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BABY BRIEFS

Healing the Youngest Children: Model Court-Community Partnerships

by Lucy Hudson, Eva Klain, Margaret Smariga, and Victoria Youcha

The relationships between young children and their neglectful or abusive parents have been damaged by the events that brought them to the child welfare system. The science of early childhood is shaping effective approaches for healing those relationships and getting young children and their families back on track.

Using scientific knowledge, legal professionals in the child welfare system can make informed decisions and advocate for programs and policies that protect and promote permanency for the youngest children in care.[1]

This article describes four model court-community partnerships that apply research to court practices to improve outcomes for maltreated infants, toddlers, and their families. Sample cases are provided to show how each model serves and improves outcomes for young children and their families. The article also shares tips for implementing successful court-community partnerships drawn from the four models profiled here.

The Models

Court Teams for Maltreated Infants and Toddlers

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

Working with the Miami Court Team, ZERO TO THREE developed a project to work with juvenile and family court judges to improve the health and well-being of the youngest victims of abuse and neglect. ZERO TO THREE identified judges for its Court Teams project and designed a two-phase process to use in juvenile and family courts in Fort Bend County, Texas; Des Moines, Iowa; and Hattiesburg, Mississippi.

Phase 1. Develop a partnership between a judge and a local community coordinator to establish a court-community team composed of key child-serving stakeholders, build knowledge and raise awareness of the needs of young children in foster care, and complete a community needs assessment that identifies available services and gaps.

Phase 2. Provide additional services for babies, starting with court-ordered referrals for health and dental care, quality

(Continued on page 182)

What's Inside:

ABA Focuses on Advocacy for Infants and Toddlers

The ABA Center on Children and the Law has a five-year collaborative grant from the Department of Health and Human Services Maternal and Child Bureau entitled, "The Health of Infants, Toddlers, and Preschoolers in the Child Welfare System."

This project builds upon the existing relationship among three national organizations to improve health outcomes for young children (0 to 5) who come to the attention of the legal and judicial systems. The American Bar Association and ZERO TO THREE: National Center for Infants, Toddlers and Families, with the assistance of the National Council of Juvenile and Family Court Judges, are developing materials and providing training and technical assistance to improve child health-related knowledge and skills of attorneys and judges who handle cases involving young children.

CLP articles addressing these issues are also being developed. In addition to this issue's article on community-court partnerships, watch for articles on:

- ❏ visitation for infants and toddlers in the child welfare system
- ❏ policy and practice issues for infants and toddlers
- ❏ responding to infants and toddlers affected by substance abuse

For more information about this project, contact Eva Klain, project director, 202/662-1732, klaine@staff.abanet.org

(Continued from front page)

child care, behavioral and developmental assessments, therapeutic services, and frequent visits with parents.

Local statistics supported the need for the project in each jurisdiction. For example, in 2004 children ages three and younger accounted for 21 percent of Iowa's child population but more than 34 percent of the victims of maltreatment. This discrepancy highlights the special vulnerability of the youngest children.[2]

Court Teams Sample Case

Case Facts

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

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

Intervention

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

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

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

Outcome

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

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

Babies Can't Wait
New York, New York

Babies Can't Wait (BCW) is a project of the New York State Permanent Judicial Commission on Justice for Children.[4] BCW identifies and tracks infants in family court; provides for their special health and developmental needs; and promotes permanency.[5] BCW projects are underway in New York City; Erie County, New York (includes Buffalo); Monroe County, New York (includes Rochester); and Philadelphia, Pennsylvania.[6]

The BCW projects in these communities respond to infants and toddlers in the child welfare system through three major tasks: (1) providing training on infant health and development to those working in the court and child welfare systems; (2) creating a judge's bench card for infants that addresses the special developmental and medical needs of infants; and (3) working with the child welfare agency to improve how cases involving infants are handled.[7] In addition, the BCW process includes five components to improve health outcomes for infants in foster care:

1. Identify and convene local stakeholders.
2. Provide judicial leadership.
3. Build knowledge and offer accessible ways to share that knowledge.
4. Create a favorable climate for collaborative problem solving.
5. Collect data that will help drive program design and training content, and shape service plans and court orders.[8]

BCW Sample Case[9]

Facts. Born prematurely at 27 weeks' gestation, Jamal weighed one pound, 12 ounces, and tested positive for cocaine. At birth, his three older siblings were all in foster care. His mother walked out of the hospital shortly after his birth and he remained in the hospital for three months where he was treated for a heart defect and retinopathy. At his three-month birthday, he had gained enough weight for discharge.

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

- an investigation into why the child had not been placed in care during his hospital stay.
- appointment of a CASA to find answers to the infant checklist questions[10] and ensure Jamal was referred to early intervention (EI) services.
- a diligent search for the baby's mother, which ended several weeks later when she was found murdered.

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

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

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

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

Contact Information

Court Teams for Maltreated Infants and Toddlers
Victoria Youcha, Ed.D.
Director, Court Teams for Maltreated Infants and Toddlers Project
ZERO TO THREE
2000 M Street NW, Suite 200
Washington, DC 20036–3007
202/638–1144
www.zerotothree.org

Babies Can't Wait
Christine Kiesel
Statewide Family Court Improvement Project Manager
98 Niver Street
Cohoes, NY 12047
518/238–4363
www.newyorkcourts.gov

Best for Babies
Becky Ruffner
Executive Director, Prevent Child Abuse Arizona
P.O. Box 432
Prescott, AZ 86302
928/445–5038
www.pcaaz.org

Zero to Three Family Drug Treatment Court
Judge Douglas Johnson
600 Hall of Justice
1701 Farnam Street
Omaha, NE 68183
402/444–7881

judge ordered continuing services, including CASA monitoring. She changed Jamal's permanency goal to adoption and ordered the adoption process to begin.

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

Best for Babies
Yavapai County, Arizona

Children ages three and younger represent approximately 23 percent of Arizona's child population, but they account for 39 percent of the substantiated reports of child abuse and neglect.[11] This special vulnerability galvanized support for Best for Babies (B4B). Like the other models described in this article, the people who brought B4B to life knew one another and had worked together for many years. They developed a Yavapai County checklist of essential services for the community's youngest children, listing the responsibilities of the CPS caseworker; foster parents; West Yavapai Guidance Clinic, a nonprofit provider of mental health services for children and adults; and "Systems of Support," a team process developed to assist parents in recovery accomplish their case plans for reunification. Their checklist, based on *Questions Every Judge and Lawyer Should Ask About Infants and Toddlers in the Child Welfare System,*[12] was first used in October 2004 as part of the 30-day records review.

The 2006 B4B project works to: (1) convert the B4B checklist from a snapshot in time to a guide for ongoing services, (2) develop a cadre of CASA volunteers to oversee case coordination and collaboration, and (3) improve how service providers who work with babies and their families coordinate cases and collaborate with one another.

B4B Sample Case[13]

Facts. The police got a call about gunfire at a home in an area known for methamphetamine labs. Entering the home with their guns drawn, the officers found a young woman lying dead on the kitchen floor. Standing over her was a man waving a gun and shouting at her to "get up." He was so enraged that he didn't notice the police until they handcuffed him. After locking him in the back seat of their squad car, they returned to the crime scene where they found a baby lying among dirty bedclothes. They immediately called CPS.

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

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

At the preliminary hearing, the judge ordered a behavioral health assessment for children under six years old, developmental screening, dental referral, nutritional and health screening, and a relative search. The CPS attorney signed information releases allowing medical providers to release Margaret's records to the B4B team so that they could coordi-

nate assessment and treatment information.

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

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

During weekly visits with Mrs. Ortiz and Margaret, the CASA observed their daily routines and playtime. She complimented Mrs. Ortiz on how she cared for the child. At the monthly Child and Family Team meetings and in court reports, the CASA described Margaret's progress in Mrs. Ortiz's care.

By the end of the first month, Margaret had gained three pounds, had started crawling and walking, and had learned to feed herself with both hands. She began to bond with Mrs. Ortiz and the treatment team noted the growing affection between them.

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

Zero to Three Family Drug Treatment Court Omaha, Nebraska

The Zero to Three Family Drug Treatment Court (FDTC) serves Douglas County, Nebraska, which includes the city of Omaha. Of the county's 1,198 children in foster care for abuse or neglect in February 2006, 34 percent were under age six.[14] Twenty-five percent of these young children had been in more than three foster care placements, and 5 percent had been in seven or more placements. In a 2004 sample of infants and toddlers reviewed by the Foster Care Review Board, substance abuse was an issue for 64 percent of the parents.[15]

The FDTC team became part of the national drug court movement but with a unique focus on families with children between birth and three years. Borrowing from the best practices of the National Council of Juvenile and Family Court Judges Model Court jurisdictions that have convened drug courts, the FDTC focused on babies.[16] Sobriety was a key component, but clean drug tests did not guarantee a parent could safely care for a young child. The team created a five-phase program that encourages parents to visit their children regularly, progressing quickly to unsupervised contact if they remain sober and improve their parenting skills. A part-time coordinator was hired with a grant from the Nebraska State Patrol.

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

FDTC Sample Case[17]

Facts. When Delphine came to FDTC, she was 19 years old. Her mother had introduced her to methamphetamine (meth) when she was 13. At 15, she became pregnant with Devon. Between trying to care for Devon and her meth habit, she had little time for school. Her habit grew so out of control that the Department of Health and Human Services (HHS) removed Devon from her custody.

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

Delphine, with help from her lawyer and her aunt completed the application. After a substance abuse evaluation, a psychological assessment, and a criminal records background check, she met with the FDTC coordinator for an interview and orientation to make sure she understood the program requirements and was motivated and willing to participate. Delphine was admitted to phase 1 of the FDTC. The judge explained that federal laws protected Devon from spending his childhood waiting for her to get sober. If Delphine failed, Devon would be

freed for adoption. Other FDTC team members explained the program phases and her responsibilities. She met several program participants and listened while the FDTC team talked with them about their progress.

Delphine moved in with her aunt and began outpatient substance abuse counseling and daily visits with Devon in his foster home. At weekly court appearances, she answered the judge's questions about her visits with Devon. She told the FDTC team that Mrs. Thompson, the foster mother, was "really nice" and answered her many questions about what Devon did when she wasn't there. Mrs. Thompson encouraged Delphine to attend Devon's medical appointments and developmental screening. At each court hearing, Delphine was congratulated for her success and received a small gift for herself or Devon.

At seven weeks, Delphine received a certificate for completing phase 1. She knew phase 2 would be hard, but she was determined to develop the required educational and job plan and to continue to improve her parenting. She met with the HHS social worker to talk about getting her GED and pursuing cooking school. She continued attending Narcotics Anonymous (NA), and her drug screening continued to prove she was staying clean. For Delphine, the best part of phase 2 was that she was allowed to take Devon for walks in Mrs. Thompson's neighborhood.

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

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

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

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

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

Core Components and Practice Tips

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

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

Advocates interested in bringing these projects to their communities or adapting elements of them should consider the following tips. These tips emphasize the practical steps that the model court-community programs took to implement 13 core components that characterize their success.

1. Judge as Leader and Catalyst

- ❑ Identify a strong, proactive judge to lead the court's efforts to focus on very young children. Judges play a key role marshaling community services and assistance on behalf of young children and families. The judge has a unique ability to encourage action among public and private child-serving agencies.

2. Child Development Expertise

- ❑ Hire an expert in early childhood development or children's mental health to work with the judge and

other team members to address the needs of maltreated young children. A partnership between the judge and a child development/mental health expert joins two distinct disciplines to improve outcomes for young children.

3. Court-Community Team

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

4. Attorneys Who Know and Respond to the Needs of Babies

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

5. Research-based Interventions

- ❑ Develop tools to allow the court and child welfare staff to respond knowledgably to the medical and developmental needs of babies and promote permanency.
- ❑ Collect data to support new approaches to meeting the needs of young children and parents in the child welfare system. For example, the National Research Council and the Institute of Medicine's *From Neurons to Neighborhoods,* a synthesis of current scientific knowledge of child development from birth to age five, calls on the nation to thoroughly reassess policies that affect young children and increase its investment in their well-being.[18]

6. Access to Early Intervention Services

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

7. Mental Health Services

- ❑ Develop the community's capacity to offer mental health interventions to parents and young children together. For example, child-parent psychotherapy improves the relationship by increasing parents' responsiveness and sensitivity to their baby and creating strategies for parents to respond to their children's cues in ways that support their development.
- ❑ Train local mental health clinicians to provide interventions tailored to young children and their parents.
- ❑ Research funding sources for interventions and supports for young children and their parents (e.g., Medicaid; Victims of Crime Act, which covers therapeutic services for crime victims).

8. Case Monitoring/Tracking

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

9. Child-Focused Court-Ordered Services

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

10. Training

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

11. Resources for Professionals and Parents

- ❑ Develop and share resource materials to guide project team members, birth parents, and foster parents (e.g., publications and training guides, participant manuals, checklists).

12. Funding

- ❑ Find funding to hire an expert in early childhood development or children's mental health who will work with the judge to address the needs of young children in child maltreatment cases. Consider Court Improvement Projects, state and federal grants, and private foundation funding.
- ❑ Seek in-kind donations from court team members to help implement and sustain the effort.

13. Program Evaluation

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

Conclusion

By focusing on the developmental needs of very young children, the four court-community models seek to improve outcomes for children now and as they grow up. What makes these programs special is collaborative judicial leadership, committed colleagues in all child and family-serving disciplines, and a willingness to expand their knowledge and try new approaches to old problems. They have turned their despair over the families who come before them into strategies for healing them. As Judge Johnson of Omaha commented, "It's about the kids. People talk about parents getting their children back. But really, this is about the children getting their parents back."[19]

Lucy Hudson, M.S., is a policy analyst at ZERO TO THREE; *Eva Klain,* J.D., is director of The Health of Infants, Toddlers and Preschoolers in the Child Welfare System project at the ABA Center on Children and the Law; *Victoria Youcha,* Ed.D., is director of the Court Teams for Maltreated Infants and Toddlers Project at ZERO TO THREE; *Margaret Smariga,* M.A., is a project writer at ZERO TO THREE.

This article was adapted from an in-depth judicial brief on court-community partnerships developed by staff at Zero to Three and the ABA Center on Children and the Law. The full brief, *Healing the Youngest Children: Model Court-Community Partnerships,* is available for free download at the ABA Center on Children and the Law's web site, http://www.abanet.org/child/baby-health.shtml and Zero to Three's web site, www.zerotothree.org

Endnotes

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

[2] U.S. Department of Health and Human Services. *Child Maltreatment 2004,* table 3–9.

[3] In all case scenarios, names of individuals and some case facts have been changed to protect the confidentiality of the children, their families, and their foster families.

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

[5] Ibid., 32.

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

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

[8] Ibid., 32.

[9] Sheryl Dicker, "Jamal's Story," personal communication with Lucy Hudson, August 14, 2006.

[10] These questions are included in Ensuring the Health Development of Foster Children: A Guide for Advocates and Child Welfare Professionals, developed by the New York State Permanent Commission on Justice for Children. Visit http://www.courts.state.ny.us/ip/justiceforchildren/PDF/ensuringhealthydevelopment.pdf or http://www.courts.state.ny.us/ip/justiceforchildren/PDF/Infant%20Booklet.pdf

[11] U.S. Department of Health and Human Services. *Child Maltreatment 2004,* Table 3–9.

[12] Osofsky, Joy, Candice Maze, Cindy Lederman, Martha Grace, and Sheryl Dicker. *Questions Every Judge and Lawyer Should Ask About Infants and Toddlers in the Child Welfare System.* Reno, NV: National Council of Juvenile and Family Court Judges, 2002.

[13] Sally Campbell, personal communication with Lucy Hudson, July 13, 2006.

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

[15] Nebraska Foster Care Review Board. "Children Age 0–3 and Parental Substance Abuse." February 2006. Available from Lucy Hudson at Zero to Three, E-mail: lhudson@zerotothree.org

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

[17] Lou Shilton, personal communication with Lucy Hudson, July 13, 2006.

[18] Shonkoff, Jack P. and Deborah A. Phillips, eds. *From Neurons to Neighborhoods: The Science of Early Childhood Development.* Washington, DC: National Academies Press, 2000.

[19] Nygren, J. "Drug Court Grads Show Appreciation." *Omaha World-Herald,* March 1, 2006.

IN THE STATES

Look around. States are getting creative to improve children's lives. A new program here, a joint effort there, an idea for reform. . . Good ideas deserve to be shared.

Indiana Recommends Steps to Prevent Child Fatalities

A new report by Indiana's Child Fatality Review Team makes 27 recommendations to prevent child fatalities caused by abuse and neglect, accidents, and unsafe practices. Indiana has the highest per capita rate of child abuse and neglect deaths, and leads the nation in preventable deaths among children younger than one. The recommendations are based on a review of 57 child deaths identified by the Department of Child Services in 2005.
www.clarian.org/pdf/2005_childfatalities.pdf

New Jersey Boosts Adoptions

Judges and child welfare workers in New Jersey have been working to boost adoptions of children in the state's foster care system. Their efforts have resulted in 1,361 adoptions during 2006—a 24% increase over the target goal set by a settlement agreement between the state and Children's Rights, Inc.. Steps taken to cause the turnaround include closer state oversight, judicial efforts to move cases faster, and reopening specialized adoption offices that were closed in 2004 and 2005 as part of a revamping of adoption practices.

- **NJ adoption and permanency data:** www.state.nj.us/dcf/home/childdata/AnnualSummary01_10_07.pdf
- **Settlement agreement promoting child welfare reforms in NJ:** www.state.nj.us/dcf/home/Modified_Settlement_ Agreement_ 7_17_06.pdf
- **NJ's child welfare reform plan:** www.state.nj.us/dcf/home/NJ_CWR_Focusing_on_the_Fundamentals_June_28_2006.pdf

Rhode Island Links Children to Mental Health Services

To quickly link children with mental health services, Rhode Island's Department of Children, Youth and Families has teamed with Gateway Healthcare to launch Kid's Link. This state-run confidential hotline allows a child or parent to speak with a trained clinician, who can assess the child's needs and arrange appropriate services. The program provides a single point of entry into the mental health system for children who receive state-funded health care. It is designed to intervene early with children suffering from behavioral problems or mental health issues and to link them to quality mental health services.
http://www.gatewayhealth.org/KidsLinkRI.asp

Washington Posts Child Welfare Data

What makes a good family preservation program? How do court continuances affect foster care stays? How do federal timelines affect services for parents in child welfare cases? These questions are on the radar screens of policy makers and practitioners nationwide. The Washington State Institute for Public Policy provides state data that answer these and other timely child welfare questions at its web site.
http://www.wsipp.wa.gov