment Form (Crowell) *continued*

VARIABLE	DATA SOURCE AND CODES
Task 4	
Behavioral responsiveness	Score (from 1 to 7)
Emotional responsiveness	Score (from 1 to 7)
Positive affect	Score (from 1 to 7
Withdrawn/depressed	Score (from 1 to 7)
Irritability/anger/hostility	Score (from 1 to 7)
Overall: Behavioral responsiveness	Score (from 1 to 7)
Overall: Emotional responsiveness	Score (from 1 to 7)
Overall: Parent positive affect	Score (from 1 to 7
Overall: Parent withdrawal/depression	Score (from 1 to 7)
Overall: Parent irritability/anger	Score (from 1 to 7)
Overall: Parent use of physical aggression	1 = none, 2 = moderate, 3 = physical aggression (hits, spanks, slaps, kicks)
Child variables	
Free play	
Child positive affect	1-7
Child withdrawn/depressed	1-7
Child irritability/anger	1-7
Child noncompliance	1-7
Child aggression toward parent	1-7
Child enthusiasm with task	1-7
Child persistence	1-7
Clean Up	
Child positive affect	1-7
Child withdrawn/depressed	1-7
Child irritability/anger	1-7
Child noncompliance	1-7
Child aggression toward parent	1-7
Child enthusiasm with task	1-7
Child persistence	1-7
Bubbles	
Child positive affect	1-7
Child withdrawn/depressed	1-7
Child irritability/anger	1-7
Child noncompliance	1-7
Child aggression toward parent	1-7
Child enthusiasm with task	1-7
Child persistence	1-7

Clinical Assessment Form (Crowell) *continued*

VARIABLE	DATA SOURCE AND CODES
Task 1	
Child positive affect	1-7
Child withdrawn/depressed	1-7
Child irritability/anger	1-7
Child noncompliance	1-7
Child aggression toward parent	1-7
Child enthusiasm with task	1-7
Child persistence	1-7
Task 2	
Child positive affect	1-7
Child withdrawn/depressed	1-7
Child irritability/anger	1-7
Child noncompliance	1-7
Child aggression toward parent	1-7
Child enthusiasm with task	1-7
Child persistence	1-7
Task 3	
Child positive affect	1-7
Child withdrawn/depressed	1-7
Child irritability/anger	1-7
Child noncompliance	1-7
Child aggression toward parent	1-7
Child enthusiasm with task	1-7
Child persistence	1-7
Task 4	
Child positive affect	1-7
Child withdrawn/depressed	1-7
Child irritability/anger	1-7
Child noncompliance	1-7
Child aggression toward parent	1-7
Child enthusiasm with task	1-7
Child persistence	1-7
Overall: Child positive affect	1-7
Overall: Child withdrawn/depressed	1-7
Overall: Child irritability/anger	1-7
Overall: Child noncompliance	1-7
Overall: Child aggression toward parent	1-7
Overall: Child verbal aggression (swearing, threatening to hurt)	0 = no, 1 = yes
Overall: Child enthusiasm with task	1-7
Overall: Child persistence	1-7

Appendix C

Training Topics for Clinicians and Other Service Providers Participating in Child Well-Being Court

Determining eligibility criteria of parent and child for CWBC. The parent must be in full compliance with the case plan to be part of the CWBC. The clinician's role in the CWBC is to be a linchpin for the services that the parent and child are receiving. Training should include a system for clinicians to receive information about parents' compliance with the case plan on all treatments, including substance abuse; evaluations that the client has been ordered to as part of the reunification plan; and evaluations needed as part of the psychotherapeutic plan (e.g., psychological evaluation, including IQ, to determine ability to gain insight from services or to see whether special considerations are needed for service planning). Clinicians should not accept clients who are not compliant with case plan tasks. Additionally, the parent must be in compliance with consistent visitation with the child.

Establishing the first contact with other systems related to the court. Understanding differences in philosophies of each system involved with the court's work is critical to recognizing different perspectives and ensuring that expectations from other systems are realistic and clinically appropriate. Training should include the type of paperwork and issues that need to be covered before a case is open through a call of all parties (CWS, GAL or CASA, lawyers).

Understanding general characteristics of clinical work with parents in dependency court. Implementation of the court-ordered case plan for the family requires treatment goals and specific interventions to help parents achieve the goals within a time frame that is reasonable for the children. The *sine qua non* of treatment goals is helping parents accept responsibility for their children's maltreatment[1] diminish risk factors, and improve safety.

Identifying common clinical risks associated with highly vulnerable clients. In CWBC, clinicians work with a highly vulnerable population. Many parents have a history of trauma and spent their own childhoods in foster care—or, if they are adolescents, they may still be in foster care. Training is needed to prepare clinicians for common clinical problems related to intense countertransference, like enabling their clients (doing too much for an adolescent mother instead of letting her take ownership and develop maturity and responsibility over her life and the care of her child), or having only a superficial or intellectual comprehension of CWS concerns (e.g., high alignment with the parent's perspective that impedes processing the maltreatment allegation that brought the parents to dependency court).

Experiencing incongruity. The challenges of working with court clients and the need to integrate a therapeutic jurisprudence approach in the work of all professionals involved in the CWBC usually brings a lack of congruity between the way professionals see themselves in their roles and the new requirements in the context of the CWBC. Offering a training forum to share perspectives, visions, and goals before beginning the training process will help clinicians comprehend the new tasks that they must perform in the context of the CWBC. This forum should also allow all professionals involved in the CWBC to recognize their own roles, appreciate the diverse roles of the CWBC team members, develop mutual respect for and recognition of each other's professional expertise, and understand and be clear about professional roles and duties. The highest goal of this forum is to set clear goals for the CWBC and for all members to understand and agree to them.

Understanding the CWS role. Clinicians need to learn what a case looks like through CWS eyes and what CWS responsibilities are in terms of safety and timelines, what rules and regulations

CPS must observe, what information staff gather, what caseworkers assess from a family, what their operational lenses are, and what information they can share with clinicians. Information about relevant federal and state laws and agency regulations related to child maltreatment is essential for clinicians to understand the work and legal responsibilities of caseworkers. Training should include regulations at state and county levels, as well as CWS permissions to release information about a family to a clinician (memorandums of agreement, confidentiality agreements, and other forms that clinicians and families need to complete before information release).

Working with CWS. All participants should have an initial meeting to present the problems or risks that have to be worked on. The presenting problems that have to be resolved are more important than the findings. Clinicians need to know what needs to be fixed, even if it is not in the allegation or findings, and learn the behind-the-scenes landscape for the parent and child.

Knowing what to do when systems have opposite perspectives. Training should prepare clinicians for different perspectives between CWS and clinicians on risk factors and severity of the case—even to the point of reaching opposite conclusions on a permanency plan.

Understanding the elements of a juvenile court case. Training is needed to describe the main elements of the court, including petition, preliminary hearing, pre-trial, trial or adjudication, dispositional hearing, dispositional review hearings, permanency planning hearings, reunification or dismissal, and termination of parental rights and post-termination reviews.

Establishing credibility. It is the lawyers' ethical obligation to probe the clinician's testimony to establish that the clinician is credible. Lawyers working with the court need to prepare clinicians using case studies and mock courts before clinicians are directly exposed to a court hearing. Case studies should be carefully designed to pose challenging questions in clinically gray areas that allow clinicians to be exposed to questioning related to clinical criteria. Lawyers need to demonstrate how professional credibility will be routinely checked for all services providers working with the court for the first time. Helping clinicians to practice with case studies and mock courts allows them to learn the process in a protected environment, receive help in understanding how their answers can be used, and learn not to take it personally when their professional credibility is questioned. This is a critical issue, as clinicians can feel that while providing testimony or reporting to the court, they are being tested or there are doubts in terms of either their professional capacity to help the client or the effectiveness of the therapeutic intervention.

Preparing court reports. General guidelines on report preparation can be found elsewhere in this handbook. Clinicians need training on court reports from experienced clinicians and support from lawyers in the terminology and proper legal terms that are expected and shared by other court professionals.

Preparing to present at court. Clinicians need to have the opportunity to observe court proceedings in advance and familiarize themselves with the operation of the court. Specific topics include grasping the high variability among courtrooms even within a county, and being prepared to face the parents' attorneys, who sometimes are not part of the CWBC process.

Clinicians need to learn how to feel confident in court, what are some do's and don'ts of testifying, what to share and what not to share, and what to do when an attorney asks the clinician to speculate. The thorough clinical assessment of the child, parents, and family will help the clinician prepare a description of the strengths and challenges to be encountered in the clinical work. A detailed description of safety and risk issues needs to include a rationale that makes the nexus between each of the safety and risk concerns and the implications for the well-being, permanency, and safety of the child. Making the nexus between a risk factor and implications for the main three areas of child outcomes requires scientific support based on updated publications that causally demonstrate the relation between risk factors and negative child or relationship outcomes. Appendix 8 includes a list of scientific publications that clinicians can use as a starting point. In training, clinicians should be provided with published resources as well as examples of the 1-page summaries that they would present at hearings. The summaries should include sections making the nexus and supporting it with research evidence. In mock courts, clinicians need to practice using the 1-page summary and responding

to the questioning that follows. Training should also include avoiding "guessing" and other behaviors damaging to the clinicians' credibility (making connections that are not there). Finally, lawyers in the training should discuss how the clinician can explain in nonclinical terms how the clinician is working with the client.

Providing information about risk factors. Substance abuse is frequently the main risk factor overshadowing relational risk observed in the parent-child interaction. Clinicians need training to (1) provide information in their report in a way that receives attention from CWS and attorneys, including use of subsections in reports that focus on specific concerns related to parent-child interactions, and (2) communicate relational risks and other relevant risks in court and make the nexus between parents' not being able to meet the socioemotional and relational needs of the child and the impact on the child's safety (e.g., emotional neglect) and well-being.

Comprehending the concerns and perspective of each type of lawyer. Understanding the legal mandates and responsibilities of each type of lawyer participating in the court is critical for predicting the type of questions that each will pose to the services provider. Clinicians can communicate with lawyers in advance and request the questions that they are planning to ask during the hearing. At the most fundamental level, when a lawyer is asking a question she wants to know whether the child is safe, whether the risks are still unresolved, whether risks have been reduced enough that the child can be safe in whatever arrangement is being planned, and whether the people in charge of the child are responding to his needs.

Lawyers' "unlinking" of information. Learning about the perspective and responsibilities of each lawyer would also help clinicians respond to attempts by lawyers to try to unlink the information that the clinician has been connecting during the presentation of the report.

Responding to interrogation during the hearing. As important as preparing in advance for the questions that lawyers and the judge will pose is the opportunity for clinicians to learn about the type of questions that they do not need to answer or to which they can clearly say, "I don't know." Predictions of potential behaviors by parents beyond the focus of the service provided is one area that providers should avoid, as it is beyond their scope of work. Clinicians need to learn and rehearse how to maintain their position even with all the questions that lawyers frequently use trying to stir up witnesses. Learning how to stand on their report and treatment recommendation and not allow themselves to be pushed one way or the other requires support and practice.

Dealing with over-expectations on the role of the clinician and the outcomes of therapy. Many allegations reported to CPS are very difficult to investigate, and unknown elements persist across the life of an opened file. The CWS attorney may try to get to the bottom of the allegation and have the expectation that the clinician will uncover this big mystery. It is a shared experience in the CWS to have mysteries, including infants with broken femurs and unknown sources of transmissions of STDs to young children. Some of these mysteries are never going to be resolved. Clinicians need training on how to work with other professionals' expectations, while educating the parent on the issue that this abuse can really happen, how to prevent it, and how a child gets an STD so the parent can prevent this in the future. Training is needed to help the clinician do this work without betraying the relationship trust, which is very difficult to protect when the clinician has to report to the court. The court needs to evaluate that work is being done so the parent can gain insight and the child can be safe.

Keeping the focus on the needs of the child and his well-being. The CWBC helps all professionals involved with court to learn to keep the focus on the needs of the child, including dealing with her developmental problems and meeting her needs for healthy relationships, physical safety, and emotional security. At the same time, all of those working at the court need to be on high alert to avoid having a child lingering in the system without permanent caregivers. Clinicians need to inform the court about how feasible it is for this parent to get his act together and whether this parent can sustain the good behavior across time and under different levels of stress. Socioemotional aspects of the parent-child relationship should be described in relation to child well-being, safety, and permanency.

Presenting information from the perspective of the young child. Lawyers do not know how the child perceives and feels the environment that is

surrounding him or how this perception is related to the developmental level of the child. Clinicians need training to provide in clear and direct language information about how the child experiences domestic violence, maternal depression, multiple placements, loss of caregivers, and in general chaotic and unpredictable environments. Such information helps lawyers focus on the needs of the child for stability and reliable relations. An accurate description of the child's experience requires solid knowledge of child development and opportunities to practice how to provide a succinct but truthful description of the internal life of the child.

Presenting information that focuses on the therapeutic process. Learning how to present the work in progress with a client requires a description of the therapeutic stage at the time of a hearing. The judge needs to hear from the clinician not only about the improvements on therapeutic goals, but also about what must still be worked on. The clinician must demonstrate that she is aware of the risk factors and the areas that need further work. Training through mock courts is critical to learning how to be on the stand, accepting how much pressure it is, and "translating" clinical language to judicial language. Training should be provided to clinicians on how to convey information to a nonclinical audience. Clinicians who have excess information need to know what the lawyers need and what they need to hear. Training should also support clinicians to respond to court requests to recommend what's best for children. A collaborative team approach should be considered (clinician, CWS, attorneys) that incorporates the clinical insight into the emotional needs of the child to identify if there is a caregiver who meets the child's emotional and physical needs and who is willing to provide permanency and protect the child's safety and well-being.

Understanding how judges rule. Clinicians need training on court rulings and the consequences of rulings to the child and parents to help the client process the hearing experience. The client may find the hearing confusing and chaotic; if the client is angry, anxious, or lost, even the language used by lawyers and CWS to explain the hearing may sound confusing. Follow-up after court or therapeutic sessions is needed to explain what happened and how the judge ruled.

Developing relationships with the team while maintaining professional integrity. The process of receiving training and support from lawyers to prepare for hearings, and the shared experience of working regularly to help families in the CWS, creates bonds and friendships among professionals. While friendly relationships are healthy and important for mutual support, friendship should not come between the issues that need to be presented at hearings, even under pressure from other professionals. Learning to send reports in advance and to put issues on the table is a critical part of services providers' training. As one clinician noted, "Once 'out there,' issues cannot be avoided." As important as maintaining professional integrity is services providers' learning to strategically work with their team. Clinicians can work with caseworkers and decide on information that will be presented by the caseworker (e.g., negative information) that is needed by the clinician at the hearing not only to inform the judge but also to inform the therapeutic process and be integrated as a goal of the intervention.

Developing supportive materials. Services providers need to prepare information that sustains their recommendations. Research and publications supporting clinical statements should be part of the clinician's library and be updated regularly. Appendix 8 offers a list of supportive materials.

Knowing what to do when a CWBC case is moved to another court. Sometimes cases are reassigned to other judges who are not involved with the CWBC. Complex issues emerge when a case is moved to another court. These, including the following, should be the focus of training: ensuring that the clinician is included in the new hearings, mobilizing resources to ensure clinician participation, being called to present testimony, and preparing the client if more information will have to be exposed to inform parties that are not knowledgeable about the child's developmental and clinical issues.

Reference

1. Zeanah CH, Larrieu JA. Intensive intervention for maltreated infants and toddlers in foster care. *Child Adolesc Psychiatr Clin N Am*. Apr 1998;7(2):357-371.