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# Chapter 6: Summary of the 2018-2019 Early Childhood Court Evaluation

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Introduction

In 2018, the Office of Court Improvement (OCI) contracted the Florida Institute for Child Welfare (hereinafter, “the Institute”) to conduct a program evaluation of Florida’s Early Childhood Courts (ECCs). The purpose of the evaluation is to examine the implementation processes and outcomes among ECCs across the state, as well as child and family outcomes. In addition to determining the impact that the ECC approach has on recidivism, permanency, and reunification of families, the goal of this evaluation is to track the broader implementation of the ECC approach across the state, while identifying successful strategies and challenges encountered during implementation. Recommendations generated from the statewide evaluation will inform program improvements. Another goal of the evaluation is to examine ECC outcomes as compared to traditional dependency court outcomes in order to determine in what ways the approach may be more effective, efficient, child- and family-centered, and whether there is a cost-savings to be gained by using the ECC approach. The overall evaluation is a multiphase mixed methods study, with a particular focus on contrasting ECC processes and outcomes with traditional dependency court.

To assist in carrying out the evaluation, the Institute sub-contracted Dr. Jennifer Marshall of the University of South Florida (USF) College of Public Health Chiles Center for both her expertise in evaluation methods and familiarity with the ECC approach. Together, the Institute and USF staff completed two evaluation phases. In Phase One, the evaluation team collected and analyzed both quantitative and qualitative data from ECC team members, primarily professional team members across the state. Phase One data indicated that ECC is a multidisciplinary approach, with strong judicial leadership. Team members perceive ECC to be more compassionate and personal than traditional dependency court and that the increased frequency of meetings result in greater accountability and faster time to permanency. Participants shared several keys to success including communication, trusting relationships, parental engagement, and judicial leadership. Notably, an internal OCI analyst previously examined differences in key outcomes between ECC and traditional dependency court (for cases in 2014 and 2018), finding that ECC resulted in both faster time to permanency and less recidivism.
In Phase Two, which took place between January and May 2019, evaluators narrowed their foci to gain a more in-depth understanding of ECC processes and outcomes. This included four areas of inquiry, which are presented as chapters within this final report:

1. Seeking the perspectives of parents, caregivers, and foster parents
2. Exploring fidelity to the approach by individual ECC teams
3. Conducting a cost-effectiveness analysis
4. Comparing ECC processes and outcomes by coordinator funding source

EVALUATION TEAM
Florida Institute for Child Welfare
Lisa Magruder, Ph.D., MSW, is a Postdoctoral Scholar with the Institute. Her research focuses on violence, primarily intimate partner violence, as she examines the victimization experiences of vulnerable and marginalized populations as well as systemic collaboration among responding professionals. Lisa holds both a BS in psychology and sociology and an MSW from Florida State University as well as a PhD from the University of Denver Graduate School of Social Work. As a co-investigator, Lisa’s role in the 2018-2019 Florida Early Childhood Court evaluation was as Lead Evaluator for the Institute, which included contributing to the conceptualization and development of the evaluation plan; communicating with stakeholders; assisting in the development of evaluation measures; collecting, analyzing, and interpreting data; and disseminating findings.

Marianna Tutwiler, MSW, MPA, is the Program Director of the Institute. Prior to this position she was with FSU’s Center for Prevention and Early Intervention Policy. She directed a multi-million-dollar project to prepare the Young Parents Project for evaluation and to educate physicians, social workers, nurses, obstetricians, and early care coordinators that serve children and families in the child welfare system about toxic stress and increase their understanding and appreciation for infant and early childhood mental health. While working 12 years for the Lawton and Rhea Chiles Center at the University of South Florida, she was the Principal Investigator for over $10 million of contracts and awards that addressed the needs and/or evaluated the outcomes of vulnerable families. Ms. Tutwiler’s role in the 2018-2019 Florida Early Childhood Court evaluation was as project manager.

Jessica Pryce, Ph.D., MSW, is the Executive Director of the Institute. She has extensive experience in curriculum development and graduate-level instruction. In addition, Dr. Pryce provided technical assistance to the Administration for Children Services’ (ACS) Professional Development Program, which is located in New York City. In this role, she was actively engaged in procurement procedures in order to select individuals who had experience and skill in training child welfare workers. She also monitored ongoing professional development by meeting with child welfare interns and their supervisors, organized workshops and field days, and oversaw the annual capstone projects. She was also the principal investigator on a statewide Level 3 evaluation of Forensic Interviewing Best Practices Training, which was done by the National Child Advocacy Center. Dr. Pryce’s role in the ECC evaluation was Co-Principal Investigator.

The Institute would like to acknowledge Emily Joyce, Editor, and Alina Bachmann, Publication Graphic Artist, for their contributions to this report.

University of South Florida College of Public Health
Jennifer Marshall, Ph.D., MPH, is an Associate Professor with the USF College of Public Health. She conducts community-based systems research, assessing infant mortality prevention programs, safe infant sleep practices and interventions, family-centered care and access to services for families of children with birth defects, and infant mental health/early childhood court systems. Dr. Marshall holds a BA in psychology and child development from the University of Washington, and her MPH and Ph.D. from the University of South Florida. She completed her postdoctoral fellowship which involved conducting early intervention outcomes research in the Department of Teaching and Learning at the University of Miami. Dr. Marshall’s role in the ECC evaluation was to serve as Principal Investigator and to lead the USF components of the evaluation—qualitative, quantitative (survey), and case study design, data collection, analyses, and reporting.

Joanna Mackie, MPP, is a doctoral student at the University of South Florida College of Public Health in the Department of Community and Family Health. Her professional and research interests are centered on children ages 0-5 and their families. As a graduate research assistant on the ECC evaluation, Ms. Mackie assisted with evaluation tool development, data collection and analysis, reporting, and dissemination.

Tara Foti, MPH, is a doctoral candidate in the College of Public Health at the University of South Florida with a concentration in Community and Family Health. Her research interests involve family violence prevention, with a focus on improving pregnancy and early childhood outcomes for women who have experienced abuse, trauma, and stigma. She is planning to target her dissertation research on opioid use disorder during pregnancy. As a graduate research assistant for Dr. Marshall, Tara’s role in the ECC evaluation included assisting with evaluation tool development, data collection and analysis, and reporting and dissemination.

Ngozi Chukwuka Agu, MD, MPH, received her medical degree from University of Port Harcourt in Nigeria and her MPH degree in Maternal and Child Health from the University of South Florida. She is currently a doctoral candidate in the College of Public Health at the University of South Florida. Ngozi has expertise in mixed methods and is qualitatively trained. Her research interests include violence prevention, family violence, and child health. Ngozi worked as a research associate on the ECC evaluation.

Troy Quast, Ph.D., is an economist who received his doctorate in Economics from the University of Florida and his Master’s degree in Economics from The University of Texas. His research interests include the impact of economic conditions on health status, Medicaid policy, and the impact of natural disasters on health status and the utilization of health services. Dr. Quast conducted the cost effectiveness analysis for the ECC evaluation.
Chapter 1: Background

Lisa Magruder, Jennifer Marshall, Joanna Mackie, & Tara Foti

A BRIEF HISTORY OF EARLY CHILDHOOD COURTS

Early Childhood Court (ECC) emerged in the 1990s when a Miami judge began collaborating with a psychologist and early childhood expert on dependency cases. From there, ZERO TO THREE (ZTT), a national organization dedicated to the well-being and outcomes of babies and toddlers, developed the Safe Babies Court Team (SBCT) approach to dependency court. The problem-solving-court, the SBCT approach is meant to 1) protect vulnerable infants and toddlers from further harm, 2) address “the damage already done,” and 3) identify the structural barriers within the child welfare system that impede family success. Relying on judicial leadership, a local community coordinator, and a team of other stakeholders, families receive comprehensive services that address their myriad needs. Moreover, team members build rapport with parents by demonstrating dignity and respect, and work toward building “genuine relationships of concern and support.” There is some empirical evidence to support the use of the SBCT approach, with the California Evidence-Based Clearinghouse for Child Welfare (CEBC) listing it as having “promising research evidence.” McCombs-Thornton and Foster conducted a quasi-experimental study comparing foster care exit outcomes of children receiving ZTT court services and those receiving services as usual. Children in ZTT court most often exited foster care through reunification (37.6%), while children receiving services as usual were most often adopted (40.7%). Moreover, compared to children receiving services as usual, children receiving ZTT court services exited foster care faster, regardless of placement. The goal of the 2018-2019 Florida ECC evaluation is to explore how this promising approach is being implemented across Florida, with attention to processes, outcomes, and cost-effectiveness.

THEORETICAL FRAMEWORK FOR EVALUATION

Community Coalition Action Theory (CCAT) stems from previous community partnership models, using a Stage Theory to describe how a group of stakeholders come together to develop a coalition for a common purpose. CCAT specifically measures coalition development, functioning, synergy (working together collectively), and organizational and community changes that may lead to increased community capacity and improved health and social outcomes. Figure 1 shows the 14 constructs of CCAT. CCAT also considers community contextual factors such as sociopolitical climate, geography, history, and norms surrounding collaborative efforts.

METHODS

This section of the report provides a review of the primary research questions and overarching methods of the evaluation. Methodologies for specific components of the Phase Two evaluation are presented within each accompanying chapter. The evaluation follows the Centers for Disease Control and Prevention (CDC) Evaluation Framework (Figure 2), which includes:

- Engaging stakeholders by participating in the state, regional, and national ECC workgroups, meetings, and calls
- Describing the program by measuring ECC implementation statewide and by community monitoring the community
- Designing an evaluation framework that is useful and feasible for the OCI, the Institute, and ECC stakeholders
- Gathering credible evidence of ECC quality, effectiveness, and impacts through examination of existing data collected through surveys, focus groups, and interviews, with consideration of propriety/ethical conduct and accuracy/validity
- Justifying conclusions by compiling and synthesizing/ triangulating quantitative and qualitative results
- Ensuring the use of results and sharing lessons learned with all stakeholders through reports, briefs, and presentations.
Logic Model
Drawing on the Florida Early Childhood Court Best Practice Standards1 and the CEBC’s review of the Safe Babies Court Team,2 the evaluation team created a logic model to guide both process and outcome evaluation activities.6 The model considers the inputs (e.g., personnel) and outputs (e.g., activities, targets) of ECC, as well as short-, medium-, and long-term outcomes. Multiple phases of evaluation will be needed to address all elements of the logic model. Phase One of this evaluation explored the process of implementing ECC from the perspective of ECC team members, focusing primarily on the inputs and outputs of ECC. In Phase Two, the evaluation team continued to explore elements of the logic model across research activities. Findings as they relate to the Logic Model will be discussed in Chapter 6: Summary of the 2018-2019 Early Childhood Court Evaluation.

Research Questions
Across phases, the 2018-2019 Florida ECC evaluation aimed to answer the following four research questions:

1. How does ECC differ from traditional dependency court in terms of implementation (e.g., processes, staffing, parent involvement, focus on child development/infant mental health, costs) and outcomes?
2. Are some ECC teams more successful in their ECC implementation (i.e., fidelity to best practices/standards); and, if so, what factors lead to being successful?
3. What challenges and successes have been encountered in Florida’s ECCs?
4. Are there particular circumstances in which ECC may be significantly more effective than traditional dependency court?

Overarching Research Design
The present ECC evaluation is a multiphase design, wherein quantitative and qualitative data are collected and analyzed over several phases to address a particular program objective (i.e., evaluation).7 In the first phase, which occurred between July 1, 2018 and December 31, 2018, the evaluators implemented a parallel, convergent, mixed methods design.7 In this design, quantitative and qualitative data are collected concurrently, analyzed separately, and then merged in interpretation.7 In the second phase, which occurred between January 1, 2019 and June 30, 2019, the evaluators again implemented a parallel, convergent, mixed methods design.7

In the proceeding chapters, the evaluators present findings on each area of inquiry undertaken in Phase Two: 1) qualitative interviews with parents, foster parents, and caregivers served by Florida’s ECC teams; 2) assessment of fidelity to the ECC approach, both generally and by team; 3) a cost-effectiveness analysis of Florida’s ECC; and 4) an examination of the impact of community coordinator funding source. The final chapter aggregates and summarizes the findings of both Phases One and Two, and includes recommendations for ECC expansion.

Chapter 2: Parent and Caregiver Experiences of Early Childhood Court
Joanna Mackie, Tara Foti, Ngozichukwuka Agu, & Jennifer Marshall6

INTRODUCTION
In 2018, the evaluation team provided a comprehensive overview of Early Childhood Court (ECC), primarily from the perspectives of professionals affiliated with ECC teams (hereinafter referred to as “Phase One”). To enhance our understanding of how all stakeholders experience ECC, the team continued their qualitative inquiry through interviews with parents, foster parents, and non-relative caregivers. Including feedback from individuals in these integral roles enriches previous findings by identifying themes that were consistent across parents/caregivers and the professional team members as well as differing perspectives.

BACKGROUND
Findings from the 2018 report showed ECC professionals’ descriptions of team processes, including communication, collaboration, and conflict among the ECC team members; the various roles and responsibilities of ECC team members; how ECC-served families are selected to participate; common issues encountered by ECC-involved families, such as substance misuse and intimate partner violence (IPV); and how the ECC program overall compares to traditional dependency court.

METHODS
Data Collection
In Spring 2019, the evaluation team recruited potential participants (i.e., parents, foster parents, parent partners, relative caregivers, non-relative caregivers) through ECC community coordinators, ECC foster parent informal networks, and other ECC team members. The evaluators provided an electronic flyer to all community coordinators and ECC circuit judges/stakeholders, who were asked to communicate the opportunity to participate to ECC-served adults with whom they were working with or had worked with in the past six months. The evaluators also relied on snowball sampling by asking participants to refer ECC-served friends or acquaintances to the study.

In total, nine ECC-served caregivers from six counties reached out to the evaluation team to complete a telephone interview during March and April 2019. A member of the evaluation team reviewed the informed consent document with each participant to ensure their understanding of the risks and benefits of participation. Once verbal consent was obtained, an audio-recorded telephone interview was conducted. On average, interviews lasted approximately 30-45 minutes. Interviews were conducted with a semi-structured interview guide adapted from the one used with ECC professionals to include questions designed to elicit more depth and understanding of the unique experiences of parents and caregivers.

Data Analysis

The evaluation team transcribed all digital audio files verbatim, then uploaded transcripts to MAX QDA v12 for analysis. A hybrid deductive/inductive process was used for analysis: first, the a priori codebook from the Phase One evaluation with the ECC professionals was used to apply thematic analysis using constant comparison and deductive coding. Next, evaluators used inductive coding to understand and describe the themes that emerged from the data. This analysis process was selected because of the unique role of parents/caregivers, and the evaluators expected resultant themes to have some similarities with what the professional team reported, but also some differences. The two coders, who had previously established inter-coder reliability during the first part of the evaluation, met weekly to discuss, refine, and describe each theme using an iterative process. Evaluators also conducted code co-occurrence analysis to understand whether common patterns of code co-occurrences could illuminate specific aspects of parent/caregivers’ experiences in ECC.

The evaluators would like to note two important points ahead of the presentation of results. First, given many of the themes and patterns that emerged in the data are inextricable, data were, at times, coded to more than one concept. For example, a particular quote might exemplify both Trauma and Intimate Partner Violence (IPV) or Logistics and Time. Second, throughout the results of this chapter, a child’s “parent” is referred to as “parent” or “biological parent.” While the evaluators acknowledge that not all ECC-served parents are a child’s biological parent, this language was chosen to both honor the words used by the participants and easily differentiate between parents and foster parents.

RESULTS

Of the nine participants, most were foster parents (n = 6), though there was some representation from parents (n = 2), and a non-relative caregiver (n = 1). Given the small sample size, the results are aggregated in this report to maintain participant confidentiality. For context, participant role will be provided, though exemplar quotes will be labeled (e.g., Participant A, Participant B) to further protect participant identities. All references to counties, locations, or agency names have been removed.

As previously noted, the same codebook developed for qualitative data collection with ECC professionals was applied to the present analysis. There were several notable changes to the initial codebook based on what emerged in the present interviews. First, parent/caregiver respondents spoke about ECC professional team members more in terms of their relationships and interactions with each other (i.e., parent and foster parent/caregiver). This was in contrast to professional team respondents, who spoke more in terms of ECC professionals’ roles and responsibilities. Second, parents and caregivers spoke about time both in terms of quicker time to permanency and the intensive time commitment of participating in ECC services. Thus, the code Time was used to capture both concepts. Third, parents/caregivers did not describe Team Conflict and Collaboration, so a new code, Logistics, was used for their descriptions of ECC processes. In total, 44 codes and sub-codes were used in the analysis.

Six themes emerged from the parent/caregiver interviews:

1. Relationships
2. Judicial Leadership
3. Characteristics of ECC Families
4. Logistics
5. Community and Agency Context
6. ECC versus Traditional Dependency Court.

Each of these themes is described in more detail below.

Theme 1: Relationships

Relationships emerged as a central theme from these interviews. It covered myriad important aspects of ECC, including relationships between parents and foster parents/caregivers as well as relationships between parents/caregivers and members of the professional ECC teams. Within the broad parent code of Relationships are the sub-codes of Trust, Communication, Power, and Emotions.

Trust was described as an integral part of ECC processes. Trust operated between biological parents and foster parents/caregivers regarding the care of the child(ren) and engaging in ECC activities, such as meetings, hearings, and visitations. In addition, parents/caregivers had to trust members of the professional team to provide appropriate support. One foster parent explained that she could trust the professional team to be there to provide ongoing support and information when others weren’t available. Trust was facilitated by open and clear communication across caregivers and providers. Respondents described using phone calls, text, and Facetime in addition to face-to-face communication to work out important issues. Power also played a key role in ECC relationships, especially with the clear power differential between biological parents and foster parents. In addition to custody of the child(ren), more than one foster parent mentioned having graduate-level training in education, giving them a resource of applicable information and expertise relative to the biological parents. Finally, emotions were described as running high during many ECC moments. Respondents described instances of others, usually parents, crying or walking out of the room during difficult moments. One foster parent described a parent who “just started bawling” (Participant H) during their first meeting, illustrating the enormous stress that parents are feeling during key moments in the ECC process.

Relationships Between Parents/Caregivers

Parents and caregivers are the experts on the children, and as such, are critical participants to engage in ECC processes. As one respondent said: “I know [this baby] because I’m with her 24 hours a day” (Participant D). Supportive relationships between parents and caregivers were described as facilitating ECC processes (e.g., meetings, visitations). For example, one foster parent described voluntarily driving the child to the parent and supervising an additional weekly visit beyond what the community agency could provide. She reflected on how that additional visit gave her special time with the mom, and they developed a bond: “I got the chance to know the mom and spend that time with her and just kind of ‘co-parent’...it just made it more of a connection for us” (Participant B).
A different foster parent also credits the ECC approach with supporting a positive relationship between herself and the child’s mom, stating “[the ECC approach] really normalized our relationship” with the parent. She described further how this parent walked into the courtroom and sat next to her, which signified that she was comfortable and viewed her as an ally (Participant C).

Several other respondents described positive relationships between parents and foster parents extending beyond the end of the ECC program. Participant E, a foster parent, described continuing the relationship with a foster child and mother even after reunification:

“Yes, [the child] was back. He was back and he actually was at my house. Two weeks ago, he spent the night with us on a Friday night and spent all day Saturday here and the parents picked him up Saturday afternoon. I still— his mom, if she has questions about anything or if she needs parenting advice, she still reaches out to me.

When parents and caregivers have strong relationships and they trust each other, it can facilitate decisions being made with the best interest of the child in mind, an important concept within the ECC approach. One foster parent described resolving a highly sensitive issue when a positive drug test meant that the biological parent could not have the child for an important planned holiday. Emotions were running high and the foster parent described trying hard to maintain trust with the biological parent even under very difficult circumstances, as well as acknowledging the child’s need to be with someone they know and trust. Participant D illustrated how trust can reflect across the child/foster parent/parent triad:

“We were able to sit down and hash it out and put together a plan that [was] not [what] mom and dad wanted, I figured it was in the best interest of the kids… I was able to say to [the mom]… ‘the [children]… can also come… with us and they can be with somebody that they know… honestly that was the best thing for the [children], to be with people that they knew… [during that time].’

This same foster parent described a similarly broad perspective of relationship building and fostering the whole family: “When we met [the parents] in court… we realized… these are real people and we need to treat them with dignity and love… To me it’s critical because I see it as a holistic approach to foster care—that we’re sort of fostering the whole family.”

However, negative relationships between parents and caregivers have the potential to impede ECC progress. Parents/caregivers acknowledged the unique situation of having a child placed in care with a person who is not the parent, which can present emotional challenges at various stages in the process. Participant C, a foster parent, shared her experience of a very young child referring to her as “mom” in the presence of the mother, and succinctly summarized the experience as a “really hard moment.” At times, these emotional challenges can influence parental participation. The same participant offered reflection on another specific parent interaction: “Then after, we all kind of… debrief and talk about what happened. Sometimes [the parent] sits in for that. Sometimes she really is upset and she leaves.”

In other situations, a perceived lack of engagement by the parent can create difficulty in the relationship between parents and foster parents. Participant F, a foster parent, describes their frustration with a parent:

“The [mother] never passed a single drug test… She never had stable housing. She only had a job for barely three months… There were so many things that she wasn’t doing… She wasn’t literally doing anything, so that’s why I think it was so aggravating that it continued to drag out.

This same participant shared that it is “not always a good idea to have a relationship with the [parent]” and described having to end communication when the parent “started getting ugly.”

Another foster parent (Participant C) described her disappointment in a parent who did not show up for important court hearings, but described how this was only one facet of the relationship: “When things are going really good, they are so good and we’re all going to lunch and celebrating [the child’s] birthday together and things like that. Then… she really went missing… [and missed the court date]… [but] we have some really good memories.”

Relationships between Parents/Caregivers and Professionals

Similar to how relationships between parents/caregivers are described as important for ECC processes, relationships between parents/caregivers and professionals are also important. The same sub-codes of Trust, Communication, Power, and Emotions could be seen in examples of parent/caregiver and professional relationships, although communication seemed to be described primarily as a mechanism for facilitating relationships.

One parent (Participant A) described feeling generally supported by her relationships with ECC professionals in the community, stating: “I have a great relationship with the two [people from a local agency]. One of them… we’re working on the therapy like child psychotherapy… and the other one, [name], she is more of the coordination of resources and what do I need, what do the kids need.” This same participant continued to describe how the open communication and strong positive relationships helped her to keep trying:

“All the people I’m surrounded with, the ECC coordinator, [name], and her [staff], and everybody that I work with, I feel I have an open line of communication… they all have open doors. There’s a lot of positivity. ‘You can do this,’ and even when things don’t work as well as I want them to, ‘Don’t worry about that. We’re going to keep moving forward.’ There’s just a lot of encouragement and a lot of positivity overall.”

Another parent similarly described how her relationship with an ECC professional team member facilitated her search for a job: “My case worker, she tells me about new jobs, that are hiring— she texts me all week long with new information. They’ve been great” (Participant G). This same participant continued on to describe in more depth how the entire ECC team has “gotten to know her” and helped her feel cared for and identified that she needs assistance without her having to ask:

“…Like I’ve said, they’ve gotten to know me and they could just tell something was off. I wasn’t saying anything and they always ask me, you know, ‘What’s going on?’”
Finally, participants described that they were expected to actively engage with the program and communicate with the professional team as well. Participant G, a parent, agreed there is an expectation for participation and she felt the team valued what she had to say: "They don’t just let me come in there and say nothing. They want to know what’s going on with me, how I’m doing… it’s nice… last week I was able to share [about a problem I was having] and not feel like it’s a burden.”

Theme 2: Judicial Leadership

During interviews and focus groups with the professional team in Phase One, respondents tended to describe the roles and responsibilities of various individual ECC participants. However, interviews with the parents/caregivers revealed a different perspective about the ECC team. Parents/caregivers were aware of the ECC team approach and that multiple professionals were involved. However, they described other ECC team members more in terms of their relationships with them rather than individual roles. In fact, in some instances, parents/caregivers did not clarify which ECC role they were talking about. In other words, when describing their interactions with ECC professional team members, they did not say, “I called the case manager or the child-parent psychotherapy (CPP) provider.” They said, “I called [name] and then…” This indicates that overall, there was less differentiation by parents/caregivers about ECC professional team members in terms of their role. However, parents/caregivers described having important relationships with a small number of key ECC professionals, and these relationships were often characterized as having frequent, trusting communication. (Some of these relationships are described in the previous section, Theme 1: Relationships.)

One key exception regarding parent/caregiver perspectives of the ECC team is the role of the judge. Several parents/caregivers described the role of the judge and their impression of them and explained how the judge influenced their experience of ECC processes. This confirms our findings from Phase One, during which professional team respondents described the judge as “setting the tone” in the courtroom and “coming to the table.” In addition, this is consistent with the national SBCT approach, which includes judicial leadership as an important component. Notably, other than the judge, parents/caregivers did not describe much in the way of other team member roles and responsibilities, except for a small number of descriptions of the case manager. This reinforces the significance placed on judicial leadership within ECC from the perspective of its service recipients.

Participant B, a foster parent, described her impression of the courtroom and the judge: “Her courtroom had shelves of books [and] stuffed animals and she actually did not sit up higher on a bench. She had a table down below that she sat at and was at the same level as everybody else.” This same foster parent continued describing their experience in the ECC courtroom and the judge’s role in helping them feel comfortable in a potentially tense situation:

> It was really [a] good and warm feeling. We were looking and expecting for something to be a bit more sterile or stoic and [the judge] was just someone more relatable…we were nervous anyway…[the judge] has made us feel a bit more comfortable and I guess not as intimidated and we could have been had it been a different type of court room.
Similarly, Participant H, a foster parent with multiple children, described how the judge facilitates a more family-friendly environment in ECC compared with traditional courtrooms. She described how the environment is supportive and collaborative, with multiple people helping her in a difficult situation, rather than "escorting her out":

I was walking into court...and this is partly because the judge who ran ECC. She's just like a very, she's very calm and informed, she's excited about this kid rather than just [being] very formal and [following] a checklist. Like if I walked into her courtroom with [my two very young children], and [one child is] having his tantrums...and then I got [one] asleep on my shoulder, instead of like, if I were to walk in any other dependency courtroom, I'd have the bailiff—like escorting me out. But in an ECC courtroom, like the ECC people are all of a sudden at my side [helping me].

Another foster parent, Participant C, was impressed with the judge's ability to navigate the complex needs of families, and the range of emotional experiences that are common in the ECC courtroom. She described observing the judge during previous cases while waiting for her own to come up:

These court cases will just go back, [to] back, [to] back... Basically, we, in a short span of 30 minutes, got to see...a family that has been reunified...The kids walked back to sit with their parents...It's like this really high moment. Then right after that, it was a family who had to sign over surrender and the child was going to live with [a relative caregiver] And that was really hard to see like watching this family crying because they get to spend their life together. Then, we're watching this family crying because they don't...Then, I thought of our judge. So, he's sitting up there. I mean that's his reality every hour, every day, every hour, and so this kind of taught me to give grace to him also.

Finally, the influence of the judge in ECC processes made an impression on parents as well. Participant A, a parent, described how important it was for her participation and progress to not feel "judged" by the ECC judge:

I did have a fallback...and I made a mistake...the first thing the judge said was, "I see we've had some struggle since our last court hearing. What can we do to make sure we keep you on the right track?" That was the first thing she said. She didn't judge me. [Soft crying] I mean, she's a judge, but you know what I mean...She didn't tell me how stupid I was. She didn't tell me I should know better. She asked what they could do to help me.

Because the child population in ECC is comprised of young children who have experienced maltreatment, some characteristics of ECC-involved families are straightforward: parents are often young, as one foster parent shares: "[biological mom] was 15 when she had [child]... she's only 18 now" (Participant C). In addition, ECC-involved families are virtually always experiencing high levels of risk behavior (i.e., substance misuse) and trauma (i.e., current or previous exposure to violence, involvement in child welfare and/or foster care). We heard about these characteristics in Phase One, from the professional team, and it was confirmed during the interviews with parents/caregivers in Phase Two.

In addition to these general characteristics, we heard more depth about the complexity of family situations, such as current or previous involvement with the child welfare or criminal justice systems. We also heard more detail about the children, who were not the focus of much discussion during the professional team interviews and focus groups in Phase One. This is understandable given that parents and caregivers are often more directly involved with the children and their daily activities. Finally, we heard more in-depth about children and parents' past trauma. Many of the ECC-involved family characteristics were deeply intertwined, and examples often included elements of more than one characteristic (e.g., substance misuse and IPV).

ECC-Involved Families: Children
Aligned with the focus of the intervention, ECC-involved children are very young, and many are infants during their participation in the program. Due to their experience of trauma during a sensitive developmental period, some ECC-involved children have developmental issues that need to be addressed. Foster parents and caregivers, because they are involved in the child's daily lives, indicated a deep awareness of the unique developmental and behavioral needs of ECC-involved children. Participant E shared: "[The child] had kind of a few delays." Similarly, Participant B says: "Our foster baby has had early developmental assessments." In addition, some foster parents/caregivers described ongoing behavioral issues related to trauma (also described in the Trauma section below). In one case, the child reportedly had an increase in tantrums and toileting accidents following changes in routine, such as when their regular transportation provider and parental visitation supervisor were out of town. Several parents/caregivers described taking children to therapy appointments. This differed from Phase One, when ECC professional team members spoke little about pediatricians, Part C/Early Steps, or developmental therapy providers (other than those providing CPP) as being involved in the ECC process.

Regarding the ECC program, another foster parent described how her knowledge of the child's experience in developmental services and school was an important part of ECC meetings, saying that during ECC meetings: "We typically just will speak to the development of [child] and so we’ll talk through how [child’s] speech therapy’s been doing and how [child is] doing in school and those kinds of things" (Participant C). Foster parents generally described knowledge and awareness of the child's developmental situation, and could communicate this to the larger ECC team.

Theme 3: Characteristics of ECC-Involved Families
Parents and caregivers had little to say regarding why their particular case was recommended for the ECC program. The two parent respondents indicated that they participated in ECC because their child was young and the process would be more efficient; however, in these interviews, this was not a major topic of discussion. This may reflect that the decision-making process of who to include in ECC is more a decision of the judge and community coordinator, or that the inclusion criteria differ from site to site.
ECC-Involved Families: Trauma

Trauma was a new code in Phase Two, used for descriptions of ECC-involved parents’ and children’s previous traumatic experiences. Trauma intersects with other codes, such as Dual Involvement (e.g., previous experience in foster care) and IPV. Children involved in ECC cases have already experienced the trauma of maltreatment and/or neglect, and sometimes this comes out in their behavior. A foster parent shared how past trauma influences the child in her care: “When we were first placed with her, like I said, she had no words. She was terrified of any knocks on the doors or any siren noises, police lights, or anything like that, any people that remind [her] of her past” (Participant C).

Similarly, another foster parent described how she had to learn about how the child in her care could be “triggered” by being reminded of past trauma:

...a lot of the times we would all [be] sitting eating dinner and things just seem[ed] totally normal, and you wouldn’t see anything that would seemingly trigger anybody, and then all of a sudden, [the child is] throwing her stuff, throwing her food, trying to hurt people just out of nowhere, and I didn’t understand how to stop it or how to help her or even why it was happening. (Participant H)

Addressing parents’ trauma is an important part of the ECC program, as one foster parent described: “[Child’s mom] and [child] had therapy session together to help work out whatever trauma his mom had had and that could be displaced onto her parenting styles with him” (Participant B). Another foster parent spoke about a mother and father who had experienced dual involvement and posttraumatic stress disorder, respectively, due to their own distinct traumatic experiences, indicating that past traumas negatively influence the parents’ capabilities to parent their child. (Participant E).

A parent shared her experience recognizing and working through her own childhood trauma: “It’s difficult because I, um, I myself am an ACE [Adverse Childhood Experiences] kid and I’m trying to prevent that for my little children” (Participant A). This same respondent went on to describe how childhood trauma impacts adult life:

You learn all these unhealthy things on your little childhood-pristine hard drive that’s absolutely clean and you know nothing else and then those grow into these awful behaviors that you don’t even realize. Other things come up and you find different negative tools for emotional avoidance, and sometimes you know better and sometimes you don’t.

ECC-Involved Families: Intimate Partner Violence (IPV)

Several respondents described IPV as a major element in ECC cases and in the lives of ECC-involved families. IPV is linked to Dual Involvement (as described in a previous section) because some parents experienced arrests as a result of IPV. Involvement in the criminal justice system could add to the complexity of an ECC case, as noted above with the child whose father is in prison in another county. IPV is also clearly linked to Trauma (as described in this section).

One parent/caregiver respondent described how in their case, both parents had previous arrests, the mother for domestic violence (IPV) and the father for “other things” (Participant I).

Another respondent (Participant C) described how IPV was the reason for the child’s removal:

The reason [the child] was removed from the home was domestic violence from her father and it kind of extended to her mom. Her mom had a [criminal] record as well… [and], but [she] ultimately didn’t understand or see why [the child] couldn’t be in the same home… [and she] wasn’t able to keep her safe.

Finally, one parent (Participant A) described how she had moved to another part of the state to get away from IPV and drug use of the child’s biological father. She also described how the impact of IPV can be complex and far-reaching, influencing her behavior even after she was away from him:

…it was a very unhealthy relationship, domestic violence and, and um yeah, drug use and, and things like that. So I left him…because I just couldn’t take it anymore. He was just not changing and there were some things that had become worse…. [but] after I had gotten here, I didn’t realize how it had affected me and in what ways it had affected me, um, including some difficulties I had in my childhood that also carried into that relationship and styles and behaviors that I didn’t recognize or see, and um but unfortunately affected me deeply without my realization.

ECC-Involved Families: Dual Involvement

In these interviews, we heard more from parent/caregiver respondents about the complexity of ECC-involved families. Dual Involvement became a code that was used for descriptions of any current or previous involvement in the child welfare or criminal justice systems by either biological parent. In fact, more than half of respondents (5 out of 9) mentioned dual involvement in some way. This indicates that this is an issue that is not uncommon and that it is salient in clients’ minds when they describe their experiences in ECC.
ECC-Involved Families: Substance Misuse

Misuse of substances, including alcohol and marijuana, was described by many participants. Comments included substance misuse in relation to the child’s father, turning to alcohol when not using drugs, and understanding the motivations/root causes for drug use. In several cases substance misuse intersected with IPV and mental health, and was also described as an important barrier to a co-parenting relationship between parents and foster parents/caregivers.

A parent provided an important perspective on their own struggle with substances, and the acknowledgement of the risks to the child that substances can pose: “I’ve been battling with addiction my whole life, but I felt like I was doing pretty well. I just had a slip but, you know, that slip could have made my baby fall off the bed and my baby was crying and I was too messed up to care for her” (Participant G).

Another respondent expressed her concern that substances are used to address untreated mental illness, and that screening for these issues should happen early in the ECC process: “Maybe that would be something that can be determined at the beginning of the case, if there is a substance abuse issue…because there could be some untreated mental illness. Part of that violence was mental illness that they’re not being treated for” (Participant I).

Still, even with help, substance misuse is a pervasive problem for ECC-involved families. A foster parent (Participant D) described their experience of biological parents returning to substance use after reunification and case closure:

They succeeded, they got their kids back and they made it and they did everything that was asked of them and then as soon as we weren’t in their lives on a daily or weekly basis they went back to everything that they wanted to do… substances in particular.

Finally, one foster parent described how substance misuse on the part of the parent has been a key issue in the case and in her relationship with the biological mom. She seemed to indicate that the mom’s substance misuse broadly influenced the overall case, describing the substance misuse issue as something “we” struggled with: “I know since then, she’s failed drug tests and things like that. I’m not sure if it’s something she struggled with while she was pregnant or even before then, but I do know that was definitely part of removal and even beyond. That is something we have struggled with” (Participant C).

Theme 4: Logistics

Given their unique point of view, parents/caregivers spoke about the ECC team processes differently than the professional team. Parents/caregivers tended to focus more on logistics, while the professional team described ECC team processes more in terms of conflict and collaboration. Therefore, a new code, Logistics, was used to capture these comments, which were primarily descriptions of negative or challenging experiences.

Parents/caregivers reported positively about the monthly court dates because everyone was updated regularly about the case. However, one or two participants commented that it can be a burden to attend too many meetings, especially for working parents/caregivers. In addition, some described confusion regarding scheduling. Additional negative comments provided were related to turnover or change in case workers or communicating changes in the child’s case plan. Parents/caregivers were sensitive to how difficulties in logistics, such as staff turnover, impeded ECC case progress. For example: “we went through three or four different case workers in the 10 months [the child] was with us. Each time that also slows the process down because I felt like they would come in and also start back over to see where the case was and re-evaluate mom so that definitely was huge in slowing some processes down” (Participant F).

Another foster parent shared the practical difficulty of getting out of work for frequent ECC meetings: “We were a little [annoyed] at how many meetings there were and you have a family team meeting and they come in for 20 minutes, but ours always took at least 40 minutes, and then a day or two later we would have court so I was getting out of work for this and it was a lot of missed time at the office” (Participant D). Another (Participant F) described feeling like they never knew about scheduled meetings with adequate notice: “a lot of times meetings are scheduled monthly and we weren’t finding out until last minute half the time when they were, what times they were.”

Finally, another respondent (Participant C) described how a paperwork mistake delayed the case, leaving the foster parents in limbo regarding their role and the possibility of adoption: “It was so disappointing. It wasn’t, like, anybody specifically on our team… it was a random [staff person who didn’t file a paper].”

On a positive note, a parent (Participant A) described asking for additional therapy time, and being accommodated to arrange a new schedule: “...so I’m getting more help and more counseling so that I can continue to do good things.”

Theme 5: Community and Agency Context

Participants tended to talk about community and agency context in terms of services, employment, transportation, and housing. ECC-involved families often needed services in the community in order to fully participate in the program, and they described service delivery experiences both negatively and positively. One foster parent (Participant B) described the reality of encountering a range of experiences in working with a community agency:

We have support workers [from a community agency] that kept us involved in what’s going on. We have a CA that is now really good. We had one that just didn’t seem to keep us involved in stuff before, but the one we have now is really—she stays on top of things. She talks to me. She lets me know, “This is what’s going on for mom’s case.” “This is what’s going on for the baby’s case.”

It was noted that teams do check in with participants to assess their needs. A parent (Participant G) described how at the monthly staffing meetings, ECC professionals ask what she needs in the way of community resources:

Every month, we get together at the staffing and they’re all very helpful. They ask what services can be provided to me for help. My case worker, she tells me about new jobs, that are hiring—she texts me all week long with new information. They’ve been great.

Another parent (Participant A) described the practical necessity of getting resources for transportation: “They helped me with Uber cards and then, now [that] I have a vehicle, they gave me a gas card.” She continued on to describe getting assistance with other
community resources: “[An agency staff member] does more of the coordination of resources—what do I need, what do the kids need, what can she help me get, what can she help me do…”

Still, not all experiences are positive, as a parent (Participant G) described her experience with a social services professional who came to the home:

They come to your house three times a week. That was not helpful at all. It was a waste of time. I didn’t get anything positive out of that. [Laughter] I don’t like to put anything down but… [the person was] very flaky. [They] never showed up on time. [They] wasted more of my time than [they were] actually here.

On another negative note, a foster parent (Participant E) perceived a local agency’s workforce as inexperienced due to low pay and high turnover:

These providers, to my knowledge, they can bill for their clinical services but they’re not necessarily getting paid to sit in an ECC team meeting and talk about the case or to sit in court or to testify. The hours they spend after they provided clinical services, for writing reports, they’re not necessarily getting reimbursed for that… The number of [providers] that I’m aware of that have come and gone in just [the past few years] is astronomical. (Participant E)

The same respondent elaborates further: “nobody wants to work 60 hours a week making $30,000 a year… it’s a huge funding issue… [and] at the end of the day, the kids are the ones that suffer.”

**Theme 6: ECC Versus Traditional Dependency Court**

The majority of respondents had experience in ECC as well as traditional dependency court, and many described the positive attributes of ECC as providing more encouragement, cooperation, optimism and praise. The salient characteristics of ECC that were described in Phase One, such as more frequent meetings, more timely processes, and compassionate practices, were confirmed in these interviews. In addition, parents/caregivers provided more depth on the time commitment of participating in ECC, the experience of being in the ECC courtroom, the focus on supporting biological parents, and accountability. Thus, the subthemes of Time, Child-centered, Parent-centered, and Accountability summed up comments related to ECC versus traditional court.

**Time**

Though the sample size of parents is small, initial evidence suggests the prospect of a quicker time to reunification can be a powerful motivator for parents. When asked why she chose to participate in ECC, one parent (Participant A) explained she did so because “they said that the court case would be more often… more hands-on… also potentially be a shorter amount of time and I would really get the help that I needed.” Similarly, Participant G, another parent, shared:

They said it would either mean—if I wasn’t doing what I was supposed to, I could lose my child quicker. If I was doing everything I was supposed to, then I could get her back quicker. For me, doing everything right, that was a blessing, to get her back quicker.

More frequent services and a greater time commitment were also described, especially by the foster parents (see also Theme 4: Logistics). One participant described how the time demands of participating in ECC is not compatible with working full time: “I’m a very big fan of Early Childhood Court, I feel like that is how all courts should be running. But also, when I tell my friends about it, I say, ‘Listen, if you’re working a full-time job and you’re not available to go to these team meetings, your unavailability breaks the whole point of ECC’” (Participant H). Another (Participant I) shared:

It’s difficult being a caregiver and getting off work every month at least twice a month, and that’s at least two days… and in addition, you may have children that are sick, or you have your own personal life and your own personal emergencies. I think that the actual ECC schedule, it can be a little demanding for those that are involved.

A final aspect of Time, which was also discussed in the Phase One interviews, is the overall timeline of ECC, and whether it provides enough time to appropriately address underlying challenges faced by parents (such as substance misuse). A foster parent (Participant D) who has experienced children reunified and then come back into their care, commented: “The hard lessons that I’m learning in other cases is that in order to deal with the underlying causes of substance abuse, you have to take an appropriate amount of time in order to do that.”

**Child-centered**

While in Phase One, discussion of ECC-served children was limited, in Phase Two, parents/caregivers described ECC as child-centered. One parent (Participant A) shared how she feels the team approach in ECC is ultimately focused on the child:

…at the end of the day, it is Team Kid or Kids. It’s team [names of children], [and] they’re focused and me too. Really, everything I’m doing, it’s for the kids’ safety and my kids’ health and to ensure that they’re okay and that… the focus is with them.

A foster parent (Participant C) described how ECC is focused on the best interest of the child, which allows for flexibility. This foster parent determined that it would be traumatic for the child to attend court, and when she approached the case worker with her concern, the caseworker gave the foster parent permission to not bring the child.

Participants also confirmed that the feeling in an ECC courtroom is different from regular court, and that it feels more child- and family-friendly (see also Theme 2: Judicial Leadership): “If you walk in, there are stuffed animals for them, snacks and drinks. I have a lot of cases [that aren’t ECC], and I will walk into those courtrooms and [if] one of my kids making a peep, they’re escorting me out. It’s a completely different situation [in ECC]” (Participant H).

Another foster parent (Participant D) described going from an ECC to a non-ECC case, and how different it was. They implied that there are many aspects of ECC that could be beneficial to other cases:

Well, our first ECC case was really our first experience with the whole system, and then we got a standard case… I think we were kind of shocked at how little communication there was, how little involvement there was with the non-ECC cases… the ECC model has so many good things in it that are beneficial outside of that model even.
Parent-centered

In addition to being child-centered, ECC was also described as parent-centered, though this aspect of the ECC program was described with some complexity. On the one hand, one parent (Participant A) described how she felt supported, especially by the ECC judge:

I feel like the judge... is very much rooting for the parent, very much wanting to have things go with the direction that's in favor of reunification and working on those things. She's very gracious and so to me, that stands out that she really seems to have passion for what she's doing, and she cares about the kids that come into her courtroom...

This same participant also described a specific experience of feeling highly supported by the ECC processes: "I had a lot of growth and done a lot of things right... I [had] praises about my visit and praises from my [dependency case manager] and just a lot of, a lot of good things said in, in both the family team meetings, and then the court later that day, [I] got a round of applause at the table as well as an applause from the judge."

Conversely, foster parents/caregivers expressed frustration that there may be too much focus on or too much time spent giving parents encouragement during team meetings and court. Participant I shared:

...but one thing I could say with my case is being focused more on the parents and their status instead of the status of the children. Because there have been times that you know, the entire meeting was focused on the parents, and I'm there as a caregiver and I have things to share about the children, and I'm at the very end of the meeting which is maybe one to two minutes to share something about the children.

Accountability

Similar to Phase One, participants described the benefits of accountability in the approach, largely due to more frequent meetings. Several foster parents talked about accountability in ECC, including Participant C: "I love the team approach... I think that's what works best, just the checks and balances, accountability, and making sure kids don't get lost in the system." A parent (Participant A) also described the high level of accountability in ECC:

Follow-up and follow-through and accountability, those are big things that personally I understand and follow... It's hard sometimes to feel like I have to be responsible for other things or extra things, but at the same time... I know I'm doing what I have to do and showing the enthusiasm and accountability for myself in trying to get through this the best as possible.

For parents, this expectation of accountability continues post-reunification: "They just need to make sure I'm not going to go back and start using again now that I have her back. They come and see me every other week, my case worker, and I get drug-tested once a month... They just make sure that I'm still doing what I'm supposed to" (Participant G).

However, some foster parents expressed concern that biological parents may not be ready or able to engage in the intensive ECC services. They wondered if all of the services were "enabling" parents rather than providing accountability, as Participant C said:

I think ultimately it really is up to the biological parent to decide [whether] the extra therapies and all of that is helpful... I think those supports are huge, but there's just that line of when does it become enablement... We realized with FaceTime... it was us being, 'Are you ready? Do you want to talk to your daughter? Do you want to talk to your daughter? Do you want to talk to your daughter?' instead of, 'Let her reach out. Let's see if there's something she wants'... So, that's something we're currently honestly just working through too.

Concern about the parents' ability to successfully engage with ECC was also described as not giving parents an "opportunity to fail" by a foster parent, Participant D, who had ECC-involved children return to care after reunification with biological parents:

In the ECC model it's so intense that you don't really give parents an opportunity to fail and it's not that I want parents to fail but if we're going to fail, I'd rather them fail during the ECC model while everybody's watching and so that we can keep the kid safe. When you remind them about the meetings and you remind them about it and you make sure that that they're there, you tell them how important it is, when you give them the blueprint for success and then help them accomplish that and then back out there is the potential that they're going to fail. What I wouldn't want to see is that the ECC model is a crutch for some families and it turns [out] that children are going home too soon.

CONCLUSION

Overall, parents and caregivers who participated in these interviews confirmed that the ECC approach utilizes a team approach that maintains a trauma-informed and child-centered focus, with a shared goal of problem solving to address family issues in order to determine the best placement for the child in a timely manner. In addition, participants provided greater depth on relationships among parents and caregivers, ECC-involved family characteristics, and the overall experience of ECC as a parent/caregiver participant. These interviews reinforced our findings from other components of the evaluation that communication, relationships, consistency in team members, and attention to the logistics of the ECC process are important for smooth and effective implementation of the approach.

Limitations and Strengths

This analysis was limited by the small number of participants. With only nine respondents total from six counties, findings may not be generalizable across ECC circuits. It is also possible that due to social desirability bias, participants may not have been forthcoming about all challenges experienced in ECC. To minimize this, we communicated that interviews were conducted as part of an independent evaluation team and trained and experienced interviewers along with an open-ended interview guide were employed to put participants at ease. In-depth interviews of ECC clients provided richness and depth to our understanding of their experiences that would be challenging to obtain with other methods. In addition, these findings reinforce some of the findings from Phase One, as well as provide important next steps for further research.
Next Steps

Within the group of caregivers, biological parents have a unique perspective that would benefit from further exploration. Unfortunately, in spite of recruitment efforts, only two biological parents participated in this evaluation. All caregivers provided rich information, but the biological parents can provide information that is essential for understanding how ECC can be successful in implementation and outcomes. Furthermore, foster parents and other caregivers come from a perspective of relative privilege compared to the biological parents, in terms of power/control over their own involvement in the case, their material resources, and knowledge and experience relative to the biological parents. Although not every biological parent is ready and able to engage in ECC services and put their child’s needs ahead of their own, some are, and there is likely a range of readiness. A case study of one or more dyads of providers (e.g., biological and foster parent of same child) could provide further depth into the relationships among caregivers, how the ECC program may facilitate or impede those relationships, and how those relationships, together with the trauma-informed ECC program, may influence outcomes. It would be prudent to seek the perspectives of individuals who experienced disparate outcomes (e.g., reunification, termination of parental rights) to understand each experience, as well as inform future programmatic efforts aimed at improving both child and parental well-being.

Chapter 3: Fidelity to the Early Childhood Court Approach

Lisa Magruder

BACKGROUND

In April 2018, the Dependency Court Improvement Panel drafted the Florida Early Childhood Court Best Practice Standards. The Best Practice Standards, which address nine overarching topics, have been approved by the Steering Committee on Families and Children in the Court and are awaiting approval by the Supreme Court of the State of Florida. The Best Practice Standards are based on emergent Safe Babies Court Team/Early Childhood Court research, though they also heavily borrow concepts from the Florida Adult Drug Court Best Practice Standards, for which there is more supportive empirical evidence.

METHODOLOGY

As part of the larger process evaluation, the evaluators relied on the survey data collected in Fall 2018 to examine fidelity to Best Practice Standards, as reported by professional ECC team members. Analysis began with 150 responses, representing 144 individual participants (i.e., some worked for more than one team and provided multiple responses). Cases were removed if they did not complete the entire survey ($n = 23$) as most only answered a few questions before exiting the survey. Thus, the final analytic sample size is 127, representing 121 individual participants. Notably, in the Fall 2018 evaluation report, responses of “I don’t know” were considered missing. In the present report, the evaluators chose to include these responses as their own answer category for several variables for informational purposes. Several Best Practice Standards-related items had high frequencies of “I don’t know” responses, which could indicate areas where additional training is necessary. Explanations of data analyses techniques are described with their respective best practice standard in the subsection Results: Implementation of.

The survey from which the data are drawn from was developed with best practices in mind and with input from the OCI. The Interim report provided an overview of how Florida ECCs were running. The present report extends analysis to directly link many of these items directly to the Best Practice Standards document, in order to provide more nuanced guidance to both the OCI and individual teams on fidelity to the approach. With that, this chapter presents aggregate data on how all ECC teams are functioning with respect to Best Practice Standards. This data was disaggregated and analyzed at the team level for the 15 teams that had at least five participants in their sample. Individual team reports are included as Appendix A. The evaluators would like to acknowledge that team inception varies from team to team, as does resources available to them based on their individual communities. Therefore, we encourage individual teams and the OCI to evaluate individual team reports with caution, paying particular attention to how the nuances of a particular team or community might impact their scores.

Quantitative analyses were conducted using IBM SPSS Statistics v25. The authors used guidance from Laerd Statistics for reporting of statistical tests and findings.

Determining Fidelity

The evaluation team assessed familiarity with Best Practice Standards, as well as fidelity to each of the nine best practice domains. For the purposes of this report, evaluators considered these to be ten distinct best practice domains. Each domain was evaluated for fidelity, as reported by team member perceptions. If the standards of a best practice domain was being met with little to no significant remedial action recommended, this was considered operating with fidelity to that domain. This was repeated for each domain and subdomain. Notably, Best Practice Standard VII (Multidisciplinary Teams) has several subdomains. Fidelity within all subdomains was required to be considered operating with fidelity for Best Practice Standard VII.

A score was then calculated based on how many of the best practice domains were considered as operating with fidelity. The evaluation team developed three levels of fidelity.
**Expected fidelity** occurs when 70 percent or more best practices are in place. **Developing fidelity** occurs when 40-60 percent of best practices are in place. **Beginning fidelity** occurs when 30 percent or fewer best practices are in place. Variables used in analysis for each domain are outlined below.

**Best Practice Domains and Associated Variables**

This section provides an overview of the ten best practice domains, along with the variables and analytic techniques used to determine fidelity.

**Familiarity with Best Practices**

While not a best practice in and of itself, the evaluators considered familiarity with the Best Practice Standards as part of fidelity to the approach. **Familiarity with Best Practice Standards** was assessed dichotomously (yes/no) through the item: “Are you familiar with Florida’s draft ECC Best Practice Standards?” For those who responded “yes,” a dichotomous (yes/no) follow-up item was presented: “Have you read Florida’s draft ECC Best Practice Standards?” This item represents **Engagement with Best Practices Standards Material.**

Frequencies were run on both items to assess responses. The familiarity data included in this report represents the 121 unique ECC professionals who responded to the survey. That is to say, for those professionals working on more than one team, data on familiarity with Best Practice Standards was only collected once.

**Best Practice Standard I: Target Population**

To assess fidelity to best practices in serving the target population, evaluators examined the existence of eligibility and exclusion criteria (Best Practice Standard I-A). Other best practices related to target population were excluded from examination as they are more subjective and dependent on the resources of a particular community or team (e.g., risk and need of children and families, criminal history disqualifications, clinical disqualifications).

**Presence of eligibility criteria** was assessed dichotomously (yes/no) with one item: “Does your ECC team have criteria for eligibility and exclusion for participation in ECC?” There was an “I don’t know” response option. For those who responded “yes,” written eligibility criteria were assessed dichotomously (yes/no) with one item: “Are these eligibility and exclusion criteria specified in writing?” For those who responded “yes” to **written eligibility criteria**, two additional questions were posed, both assessed dichotomously (yes/no), with an “I don’t know” option: 1) **reliance on written eligibility criteria** (i.e., “Does your ECC team rely on the written criteria for family eligibility?”); and 2) **communication of written criteria** (i.e., “Are eligibility and exclusion criteria communicated to potential referral sources (e.g., judges, attorneys, child welfare professionals, treatment professionals)?”).

Frequency analyses were run to assess responses.

**Best Practice Standard II: Disadvantaged Groups**

Best Practice Standards require that individuals from marginalized or oppressed groups be provided both equivalent access to ECC and equivalent treatment within ECC.

**Equivalent access to ECC and equivalent treatment within ECC** for marginalized groups was assessed with two items. Participants were prompted to think of “clients of marginalized groups” as those “who may have experienced discrimination or reduced opportunities because of their race, ethnicity, gender, sexual orientation, sexual identity, physical or mental disability, religion, or socioeconomic status.” Participants were asked how much they agree with the following statements: 1) “Individuals from disadvantaged groups have equivalent access to ECC participation compared to individuals not from disadvantaged groups;” and 2) “Individuals from disadvantaged groups receive equivalent treatment in ECC compared to individuals not from disadvantaged groups.” Response options ranged from 0 (strongly disagree) to 4 (strongly agree), with an “I don’t know” option. Frequency analyses were run for each item to assess how many participants endorsed each ordinal response option.

**Best Practice Standard III: Roles and Responsibilities of the Judge/Magistrate**

As a key member of the ECC team, judges/magistrates should interact frequently and respectfully with families and caregivers and consider the input of all team members. To protect the confidentiality of judges and magistrates who participated in the survey, the evaluators will not report on their professional training or length of service. In addition, we did not collect data on consistency of docket or judge-led permanency planning.

**Appropriate judicial demeanor** was assessed with a five-item scale developed from best practice language (e.g., sets a tone of dignity and respect, demonstrates an understanding of how traumatic experiences influence parental behavior). Response options ranged from strongly disagree (0) to strongly agree (4), with a range of 0-20 for total score; there was an “I don’t know” option, which was coded as missing. Participants who did not answer all five items were excluded from analysis.

**Judicial parental support** was assessed with a five-item scale developed from best practice language (e.g., offers supportive comments to parents, stresses to parents the importance of their commitment to treatment). Response options ranged from 0 (strongly disagree) to 4 (strongly agree), with a range of 0-20 for total score; there was an “I don’t know” option, which was coded as missing. Participants who did not respond to all five items were excluded from analysis.

**Judicial caregiver support** was assessed with a four-item scale developed from best practice language (e.g., acknowledges the critical role caregivers play in the lives of children and parents, thanks caregivers for their role in the ECC process). Response options ranged from 0 (strongly disagree) to 4 (strongly agree), with a range of 0-16 for total score; there was an “I don’t know” option, which was coded as missing. Participants who did not respond to all four items were excluded from analysis.

**Inclusive judicial decision-making** was assessed with a three-item scale developed from best practice language (e.g., considers input from the multi-disciplinary team members). Response options ranged from 0 (strongly disagree) to 4 (strongly agree), with a range of 0-12 for total score; there was an “I don’t know” option, which was coded as missing. Participants who did not respond to all three items were excluded from analysis.
Best Practice Standard IV: Child Parent Therapy

Per Best Practice Standard IV.A, “an infant mental health specialist conducts an in-depth clinical assessment of the parent, the child, and the attachment relationship, which informs the case plan and treatment plan.” Evaluators assessed the implementation of infant mental health assessments with one dichotomous (yes/no) item. There was an “I don’t know” option.

Due to the small and potentially identifying sample size of child-parent therapy providers, the evaluators did not collect data on evidence-based based treatment modalities implemented or provider training and credentials. In addition, treatment intensity and duration was not explored as this is subjective and individual to families served.

Best Practice Standard V: Additional Treatment and Social Services

In addition to the infant mental health assessment, professionals well-versed in early childhood development and trauma should perform additional assessments to determine needed treatments, both for children and parents. The ECC team should provide additional treatment and social services to all families served, as necessary. Given that necessary additional treatments and social services are individual to each family, the evaluators did not collect data on specific services (i.e., substance abuse and mental health treatment, additional supports and services); rather, the evaluators provide an accounting of team members’ perceptions of assessments performed. This was measured dichotomously (yes/no), with an “I don’t know” option for eight types of assessments: 1) trauma assessment (child); 2) medical exam (child); 3) developmental screening (child); 4) dental exam (child); 5) parent-child relationship assessment; 6) mental health assessment (parent); 7) trauma assessment (parent); and 8) assessment of other needed resources (e.g., transportation, housing assistance, parent medical/dental treatment, vocational/educational programs).

We also assessed post-reunification treatment, supports, and services. Post-reunification support was assessed with a check-all-that-apply response option, including: 1) support groups; 2) home visitation; 3) ongoing counseling; 4) Head Start/early childhood education or childcare; and 5) early intervention (Early Steps, or developmental therapies/services). Frequency analyses were run to determine how many participants endorsed each type of support (i.e., said “yes” as opposed to “no,” “I don’t know,” or missing responses).

The evaluators also collected data on infant mental health specialists’ use of the Progress in Treatment Assessment (PITA), which was measured dichotomously (yes/no) with an “I don’t know” option. A frequency analysis was run to assess responses. If the participant reported they use the PITA, a follow up item was presented to assess Updates to PITA: “Is the PITA regularly updated as case plan interventions move forward?” This was measured dichotomously (yes/no) with an “I don’t know” option. A frequency analysis was run to assess responses. Please note, due to the potentially identifying nature of the responses within a team context, the evaluators have elected not to include information about infant mental health specialists’ use of the PITA in individual team reports. However, it is included in the results below in aggregate form.

Best Practice Standard VI: Family Time

The ECC team should ensure both frequent and meaningful contact between parents and children. Family time was assessed with two items to address adherence to Best Practice Standards. Participants were asked how much they agree with the following statements: “When ECC parents have family time with their child(ren): 1) it is frequent; 2) it is meaningful.” Response options ranged from 0 (strongly disagree) to 4 (strongly agree). There was also an “I don’t know” option. Frequency analyses were run for each item to determine how many participants endorsed each ordinal response option.

Best Practice Standard VII: Multidisciplinary Team

ECC requires the participation of numerous professionals to best meet the needs of the families it serves. The community coordinator, with the judge, co-leads the team and acts as a liaison between the judge and other team members. The team should hold both monthly team meetings and status hearings, and be trained in topics pertinent to ECC.

Community Coordinator

Fulfillment of community coordinator responsibilities was assessed with eight individual, ordinal items developed from best practice language. These responsibilities are drawn from both the Best Practice Standards and the Essential Components of The Safe Babies Court Team approach. Participants were asked to indicate how much they agree with eight statements (e.g., the community coordinator works to: act as a liaison between the judge and the ECC team, identify potential resources for families). Response options ranged from 0 (strongly disagree) to 4 (strongly agree), and there was an “I don’t know” option.

Family Team Meetings

Monthly family team meetings are an essential component of Early Childhood Court, where team members (excluding the judge) should convene for case planning and monitoring. Frequency of family team meetings was measured dichotomously (yes/no) through the item: “Does your ECC team have at least one family team meeting per month?” An “I don’t know” option was provided. A frequency analysis was run to assess responses.

The family team meeting leader, should be the community coordinator, in accordance with Best Practice Standard VII-B2. This was assessed with one item (i.e., Which role leads the family team meetings). Response options included community coordinator; someone else, please specify role; and I don’t know. A frequency analysis was run to determine how many participants endorsed each categorical response option.

Family team meeting activities were assessed with a check-all-that-apply response option, and included: addressing concurrent planning, ensuring placement stability, monitoring transitions in placement, assessing treatment progress, assessing progress with case plans, considering additional needs of the families, and considering strengths of the parents. Frequency analyses were run to determine how many participants endorsed each activity (i.e., said “yes” as opposed to “no,” “I don’t know,” or missing responses).
**Team Communication and Decision-Making**

Qualitative data indicate that, in general, Florida ECC team members perceive there is respectful communication between team members,\textsuperscript{11} though this was not measured quantitatively by team. Individual teams should consult Best Practice Standard VII-D to determine if they are meeting communication standards (e.g., execution of memorandums of understanding).

Team members’ satisfaction with team decision-making was assessed using a three-item adapted version of the decision-making subscale of the Partnership Self-Assessment Tool.\textsuperscript{14} Because the scale demonstrated poor reliability in the Fall 2018 analysis, the evaluators presented response option frequencies for each of the three items, which range from strongly disagree to strongly agree, and includes an “I don’t know” option.

**Status Hearings**

Per Best Practice Standards, status hearings should be held monthly and be consistently attended by team members. In addition, team members are expected to make relevant contributions for the court’s consideration. And, while not an explicit best practice, the OCI recommends teams attempt to resolve issues and craft recommendations prior to attending court.

**Frequency of ECC hearings** was assessed categorically with response options of less than once per month, once per month, and more than once per month. There was also an “I don’t know” option. A frequency analysis was run to determine how often ECC hearings are held.

ECC hearing activities were assessed by three dichotomous variables (yes/no): 1) consistent hearing attendance (i.e., “In general, do team members attend ECC hearings consistently?”); 2) hearing contributions (i.e., “In general, do team members contribute relevant information and recommendations for the court’s consideration?”); and 3) pre-hearing preparedness (i.e., “In general, do team members resolve most case issues and craft recommendations prior to ECC hearings?”). Frequencies were run on all items to assess responses, include the “I don’t know” option.

**Team Trainings**

ECC team members should be trained in best practices prior to working on the team and should participate in continuing education on at least an annual basis. Team members should also receive training on trauma-informed care, adverse childhood experiences, and the impact of trauma. The training data included in this report represents the 121 unique ECC professionals who responded to the survey. That is to say, for those professionals working on more than one team, training data was only collected once.

Annual training participation was measured dichotomously (yes/no) through the item: “Do you participate in ECC-related training on at least an annual basis?” A frequency analysis was run to assess responses.

Both training received and training needed were assessed dichotomously (yes/no) across thirteen topics. There were missing data for many responses, which could indicate that instead of responding “no,” participants did not respond at all. Thus, during analysis, evaluators decided to present training received and training needed as the frequency with which participants endorsed each topic (i.e., said “yes” as opposed to “no,” “I don’t know,” or missing responses).

**Best Practice Standard VIII: Early Childhood Court Caseloads**

The ECC should serve as many eligible families as possible, while maintaining fidelity to the approach. Arbitrary caseload caps are discouraged, and instead should be set based on community need and resources, as well as the capabilities of the team to carry out ECC best practices. Best Practice Standards suggest that program operations be carefully monitored if the ECC caseload size exceeds 20.

**Number of ECC cases** was assessed as the participant’s current number of ECC cases on a particular team. As this was an open-ended item, evaluators recoded the item, using a midpoint if a range was given (e.g., “5 to 10” = 7.5). In some instances, participants noted the number of children, rather than number of cases. For consistency of the variable, these participants’ responses were excluded from analysis. Descriptive statistics (i.e., mean, standard deviation) on caseload size are provided.

**Perception of caseload size** was measured by asking if the participant considered their number of ECC cases to be too high, too low, or about right. A frequency analysis was run to determine how many participants endorsed each categorical response option.

**Best Practice Standard IX: Monitoring and Evaluation**

Outside of family team meetings and status hearings, ECC teams should meet at least quarterly to discuss ECC-related issues. In addition, several best practice topics should be addressed: discussion of available services in the community, review of data, identification of gaps in services, and discussion of issues and patterns observed in the cases being monitored by the team. While this is considered a function of the multidisciplinary team (Best Practice Standard VII), the evaluators included it as part of monitoring and evaluation efforts given the best practice topics of discussion.

**Frequency of other meetings** was assessed with one item: “Other than family team meetings, how frequently does your ECC team meet to discuss ECC-related issues?” Response options included weekly, bi-weekly (every other week), monthly, bi-monthly (every other month), quarterly, semi-annually (twice per year), annually, never, and other (please specify). Frequency analyses were run to determine how many participants endorsed each response category. An “I don’t know” option was included.

**Other meeting activities** were assessed with a check-all-that-apply response option and included: discussion of available services in the community, review of data, identification of gaps in services, and discussion of issues and patterns observed in the cases being monitored by the team. Analyses were run to determine the frequency with which participants endorsed each activity (i.e., said “yes” as opposed to “no,” “I don’t know,” or missing responses).

In addition to ongoing monitoring and evaluation efforts, Best Practice Standard IX-C1 necessitates an independent evaluator to examine fidelity to ECC best practices every five years. The 2018-2019 Early Childhood Court Evaluation meets this Standard.
Additional Data
In addition of the Best Practice Standards, the evaluators collected additional data from ECC team members on team processes. Individual teams should interpret these findings within the context of their particular team (e.g., how established the team is, available resources). These data were not included in the analysis of best practices fidelity, though are provided as additional guidance to leadership on the status of their teams.

Team Membership

Perceptions of Peers
Perceptions of peers was assessed with three items: perceptions of adequate peer training, perceptions of peer qualifications, and perceptions of team’s reflection of client diversity. Items were measured ordinaly on a five-point Likert scale, with response options ranging from 0 (strongly disagree) to 4 (strongly agree). Frequency analyses were run on each item to determine how many participants endorsed each ordinal response option. An “I don’t know” option was also included.

Team Synergy
Team synergy was measured using a nine-item adapted version of the Synergy subscale of the Partnership Self-Assessment Tool. Response options ranged from 0 (strongly disagree) to 4 (strongly agree), with a range of 0 to 9 for total scale score; there was an “I don’t know” option, which was coded as missing. Cases were removed if they did not respond to all team synergy items. A higher score indicates greater reported synergy.

Perceived Turnover
Perceived team turnover was assessed dichotomously (yes/no) with one item: “Do you consider team turnover to be problematic on your ECC team?” A frequency analysis was run to assess responses. An “I don’t know” option was also included.

Perceptions of the Job and Team

Community Coordinator Leadership
Community coordinator leadership was measured using an eleven-item adapted version of the Leadership subscale of the Partnership Self-Assessment Tool. Response options ranged from 0 (strongly disagree) to 4 (strongly agree), with a range of 0 to 44 for total scale score; there was an “I don’t know” option, which was coded as missing. Cases were removed if they did not respond to all community coordinator leadership items. A higher score indicates greater reported leadership.

Time Pressure
Time pressure in role was assessed using an adapted five-item scale originally developed by the Butler Institute and used in the Comprehensive Organizational Health Assessment (COHA). Response options ranged from 0 (strongly disagree) to 4 (strongly agree), with a range of 0 to 20 for total scale score. Responses were removed if they did not respond to all time pressure items.

Self-Efficacy
Self-Efficacy in role was assessed using a five-item self-efficacy scale used in the COHA. Response options ranged from 0 (strongly disagree) to 4 (strongly agree), with a range of 0 to 20 for total scale score. Responses were removed if they did not respond to all self-efficacy items.

Participation Satisfaction
ECC Participation Satisfaction was assessed using a five-item adapted version of the Satisfaction with Participation subscale of the Partnership Self-Assessment Tool. Response options ranged from 0 (strongly disagree) to 4 (strongly agree), with a range of 0 to 20 for total scale score. Responses were removed if they did not respond to all participation satisfaction items.

Participation and Inclusion
Drawing from Best Practice Standards language, the evaluation team assessed both parent and caregiver inclusion with five-item scales. Participants also provided their perceptions of frequency of parental participation.

Parental inclusion was assessed with a five-item scale developed from best practice language (e.g., the parents we serve are given an opportunity to actively participate in the ECC process; when a parent’s request cannot be accommodated, the team takes time to provide a clear explanation for them). Response options ranged from 0 (strongly disagree) to 4 (strongly agree), with a range of 0-20 for total scale score; there was an “I don’t know” option, which was coded as missing. Participants who did not answer all five items were excluded from analysis.

Caregiver inclusion was assessed with a five-item scale developed from best practice language (e.g., caregivers are given an opportunity to actively participate in the ECC process, ECC team members check in with caregivers to ensure they have necessary supports). Response options ranged from 0 (strongly disagree) to 4 (strongly agree), with a range of 0-20 for total scale score; there was an “I don’t know” option, which was coded as missing. Participants who did not respond to all five items were excluded from analysis.

Parental participation was assessed with the item: “Approximately what percentage of parents in your ECC actively participate in the ECC process?” Categorical response options include 0-25 percent, 26-50 percent, 51-75 percent, 76-100 percent. There was also an “I don’t know” option. A frequency analysis was run to determine how many participants endorsed each categorical response category.

Special Topics

Opioids
Concern for opioid-related issues was assessed dichotomously (yes/no), with an “I don’t know” option through the item: “Do you consider opioid-related issues to be a concern among the families you work with on your ECC team?” For those who indicated “yes,” three statements were presented to assess their perception of their team’s preparedness to address opioid-related issues through training, knowledge, and available community resources, with response options ranging from 0 (strongly disagree) to 4 (strongly agree). An “I don’t know” option was also included. Frequencies were run on all items to assess responses.
**Intimate Partner Violence (IPV)**

Concern for IPV was assessed dichotomously (yes/no), with an "I don’t know" option, through the item: "Do you consider intimate partner/domestic violence to be a concern among the families you work with on your ECC team?" For those who indicated "yes," three statements were presented to assess their perception of their team’s preparedness to address IPV through training, knowledge, and available community resources, with response options ranging from 0 (strongly disagree) to 4 (strongly agree). An "I don’t know" option was also included. Frequencies were run on all items to assess responses.

**SAMPLE**

The sample used for these analyses includes 127 responses from 121 unique participants. Among the 121 respondents, the most frequently reported role was attorney (21.5%), while the least frequent was other team member. Figure 3 provides a breakdown by role. Note, other team members include roles such as administrative staff and community partner, while other service providers include roles such as mental health, substance abuse, and IPV service providers.

Participants represented teams from all across Florida. At the time of data collection, there were 21 ECC teams. Twenty teams had at least one team member participate in this survey. See Table 1 for a breakdown by team (labeled by the Judge/Magistrate presiding over the court at the time of data collection).

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**Table 1. Survey participants’ reported teams (N = 127)**

<table>
<thead>
<tr>
<th>Team Membership</th>
<th>Frequency (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Judge Allen</td>
<td>5.5% (7)</td>
</tr>
<tr>
<td>Judge Bristol/Magistrate Boven</td>
<td>3.9% (5)</td>
</tr>
<tr>
<td>Judge Curley</td>
<td>6.3% (8)</td>
</tr>
<tr>
<td>Judge Dees</td>
<td>7.1% (9)</td>
</tr>
<tr>
<td>Judge Essrig</td>
<td>3.9% (5)</td>
</tr>
<tr>
<td>Judge Jolley</td>
<td>2.4% (3)</td>
</tr>
<tr>
<td>Magistrate Kissner</td>
<td>4.7% (6)</td>
</tr>
<tr>
<td>Judge Kroll</td>
<td>0.8% (1)</td>
</tr>
<tr>
<td>Judge Latimore</td>
<td>5.5% (7)</td>
</tr>
<tr>
<td>Magistrate Lord</td>
<td>7.9% (10)</td>
</tr>
<tr>
<td>Judge Patterson</td>
<td>3.9% (5)</td>
</tr>
<tr>
<td>Magistrate Pedroso</td>
<td>0.8% (1)</td>
</tr>
<tr>
<td>Judge Polson</td>
<td>7.9% (10)</td>
</tr>
<tr>
<td>Judge Robinson</td>
<td>3.1% (4)</td>
</tr>
<tr>
<td>Judge Sjostrom</td>
<td>6.3% (8)</td>
</tr>
<tr>
<td>Magistrate Strawbridge</td>
<td>6.3% (8)</td>
</tr>
<tr>
<td>Judge Tepper</td>
<td>10.2% (13)</td>
</tr>
<tr>
<td>Judge Todd</td>
<td>3.9% (5)</td>
</tr>
<tr>
<td>Judge Walker</td>
<td>4.7% (6)</td>
</tr>
<tr>
<td>Judge Warren</td>
<td>2.4% (3)</td>
</tr>
<tr>
<td>Not Provided</td>
<td>2.4% (3)</td>
</tr>
</tbody>
</table>

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**RESULTS: IMPLEMENTATION OF BEST PRACTICE STANDARDS**

**Familiarity with Best Practice Standards**

All but one participant indicated their familiarity with ECC’s Best Practice Standards (n = 120), with 78.3 percent reporting they are familiar with them and 21.7 percent reporting they are not. Of the 94 participants who said they are familiar with the Best Practice Standards, 75.5 percent have read them. Notably, this data represents the unique ECC professionals who responded to the survey. That is to say, for those professionals working on more than one team, familiarity with best practices was only collected once.

**Recommendations**

1) The OCI should ensure all teams have received the most recent Best Practice Standards and assist teams in understanding expectations.

2) Judges/magistrates and community coordinators should co-lead a team review of ECC Best Practice Standards to ensure consistent understanding of expectations among all team members.
Best Practice I: Target Population

Based on 126 responses, 86.5 percent of participants agreed that eligibility criteria exist for their ECC team, of which 50.5 percent confirmed the criteria are in writing (see Table 2). Notably, nearly two-fifths did not know if criteria were written. Of the 55 participants who indicated criteria is written, 72.7 percent agree is relied upon and 81.8 percent agree it is communicated to referral sources.

Table 2. Meeting the target population

<table>
<thead>
<tr>
<th>Eligibility criteria for ECC-involved families</th>
<th>Yes</th>
<th>No</th>
<th>I don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria exists ( (n = 126) )</td>
<td>86.5%</td>
<td>1.6%</td>
<td>11.9%</td>
</tr>
<tr>
<td>Criteria is written ( (n = 109) )</td>
<td>50.5%</td>
<td>10.1%</td>
<td>39.4%</td>
</tr>
<tr>
<td>If written, relied upon ( (n = 55) )</td>
<td>72.7%</td>
<td>9.1%</td>
<td>18.2%</td>
</tr>
<tr>
<td>If written, communicated to referral sources ( (n = 55) )</td>
<td>81.8%</td>
<td>1.8%</td>
<td>16.4%</td>
</tr>
</tbody>
</table>

Recommendations

1) Ensure all teams have written eligibility criteria for ECC participation.

2) The judge/magistrate and community coordinator should implement continuing education for all team members on the existence and enforcement of written eligibility criteria for their ECC team.

Best Practice II: Disadvantaged Groups

Approximately three-quarters of participants perceive that disadvantaged groups are afforded both equal access to and treatment within ECC (see Table 3). While few participants disagreed, more than one in ten did not know.

Table 3. Equivalent access and treatment

<table>
<thead>
<tr>
<th>Members of disadvantaged groups receive...</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>I don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equivalent access ( (n = 125) )</td>
<td>1.6%</td>
<td>2.4%</td>
<td>6.4%</td>
<td>31.2%</td>
<td>42.4%</td>
<td>16.0%</td>
</tr>
<tr>
<td>Equivalent treatment ( (n = 125) )</td>
<td>0.8%</td>
<td>2.4%</td>
<td>5.6%</td>
<td>31.2%</td>
<td>46.4%</td>
<td>13.6%</td>
</tr>
</tbody>
</table>

Recommendation

Continue to follow best practices.

Best Practice III: Roles and Responsibilities of the Judge

Out of 123 responses, 95.9 percent reported that ECC hearings are held at least once per month, in accordance with Best Practice Standard III-D. Participants perceive that judges and magistrates demonstrate appropriate judicial demeanor \( (M = 17.88, SD = 3.95, n = 122) \), are supportive to parents \( (M = 18.39, SD = 2.76, n = 122) \) and caregivers \( (M = 14.43, SD = 2.40, n = 120) \), and exercise inclusive decision-making \( (M = 10.73, SD = 1.98, n = 120) \).

See Figure 4.

Figure 4. Judicial best practices

Recommendation

Continue to follow best practices.

Best Practice IV: Child-Parent Therapy

Based on 126 responses, 77.0 percent reported infant mental health assessments are made. While only 1.6 percent said they were not, over one-fifth (21.4%) said they did not know.

Recommendation

Continue to follow best practices. Ensure all team members are aware of the infant mental health assessment.
Best Practice V: Additional Treatment and Social Services

In Florida’s ECCs, there is varying familiarity with assessments completed (see Table 4). For example, many participants reported not knowing if children receive dental exams (38.7%) or if parents receive trauma assessments (23.4%). Among those who did know, the vast majority reported that every type of assessment is completed. This indicates that, although assessments are likely occurring, team member awareness of assessments could improve.

Table 4. Conducting assessments for treatment and services

<table>
<thead>
<tr>
<th>Assessment Type</th>
<th>Yes</th>
<th>No</th>
<th>I don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma assessment (child) (n = 125)</td>
<td>72.8%</td>
<td>5.6%</td>
<td>21.6%</td>
</tr>
<tr>
<td>Medical exam (child) (n = 125)</td>
<td>78.4%</td>
<td>1.6%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Developmental screening (child) (n = 124)</td>
<td>81.5%</td>
<td>1.6%</td>
<td>16.9%</td>
</tr>
<tr>
<td>Dental exam (child) (n = 124)</td>
<td>57.3%</td>
<td>4.0%</td>
<td>38.7%</td>
</tr>
<tr>
<td>Parent-child relationship assessment (n = 126)</td>
<td>84.1%</td>
<td>1.6%</td>
<td>14.3%</td>
</tr>
<tr>
<td>Mental health assessment (parent) (n = 126)</td>
<td>77.8%</td>
<td>4.0%</td>
<td>18.3%</td>
</tr>
<tr>
<td>Trauma assessment (parent) (n = 124)</td>
<td>70.2%</td>
<td>6.5%</td>
<td>23.4%</td>
</tr>
<tr>
<td>Assessment of other needed resources (e.g., transportation, housing assistance, parent medical/dental treatment, vocational/educational programs) (n = 125)</td>
<td>79.2%</td>
<td>2.4%</td>
<td>18.4%</td>
</tr>
</tbody>
</table>

In addition to assessments throughout the case, ECC team members were asked to report which post-reunification supports their team arranges or provides families with:

- Support groups: 40.2%
- Home visitation: 71.7%
- Ongoing counseling: 74.8%
- Head Start/Early Childhood Education/Child care: 64.6%
- Early Intervention (Early Steps, or developmental therapies/services): 70.9%

Of the 13 specialists in the sample, 69.2 percent reported they assess parental progress using the PITA, while 23.1 percent do not, and 7.7 percent reported they did not know. Evaluators asked the nine who responded that they do use the PITA, if the PITA is regularly updated as case plan interventions move forward. Eight provided a response, with six (75.0%) indicating the PITA is updated, one (12.5%) indicating it is not, and one (12.5%) reporting they do not know.

Recommendations

1) The OCI, in collaboration with individual team leadership, should ensure all members are aware of the comprehensive battery of assessments conducted for each family.

2) Though not all families require the same post-reunification support, consider increasing efforts to provide for or arrange services. In particular, explore options for support groups for families, as less than half of participants agreed this post-reunification support occurs. These discussions should be co-led by the community coordinators and the community-based care case managers, per Best Practice Standard V-E2.

3) Infant Mental Health Specialists should use and, as necessary, update the PITA when assessing parental progress, in accordance with Best Practice Standard V-A.

Best Practice VI: Family Time

While over half of participants reported that family time is both frequent and meaningful, not everyone felt strongly about this, and several reported they did not know. See Table 5.

Table 5. Family time best practices

<table>
<thead>
<tr>
<th>Family time is…</th>
<th>Strongly Agree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>I don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequent (n = 125)</td>
<td>1.6%</td>
<td>4.8%</td>
<td>15.2%</td>
<td>48.8%</td>
<td>19.2%</td>
<td>10.4%</td>
</tr>
<tr>
<td>Meaningful (n = 125)</td>
<td>0.8%</td>
<td>3.2%</td>
<td>16.8%</td>
<td>49.6%</td>
<td>12.0%</td>
<td>17.6%</td>
</tr>
</tbody>
</table>

Recommendation

To assist in improving the meaningfulness of family time for ECC-involved families, consult the Family Time Protocols section of Florida’s Dependency Benchbook.
Best Practice VII: Multidisciplinary Team

Community Coordinator

Of the 126 participants who provided a response to the question, 93.7 percent reported their team has a dedicated community coordinator, while 0.8 percent said they did not, and 5.6 percent did not know. Using a scale of strongly disagree to strongly agree, participants who reported their team had a community coordinator \( (n = 118) \) were asked how much they agree that their team’s coordinator carries out their responsibilities. Participants generally perceive that the community coordinators carry out their duties well, though there was discrepancy and uncertainty for several of the listed responsibilities. See Table 6.

Table 6. Fulfillment of Community Coordinator Responsibilities

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>I don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Act as a liaison between the judge and the ECC team</td>
<td>0.8%</td>
<td>2.5%</td>
<td>10.2%</td>
<td>23.7%</td>
<td>61.0%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Identify potential resources for families ( (n = 117) )</td>
<td>0.9%</td>
<td>3.4%</td>
<td>6.0%</td>
<td>31.6%</td>
<td>53.0%</td>
<td>5.1%</td>
</tr>
<tr>
<td>Identify potential resources for caregivers/ foster parents</td>
<td>1.7%</td>
<td>3.4%</td>
<td>11.9%</td>
<td>31.4%</td>
<td>44.1%</td>
<td>7.6%</td>
</tr>
<tr>
<td>Recruit new ECC team members ( (n = 117) )</td>
<td>1.7%</td>
<td>4.3%</td>
<td>15.4%</td>
<td>27.4%</td>
<td>31.6%</td>
<td>19.7%</td>
</tr>
<tr>
<td>Secure community partnerships to benefit families served by the ECC ( (n = 117) )</td>
<td>1.7%</td>
<td>6.0%</td>
<td>12.0%</td>
<td>26.5%</td>
<td>37.6%</td>
<td>16.2%</td>
</tr>
<tr>
<td>Track data about the families served by our ECC team ( (n = 117) )</td>
<td>0.9%</td>
<td>2.6%</td>
<td>6.0%</td>
<td>26.5%</td>
<td>51.3%</td>
<td>12.8%</td>
</tr>
<tr>
<td>Represent our ECC team in the local community</td>
<td>1.7%</td>
<td>2.5%</td>
<td>12.7%</td>
<td>22.9%</td>
<td>45.8%</td>
<td>14.4%</td>
</tr>
<tr>
<td>Represent our ECC team in the national ECC learning community</td>
<td>0.8%</td>
<td>0.8%</td>
<td>11.0%</td>
<td>24.6%</td>
<td>42.4%</td>
<td>20.3%</td>
</tr>
</tbody>
</table>

Recommendations

1) Continue best practices, as indicated by majority participant agreement in most responsibility categories.

2) The community coordinators should work toward increasing fulfillment of responsibilities and/or the visibility of fulfillment of responsibilities to other team members (e.g., by providing regular updates on efforts). The coordinators should focus specifically on responsibilities where disagreement was indicated (i.e., recruitment of new ECC team members, securing community partnerships to benefit families served by ECC) and where participants did not know if the coordinator was fulfilling responsibilities (i.e., representing their ECC team in the national ECC learning community).

Family Team Meetings

Of 125 responses, 95.2 percent said family team meetings are held monthly. Only one person reported they are not, while 4.0 percent did not know. Among 125 participants, 83.2 percent agreed the community coordinator leads the family team meetings; notably, 8.8 percent said it was someone else and 8.0 percent did not know.

Participants were also asked to confirm if particular best practice activities take place at the family team meetings:

- Addressing concurrent planning: 71.7%
- Ensuring placement stability: 78.0%
- Monitoring transitions in placement: 70.1%
- Assessing treatment progress: 85.0%
- Assessing progress with case plans: 85.0%
- Considering additional needs of the families: 85.0%
- Considering strengths of the parents: 80.3%

Recommendation

Continue to follow best practices. Ensure discussion of all best practice topics during family team meetings.
Team Communication and Decision-Making

Most participants are comfortable with the way decisions are made on the team and support the team’s decisions (see Table 7). Responses were more discrepant for inclusion in decision-making, with nearly one-quarter indicating they feel excluded from the decision-making process.

Table 7. Decision-making satisfaction

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>I don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am comfortable with the way decisions are made on the team.</td>
<td>4.0%</td>
<td>8.7%</td>
<td>16.7%</td>
<td>54.0%</td>
<td>16.7%</td>
<td>0.0%</td>
</tr>
<tr>
<td>(n = 126)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I support the decisions made by the team. (n = 126)</td>
<td>0.0%</td>
<td>6.3%</td>
<td>15.1%</td>
<td>62.7%</td>
<td>15.9%</td>
<td>0.0%</td>
</tr>
<tr>
<td>I feel I am left out of the decision-making process. (n = 125)</td>
<td>13.6%</td>
<td>40.0%</td>
<td>22.4%</td>
<td>16.0%</td>
<td>8.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Recommendation

Continue to follow best practices. Team leadership should consider checking in with team members regarding their inclusion in the decision-making process, as appropriate.

Team Trainings

Among 120 responses, 69.2 percent of team members participate in ECC-related training on at least an annual basis, while 30.8 percent do not. Participants were asked if they received and needed training on several topics. Note, not all of these topics are outlined in the Best Practice Standards; however, they are relevant to ECC-related work. Table 9 depicts the percentage of participants who responded “yes” to receiving and or needing training on various ECC-related topics.

Table 8. Status hearing activities

<table>
<thead>
<tr>
<th>In general, team members…</th>
<th>Yes</th>
<th>No</th>
<th>I don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consistently attend ECC hearings (n = 123)</td>
<td>87.8%</td>
<td>3.3%</td>
<td>8.9%</td>
</tr>
<tr>
<td>Contribute relevant information and recommendations for the court’s consideration (n = 123)</td>
<td>90.2%</td>
<td>4.1%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Resolve most case issues and craft recommendations prior to ECC hearings (n = 121)</td>
<td>78.5%</td>
<td>12.4%</td>
<td>9.1%</td>
</tr>
</tbody>
</table>

Table 9. Training received and needed by team members

<table>
<thead>
<tr>
<th>Training Topic</th>
<th>Received (Yes)</th>
<th>Needed (Yes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe Babies Court Team approach</td>
<td>71.1%</td>
<td>24.8%</td>
</tr>
<tr>
<td>Multidisciplinary collaboration</td>
<td>66.1%</td>
<td>21.5%</td>
</tr>
<tr>
<td>Adverse Childhood Experiences (ACEs)</td>
<td>79.3%</td>
<td>15.7%</td>
</tr>
<tr>
<td>Trauma-informed care</td>
<td>86.8%</td>
<td>19.8%</td>
</tr>
<tr>
<td>Working with diverse populations</td>
<td>76.9%</td>
<td>18.2%</td>
</tr>
<tr>
<td>Social development of infants and toddlers</td>
<td>69.4%</td>
<td>23.1%</td>
</tr>
<tr>
<td>Emotional development of infants and toddlers</td>
<td>66.9%</td>
<td>28.1%</td>
</tr>
<tr>
<td>Infant mental health</td>
<td>61.2%</td>
<td>33.9%</td>
</tr>
<tr>
<td>Historical trauma</td>
<td>67.8%</td>
<td>29.8%</td>
</tr>
<tr>
<td>Fetal Alcohol Spectrum disorders</td>
<td>60.3%</td>
<td>35.5%</td>
</tr>
<tr>
<td>Childhood sexual abuse</td>
<td>65.3%</td>
<td>29.8%</td>
</tr>
<tr>
<td>Neonatal Abstinence Syndrome</td>
<td>34.7%</td>
<td>50.4%</td>
</tr>
<tr>
<td>Intimate partner/domestic violence</td>
<td>79.3%</td>
<td>22.3%</td>
</tr>
</tbody>
</table>
Recommendations

1) The OCI should work with individual team community coordinators to ensure all team members receive annual ECC training.

2) Specifically, the OCI and coordinators should collaborate to ensure all team members receive training on best practice topics: Safe Babies Court Team approach, trauma-informed care, ACEs, and historical trauma.

3) The OCI should consider providing training opportunities for all ECC teams on Neonatal Abstinence Syndrome, based on demand.

Best Practice VIII: ECC Caseloads

The average caseload size for all ECCs is 8.50 (SD = 8.47), with a range of 0-40 cases (n = 119). Variation in reporting could be due to role differences among team members. Evaluators also asked participants if they considered their number of ECC cases to be too high, too low, or about right. Of the 122 participants who responded, 58.3 percent said the number of caseloads was about right, while 34.2 percent said it was too low. Only 7.5 percent said it was too high.

Recommendations

1) The OCI should work with individual teams to increase the number of families served, the possibility of which is indicated by low caseloads (i.e., less than half the suggested caseload size of 20) and one-third of team members’ desire for more ECC cases. However, the decision to increase caseload size should be specific to each team, based on available resources.

2) As caseload size increases, teams should continue to monitor operations to ensure adherence to best practices and consider adjusting the caseload cap if and when best practices are not being met.

Best Practice IX: Monitoring and Evaluation

Outside of family team meetings and status hearings, ECC teams should meet at least quarterly to discuss ECC-related issues. The majority of participants agreed the team meets at least quarterly (73.8%), while one participant was unsure of meeting frequency. Participants were also asked to confirm if particular best practice monitoring and evaluation activities take place when their team meets:

- Discussion of available services in the community: 71.7%
- Review of data: 52.8%
- Identification of gaps in services: 66.1%
- Discussion of issues and patterns observed in the cases being monitored by the team: 75.6%

While approximately three-fourths of ECC team members reported that they discuss both patterns in cases and available services in the community, there is less discussion of identification of gaps in service. Only about half reported that the team reviews data as part of evaluation efforts. Notably, there was much variation in the reporting of “other” meeting frequency, with participants reporting weekly (9.8%), biweekly (4.9%), monthly (33.6%), and quarterly (18.9%) meetings; one participant reported being unsure of “other” meeting frequency. Others reported less frequent meetings: semi-annually (2.4%), annually (0.8%), and never (7.1%). Some participants marked “other” frequency and elaborated that teams often meet “as needed” or “communicate between meetings.” With this, it is possible that there is not a singular meeting during which all team members discuss monitoring and evaluation-related topics. This could explain why some participants did not endorse the above-mentioned monitoring and evaluation activities, which might take place at meetings at which they are not in attendance.

Recommendations

1) The OCI should reinforce the importance of quarterly stakeholder meetings and remind teams to be sure they address each of the four best practice topics noted.

2) If not already in practice, teams should ensure that all relevant team members are invited to all meetings wherein evaluation and monitoring are discussed to ensure comprehensive representation.

3) For their role in meeting Best Practice Standard IX-C2, individual teams should “develop a remedial action plan and timetable to implement recommendations from the evaluator.”
SUMMARY OF STATEWIDE RECOMMENDATIONS BY BEST PRACTICE

Table 10 provides a summary of recommendations by best practice standard for Florida’s ECCs. Green boxes indicate ECC, in general, is implementing this best practice standard with high fidelity, though minor suggestions for improvement might be made. Yellow boxes indicate ECC is not implementing this best practice standard with high fidelity and remedial action is recommended.

Table 10. Summary of best practice standard-related recommendations

<table>
<thead>
<tr>
<th>Best Practice Standard</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I</strong> Target Population</td>
<td>1) Ensure all teams have written eligibility criteria for ECC participation. 2) The judge/magistrate and community coordinator should implement continuing education for all team members on the existence and enforcement of written eligibility criteria for their ECC team.</td>
</tr>
<tr>
<td><strong>II</strong> Disadvantaged Groups</td>
<td>1) Continue best practices. 2) In accordance with Best Practice Standard II.A.1-2, review eligibility criteria to ensure they are nondiscriminatory in intent and impact. Continue to monitor and adjust criteria if they could restrict access for members of a disadvantaged group.</td>
</tr>
<tr>
<td><strong>III</strong> Roles and Responsibilities of Judge/Magistrate</td>
<td>Continue to follow best practices.</td>
</tr>
<tr>
<td><strong>IV</strong> Child-Parent Therapy</td>
<td>Continue to follow best practices. Ensure all team members are aware of the infant mental health assessment. 1) The OCI, in collaboration with individual team leadership, should ensure all members are aware of the comprehensive battery of assessments conducted for each family. 2) Though not all families require the same post-reunification support, consider increasing efforts to provide for or arrange services. In particular, explore options for support groups for families, as less than half of participants agreed this post-reunification support occurs. These discussions should be co-led by the community coordinators and the community-based care case managers, per Best Practice Standard V-E.2. 3) Infant Mental Health Specialists should use and, as necessary, update the PITA when assessing parental progress, in accordance with Best Practice Standard V-A.</td>
</tr>
<tr>
<td><strong>V</strong> Additional Treatment and Social Services</td>
<td>1) Continue best practices, as indicated by majority participant agreement in most responsibility categories. 2) The community coordinators should work toward increasing fulfillment of responsibilities and/or the visibility of fulfillment of responsibilities to other team members (e.g., by providing regular updates on efforts). The coordinator should focus specifically on responsibilities where disagreement was indicated (i.e., recruitment of new ECC team members, securing community partnerships to benefit families served by ECC) and where participants did not know if the coordinator was fulfilling responsibilities (i.e., representing their ECC team in the national ECC learning community).</td>
</tr>
<tr>
<td><strong>VI</strong> Family Time</td>
<td>1) To assist in improving the meaningfulness of family time for ECC-involved families, consult the Family Time Protocols section of Florida’s dependency benchbook.</td>
</tr>
<tr>
<td><strong>VII</strong> Multi-Disciplinary Team: Community Coordinator</td>
<td>1) Continue best practices. 2) The community coordinators should work toward increasing fulfillment of responsibilities and/or the visibility of fulfillment of responsibilities to other team members (e.g., by providing regular updates on efforts). The coordinator should focus specifically on responsibilities where disagreement was indicated (i.e., recruitment of new ECC team members, securing community partnerships to benefit families served by ECC) and where participants did not know if the coordinator was fulfilling responsibilities (i.e., representing their ECC team in the national ECC learning community).</td>
</tr>
<tr>
<td><strong>VII</strong> Multi-Disciplinary Team: Family Team Meetings</td>
<td>Continue to follow best practices. Ensure discussion of all best practice topics during family team meetings.</td>
</tr>
<tr>
<td><strong>VII</strong> Multi-Disciplinary Team: Communication and Decision-Making</td>
<td>Continue to follow best practices. Team leadership should consider checking in with team members regarding their inclusion in the decision-making process, as appropriate.</td>
</tr>
<tr>
<td><strong>VII</strong> Multi-Disciplinary Team: Status Hearings</td>
<td>Continue best practices. 1) The OCI should work with individual team community coordinators to ensure all team members receive annual ECC training. 2) Specifically, the OCI and coordinators should collaborate to ensure all team members receive training on best practice topics: Safe Babies Court Team approach, trauma-informed care, ACEs, and historical trauma. 3) The OCI should consider providing training opportunities for all ECC teams on Neonatal Abstinence Syndrome, based on demand.</td>
</tr>
<tr>
<td><strong>VIII</strong> Early Childhood Court Caseloads</td>
<td>1) The OCI should work with individual teams to increase the number of families served, the possibility of which is indicated by low caseloads (i.e., less than half the suggested caseload size of 20) and one-third of team members’ desire for more ECC cases. However, the decision to increase caseload size should be specific to each team, based on available resources. 2) As caseload size increases, teams should continue to monitor operations to ensure adherence to best practices and consider adjusting the caseload cap if and when best practices are not being met.</td>
</tr>
<tr>
<td><strong>IX</strong> Monitoring and Evaluation</td>
<td>1) The OCI should reinforce the importance of quarterly stakeholder meetings and remind teams to be sure they address each of the four best practice topics noted. 2) If not already in practice, teams should ensure that all relevant team members are invited to all meetings wherein evaluation and monitoring is discussed to ensure comprehensive representation. 3) For their role in meeting Best Practice Standard IX-C2, individual teams should “develop a remedial action plan and timetable to implement recommendations from the evaluator.”</td>
</tr>
</tbody>
</table>
Of the 10 Best Practice Standards listed in the table above (0-IX), ECC teams, as a whole, are implementing 30% of them with little to no recommended remedial action. Based on team member perceptions, the Florida ECCs are operating with beginning fidelity.4

Florida's ECC team members reported numerous areas of strength, including:

4. Equivalent access to and treatment within ECC for disadvantaged groups
5. Fulfillment of judicial roles and responsibilities
6. Implementation of infant mental health specialist screenings
7. Fulfillment of community coordinator duties
8. Carrying out necessary discussions during family team meetings
9. Team decision-making
10. Consistent participation of ECC team members at status hearings

Conversely, team members' responses indicate the OCI should focus on the following areas for improvement:

1. Familiarity with Best Practice Standards for all team members
2. Meeting the target population
3. Post-reunification support for families
4. Increasing meaningfulness and frequency of family time
5. Ensuring annual ECC training for team members
6. Monitoring and evaluation efforts
7. Maintaining appropriate caseloads

### Additional Findings

#### Team Membership

**Perceptions of Peers**

Results indicate ECC team members believe their fellow team members are qualified to work on the team, though team diversity and ECC-related training by role could be strengthened. See Table 11.

#### Table 11. Perceptions of teammates

<table>
<thead>
<tr>
<th>Perception</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree nor Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>I don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receive adequate ECC-related training pertinent to their role (n = 126)</td>
<td>38.1%</td>
<td>24.6%</td>
<td>10.3%</td>
<td>13.5%</td>
<td>1.6%</td>
<td></td>
</tr>
<tr>
<td>Are qualified to work on the team (n = 126)</td>
<td>50.8%</td>
<td>32.5%</td>
<td>4.8%</td>
<td>4.0%</td>
<td>0.8%</td>
<td></td>
</tr>
<tr>
<td>Reflect the diversity of the families we serve (e.g., race, ethnicity, gender identity, language) (n = 126)</td>
<td>41.3%</td>
<td>28.6%</td>
<td>4.8%</td>
<td>13.5%</td>
<td>0.8%</td>
<td></td>
</tr>
</tbody>
</table>

### Team Synergy

The mean total Synergy scale score (n = 97) was 27.63 (SD = 6.96), indicating a high level of perceived team synergy.

### Perceived Turnover

Among the 126 participants who provided a response, 27.0 percent perceived turnover to be a problem on their teams. More than half (58.7%) did not, and 14.3 percent reported they did not know if turnover was problematic.

### Perceptions of the Job and Team

**Community Coordinator Leadership**

There was a wide range of responses for community coordinator leadership (0.0 to 44.0). However, the mean total scale score (n = 90) was 35.20 (SD = 10.11), indicating a high level of perceived community coordinator leadership.

### Time Pressure

There was a wide range of responses for time pressure (0.0 to 20.0). However, the mean total scale score (n = 122) was 8.68 (SD = 4.47), indicating a low level of time pressure.

### Self-Efficacy

There was a narrow range of responses for self-efficacy compared to other scales in this section (8.0 to 20.0). The mean total scale score (n = 123) was 16.03 (SD = 2.60), indicating a high degree of reported self-efficacy among team members.

### Participation Satisfaction

Again, there was a wide range of responses for participation satisfaction (0.0 to 20.0). However, the mean total scale score (n = 123) was 13.98 (SD = 4.18), indicating a moderate degree of participation satisfaction.

### Participation and Inclusion

**Parent and Caregiver Inclusion**

Results indicate that team members perceive that both parents (M = 17.44, SD = 3.49, n = 114) and caregivers (M = 16.70, SD = 3.00, n = 97) are included in the ECC process. See Figure 5.

![Figure 5. Inclusion scale scores](chart)

---

4 The evaluation team developed three levels of fidelity. **Expected fidelity** occurs when 70% or more best practices are in place. **Developing fidelity** occurs when 40-60% of best practices are in place. **Beginning fidelity** occurs when 30% or fewer best practices are in place.
Parental Participation
Based on 115 responses, the majority of respondents (83.4%) perceive at least 51 percent or more ECC-involved parents actively participate (see Figure 6). However, some team members reported less participation.

Figure 6. Frequency of parental participation in ECC

Special Topics

Opioids
Among 126 participants who provided a response, 82.5 percent consider opioid-related issues to be a concern among the families they work with on the ECC team. Fewer reported it is not a problem (11.1%) or that they did not know if it was a problem (6.3%). Evaluators asked the 104 participants who agreed it was a problem to indicate how prepared they feel their team is to handle opioid-related issues. See Table 12.

Table 12. Preparedness to handle opioid-related issues

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>I don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our ECC team has received training on opioid-related issues</td>
<td>2.9%</td>
<td>15.4%</td>
<td>12.5%</td>
<td>30.8%</td>
<td>15.4%</td>
<td>23.1%</td>
</tr>
<tr>
<td>Our ECC team is knowledgeable about opioid-related issues</td>
<td>1.0%</td>
<td>12.5%</td>
<td>13.5%</td>
<td>45.2%</td>
<td>14.4%</td>
<td>13.5%</td>
</tr>
<tr>
<td>Our community has the resources it needs to serve clients with opioid-related issues</td>
<td>7.7%</td>
<td>20.2%</td>
<td>15.4%</td>
<td>31.7%</td>
<td>15.4%</td>
<td>9.6%</td>
</tr>
</tbody>
</table>

Nearly 60 percent agreed that their team is knowledgeable about opioid-related issues, though fewer (46.2%) agreed that their team has received training on these issues. Slightly fewer than half (47.1%) agreed that their community has the resources it needs to serve clients facing opioid-related issues.

Intimate Partner/Domestic Violence
Among 126 participants who provided a response, 92.9 percent consider IPV-related issues to be a concern among the families they work with on the ECC team. Fewer reported it is not a problem (5.6%) or that they did not know if it was a problem (1.6%). Evaluators asked the 117 participants who agreed it was a problem to indicate how prepared they feel their team is to handle IPV-related issues. See Table 13.

Table 13. Preparedness to handle IPV-related issues

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>I don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our ECC team has received training on intimate partner/domestic violence</td>
<td>1.7%</td>
<td>10.3%</td>
<td>7.7%</td>
<td>47.9%</td>
<td>16.2%</td>
<td>16.2%</td>
</tr>
<tr>
<td>Our ECC team is knowledgeable about intimate partner/domestic violence</td>
<td>0.0%</td>
<td>7.8%</td>
<td>9.5%</td>
<td>56.9%</td>
<td>17.2%</td>
<td>8.6%</td>
</tr>
<tr>
<td>Our community has the resources it needs to serve clients with intimate partner/domestic violence concerns</td>
<td>2.6%</td>
<td>9.4%</td>
<td>12.8%</td>
<td>49.6%</td>
<td>18.8%</td>
<td>6.8%</td>
</tr>
</tbody>
</table>

The majority (74.1%) agreed that their team is knowledgeable about IPV-related issues, though fewer (64.1%) agreed that their team has received training on these issues. Approximately two-thirds (68.4%) agreed that their community has the resources it needs to serve clients facing IPV-related issues.

CONCLUSIONS
According to team member perceptions, Florida’s ECCs are operating with developing fidelity based on the Best Practice Standards. Generally, ECC teams are doing well in providing equal access to and treatment within ECC for disadvantaged groups, fulfilling judicial responsibilities, and implementing mental health assessments. While remedial action was recommended for the multidisciplinary team regarding training, coordinators are fulfilling their duties; family team meetings are occurring regularly and addressing necessary topics; and team members are satisfied with team decision-making and are consistently attending and contributing to monthly status hearings. Based on these findings, professional ECC team members have bought into the ECC approach, as evidenced by their participation and fulfillment of responsibilities. This is important as previous qualitative research with Safe Babies Court Team professionals found that buy-in was a necessary component for interdisciplinary collaboration.17
What remains to be improved are more instrumental aspects of implementing ECC, many of which can be achieved regardless of availability of community resources available. This includes ensuring that ECC professionals:

- Are aware of and have read the Best Practice Standards
- Have written eligibility criteria that is relied upon and communicated to potential resources
- Are educated in best practice topics (i.e., the Safe Babies Court Team approach, trauma-informed care, ACEs, and historical trauma)
- Participate in annual ECC-training
- Monitor and evaluate their teams regularly.

There are, however, some improvements that are likely more dependent on available community resources, such as increasing post-reunification supports (i.e., support groups), ensuring frequency and meaningfulness of family time, and increasing team caseload sizes.

Limitations

Though the present analysis included cases in which the participants finished the survey, data come from the same survey that was reported on in the Interim Report and, as such, the same limitations apply. In terms of the sample, self-selection bias is a concern, as participation in evaluation activities is strictly voluntary. Those who participated may have had particular motivations for doing so or otherwise have different ECC experiences from those who chose not to participate. Moreover, only current ECC members were surveyed, which excludes the perspectives of former professionals. Relatedly, parental and caregiver perspective was not included. With this, current findings are not generalizable, they should be interpreted with caution.

Related to the Best Practice Standards themselves, the evaluation team acknowledges that they have yet to be approved by the Supreme Court, thus varying familiarity with them is to be expected to some degree. Also, the evaluation team did not look at every aspect of the Best Practice Standards, some of which would have required much more nuanced data, which may or may not have been available for analysis (e.g., service provider records).

Finally, there is much variation in teams, from how long they have been in existence to how much turnover they experience. Certain Best Practice Standards, such as ensuring annual training, might not have been applicable to some of the newer teams or team members responding to the survey. For this reason, the evaluation team suggests examining not only the overall report, but the individual reports as well, taking into consideration the particular context for that team. Individual reports are available in Appendix A.

Summary and Next Steps

Quantitative data representing ECC team members’ perceptions of processes indicate that ECC is operating with beginning fidelity. This is perhaps unsurprising given that ECC began only five years ago and these findings aggregate data from all teams, which are in various stages of implementation. For this reason, the individual team reports will likely be more useful in directing teams toward improved practices specific to what their team members shared. However, the OCI should be advised of the consistent areas of strength and suggested improvement across teams in order to assist in facilitating fidelity statewide. Notably, across teams, there were three areas of consistent strength:

1. Judges and magistrates are fulfilling their role and responsibilities,
2. Infant mental health assessments are being conducted, and
3. Status hearings are consistently attended, with team members making relevant contributions for the court’s consideration.

Conversely, there were several consistent areas of improvement noted:

1. Team members lack adequate familiarity with Best Practice Standards;
2. Team members are sometimes unaware of the comprehensive battery of assessments families receive;
3. Post-reunification supports are lacking, specifically support groups; and
4. Team members are not receiving annual ECC-related training.

There were mixed findings by team for other Best Practice Standards (e.g., equivalent access/treatment for marginalized groups, community coordinator duties, caseload size, monitoring and evaluation efforts). Evaluators suggest that teams meet to review their individual reports, ideally inclusive of the OCI leadership. Again, teams should interpret findings within the context of their team capacity and available community resources.

For their role in meeting Best Practice Standard IX-C2, individual teams should “develop a remedial action plan and timetable to implement recommendations from the evaluator.”
Chapter 4: Cost Effectiveness Analysis

Troy Quast, Jennifer Marshall, and Lisa Magruder

BACKGROUND

The goal of this cost effectiveness analysis was to assess the relative costs and outcomes of traditional dependency court versus Early Childhood Court (ECC) approaches. The first step was to estimate the labor costs of professionals consistently involved in ECC and traditional dependency cases via self-report survey responses and national and state salary estimates. The cost effectiveness analysis then compared those costs to two outcomes of interest: 1) time to permanency of placement for the child and 2) re-removal. While there were important limitations in this study (discussed below), the analysis indicated that overall, relative to traditional cases, ECC cases were associated with lower costs and better outcomes.

METHODS & RESULTS

Data Collection

A Workload Survey was developed by the evaluation team, with feedback provided by the OCI prior to dissemination. Participants were asked to provide their role, judicial leader, salary, and time spent at work (on all activities). In addition, they were asked to provide data on their monthly activities for both ECC and traditional dependency cases, including number of cases and hours spent on each type of case. Further, for each type of case, we asked participants to report approximate time spent on specific activities (e.g., intakes and assessments, family team meetings, travel, professional training).

Data Analysis and Findings

To determine the cost-effectiveness of the approach, the evaluation team explored the costs of ECC vs. traditional dependency court and triangulated that data with previous OCI analysis of differential outcomes for the two courts.

Costs

This analysis analyzed several variables related to cost: salaries, hours per case, and cost per case. A summary of analysis and findings for each is presented below.

Salaries

Table 14 details the cost analysis. The first step of the cost analysis was to estimate salaries and time spent for each traditional versus ECC case per month. We calculated hourly salary estimates for each role based on average statewide salary data from Occupational Employment Statistics published by the U.S. Bureau of Labor Statistics (BLS). The BLS estimates were judged to be more reliable than those reported by survey respondents given they were representative of the entire state, whereas the respondents were from limited geographic areas. The case roles were matched to the BLS occupations based on job titles, descriptions, and salaries. The hourly salaries were then adjusted assuming a 31.4 percent fringe benefit.

Hours per case

The average hours per case per month by role were then derived from the responses to questions regarding the time spent on and number of traditional and ECC cases. The average hours per case per month were fairly similar for most roles, with the exceptions that monthly hours spent per ECC case were much lower for dependency case managers and much higher for infant mental health/Child-Parent Psychotherapy providers than for non-ECC cases. As a result, the time spent per case per month by the collective of professionals was nearly identical (30.7 vs. 30.6 hours per month on average time spent with one traditional or ECC case, respectively).

Cost per case

The average cost per case per month was calculated by multiplying the estimated annual salary by the average hours per case per month. Again, these were quite similar: $990 and $1,012 per month for traditional and ECC cases, respectively. Finally, for each role, the average cost per case per month was then converted to the average for the duration of the case by multiplying by the average time to permanency by case type (traditional 22.8 months, ECC 18.2 months). The estimated average labor cost per case was $22,561 for traditional cases and $18,422 for ECC cases.

Effectiveness

The analysis also considered two outcomes: time to permanency and the recidivism/re-entry rate. Relative to traditional cases, the ECC cases had both a shorter time to permanency (18.2 months versus 22.8 months) and a lower recidivism/re-entry rate (6.2% versus 9.8%).

Suggested citation:
Table 14. Average labor costs per case: Traditional versus ECC

<table>
<thead>
<tr>
<th>Role</th>
<th>ESTIMATED HOURLY SALARY</th>
<th>AVERAGE HOURS PER CASE PER MONTH</th>
<th>AVERAGE MONTHLY COST PER CASE</th>
<th>AVERAGE TOTAL COST PER CASE</th>
<th>Traditional</th>
<th>ECC</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Judge/Magistrate</td>
<td>$78</td>
<td>0.8</td>
<td>$85</td>
<td>$1,930</td>
<td>$1,443</td>
<td></td>
<td>-$487</td>
</tr>
<tr>
<td>Community coordinator</td>
<td>$19</td>
<td>5.0</td>
<td>$146</td>
<td>$2,335</td>
<td>$2,253</td>
<td></td>
<td>-$80</td>
</tr>
<tr>
<td>Dependency case manager</td>
<td>$16</td>
<td>7.7</td>
<td>$292</td>
<td>$6,660</td>
<td>$2,957</td>
<td></td>
<td>-$3,703</td>
</tr>
<tr>
<td>Parent attorney</td>
<td>$61</td>
<td>1.1</td>
<td>$100</td>
<td>$2,271</td>
<td>$1,575</td>
<td></td>
<td>-$697</td>
</tr>
<tr>
<td>CLS Attorney / Assistant State’s Attorney / Asst Attorney General</td>
<td>$61</td>
<td>1.8</td>
<td>$167</td>
<td>$3,814</td>
<td>$2,563</td>
<td>-$1,251</td>
<td></td>
</tr>
<tr>
<td>Guardian ad litem attorney</td>
<td>$26</td>
<td>0.9</td>
<td>$29</td>
<td>$664</td>
<td>$1,008</td>
<td></td>
<td>$344</td>
</tr>
<tr>
<td>Infant Mental Health Specialist/Child-Parent Psychotherapy Provider</td>
<td>$22</td>
<td>1.2</td>
<td>$171</td>
<td>$3,888</td>
<td>$6,625</td>
<td>$2,737</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>30.7</td>
<td>30.6</td>
<td>$990</td>
<td>$22,561</td>
<td>$18,422</td>
<td></td>
<td>-$4,139</td>
</tr>
</tbody>
</table>

DISCUSSION

Cost effectiveness analyses incorporate cost and outcomes data from the program options (traditional and ECC) to assess their relative value. The incremental cost effectiveness ratio (ICER) is typically calculated when one of the options achieves better outcomes at a higher cost. Under this scenario, the ICER is an estimate of the cost of the improved outcome from the more expensive program option. However, when an option has both lower costs and better outcomes, the option is dominant and there is no need to calculate the ICER. Here, ECC cases have both a lower average cost and better average outcomes (i.e., faster time to permanency and lower recidivism/re-entry rate, as previously reported by the OCI). Thus, the ECC approach is the dominant option relative to a traditional dependency court approach.

Limitations

The above analysis has several significant limitations. First, the survey of time spent by role was based on a relatively small and nonrandom sample of 62 individuals. Notably, data was collected following a large natural disaster in Florida and participation, particularly from significantly impacted areas, could have been impeded by this. Thus, these responses may not be representative of all individuals in these roles or across geographic areas. In addition, the assignment of cases to an ECC approach is not random, thus differences in the time estimates by role and time to permanency may reflect, in part, differences in cases rather than differences between the traditional and ECC approaches.

The current analysis only considers labor costs. A complete picture of costs would include fixed and indirect case costs. A previous cost analysis of similar programs had more comprehensive cost estimations and had different financial conclusions. Foster & McCombs-Thornton compared the costs of four Safe Babies Court Teams to a comparison sample derived from the National Survey of Child and Adolescent Well-Being. Their analysis included both direct costs (i.e., salary, fringe of program staff) as well as other costs, such as in-kind costs (e.g., additional staff time and mileage to support Court Team meetings, court hearings), use of other services (i.e., Medicaid reimbursement rates for developmental, health, dental or parent-child services as well as CPP), and out of home placement/foster care costs. With this, they estimated the direct costs across four Safe Babies Court Teams to average roughly $29,499 per child compared to $19,218 for the comparison group. Not only are these figures higher than what the current cost-effectiveness analysis found, but they also indicate that the Safe Babes Court Team approach is more expensive than that of traditional dependency court. Given that the current analysis only included labor costs, it is likely this is an underestimation of true costs. The current analysis also did not consider time spent by biological, foster, or family/kinship parents or caregivers, volunteer Guardians ad Litem, or others who volunteer their time. Lastly, there are also a variety of professionals involved in dependency court cases that may not be a consistent member of every circuit or case team (e.g. substance abuse treatment counselors, early intervention providers) that may add to costs.

Finally, outcomes are based on previously published findings by the OCI, as de-identified outcome data was not provided to the evaluation team until after the completion of the cost analysis. Still, outcome data are based on a comprehensive analysis of all closed cases from 2014-2018. Future evaluations should include data on cases closed beyond 2018.

Suggestions for Future Research

Future evaluation should also include capturing more detailed salary data and identifying additional team members involved in each of the ECC circuits. Costs estimates of parent and foster parent time may also be considered. Furthermore, time to permanency does vary across cases in both approaches. Chuang, Moore, Barrett, and Young found that Family Dependency Treatment Courts, which address the needs of families in dependency court with substance use disorders, resulted in higher rates of reunification and reduced recidivism/re-entry, but also longer time to permanency. Future studies of the ECC approach may want to consider conducting separate analyses for cases involving substance use.

Summary

In summary, because costs per case were similar in both approaches, the superior cost-effectiveness of the ECC approach is due to its better average outcomes. Timely permanency is one goal of the ECC program, with consideration to ensure that recidivism/re-entry is not an unintended consequence. Prior analyses found that recidivism/re-entry was, in fact, lower than the traditional approach. It would be beneficial to estimate the monetary value of these outcomes (cost-savings). For example, Fang and colleagues estimated average lifelong costs of maltreatment to a surviving victim to be $210,012. Therefore, the investment in ECC support to families could result in substantial cost savings if recidivism/re-entry is prevented. Foster and McCombs-Thornton also pointed out that these program costs are reasonable in that they are comparable to well-supported prevention programs such as Early Head Start ($20,972 per child/per year). Nurse Family Partnership ($9,118) and Comprehensive Child-Development and Infant Health and Development Programs (<$35,000).
Chapter 5: Relationships Between Community Coordinator Funding Source and Early Childhood Court Processes and Outcomes

Lisa Magruder

INTRODUCTION

Community coordinators (hereinafter, coordinators) are an essential member of Early Childhood Courts (ECCs). A survey of Florida ECC team members in Fall 2018 found that nearly all participants (98.5%) reported their team had a dedicated coordinator, who serves as the “central hub” of the team, in partnership with the judge. According to most ECC team members, coordinators demonstrate leadership and fulfill their responsibilities (e.g., acting as a liaison between the judge and team, identifying potential resources for families, data tracking; see Chapter 3: Community Coordinator). Despite generally positive perceptions of coordinators’ roles on ECC teams, varying funding mechanisms for the position raised concerns for some team members. Participants shared concerns that 1) multiple funding streams result in confusion about responsibilities; 2) unsecured funding impedes professional growth of the coordinator and their team as they cannot plan for the future; and 3) non-court funded coordinators’ lack of necessary neutrality in their role. Previous research on the ECC approach similarly found lack of community coordinator funding as impeding implementation of the approach. Given this, the evaluation team examined how coordinator funding source impacts ECC, both in terms of team processes as well as outcomes.

METHODS

For the present analyses, funding source was dichotomized into court and non-court. Based on November 2018 administrative data from the OCI, four of 21 ECC teams had a court-funded coordinator; the remaining 17 courts had non-court-funded coordinators.

Data Analysis: Team Processes

Data for processes were derived from the Early Childhood Court Team Member Survey, distributed in Fall 2018, the full methodology of which has been described in the Interim Report to the OCI. Briefly, 144 participants provided 150 responses (i.e., several worked for more than one team). Of the 150 responses, participants were removed if they did not complete the entire survey (n = 23). Three additional participants were excluded because they did not provide their judicial leader, which was necessary for analysis. Judicial leader was used to determine the dichotomous independent variable, court funded (yes/no). In total, 124 responses were included in the present analysis. Notably, the Broward County ECC team has two coordinators—one who is court-funded and one who is not. However, the one who is not court-funded is co-located at the courthouse. Thus, this team was considered “court-funded.” We examined differences by coordinator funding source in several dependent variables. Though the same dataset was used for team fidelity reports, responses of “I don’t know” were excluded from the present analyses. Quantitative analyses were conducted using IBM SPSS Statistics v25. The authors used guidance from Laerd Statistics for reporting of statistical tests and findings.

Dependent Variables

Numerous variables were included in the analyses of processes. Two types of analyses were conducted: chi-square analyses and independent samples t-tests. Variables are explained below by type of analysis.

Prior to running analyses, evaluators assessed missing values. Several variables were missing not at random. Specifically, there was a significant association between missing values and coordinator funding source. For each variable, data were more frequently missing for participants from court funded teams, as determined by Fisher’s Exact Tests: frequency of status hearings (p = .049), consistent hearing attendance (p = .046), hearing contributions (p = .043), hearing preparedness (p = .001), frequency of parental participation (p = .004), parental inclusion (p = .012). These variables were excluded from further analyses.

Assessed using Chi-Square Analyses

The following variables were analyzed using a chi-square analysis to determine significant differences by coordinator funding source. When necessary due to small cell sizes, results were interpreted based on Fisher’s Exact Tests. Responses of “I don’t know” were excluded from analyses.

Frequency of family team meetings was measured dichotomously (yes/no) through the item: “Does your ECC team have at least one family team meeting per month?” Five cases were excluded for answering “I don’t know.” One case was missing.

The family team meeting leader was assessed with three response options: community coordinator; someone else, please specify role; and I don’t know. Responses were re-coded into community coordinator as leader (yes/no). If a participant’s someone else response indicated the community coordinator co-leads family team meetings, this was recoded as yes. “I don’t know” responses were excluded (n = 10) and there were no missing values. Notably, there were significantly more individuals from court-funded teams (23.5%) than non-court-funded teams (5.6%) who reported they did not know who led the team meetings, as indicated by Fisher’s Exact Test, p = .031.

Family team meeting activities were assessed with a check-all-that-apply response option, and included: addressing concurrent planning, ensuring placement stability, monitoring transitions in placement, assessing treatment progress, assessing progress with case plans, considering additional needs of the families, and considering strengths of the parents. The variables were dichotomized into yes/no based on whether or not the respondent checked the item, thus there were no missing values.

Quarterly meetings were assessed with the item: “Other than family team meetings, how frequently does your ECC team meet to discuss ECC-related issues?” Response options included weekly, bi-weekly (every other week), monthly, bi-monthly (every other month), quarterly, semi-annually (twice per year), annually, never, and other (please specify). One case reported “I don’t know” and was excluded. Four cases were missing at random. The remaining cases were recoded into quarterly meetings (yes/no), where responses of weekly, bi-weekly, monthly, bi-monthly, and quarterly were “yes” and all others were “no.”

Suggested citation:
Fulfillment of coordinator responsibilities was assessed with eight individual, ordinal items developed from best practice language. Only participants who indicated they had a designated community coordinator were presented these items (n = 116). Participants were asked to indicate how much they agree with eight statements (e.g., the community coordinator works to: act as a liaison between the judge and the ECC team, identify potential resources for families). Response options ranged from 0 (strongly disagree) to 4 (strongly agree). Responses were dichotomized into yes (strongly agree, agree) and no (neither agree nor disagree, disagree, strongly disagree). Responses of "I don’t know" were excluded. Several items had one case missing each.

Perceived team turnover was assessed dichotomously (yes/no) with one item: "Do you consider team turnover to be problematic on your ECC team?" Eighteen participants did not know and were excluded. There were no missing cases.

Satisfaction with team decision-making was assessed using a three-item adapted version of the Decision-making subscale of the Partnership Self-Assessment Tool.14 Response options ranged from 0 (strongly disagree) to 4 (strongly agree). The Interim Report analysis indicated the adapted satisfaction scale demonstrated poor reliability and, subsequently, the evaluators chose not to present scale scores, but response option frequencies for each of the three items. These response options were dichotomized into yes (strongly agree, agree) and no (neither agree nor disagree, disagree, strongly disagree) for the present analysis. One item had one missing case.

Family time was assessed with two items to address best practices. Participants were asked how much they agree with the following statements: "When ECC parents have ‘family time’ with their child(ren): 1) it is frequent; and 2) it is meaningful." Response options ranged from 0 (strongly disagree) to 4 (strongly agree). These response options were dichotomized into yes (strongly agree, agree) and no (neither agree nor disagree, disagree, strongly disagree). Responses of "I don’t know" were excluded. Each item had one missing case.

Post-reunification support was assessed with a check-all-that-apply response option, including: 1) support groups; 2) home visitation; 3) ongoing counseling; 4) Head Start/early childhood education or childcare; and 5) early intervention (Early Steps, or developmental therapies/services). The variables were dichotomized into yes/no based on whether or not the respondent checked the item, thus there were no missing values.

Equivalent ECC access for and equivalent ECC treatment of disadvantaged groups was assessed with two items. Participants were prompted to think of "clients of marginalized groups" as those "who may have experienced discrimination or reduced opportunities because of their race, ethnicity, gender, sexual orientation, sexual identity, physical or mental disability, religion, or socioeconomic status." Participants were asked how much they agree with the following statements: 1) "Individuals from disadvantaged groups have equivalent access to ECC participation compared to individuals not from disadvantaged groups" and 2) "Individuals from disadvantaged groups receive equivalent treatment in ECC compared to individuals not from disadvantaged groups." Response options ranged from 0 (strongly disagree) to 4 (strongly agree). These response options were dichotomized into yes (strongly agree, agree) and no (neither agree nor disagree, disagree, strongly disagree). Responses of "I don’t know" were excluded. Each item had one missing response.

**Assessed using Independent Samples t-tests**

Community coordinator leadership was assessed using an eleven-item adapted version of the Leadership subscale of the Partnership Self-Assessment Tool.14 Response options ranged from 0 (strongly disagree) to 4 (strongly agree), with a range of 0 to 44 for total scale score; there was an "I don’t know" option, which was coded as missing. Cases were removed if they did not respond to all community coordinator leadership items (n = 36) and missingness did not significantly differ by coordinator funding source. There were six outliers for non-court-funded cases, whose scores ranged from 0.0 to 12.0. These were retained in analysis. The assumption of normality was violated for non-court-funded cases, though independent samples t-tests are robust to these violations. The assumption of homogeneity of variances was met.

Team synergy was assessed using a nine-item adapted version of the Synergy subscale of the Partnership Self-Assessment Tool.14 Response options ranged from 0 (strongly disagree) to 4 (strongly agree), with a range of 0 to 36 for total scale score; there was an "I don’t know" option, which was coded as missing. Cases were removed if they did not respond to all team synergy items (n = 29), and missingness did not significantly differ by coordinator funding source. The final analytic sample size for team synergy was 108. There were three outliers for non-court-funded cases, whose scores ranged from 0.0 to 9.0. These were retained in analysis. The assumption of normality was violated for non-court-funded cases, though independent samples t-tests are robust to these violations. The assumption of homogeneity of variances was met.

Time pressure in role was assessed using an adapted five-item scale originally developed by the Butler Institute and used in the Comprehensive Organizational Health Assessment (COHA).15 Response options ranged from 0 (strongly disagree) to 4 (strongly agree), with a range of 0 to 20 for total scale score. Responses were removed if they did not respond to all time pressure items (n = 4) and missingness did not significantly differ by coordinator funding source. The final analytic sample size for team synergy was 120. There were two outliers for court-funded cases (scores: 0.00 and 17.00). These were retained in analysis. The assumption of normality was violated for non-court-funded cases, though independent samples t-tests are robust to these violations. The assumption of homogeneity of variances was met.

Self-efficacy in role was assessed using a five-item self-efficacy scale used in the COHA.15 Response options ranged from 0 (strongly disagree) to 4 (strongly agree), with a range of 0 to 20 for total scale score. Responses were removed if they did not respond to all participation satisfaction items (n = 3) and missingness did not significantly differ by coordinator funding source. The final analytic sample size for team synergy was 121. There were five outliers for non-court funded cases (score range: 8.00 – 10.00) and 2 for court-funded cases (score of 10.00). These were retained in analysis. The assumption of normality was violated for non-court-funded cases, though independent samples t-tests are robust to these violations. The assumption of homogeneity of variances was met.
ECC Participation Satisfaction was assessed using a five-item adapted version of the Satisfaction with Participation subscale of the Partnership Self-Assessment Tool.14 Response options ranged from 0 (strongly disagree) to 4 (strongly agree), with a range of 0 to 20 for total scale score. Cases were removed if they did not respond to all self-efficacy items (n = 3) and missingness did not significantly differ by coordinator funding source. There were 17 outliers for non-court funded cases, seven being extreme (scores: 0.00 – 6.00). Once extreme outliers were removed, four outliers remained (scores: 6.00 – 15.00). These were retained for analysis and the final analytic sample size for team synergy was 114. The assumption of normality was violated for non-court-funded cases, though independent samples t-tests are robust to these violations. The assumption of homogeneity of variances was met.

Caregiver inclusion was assessed with a five-item scale developed from best practice language (e.g., caregivers are given an opportunity to actively participate in the ECC process, ECC team members check in with caregivers to ensure they have necessary supports). Response options ranged from 0 (strongly disagree) to 4 (strongly agree), with a range of 0-20 for total score; there was an “I don’t know” option, which was coded as missing. Participants who did not respond to all five items were excluded from analysis (n = 28) and missingness did not significantly differ by coordinator funding source. The final analytic sample size for team synergy was 96. There were two outliers for non-court funded cases (scores: 6.00 and 7.00). These were retained in analysis. The assumption of normality was violated for non-court-funded cases, though independent samples t-tests are robust to these violations. The assumption of homogeneity of variances was met.

Data Analysis: Case Outcomes
In April 2019, the OCI staff provided the evaluators with de-identified outcome data for all closed cases since ECC inception (N = 473). Four cases were removed for missing or inconsistent data. An additional 10 cases were removed because there was a change in funding source for one ECC team, and those cases spanned across that time point, indicating they could have been served by both court- and non-court-funded coordinators. Finally, 10 cases were removed for atypical outcomes (death, unknown/ unspecified, voluntary dismissal without prejudice). Thus, the final analytic sample was 449 cases.

Dependent Variables

Case Outcomes
Case outcome options included adoption, guardianship (non-relative), guardianship (relative), permanency (both parents), and permanency (one parent). Few cases ended in non-relative guardianship, none of which were served by a court-funded coordinator team. Further, only approximately one-fifth of all cases were served by court-funded coordinator teams, so some outcomes had little representation for individual outcome categories. Evaluators decided to collapse outcomes into: adoption, guardianship (either type), and reunification (permanency with one or both parents). A chi-square analysis was conducted to determine if there is significant variation by coordinator funding source.

Time to Closure
Time from removal to case closure was measured in days. An independent-samples t-test was conducted to determine if there is a significant difference in time to closure by coordinator funding source. There were seven outliers for non-court funded cases and two for court-funded cases, one of which was extreme (days: 1297.00). The extreme outlier was removed, though the remaining eight were retained for analysis. The assumption of normality was violated for both non-court- and court-funded cases, though independent samples t-tests are robust to these violations. The assumption of homogeneity of variances was violated, as assessed by Levene’s test for equality of variances (p = <.001).

Removals
Several removal-related variables were captured. The following variables were measured dichotomously (yes/no): more than one removal, removal prior to case closure, removal after case closure. Chi-square analyses were conducted with each removal variable to determine if there is significant variation by coordinator funding source. There were two outliers for non-court funded cases, one of which was extreme (8 placements), and two for court-funded cases. The extreme outlier was removed, though the remaining three were retained for analysis. The assumption of normality was violated for both non-court- and court-funded cases, though independent samples t-tests are robust to these violations. The assumption of homogeneity of variances was met.

Total Number of Placements
Total number of placements was measured continuously. An independent-samples t-test was conducted to determine if there is significant variation by coordinator funding source.

Termination of Parental Rights
Termination of parental rights was measured dichotomously (yes/no). For those cases with termination of parental rights, parental relinquishing of rights was also measured dichotomously (yes/no). Chi-square analyses were conducted with each parental rights variable to determine if there is significant variation by coordinator funding source.

RESULTS

Processes
Of the 124 responses in the analysis, only 13.7 percent (n = 17) were fully court funded, while 86.3 percent (n = 84.3%) were not. Tables 15 and 16 provide specific statistical results by variable. There were few significant differences in perceptions of ECC processes by team coordinator funding source.

- Significantly more non-court funded coordinator team respondents (94.1%) indicated the coordinator leads the family team meetings than did court-funded coordinator team respondents (61.5%), as determined by a Fisher’s Exact Test, p = .003.
- Significantly more non-court funded coordinator team respondents indicated the team engages in best practice family team meeting activities than did court-funded coordinator team respondents, as determined by a series of Fisher’s Exact Tests. See Table 15 for statistics by activity.
- Significantly more non-court funded coordinator team respondents (44.9%) indicated their team arranges for or provides support groups as part of post-reunification support than did court-funded coordinator team respondents (17.6%), as determined by a Fisher’s Exact Test, p = .034.
<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>Non-Court</th>
<th>Court</th>
<th>$\chi^2$</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly team meetings</td>
<td>118</td>
<td>100.0%</td>
<td>9.17%</td>
<td>.102</td>
<td></td>
</tr>
<tr>
<td>Coordinator leads family team meetings</td>
<td>114</td>
<td>94.1%</td>
<td>61.5%</td>
<td>.003**</td>
<td></td>
</tr>
<tr>
<td>Family team meeting activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Addressing concurrent planning</td>
<td>124</td>
<td>13.9</td>
<td>$292^*$</td>
<td>.001**</td>
<td></td>
</tr>
<tr>
<td>Ensuring placement stability</td>
<td>124</td>
<td>78.5%</td>
<td>35.3%</td>
<td>&lt;.001***</td>
<td></td>
</tr>
<tr>
<td>Monitoring transitions in placement</td>
<td>124</td>
<td>86.9%</td>
<td>35.3%</td>
<td>&lt;.001***</td>
<td></td>
</tr>
<tr>
<td>Assessing treatment progress</td>
<td>124</td>
<td>80.4%</td>
<td>17.6%</td>
<td>.013*</td>
<td></td>
</tr>
<tr>
<td>Assessing progress with case plans</td>
<td>124</td>
<td>89.7%</td>
<td>64.7%</td>
<td>&lt;.001***</td>
<td></td>
</tr>
<tr>
<td>Considering additional needs of families</td>
<td>124</td>
<td>91.6%</td>
<td>52.9%</td>
<td>&lt;.001***</td>
<td></td>
</tr>
<tr>
<td>Considering strengths of parents</td>
<td>124</td>
<td>92.5%</td>
<td>47.1%</td>
<td>.001**</td>
<td></td>
</tr>
<tr>
<td>Quarterly meeting</td>
<td>119</td>
<td>72.1%</td>
<td>93.3%</td>
<td>.111</td>
<td></td>
</tr>
<tr>
<td>Community coordinator duties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Act as a liaison between the judge and the ECC team</td>
<td>114</td>
<td>85.0%</td>
<td>92.9%</td>
<td>.688</td>
<td></td>
</tr>
<tr>
<td>Identify potential resources for families</td>
<td>109</td>
<td>88.4%</td>
<td>92.9%</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Identify potential resources for caregivers/ foster parents</td>
<td>107</td>
<td>81.1%</td>
<td>83.3%</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Recruit new ECC team members</td>
<td>92</td>
<td>74.4%</td>
<td>70.0%</td>
<td>.717</td>
<td></td>
</tr>
<tr>
<td>Secure community partnerships to benefit families served by the ECC</td>
<td>96</td>
<td>79.1%</td>
<td>60.0%</td>
<td>.230</td>
<td></td>
</tr>
<tr>
<td>Track data about the families served by our ECC team</td>
<td>100</td>
<td>90.8%</td>
<td>76.9%</td>
<td>.153</td>
<td></td>
</tr>
<tr>
<td>Represent our ECC team in the local community</td>
<td>100</td>
<td>82.0%</td>
<td>63.6%</td>
<td>.223</td>
<td></td>
</tr>
<tr>
<td>Represent our ECC team in the national ECC learning community</td>
<td>92</td>
<td>86.7%</td>
<td>66.7%</td>
<td>.136</td>
<td></td>
</tr>
<tr>
<td>Problematic turnover</td>
<td>106</td>
<td>67.4%</td>
<td>72.7%</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Satisfaction with team decision-making</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am comfortable with the way decisions are made on the team.</td>
<td>124</td>
<td>72.0%</td>
<td>58.8%</td>
<td>1.21</td>
<td>.271</td>
</tr>
<tr>
<td>I support the decisions made by the team.</td>
<td>124</td>
<td>80.4%</td>
<td>64.7%</td>
<td>.202</td>
<td></td>
</tr>
<tr>
<td>I feel I am left out of the decision-making process.</td>
<td>123</td>
<td>23.6%</td>
<td>23.5%</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Family Time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequent</td>
<td>111</td>
<td>74.0%</td>
<td>90.9%</td>
<td>.290</td>
<td></td>
</tr>
<tr>
<td>Meaningful</td>
<td>102</td>
<td>74.2%</td>
<td>77.8%</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Post-reunification support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support groups</td>
<td>124</td>
<td>44.9%</td>
<td>17.6%</td>
<td>4.49</td>
<td>.034*</td>
</tr>
<tr>
<td>Home visitation</td>
<td>124</td>
<td>74.8%</td>
<td>58.8%</td>
<td>.240</td>
<td></td>
</tr>
<tr>
<td>Ongoing counseling</td>
<td>124</td>
<td>78.5%</td>
<td>64.7%</td>
<td>.226</td>
<td></td>
</tr>
<tr>
<td>Head Start</td>
<td>124</td>
<td>66.4%</td>
<td>58.8%</td>
<td>.367</td>
<td>.544</td>
</tr>
<tr>
<td>Early Intervention</td>
<td>124</td>
<td>74.8%</td>
<td>52.9%</td>
<td>.082</td>
<td></td>
</tr>
<tr>
<td>Disadvantaged groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equivalent access</td>
<td>103</td>
<td>87.9%</td>
<td>83.3%</td>
<td>.646</td>
<td></td>
</tr>
<tr>
<td>Equivalent treatment</td>
<td>106</td>
<td>89.4%</td>
<td>91.7%</td>
<td>1.00</td>
<td></td>
</tr>
</tbody>
</table>

Note: Missing chi-square ($\chi^2$) values for associations interpreted using Fisher’s exact test due to expected cell counts <5
There were no significant differences between teams with court-funded and non-court-funded coordinators in perceptions of:

- Frequency of family team meetings
- Quarterly meeting occurrence
- Fulfillment of coordinator duties
- Problematic turnover
- Satisfaction with team decision-making
- Family time frequency or meaningfulness
- Most post-reunification supports (i.e., home visitation, ongoing counseling, Head Start, early intervention)
- Access to or treatment within ECC for disadvantaged groups
- Community coordinator leadership
- Team synergy
- Time pressure
- Self-efficacy
- Participation satisfaction
- Caregiver inclusion

**Outcomes**

Among the 449 cases included in analysis, 20.7 percent were served by teams with a court-funded coordinator, while 79.3 percent were served by teams with a non-court-funded coordinator. The mean age of the child at time of removal was 13.91 months (SD = 14.43), or just over one year old. Cases were supervised by one of twenty-four judges or magistrates, spanning 11 circuits across Florida. It should be noted that not all judges/magistrates are those included in the overall ECC evaluation.

**Case Outcome**

The majority of cases were closed to permanency with either one parent (33.2%) or both (19.6%). Approximately one-third of cases were closed to adoption (36.1%), while a minority were closed to either relative guardianship (7.8%) or non-relative guardianship (3.3%). As previously noted, due to small cell sizes for some outcomes, the evaluators decided to collapse case outcome into three categories: adoption, guardianship (with relative or non-relative caregiver), and reunification (with one or both parents). See Table 17.

A chi-square analysis was run to assess for a difference in case outcome by coordinator funding source. Using a Bonferroni adjusted p-value of .017, there was a significant difference in case outcome by funding source, \( \chi^2(4, 449) = 11.12, p = .001 \). Cases served by court-funded coordinators closed significantly faster (\( M = 488.97 \text{ days, } SD = 129.18 \)) than cases served by non-court-funded coordinators (\( M = 568.79 \text{ days, } SD = 238.00 \)). The mean difference is 79.82 days, or approximately two-and-a-half months.

Given that there were several outliers that were retained, a second t-test was conducted that excluded all nine outliers earlier identified. While the mean difference decreased to 73.36 days, time to closure was still significantly faster for court-funded teams than non-court-funded teams, \( t(263.54) = 4.20, p = .001 \).

**Removals**

Across all cases, 11.8 percent experienced more than one removal. Results of a chi-square analysis indicate no significant difference in multiple removals by coordinator funding source, \( \chi^2(1, 449) = .000, p = .994 \). For both court- and non-court funded coordinators, the frequency of more than one removal is 11.8 percent.

Removals were made prior to case closure in 4.7 percent of all cases. Results of a chi-square analysis indicate no significant difference in the frequency of removals prior to case closure, \( \chi^2(1, 449) = .037, p = .847 \). The frequency of removal prior to case closure was 4.3 percent and 4.8 percent for court- and non-court-funded coordinator teams, respectively.

Removals were made after case closure in 7.1 percent of all cases. Results of a chi-square analysis indicate no significant difference in the frequency of removals after case closure, \( \chi^2(1, 449) = .028, p = .866 \). The frequency of removal after case closure was 7.5 percent and 7.0 percent for court- and non-court-funded coordinator teams, respectively.

---

**Table 16. Independent samples t-test analyses of coordinator funding source**

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>Non-Court M (SD)</th>
<th>Court M (SD)</th>
<th>df</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Coordinator Leadership</td>
<td>88</td>
<td>35.38 (33.45)</td>
<td>33.45 (7.83)</td>
<td>86</td>
<td>.584</td>
<td>.561</td>
</tr>
<tr>
<td>Team Synergy</td>
<td>95</td>
<td>27.81 (7.16)</td>
<td>25.75 (5.46)</td>
<td>93</td>
<td>.954</td>
<td>.343</td>
</tr>
<tr>
<td>Time Pressure</td>
<td>120</td>
<td>8.58 (4.56)</td>
<td>9.41 (4.21)</td>
<td>118</td>
<td>-.702</td>
<td>.484</td>
</tr>
<tr>
<td>Self-Efficacy</td>
<td>121</td>
<td>16.01 (2.57)</td>
<td>16.01 (2.90)</td>
<td>119</td>
<td>-.072</td>
<td>.943</td>
</tr>
<tr>
<td>Participation Satisfaction</td>
<td>114</td>
<td>14.78 (3.29)</td>
<td>13.29 (3.62)</td>
<td>112</td>
<td>1.698</td>
<td>.092</td>
</tr>
<tr>
<td>Caregiver inclusion</td>
<td>96</td>
<td>16.87 (3.12)</td>
<td>16.82 (1.99)</td>
<td>94</td>
<td>.054</td>
<td>.957</td>
</tr>
</tbody>
</table>

**Table 17. Case outcome type by coordinator funding source**

<table>
<thead>
<tr>
<th></th>
<th>Court-funded</th>
<th>Adoption Freq (%)</th>
<th>Guardianship Freq (%)</th>
<th>Reunification Freq (%)</th>
<th>Time to closure M (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>34.4%</td>
<td>2.2%</td>
<td>63.4%</td>
<td>488.97 (129.18)</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>36.5%</td>
<td>13.5%</td>
<td>50.0%</td>
<td>568.79 (238.00)</td>
</tr>
</tbody>
</table>

**Time to Case Closure**

Results of an independent samples t-test indicate a significant difference in mean time to case closure by coordinator funding source, \( t(267.85) = 4.33, p = .001 \). Cases served by court-funded coordinators closed significantly faster (\( M = 488.97 \text{ days, } SD = 129.18 \)) than cases served by non-court-funded coordinators (\( M = 568.79 \text{ days, } SD = 238.00 \)).
Across all cases, the modal—or most frequent—number of placements was 1 (see Figure 7). There was no significant difference in termination outcomes between court-funded ($M = 1.40$, $SD = 0.80$) and non-court-funded coordinator teams ($M = 1.56$, $SD = 0.79$). ($t(446)$, $= 1.68$, $p = .094$.

As this uses the same quantitative data from Chapter 3, the same limitations apply; namely, self-selection bias and exclusion of former team member and parent/caregiver perspective. Methodically, it is important to note that the outcome data were unbalanced in that only four teams had court-funded coordinators, while 17 had non-court funded coordinators. This impacted the breakdown of the number of cases served by each type of team. Particularly for nuanced sub-analyses, which have smaller sub-sample sizes (e.g., case outcomes), this can impact the ability to detect significant differences. Evaluators encourage the continued analysis of data as more cases are closed, providing a larger sample size and more power for analysis.

In addition, based on information received from the OCI, one team has two coordinators—one being court-funded and the other being non-court-funded, but co-located at the courthouse. Evaluators elected to code cases served by this team as “court-funded,” which could impact findings. This decision, however, was supported by the OCI.

Finally, this is only an initial analysis of how coordinator-funding source might impact ECC processes and outcomes. Other factors could account for these findings, such as the tenure of the team, eligibility criteria, and availability of community resources. There could also be other community coordinator-related factors that impact these findings, such as their employment status (i.e., part-time or full-time) and the number of coordinators working on a particular team, which does vary according to internal OCI documentation.

**CONCLUSIONS**

In Phase One of the Evaluation, several professional team members shared concerns about how the community coordinator funding source can impact how the teams function, specifically mentioning lack of neutrality when the coordinator is not funded by the court. Though we did not specifically assess the concept of coordinator neutrality, variables related to how the teams function (i.e., processes) indicate very few differences in teams with court- and non-court funded coordinators. In fact, after examining thirty variables spanning 10 topics, only three significant differences were found (i.e., community coordinator leads family team meetings, family team meeting activities, post-reunification support groups) and all favored teams with non-court-funded coordinators. However, the opposite was true when examining outcomes, which favored court-funded coordinator teams when differences existed.

Specifically, teams with court-funded coordinators had greater frequency of reunification and faster time to permanency than teams with non-court-funded coordinators.

**Limitations**

The present analysis has several limitations to note. First, the primary impetus for this analysis was based on ECC team professionals’ concern over the neutrality of non-court-funded community coordinators. The evaluation team decided against requesting additional survey data from participants on this topic, so as not to overburden them. Participants had previously been asked to participate in qualitative interviews/focus groups and complete both the main survey, as well as a brief follow-up survey for the cost-analysis. Instead, data used for the process analyses were derived from the main survey sent in Fall 2018. Evaluators examined process variables as a proxy for neutrality and found few differences. However, it is important to note that neutrality specifically was not quantitatively assessed.

**Summary and Next Steps**

Initial evidence suggests that community coordinator funding source does impact ECC processes and outcomes in few, but important ways. In terms of processes, teams with non-court-funded coordinators appear to better meet Best Practice Standards for family team meetings (i.e., coordinator leads the meetings, best practice topics are discussed). These teams also appear to more frequently provide or arrange for support groups as a form of post-reunification support, which was noted as an area of improvement for fidelity to Best Practice Standards (see Chapter 3: Fidelity to the Early Childhood Court Approach).

In terms of outcomes, court-funded teams more frequently had outcomes of reunification and faster time from removal to case closure. Prior research has found that, in general, ECC has better outcomes than traditional dependency court—specifically, faster time to permanency and lower recidivism/re-entry rates. These findings provide initial evidence that these better outcomes might be even further enhanced if cases are served by teams with court-funded community coordinators. Future evaluation efforts should continue to do more nuanced follow-up inquiry on ECC funding mechanisms, with specific attention to coordinator funding source, and controlling for pertinent variables (e.g., length of team existence, eligibility criteria, number of coordinators).
While Early Childhood Court demonstrates much promise to serving some of Florida’s most vulnerable children and families, as a whole, the program is operating with beginning fidelity to Best Practice Standards. Evaluators anticipate that this is due in part to the fact that the Best Practice Standards are still considered a draft and are pending Supreme Court approval, and the fact that individual teams are operating with varying levels of fidelity. Notably, no team has reached what the evaluators consider “expected” fidelity, defined as meeting 70 percent of Best Practice Standards, though the vast majority were considered “developing” fidelity—meeting 40-60 percent of Best Practice Standards.

LINKING FINDINGS TO THE LOGIC MODEL

At the outset of the evaluation, the team crafted a logic model to represent the various processes and outcomes of ECC, with regard to Best Practices Standards (see Figure 8). The findings of the 2018-2019 ECC evaluation allowed the team to summarize findings by logic model element.

Figure 8. Florida Early Childhood Court logic model

There are three primary inputs of ECC: personnel, training, and funding.

Personnel

The evaluation indicates that, in terms of personnel, teams are truly multidisciplinary. Strong judicial leadership was noted across phases, through both qualitative interviews with team members and parents/caregivers, as well as survey responses. Judges and magistrates “set the tone” of the ECC and, across teams, demonstrate appropriate judicial demeanor, support parents and caregivers, and exercise inclusive decision-making. They are well-trained in best practice topics, the Safe Babies Court Team Approach, trauma-informed care, ACEs, and historical trauma. They take a more personal approach the courtroom (e.g., not wearing robes, coming down from the bench) and demonstrate compassion when engaging with ECC-served families. These efforts were not lost on parents and caregivers, who shared how influential these practices were in their ECC case.

Community coordinators are seen as the “central hub person at every ECC site along with the judge.” While community coordinators’ fulfillment of duties varied by individual team, in general, team members perceive that Florida’s ECC coordinators are doing their jobs well. Data indicate that some team members do not know whether or not coordinators are fulfilling their duties, which suggests a need for coordinators to make their efforts more visible to their colleagues. Though not applicable to all teams, several duties stand out as areas of improvement for community coordinators: recruiting new ECC team members, securing community partnerships to benefit families served by the ECC, and tracking data about the families served by the ECC team.

Infant mental health specialists provide a multitude of assessments with parents and children and consistently conduct infant mental health assessments, in accordance with Best Practice Standards. However, survey data indicate that only two-thirds of specialists implement the Progress in Treatment Assessment (PITA), suggesting an area of improvement for this role. Funding for providers is further discussed below (see Funding).

Attorneys described their role as assuring the letter of the law is followed in ECC proceedings. Attorneys did note that their accountability could be perceived by other teammates as being antagonistic or otherwise not family-centered. Indeed, fellow teammates shared that attorneys prioritize the law over the more therapeutic approach taken by others on the team. Attorneys reported that their role is not well understood and their opinions are not always respected by others. As one attorney shared, “I am the wrench...in the system because I still have to hold them accountable to my legal standards...I still have state and federal guidelines I have to meet.”

There was little discussion about the role of guardians ad litem and other team members (e.g., ancillary service providers, community partners). The role of child welfare workers is discussed further below (see Case Management). In addition, while the OCI considers parents and caregivers to be members of the ECC team, as they are not “personnel,” they are also described elsewhere (see Outputs/Targets).
Training

While many professional team members have received training on Best Practice topics (i.e., the Safe Babies Court Team Approach, trauma-informed care, ACEs, historical trauma), and additional related topics (e.g., intimate partner violence, Fetal Alcohol Syndrome, working with diverse populations), not all team members participate in training on an annual basis, in accordance with Best Practice Standards. In addition, not all team members are familiar with the Best Practice Standards and, even among those who are familiar, many have not read them. All ECC personnel should be well versed not only in the Best Practice Standards, but ECC-related topics. Thus, additional training is recommended. Notably, across teams, there was a desire for additional training on Neonatal Abstinence Syndrome. Despite some training deficiencies, team members generally perceive their teammates to be knowledgeable about ECC-related topics and qualified to work on the team.

Funding

Though the evaluation team did not intend to address funding outside of the scope of the cost effectiveness analysis, ECC team members, including some coordinators themselves, expressed concern over the neutrality of the community coordinator role when it is funded by an entity or entities other than the court. There was also concern that when a coordinator is funded by multiple sources, it can create competing responsibilities. Coordinators noted that without a lack of consistent funding and support, the team cannot grow to its full potential. Consistent funding would allow teams to “think about growth and long-term strategies…[and] know that this is going to continue.”

At the time of data collection (Fall 2018), there were 21 teams, only four of which had court-funded community coordinators. Follow-up analyses found few, but important differences in coordinator funding source. While teams with non-court-funded coordinators met several Best Practice Standards with more fidelity (i.e., family team meetings, post-reunification support groups) than teams with court-funded coordinators, the opposite was true for outcomes. Teams with court-funded coordinators had significantly faster time to case closure and a higher frequency of cases ending in reunification.

A separate funding issue noted was the lack of financial support for some child-parent psychotherapy (CPP) providers. Professional team members noted that CPP providers are deterred from participating in ECC due to the amount of non-billable hours they put into cases. Parents and caregivers similarly brought up issues of low pay causing turnover for agency workers who can bill for clinical services, but not time spent in ECC meetings or testifying in court.

Outputs/Activities

By nature of the program, all ECC cases are on a specialized docket and the team conducts numerous activities as part of its processes. The only activities not specifically addressed in this evaluation was the development of memorandums of understanding and additional stakeholder activities.

Family Team Meetings

Monthly family team meetings are an essential component of Early Childhood Court, where team members (excluding the judge) should convene for case planning and monitoring. Team members report these meetings happen monthly and are generally led by the community coordinator, in accordance with the Best Practice Standards. Moreover, Best Practice topics are discussed during these meetings (e.g., concurrent planning, monitoring transitions in placement, considering strengths of the parents). Notably, teams with a non-court funded community coordinator more often reported these meetings are led by the community coordinator and that each Best Practice topic is discussed. Team members perceive these regular and frequent meetings to be related to greater accountability and faster time to permanency. It can, however, be challenging for parents and caregivers to attend numerous meetings, particularly for those who are employed. In addition, sometimes meeting dates are not communicated with parents and caregivers in a timely manner, putting undue stress on families trying to actively participate. This is an important area of improvement given that parents’ and caregivers’ intimate knowledge of the child’s life contributes to these meetings. There can be frustration, however, at the lack of caregiver voice, if they are not given adequate time to provide the team with updates on the child during these meetings.

Evidence-Based Practice Child-Parent Therapy

While Best Practice Standards do not mandate the use of CPP, it was the most frequently cited therapeutic modality in the evaluation. CPP providers educate ECC team members about attachment, and advocate for secure attachment of the child with both parents and caregivers. Some team members perceive CPP to be a deciding factor in ensuring a “successful” case.

Identification of Service Coordination and Co-Morbid Issues

ECC-served families tend to have several intersecting risk factors. To help determine the specific needs of these families, they receive myriad assessments, such as parent-child relationship assessments; child assessments (trauma, medical, dental); and parental assessments (trauma, mental health, needed resources). Notably, while very few professional team members reported these assessments do not take place, depending on the type of assessment, anywhere from 14.3 to 38.7 percent did not know if they were taking place. This indicates that assessments are likely occurring, though some team members lack awareness of them. While service receipt was not directly examined in this evaluation, parents/caregivers reported that, in general, their team helps meet their needs. Still, only two-thirds of team members reported that quarterly stakeholder meetings involve identifying gaps in services, which is a suggested area of focus for improvement efforts.

Completion of Progress in Treatment Assessment (PITA)

While Infant Mental Health Specialists (IMHS)/CPP providers reported using a variety of assessments, Best Practice Standards indicate the use of the Progress in Treatment Assessment (PITA), which is to be updated as case plan interventions move forward. In an examination of fidelity to best practices, only about two-thirds of IMHS/CPP providers reported using the PITA, though the majority who use it update it as necessary.
Case Management
Team members described case managers as overseeing the entire case, which case managers corroborated in their description of duties (e.g., conducting monthly home visits, attending family team meetings, meeting with providers and parents, attending court, supervising visits, advocating for clients). One noted that their “recommendations are built upon the recommendations of other professionals.” Case managers reported working closely with both community coordinators and CPP providers. Notably, when turnover was discussed as problematic, it most often described case management turnover. Team members noted that it can be a “revolving door” and that changes in the dependency case manager often cause disruptions in case progress, as it takes time to on-board the new case manager and the ECC team must allow time for families to build rapport with a new professional. One parent reported that they were not informed when their dependency case manager changed.

Family Time/Visitation
Family time was assessed in term of best practices, which indicate the time should be both frequent and meaningful. Findings varied across individual teams, though as a whole, only about two-thirds of team members agreed with these items. Notably, while 10.4 percent of team members did not know frequency, 17.6 percent did not know meaningfulness. This might indicate that team members were more confident in frequency as an objective measure, but that meaningfulness would be better assessed through client input. Parents/caregivers were not directly asked about this, and future research should incorporate their perspective.

Post-Reunification Support
Like family time, post-reunification support varied by individual team. Statewide, nearly two-thirds or more of the team members reported that their team provides or arranges for home visitation, ongoing counseling, Head Start/Early Childhood Education/child care, and early intervention. While some teams had most or all of their team members report support groups are available, many did not and, as such, the evaluation team has recommended this an area of improvement.

Community Coordinator-Led Quarterly Meetings with Additional Stakeholders and Monitoring and Evaluation of ECCs
Approximately three-quarters of team members reported that their teams meet at least quarterly to discuss ECC-related issues. In general, teams do discuss available services in the community and issues and patterns observed in cases, though fewer identify gaps in services and review data. However, it is possible that there is not a singular meeting during which all team members discuss monitoring and evaluation-related topics, as indicated by varied responses in how often the team meets to discuss ECC-related issues (outside of team meetings and court hearings). This could explain why some participants did not agree that their team addressed best practice topics. The OCI should reinforce the importance of quarterly stakeholder meetings and remind teams to address each best practice topic.

Outputs/Targets
The target populations for ECC are 1) abused and/or neglected children ages 0-36 months who are removed and placed in out-of-home care (relative, non-relative, foster care); 2) parents; and 3) out-of-home caregivers. Administrative data indicate the mean age of ECC-served children at the time of removal is 13.91 months (SD = 14.43), or just over one year old. Due to the trauma during their early years of life, parents and caregivers noted that these children have both ongoing developmental and behavioral needs.

Across phases of the evaluation several characteristics, often interrelated, were used to describe parents involved in ECC, including substance misuse, mental health problems, experiences of intimate partner violence, and histories of (intergenerational) trauma and dual involvement (i.e., as a child in the child welfare system or as an adult in the criminal justice system). Though there was minimal representation from parents in the evaluation, the ones who did participate acknowledged their own histories of trauma.

While parental and caregiver inclusion scores were generally high, professional team members often did not describe parents and caregivers as members of the team, though they did acknowledge their participation. Team members described parents as working closely with the CPP provider, case manager, community coordinator, and caregivers. The concept of parents engaging primarily with a few members of the larger team was corroborated by parents themselves. With regard to caregivers, the professional team members consider them to be an important part of the ECC process. They are expected to both engage with the parent and bond with the child(ren). One case manager noted that, “We will not keep a kid in a home if the caregiver is not involved.”

Parents and caregivers who participated in interviews indicated an overall satisfaction with services. Though they can be logistically challenging to attend, monthly hearings and meetings are helpful in keeping everyone apprised of the case. Generally, parents and caregivers felt supported and received necessary community-based services, though this was not always the case. While some parents spoke of “not getting anything out of” certain social services, professional team members talked more about a lack of necessary resources to best serve ECC-involved families. Housing and transportation options were noted as particularly scarce. One parent noted that their team helped with transportation needs by providing ride share and gas gift cards.

Relationships with parents are an integral part of ECC, both between parents and caregivers, as well as between parents/ caregivers and the rest of the team. There can be inherent power imbalances as well as emotional challenges when participating in ECC, and trust and communication appear to be what combats these challenges. When communication does not occur (e.g., not informing parents of a change in ECC team member), it can decrease parents’/caregivers’ satisfaction with overall ECC experience. As in other phases of the evaluation, parents/caregivers who completed interviews indicated that the judges/magistrates greatly impact their ECC experience. Their stories indicate that, overall, ECC court is more family-friendly and compassionate than traditional dependency court.
Short-Term Outcomes

Short term outcomes are indicated for both professionals and clients, as well as the process as a whole. For professionals, participation in ECC should result in increased knowledge and skills regarding trauma-informed practice. While the present analysis did not assess for specific knowledge and skills, data indicate that most ECC professionals have participated in trauma-informed trainings. Further, teammates generally perceive one another to be knowledgeable and well-trained in ECC related-topics. Similarly, we did not address cultural competency, though the majority of ECC team members have received training in working with diverse populations and they agree that historically marginalized or disadvantaged groups receive equivalent access to and treatment within ECC compared to their peers.

For parents, participation in ECC should result in an increased understanding of past trauma on parenting and improved parenting capacity. The present evaluation had minimal participation from parents, but those who did share their experiences with the evaluation team seem to provide support for these outcomes. One parent recognized themselves as “an [Adverse Childhood Experience] kid” who is “trying to prevent that for my little children.” A foster parent spoke of a therapy session between a parent and child wherein the parent was educated on how their trauma could be transferred into their parenting style with the child. While these are isolated examples, they offer some evidence that activities to support these outcomes are happening. Though outcomes themselves cannot be determined, lower rates of recidivism/re-entry for ECC-served families (compared to families served by traditional dependency court) provides some indirect evidence that parenting capacity has improved.

While caregiver motivation was not directly measured, foster parents/caregivers who participated in interviews were generally satisfied with ECC. Still, some were critical of certain aspects of the approach. In terms of logistics, improvements could be made with regard to more timely communication of meetings and offering more time to provide their input on the case in those meetings. Being a working caregiver can be especially challenging given the intensive time commitment of the ECC approach. In addition, some perceive the intensive wraparound approach to be “enabling” and not giving parents “an opportunity to fail.” Still another expressed aggravation about cases that are allowed to “drag out” when parents were not compliant with case plans. It is plausible that caregiver motivation to participate might be reduced when they encounter these challenges or circumstances.

In terms of processes, participation should result in timely connection to necessary services. In examining Best Practice Standards, the majority of professionals agreed that cases are monitored closely during family team meetings, with 85 percent indicating that part of the meetings are spent considering additional needs of the families. Parents corroborated this, providing examples of concrete ways their team helped them get what they need (e.g., transportation, employment). Caregivers similarly indicated that they receive the assistance they need from support workers.

Medium-Term Outcomes

As with short-term outcomes, participation in ECC should result in medium-term outcomes for both professionals and clients. For professionals, one intended medium-term outcome is improved communication. Team members did report that team collaboration was often associated with clear and frequent communication, and an understanding of each other’s roles. Even when disagreements occur, communication is generally respectful.

While the majority of team members reported receiving trauma-related training (i.e., ACEs, trauma-informed care, historical trauma), implementation of trauma-informed care was not evaluated. Some indirect evidence indicates ECC operates from a trauma-informed lens. For example, both professional team members and parents/caregivers report that judges/magistrates demonstrate appropriate judicial demeanor and parental support, based on scales developed from the Best Practice Standards.

Nearly three-quarters of professional team members reported that their team addresses concurrent planning at monthly family team meetings. Service coordination was previously discussed in this chapter. See Identification of Service Coordination and Co-Morbid Issues above. The present evaluation did not examine differences in service coordination by court type (i.e., ECC vs. traditional dependency court).

Team members’ perceptions of team decision-making indicate that there is, generally, an understanding of cases from multiple perspectives. The majority are supportive their teams’ decisions and are comfortable with the way decisions are made. However, some do report being left out of the decision-making process, indicating a potential area of improvement. In terms of incorporating parent/caregiver perspectives in the case, team members indicate high parental and caregiver inclusion scores. Parents reported that they know there is an expectation that they actively participate (e.g., “They don’t just let me come in there and say nothing. They want to know what’s going on with me.”). Though caregivers were included in the process, they do not always feel that their time is respected (e.g., waiting at the courthouse for their hearing to start, not knowing about meetings until the last minute, being given only a few minutes at the end of team meetings to provide an update on the child).

For clients, participation ideally results in a reduction of re-abuse. Prior data analysis conducted by the OCI found that only 6.2 percent of ECC-served families re-enter the system, compared to 9.8 percent of families served by traditional dependency court. The ECC approach should also promote consistency of supportive placements for children. Analyses of closed cases found that the modal—or most frequent—number of placements for an ECC-served child is one. Moreover, in nearly all closed cases (88.9%), most children experienced only one (61.4%) or two (27.5%) placements. While the evaluation team did not compare total placements by court type (i.e., ECC vs. traditional dependency), one reason for the low number of placements might be the aforementioned support ECC provides to caregivers.

Improving parent-child relationships is a major tenet of ECC. In the fidelity analysis, most team members indicated a parent child assessment is conducted with families. More research, ideally involving IMHS/CPP providers and families, is necessary to better understand it and how parent-child relationships actually improve. From the limited parent-provided data, initial evidence suggests
that parental engagement and trust in the process occurs. Parents described that they were expected to actively engage with the program and communicate with the professional team. However, more parent perspectives are needed to confirm this.

As previously reported, relationships between parents and caregivers were described as integral to ECC, lending initial evidence to support that ECC participation meets the medium-term outcome of promoting co-parenting relationship between parents and caregivers. Indeed, parents/caregivers talked about getting to know one another and their ability to “co-parent” the child. Some spoke about how they shared physical space (i.e., by sitting next to each other in court) and how they continued their relationship beyond reunification. Parents/caregivers reported that this co-parenting approach helps them make decisions with the best interest of the child in mind. However, not every participant reported a positive relationship with their counterpart. This was primarily expressed by caregivers who were disappointed when parents did not engage with ECC.

Given that ECC-served families often face myriad challenges (e.g., IPV, mental health problems, substance abuse), another medium-term goal is reducing co-morbid problems. The evaluation did not specifically examine if and how ECC participation reduces co-morbidities. However, in examining ECC teams, evaluators found that the vast majority of participants find both opioids and IPV to be a concern among the families they served. Despite this, individual team analyses indicate that not every community is adequately prepared to address these issues. Substance use in particular came up frequently. Some teams have eligibility criteria that exclude potential participants based on the severity of substance abuse. Other team members voiced concern with how substance use fits into the timeline to permanency. Specifically, those with substance abuse problems might need more time than ECC typically allows to achieve sustained sobriety. A foster parent corroborated this, noting that they had worked with a family who reunified, only to return to substance misuse “as soon as we weren’t in their lives on a daily or weekly basis.”

Finally, participation in ECC ideally results in reduced time to permanency. Prior OCI analyses found that, compared to traditional dependency court, ECC cases closed an average of 142.1 days faster. Building on those findings, the current evaluation found that, within ECC, cases served by teams with a court-funded community coordinator close approximately two-and-a-half months faster than cases served by teams with non-court-funded coordinators. Notably, though based on limited parental input, faster time to permanency seems to serve as a motivating factor for parental participation in ECC.

**Long-Term Outcomes**

Most long-term outcomes focus on clients: increased rates of reunification, reduced recidivism (i.e., reentry into the child welfare system), increased court system satisfaction, and improved trust between caregiver and parent (regardless of outcome). Though this evaluation did not compare reunification rates between ECC and traditional court, analysis did find that teams with court-funded community coordinators had significantly more cases end in reunification (63.4%) compared to teams with non-court-funded coordinators (50.0%). In terms of reduced recidivism, as previously shared, prior OCI analysis found that while 9.8 percent of families served in traditional court re-entered the system, only 6.2 percent of ECC-served families re-entered. Moreover, the parents/caregivers who participated in an interview generally spoke positively about their ECC experiences. Most of them had experience in both ECC and traditional courts and noted benefits of the ECC approach. While the data also indicate trust and co-parenting between parents and caregivers, there was not enough variation in case outcomes to either a) compare the co-parent relationship within ECC outcomes, or b) compare the co-parent relationship between ECC and traditional dependency court. Future research with co-parent dyads (i.e., parent-caregiver) would be beneficial.

In addition to client outcomes, ideally the ECC produces cost savings compared to the traditional approach. In 2017, Florida’s ECC earned a Taxwatch Prudential Productivity Award for its innovative, cost saving practices. With its limitations in mind, this evaluation found that direct monthly costs (i.e., salary, fringe) are similar for both ECC ($1,012) and traditional dependency court ($990). However, given data that ECC cases close more quickly than traditional courses, over the life of the case, ECC is less expensive ($18,422 vs. $22,561). However, Foster and McCombs-Thornton’s cost analysis of the Safe Babies Court Team (SBCT) approach found that ECC was more expensive per child than the comparison group ($29,499 vs. $19,218). Notably, this analysis accounted for additional costs, such as in-kind services, Medicaid reimbursement, and out-of-home care cost. Still, even with these added costs Foster and McCombs-Thornton concluded that 70% of direct costs associated with the SBCT approach are recouped within the first year and that if children do not re-enter the system, long-term savings will accumulate and pay for the program.

**GENERAL ANSWERS TO EVALUATION QUESTIONS**

How does ECC differ from traditional dependency court in terms of implementation and outcomes?

Both professional team members and parents/caregivers reported that ECC meets more frequently, moves on a quicker timeline, and has a more compassionate culture compared to traditional dependency court experiences. The general consensus is that the greater frequency of meetings provides greater accountability and a faster time to permanency. Prior OCI analysis does, indeed, indicate that ECC cases close, on average, 142.1 days faster than traditional dependency court—a difference of over four-and-a-half months. Parents/caregivers, many of whom have experience in both types of court, reported the ability to co-parent as a strength of the ECC approach.

Are some ECC teams more successful in their ECC implementation; and, if so, what factors lead to being successful?

Statewide, ECC is operating with beginning fidelity to the approach. However, among the 15 teams analyzed individually, the majority are considered to be “developing fidelity,” meaning they are implementing between 40 and 60 percent of the Best Practice Standards with little to no remedial action recommended.
Professional noted the importance of caregivers being “on board” with the approach and demonstrating a willingness to mentor parents by serving as a positive parenting role model. Notably, some team members shared that there were instances where they did not anticipate a family’s outcome; they either anticipated reunification, which then did not happen, or vice versa. This indicates that it may not always be possible to predict case outcomes.

**Recommendations**

In Chapter 3, the evaluation team offered recommendations for remedial action based on fidelity to Best Practice Standards. Appendix A includes individual team reports, which show the recommendations tailored to each team. For each team’s role in meeting Best Practice Standard IX-C2, the evaluation team encourages them to “develop a remedial action plan and timetable to implement recommendations from the evaluator.”

- **Recommendation 1:** The OCI should work with community coordinators to enhance coordinators’ capacities to fulfill their duties.

- **Recommendation 2:** The OCI should consider funding all community coordinator positions through the court.

Participants expressed that the lack of a neutral funding source can impact processes, specifically the focus of the coordinator. Some expressed concern that non-court funded coordinators might lack neutrality or otherwise have competing priorities when not funded by a singular source. Moreover, some coordinators find it hard to plan for team growth without a sense of security for their position.

Initial analyses indicate that cases served by a team with a court-funded coordinator close two-and-a-half months faster (medium-term outcome) and more often to reunification (long-term outcome of interest) than cases served by teams with a non-court-funded coordinator. Relatedly, there was no significant difference in removals after case closure by funding source. Given the faster time to permanency and comparable reentry rates, there could be additional cost-savings per case that would defray some of the cost for these court-funded positions. Still, these are initial analyses. A cost-benefit analysis of coordinator funding source would be prudent to provide a more comprehensive picture.
Both professional team members and parents/caregivers noted that some providers are reluctant to participate in ECC given that much of their time is not billable. Lack of available providers can create a strain on the ECC process. Florida’s Drug Court Standards, which ECC’s Best Practice Standards are heavily based upon, note that case managers should leverage Medicaid expansion and health-insurance exchanges created by the Affordable Care Act to meet the medical and mental health needs of drug court participants. This option should be explored for ECC to incentivize clinician participation in ECC to meet the therapeutic and ancillary service needs of its participants.

**Recommendation 3:** The OCI should explore options for Medicaid reimbursement for ancillary and therapeutic services.

**Recommendation 4:** The OCI should provide or arrange for a statewide training for ECC team members on Neonatal Abstinence Syndrome.

While there was variation in professional team members’ desire for more training, Neonatal Abstinence Syndrome consistently emerged as one topic on which they wanted more education.

**Recommendation 5:** ECC should prioritize frequent, timely, and clear communication with parents and caregivers.

A logistical challenge noted by several of the parents/caregivers who participated in this evaluation is that meeting dates are not always communicated in a timely manner. Working parents/caregivers noted particular difficulty in taking time off work and re-arranging their schedule to be able to attend the numerous meetings and hearings for their cases. Ensuring that meetings are communicated well in advance can provide parents/caregivers more time to adjust their schedules in order to meaningfully participate in the process.

**Next Steps**

Florida’s Early Childhood Court is a robust program with numerous components. The 2018-2019 Evaluation of Florida’s Early Childhood Courts took a broad approach to evaluation to obtain baseline data on ECC’s processes and outcomes and, as such, more nuanced follow-up research is recommended.

1. **Evaluate team knowledge and skills related to trauma-informed care.** As implementing a trauma-informed lens is a key component to ECC, it would be prudent to evaluate the trauma-related knowledge and skills of ECC team members. While training on these topics is occurring, it is important to know if trainings are translating into practice for all members of the team.

2. **Explore case management models of ECC teams.** Turnover among case management was noted as particularly problematic for ECC teams, impacting the process for both professionals and families. Though child welfare turnover is common, it may be more problematic for ECC cases, which meet far more frequently than traditional dependency cases. Moreover, ECC case management differs between teams. For example, some community-based care agencies have a dedicated ECC case manager, while others have multiple case managers taking on ECC cases as part of their overall caseload.

3. **Conduct a targeted cost-effectiveness analysis.** While the present cost evaluation had breadth, it would be prudent to select a smaller number of representative circuits and gain a more complete picture of costs by examining the costs of all roles, as well as additional costs, such as those examined in the Foster and McComb-Thornton analysis.

4. **Seek additional client input.** Despite recruitment efforts, there was minimal participation from parents in the current evaluation. Their perspectives are critical in understanding how ECC impacts lives, as team members may have differing perspectives on or not know the experiences of clients in ECC. For example, nearly one-fifth of professionals did not know how meaningful family time is for ECC-served clients. This question is likely better answered by clients as it is subjective to their individual experiences and perceptions. In this same vein, research with parent-caregiver teams would be useful. For example, a case study of one or more dyads of providers (e.g., parent and foster parent of the same child) could provide further depth into the relationships among caregivers, how the ECC program may facilitate or impede those relationships, and how those relationships, together with the trauma-informed ECC program, may influence outcomes.

5. **Evaluate the effectiveness of therapeutic modalities used in ECC.** The ECC approach indicates improved parent-child relationships as a medium-term outcome. Future research should examine whether the current treatment modalities implemented result in improved relationships. Ideally, this research would include both client and therapist perspectives. Though CPP is not indicated as the only therapeutic modality, it was the most frequently cited throughout the evaluation. With that, a comparison of the effectiveness of CPP and other modalities would provide even greater nuance to this line of research.

6. **Explore the role of ECCs in promoting equity for disadvantaged groups in the dependency court system.** Though generally speaking, team members perceive that their teams afford equal access to and treatment within ECC, this varied by team, and client perspective might differ. Examining how pertinent characteristics (e.g., race, socioeconomic status) impact both case processes and outcomes would provide a richer understanding of ECC as a whole and illuminate areas for improving equity.

7. **Identify client characteristics or circumstances most likely to benefit from the ECC approach.** Given the myriad challenges and risk factors families face, an examination of how these factors (e.g., cases with co-occurring issues, housing safety/stability, repeat cases) impact processes and outcomes would be useful.

8. **Examine longitudinal outcomes.** Florida’s ECC is relatively new, with cases beginning in 2014. As time goes on and more data is collected, longitudinal outcomes for ECC-served families should be examined and compared with cases served by traditional dependency court.
References

1. Supreme Court of the State of Florida [Supreme Court]. (2018). Florida Early Childhood Court Best Practice Standards. Internal draft awaiting Court approval.


