THE MIAMI CHILD WELL-BEING COURT™ MODEL

A Handbook for Clinicians

Prepared by
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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.

This handbook is the product of a multisite translational research project focused on effective dissemination and implementation of the Miami Child Well-Being Court™ Model. The development of this publication was supported in full by Grant No. R18 CE001714 from the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC.

Acknowledgments

The authors would like to thank the entire team of collaborators across the three study sites for their many contributions. We are grateful to Joy Osofsky for her instrumental involvement in the proposal and planning phase of the project. We also thank Dean Fixsen and Allison Metz of the National Implementation Research Network for their guidance in applying principles of implementation science to a systems integration effort.

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Miami Child Well-Being Court Initiative. (January 2013). *The Miami Child Well-Being Court™ Model: A Handbook for Clinicians*. Miami, Florida.

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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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Contents

Introduction

The Miami Child Well-Being Court™ (CWBC) is a judicially led and child-centered model of systems integration focused on promoting the well-being of infants and young children involved with the child welfare system (CWS) and the court. The model is led by a judge who fosters collaboration in the courtroom, values the science of early childhood development, and prioritizes evidence-based services to ameliorate the effects of stress and trauma on the young child. In this model, judges "trade their typical role of objective referee for one of mentor and advisor" and mobilize the court to be "the catalyst and overseer of the healing process."[1]

The Miami CWBC, now more than a decade old, is widely recognized as one of the country's flagship court improvement efforts. The model is anchored by three essential principles:

- The needs of vulnerable children involved in dependency court (for child abuse and neglect) will be best served through a problem-solving 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.[a]
- 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).[3-5] The practice changes for CPP as applied in the Miami model are described in detail in this handbook.
- 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 traditionally involved in court proceedings. This unusual role for the clinician in the dependency court process is actively supported by the judge.

> "Dependency judges across the United States have the most important, yet painful, jobs in the American justice system. We preside over hundreds of cases each week, making crucial, sometimes life-altering, decisions in a matter of moments. As students of human behavior and experts in human suffering, we try to develop some expertise in promoting healing. We realize that the children and families we see in court have come to us as a last resort when everyone and everything else has already failed them. The children enter our doors precisely because they have been deprived of the most important keystone of child development. They have been harmed by those who are supposed to love and protect them. If we do not take into account the fundamental needs of the child while seeking to meaningfully change the parents' capacity to care for that child, we are indeed cruelly inadequate."
>
> —Judge Cindy S. Lederman[2]

As would be expected, this unique court model depends on the long-term commitment and shared vision of decision-makers at all levels of policy and program planning. Equally important is the openness of front-line professionals who work day to day in the court to expanding their knowledge

[a] We use the term "caseworker" to refer to the front-line practitioner assigned to the case by the child welfare agency. We use "parent" and "parents" interchangeably, as we do "clinician" and "clinicians." Similarly, we alternate between "he/his" and "she/her"; no exclusion is implied.

and understanding of the clients they serve and to changing familiar and routine practices.

For you, the clinician, the demands will extend beyond openness to change. Your participation in a CWBC team means stretching your professional skills past conventional therapeutic practice and engaging in practices that can feel in conflict with the relational work in which you specialize. The court is alien territory. There is much to learn to achieve a level of comfort and confidence. A starting place is becoming familiar with the statutory processes and perspectives driving the court and the CWS in your jurisdiction. It will also be critical to learn how to communicate effectively with professionals from different backgrounds and systems-driven perspectives and priorities. And, perhaps most challenging, you will need to develop and protect the therapeutic relationship in the often adversarial context and tight timeline of court-ordered treatment. Clearly, it is important that you are fully aware of the nature and scope of practice change that will fully maximize your role in the model before you commit to taking on this new professional challenge. Similarly, for your supervisor and others making decisions about how to support and maintain the best practices described in this handbook, it is important that specialized training, clinical supervision, and reflective supervision are in place and ongoing from day one.

The pages that follow provide an overview of the type and scope of supports needed to implement the clinical components of the Miami CWBC™ model. As such, this handbook is a road map for clinicians, their supervisors, directors of community-based mental health services organizations, and decision-makers at child welfare agencies exploring or planning the initial implementation of the model. It is relevant to all stakeholders in a CWBC initiative, so that everyone at the table can appreciate the critical contributions and challenges you will face. It is also relevant to jurisdictions already engaged in systems integration and targeted case management for young children in the CWS, offering guidance for transformational systems change at the behavioral level.

This handbook is meant to be used as a companion to two other resources in the *Miami CWBC™ Dissemination Tool-Kit:* (1) *Child-Centered Practices for the Courtroom & Community: A Guide to Working Effectively with Young Children and Their Families in the Child Welfare System*,[1] which offers comprehensive and practical guidance for legal, child welfare, and mental health professionals; and (2)*The Miami Child Well-Being Court™ Model: Essential Elements and Implementation Guidance,*[b] a technical assistance brief that defines the practice changes (i.e., behavioral anchors) essential to the Miami CWBC™ model across all members of the court team, provides self-assessment tools for monitoring progress in adopting these new practice changes, and describes a set of critical steps and actions that communities can pursue to support successful and sustainable implementation.

Both the *Essential Elements* technical assistance brief and this handbook are products of a translational research project, funded by the Centers for Disease and Control and Prevention, focused on dissemination strategies for supporting effective uptake of the Miami CWBC™ model in new communities. The project was carried out by a multisite consortium comprising the originating site team in Miami-Dade County, Florida; implementation researchers specializing in infant mental health at RTI International; and community stakeholders at two new sites seeking to adopt the model: Wayne County, Detroit, Michigan, and Leon County, Tallahassee, Florida. The content of this handbook is based, in part, on qualitative study of the core components of the model through court observations and interviews with key informants on the originating Miami team (i.e., decision-makers and front-line court team professionals) and with community stakeholders involved with implementation of the model at the two dissemination sites. The material presented herein reflects the collective experience of both the original and newly adopting sites, which crystallized through the process of training and technical assistance (coaching) and was captured through exhaustive documentation of planning and steering meetings at the dissemination sites.

The handbook is organized into three sections. Section 1 briefly summarizes the evidence base for clinical interventions relevant to the Miami CWBC™ model. Section 2 presents foundational knowledge that clinicians will need to participate most effectively on a court team. Section 3 describes the many dimensions of the clinical role and adaptations to clinical work demanded by the model. Throughout the handbook the reader is directed to the appendices for sample forms and resources that can be adapted for new CWBC initiatives, as well as links to other helpful resources.

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

Section 1
Relevant Evidence-based Clinical Interventions

As noted, the use of evidence-based clinical interventions is a core component of the CWBC. In this section, we offer a brief summary of evidence-based interventions appropriate for maltreated young children. The interventions specified below have been evaluated in multiple randomized controlled efficacy trials or in at least one large effectiveness trial.[6,7,8,c]

Child-Parent Psychotherapy (CPP)[3,4] is a high-intensity (50 1-hour weekly sessions), attachment- and trauma-focused psychotherapeutic intervention. CPP has been evaluated with study populations relevant to the CWS and the court, in two separate efficacy trials (one with young children in maltreating families[3,4,9,10]) and a third efficacy trial with children ages 3–5 exposed to domestic violence.[11,12] Across this body of evidence, CPP has resulted in greater improvements in children's secure attachment behavior, representations of the attachment relationship, traumatic stress symptoms, externalizing behavior, and diagnostic status. In addition, the Lieberman trial[11,12] with children exposed to domestic violence (many of whom were also exposed to maltreatment) reported sustained benefit for a reduction in child behavior problems 6 months after treatment completion. With multiple trials demonstrating relatively long-term outcomes, CPP represents the gold standard in attachment-focused intervention addressing child exposure to trauma and disruption in the caregiver-child relationship.

In addition to CPP, several other evidence-based interventions may be appropriate for the Miami CWBC™ model. Attachment and Biobehavioral Catch-up (ABC) is a home-based approach designed to help caregivers of children ages birth to 5 years provide nurturing, sensitive care that promotes the child's regulatory capabilities and attachment formation. The intervention, which is lower intensity than CPP (10 1-hour weekly sessions), was developed specifically to address the emotional vulnerabilities of infants and young children in foster care. ABC has been evaluated in several randomized controlled trials. Two trials tested the intervention with foster parent-child dyads, comparing ABC with a psychoeducational approach[13-16] or with a wait-list control group.[16] Another trial tested the intervention with biological parent-child dyads, again comparing ABC with the psychoeducational approach.[13-15,17-20] The trials demonstrated the comparative efficacy of ABC in improving child attachment behavior, improving behavioral problems, normalizing children's cortisol regulation (cortisol is an indicator of neurobiological response to stress), or some combination of these. Additionally, ABC showed greater benefit in reducing children's negative emotionality (biological parent-child dyads) and in reducing negative parenting attitudes and parenting-related stress (foster parent-child dyads).

Two other interventions that are highly relevant for children involved with the CWS and the court are Parent-Child Interaction Therapy (PCIT) and SafeCare®. Both approaches have strong evidence supporting their efficacy and effectiveness in reducing child re-reports to CWS; the strongest research for these interventions, cited here, does not include child emotional well-being or developmental outcomes. PCIT, which incorporates both a behavioral and attachment orientation, is a clinic-based approach primarily focused on direct coaching of the parent to support more positive child behavior and child-parent interaction. Standard PCIT is typically provided in 14–20 1-hour sessions but allows for a sufficient number of sessions for the parent's mastery of new parenting skills and behaviors. PCIT has been adapted for physically abusive parents (reducing the frequency and durations of sessions to 12–14 1-hour dyadic sessions) and evaluated in both an efficacy and an

[c] The Agency for Healthcare Research and Quality (AHRQ) defines "efficacy" as "whether a drug or other treatment works under the best possible conditions" and "effectiveness" as "whether a drug or other treatment works in real life." Additional explanations and examples are available at the AHRQ Glossary of Terms (http://effectivehealthcare.ahrq.gov/glossary-of-terms/).

effectiveness trial. Both trials were conducted with study populations that mixed younger and older children (ranging from 2.5 to 12 years). Additionally, both trials evaluated an intervention package combining PCIT with a motivational intervention (an orientation preceding PCIT comprising 6 parent group–based sessions). These studies found that the PCIT-motivational intervention package significantly reduced child re-reports to the CWS compared with usual care.[21,22]

SafeCare®, formerly known as Project 12-Ways, is a home-based approach which provides multifaceted services addressing parent-child interaction, parental stress, and home safety risks, among other areas (e.g., multisetting behavior management, infant and child health and nutrition, social support, money management, problem solving, alcohol abuse referral). SafeCare® is a medium-intensity approach, typically providing 18–20 weeks of 1-to 2-hour weekly or biweekly home visiting sessions. SafeCare® has recently been evaluated in a large effectiveness trial with maltreating parents and their children (0–12 years). The majority of children in the sample were preschool age (76%).[23] Based on the study findings, families who received SafeCare® were 21%–26% less likely to experience re-reports than families receiving usual care home visiting services. The authors estimated that SafeCare® would prevent 64 to 104 first-year recurrences per 1,000 treated cases.

Clearly, there are marked differences in the depth of the therapeutic relationship across these approaches, particularly in terms of trauma-sensitive and relational clinical processes. Nonetheless, each approach calls for highly trained professionals who, through their intensive work with the parent-child dyad, are positioned to bring a highly informed clinical perspective on progress in the parent-child relationship into the court process. Thus, they represent important service options for communities seeking to adopt the model. As can be seen in the sections that follow, despite their differences—and with appropriately small caseloads—they all can be adapted to take on the additional roles and responsibilities of a clinician in the CWBC model.

Section 2
The Basics

After a visit to observe the Miami CWBC™ in action, a judge commented, "I learned a big lesson today—the clinician is in court." This is a simple statement on the surface, but one that reflects the paradigm shift in the culture of dependency court and engagement of the clinician in the court process—a shift facilitated by vigorous therapeutic jurisprudence carried out through the CWBC problem-solving approach. How does this look in practice? In the CWBC model, the judge ensures that the clinician is a regular and active participant in hearings. The judge looks to the clinician for the critical substantive information that can effectively guide the attorneys and caseworkers in their respective work and inform the decisions made on the case.

At each hearing you will be asked to inform the court through court reporting and testifying about the following (more information provided later):

1. The child's developmental status, including milestones in each developmental domain that are typically reached for a child that is your client's age, whether your client is reaching those milestones, factors in the child's environment that support or negatively impact typical development, and your interpretation of the developmental assessment conducted by Part C of the Individuals with Disabilities Education Act of 1990 (IDEA).
2. The parent-child relationship, including behaviors that you are seeing that indicate the quality of the attachment relationships between the child and all of her caregivers; the parent's understanding of his child's needs; the role that the parent-child relationship plays in supporting optimal development; the way that risk factors (like substance abuse, intimate partner violence, a history of childhood trauma, isolation, teen parenting, etc.) impact the parent's ability to provide consistent, reliable, sensitive, and predictable care; the parent's ability to read the child's cues and respond appropriately and timely; and the provision of a developmentally appropriate environment for the child.
3. Your work with the parent and the parent's progress including: the issues on which you are currently working, the parent's responsiveness to these issues, the parent's increasing ability to reflect on how her behavior impacts her child's well-being, and how the parent perceived the child impacting his/her ability to parent.

This is vastly different from the typical experience of clinicians who report to and are called to testify in court. Traditional hearings can make clinicians feel that they are being treated unprofessionally when their qualifications, credibility, and professional opinions are challenged by lawyers in the case. Clinicians may feel publicly humiliated when the information they are providing is questioned and considered invalid. For new sites wanting to implement a CWBC, planners must be sure that the clinician has the credentials and training to conduct evidence-based interventions. Clinicians should be (1) selected based on basic competencies of early childhood therapists and demonstration of credentials and (2) prepared through training to anticipate and respond to fierce cross-examination in the case of a trial.

The CWBC model expects that all involved—the parent's attorney, attorney representing the state, caseworker, and clinician—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. In this context, although potentially subject to cross-examination, the clinician's contributions are fully integrated into the solutions offered to the judge.

Before the CWBC project was implemented at the adopting sites, clinicians were rarely invited to the courtroom to discuss the work they were doing with infants and families. When they were invited to participate, they were not "at the table" and

were sometimes asked questions by attorneys that unintentionally discredited them and negatively impacted the therapeutic relationship that is critical to treatment. In one site, for example, now clinicians are literally at the courtroom table, sitting beside their clients. They are asked to describe their clients' progress. Attorneys, caseworkers, and judges are sending the message that dyadic treatment is important and helpful and that they want the parent to participate.

Getting to this place of mutual respect doesn't happen overnight, just because a community adopts a court team approach. While everyone on the team begins with the same goal—for infants to be safe and nurtured—the ways in which each discipline goes about achieving the goal are very different. The section below describes effective communication. One way that the clinicians communicated their expertise and earned the respect of the judge, attorneys, and caseworkers was through comprehensive report writing.

Judges interested in establishing a CWBC team tell us that they need for parent-child clinicians to be credible in court. Clinicians have to be prepared and confident; they must be able to tell the court about what clinical goals exist for the family, what they are doing with the family to work toward those goals, and what evidence they have that the parent and infant are making progress. If clinicians cannot tell these basic things, their credibility is called into question. Detailed reports help judges to know what is happening in the parent-child relationship and help them see that the family is making progress.

The collaborative, less confrontational approach also 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. When a child's safety is at stake, a clinician who has little knowledge about the circumstances of the case can be terrified to weigh in. In the CWBC model, the clinical input is regular and consistent. 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.

Challenge: Effective Communication

Effective communication begins by understanding each other's roles: "If [members of the team] do not understand each person's role, it makes room for more and more conflict between parties. We know that we can't be best friends when there are different things that are best for each of our clients, but we can develop a mutual respect for each person's position on the team," said one attorney.

Clearly, the unique role of the clinician in the CWBC model is contingent on a judge who values the clinical perspective and fosters an atmosphere of respect for it across the members of the court team. As can be seen in the quote above, the clinician influences the degree to which the judge trusts the clinicians' observations and recommendations. The judge does this by opening the floor to the clinician through routine targeted inquiries about treatment progress as well as returning to the clinician for his perspective throughout the hearing.

But the judge's facilitation of the clinical voice in the courtroom is only part of the equation. It is also incumbent on the clinician to be as effective a communicator as possible.

This clearly is no easy task. It is challenging to present clinical information to professionals from other disciplines with little or no knowledge about young children's emotional needs and the nature of clinical treatment that addresses child trauma and parenting dysfunction. Most clinicians have limited experience presenting in a courtroom and may not fully understand the court process. The clinician should not have to guess how much detail to present or how to present it effectively in the court.

For these reasons, training for clinicians on the rules, responsibilities, and roles of the respective members of the court team is essential. Such background information is fundamental to prepare clinicians to meet the demands of their role on the team and to understand the pressures and demands of their colleagues' roles as well. Core foundational topics for training and technical assistance are listed below.

One of the most requested training topics from clinicians was writing effective reports and providing testimony. The fear that questions would be asked that undermined or endangered their relationship with their client was paramount: "Ironically, the way that the clinicians feel in court is very similar to the way that their clients feel too. They both feel as if they are being evaluated," an attorney observed.

Basics About Court and Appellate Processes

- Participants and roles in court proceedings:
  - the parties (parent, child, and legal guardians or custodians)
  - the state (the child protective services [CPS] investigator, caseworker, adoption caseworker)
  - the judge
  - the attorneys (such as the state's attorney general, GAL, or an attorney for the parent)
  - the witnesses
- Legal mandates and responsibilities of the different lawyers involved with dependency cases
- Legal mandates and responsibilities of the caseworker
- Elements and flow of a dependency court case (see Appendix 1 for a brief overview):
  - preliminary protective hearings
  - adjudicatory hearings
  - dispositional hearings
  - review hearings
  - permanency hearings
  - adoption hearings
  - termination of parental rights (TPR) hearings
- Legal basics:
  - terminology
  - core rules of evidence
  - hearsay and hearsay exceptions
  - types of testimony
  - the best interests of the child (this will differ by state; for example, Michigan has a children's bill of rights that guides best interest)
- Different types and purposes of court proceedings (see Appendix 2 for a brief overview of court proceedings and Appendix 3 for a decision tree for clinical intervention):
  - Adjudicatory and TPR hearings are more similar to trials and focus on proving the allegations in the dependent or TPR petitions.
  - Disposition, review, and permanency hearings are focused on the safety, permanency, and well-being of the child and assess what services are needed to rehabilitate the family, meet the child's special needs, and ensure that permanency is achieved in a timely manner.
- Preparation of court reports:
  - structure and organization
  - content
  - degree of detail
  - clarity
  - factual supporting evidence for opinions
- Tips for presenting in court:
  - how to be a credible witness
  - how to dress
  - what to bring
  - whom to look at when responding to a question

Basics About the Child Welfare Process

All cases in foster care begin with a CPS investigation to determine if children are at significant risk and removal from the home is necessary. This process requires timelines and a series of steps. Once the case moves to foster care, the child welfare agency has legal responsibilities for ensuring child safety and following mandated timelines; federal, state, and county regulations; and agency rules related to these responsibilities. The legal responsibilities include

- moving the case through the system and honoring required timelines and specific steps in the process;
- ensuring completion of family needs and risk assessment—content, process, and timing; treatment planning and referral process, including restrictions related to adding new services; and the landscape of other community service providers contracted by the agency; and
- carefully tracking the parent's compliance with the parent-agency agreement and fully communicating regulations about sharing information about a family with clinicians (e.g., memoranda of agreement, confidentiality agreements, other relevant forms).

Training Resources and Activities

The Administration for Children and Families Children's Bureau funds an expansive network of training and technical assistance centers that provide information that is useful to clinicians who are navigating the child welfare and judicial systems (see sidebar). The National Resource Center for Legal and Judicial Issues[d] is an excellent place to start, as it offers training and consultation on a variety of foundational topics, both for clinicians and for stakeholders developing a court improvement initiative. These topics include

- 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.

In addition to obtaining training and technical assistance from outside entities, another strategy is to convene regular lunch-and-learn sessions facilitated by local experts, members of the court team, or both. Such low-key opportunities for shared learning build the team's capacity, build credibility between team members, train and integrate new staff as they join the court initiative, and strengthen the cross-systems relationships on the team. For example, attorneys could use these sessions to explain specific challenges and offer helpful hints about presenting in court. Similarly, caseworkers on the team could present on their processes and timelines and lead a discussion about the challenges on a prototypical case (a list of topics for training is provided in Appendix 4). The nonclinical members of the court team will also need to learn foundational concepts in infant and child mental health and about clinical intervention, including attachment, trauma, relationship-based intervention, and types of assessments and outcomes. Judges, attorneys, and caseworkers become more knowledgeable through hearing the clinician's perspective during hearings and during interactions with the clinician between hearings. However, such naturalistic knowledge transfer should be supplemented by formal and informal learning opportunities facilitated by local child mental health resources (e.g., by the state association for infant mental health) and the clinicians involved on the court team. For example, the National Child Traumatic Stress Network (NCTSN) offers many training resources relevant to child trauma and treatment. These include

[d] This center 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.

Training and Technical Assistance Network funded by the Children's Bureau, Administration for Children and Families

National Resource Centers

National Child Welfare Resource Center for Organizational Improvement

National Resource Center for Child Protective Services

National Resource Center on Legal and Judicial Issues

National Resource Center for Permanency and Family Connections

National Resource Center for Child Welfare Data and Technology

Information is available on the ACF Web site at http://transition.acf.hhs.gov/programs/cb/assistance/national-resource-centers.

Quality Improvement Center (QICs)

National QIC on Early Childhood

National QIC on the Representation of Children in the Child Welfare System

Regional Implementation Centers

Atlantic Coast Child Welfare Implementation Center

Midwest Child Welfare Implementation Center

Mountains and Plains Child Welfare Implementation Center

Northeast and Caribbean Child Welfare Implementation Center

Western and Pacific Child Welfare Implementation Center

National Center on Substance Abuse and Child Welfare

National Technical Assistance Center for Children's Mental Health

Technical Assistance Partnership for Child and Family Mental Health

webinars through the NCTSN Learning Center for Child and Adolescent Trauma and a Child Welfare Trauma Training Toolkit that provides step-by-step guidance and materials for conducting training on trauma-informed child welfare practice. Other useful resources on the science of child development include the following:

- Harvard University's Center on the Developing Child (http://developingchild.harvard.edu/)
- Zero to Three (http://zerotothree.org/)
- Handbook of Infant Mental Health[24]
- Handbook of Attachment[25]

Once the team is grounded in foundational knowledge, the next challenge is for each professional to learn the new dimensions of his or her work. In Section 3, we detail the steps and activities of the clinician's role across the trajectory of a CWBC case.

Summary

Training is as an essential and ongoing component of a complex court improvement initiative such as the Miami model. It is essential that ongoing training is in place to integrate new clinical and other professional staff onto the court team, as turnover is a constant challenge in the field. It is also particularly important to reassess the training needs of the team at regular intervals to identify topical areas to revisit and new areas to address. A comprehensive list of suggested training areas for clinicians and other professionals participating in a CWBC team is provided in Appendix 4. This list encompasses the areas discussed in this section and the sections that follow. Additionally, information about the CWS and training is available at https://www.childwelfare.gov/management/training/curricula/caseworkers/.

Section 3
Clinical Practice in the CWBC Model

Opening the Case

When a family is under court jurisdiction, following a CPS allegation, they are ordered by the court to participate in services to address the concerns that brought them to the attention of the CWS. As a first step, the child welfare agency initiates a case plan for the family. The case plan includes services that *all* parties agree must be completed by the parent to reunify with the child. Fathers should always be considered essential to the process of the reunification unless there are legal impediments. All too often, they are ignored in the treatment process.

In the CWBC model, the parents, supported by their attorney, should have been integral in the case planning process. The parents' attorney should ensure that the parents make an informed choice (i.e., that they understand the terms of participation and legal repercussions of not complying with the case plan). Once the case plan has been agreed upon, the caseworker will then obtain a signed release from the parent allowing the clinician and all other parties (e.g., the child welfare agency, attorneys, the court, other mental health providers, day care teachers) to share information about the status of the parent and child and salient issues affecting the progress of the case plan. The caseworker assigned to the family will then make the referral to your organization as a contracted provider. Typically, the referral is made once the child has been placed in a shelter, in the care of a relative, or with a foster parent.

Once you have received a copy of the referral form, you will begin the clinical intake process by collecting essential documentation needed to determine whether the treatment is appropriate for the parent and child and, if so, to inform the development of the treatment plan and delineate clinical work related to risk factors and safety concerns (see Box 1). Ideally, a protocol will be in place at the child welfare agency that ensures that the case plan, legal documents, and other critical information about the case will routinely be provided to you by the caseworker (or another designated person) as part of the referral process. The type of information you'll need includes the reason the child came into care; the type and scope of services the parent has agreed to participate in, including substance abuse treatment and domestic violence intervention; and psychiatric or psychological evaluations.

Ideally, the referral form should have a section that indicates whether the parent has received services from a clinical provider in the past for any interventions, including infant mental health services. Even with a protocol in place for information sharing, you will likely need to be assertive and proactive in communicating with the caseworker, GAL, and child's attorney to be sure that you are apprised of all relevant information that may be

Box 1. Essential Documentation for Initiating Intake and Treatment Planning

- Therapeutic treatment referral form (court or child welfare agency)
- Verified petition for dependency or shelter petition (preliminary protective hearing petition)
- Adjudicatory order (if the child has been adjudicated dependent)
- Safety plan (developed whenever it is determined that the child is at risk of imminent harm)
- Case plan, which follows the family assessment and details the type and scope of services the parent has agreed to participate in; sets forth the goals and outcomes, including concurrent permanency planning if applicable; and describes how the family will work toward these outcomes
- Psychiatric or psychological evaluations
- Any other documentation on risk and safety, including a home study conducted by the caseworker

in the court records. Not having this information compromises your ability to develop a clear and meaningful treatment plan for your clients. For treatment planning, you may want to explore what other information is available in the client's court record (see Box 2). Don't hesitate to request copies of additional information during the intake process. Keep in mind that cultural and language characteristics of the families will also mediate the implementation of your clinical work.

Box 2. Reports and Information Typically Available in Court Records

- Reports from the caseworker, adoption worker, or both
- Social service and home visit reports from the caseworker
- Birth dates of all potential clients
- Medical records
- Academic records, evaluations, or both
- Evaluations—psychological, psychiatric, or both
- Reports from other mental health professionals
  - Name of clinician, supervisor, and contact information, including address, phone, and fax
  - Name of client or clients
  - Dates of scheduled appointments
  - How many appointments kept and reasons for missed appointments
  - Purpose of therapy—e.g., individual, family, substance abuse, grief and loss
  - Diagnoses

Be particularly vigilant about issues such as the parent's criminal history, prior involvement with the CWS or previous referrals that didn't result in court involvement or removal of the child from the home. It is also appropriate for you to speak with the parent's attorney regarding any information she may have that is not contained in the court file related to the parent's criminal background or history with the CWS. Please note that there is a lot of information *not* contained in the court file about the parent that would possibly be important to know. A complete understanding of your client's background will be essential to developing an appropriate and effective therapeutic plan. Moreover, being caught off guard by such information coming to light during a hearing could seriously undermine your credibility and call into question your clinical recommendations.

After reviewing the relevant documentation and consulting with the caseworker, you will need to consider several fundamental issues before opening the case:

- Will therapeutic contact between the child and parent be allowed, or do the circumstances of the case prohibit such contact?
- Has the parent been in compliance with his or her case plan to date?
- If applicable, is it therapeutically appropriate (best for the parent and child) to have a clinician who previously worked with the family open the case? This situation may occur if a parent is initially noncompliant (and the treatment is closed) but is then re-referred when he or she becomes ready to engage in the court-ordered services.

In Miami, a formal eligibility screening protocol is in place for assessing a parent's readiness for intake into CPP (see Appendix 5, Child-Parent Psychotherapy Referral Process Triage Procedure). A first-level eligibility screening is conducted by a clinician assigned to the case, in consultation with the caseworker. Readiness for treatment requires that (1) the parent has access to or custody of her child, as it is an interactive dyadic therapeutic model (if the parent is denied access to her child, the counseling program cannot enroll them until the situation changes); (2) the parent not be currently abusing drugs or alcohol; and (3) the parent or child not have severe mental or physical health issues that make participation unfeasible. If the referral does meet the first-level eligibility criteria, an initial evaluative session is then scheduled wherein the clinician conducts a structured observational assessment of parent-child interaction. The assessment should be based on instruments with adequate psychometric properties (some recommended assessment tools are provided in Appendix 6). In Miami, the assessment is a modified adapted version of the modified Parent-Child Relationship Assessment.[26] Parents who display a negative or flat affect, are intrusive, or engage in inappropriate discipline strategies are identified as potentially benefitting from therapeutic intervention to improve their relationships with their children.

If a parent is determined to be ineligible for CPP, the caseworker will refer the parent to an evidence-

based parenting program in the community and to any other needed services for the parent, the child, or both (e.g., Part C/Early Intervention, adult mental health). In other jurisdictions, agencies providing CPP may be required to open a case if the court orders these services. You open the case and work with the infant and his biological parents, foster or kinship caregivers, or both.

If the decision is made to open the case or your county or agency requires you to open a case that is referred, it will be essential for you to explain to the parents at the outset that you are required to inform the judge of the clinical treatment status of parent and infant and the parent-child relationship. This informed consent portion of intake should provide the parents with detail regarding the information that will be provided to the court and make clear the limits of confidentiality. You should allow plenty of opportunity for the parents to ask questions to ensure that they fully understand the reporting process. Appendix 7 provides a sample consent form that was developed for the Miami CWBC. It obtains the parents' signature consenting to participation in the therapeutic intervention and acknowledging that they fully understand the legal repercussions of not complying with the treatment plan. They are advised to consult with their attorney before signing the consent.

Conducting the Initial Parent-Child Assessment

Your next step is to conduct an initial parent-child assessment. Areas to address in this initial assessment are described below.

Quality of the Caregiving Environment

The caseworker is required by law to complete a home study to approve the environment in which the child is or will be residing (whether biological or foster caregiver). The caseworker's report on the home study will be in the documentation you reviewed before intake. However, for your initial assessment, it will be critical for you to visit the home (in which the child is residing or the parent's home) and make your own observation of the appropriateness of the caregiving environment. Your assessment is not complete until you have observed the infant with his biological parents as well as in his current caregiving setting. Pay special attention to the following:

- Caregiver's and child's level of comfort with each other (e.g., shared affection, touch, amount of verbal communication)
- Child's seeking and use of support from the caregiver; response to the caregiver
- Caregiver's emotional and behavioral responsiveness, particularly when the child is distressed or the caregiver is stressed (e.g., developmental sensitivity, nurturing behavior, ability to help the child self-regulate, ability to read the child's cues)
- Caregiver's limit setting; how the caregiver provides structure; how the caregiver supports the child during tasks or expected behaviors (e.g., how the caregiver and the child handle disagreements, caregiver-child balance of demands during the interview)
- Caregiver's understanding of and empathy for the child's special needs and circumstances; appropriateness of perceptions of the child and developmental expectations
- Stability and structure of home life (e.g., established routines, predictability in the environment)
- Sleeping arrangements, making sure to ask about sleeping habits
- Stimulating toys, books, and daily activities

In addition to the biological and foster home visits, it is equally important that you visit the child's child care or preschool setting (if applicable) to assess the quality and appropriateness of care. As part of the visit, it is important to build in time to talk with the child's child care provider or preschool teacher, as well as the director, about their perspectives on the child's well-being and the risks posed by the parent. Keep in mind that they may have had contact only with the foster parent or relative caregiver, not the biological parents. Be sure that the case worker has alerted the child care provider that you will be coming to observe so that they understand you have permission to visit the child.

If you have concerns regarding either the home or the child care environment, share your clinical observations with the other members of the team as soon as possible. The team can then prepare a recommendation to the judge as to a viable alternate care arrangement that will be appropriately nurturing and stimulating. There may be differing

opinions on the team about what is appropriate or acceptable. This issue is further described in other sections.

Safety and Risk

In traditional courtroom practice, judges rely primarily on the caseworker to regularly assess and monitor risk and safety. In the CWBC model, the judge will rely equally on your clinically informed assessment of the parent's progress or continuing concerns related to safety and risk. Indeed, the clinician's role is not just providing therapy but also helping to remedy the problems that brought the child into care. In other words, your work in fostering the parent-child relationship must be carried out purposively in the context of all the problems that put the safety and well-being of the child at risk.

Box 3 presents a set of key questions related to safety and risk that the judge, attorneys, and the caseworker will be assessing throughout the life of the court case. They relate to core areas that you will focus on in treatment, assess via structured assessment and clinical observations, and report on to the court:

- the parent's capacity to be a reliable protector of the child as indicated by (1) the degree to which he accepts responsibility for the maltreatment and (2) his commitment to meeting the child's needs as demonstrated by compliance with visitation, medical appointments, other services required as part of the case plan, and random drug tests;
- his participation in treatment and level of insight in regard to the case plan and treatment goals;
- parental risk (e.g., continued substance abuse) and protective factors (e.g., support system);
- the appropriateness of the parent's home for reunification; and
- the degree of success or problems during supervised and unsupervised visits.

Each time there is a hearing, we recommend that clinicians make or update a list of all of the protective factors and all of the risk factors. This basic list will help to describe how the continuing risk factors will impact the best interest of the child.

Box 3. Safety and Risk Assessment

This information is taken from *Child Safety: A Guide for Judges & Attorneys.*[27]

Safety and *risk* are concepts that are frequently used interchangeably; however, they have very different meanings and implications in the child welfare arena. Conclusions about *risk* are based on the likelihood of maltreatment and have open-ended time frames; consequences may be mild or serious. In comparison, conclusions about *safety* consider how soon something may occur, how severe the consequences will be, and how out of control the conditions are.

According to *Child Safety*, a child's safety depends on the threat of danger, the child's vulnerability, and the family's protective capacity. Thus, "Children are unsafe when: (1) threats of danger exist within a family *and* (2) children are vulnerable to such threats, *and* (3) the parents have insufficient protective capacities to manage or control threats." Conversely, "Vulnerable children are safe when there are no threats of danger within the family *or* when the parents have sufficient protective capacity to manage any threats" (p. 2).

To make informed decisions about child safety, judges, clinicians, social workers, and attorneys need, at the very least, the following information (p. 3, Benchcard A):

"1. What is the nature and extent of the maltreatment?
2. What circumstances accompany the maltreatment?
3. How does the child function day-to-day?
4. How does the parent discipline the child?
5. What are the overall parenting practices?
6. How does the parent manage his own life?"

Appropriateness of Visitation

Another critical assessment area is whether the plan for parent-child visitation is appropriate for the child. The visitation plan is usually determined by the child welfare agency before the referral for therapy, and the judge will have ordered visitation. However, once clinical treatment is initiated, you can bring your perspective to the visitation plan. You may see the need to request significantly more frequent visitation or change the timing or type of visitation (supervised, unsupervised, or therapeutic), depending on the child's needs and the dynamics of the relationship between the parent and child. You may observe that visits are distressing to the child and recommend therapeutic visitation to supervise and assist the parents in making the visits more pleasurable and productive.

Frequent and meaningful family time can enhance the child-parent relationship, as well as expedite permanency by engaging the parents. Meaningful and regular contact (in all forms) with a child removed from the parent can be critical to motivating a parent to voluntarily start on case plan tasks from as early as removal or arraignment, regardless of whether the dependency action is being contested. Regardless of the age of the child, a growing trend in Florida has been demonstrating that this individualized, frequent, and meaningful contact between the parent and the child is generally beneficial to both. While there is no empirical evidence yet to support this, informed practice by experienced dependency judges across the country lends credence to the benefits of family time. The goal of family time is to promote reunification by strengthening the parent-child relationship and reducing the potentially damaging effects of separation; there are also collateral benefits to family time. Based upon the individual needs of the child and the circumstances of the family, the court should consider all options available to maximize safe and nurturing family time. The following are benefits of family time noted by experienced dependency judges:

- Eases the pain and potential damage of separation for all.
- Reassures a child that the parent is all right.
- Helps the child to eliminate self-blame for removal.
- Supports the child's adjustment to the caregiver's home.
- Reinforces the parent's motivation to change.
- Offers a potentially therapeutic intervention, rather than just "a visit."
- Provides a unique opportunity for the parent to learn parenting skills from foster parents who are willing to co-parent.
- Provides an opportunity for parents to practice new skills and, if using a parenting coach, to acquire new skills and improve parent-child interactions.
- Helps parents gain confidence in their ability to care for their child.
- Provides opportunities for parents to be kept up to date on their child's developmental, educational, therapeutic, and medical needs as well as their child's religious and community activities.
- Increases the likelihood of reunification.
- Permits safe, increasingly unsupervised family time and overnights with a goal of moving toward reunification.
- Provides critical information to the court about parental capacity to safely meet the needs of their child in a less restricted form of family time, such as unsupervised or overnight.
- Offers critical information to the court about parental capacity to meet the needs of the child and whether reunification is the best permanency option for the child. If reunification is not the best option, the lack of parental commitment or capacity will be apparent much sooner and may result in an earlier, often uncontested change in goal, resulting in expedited permanency.
- Reduces the time in out-of-home care and expedites permanency.
- Can also provide an opportunity to heal damaged or unhealthy relationships between the parent and other family members who may be caregivers.

The ways to support a young child and build or repair the child's relationship with the parent must be adapted to the child's developmental capacities. In particular, all adults involved must be aware of early capacities and limitations in social-emotional development and self-regulation.

In typical behavioral development, children

- are sensitive to others' emotions from birth;
- show pleasure and joy by 2–3 months;
- show fear or wariness toward strangers by 7–9 months;
- actively look to familiar adults for "emotional cues" about how to respond to new situations or people by 12 months; and
- exhibit separation protest from parents or key caregivers, which is typical for toddlers and can be highly distressful for both children and adults. When a child does not show these emotions, there is cause for concern; the child and her caregiving relationships need further attention and assessment.

Self-regulation includes the capacity to control and modulate one's alertness, attention, emotions, and behavior. Babies are not born with this capacity; however, activities like sucking can be the earliest attempts at self-soothing. It is through a caregiver's

sensitive support and guidance that children learn to self-regulate across the first few years of life; during this time, adults' "co-regulation" skills (adults' use and management of their own feelings, language, and behaviors to help children understand and control emotions) are essential to support eventual self-regulation.

Through their nurturing and sensitive care, parents and caregivers provide the support that soothes and calms a young child, which in turn enables greater emotional and behavioral control. Family stress and disruption can lead to high levels of distress in both children and adults, and they may need assistance in creating positive co-regulation strategies.

> "For parent-child visits to be beneficial, they should be frequent and long enough to enhance the parent-child relationship."
>
> Source: American Academy of Pediatrics. Developmental issues for young children in foster care. Pediatrics. 2000; 106(5), p. 1148.

Keep in mind the following considerations when determining visitation frequency:

- All visitations should be individualized based on the needs of the child and parent, including initial considerations concerning the type of maltreatment, developmental needs, and ongoing attention to the child's stress responses to the visitation process.
- Based on judicial experience and practice, the general assumption is that frequent visitation expedites permanency. Judges certainly have the discretion to suspend visits when the child is showing signs of stress or, conversely, to order unsupervised and increased visitation when appropriate.

Additional considerations for young children:

- **Frequency.** Although the exact number of visits is not known, best practice indicates that the frequency of visitation is linked to permanency. Practice suggests that infants and toddlers can benefit from frequent, even daily visitation, ideally several times per week when *individual circumstances permit*.[e] These circumstances may include consideration of the availability of supervisors, the length of the visit, the distance the child is required to travel, the ability to participate in the visit, or the location of the visit. A longer visit that includes the caregiver and gives the parent the opportunity to be involved in routine activities and play may be preferable to several very short visits supervised by a transportation worker in an office setting. There should never be a "cookie cutter" approach to establishing family time. Courts should have a meaningful discussion with the parent, relatives who appear in court, the child protective investigator, caseworker, prospective supervisor, and caregiver to devise a meaningful plan that works for all involved. Nevertheless, never should there be a presumption against frequent, varied, and meaningful contact. Visits simply based on what has "historically" been permitted by the courts and the department, or "typical" in any given jurisdiction or merely for the "convenience of staff," are not individualized to meet the needs of the child and the child's circumstances. Time and money put into front-end services is money saved if the case results in timely, stable reunification.
- **Visitation Logistics.** Efforts should be made to ensure that transportation and logistics are not barriers to visitation or visitation frequency. When children travel for visits, familiar caregivers should accompany and transport children. The travel itself may be stressful, especially with a stranger, and when the child feels distress at the visit's completion, a familiar person may be more able to soothe and support the child. Caregivers and foster families may also need assistance in coping with children's post-visit distress in an understanding way. Parental visits at child care centers may be a possibility, as the child would be in a familiar setting; however, child care teachers need to be educated in the same way caseworkers or transporters would be about routines, disruptions, possible distress, and soothing. To the extent a caregiver is willing, it is most beneficial and reassuring for a child to have the caregiver and parent present during visitation exchange.
- **Child's Routines.** Efforts should be made to respect the child's routines (e.g., eating, sleeping, other consistent daily patterns) in scheduling family time, with the understanding that disruptions in routines and unpredictable transitions can be very upsetting to infants, toddlers, and young children.

[e] Frequent and quality visitation is being embraced by many states. Minnesota's Department of Human Services encourages frequent visitation: "Infants and toddlers benefit from daily visitation, at the very least every two or three days."[6]

- **Informing Adults About Development.** Ensure that parents, caregivers, and dependency professionals (e.g., caseworkers, transporters, GALs) are informed about important social-emotional patterns:
  - Children form attachments to more than one caregiver (although there may be a *primary* attachment), so seeing children show "attachment behaviors" such as clinging to or separation protest with another caregiving adult is not unusual.
  - Emotions such as "fear of strangers" that result in clinging or distress are typical in infants and toddlers and may not be a sign of a problem or of "being spoiled."
  - While older toddlers usually start to show greater independence and "sense of self" (e.g., saying "mine" or "no"), their attachment relationships are still essential and separations from primary caregivers can cause distress and interfere with many domains of development, including language.
- **Visitation Quality.** Visitation should be as proactive as possible and should offer opportunities for
  - play and exploration to support mutual enjoyment for parents and children;
  - family or child-care routines, such as meal time, to promote the development of sensitive, predictable, and nurturing care; and
  - developmental stimulation (e.g., reading) to assist parents in understanding their children's skills and needs and ways to promote their learning.

Preparing the Initial Parent-Child Assessment Report

On the basis of your assessment, you will prepare a formal written report. The purpose of the report is to provide an assessment of the parent's progress in addressing risk and safety as described earlier, contextualized with a full description of the strengths and challenges of both the child and the parent. The assessment report is filed with the court (that is, it is formally entered into the court file) and provided to each of the parties in advance of the hearing so that its contents can be fully read and discussed among the team. A pre-hearing staffing meeting with the professionals working on the case can also be a telephone call or meeting before court to talk. This pre-hearing meeting will allow you and the other parties to clarify and resolve any issues so that the team presents the court with a collaborative plan for the case. Be assured that it is within legal bounds for the other professionals to ask the clinician questions about the report before the court hearing. The written report should address, at a minimum, the areas listed in Box 4. A list of scientific publications you may find helpful in citing in your report is provided in Appendix 8 and a sample Parent-Child Assessment Report is provided in Appendix 9.

It is up to the judge to determine the course of action (e.g., reunification, TPR). To do so, the judge needs the clinician's assessment of the parents' insight into the reason their child is in care as well as progress with their treatment. The clinician can inform the judge if the parents show progress in understanding the problems in the relationship with the child. She can delineate how the issues related to the initial allegations do or do not still pose a risk to the safety of the child, as well as whether the parents are parenting in a more sensitive and developmentally appropriate manner and the child is showing evidence of feeling emotionally and physically safe and secure.

Building and Sustaining Client Engagement in Treatment

Scheduling the initial appointment with the referred parent can be challenging. Parents involved with the dependency system are participating in multiple services and this creates stress and a feeling of frustration that can cause parents to feel overwhelmed. During the initial telephone call, informing the parent that you are willing to work within their schedule is helpful in getting the first appointment scheduled. Also it is important that you provide a short explanation of the program and make sure you mention that dyadic therapy is an additional opportunity to see their child. At the initial meeting it is helpful to listen to the client's experience as it relates to the dependency process and provide genuine empathic responses.

It is helpful for the client to leave the session with the next appointment time and date written down on a card with your phone number. The parent has many programs to attend; therefore compliance with treatment is increased when the appointment is at the same time and day every week. When

Box 4. Areas to Address in the Initial Parent-Child Assessment Report

The reason the child or parent was referred for therapy:

Review of dependency petition and involvement the family has with the department (including legal reasons for removal or allegations, e.g., neglect, physical abuse, exposure to substance abuse, exposure to domestic violence)

Caregiver/family background information, including the following:

- family history/psychosocial history (including history of domestic violence and history of sexual abuse)
- caregiver substance abuse history
- caregiver mental health history
- caregiver employment history
- legal history

Child's developmental history:

- prenatal, birth, and postnatal history
- when developmental milestones were achieved
- developmental and other concerns (early intervention services; medical treatments)

Collateral reports of the child's current functioning, based on the following:

- child care observation:
  - child response to environment and caregivers at day care
  - problems at day care falling asleep, staying asleep, feeding, playing
- home visit observation (child with present caregiver)
- supervised visitation observed between parent and child:
  - child's response to parent's arrival
  - quality of interactions during visit
  - child's reaction to end of visits, goodbyes, and separation
  - frequency, place, and length of visitations

Placement history:

- removal and placements of the child
- type of caregivers
- duration of each placement
- age of the child during each placement

Clinical observation and assessment:

- child's present developmental status (using a valid and reliable standardized measure such as the developmental screening Ages & Stages Questionnaire [ASQ][28] and, as appropriate, a diagnostic tool such as the DC0-3R)[29]
- quality of the parent-child interaction and relationship (e.g., the parents' ability to read cues during routine activities—eating, sleeping, playing—and their level of sensitivity and responsiveness to the child's cues and the child's responses)
- parental risk factors (e.g., depression, emotional distress, traumatic stress associated with intimate partner violence, substance abuse)

Conclusion and specific recommendations:

Clinical interpretation of all information gathered, including strengths and areas of needed intervention and parental risk factors. Explain why each concern represents significant risk and its implications for the child's well-being, permanency, and safety. Describe what could happen if the concern is not addressed. For example, a parent having high expectations of the child could lead to harsher discipline; a parent with impulse control or anger problems could lead to physical abuse. Recommend services and supports for the parent, for the child, and for the relationship.

attendance is an issue, be persistent. Call the client and caseworker after every missed session. Ask the client if there are any barriers to attending the scheduled appointments and offer assistance. For example, the client may have lost his bus card and not have money for public transportation. You can call the caseworker and brainstorm ways that the client can be provided with financial assistance or a temporary bus card. Helping a client with challenges and barriers that arise goes a long way in gaining his trust, which translates into therapeutic compliance.

During the very first meeting, it is important for the client to establish an understanding as to the limits of confidentiality and your responsibility to the court to provide therapeutic progress reports. The client needs to know that all of the information that will be provided in court and discussed with the caseworker and other individuals will first be discussed and processed in session. *"No surprises"* should always be the policy of the clinician. Trust, honesty, and transparency are the foundation to a productive therapeutic alliance. Another tip to keep the client

engaged is to have her participate in the creation of the treatment plan. Let her know that her feedback is critical and that therapy is a collaborative process between client and clinician.

The parent's continued engagement will depend on the behaviors you demonstrate and your attitude toward him throughout the healing process. Key aspects will include empathetic listening, patience, creative problem solving addressing his real-world issues, demonstrated advocacy, and parent empowerment. Acknowledgment of the daily life stressors he faces throughout the life of the process will help support the relationship you will build with him.[1]

Remember that there are at least two clients here: parents and infants. Thus the focus of the intervention is on the relationship between them. Remember the golden rule that you can't be better than the parent; you have to hold back a little on interacting with and holding the baby. All overtures made toward the child should be done in a way that respects the child's primary relationships.

Protecting the Therapeutic Relationship

Bringing Outside Information Into the Clinical Work

Clinicians are accustomed to working with clients who come voluntarily for treatment in the privacy of their practice. In usual practice, clinicians rely on the client's self-reporting to identify problems and issues to address in the therapeutic work. In the CWBC context, clients are ordered to treatment, which sets the stage for noncompliance, resistance, and a lack of openness toward the clinician. More often than not, your client will be harboring a deep lack of trust in "the system" due to previous negative experiences, and this lack of trust will readily spill over to any affiliated individuals (including mental health providers). It is not surprising, then, that the parent's self-report may be incomplete and that critical information may be actively withheld from you.

In a perfect world, relevant information would be provided to you in a timely fashion by your colleagues on the court team. But even with agreements and protocols in place for information sharing, you shouldn't assume that you are fully apprised of any new developments. As noted earlier, you must be vigilant in seeking information. You don't want to run the risk of being surprised during a hearing and having your credibility and clinical recommendations undermined. Be particularly vigilant regarding your client's substance abuse or psychiatric concerns and treatment as well as his or her relationship choices where significant relationships are impacted by domestic violence or substance abuse by others.

If you do learn of new information or concerns from the other professionals involved in the case, you will need to bring this information into the clinical treatment. It will be necessary to provide space during clinical sessions to process this information and help the parent develop insight on risk and safety problems. For example, you may ask your client, "I learned from your caseworker that you tested positive for marijuana. We need to talk about what it is like for your child when you are high. What do you think happens to your child when you're high?" (or "What do you think happens to your relationship with your child when you are high?")

See Box 5 for reflections by a clinician and attorney on the challenges and importance of information sharing in the CWBC clinical role. There are clear implications for what can happen when sharing does not take place. This model encourages you to share information because you and the caseworker each have information. Together you can develop a more comprehensive understanding of your client's strengths and needs.

In addition to protecting yourself from discrediting questions, information sharing helps your clients. As a parents' attorney noted, "Communication on [CWBC] cases allows me to be more informed about my client's case and to get a deeper understanding of what is going on in the case as a whole. This deeper understanding has helped with communicating with clients and being able to advocate for them."

Similar observations come from a caseworker: "Collaborating [with the other members of the court team] is very helpful for the families because they know they have multiple people who are supporting them and working to help them. It provides [them] with more professionals they can go to for help and saves them from having to repeat the same story multiple times. It also allows the family to share information with whomever they feel most

Box 5. The Value of Information Sharing: A Closer Look

Note: This conversation took place between an attorney and a clinician during a CWBC training.

CWBC Lawyer. We need clinicians to take the initiative to make sure that they have the latest information on other risk factors for which the parent is being treated. For example, if they are using substances, we want therapists to know if their clients are still using and are complying with treatment. (To clinician) How often is it that you get contradictory information?

CWBC Clinician. All the time, absolutely. More often than not, I get contradictory information from my clients. Working in this court team has helped me learn that in order to really be helpful to this parent, to this child, to the relationship, I need to get truthful, accurate information so that I can discuss it in session with my client. For example, a parent I worked with some years ago was participating in services to address domestic violence (she was abused by her partner) and anger management (she would also initiate fights with her partner and other people). In sessions with me, the parent was able to perfectly articulate how she was able to gain insight on the negative impact of her partner's behavior on her and her child. In a routine call to the leader of the domestic violence group, I learned that while she was at the program, her boyfriend was wanting for her outside and she lashed out at him. The domestic violence program had to call the police. She was the instigator of the violence, he was not, and the fact was that she was violent. She was not integrating in her insight the impact on her child of both her partner's violence and her own violence toward this man. If I had not taken the initiative to call the domestic violence program, I would not have known that (1) she was still involved with her boyfriend and (2) she continued to instigate violence. In the next session I was able to say, "Look, I got this information, and I am confused between what you said and what I just heard from the domestic violence facilitator; can we talk about this?" And it really gave me a port of entry to say, "What's going on? You tell me that you understand how your involvement in a violent relationship is harmful to you and your child, yet you are still seeing your boyfriend and instigating fights. Help me understand. Is this relationship what you really want for you, and what is best for you and your child?"

CWBC Lawyer. The flip side of this is that if the clinician had gone to court without knowing this information, to a hearing deciding reunification, and spoke glowingly about the parent, she could face a very difficult cross-examination from the agency attorney. It might go something like this:

> **Lawyer for the State.** "Ms. Smith, did you obtain information that the parent is the aggressor in this relationship?"
>
> **Clinician.** "No."
>
> **Lawyer for the State.** "If I were to tell you that we received a report indicating that the parent is still with her boyfriend and the police had to be called because she instigated a fight with him after a group session, would you still recommend reunification?"

Now the clinician is in a difficult position. If she says that she cannot recommend reunification, she is discrediting herself right in front of the judge; her reputation is shot. She has been humiliated. Yet, given this new information, she cannot say that she still recommends reunification. It is imperative that you get all of the necessary information before you go to court.

comfortable, knowing the information will be passed on when necessary…. I talk to the clinician [multiple times] a day…. It is helpful to have another person who knows the case as well as [the caseworker] does and who is able to provide a different pair of eyes and be a sounding board. The clinician brings knowledge about the clinical and emotional side of the case and what would be best for both the parent and the baby, and that information is extremely helpful…. The reports they provide play a huge role in my case recommendations. I will not make a recommendation on a case until I have had the chance to discuss it with the [clinician]."

Preparing for Court Hearings

The fragile alliance between a clinician and a client who is engaging in treatment involuntarily is constantly jeopardized by the court hearings, during which the clinician must report on issues—that the parent could easily consider to be a betrayal. Thus it is crucial that you help the parent understand what information will be presented in court and why, to protect the therapeutic relationship and the client's trust in you. It will be important to plan the content of your report in clinical supervision and perhaps even to engage in role playing with your supervisor or colleagues to rehearse how the discussion may

go with your client. It may be best to review the report in a session with the parent alone. Begin by orally reviewing its contents, processing with the parent everything that will be presented. Encourage the parent to express any concerns or worries. Use simple direct language and paraphrase information in a way that the parent can understand: "This is what my report is going to say; here are your strengths; here are the areas I'm seeing that you still need to work on; here are the risk factors that I still worry about." As illustrated in the example provided in Box 6, the challenging nature of preparing a client for court is best handled with directness and honesty.

> "Courts expect clinicians to provide information that will help meet the objectives of serving justice and resolving disputes, but offering that information may compromise therapeutic processes and goals by hindering clinicians' ability to maintain the usual neutral, non-judgmental stance toward clients, and potentially jeopardizing the effectiveness of treatment."
>
> —Clinician[30]

Typically there will be an opportunity to meet briefly with the parent at the court on the day of the hearing, just before the case is called. This is another important opportunity to reinforce the parent's sense of your support, to remind her that you will be presenting strengths and also concerns, and to reassure her that the team has been working together closely on the case so there should be no surprises. In the CWBC model, the parent's attorney will also explain to your client that you will be asked about the progress that she has made in meeting the parent-agency agreement and that she should expect that you will be honest with the judge while continuing to help the parent reach her goals. Parent's attorneys can also encourage their clients to be honest with you throughout treatment.

Although not ideal, there will be times that you will be informed about a court hearing at the last minute and will not have had the opportunity to prepare for the hearing with the client during a therapy session. In these cases, you should arrange to meet with the client at the courthouse before the hearing to review with her and prepare her for what will be said to the judge.

Box 6. Preparing for Court Hearings

You review with the client, who is a young parent, how you plan to describe in court her progress toward meeting the treatment goals for child-parent psychotherapy (referred to in the Miami court vernacular as dyadic therapy). You share examples of progress with her that you will describe in court: that she is demonstrating the ability to communicate more positively with her child, showing more empathy toward her child, and helping the child regulate his emotions and behavior. You also share observations of the child's responses to the parent during their interactions. After reviewing the positive parts of your report with the parent, you then move into a discussion of the problematic area that you will be presenting to the judge. In this case, the issue is the parent's blind spot with respect to an abusive partner, an area that you learned about from other sources because the parent has denied to you that the relationship is continuing. She has not discussed the relationship in sessions. You let the parent know that you will be referencing in court the proof—arrest data and eyewitness testimony—that this abusive relationship is continuing and that you will be making a strong statement to the judge that if the parent continues in this relationship, her child will continue to be at risk of harm.

After discussing the clinical concerns it is expectable that a parent may shut down emotionally or express anger toward the clinician about the needed disclosure to the judge. Many court clients are not used to feedback such as this before a hearing; it would be helpful for the clinician to explain to the client that she is trying to begin a relationship based on transparency and trust, and the only way for treatment to be successful is for both the client and clinician to be honest with each other. It is also important for the client to have an opportunity to process her anger in a healthy way before court so that she is composed in front of the judge. This experience can really help clients learn to manage their feelings and express them appropriately. Although discussed before court, the client's anger may resurface after a hearing once the judge has reacted to a clinician's report. It will be easier for the clinical relationship to recover if the clinician can remind a client that she was told prior to the hearing what would be said, reminding her that the clinician was honest with her. Sessions can then be used to process the client's feelings in a healthy way and to discuss what the risk factor is (the violent relationship in this case) and how it is affecting the dyad. This experience can create a port of entry for treatment and actually strengthen the clinical relationship in some cases.

Processing After a Hearing

It is critical to help the parent understand what took place in the courtroom. In some instances you can spend time with the parent at the courthouse and let him know that you would like to reserve as much time as necessary, when you see each other next, to discuss what took place at the hearing and help him process and manage his emotions surrounding it. You may need to consider whether it is appropriate for the child to be present during the debriefing session. Factors to consider include the child's age and level of understanding and the current status of the parent-child relationship. The baby's presence may be important to the parent's debriefing and allow the clinician an opportunity to speak for the baby. Conversely, there are situations where the parent's emotions and behaviors are frightening to the child and in that circumstance careful attention needs to be paid to the infant's support needs. It may be that this debriefing session is best conducted without the child present so that the parent can have the space to verbalize his emotions without frightening the child. If it not possible to conduct this session with the parent alone, model appropriate communication while in the presence of the child. Let your client talk about his experience and allow time to answer any and all questions. Many times, the parent will be angry with you because of an unfavorable report. However, most clients avoid discussing their anger, so you will likely need to bring it up in a therapeutic manner, allowing and encouraging the parent to discuss the angry feelings he has toward you. This process is extremely important because, for many parents, this may be the first time they have an opportunity to discuss their anger in a safe setting and a safe relationship with a person who will neither physically harm them nor go away in response to their anger. If a parent becomes extremely loud or verbally aggressive, you'll attempt to defuse the anger (see Box 7).

Box 7. Processing After a Hearing

Clinician. I wanted to spend some time today talking about your court hearing yesterday. You seemed very upset after we walked out and I know you said you didn't feel like talking about it. Can we talk about it now?

Client. It was fine; I don't care. I wanted to get unsupervised visits, though, and my lawyer said we couldn't even ask because of some of the stuff being said.

Clinician. I know that there were some parts of my report that were difficult to hear in court. Like we talked about last week, I had to report that you missed the last few sessions of your outpatient drug treatment and that you missed a few sessions here. Is that what you think your lawyer was talking about?

Client. (turning away from clinician) Yeah, probably.

Clinician. I know it was difficult to have me tell the judge that, when things have been going so well lately. Even though I told the judge about how strong the relationship is with your daughter and how much your parenting skills have improved, it seems like all the focus was on those missed sessions.

Client. I know. No matter how hard I try, I never get ahead. I am never going to get her back.

Clinician. It is so hard for you to be away from your daughter, you miss her….

Client. I do, I miss her so much! I just want her to come home. I have so many appointments for court and I have to go to work; I just can't keep up.

Clinician. I can hear how frustrated you are. You are trying very hard to manage all of your responsibilities for court while also keeping your job. Let's talk a little more about this so we can try to make your next hearing go the way you want it to.

Adjusting the Therapeutic Timeline to the Court's Time Frame and Decisions

Since 1997, the Adoption and Safe Families Act (ASFA, P.L. 105-89)[f] has promoted accelerated permanent placement by requiring most permanency hearings to be held no later than 12 months after the child enters foster care. A permanency hearing determines whether the permanency plan has been achieved and, if not, whether a minimal extension will be provided or whether a new permanency plan will be established. If a child has been in foster care for 15 of the most recent 22 months, the agency must initiate court proceedings (file a TPR petition) to free the child for adoption unless either (1) doing so would not be in the best interest of the child or (2) the child is in the care of a relative. Thus, a judge may try to give a little more time to a parent to complete his treatment if reunification is imminent. These conditions also apply if the child is living with a relative, in which case the relative either adopts the child or becomes the guardian after demonstrating that doing so is in the child's best interest.

[f] The text of ASFA is at http://www.acf.hhs.gov/programs/cb/laws_policies/cblaws/public_law/pl105_89/pl105_89.htm.

In addition to ASFA, your state may also have statutes that impose additional time limits.

As you can see, the court time frame demands adjustment of the therapeutic intervention. This timeline must be explained clearly to the parent (reach out to the parent's attorney for simple language to use with the parent), and an agreement should be reached on a realistic time frame for treatment completion. During the course of treatment, the clinician and parent should regularly discuss the progress of the parent-child relationship. They should change the frequency of sessions to incorporate monthly hearing decisions, and the clinician should make referrals for additional services to encourage progress before the 12-month permanency hearing. Your client will likely need reminders as to how many months are still available for treatment; often, by the time work begins with a clinician, only 6–8 months remain.

Many parents want only to be reunified with their children and forget the painful experience and all reminders of the time their children were taken away from them. This may include their work with you. However, parents and children who come to the attention of the court have complicated needs and will likely make progress, but not complete treatment by the time that the case closes. These are conversations that the clinician and the client should discuss. In the case that treatment continues, the clinician may be asked to report progress to the court.[g]

Financing the Clinician Role

States have developed different mechanisms for paying for court-mandated treatment; in some cases, treatment can continue after the case is closed if it is determined the parent-child dyad would benefit from ongoing therapeutic work. In some states, treatment is covered by Medicaid. In other states, the child welfare agency contracts for services. The most challenging coverage pertains to the out-of-session work so critical to the model (communicating with the caseworker and attorneys, being in court, writing reports, and engaging in reflective supervision). These collateral activities are, as yet, dependent on flexible funding (local, state, and federal grants and private donors).

Florida offers an example of a state that was successful in obtaining Medicaid coverage for the key components of the CWBC clinical work. These key components were identified and cross-walked to Medicaid, which covers two-thirds of the needed activities. Florida was one of the first states to allow Medicaid reimbursement for dyadic therapy for children 0–5. Medicaid authorizes 26 sessions of parent-child psychotherapy. The 26 sessions are annual for an individual or family, but more intensive treatment can be done if authorized through therapeutic behavioral on-site services. This service can also include infant mental health consultation.

Michigan provides another important model for public financing of dyadic treatment services. In Michigan, Medicaid covers home-based services programs that combine services to restore or enhance the young child's social, psychological, or biophysical functioning. This includes relationship-based dyadic therapy, developmental guidance, emotional support, concrete needs, and advocacy. Despite the fact that Medicaid will pay for these services, it is difficult for clinicians to carry a traditionally defined full caseload of clients in a court team model because of all of the collateral contacts that must be made. Clinicians report that if one's entire caseload is comprised of CWBC cases, one could handle only about eight cases because the CWBC cases take significantly more time than a typical case with a high-risk family.

Building a Support System With Individuals Identified by the Parent

As you well know, social isolation and high levels of stress are associated with risk for child maltreatment and recurrence of maltreatment. Thus, throughout the therapeutic process you will need to support the parent to identify and develop, to the degree possible, healthy relationships with people who can be a support system and to define the extent and strength of the support that can be provided by each person. Across sessions, it will be important to follow up with the parent on his progress in developing a support system. By supporting the parent to invite the identified persons to a session, you can help him define in advance the types of support needed, the frequency of provision of support, ways to request support, and ways to discuss and agree on needed support. Building a support system is critical to ensure that a parent reunified with the

[g] There is a 6-month period of supervision by the court after a child is reunified with the biological parent.

child does not become isolated and overwhelmed once the case—and all the supportive services—is closed. Even in cases in which the parent's rights are terminated, a support system is crucial for preventing re-entry into the system for abuse or neglect of another child.

> "When we're out of their life, that's when we see the relapse. For example, the client that goes back to the abusive boyfriend, stating they need money to survive. Establishing in treatment why they are in the court system and helping them to identify someone they can depend on is critical. Bringing that support system to the table, inviting them to staffings, court hearings. Having the support people become involved while we're still on the case so once we close it they continue to be involved. That's an integral part of the model."
>
> —Clinician

Participating in Dependency Court Hearings

Ideally you will attend all hearings involving the parent, child, or both. Hearings commonly generate considerable anxiety for the parent, hindering her ability to process an experience that is already confusing—given the fast pace of court proceedings and the unfamiliar language of the courtroom. Your participation in court hearings is critical for supporting the parent, protecting your relationship with your client, and helping her to understand the decisions that were made and the next steps needed to reach the case plan goals. Your support and preparation with the parent for the hearing is also critical to ensure that the parent will be able to articulate her experience when directed by the judge (see Box 8).

For court appearances, you should prepare in advance—and review in clinical supervision—the specific narrative that you will present orally in court. This narrative should be a tightly organized, condensed version of the written report that is submitted to the judge. The narrative will serve as your notes to refer to during your testimony. To be most effective, you must demonstrate a thorough knowledge of the case and speak authoritatively about the parent's progress, the child's responses, and ongoing concerns *as they relate to the initial allegations*.

Box 8. Extract From Hearing Proceeding

Judge. Okay, so what happened?

Parent. You know, I've been so many times angry with [clinician] until I had to really go back and think, "Okay, she is right." I wasn't there (referring to services appointments). Okay, I did have an excuse, but I wasn't there. I always give an excuse. And now I'm getting it just through the whole situation. Like when I was first brought into the court system I was like, "I can't do these tests. I don't want to do this. What am I doing this for? Why can't I see my kids?" But now she (clinician) brought it all down to me. The stress levels, I learned about that with her. If I don't connect, my kids are going to lose. I don't want that for my kids. I'm learning a lot. I'm learning how to be attentive to my children. I could tell you if my child is in fear. I can tell you if my child is cold. I could tell you all of that. I think, to be honest, if this didn't happen, I would be on the road to destruction, and it would probably be worse off than what it was.

Judge. Wow.

Parent. I'm being honest.

Judge. I, boy, I am so proud of you. Really. And you really did a lot of thought. I am just so proud of you. This is one of the most insightful speeches I have heard here. She (clinician) is a miracle worker.

Parent. She is.

Judge. I am glad that you got her (clinician). There are very few moms, unfortunately, in the whole system that get [clinician]. There are a few other people who do this. It just makes all the difference when you are smart enough to realize she (clinician) is on your side.

Parent. Right.

Judge. And she is on your children's side.

Parent. Right.

Because this is a crucial opportunity to establish your credibility in the courtroom, take the time to rehearse the presentation you will make to the court so that it is concise and clearly aligned with the points you make in your assessment report. You should plan for no more than 5 minutes to present, so identifying the key points you want to make and rehearsing to keep it short and to the point is very important.

Focus your testimony on the following five areas:

- The status of the child's developmental functioning, relationship progress, and the

extent to which the developmental needs of the child are being met through the referral and support services in the case plan. Describe how you assessed the child's development, what the child can currently do that is developmentally appropriate, and what he is not yet doing that you would expect him to be doing. Explain the difference between a developmental screen and a developmental assessment, as attorneys and judges usually do not know the difference and will assume that the information obtained from screeners and full assessments is equivalent.

- The status of the therapeutic treatment: degree of compliance with and level of engagement in treatment, the parent's understanding of the child's needs, the quality of the parent-child relationship, the status of the parent's insight into the allegation of removal, 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 impact 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 TPR; see Box 9).
- Ongoing clinical concerns and corresponding recommendations regarding current or needed services and treatments to support the parent, the parent-child relationship, and the young child's developmental needs.

If you use a clinical term during your testimony, be sure to explain the term using more general language so that all parties and participants can understand. Be as specific as possible when describing the child's developmental progress and caregiving or developmental needs and the attainment of

Box 9. Concurrent Planning

Concurrent planning is a case planning approach that involves simultaneously pursuing two permanency plan goals—a primary goal (i.e., reunification) and a secondary goal (i.e., guardianship with a relative). Concurrent planning has been shown to shorten time to achieve permanency. Effective concurrent planning requires early and comprehensive family and placement assessment. However, CWS stakeholders may not aware of how to meaningfully implement concurrent planning on a case-by-case basis. The National Resource Center for Permanency and Family Connections has identified the following nine core components of concurrent planning (*Concurrent Planning: What the Evidence Shows*, available at https://www.childwelfare.gov/pubs/issue_briefs/concurrent_evidence/concurrent_evidence.pdf)[7]:

1. "An individualized understanding of the personal, interpersonal, and environmental context of the child and family through initial assessments of safety and risk, indepth assessment of family functioning, and child evaluation is combined with a consideration of factors that make timely reunification more or less difficult and more or less likely.
2. Full disclosure to all participants in the case planning process. A respectful, candid discussion that begins when the child enters foster care and continues throughout the life of the case.
3. Family search and engagement
4. Family group conferencing/teaming
5. Parent-child visiting during out-of-home care
6. Setting clear time limits for permanency decisions. Establishing a timeframe in which both reunification and alternative permanency options are pursued helps focus case planning on early and intensive services to enhance a parent's ability and willingness to make necessary changes.
7. Transparent written agreements and documentation give all parties a clear understanding of what both the agency and the family must do to achieve reunification.
8. Committed collaboration between child welfare, the courts, and service providers is necessary to ensure that timely casework is paired with smooth progress of cases through the court. Support from service providers, including foster parents, ensures that all parties are working toward the same goals.
9. Specific recruitment, training, and retention of dual licensed resource families."

The practice of concurrent planning has increased during the past 20 years. During the last round of Child and Family Services Reviews, 41 states were found to have formal policies for concurrent planning; all 50 states, the District of Columbia, and Puerto Rico said they were implementing concurrent planning in some form; and 20 states had provided training on concurrent planning to their child welfare, court, or other staff (*Concurrent Planning*, p. 4). In addition to reducing time to permanency, concurrent planning has been shown to build relationships between foster families and biological families. A related effect is the increased likelihood of voluntary relinquishment of parental rights as well as a greater likelihood of open adoption.

therapeutic goals driving progress and change in the parent-child relationship. Provide specific examples to reinforce your testimony whenever possible, including the results of a standardized developmental assessment and structured and unstructured observations of parent-child interaction. Consider this a teachable moment—an opportunity to elevate everyone's understanding of the young child's needs; the centrality of the parent-child relationship in the child's well-being; and the impact that an evidence-based intervention can have on the parent, child, and parent-child relationship.

> "The hardest thing for me to learn was how I could communicate the clinical jargon effectively into legal language, so we could communicate effectively and I could give them what they need and they could give me what I needed."
>
> —Clinician

Be ready to answer questions asked by the judge and the attorneys, who may want to hear more about the reasoning behind your recommendations. Be prepared to defend your recommendations with specifics as to why the steps for which you are advocating (such as moving to unsupervised visitation), additional services, or changes in existing services are necessary for reducing risk and improving safety. In preparing for these questions, think about the different perspectives that the professionals in the room will be bringing to the table:

- The judge's patience may have run its course with your client, particularly if it's late in the dependency timeline.
- The caseworker and child's attorney may be wary and skeptical of your assessment of the parent's strengths and recommendations that pertain to those strengths.
- Your relationship-building might be perceived as too much "hand-holding." A judge needs to know that a parent can provide for her child without intensive services in place before she can be reunified with her child. A member of a CWBC team explains, "Moms who have never been parented themselves need a lot of relationship-based hand-holding and support that they missed. This therapeutic relationship base is essential to build trust between the mom and her therapist and to experience, perhaps for the first time, what it is like to have someone who will not go away when there is trouble and will not hurt them. The mom's experience of this is critical, so that she can in turn provide this consistent support for her child."

> "I am working in a system that is very focused on parent compliance, sometimes without focused attention on how the baby benefits from services. I see my role as communicating the baby's needs to the court and so I consider all aspects of the case from the baby's perspective as I formulate my information and recommendations to the court."
>
> —Clinician

- Parent's attorneys will likely be resistant to additional services, as they traditionally see this as a burden on the clients. Also, the hearing is an opportunity for the parent's lawyer to demonstrate to the parent that the attorney is, by legal and ethical definition, on her side, supporting the parent's goal of reunification. While you may experience the lawyer's support to the parent as being aggressive toward you, consider his behavior in the context of the parent's need at a time of high stress and uncertainty. As one lawyer observed, "If we are 'mean' to you, it may be because this is the only chance that we have to help our client feel that somebody has heard them and is representing them as parents."
- For you, as well, the hearing presents important opportunities to verbally and nonverbally support the parent in court and to help the parent appropriately manage disappointment, anger, and sadness experienced during and after the court proceeding.

Ideally, concerns on the part of other team members will have been discussed and resolved among the team before the hearing. Nonetheless, you should fully expect to be questioned and be fully prepared to present the most cogent response for the court. Keep in mind that if a question is raised that you are not adequately prepared to respond to, of if you are unsure of how to answer a question, you should wait a moment before answering to collect your thoughts. Also, you should not be afraid to say you don't know the answer, if that is the case.

Box 10 provides basic tips on taking the stand and responding to questioning in court.

Box 10. Testifying in Court: Helpful Tips*

Taking the Stand: Making Yourself Comfortable in the Witness Chair

- Dressing professionally will get you more respect and help you feel more confident.
- Take the time to feel comfortable in your seat.
- Bring your CV, report, file, purse—whatever is permitted that you want to have with you. Sometimes water or tissue is allowed as well.
- Every word is being recorded. Speak clearly, to only one person at time, and say "Yes" or "No" rather than nodding or shaking your head or responding with "Mm-hmm."

Do's

- Do listen to the question *carefully.*
- Do answer only that question.
- Do be serious and polite.
- If you don't understand the question, ask the attorney to rephrase it.
- If you don't know the answer, you may say, "I don't know."
- If pressed, frame your answers in terms of reasonable probabilities.
- Do expect to be asked about negative information about your client—some of which may be a surprise to you. Your credibility will be based on your knowledge of both positive and negative facts about your client.
- If you hear "**Objection**," wait for the attorneys to argue and for the judge to rule. The judge will tell you if and when you can answer the question. You may ask for the question to be repeated if you don't remember it.

Don'ts

The expert witness should be completely objective and impartial. Let the attorneys be the advocates. The expert's role is to assist the court, not to decide the case. The following "don'ts" will assist you in fulfilling your role.

- Don't ramble or volunteer information.
- Don't guess at answers.
- Don't argue with the attorney if you are asked about a fact you do not know or whose validity you are uncertain of.
- Don't exaggerate or understate.
- Don't argue or lose your temper.
- Don't get upset. It's not personal. All parties have specific roles and will question you consistent with their legal and ethical agendas for that hearing.
- Don't answer the question if you hear "**Objection**." Wait for the attorneys to argue and for the judge to rule. The judge will tell you if and when you can answer the question. You may ask for the question to be repeated if you don't remember it.

Example

You are asked about something you were not aware of regarding your client: "Did you know that your client tested positive for marijuana three months ago?" Answer the question based only on what you actually know. If you did not know, you may be asked, "Would that change your recommendation?"

- Experts can offer hypothetical answers. You can explain how, if this were a fact known to you, this would have been analyzed or addressed in treatment and your report. Remember: The judge or jury decides which facts are true and which legal issues are ultimately at stake.

* From *Baby Court cross-disciplinary training*, a presentation by L. Kellett, G. Miller, and R. Mustafa. Detroit, MI, February 24, 2012.

Engaging in Clinical and Reflective Supervision of Court Cases

Because of the multiple expectations placed on the clinician working in the CWBC and the life-changing consequences of the judicial process for parent and child, reflective supervision is indispensable. The treatment of a client-child relationship in a dependency case is very challenging for the clinician and will vary depending on the parent, the child, and their relationship's needs and strengths. Zeanah & Larrieu[31] described the clinical and ethical dilemmas of clinicians working with dyads in dependency cases as well as the intense countertransference reactions that emerge when working with maltreated children, particularly vulnerable infants. These challenges include overidentification with the child, overidentification with the parent, impotence, lack of control, and frustrations with the many systems involved with the family, or, on the other side, feelings of being overwhelmed and of having all court decisions resting on the clinician's report: "Maltreatment represents a profound failure of the protective function in parents that elicits strong abhorrence in most people. Being able to reach out to alienated and often marginalized parents who have maltreated their infants is a challenge" (p. 369).[31] For these reasons, it is critical that a supervisor is on call who will allow you to process your feelings and to reflect on how the treatment with the client is going (see case supervision examples in Boxes 11 and 12). The supervisor must have extensive child development expertise and solid working knowledge of the court process, dependency law, and the ways in which parental risk factors affect child safety.

Many times, a parent may do well in dyadic therapy but still fail to gain insight as to the allegations, often substance abuse or domestic violence, that brought the child into the dependency system. Even if the parent-child relationship is good enough within the walls of the therapy room, the parent may not be able to keep the child safe if, for example, the parent is still using substances, involved with a substance user, or in a violent relationship. These are the most heart-wrenching cases for clinicians as it is so hard to work with someone who is an adequate, or even skilled, parent, but whose other challenges may prevent him from regaining custody of his child.

Box 11. Clinical and Reflective Supervision of Court Cases, Case 1

Clinician. I feel like this mom is making progress, but we are running out of time. I feel pressured by the team. The caseworker thinks I am idealizing the mom and I feel like the child's attorney is pressuring me to get on board. The judge is saying it is beginning to sound hopeless. I think that the mom is making progress.

Supervisor. How long has it been since this case was open and the baby has been out of the home?

Clinician. 18 months.

Supervisor. If you were this toddler, what would you want everybody to know right now?

[long pause]

Clinician. I think he would say that I need a mommy and I don't have one.

Supervisor. And that is very painful for you to consider.

Clinician. It's all mom talks about: "When I get my child back…."

Supervisor. So I think it would be helpful for us to talk about how you will talk with mom. What is it like to think about that?

Clinician. It's hard. This mom has lost so many people; I wanted to be the one who could help her have a different chance.

Supervisor. Would it be helpful for you to think about how this mom never grew up with a mom who took care of her? Where this stops is with her. Her baby can grow up with a mom.

Clinician. I'll have to think about it. Can we talk again tomorrow?

Supervisor. Sure.

For the reflective supervision sessions, the clinician should bring the results of assessment instruments and progress notes for review of the status of the court case and signature of the supervisor. Review of the status of the court case includes quality of the parent-child relationship, risk factors, safety, the dependency petition, and other legal and collateral documents.

Box 12. Clinical and Reflective Supervision of Court Cases, Case 2

Clinician. The parent and child have really good interactions—very positive, with many strengths. The dyad has improved so much. But I am struggling with the fact that since the unsupervised visitations started the child has been talking a lot about the father.

Supervisor. Tell me about your struggle. You look very concerned.

Clinician. The child is talking about the father having a history of substance abuse and domestic violence charges. The parent is supposed to stay away from him because he has not complied with his case plan and refuses to do drug tests.

Supervisor. Have you asked the parent about her current relationship with the father?

Clinician. Yes, but she says that she is not in a relationship with him and does not allow her child to see him. I don't know what to do. She is doing so well, she never misses sessions, the child is so happy with her—but I am worried that the parent is not keeping her child safe.

I don't know what to do. I know I have to report it to the caseworker—but if I do, I know the parent is going to be really angry at me and possibly stop coming to therapy. She is not going to trust me anymore and it took a really long time for her to trust me and let me help her.

Supervisor. I can see that this is a really big dilemma for you and that you are really worried about how it is going to affect your relationship with the parent. I am wondering if there is a way for you to maintain the trust you have established with the parent and at the same time keep the child safe.

Supervision will focus on challenges you are encountering in the court process and provide space for reflection (with the supervisor and peers, if applicable) about legal decisions affecting the client's progress or the therapeutic relationship, as well as the clinical meaning of the client's behavior. Clinical supervision sessions should regularly include a reflection on your responses to the caregiver, the child, and their interactions; changes in treatment goals for the parent and child; the clinician's emotional experience with the court process; and parallel timelines and activities in court process, therapy, and supervision.

Closing the Clinical Case (Discharge Summary)

Regardless of the outcome (i.e., reunification, TPR, adoption, or guardianship), the court will need you to submit a closing clinical report to be filed as part of the case documentation. The final report should include

- a brief description of the treatment;
- pending concerns about the parent, child, and relationship;
- a summary of your child-focused, family-centered recommendations; and
- the status of risk and safety issues for both parent and child.

Additionally, you will need to follow your organization's protocol for providing the client with post treatment supports and resources. A sample discharge summary is provided in Appendix 10.

Collaborating on the Court Team

Establishing and Maintaining a Collaborative Team

The CWBC model requires ongoing communication throughout the life of the case to engage all members of the court team in the collaborative case planning process. As the parties learn to work together toward the shared goal of protecting and improving the safety, permanency, and well-being of maltreated children, each will begin to understand the value of the other perspectives and where they diverge related to their specific areas of expertise or assessments of risk. It is important for each professional to express her opinion and to understand that healthy disagreement is part of the process. Ambushing happens regularly in traditional dependency court, hindering the judge's ability to make informed decisions, creating tension and anger, delaying the process, and using precious time needed to resolve critical problems. But a court team in the CWBC model actively avoids courtroom ambushes—that is, the team avoids the traditional adversarial culture in which people testifying or providing a report to the court are confronted with unanticipated information that contradicts their testimony, essentially invalidating their statements and recommendations and undermining their credibility.

A collaborative team depends on regular communication (weekly if possible) with all parties throughout treatment, although typically most information-sharing will be among you, the caseworker, and the child's advocates (attorney, GAL or CASA). Information-sharing should be regular and independent of hearing schedules and timelines for status reports. Your participation in case planning and other meetings is critical to developing and maintaining a positive working relationship with your colleagues on the court team. Regular communication also avoids triangulation across disciplines and among different types of mental health and other service providers. Such triangulation can derail the therapeutic process and waste critical time.

By your sustained and active participation, you will be able to deliver timely and substantive information about the needs, progress, and challenges of both the parent and child. In so doing, you will do your part to ensure that the child's emotional needs and a meaningful assessment of the parent's capacity to care for her child are not lost in the tangle of complex problems common in families involved with the CWS. It is also important for parents to know that all professionals are sharing information and working together on their behalf.

You will also rely on the other parties for facts concerning the family you are working with, even if not all family members are your clients. You will want to ask the caseworker about his view of the client's progress in the case plan and whether there are new documents you should review before preparing your court report. You will want to ask the parent and child attorneys what questions will be asked of you and others during the hearing and check to be sure that you will have seen and had a chance to review all relevant documents. In this collaborative context, you can also ask the attorneys to review with you what the judge will expect to hear from you, even running through your testimony with the team to be certain that you are clear and hit your intended mark when appearing in court.

In jurisdictions working to establish and maintain a CWBC model, a regular steering committee, usually led by the judge, will be convened. Steering committees typically comprise those in positions to make decisions and oversee the front-line providers serving on a court team. These meetings provide another important bridge for directly connecting different systems and for raising concerns related to court-referred parents and children. Depending on your community, you may be asked to participate in the steering committee regularly, or you may be invited as needed to discuss and resolve challenges as they arise.

In forging and building your collaborative relationships across disciplines, keep the following in mind:

- The caseworker will value your clinical opinion and welcome your involvement, knowing that it will ensure the best services for parent and child.
- You will need to help the parents' attorneys understand that your main objective is to help their clients who are parents of vulnerable infants and toddlers. When concerns arise, you can assist the parents in communicating effectively with their lawyers. When discussing negative information about the client, you can explain what steps you are taking to support the parents. Whether your feedback is positive or negative, the parents' lawyers will appreciate being informed of their clients' strengths and weaknesses. The parents' lawyers can also support you in helping the parents understand the potential legal impact of certain choices and behaviors. The lawyers can also help you understand a particular court decision or process.
- The child's attorney is not seeing the child as you are, but rather in a legal/ethical representation context.
- For clinical areas that require specialized expertise, like substance abuse or adult trauma, you will need to collaborate with other mental health providers. For example, it is the substance abuse clinician's responsibility to provide treatment in that area. However, there will necessarily be some overlap—and ideally coordination—across the clinical work in the adult's treatment and your work with the dyad related to the impact of the substance abuse on the child's safety and well-being.

Managing Disagreements

Disagreements occur frequently between professionals working at the court, and it's important to recognize that differences between professional perspectives can be healthy disagreements. As a member of the court team you should expect disagreements, even when all members of the team are focused on the same thing (the child's

placement in a safe, permanent, nurturing home). You should expect stress and struggles between the disciplines in the beginning, when each member is learning her new role while also learning about how it complements other members' roles. These initial struggles present an opportunity for your team to learn how to listen and work together. Each professional has an area of expertise and has a right to provide the information that he considers pertinent to protect the safety and well-being of the child, advocate effectively for the client, or both. As you and the other team members become confident in your respective roles and develop respect for each other's positions, you will use these disagreements to learn how to better convey your expertise and to determine if additional situation-specific training is necessary.

Reaching consensus before the hearing would be commendable, but it's not always possible. As conflicts arise, each person should form an opinion and share it; when it is not possible to reach consensus, your supervisor can help you take the perspective of the other member of the court team with whom you are disagreeing and help you to find a different way to communicate. Even seasoned court teams sometimes just can't agree. In this case, each member should summarize her position and supporting information and present it to the judge. It is then the role of the judge to synthesize the most relevant findings and observations from the different perspectives to make decisions.

For example, when advocating for the parent and child, there may be times when you will need to point out insufficiencies you have observed in the management of the case in the court. In this case, you should explore with your caseworker colleague how to resolve the concerns before appearing before the court, and you should be sure to acknowledge the caseworker's hard work whenever possible. Regular information-sharing and collaborative case planning before hearings can generally help avoid situations that undermine the collaborative relationship.

Preparing Status Reports

The caseworker should give you, as a member of a CWBC team, at least a week's notice when requesting a status report. The caseworker will send the status report to the rest of the team before a court hearing to give everyone time to review it. It is best practice for status reports to be discussed before the hearing—at least with the caseworker and child's attorney or GAL—via conference call or in person. This allows the child's advocates to share their observations and to collaborate with the clinician and attorneys as to the best approach for both child and parent. Ideally, you will also be able to meet with the client and her attorney before the hearing to discuss strengths, weaknesses, prognosis, and recommendations. The attorney's involvement here is quite different from traditional practice, in that the caseworker typically provides the status report to the attorney and the attorney contacts the clinician only if clarification is needed regarding the status report.

If you are not able to attend the court hearing, a discussion of the report with the caseworker or attorney for the state and GAL is indispensable to make sure that the other parties understand the report and have the opportunity to ask questions of you. It is crucial that you make yourself available to all parties to answer any questions they have in advance of the hearing. Making yourself available to attorneys before the hearings also allows them to ask you questions in private that could be damaging to the therapeutic relationship if asked in court. Status reports should include the following information:

- 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

Because the court cannot make the determination of TPR or reunification without looking back at the initial petition and seeing that those problems are resolved, if your status report's take-home message is, "I can tell you that they have a great relationship, but I can't tell you about the substance abuse problems," then you haven't answered the court's questions in the way that the court is expecting you to do to help the court make a determination. As discussed previously, safety and risk are not the exclusive responsibility of the CWS; they need to be integrated in the therapeutic work and be described

in your treatment status reports. One way to do this is to report an interaction that you observed between the parent and infant surrounding a specific risk that illustrates the continuing presence of the risk to a child's safety. Another way is to review the literature on the specific risks associated with the case (for example, substance abuse) and how or whether these risks are related to parenting, a secure attachment relationship, and child well-being. Readings in Appendix 8 provide a starting point for you.

It is important to be prepared for last-minute team meetings to be scheduled right before the hearing. These happen regularly. Even if several discussions have been held and agreements have been reached in the previous weeks about what will be presented at the hearing, last-minute information that comes to light the day before or of a hearing—such as a positive drug test—may impact the strategy that had been previously agreed upon by the team. You must be prepared for these types of situations, as relapses and setbacks are common among parents of children in dependency court, particularly before a hearing. See Box 13 for an excerpt of a court transcript describing such a scenario.

Box 13. Late-Breaking Problems: A Common Scenario

Court dialogue from a dispositional hearing in the case of two children who have been in foster care for more than a year. Father experienced a relapse and is positive for cocaine.

Judge. [Addressing the father]: Mr. X, what are you doing about your substance abuse problems?

Father. I'm dealing with it head on. I have a new sponsor.

Judge. You are positive for cocaine today. So you are not dealing with your substance abuse.

Father's Attorney. Judge, what we would like to say to the Court is this. Mr. X does have a substance abuse problem…. He voluntarily put himself in treatment last month. He successfully completed inpatient at [place]…. And he did outpatient that he successfully completed. At this point it is a relapse and it's the one isolated incident that he's had the entire case. And unfortunately it's come at the worst time.…

Caseworker. Your Honor, the father did not go voluntarily. It was because of criminal court that he went to the inpatient treatment program. The inpatient program sent him for a psychological and they did a psychiatric evaluation. But [he has] not been back there for follow-up.

Father's Attorney. I would like to address that issue and say to the Court the following. Mr. X did go to therapy at the residential program and I have witnesses that will testify they gave him individual therapy. In addition to that, my client has been on medication. He has been on [a medication that treats major depression, bipolar disorder, and schizophrenia]. We have a print-out from the drugstore. We have some records from his doctor. There may have been a time where there was a lapse for two months, in-between, but he basically has been on the medication. I think that coordinating the psychiatric services has a lot to do with the relapse.

Judge. Well, that can be your argument at the TPR trial because this case clearly belongs in TPR. These children need permanency. It's been way too long.

Clinician. Judge, if I could just state that we were prepared to present something very different this morning. The team has been speaking with one another since we learned of the relapse a week ago—we've been talking at night, over the weekend, really collaborating together to figure out how to proceed.

Attorney for the State. We've spent hours on this case in the last week.

Judge. I know.

Clinician. So what happened this morning, it helps us find a direction with the case but it's.…

Judge. It's heartbreaking, heartbreaking. [Addressing therapist] Do you want to say more about your work with this family.… How long have you been working with this family?

Clinician. Well, I closed this case two months ago because I did not observe insight on the part of either of the parents during the course of the therapeutic treatment. Then the parents contacted me. The father had completed his parenting program and, according to the report from that program, had gained insight. My concern was whether his substance abuse and other mental health issues were being addressed—and if that were the case, I would consider reopening the case to dyadic treatment.

Judge. I do not want you to reopen it. I want you to use the limited resources we have to provide dyadic treatment to a family that is not going to continue to use drugs. So we are here set for a termination of parental rights trial. Everyone needs to be there and these children, after 13 months in foster care, deserve better.

* The courtroom dialogue presented here is based on a court transcript of a case served in the Miami CWBC.

Tools for Self-Assessment

This section has described the practice changes in your work that are essential to the Miami CWBC™ model. Two self-assessment tools, developed as part of the *Miami CWBC™ Dissemination Toolkit*, are available to help you monitor your progress in mastering the new skills and professional practices essential to the model. The first tool, the *Miami CWBC™ Clinician Self-Assessment Tool*, pertains to the new dimensions of your clinical work, and including your involvement on a court team. New practices pertaining to your participation in court hearings are captured in a *Miami CWBC™ Observation Tool*. Both are included in the Implementation Guide.

The purpose of these self-assessment forms is not to be a research tool but to provide a way for you, together with the support of your clinical supervisor, to monitor progress in implementing the new practices associated with the model and to assess your improvement in those practices.

The court observation tool was designed for all front-line members of a court team, and supervisors, to use as a self-assessment tool for gauging the degree of collaboration across the team and challenges to the collaborative process. It is recommended that the tool be used monthly when communities are in the initial phase of implementing the CWBC model and then periodically to maintain a focus on the collaborative behaviors inherent in the model.

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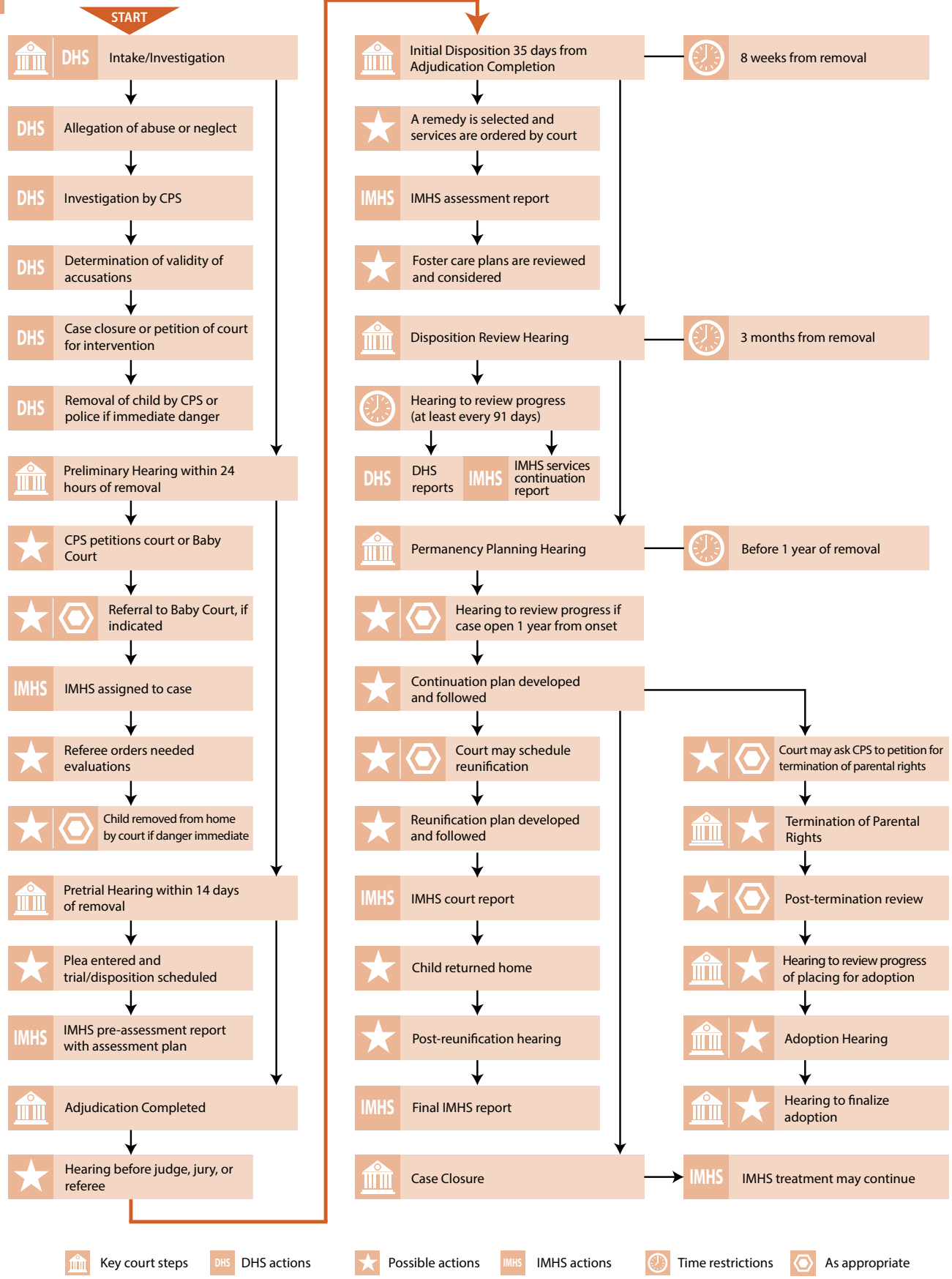
Appendices

Appendix 1

Wayne County Baby Court Process



Appendix 2

Different Types and Purposes of Dependent Court Proceedings

Although state statutes are required to align with major federal child welfare legislation (i.e., ASFA), each state has its own laws that govern the child welfare legal process and its own time frames for holding these hearings. A variety of terms are used by states for each type of hearing, and implementation of the required hearings may differ at the local level. The following is an overview of the typical hearings in a dependency case. More complete descriptions are provided in the National Council of Juvenile and Family Court Judges Resource Guidelines, https://www.ncjrs.gov/pdffiles/resguid.pdf.

Preliminary Protective Hearing. This is the first hearing in a dependency case and it occurs very soon before or after a child has been removed from his or her parents. Depending on the jurisdiction, this hearing may be called a "shelter care hearing," "detention hearing," "emergency removal hearing," or "temporary custody hearing." Although state law varies, the hearing is usually held 1–3 days after the removal. The purpose of the preliminary protective hearing is to determine whether or not the state was justified in removing the child and to determine whether or not the child must remain out of the home or can be safely returned pending adjudication. This is an important hearing, and the outcome is often based on the testimony or sworn affidavit of the person who investigated the allegations and made the decision to remove the child. If the judge approves the removal of the child, the case proceeds to the next phase of the legal process.

Adjudicatory Hearing. The adjudication hearing is the trial about the allegations that caused the removal or brought the child to the attention of the court. There are witnesses, and the rules of evidence apply. In some jurisdictions, this is called the "jurisdictional hearing" or "fact-finding hearing." The judge determines whether the initial allegations are supported by the evidence and, if so, whether the allegations rise to the level of a finding that the child must be found dependent (finding of dependency or jurisdictional finding). Although state law controls the timing of the adjudication hearing, it takes place early in the process.

Adjudication of dependency may also take place without a full trial. Parents may "consent" to the finding of dependency. In this instance, they are neither admitting nor denying the allegations, just agreeing to the dependency and to the court's having jurisdiction over the child. In other instances, a parent may "admit" to the allegations in the dependent petition. Both of these pleas have the same effect as the adjudicatory hearing: they result in a finding of dependency.

Disposition Hearing. While the adjudication provides the basis for state intervention into a family, disposition determines the type of intervention. Once the child is adjudicated dependent, the judge may then decide where the child will live, interventions to be provided to the child, and the services that the parents must engage in to remedy the circumstances that brought the child under the jurisdiction of the court. Reports are submitted by the state agency, GAL/CASA, and other service providers along with the written case plan. These are reviewed by the court to determine whether the state made reasonable efforts to prevent out-of-home placement and, if the child is placed out of the home, whether this arrangement should continue. When the child is placed somewhere other than with his parents, at the disposition hearing the judge will order appropriate visitation and parent-child communication. Although efforts must be made to place siblings together, when the separation of siblings is unavoidable, visitation and communication between siblings should also be addressed during disposition.

Review Hearing. The review hearing takes place after the disposition hearing and regularly thereafter until the child has achieved permanency (typically every 5–6 months, but may be held as often as the court wishes). The purpose of review hearings is to make

sure that cases progress and that children spend as short a time as possible in temporary placement. At the review hearing, the court comprehensively reviews all aspects of the case, including placement, service provision and compliance, and visitation. The judge makes findings related to progress made by the parents and determines whether the agency is providing sufficient supports and services to the parents and child. Depending on the circumstances of the case, at the review hearing the judge re-examines the initial case plan and makes revisions as needed. Review hearings may also be held by nonjudicial entities such as Citizen Review Panels.

Permanency Planning Hearing. Permanency planning hearings (also called "permanency hearings") are typically held 12 months after a child has been removed from her parents. They must be conducted by a judge. The 12-month permanency planning hearing establishes a solid deadline by which the court has to determine whether the permanency plan for the child has been accomplished. If it has not, the judge must determine a new permanency plan or whether there are extenuating circumstances that would support a brief extension of the current permanency plan.

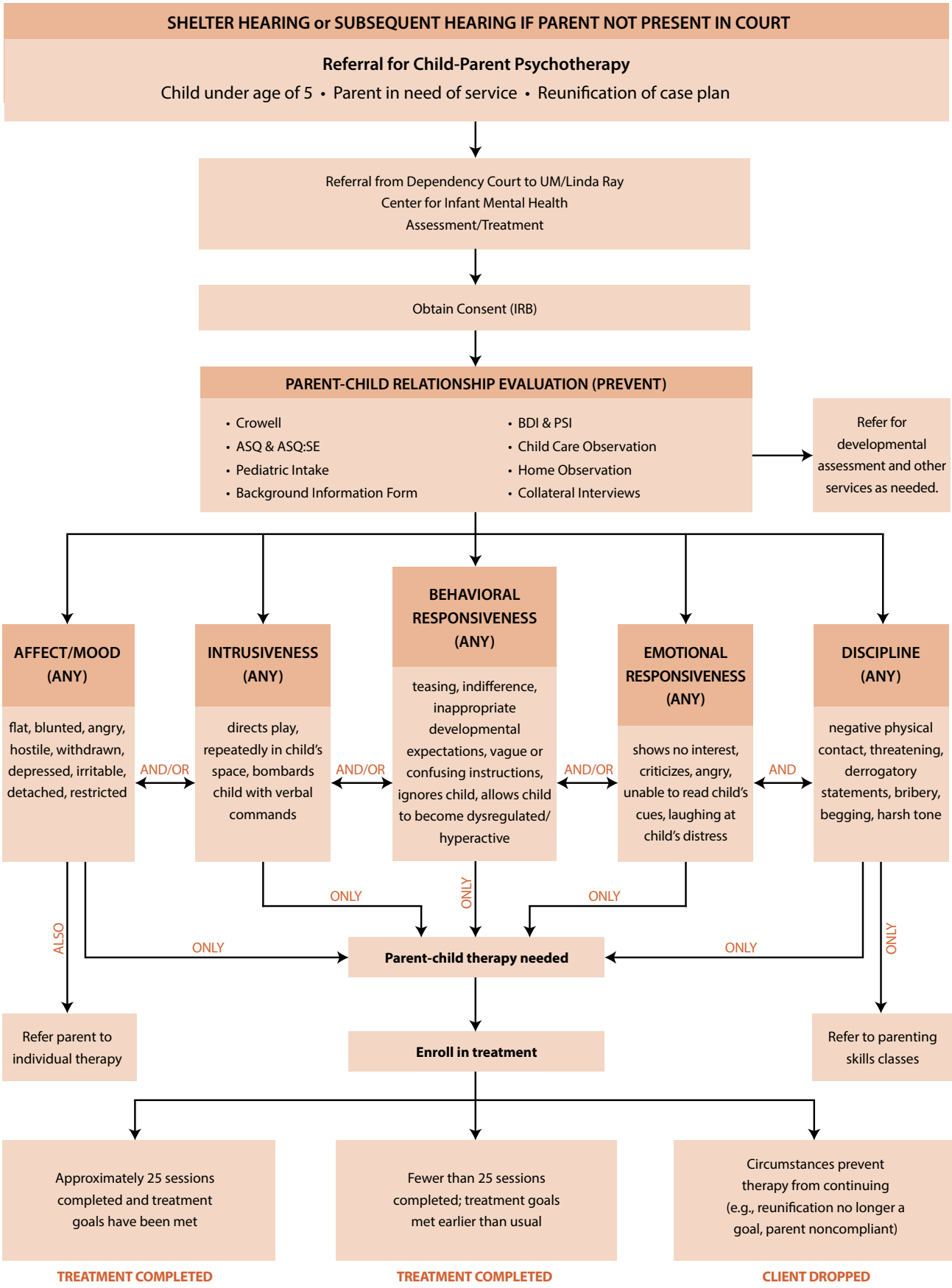
Termination of Parental Rights Hearing. At any point in the case—the review hearing, permanency planning hearing, or any other—if the judge determines that, despite reasonable efforts and sufficient opportunity offered by the state agency, the parents have not remedied the circumstances that brought the child into care, the permanency plan for the child can change from reunification to another permanency plan. This may be adoption, permanent guardianship, placement with a fit and willing relative, or another permanency planning living arrangement (APPLA). The state agency will then file a termination of parental rights (TPR) petition and the legal process for the TPR will commence. Because a TPR removes all parental rights from the parents, there are extensive procedural safeguards for the parents, including the right to notice and the right to present evidence. A TPR hearing is a formal trial, and the rules of evidence apply. In cases involving egregious abuse or other statutorily specified reasons that do not require the state agency to provide services, a TPR may be filed in lieu of the dependency petition. This may be referred to as an "expedited TPR."

A parent may decide to voluntarily relinquish his parental rights. In the event that a parent does this, there will not be a TPR trial. Instead the judge holds a hearing to determine whether the parent knowingly and voluntarily relinquished his parental rights with a full understanding of the implications thereof and without coercion.

Appendix 3

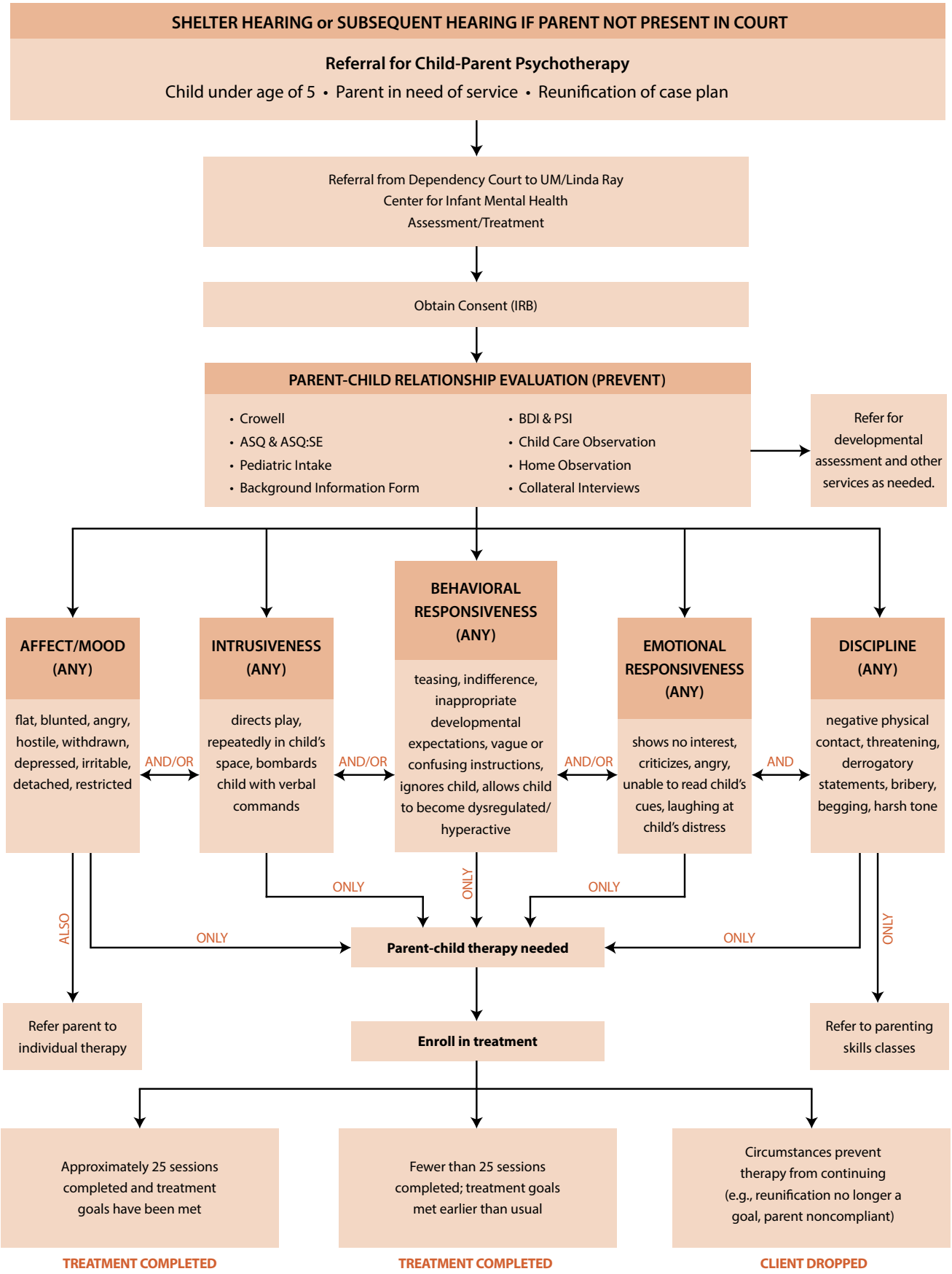
Decision Tree for Clinical Intervention

Positive



Decision Tree for Clinical Intervention

Negative



Appendix 4

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.

Appendix 5

Child-Parent Psychotherapy Referral Process Triage Procedure

Introduction

With guidance, consultation, and support from the clinical and early intervention specialists at the Linda Ray Intervention Center/University of Miami, Our Kids has implemented and funded an expansion program for Child-Parent Psychotherapy services (CPP). The purpose of the expansion is to minimize the number of children placed on a waiting list for CPP services and potentially expedite permanency for our foster care children.

Definition

CPP[1] is a specialized dyadic treatment model that improves secure attachments between parents and their infants or toddlers. This treatment approach is specifically useful with children and parents involved in the foster care system because of the impact of neglect and abuse on the parent-child dynamic.

The CPP therapist works on addressing parental stress and generational schemas that prevent a healthy relationship between parent and child. Additionally, the therapist works on assisting the parent to understand what developmental stages the child goes through and how to respond to the child's emotional needs. The CPP therapist teaches parents how to engage the child in play and develop social skills. During the therapy sessions, the parent expresses his or her thoughts and feelings, which are based on a combination of factors including

- the parent's experiences as a child,
- the parent's expectations and hopes for the child's future, and
- the relationships the parent has with other people.

The therapist's role is as an observer and interpreter of the interaction between the child and the parent. The therapist might share some of her thoughts about the behavior of the child with the parent and, by doing so, offer the parent an alternative way of experiencing the child. This technique helps the parent resolve issues with her own negative experiences during childhood and restore secure attachment with her infant. The process also helps reduce the risk of the child's developing a mental health disorder.

Referral Sources

- Level of Care Assessors will prioritize referrals for CPP if the parent is a first-time parent or if this is the first time that a child was removed from the parent's custody *and* it is not an expedited TPR case. Assessors will also continue to recommend CPP where significant dysfunction between the parent and the child is observed.
- In lieu of CPP services, the Level of Care Assessors may recommend that the parent be referred to a court-approved parenting training provider. All parenting training providers are trained to recognize critical issues that would warrant a referral for CPP.
- If the parent has severe mental health issues or cognitive or developmental delays, the case will not be considered for referral.
- Judges may order a referral for services; however, the CPP provider will make the final determination as to eligibility and clinical suitability.

Referral Process

- The case management agency will select the CPP provider that is the best fit for the parent (typically by geographic location).
- If the provider of choice has a waiting list, the case management agency will select another provider from the Our Kids approved vendor list.
- The dyadic therapy provider will request that the full case management agency complete a CPP eligibility list.
- The full case management agency returns the eligibility list to the CPP provider.

- If the family is eligible, the CPP provider will schedule an intake appointment and a baseline assessment.
- If the family is not eligible, the CPP provider will indicate the reason and offer recommendations for alternative actions. Examples of reasons for service denial include
  - parent does not comply with treatment;
  - parent is noncompliant with other services, medications, etc.;
  - parent is not allowed visitation with the child; or
  - parent has severe mental health issues or cognitive or developmental delays.

In any of the cases indicated above, the referral may be postponed, the case manager will be asked to refer the parent to a court-approved parenting training provider, or both.

Assessment and Service Process

- Initial baseline assessment and collaterals will be conducted by an Our Kids–approved CPP provider.
- A treatment plan will be developed on the basis of assessment findings.
- The CPP provider will deliver monthly progress reports to the case management agency, the dependency judge, and Our Kids.
- If a parent misses three consecutive assessment or therapy sessions without court-approved absence documentation, the case will be closed.

Reference

1. Lieberman AF, Van Horn P. *Don't hit my mommy! A manual for child parent psychotherapy with young witnesses of family violence*. Washington, DC: Zero to Three Press; 2005.

Appendix 6

Choosing Assessment Measures

As the therapist on the court team, you will be asked to describe infant development, parenting, and parent-infant interaction and perhaps comment on parent-infant attachment. In addition to needing training in observation and attachment or bonding, you will need to select measures that document change in these areas. We do not recommend limiting your assessments to parent self-report measures because parents under court supervision may understandably be reluctant to report on their own or their child's negative behaviors or emotions because they fear that it will have a negative impact on their case. Observations and direct assessments are most useful and if video recorded can be used during video feedback sessions with the parent. It is critical that the measures you select have adequate psychometric properties.

Psychometric properties help you judge the degree to which you can trust that the assessment you are using is actually measuring what you want to assess (called validity) and that the measure is accurate (reliability). you should be prepared to answer questions, when you testify, about the psychometric properties of the measures you used in your assessment and also briefly include this information in your court report. This information can be found in the administration and scoring manuals of most assessment tools. Remember that you also want to know if the assessment has been used with high-risk and/or maltreating families and if it discriminates between maltreating and non-maltreating dyads. If your court team has a university partner, that person can be a resource for selecting appropriate measures and can help you understand and evaluate psychometric properties. They should be able to provide you with a variety of options so that you can choose what is the best fit for your clinical approach and your agency. Before describing some measures that we think are appropriate for both clinicians and researchers we review information about reliability and validity.

There are four types of validity that will help you to determine if the assessment you are using actually measures what you want to assess: predictive validity, criterion-related validity, construct validity and face/content validity. The examples below will help you understand these three types of validity and why it is important to consider validity when selecting an assessment tool. Imagine that you want to assess caregiver sensitivity and an infant's attachment to his or her caregiver and you find a parenting survey that has an attachment scale. Just because this scale contains the constructs parenting and attachment doesn't mean that it assesses sensitivity or attachment in a way that is meaningful to you as a clinician or to the court.

Predictive validity refers to whether the assessment predicts what it should. For example, a valid measure of attachment should be able to predict that children with a more secure attachment will demonstrate fewer behavior problems and have higher levels of social competence.

Criterion-related validity is concerned with how related two measures are that claim to assess the same construct. You want to know that your assessment of parenting and attachment is related to "gold standard" measures in the field. There should be evidence that scores on your measure are significantly related to other measures of parenting and attachment.

Construct validity is the degree to which your measure actually measures the construct you are trying to study. You want to know if the authors of the measure you want to use assessed groups of children who were secure, insecure, and disorganized and looked to see if there were differences in scores by classification. You also want to know if maltreating parents score lower on the measure of parenting than parents who have never been reported for maltreatment.

Face validity refers to whether the assessment or measure you are using captures important characteristics of what you are trying to measure. Measures of attachment should assess infant behaviors related to exploration in times of safety, returning to a parent in times of stress. If the items that correspond to the attachment scale do not ask these questions, but ask questions about eye contact, smiling, and parent responsiveness you should be skeptical because there is not research to suggest that these behaviors alone are indicative of attachment classifications.

Understanding a measure's reliability helps you know if the scores that your assessment yields are consistent and dependable. Imagine that a physician needs to know your weight to administer the right amount of a drug. A scale that provides large differences in your weight will not be of use in prescribing the right amount of medication. A parenting scale that is not reliable will not be able to accurately assess parenting. There are three kinds of reliability that you should consider when using self-report questionnaires, test-retest reliability, split-half reliability, and internal consistency. When using observational measures you also need to consider inter rater reliability.

Test-retest reliability describes reliability across time. Imagine that you are trying to lose weight and you know that a bathroom scale is the best measure of weight loss. You expect that when you get on the scale in the morning and in the evening the weight on the scale will be pretty similar. If you stepped on the scale in the morning and learned that you weighed 120 pounds, but then stepped on the scale in the evening and learned that you weighed 140 pounds you would probably know that your scale wasn't reliable for accurately measuring your weight. The same is true when you are assessing constructs like parenting, mental health and child development. For example, if you assess toddler social-emotional development at the beginning and at the end of the first session, using the same measure the score should be the same. Even over the course of a month, one wouldn't expect a child whose scores indicate developmental delay to have scores in the advanced range in a short period of time. When scores on measures that have demonstrated good test-retest reliability do change, you can feel confident that the change is accurately captured.

Internal consistency is a measure of how items on a scale relate to each other. Generally, you will want to look for tests where Chronbach's alpha is at least .80.

Inter rater reliability is a measure of reliability across different people and it is why training on observational measures of parenting and attachment is required. For example, after conducting a Strange Situation Procedure to measure attachment the video that is coded should reveal the same classification, regardless of who codes it. Coders who are considered "reliable" in using measures described below have demonstrated that they agree with master coders on a "gold-standard" set of training tapes or transcripts.

Measures of Parenting

Below, we review a few measures that are consistently used for clinical and research purposes. Because of the importance of structured parent-child observational assessments we do not include parent self-report measures. While some studies do show that a handful of these self-report measures reliably assess parenting competence our own work suggests that parents who are under court jurisdiction understandably try to respond to questions in ways that put themselves in a favorable light or do not have the insight into their own emotions or their child's emotions to accurately report on their parenting skills until after treatment. As a result, some parents whose scores on observational measures of parenting improve actually look worse over time on measures of mental health and parenting as they become more trusting of the clinician and more aware of their own feelings and their child's behaviors.

Caregiver-Child Structured Interaction Procedure—CROWELL (Crowell & Feldman, 1988; Heller et al. 1998)

Overview. This is a structured assessment procedure that is typically done in a laboratory setting and was adapted from a measure that was widely used clinically with infants aged 24-54 months of age. It contains a series of tasks that seek to elicit a variety of relationship behaviors from both infant and caregiver. This measure was chosen by the Miami and Detroit teams because it provides a number of contexts in which to assess parenting, including fun tasks like free play and blowing bubbles, and more difficult tasks where the parent has to provide

structure and re-direct their child in the instance of off-task behavior. Clinicians in Miami found the clinical scoring system useful and the research scoring provides a strong measure of both parent and child behaviors that are the target of dyadic treatment. As noted above, a major strength of the Crowell is that it includes tasks that are meant to provide a joyful interaction (blowing and popping bubbles) and induce moderate stress that requires the parent to structure an activity and help regulate the child's emotions (difficult teaching task). The procedure also includes a separation reunion, which doesn't assess attachment, but allows the clinician/researcher to observe attachment behaviors. This observational measure of parent-child interaction is designed for infants aged 12-43 months of age, but can be adapted for use with infants as young as 6 months. It includes nine separate episodes; a free play, clean up, play with bubbles, four teaching tasks that get progressively more difficult, separation, and reunion. This assessment is usually completed in a minimally furnished room, with a specific set of age appropriate toys; it lasts approximately 30-40 minutes. The episodes are videotaped and coded based on a variety of domains, there are two types of scoring. The clinical scoring seeks to better understand multiple aspects of the parent-infant relationship including but not limited to comfort level, familiarity, cooperation, and enjoyment. The research scoring looks at five parenting domains: behavioral responsiveness, emotional responsiveness, positive affect, withdrawal/depression, irritability/anger, and seven child domains: positive affect, withdrawn/depressed, irritability/anger, non-compliance, aggression, enthusiasm, and persistence with task.

Psychometric Properties. This assessment is scored by reliable coders who have been trained and achieved reliability on a gold-standard set of tapes. The author of the measure suggests that it helps to identify strengths and weaknesses within the parent-infant dyad, and also helps to better understand needs for intervention. Research suggests that risk factors present within the caregiving environment in turn impact the relationship between the parent infant dyad. Environmental factors and the infant parent relationship are said to be mediated by risk factors present within the caregiving environment (Zeanah, Larrieu, Heller, & Valliere, 2000). Some evidence is available regarding reliability and validity of the Crowell Procedure. For example, in a study comparing maltreating and non-maltreating dyads, the parent positive affect was significantly higher in the non-maltreating group and parent anger was significantly lower in the non-maltreating group. Maltreated children, compared to non-maltreated children showed less positive affect and more anger. The study also suggests that parent positive affect is associated with child effortful control (Robinson, Morris, Heller, Scheeringa, Boris, & Smyke, 2009). The original study by Crowell and Feldman (1988) using the procedure also suggests that the measure accurately discriminates clinical and non-clinical dyads. In the Florida Infant Mental Health Pilot study, that used an adapted version of the Crowell procedure, results suggest that among maltreating dyads receiving 25 sessions of parent-child psychotherapy significant improvements were seen in parent emotional and behavioral responsiveness, intrusiveness, and use of positive discipline (Osofsky et al., 2007).

Training. Training on the adapted version of the Crowell is a 3.5 day course run by the Dr. Sherryl Heller. The course includes introduction and discussion of coding domains, watching and coding a set of practice tapes, and finally a set of reliability tapes. Reliability is established after completion and accurate scoring of the set of reliability tapes. To learn more about training contact Dr. Sherryl Heller at (504) 988-8686.

NCAST Parent-Child Interaction (PCI) Feeding and Teaching Scales (Barnard & Eyres, 1979)

Overview. These are observational measures of parent-child interaction during either a feeding or a standardized teaching episode or both and can be completed in 10 minutes in a home or clinic setting. The assessment can be used for clinical practice and research to assess a dyad's strengths and areas needing improvement. The Feeding scales can be used from birth to 12 months of life and the teaching scales from birth to 36 months of age. There are 4 parent/caregiver behavior subscales and two child behavior subscales. The parent/caregiver behavior subscales include: Sensitivity to Cues, Response to Distress, Social-Emotional Growth Fostering, and Cognitive Growth Fostering. The child behavior subscales include: Clarity of Cues and Responsiveness to Caregivers. The PCI scales have been used in several large studies.

Psychometric Properties. Each scale contains 73 items scored as 0 (not observed) or 1 (observed). The manual that accompanies the scales describes norms for scores by racial group for the child, maternal age and education, and has identified cut-off scores for "worrisome" scores that warrant a referral. According to Sumner & Spietz, (1994), internal consistency for this measure is excellent and ranges from .83 to .90, depending on the sample and the scale. The manual provides information describing findings from a variety of studies that support the validity of the assessment, including studies using validated measures of attachment (Spieker, Oxford, Kelly, Nelson, & Fleming, 2012). The assessment has been used with a variety of cultures and in samples of mothers who are depressed, low-income, adolescent, at high-risk for maltreatment and substance using. It has also been used to assess change in parenting as a result of intervention.

Training. The PCI requires researchers/clinicians to attend a 2.5 day training that is offered by certified instructors. After being trained researchers/clinicians must register with the national office, purchase manuals and pass a reliability test using a gold-standard set of tapes. To learn more about training please visit the NCAST Programs website at www.ncast.org.

CARE – Index (Crittenden, 1981, 2007)

Overview. This is an observational coding measure of parent-child interaction that can be used with infants from birth to 15 months (the Infant Care Index) and toddlers from 15-30 months (the Toddler Care Index) as a screening tool and a guide for intervention. The CARE-Index assesses adult sensitivity in a dyadic context. The author notes that it should be used in a battery of assessments. Parents are videotaped for 3 to 5 minutes while they play with their child like they usually would and can be carried out in either a home or clinic setting. Adult sensitivity, control and unresponsiveness and infant cooperation, compulsivity, difficultness and passivity (infants) and coercion (toddlers) are assessed. An overall dyadic synchrony score can also be calculated. The CARE-Index is not tied to behaviors, rather it is tied to the interpersonal quality and meaning of the behavior and is sensitive to false positive affect (Crittenden, 2005). While this measure does not assess attachment it does measure parent behaviors that are predictive of attachment and there is some evidence to suggest that it is associated with attachment as measured by the Strange Situation Procedure (Fuertes, Dos Santos, Beeghly, & Tronick, 2007). It has been used in a variety of cultures and with high-risk dyads including maternal depression, substance abuse, serious mental illness, and those participating in parenting interventions. The CARE-Index has cutoff scores to indicate whether the dyad is at high- moderate- or low-risk for maltreatment.

Psychometric Properties. This assessment is scored by reliable coders who have been trained and achieved reliability on a gold-standard set of tapes. Research suggests that the CARE-Index is associated with attachment classifications (Fuertes, et al., 2007), abusive parenting (Crittenden, 1988), and child behavior.

Training. Training in the Infant CARE Index includes an 8 day course, including practice and a reliability test and training in the Toddler CARE Index takes another 5 days plus practice and a reliability test. The author of the measure recommends consistent use of the tool and practice coding and periodic work with the original teaching tapes. Reliability is only given for a year and must be updated with evidence of further work and continued competence. To learn more about training contact Dr. Pat Crittenden at (305) 256-9110 or pmcrittenden@gmail.com.

Parenting Interactions with Children Checklist of Observations Linked to Outcomes-PICCOLO (Roggman, Cook, Innocenti, Norman, & Christansen, 2010)

Overview. The PICCOLO is an observational assessment of positive parenting behaviors in parent child interactions with toddlers aged 1-3 years old. This coding system is used with any video-taped free play interaction lasting between 10-15 minutes. Four separate domains of positive parenting are assessed including: affection, responsiveness, engagement of autonomy, and teaching.

Psychometric Properties. Together the four scales have a total of 29 items. Each item is scored as either 0 (not observed), 1 (briefly observed), or 2 (definitely observed). Internal consistency across all four domains ranges from .73-.81. Scores for each item are added together, and domain scores are created. The authors suggest that this measure is easy to use, psychometrically sound, and can be used with many types of diverse families including European

American, African American, and Latino American Families (Roggman, Cook, Innocenti, Jump Norman, & Christansen, 2009).

Training. Training on the PICCOLO is conducted by the authors or experienced PICCOLO trainers. A one-day training with both observation and coding practice tapes is recommended. Reliability is established by demonstrating inter-rater reliability with the authors on a number of videos. For information on training or administration please contact Lori Roggman or Mark Innocenti at (435) 797-0091 or (435) 797-2006. Further information can also be found at www.cpdusu.org/projects/piccolo.

Representational Measures of Parenting

Representational measures are not traditionally used in evaluations for the court and were not part of the initial Florida Infant Mental Health Pilot. Research, however suggests that these measures are highly correlated with infant attachment classification and parenting sensitivity and they do not require laboratory space with video equipment. They are also very clinically useful. The Detroit team used the Parent Development Interview to assess parent reflective functioning and found that it was very sensitive to changes after 9 months of treatment.

Parent Development Interview (Aber, Slade, Berger, Bresgi, & Kaplan, 1985)

Overview. The PDI is a 45 item semi structured interview used to assess parent's levels of reflective functioning, mainly their ability to reflect on both their own and their child's mental states. The structure of the interview is very similar to the Adult Attachment Interview or AAI (George, Kaplan, & Main, 1984). Interview questions ask parents to think about and reflect on their own and their child's mental states. Mental states include thoughts, feelings, beliefs, desires, intentions, and behaviors. The PDI differs from the AAI in that it requires parents to think about specific memories, or experiences that really evoke their understanding of mental states of their current relationship with their child. Sample questions include, "Tell me about a time when you and your child clicked." or "When your child is upset, what does he do?" Administering the PDI requires an understanding of reflective functioning and how the questions are targeted to their participant's responses and experiences. An important aspect of administering the interview requires the interviewer to probe the parent for responses that can be utilized to understand the parent's level of reflective functioning. Prior to being coded, the interviews are recorded and transcribed, then scored by reliable coders. The PDI is scored with a single overall score being representative of the interview. This is done using the adapted coding system for reflective functioning (Slade et al., 2005). The PDI contains two types of questions, demand questions which demand the participant to reflect on their child's experience, or permit questions. Each of the demand responses are scored individually on a scale from -1 to 9, then an overall score is calculated. Higher scores represent higher levels of reflective functioning.

Psychometric Properties. This assessment is scored by reliable coders who have been trained and achieved reliability on a gold-standard set of interview transcripts. Research suggests that reflective functioning as assessed with the PDI is associated with a parent's own representation of attachment (Slade, 2005), infant attachment classification (Slade, 2005), and parental sensitivity. Reflective functioning is a construct that is useful to clinicians and researchers. Some intervention programs aim to improve parent reflective functioning as a way to improve parent sensitivity and infant attachment and mental health. Preliminary findings from these studies suggest that dyadic interventions are effective at improving parental reflective functioning.

Training. Training in administration and coding is available through the PDI Training Institute. Participants learn to administer and code the PDI and then must pass a reliability test based on a gold-standard set of transcripts coded by a set of master coders. For more information about training or reliable coders in your area please refer to the PDI Training Institute website at www.pditraininginstitute.com.

Working Model of the Child Interview (Zeanah, Benoit, & Barton, 1986; 1993)

Overview. This measure assesses parents' internal representations or working model of their relationship to a particular child via a 45-minute structured interview and can be useful for both

clinicians and researchers. The interview can be given prenatally and postnatally. The structure and coding of the interview was based on the Adult Attachment Interview (AAI), but rather than focusing on the parents' own childhood the WMCI focuses on the parents' perceptions of their infant's behavior and personality and their thoughts and feelings about their infant. Interviews are either audio or video recorded can be transcribed and coded or can be reliably coded from videotape (Rosenblum, Zeanah, McDonough, & Muzik, 2004) by a trained coder. Based on the interview coders classify the parent's representations as either Balanced, Disengaged, or Distorted, which are associated with patterns of infant attachment (Secure, Avoidant, and Ambivalent). Coders also rate the parent on 6 qualitative scales (Richness of Perceptions, Openness to Change, Intensity of Involvement, Coherence, Caregiving Sensitivity, and Acceptance), 2 content scales (Infant Difficulty and Fear for Safety) and note emotions that are expressed during the interview and assess the degree to which they color the caregiver's representation of the infant. Rosenblum and colleagues (2008) added probes to the original WMCI script and were able to code reflective functioning from the WMCI.

Psychometric Properties. A number of studies have documented predictive validity associated with this measure. For example, in non-clinical samples approximately 52% of the mothers are coded as balanced and in clinical samples, representations are more likely to be classified as insecure 66% (Vreeswijk, Maas, Van Bakel, 2012). Studies also show that mothers with higher levels of depressive symptoms are less likely to have balanced representations of their children (Minde et al., 2001; Rosenblum et al., 2002) and that balanced mothers demonstrate more sensitivity and responsiveness and less hostile-intrusive behavior (Dayton et al., 2010; Schecter et al., 2008; Sokolowski et al., 2007). Benoit et al, (1997) and Theran et al., (2005) demonstrated concordance between prenatal and postnatal maternal representations. Research also suggests that WMCI classifications are stable over time (Borghini et al., 2006).

Training. Training in administration and coding is available through the Infant Institute at Tulane University. Participants learn to administer and code the WMCI and then must pass a reliability test based on a gold-standard set of transcripts coded by experts. For more information about training or reliable coders in your area contact Linzi Conors (lconners@tulane.edu) or visit www.infantinstitute.com/training.htm.

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Appendix 7

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

Appendix 8

Scientific Resources for Court Reports

Web Sites

The Center on the Developing Child at Harvard University uses scientific findings to influence and improve child well-being. Videos, working papers, and reports are available on their Web site, http://developingchild.harvard.edu/topics/science_of_early_childhood/. Here are some examples:

- The Foundations of Lifelong Health Are Built in Early Childhood
- Young Children Develop in an Environment of Relationships
- Excessive Stress Disrupts the Architecture of the Developing Brain
- Early Exposure to Toxic Substances Damages Brain Architecture
- The Timing and Quality of Early Experiences Combine to Shape Brain Architecture
- Mental Health Problems in Early Childhood Can Impair Learning and Behavior for Life
- Maternal Depression Can Undermine the Development of Young Children
- Persistent Fear and Anxiety Can Affect Young Children's Learning and Development
- Early Experiences Can Alter Gene Expression and Affect Long-Term Development

The National Child Traumatic Stress Network (NCTSN), a collaboration of academic and community-based service centers, was established by Congress in 2000 and seeks to raise the standard of care and increase access to services for traumatized children and their families. Their Web site (http://www.nctsnet.org/resources/topics/child-welfare-system) offers a series of factsheets discussing parent trauma in the child welfare system, including the following:

- Birth Parents With Trauma Histories and the Child Welfare System: A Guide for Mental Health Professionals
- Birth Parents With Trauma Histories and the Child Welfare System: A Guide for Child Welfare Staff
- Birth Parents With Trauma Histories and the Child Welfare System: A Guide for Judges and Attorneys
- Birth Parents With Trauma Histories and the Child Welfare System: A Guide for Parents
- Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents

Another section of the site, http://www.nctsnet.org/resources/audiences/parents-caregivers/what-is-cts, covers such topics as these:

- What is Child Traumatic Stress?
- Age Related Reactions to a Traumatic Event
- Questions and Answers about Domestic Violence
- Questions and Answers about Child Sexual Abuse
- Questions and Answers about Child Physical Abuse

The National Organization on Fetal Alcohol Syndrome (FASD) provides information and resources on fetal alcohol spectrum disorders at its Web site, www.nofas.org:

- Recognizing FASD
- How the Foster Care System Can Help Identify and Support Children With FASD
- Resources by State
- Fetal Alcohol Spectrum Disorders: What Everyone Should Know

Zero to Three (http://www.zerotothree.org/child-development/) is a national organization that provides information, training, and support to professionals, policymakers, and parents to improve the health and development of infants and toddlers. They provide information on

- brain development,
- managing challenging behaviors,
- early childhood mental health,
- developmental milestones, and
- mental health screening and assessment.

Journal Articles

Bailey, H. N., Moran, G., & Pederson, D. R. (2007). Childhood maltreatment, complex trauma symptoms and unresolved attachment in an at-risk sample of adolescent mothers. *Attachment and Human Development, 9*(2), 139–161.

Bogat, G. A., DeJonghe, E., Levendosky, A. A., Davidson, W. S., & von Eye, A. (2006). Trauma symptoms among infants exposed to intimate partner violence. *Child Abuse and Neglect, 20*(2), 109–125.

Carpenter, G.L., & Stacks, A.M. (2009). Developmental effects of exposure to intimate partner violence in early childhood: A review of the literature. *Children and Youth Services Review, 31*(8), 831–839.

Casanueva, C. E., Cross, T.P., & Ringeisen, H. (2008). Developmental needs and individualized family service plans among infants and toddlers in the child welfare system. *Child Maltreatment, 13*(3), 245–258.

Casanueva, C. E., & Martin, S. L. (2007). Intimate partner violence during pregnancy and mothers' child abuse potential. *Journal of Interpersonal Violence, 22*(5), 603–622.

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Oyserman, D., Mowbray, C. T., Meares, P. A., & Firminger, K. B. (2000). Parenting among mothers with a serious mental illness. *American Journal of Orthopsychiatry, 70*(3), 296–315.

Ringeisen, H., Casanueva, C., Urato, M., & Cross, T. (2008). Special health care needs among children in the child welfare system. *Pediatrics, 122*(1), 232–241.

Roussotte, F., Soderberg, L., & Sowell, E. (2012). Structural, metabolic and functional brain abnormalities as a result of prenatal exposure to drugs of abuse: Evidence from neuroimaging. *Neuropsychology Review, 20*(4), 376–397.

Sameroff, A. J., & Rosenblum, K. L. (2006). Psychosocial constraints on the development of resilience. *Annals of the New York Academy of Sciences, 1094*, 116–124.

Scheeringa, M. S., & Zeanah, C. H. (2001). A relational perspective on PTSD in early childhood. *Journal of Traumatic Stress, 14*(4), 799–815.

Sroufe, L. A. (2005). Attachment and development: A prospective, longitudinal study from birth to adulthood. *Attachment and Human Development, 7*(4), 349–367.

Thompson, B. L., Levitt, P., & Stanwood, G. D. (2009). Prenatal exposure to drugs: Effects on brain development and implications for policy and education. *Nature Reviews Neuroscience, 10*, 303–312.

Books

Cassidy, J., & Shaver, P. R. (2010). Handbook of attachment: *Theory, research, and clinical applications.* New York, NY: Guilford.

Groves, B. (2003). *Children who see too much: Lessons from the Child Witness to Violence Project*. Boston, MA: Beacon Press.

Jones-Harden, B. (2007). *Infants in the child welfare system: A developmental framework for policy and practice*. Washington, DC: Zero to Three.

Osofsky, J. D. (2007). *Young children and trauma: Intervention and treatment*. New York, NY: Guilford Press.

Zeanah, C. H. (2009). *Handbook of infant mental health* (3rd ed.). New York, NY: Guilford Press.

Appendix 9

Sample Parent-Child Assessment

Date of Birth: XX

Chronological Age: 17 months

Corrected Age: N/A

Date of Report: XX

Ethnicity: Hispanic

Gender: Male

Mother's Name: LS **Father's name:** BS

Age: 20 **Date of Birth:** XX

Date of Birth: XX

Ethnicity: Hispanic

Referral Source: XX, full case management agency

Primary Caregiver: DM, Foster mother

Observation/Interview Dates: 11/18/10, 11/23/11, 11/30/10, 12/7/10, 12/29/10, 1/4/11

Assessment Instruments and Procedures:

Face-to-Face contact with LS, biological mother

Face-to-Face contact with DM, foster mother (home visit)

Daycare Visit/Observation

Clinical Observations of Parent/Child Interaction with biological mother

Ages and Stages Questionnaire (ASQ) 2nd Edition

Ages and Stages Social Emotional Questionnaire (ASQ: SE)

Pediatric Intake

Background Information Form

Collateral Information obtained from XX-Full case management agency: Level of Care Assessment, Judicial Review, Case Plan, Mental Health Assessment, Parenting Program reports (pre and post).

Reason for Referral:

Upon referral from case worker, JS and his biological mother, LS, participated in a Child-Parent Assessment. Ms. LS was referred due to an alleged history of substance abuse that contributes to concerns in the parent-child relationship.

According to the Verified Petition for Dependency, the Department of Children and Families became involved due to a law enforcement response to a conflict between JS' named father, BS, and the maternal family. It is reported in the petition, that the mother, maternal grandmother, and maternal grandmother's boyfriend were drug tested and that they were all positive for cocaine. As a result, LS was recommended for inpatient drug rehabilitation services. The child was not removed and allowed to remain in the mother's custody at The XX Residential Facility.

During the child-parent assessment process, the mother reported that JS is no longer in her care due to her testing positive for cocaine at a dependency court hearing. JS was placed in foster care.

At the time of the initial referral, JS' father was incarcerated for domestic violence. In addition, this clinician recommended that the father complete his Parenting Program prior to participating in the child-parent assessment with our agency. Currently, he is out of prison and has completed his parenting program. Mr. BS has an appointment on February 17, 2011 in order to start the child-parent assessment process due to his desire to regain custody of JS.

Background Information:

Parental Family History

Ms. LS describes her upbringing as chaotic, neglectful, and abusive. In conversations with this clinician, she repeatedly reports that "nobody helped" and "nobody cared" and that if she would have been removed from her mother's care she would have had a "better life."

Ms. LS reports that she was raised by her biological mother and several family members. When she was approximately 2 years old, her biological father left the home and was in and out of her life. Ms. LS states that due to her mother's chronic substance abuse problem, she moved around between family members, neighbors, and friends. She was neglected by her mother and sexually abused by her mother's boyfriends. Ms. LS reports that her mother, father, and mother's boyfriends were chronic substance abusers of alcohol, cocaine, and marijuana. Between the ages of 9-11 she lived with her maternal aunt and her husband and states that this was the least chaotic time in her life. Ms. LS has 2 brothers and reports that they are actively using drugs.

Ms. LS reports that her mother "never sent her to school" and as a result she had great difficulty learning and was placed in special education classes for learning disability. Ms. LS completed the 10th grade of high school.

Ms. LS met Mr. BS (named father for the child) when she was 17 years old and moved in with him when she was 18 years old. Ms. LS reports that she used cocaine with Mr. BS. Ms. LS was in a relationship with Mr. BS for approximately 3 years and describes him as "very controlling." They lived in a rural part of XX County in what she describes as "the back of an 18 wheeler." Ms. LS reports that approximately in August 2010 there was a domestic violence incident in which Mr. BS hit and slapped her. As a result, the police was called and Mr. BS was arrested. Ms. LS moved into a domestic violence shelter and filed a restraining order against Mr. BS. While living at the domestic violence shelter, she visited her mother's home and began drinking and using cocaine again.

Parental Support System

Ms. LS reports that she feels alone and there is no one she can count on for help. She has sporadic visits with her biological father in which he provides her with some spending money. She states that her father tells her that he is "clean" now. She has telephone contact with her biological mother but she does not visit because her mother is actively using drugs. The maternal aunt that raised her between the ages of 9-11 lives outside of XX County ("not sure where") and she does not have contact with her. Ms. LS is "afraid" of JS' biological father and therefore cannot count on him.

Parental Employment History

Ms. LS is not employed. She had one previous employment in which she worked at a Hilton hotel as a waitress for several weeks. She reports a history of prostitution during her teenage years in order to get money for drugs, which she shared with her mother. Her mother was aware of the prostitution but did not care given that she needed the money to buy drugs. Ms. LS was financially supported by her mother and the prostitution money until she was 17 years old. At 18 years old, she moved in with Mr. BS and was financially supported by him until she left him, due to domestic violence, in August of 2010.

Parental Legal History

Ms. LS reports no arrests. This information was confirmed by a background check as reported by the Level of Care Assessment report.

Parental Substance Abuse History

Ms. LS reports that she started drinking beer at the age of 3; she drank beer out of the opened cans that were left in the refrigerator and around the house. Ms. LS started smoking marijuana at age 12 and snorting cocaine at age 13. She reports that her biological mother was aware of her alcohol and drug use.

When the case first came to the attention of the dependency system, she volunteered to go to a residential drug program and started her program approximately in October of 2009. The mother reports that she left the drug program, when Mr. BS was discharged from his inpatient drug program. Ms. LS feels that she was not ready to leave the residential drug program but due to the pressure she felt from Mr. BS, she left the program and moved in him. Ms. LS relapsed (drank beer and used cocaine at her mother's house) and tested positive for cocaine at the September 2010 court hearing for her son. The mother reports that staying sober is a daily struggle.

Parental Mental Health History

Ms. LS reports that in October 2009 she entered The XX (inpatient rehabilitation) for the first time and was diagnosed with postpartum depression and was prescribed the psychotropic medication Citalopram. Ms. LS reports the medication was helpful. Ms. LS never received any mental health services prior to entering inpatient rehabilitation. When Ms. LS left inpatient rehabilitation, she did not follow up with medication management and stopped taking her psychotropic medication. Ms. LS re-entered inpatient rehabilitation in September 2010 due to her relapse and is under the care of a psychiatrist. Ms. LS is prescribed Prozac, which she feels is helping her with her depression but she continues to feel "shaky" and anxious.

In a Mental Health Assessment completed on December, 2009, Ms. LS was diagnosed with Major Depressive Disorder, Moderate, and an R/O of Attention Deficit Hyperactivity Disorder.

Parental Sexual Abuse History

Ms. LS reports that she grew up exposed to her mother's pornography and sex due to the numerous men that her mother would bring into the home. Ms. LS was molested by her mother's boyfriends "a whole bunch of times" and was raped at age 7 and then again at age 12. The history of prostitution during her teenage years was due to the need to obtain money for drugs to share with her mother.

Ms. LS disclosed that she feels she is addicted to sex and would like to receive treatment for this addiction.

Parental Domestic Violence History

Ms. LS grew up exposed to domestic violence perpetrated by the men her mother would bring into the home. Ms. LS describes a controlling and abusive relationship with Mr. BS that culminated in the domestic violence episode where Mr. BS was arrested and Ms. LS moved into a domestic violence shelter.

Placement History of Child

When JS was 1 month old, he and his parents were first identified by the dependency system and there was no removal. The parents volunteered to enter an inpatient drug rehabilitation program. JS was allowed to live with his mother and remained in her custody with the condition that she could not leave rehabilitation program with JS. JS remained at rehabilitation program with his mother until he was 5 months old. On February 2010, when JS was 5 months old, the mother and father were discharged from the rehabilitation program and granted joint custody. In August 2010, when JS was 11 months, 3 weeks old, the father was arrested for domestic violence against the mother and the mother moved with JS to a domestic violence shelter. In September 2010, when JS was 12 months old, the mother tested positive for cocaine at a court hearing and JS was removed and placed in foster care. JS experienced 2 foster care placements, lasting a few days each, prior to being placed with his current foster mother. JS has lived in his current placement since September 2010. After the removal, the mother was granted 3-4 supervised visits per week with JS. The mother has been consistent with the supervised visits.

Collateral Reports of Child's Functioning

The foster mother reports that JS is a very challenging and "very active" child. He has frequent temper tantrums and during the tantrums he throws toys, screams, throws self against floor and/or play pen. She also describes him as clumsy; falls all the time and bumps into walls. The foster mother further reports that JS resists "everything." When asked to describe what she meant by "everything" the foster mother gave examples that JS refuses daily activities such as diaper change and dressing. The foster mother also reported that JS used to "grab" his penis at all diaper changes and during the bath. The foster mother states that this behavior has decreased since she began to use redirection in which she hands him a toy during his diaper change. During meal times, JS presents with agitation and distress which make it very difficult for him to chew and swallow foods. When the foster mother is able to persuade JS to put food in his mouth, he chews very fast, stuffs his mouth with food, and most of the time spits out the food. During meal times, the foster mother has to take control of the food and give him his food one piece at a time or one spoonful at a time. In addition, she reports that JS is "too thin" and she is concerned about his weight. JS sleeps approximately 8 hours per night and wakes up 1 time during the night. JS loves music and he sings and dances. She reports that he is affectionate.

JS's teacher, Ms. RT at the XX Child Care Center, describes JS as having "a lot of energy" and more active than the average toddler. He exhibits age-appropriate peer relationships most of the time and he is affectionate with adults. He can, at times, follow simple directions such as "sit down." Ms. RT is concerned about JS's global developmental delays as observed in the classroom and confirmed on developmental assessments. He is delayed in his communication and therefore has difficulty gesturing/communicating in order to get his needs met. Ms. RT describes JS as "awkward" and clumsy in his gross motor. Ms. RT states that JS eats very fast and stuffs food in his mouth when he first begins a meal. His developmental delays have been a concern since infancy.

Developmental and Medical History

Ms. LS reports that she was 19 years old when she gave birth to JS. JS was born at 39 weeks gestation through vaginal delivery weighing 6 lbs and 9 ounces. According to the mother, she received prenatal care at the XX Hospital. Ms. LS smoked cigarettes daily and used cocaine daily when she was 5-7 months pregnant. She drank beer 1-2 times per week throughout the entire pregnancy. She reports that JS was born "clean."

The foster mother reports that there are no current medical concerns and that JS's immunizations are up to date.

Observations/Assessments:

Ages and Stages Questionnaires

The ASQ is administered to children between the ages of 1 to 66 months. The instrument is a caregiver monitoring screening instrument, based on caregiver interview with an early education specialist. It should be noted, however, that this screening could not predict the child's long-term performance, as the nature of the assessment is only to be interpreted as a guideline for practitioners and for possible referrals for early intervention.

The child's ASQ was completed in English by his teacher. A 16-month questionnaire was completed according to the child's chronological age. The child's scores are as follows:

	Score	Cutoff
Communication	15	16.81
Gross Motor	40	37.91
Fine Motor	40	31.98
Problem-Solving	40	30.51
Personal-Social	10	26.43

JS appears to be functioning below age level in the areas of communication and personal-social development. JS was functioning at the borderline level in the areas of gross motor, fine motor, and problem solving.

Ages and Stages Social-Emotional Questionnaire (ASQ: SE)

The ASQ: SE is administered to children between the ages of 3 to 65 months. The ASQ: SE is a caregiver monitoring screening instrument, based on the caregiver and child interview with an early childhood specialist. Like the ASQ developmental questionnaire, this single assessment is only to be interpreted as a guideline for practitioners for further assessment and for possible referrals for early interventions.

The child's ASQ: SE was completed in English by his teacher. An 18-month ASQ: SE questionnaire was used according to JS's chronological age to determine the child's social emotional developmental level. Scores were as follows:

Score	Cutoff
60	55

The score was just above the cutoff, indicating that JS is having difficulty in his social-emotional development.

Clinical Observation of Parent and/or Caregiver/Child Interactions

The following observations and interpretations are of a clinical nature and are not derived as a result of standardized psychological measures.

The Crowell is a semi-structured assessment that consists of a 10-minute free play period, clean up, 1 transition activity, 3 structured tasks, and a separation and reunion period. The assessment takes place in a playroom setting in which a variety of toys are provided to the parent and child. The instructions are given to the parent prior to the start of the assessment and each task is demonstrated. When it is time to transition to the next activity, the clinician signals to the caregiver without interrupting the assessment. The interactions are videotaped with the consent of the primary caregiver, which can be withdrawn at any time without consequence of risk.

The mother and child also participated in a free play observation in which the mother was asked to "play with her child." This observation lasted for 1 hour and was conducted in a playroom setting in which a variety of age appropriate toys were provided to the mother and child.

Clinical Observations Between the Child and the Mother

JS was 15 months old at the time of the Crowell assessment and at the play observation. JS was appropriately dressed, presented as very thin but appeared his stated age. During both observations, when Ms. LS arrived, JS appeared happy to see her as evidenced by approaching the mother, smiling, and raising his arms to be carried. The mother responded to JS needs by smiling, picking him up, and giving him hugs and kisses. Prior to the commencement of the play interactions, Ms. LS began to cry when discussing her history and the removal of her child.

During the observations, Ms. LS presented with positive affect intermingled with anxious (high activity level and agitation) and sad mood. There were no signs of anger or hostility towards the child. Ms. LS exhibited brief episodes of sad and tearful mood; she verbalized to her son that she was "sorry" and that she wished he could live with her. She exhibited affection as evidenced by constant kisses and hugs. She was attentive as evidenced by her focused attention on the child, and expressed concern regarding the child's safety, development, and overall well-being. Even though the mother presented as well meaning in her interactions, her anxious mood was evident in the highly physically and verbally intrusive behaviors throughout the observations. The mother's intrusive behaviors led to difficulty in reading the child's non-verbal cues and causing constant frustration and dysregulation in the child. As a result, the mother responded with a pattern of escalating dysregulation. The mother's intrusive behavior and anxious state was evident in her increased motor activity, directing the play, repeatedly in the child's space with unwanted hugs, kisses, and toys, bombarding the child with verbal commands, repeating the word "No" constantly in an attempt to set limits despite age-appropriate behavior by the child, and constantly directing the child's attention to something new when already occupied with a toy.

Summary and Conclusions:

Upon referral from case worker, JS and his biological mother, Ms. LS, participated in a Child-Parent Assessment. Ms. LS was referred due to alleged history of substance abuse that contributes to concerns in the parent-child relationship.

At the time of the initial referral, JS' father was incarcerated for domestic violence. In addition, this clinician recommended that the father complete his Parenting Program prior to participating in the child-parent assessment with our agency. Currently, according to the case worker, he is out of prison and has completed his parenting program. Mr. BS has an appointment on February in order to start the child-parent assessment process due to his desire to regain custody of JS.

During the observations, Ms. LS presented with positive affect intermingled with anxious (high activity level and agitation) and sad mood. Ms. LS exhibited brief episodes of sad and tearful mood but she also exhibited positive affection, was attentive, and expressed concern regarding the child's safety, development, and overall well-being. Her anxious mood was evident in the highly physically and verbally intrusive behaviors throughout the observations.

The mother's intrusive behaviors led to difficulty in reading the child's non-verbal cues causing constant frustration and dysregulation in the child and as a result, the mother responded with a pattern of escalating dysregulation. This intrusive and anxious pattern in play led to difficulty in accurately reading the child's cues (misinterpreting the child's behavior and affect) and also led to difficulty responding with developmentally sensitive parenting behaviors that is needed to meet the physical and emotional needs of her child. If this pattern of interaction continues to define the relationship, the developmental progress of the child is likely to be influenced adversely.

JS presents with global developmental delays and challenging behaviors which is difficult for Ms. LS to handle. Ms. LS acknowledges these behaviors but is not confident in dealing with them and becomes anxious when discussing them. As described by his caregivers, JS has frequent temper tantrums, throws toys, screams, and hits himself against floor. JS is also described as clumsy and awkward; he falls all the time and bumps into walls. In all environments and with all caregivers (with mother, at school, and with foster mother), JS presents with high energy level, tantrums, loud cry, and difficulty with transitions. In addition, during meal times, JS presents with agitation and distress which makes it very difficult for him to chew and swallow foods. JS is a thin child and his foster mother is concerned about his low weight. When the foster mother is able to persuade JS to put food in his mouth, he chews very fast, stuffs his mouth with food, and most of the time spits out the food. Based on the symptoms reported by all caregivers, it appears that JS may be experiencing sensory processing difficulties in addition to his developmental delays.

Ms. LS expressed sincere regret and remorse regarding her use of drugs and alcohol while pregnant and after the birth of her child. Ms. LS describes her upbringing as chaotic, neglectful, and abusive and does not want the same life for her son. Ms. LS accepted responsibility for the allegations that led to the removal of her son and presented as a concerned parent with a strong desire to be reunified with her son. However, evaluation of reunification prospects should proceed with caution due to the mother's long term drug use, relapse after an inpatient substance abuse program, and reported continued daily struggle with sobriety.

Ms. LS reports a horrific history of child sexual molestation, rape, and teenage prostitution. Ms. LS will benefit from continued treatment from the XX Clinical Institute. It is extremely important that the therapist from the Clinical Institute be an experienced clinician trained in evidence based trauma therapy as Ms. LS has a traumatic history, with years of sexual abuse intermixed with substance abuse, she has a high probability of relapse, and she is at risk of continuous being a victim of domestic violence.

At this time, Ms. LS lacks a support system. This therapist is concerned that if Ms. LS is reunified with her son without a healthy support system, she will return to the pattern of depending on her mother in order to meet her needs and the needs of her child. In the past, the dependence on her mother has led to drug use and prostitution to support drug use.

Diagnostic Impression JS:

D-C 0-3R Diagnosis

Axis I:	R/O Regulation Disorder of Sensory Processing: 430: Sensory Stimulation-Seeking/ Impulsive R/O 601. Feeding Disorder of State Regulation
Axis II:	PIR-GAS =40 Disordered with mother-Anxious/Tense Relationship PIR-GAS= 85 Adapted with foster mother-No diagnosis
Axis III:	Prenatal exposure to cocaine, marijuana, and alcohol Developmental delay: communication, personal-social, social-emotional; borderline: gross motor, fine motor, problem solving
Axis IV:	Psychological Stress: Severe Source of stress- parental substance abuse (prenatal-1 month, 12 months), marital discord (birth-12 months) witness to domestic violence (11 months), maternal depression (birth-12 months), separated from biological parents/foster care (12 months-present), poverty (birth-12 months), parental arrest and incarceration (11 months), parent low education-without high school diploma (birth-present)
Axis V:	Emotional and Social Functioning Functions immaturely with all caregivers

Recommendations:

1. It is recommended that the mother participate in child-parent psychotherapy in order to address concerns in the relationship (decrease anxious mood and intrusive behaviors), assist with strategies on how to help reduce JS's challenging behaviors, and assist mother in establishing a healthy support system for her and her son.
2. Due to JS' history of challenging behaviors, which go back to infancy and occur in all settings, it is recommended that he should be evaluated by an Occupational Therapist experienced in Sensory Processing Disorders. This clinician will provide the case worker with the resource information for a referral.
3. It is recommended that the foster mother/case worker/mother consult with a pediatric neurologist in order to rule out medical factors, including but not limited to Fetal Alcohol Syndrome, which may be related to JS' developmental delays and social-emotional difficulties.
4. It is recommended that Ms. LS continue to participate in supervised visitation, at the foster mother's home, 3 times per week. In addition, Ms. LS should attend all of JS's school and medical appointments.
5. The mother presents with anxious mood and states that she does not feel her current medication is helping. It is recommended that Ms. LS' individual therapist at The XXX consult with her psychiatrist in order to address the ongoing anxious mood.
6. It is extremely important that the therapist from the XX Institute be an experienced clinician trained in evidence based trauma therapy that can effectively help Ms. LS with her traumatic childhood and adolescence, with years of sexual abuse and substance abuse that places Ms. LS at high risk of substance relapse, mental health instability, and domestic violence.
7. It is extremely important that Ms. LS be provided with resources that will assist with future financial stability so that she does not have to depend on others for financial support. The mother's past financial support is associated with negative relationship choices and drug use. This clinician can assist the case worker in locating vocational training resources.
8. If Ms. LS has not participated in domestic violence treatment for victims, then a referral is strongly recommended.

Thank you for the opportunity to be of assistance. This report has been produced following clinical observations and developmental assessments of the referred parties and is intended only as a summary.

_____ _____

(Professional signature and degrees) (Date)

Appendix 10

Sample Discharge Summary

To: Case worker, Center for XX

From: (Clinician)

Date:

RE: CHILD NAME: O

MOTHER'S NAME: M

CASE NUMBER: XXXXXXX

Discharge Summary

This report is to inform the court of the successful completion of child parent psychotherapy services for the parent, M, and her son, O, 36 months at the XX Center. The parent and child attended therapy weekly at the Center and often participated in home visits since (date), attending approximately 50 sessions. The parent and child have reached all treatment goals and have completed a Post assessment.

A home visit of the child was completed at the mother's new home as well as a visit to the child's present daycare center in order to observe the child in all settings. The child was observed to be comfortable and happy in each environment. No concerns were observed. Post ASQ and ASQ:SE screenings indicate that O is on target in all areas of development.

The parent was able to make improvements in the area of increasing her knowledge of her son's social emotional development and needs. This was the most important treatment goal and the primary target of the intervention, given the allegations of domestic violence and the serious family conflicts observed early in the case. Progress in this area has clearly been observed in therapeutic sessions; specifically in the relationship that Ms. M has built with the paternal grandmother, which she knows is in the best interest of her children.

The mother has acknowledged that she continues to struggle as a young single parent. Although she will be the primary caregiver of her son once she is reunified with her child, she will rely on the paternal grandmother for childcare support when she is working late or needs assistance. Ms. M reports to have made this decision in order to ensure that her son's emotional and physical needs are met. This decision was one which was difficult for M due to her history with the paternal family, understanding and processing these relationships was for months part of the therapeutic work. M has been able to gain insight about the secure bond that her son has with his paternal grandmother and presently can understand that the security in this relationship is healthy for her son. The insight reached represents the mother's ability to put her own needs aside and make a decision which is best for her child.

When interacting in sessions and during home visits, the parent and child are observed to display mutual positive affect, reciprocity, and affection. O is observed to be happy, relaxed and

comfortable in the presence of his mother and refers to her constantly through eye contact, gestures, and speech. O's enjoyment of play is enhanced by his mother's participation. Ms. M has been observed to be more developmentally appropriate in play and is observed to follow her child's lead during play which has increased his enjoyment of the interactions and has led to a reduction of negative behaviors. Ms. M has been observed to be sensitive and affectionate, offering praise and verbal approval when appropriate which O responds well to. By being more emotionally available to O in sessions, the interactions are observed to be more reciprocal and emotionally fulfilling for O than previously observed.

M reports to be abstaining from relationships which are unhealthy and harmful to herself and her child. She has discussed in child parent psychotherapy how she has used her trauma based therapy to process traumatic experiences from her childhood and has been able to verbalize in session how her traumatic history affected her relationship with her child and with those that are available to help her, such as the paternal grandmother. Ms. M and the maternal grandmother have reported that she is displaying appropriate boundaries between her personal and family life.

When with her son, M is reportedly taking him to child friendly events and has described in sessions activities she is doing with her child in the community. These activities are enjoyable and developmentally appropriate for the child such as attending local fairs, water parks, church activities, and parks. M has shown this therapist videos and pictures she took of her child enjoying these events and seems proud of her ability to engage in activities with him.

M's home was observed to have developmentally appropriate toys and space for her and her son to play. These changes in the parent's behavior indicate an increase in safety for her child when with his mother. M reports to understand the effect negative relationships can have on her child's emotional development and has verbalized in sessions an understanding how these relationships can harm her child.

M continues to maintain gainful employment, stable housing, and according to all collateral documentation has completed all required case plan services. Given the present observations, at this time it recommended that the parent and child continue with the present plan of reunification. Child Parent Psychotherapy will continue weekly to monitor the child's reaction to the reunification and to provide support to the parent during the reunification process.

_____

(Clinician's name)

Licensed Clinical XX

License Number: