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 model has on recidivism, permanency, and reunification of families, the goal of this evaluation is to track the broader implementation of the ECC model 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 in order to determine in what ways the model may be more effective, efficient, child- and family-centered, and whether there is a cost-savings to be gained by using the model.

To assist in carrying out the evaluation, the Institute subcontracted 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 model. Together, the Institute and USF staff completed the first phase of the evaluation through the collection and analysis of both qualitative and quantitative data from ECC team members across the state. The present interim report is an accounting of these evaluation activities.

The overall evaluation is a multiphase mixed methods study, with a particular focus on contrasting ECC processes and outcomes with traditional dependency court. In the present phase, evaluators concentrated on the perspectives of ECC team members as it relates to their own and others’ roles, court processes, the families they serve, and outcomes. Results will be used to inform the next phase of research, which will involve case studies of particular case profiles or implementation sites to answer more pointed questions that arose during the first phase.
**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 is as Lead Evaluator for the Institute, which includes 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, directing a multi-million-dollar project to prepare the Young Parents Project for evaluation. Additionally, the project sought 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 is 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’ 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, organizing workshops and field days, and overseeing 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 is as 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 Assistant 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 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 is to serve as Principal Investigator and take the lead in 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 assistant on the ECC evaluation, Ms. Mackie assists with evaluation tool development, data collection and analysis, reporting, and dissemination.

Tara Foti, MPH, is a Ph.D. student 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 research assistant for Dr. Marshall, Tara’s role in the ECC evaluation includes evaluation tool development, data collection and analysis, reporting and dissemination.

Ngozi Chukwu, 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 works 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 will conduct the cost effectiveness analysis for the ECC evaluation.
Background

A Brief History of Early Childhood Courts
Early childhood court 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.1 A problem-solving-court,1 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.”2 There is some empirical evidence to support the use of the SBCT approach, with the CEBC listing it as having “promising research evidence.”2 McCombs-Thornton and Foster conducted a quasi-experimental study,3 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.3 The goal of the 2018-2019 Florida ECC evaluation is to explore how this promising model is being implemented across Florida, with attention to processes, outcomes, and cost-effectiveness.

Theoretical Framework for Evaluation
Community Coalition Action Theory (CCAT)4 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 of the evaluation as well as an explanation of the methodology of the current evaluation phase, including separate descriptions of both the qualitative and quantitative strands.

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.

Figure 2. CDC Evaluation Framework

Logic Model
Drawing on the draft of Florida Early Childhood Court Best Practice Standards5 and the California Evidence-Based Clearinghouse for Child Welfare’s6 review of the Safe Babies Court Team, the evaluation team created a logic model to guide both process and outcome evaluation activities.7 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. As the current evaluation phase explored the process of implementing ECC from the perspective of ECC team members, this report focuses primarily on the inputs and outputs of ECC. See Appendix A for the full logic model.
**Research Questions**
Across phases, the 2018-2019 Florida ECC evaluation aims 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). In the first phase, which occurred between July 1, 2018 and December 31, 2018, the evaluators implemented a parallel, convergent, mixed methods design. In this design, quantitative and qualitative data were collected concurrently, analyzed separately, and then merged in interpretation,6 which is reflected in the results section of this report.

**Qualitative Strand**
The purpose of the qualitative strand was to gather in-depth feedback from ECC team members on the process of implementing an Early Childhood Court and their perceptions of its functioning within their team.

**RECRUITMENT**
Representatives from the Office of Court Improvement provided the evaluation team with a list of all current ECC team members, along with their role, circuit, ECC site, and e-mail address, if available. In August 2018, ahead of the annual Zero to Three Cross-Sites meeting, evaluators invited Cross-Sites attendees to participate in one of several focus groups to be held during the conference. Evaluators scheduled focus groups for ECC team members in the roles of case managers, clinicians, child well-being specialists (e.g., infant mental health specialists, child-parent psychotherapy providers), guardians ad litem, attorneys, judges, and magistrates. In addition, evaluators asked caregivers (i.e., foster parents, parent partners) and administrators and funders (i.e., Community-Based Care agencies, Department of Children and Families, trial court, Juvenile Welfare Board) to schedule individual interviews during Cross-Sites at their convenience. For those not attending Cross-Sites, or those who could not participate during Cross-Sites, evaluators offered to conduct in-person or telephone interviews at a later date.

Community coordinator participation was sought separately. Specifically, we informed coordinators attending the Office of the State Courts Administrator ECC Community Coordinator Meeting in October 2018 that members of the evaluation team would be in attendance to hold focus groups with them, should they choose to participate.

**DATA COLLECTION**
All focus groups and individual interviews with ECC team members were held between August and November 2018. Evaluators intended to host Cross-Sites focus groups by role and, in some cases, by level of implementation (see Appendix B); however, several groups were combined to accommodate the schedules of some participants. For example, some clinicians joined the case manager group. Similarly, during focus groups with the community coordinators, some administrators participated.

All participants were provided a project information sheet, either in-person or via e-mail, in lieu of a consent form. The interviewers went over the project information sheet with participants prior to data collection to ensure participants understood the process and answered any questions participants might have. Focus groups and interviews were audio-recorded and transcribed verbatim to ensure accuracy of data collection.

Evaluators used a semi-structured interview guide to assess ECC team members’ perceptions of their role; ECC-involved clients; the process of implementing ECC, including how it differs from traditional dependency court; ECC collaborations; and how and how community context impacts their ECC team. Interview guides were slightly altered to be tailored to particular roles and to accommodate focus group versus individual interviewees (i.e., language). Focus group materials are provided in Appendix C as an example.

Out of 48 focus group participants, 44 also participated in a brief activity where they indicated their perceptions anonymously on a flip chart of their team’s ECC implementation, effectiveness, team dynamics, and empowerment in their role.

**DATA ANALYSIS**
For focus group and interview data, digital audio files and verbatim transcriptions were uploaded to MAXQDA v12 (VERBI Software, 2015),7 a qualitative data analysis software. Evaluation team members conducted thematic analysis using constant comparison from an a priori codebook and grounded theory, where appropriate. For more detail on the codes and emergent themes, see Appendix D.

To summarize the focus group participants’ flip chart data points, evaluators provided the frequency of responses by role. Because rankings were anonymous, any additional roles joining a group (as mentioned above) were subsumed into that role category.

**Quantitative Strand**
The purpose of the quantitative strand was to gain a better understanding of ECC team members’ perspectives of their team, including their role, team leadership, team collaboration, and clients served. In addition, quantitative data allows for comparisons across roles and teams, which will help shape the next phases of evaluation inquiry.

**RECRUITMENT**
OCI representatives provided the evaluation team with a list of all current ECC team members, along with their role, circuit, ECC site, and e-mail address, if available. In August 2018, ahead of the annual Zero to Three Cross-Sites meeting, evaluators sent an invitation to complete an anonymous, online survey to 368 ECC...
team members for whom an e-mail address was provided. The e-mail provided a brief introduction to the evaluation with a link to the online survey, hosted by Qualtrics.a

DATA COLLECTION

Once potential participants clicked the link, they were directed to a project information sheet (see Appendix E). To maintain anonymity, the evaluators did not collect documentation of consent; instead, the project information sheet provided potential participants with the details necessary to decide whether or not to participate. Continuation with the survey was considered consent to participate.

Seven reminder emails were sent to all participants between August and November 2018. Because an anonymous link was used, the evaluators could not target reminder e-mails to only those who had not completed the survey. In addition, OCI representatives shared the anonymous link through their distribution channels.

In addition to the online surveys, the evaluation team printed hardcopy surveys for ECC team members attending Zero to Three Cross-Sites Conference in August 2018 and community coordinators attending their annual meeting in October 2018. Though most data were collected online, several participants completed hardcopy surveys, for which evaluators entered responses into Qualtrics.

DATA ANALYSIS

In total, 191 ECC team members engaged with the survey, though participants were removed if they did not answer any items (n = 15); provided their role but did not answer additional items (n = 22); or had significant missing data (i.e., <10% progress on the survey; n = 10). The final analytic sample includes 150 responses, representing 144 individuals. Specifically, 23 participants reported they worked on more than one ECC team and, of those 23, 5 provided data on multiple teams. In addition, participants working on the Broward County ECC team were given an opportunity to provide judicial perception responses for both leaders. Thus, the sub-sample sizes for judicial leadership items are slightly larger (n = 156). These are specified in the Results section of the report.

Quantitative analyses were conducted using IBM SPSS Statistics v25. The authors used guidance from Laerd Statistics (2017) for reporting of statistical tests and findings.10

a. Though we did not collect names of participants, given that ECC teams have some roles that are fulfilled by only one person (e.g., judges), it is possible these participants could be identified based on the totality of their responses. Given this, evaluators must, at times, limit the data shared to protect the confidentiality of those participants.

Measures

Role

Early Childhood Court Role is a categorical variable originally collected as follows:

- Judge/magistrate
- Community coordinator
- Infant mental health specialist/child-parent psychotherapy provider
- Parent attorney
- CLS attorney/Assistant State’s Attorney/Assistant Attorney General
- Guardian ad Litem attorney
- Child protective investigator
- Dependency case manager
- Guardian ad Litem
- Mental health treatment provider
- Substance abuse treatment provider
- Domestic violence service provider
- Early childhood education provider
- Parent peer mentor
- Foster parent
- Other, please specify

Due to small sub-sample sizes for some categories, roles were recoded as:

- Judge/magistrate
- Community coordinator
- Infant mental health specialist/child-parent psychotherapy provider
- Attorney (i.e., all attorney roles)
- Child welfare (i.e., child protective investigators, dependency case managers)
- Guardian ad Litem
- Other service provider (i.e., mental health, substance abuse, domestic violence, early education, or other social service provider)
- Other team members (e.g., community partner, administrator)

Importantly, participants who indicated they were supervisors were coded with their respective fields. For example, a case manager supervisor was coded as “child welfare.” None of the survey participants identified as parent peer mentors or current foster parents.

Training

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 chi-square analysis was conducted to determine differences in annual training participation by role.
Training sources were assessed with a check-all-that-apply response option and included: Zero to Three; Florida Office of Court Improvement; National Council of Juvenile and Family Court Judges; Another Florida ECC Team(s), please specify; Another ECC team outside of Florida, please specify; and Other, please specify. Frequencies were run on all items to assess responses for each source.

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 reported “yes.”

Familiarity with best practices 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 Material. Frequencies were run on both items to assess responses.

Best practices help-seeking was assessed through one open-ended item: “If you had a question about ECC best practices, how would you seek the answer?” Responses were explored for emerging patterns.

ECC Membership and Team Activities

Lead judge/magistrate is a categorical variable operationalized as the judge or magistrate who leads the participant’s ECC team. Response options were based on court leadership at the time of survey development and response options included judges names. In this report, we present lead judge/magistrate by county: Escambia #1, Escambia #2, South Okaloosa, North Okaloosa, Leon, Wakulla, Gadsden, Duval, Marion/Sumter, Pasco, Pinellas, Volusia #1, Volusia #2, Orange, Sarasota, Manatee, Hillsborough, Bay, Jackson, Palm Beach, and Broward (two leaders with a shared docket). This variable is used as a proxy for ECC team

Since participants can serve on more than one ECC team, there was an item assessing for this. Those who indicated they worked on multiple teams were provided an opportunity to complete the team-related items (i.e., all except role and training items) for each judicial leader. In addition, participants who serve on the Broward County ECC team were given the opportunity to evaluate their judicial leadership separately.

Length of ECC service is operationalized as number of months working on the ECC team. This variable was collected as an open-item response. When participants gave a range, the midpoint was used (e.g., “3-4 months” = 3 months). When participants provided an indefinite number of months, the number provided was used (e.g., “3+ years” = 36 months). Evaluators ran descriptive statistics to determine mean length of ECC service for each role.

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?” A frequency analysis was run to assess responses.

The family team meeting leader was assessed with three response options: 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. Frequencies were run on all items to assess responses.

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. A frequency analysis was run to determine how often ECC hearings are held.

Early Childhood Court 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.

Judicial Leadership

Judicial leadership position was assessed dichotomously (yes/no) with the item: “Do you consider your ECC team’s judge/magistrate to be the team’s leader?” A frequency analysis was run to assess responses. Participants who responded “no” were asked an open-ended follow-up question to assess who they perceive to be the team leader. Responses were explored for emerging patterns.

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 to 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 (n = 15) and there was no significant difference in missingness by role. The final sample size for appropriate judicial demeanor was 141. Analyses of this five-item scale indicate initial reliability (Cronbach’s α = .954). Initial construct validity is indicated by significant bivariate Spearman correlations between all scale items and total scale score (r = .693-.881, p < .001). A one-way analysis of variance (ANOVA) was conducted to assess the mean scale score across participants and detect any significant differences between roles.

b. To assess scale reliability and construct validity, the evaluators ran Cronbach’s alpha and bivariate Spearman correlations between scale items and total scale score as initial measures of reliability and construct validity. Scale reliability indicates that participants’ responses to a set of items are consistent, while construct validity indicates the items are measuring the concept they are intended to measure (Singleton Jr. & Straits, 2010).
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 (n = 140), and there was no difference in missingness. The final analytic sample size for judicial parent support was 140. Analyses of this five-item scale indicate initial reliability (Cronbach’s α = .936). Initial construct validity is indicated by significant bivariate Spearman correlations between all scale items and total scale score (r = .761-.887, p < .001). A one-way ANOVA was conducted to assess the mean scale score across participants and detect any significant differences between roles.

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 (n = 19) and there were no significant differences in missingness by role. The final analytic sample size for judicial caregiver support was 137. Analyses of this four-item scale indicate initial reliability (Cronbach’s α = .911). Initial construct validity is indicated by significant bivariate Spearman correlations between all scale items and total scale score (r = .796-.892, p < .001). A one-way ANOVA was conducted to assess the mean scale score across participants and detect any significant differences between roles.

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 (n = 22) and there were no significant differences in missingness by role. The final analytic sample size for inclusive judicial decision-making was 134. Analyses of this five-item scale indicate initial reliability (Cronbach’s α = .912). Initial construct validity is indicated by significant bivariate Spearman correlations between all scale items and total scale score (r = .807-.916, p < .001). A one-way ANOVA was conducted to assess the mean scale score across participants and detect any significant differences between roles.

Community Coordinator

The existence of a dedicated community coordinator for a particular team was measured dichotomously (yes/no) with one item: “Does your ECC have a local community coordinator?” Participants were also provided an “I don’t know” response option, which was coded as missing. A frequency analysis was run to assess responses.

Community coordinator leadership was assessed using an eleven-item adapted version of the Leadership subscale of the Partnership Self-Assessment Tool.11 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 = 51) and missingness did not significantly differ by role, as determined with a Bonferroni adjusted p value of .002. The final analytic sample size for self-efficacy was 99. Analysis of this eleven-item scale indicate reliability (Cronbach’s α = .977). Construct validity is indicated by significant bivariate Spearman correlations between all scale items and total scale score (r = .717-.903, p < .001). A one-way ANOVA was conducted to assess the mean scale score across participants and detect any significant differences between roles.

Fulfillment of coordinator responsibilities was assessed with eight individual, ordinal items developed from best practice language. 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. Originally intended to be a scale, there was significant missing data on several of the variables and missingness was significantly different by role. Therefore, frequencies for each of the eight items is presented by role instead of scale score.

Team Membership and Synergy

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 ordinally 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.

Team Synergy was assessed using a nine-item adapted version of the Synergy subscale of the Partnership Self-Assessment Tool.11 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 = 44), and missingness did not significantly differ by role, as determined with a Bonferroni adjusted p value of .002. The final analytic sample size for self-efficacy was 106. Analysis of this nine-item scale indicate reliability (Cronbach’s α = .961). Construct validity is indicated by significant bivariate Spearman correlations between all scale items and total scale score (r = .817-.890, p < .001). A one-way ANOVA was conducted to assess the mean scale score across participants and detect any significant differences between roles.

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. For those who responded, “yes,” an open-ended follow-up item was displayed: “Can you tell us a little more about the turnover on your ECC team?” Responses were explored for emerging patterns.
Perceptions of the Job and Team

**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 were run to obtain the mean and standard deviation for each role. A one-way ANOVA was conducted to assess the mean scale score across participants and detect any significant differences between roles.

**ECC percent of caseload** was assessed as the percent of total cases/workload that a participant’s ECC caseload size represents. For example, if a participant has a caseload of 25, 5 of which are ECC cases, this is 20 percent of the total caseload. Descriptive statistics were run to obtain the mean and standard deviation for each role. A one-way ANOVA was conducted to assess the mean scale score across participants and detect any significant differences between roles.

**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.

**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 (n = 22) and missingness did not significantly differ by role. The final analytic sample for time pressure was 128. Analyses of this five-item scale indicate reliability (Cronbach’s α = .938). Construct validity is indicated by significant bivariate Spearman correlations between all scale items and total scale score (r = .841-.918, p < .001). A one-way ANOVA was conducted to assess the mean scale score across participants and detect any significant differences between roles.

Decision-Making, Goals, and Outcomes

**Satisfaction with team decision-making** was assessed using a three-item adapted version of the Decision-making subscale of the Partnership Self-Assessment Tool. Response options ranged from 0 (strongly disagree) to 4 (strongly agree). Upon analysis, the adapted satisfaction scale demonstrated poor reliability (Cronbach’s α = .119) and, subsequently, the evaluators chose not to present scale scores, but response option frequencies for each of the three items.

**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.

**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. Frequency analyses were run to determine how many participants endorsed each response category.

Client Services

**Client limit in place** was assessed dichotomously (yes/no) with one item: “Does your ECC team limit the number of families accepted into ECC?”. There was an “I don’t know” response option. For those who responded, “yes,” a follow up item was displayed: “How many cases will the ECC accept at any one time?” A frequency analysis was run to determine how many participants responded “yes.” **Client limit** was recoded to include only responses with a definite numeric number of cases. When participants gave a range, the midpoint was used. 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 were run to assess the mean and standard deviation for client limit.

**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 eligibility 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.

ECC assessments/services performed were assessed dichotomously (yes/no), with an “I don’t know” option. Assessments and services listed included: 1) infant mental health assessment; 2) trauma assessment (child); 3) medical exam (child); 4) developmental screening (child); 5) dental exam (child); 6) parent-child relationship assessment; 7) mental health assessment (parent); 8) trauma assessment (parent); 9) assessment of other needed resources (e.g., transportation, housing assistance, parent medical/dental treatment, vocational/educational programs); and 10) other, please specify. Frequency analyses were run to determine how many participants endorsed each response option.

In addition, those who identified their role as infant mental health specialist (IMHS)/child-parent psychotherapy (CPP) provider were asked several additional assessment-related questions. Use of PITA (Progress in Treatment Assessment) was measured dichotomously (yes/no) with an “I don’t know” option, which was coded as missing. 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, which was coded as missing. A frequency analysis was run to assess responses. Finally, IMHS/CPP Providers were asked the open-ended item: “What other assessment tools do you use with ECC clients?” Responses were explored for emerging patterns.

Family time was assessed with several 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; 2) it is meaningful; 3) virtual methods (e.g., FaceTime) are utilized when needed and available; and 4) caregivers transport the child(ren) to visitation.” Response options ranged from 0 (strongly disagree) to 4 (strongly agree). There was also an “I don’t know” option, which was coded as missing. Frequency analyses were run for each item to determine how many participants endorsed each ordinal response option.

Regular case plan review was measured by one item: “Does the team regularly review and tailor the visitation plan?” Response options were dichotomous (yes/no) with an “I don’t know” option, which was coded as missing. A frequency analysis was conducted to assess responses.

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 response option.

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 score; there was an “I don’t know” option, which was coded as a missing. Participants who did not answer all five items were excluded from analysis (n = 34), and there was no significant difference in missingness by role. The final analytic sample size for parental inclusion was 116. Analyses of this five-item scale indicate initial reliability (Cronbach’s α = .927). Initial construct validity is indicated by significant bivariate Spearman correlations between all scale items and total scale score (r = .815-.891, p < .001). A one-way ANOVA was conducted to assess the mean scale score across participants and detect any significant differences between roles.

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. A frequency analysis was run to determine how many participants endorsed each categorical response category.

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 = 51) and there was no significant difference in missingness by role. The final analytic sample size for caregiver inclusion was 99. Analyses of this five-item scale indicate initial reliability (Cronbach’s α = .905). Initial construct validity is indicated by significant bivariate Spearman correlations between all scale items and total scale score (r = .846-.885, p < .001). A one-way ANOVA was conducted to assess the mean scale score across participants and detect any significant differences between roles.

Equivalent ECC access for and equivalent ECC treatment of 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). Frequency analyses were run for each item to assess how many participants endorsed each ordinal response option.
Special Topics

In addition to process-related questions, evaluators asked participants about two topics noted by OCI representatives as potentially important topics for ECC teams: opioid-related issues and intimate partner violence (IPV).

**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.

**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.

**Results**

This section reports the qualitative and quantitative results of the evaluation activities carried out between July 1, 2018 and December 31, 2018. Brief descriptions are provided for both the qualitative and quantitative samples. The results are organized according to elements identified in the logic model (Appendix A): who comprises the ECC team (inputs); how does the ECC operate (outputs/activities); who does the ECC serve (outputs/targets); and outcomes.

**Sample Descriptions**

**QUALITATIVE SAMPLE**

A total of 53 ECC team members participated in 1 of 15 focus groups or individual interviews.

Table 1 provides a breakdown of the number of participants by role. To protect the confidentiality of participants, the evaluators have withheld additional identifying information.

**Table 1. Qualitative participants by role (N = 53)**

<table>
<thead>
<tr>
<th>Role</th>
<th>Frequency (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Judges/Magistrate</td>
<td>24.5% (13)</td>
</tr>
<tr>
<td>Community Coordinator</td>
<td>24.5% (13)</td>
</tr>
<tr>
<td>Clinician/CPP Provider</td>
<td>13.2% (7)</td>
</tr>
<tr>
<td>Attorney</td>
<td>13.2% (7)</td>
</tr>
<tr>
<td>Case Manager/Supervisor</td>
<td>13.2% (7)</td>
</tr>
<tr>
<td>Administrator/Policy Expert</td>
<td>5.7% (3)</td>
</tr>
<tr>
<td>Foster Parent/Parent Partner</td>
<td>5.7% (3)</td>
</tr>
</tbody>
</table>

**QUANTITATIVE SAMPLE**

The final analytic sample of 150 ECC team member responses represents numerous roles (see Table 2) and each of the 20 ECC teams (see Table 3) throughout the state. Note, qualitative participants who identified as service providers were grouped as clinicians/CPP providers. In the quantitative strand, there was more nuance, as we separated IMHS/CPP providers from other types of providers (e.g., domestic violence, substance abuse).

**Table 2. Quantitative participants by role (N = 150)**

<table>
<thead>
<tr>
<th>Role</th>
<th>Frequency (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Judge/Magistrate</td>
<td>8.7% (13)</td>
</tr>
<tr>
<td>Community Coordinator</td>
<td>12.0% (18)</td>
</tr>
<tr>
<td>IMHS/CPP Provider</td>
<td>10.0% (15)</td>
</tr>
<tr>
<td>Attorney</td>
<td>20.0% (30)</td>
</tr>
<tr>
<td>Child Welfare Case Manager</td>
<td>16.0% (24)</td>
</tr>
<tr>
<td>GAL</td>
<td>15.3% (23)</td>
</tr>
<tr>
<td>Other Service Provider</td>
<td>16.0% (24)</td>
</tr>
<tr>
<td>Other Team Member</td>
<td>3.3% (5)</td>
</tr>
</tbody>
</table>

**Table 3. Quantitative participants’ reported teams (N = 156)**

<table>
<thead>
<tr>
<th>Role</th>
<th>Frequency (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Escambia #1</td>
<td>2.6% (4)</td>
</tr>
<tr>
<td>Escambia #2</td>
<td>6.4% (10)</td>
</tr>
<tr>
<td>South Okaloosa</td>
<td>7.1% (11)</td>
</tr>
<tr>
<td>North Okaloosa</td>
<td>0.0% (0)</td>
</tr>
<tr>
<td>Leon</td>
<td>6.4% (10)</td>
</tr>
<tr>
<td>Wakulla</td>
<td>5.1% (8)</td>
</tr>
<tr>
<td>Gadsden</td>
<td>1.3% (2)</td>
</tr>
<tr>
<td>Duval</td>
<td>5.1% (8)</td>
</tr>
<tr>
<td>Marion/Sumter</td>
<td>5.8% (9)</td>
</tr>
<tr>
<td>Pasco</td>
<td>10.3% (16)</td>
</tr>
<tr>
<td>Pinellas</td>
<td>3.2% (5)</td>
</tr>
<tr>
<td>Volusia #1</td>
<td>1.9% (3)</td>
</tr>
<tr>
<td>Volusia #2</td>
<td>1.9% (3)</td>
</tr>
<tr>
<td>Orange</td>
<td>4.5% (7)</td>
</tr>
<tr>
<td>Sarasota</td>
<td>5.1% (8)</td>
</tr>
<tr>
<td>Manatee</td>
<td>6.4% (10)</td>
</tr>
<tr>
<td>Hillsborough</td>
<td>3.2% (5)</td>
</tr>
<tr>
<td>Bay</td>
<td>7.1% (11)</td>
</tr>
<tr>
<td>Jackson</td>
<td>4.5% (7)</td>
</tr>
<tr>
<td>Palm Beach</td>
<td>1.3% (2)</td>
</tr>
<tr>
<td>Broward #1</td>
<td>3.8% (6)</td>
</tr>
<tr>
<td>Broward #2</td>
<td>3.8% (6)</td>
</tr>
<tr>
<td>Not reported</td>
<td>3.2% (5)</td>
</tr>
</tbody>
</table>

**WHO COMPRISES THE EARLY CHILDHOOD COURT TEAM?**

The ECC team is made up of numerous roles, with each expected to contribute their unique expertise and perspective. As ECC is more comprehensive than traditional dependency court, training on various topics related to ECC processes and issues ECC-involved families face is necessary. Early Childhood Court teams
do not operate uniformly, with one primary difference being in how the community coordinator position is funded. The present section describes what is known about Florida ECC inputs: personnel, training, and funding (see Appendix A).

ROLES

Qualitative participants described the ECC team as being made up of various stakeholders, including a community coordinator, judge, CPP providers, various attorneys (including both parent attorneys and child welfare attorneys), and a case manager. Parents and caregivers attend team meetings and court but may not be perceived fully as team members. When asked who was on the ECC team, few respondents mentioned parents. In addition, circuits may incorporate additional team members based on the family circumstances, such as representatives from relevant social service agencies, parent partners, or other supportive persons identified by the family. Many ECC members described a core team comprised of a subset of professionals who work closely with each other. The perceptions of who comprise the core team varied by participant and role. For example, attorneys described working closely with the judge. Case managers described working closely with community coordinators and CPP providers. Foster parents, parent partners, and judges described having a close working relationship with the community coordinators. An administrator/policy expert explained:

It’s a little bit flexible site to site, but your community coordinator is your central hub person at every ECC site along with the judge. Then every site also has primary clinicians usually from one, maybe two agencies and then every site has primary social service agencies, parent’s attorneys, and child welfare attorneys. In a sense, the core team is that group of people... Now, so the supervisor of the social service agency, for example, and maybe one person would be a DV specialist, and at another site they would have a DV and a substance abuse and a child welfare service agency. So, exactly who’s in that core team maybe different from site to site depending on the agency’s involvement and so on, but it’s generally key social service agencies, clinicians, community coordinator, judge and attorneys.

Judges and Magistrates

Among the 13 judges/magistrates, the average length of ECC service is 22.72 months ($SD = 14.90$), or approximately two years. Among all survey participants who provided a response ($n = 147$), 82.3 percent perceive the judge to be their team’s leader. Among those who said they do not consider the judge to be their team’s leader, the majority said the community coordinator led their team. Similar sentiments were shared by qualitative participants: “Our judge very much sets the tone of how things go,” said one CPP provider. Participants report that judicial leadership means ensuring that the ECC model is being followed, as one judge explained, “We’re just kind of setting the vision and setting the tone and making sure that we’re keeping true to that model.”

All judges who completed the survey confirmed they have received training on Adverse Childhood Experiences (ACES) and trauma-informed care, and a majority reported they have received training on the SBCT approach and historical trauma (see Training results for more details). Further, survey respondents generally agreed that judges demonstrate appropriate judicial demeanor ($M = 17.57$, $SD = 4.33$, $n = 141$); are supportive to parents ($M = 18.04$, $SD = 3.49$, $n = 140$) and caregivers ($M = 14.07$, $SD = 3.00$, $n = 137$); and exercise appropriate decision-making practices ($M = 10.46$, $SD = 2.36$, $n = 134$).

A one-way analysis of variance (ANOVA) was conducted to determine differences in perceptions of appropriate judicial demeanor by role. Data were normally distributed, as assessed by examination of Q-Q plots. Inspection of boxplots indicated several outliers, though these cases were retained in analysis. The data met the assumption of homogeneity of variance, as assessed by Levene’s test of homogeneity of variance ($p = .098$). Results indicate that there were no significant differences in perceptions of appropriate judicial demeanor by role, $F(7, 133) = 1.052$, $p = .398$.

A second one-way ANOVA was conducted to determine differences in perceptions of judicial parental support by role. Data were normally distributed, as assessed by examination of Q-Q plots. Inspection of boxplots indicated several outliers, though these cases were retained in analysis. The data violated the assumption of homogeneity of variance, as assessed by Levene’s test of homogeneity of variance ($p = .002$). Results show a significant difference in perceptions of judicial parental support by role, Welch’s $F(7, 46.923) = 2.528$, $p = .027$. Results of a Games Howell post-hoc analysis indicate that attorneys’ perceptions of judicial parental support ($M = 17.17$, $SD = 3.16$) are significantly lower than other team members’ perceptions ($M = 19.67$, $SD = 0.82$). There were no additional significant differences.

A third one-way ANOVA was conducted to determine differences in perceptions of judicial caregiver support by role. Data were normally distributed, as assessed by examination of Q-Q plots. Inspection of boxplots indicated several outliers, though these cases were retained in analysis. The data violated the assumption of homogeneity of variance, as assessed by Levene’s test of homogeneity of variance ($p = .004$). Results show a significant difference in perceptions of judicial caregiver support by role, Welch’s $F(7, 45.299) = 2.689$, $p = .014$. Results of a Games Howell post-hoc analysis indicate that attorneys’ perceptions of judicial caregiver support ($M = 13.48$, $SD = 3.02$) are significantly lower than other team members’ perceptions ($M = 15.67$, $SD = 0.82$). There were no additional significant differences.

Lastly, a one-way ANOVA was conducted to determine differences in perceptions of inclusive judicial decision-making by role. Data were normally distributed, as assessed by examination of Q-Q plots; however, other team members ($n = 7$) lacked necessary variance and were dropped from the ANOVA. Inspection of boxplots indicated several outliers, though these cases were retained in analysis. The data met the assumption of homogeneity of variance, as assessed by Levene’s test
of homogeneity of variance (p = .070). Results indicate no significant differences in perceptions of inclusive judicial decision-making by role, \( F(6, 121) = 1.576, p = .160 \).

Qualitative participants corroborated these findings, agreeing that judges are trauma-informed and engage parents by talking to them, remembering things about them, holding them accountable, and providing encouragement. They ensure that the court runs differently than traditional dependency court by taking a more personal approach, such as not wearing their robes, coming down from the bench, sitting at the table, engaging with all team members, and ensuring a positive environment with high team functioning. Judges were referred to as the “convener,” “problem-solver,” “conductor,” and “reflexive”. One judge provided a detailed summary of their role:

I see my role really two ways. I see myself as the glue to the team, just making sure that we are always working together as a team and not individually. I want to make sure that we have an open dialogue with each other; we understand what each other brings to the table when it comes to ECC court, respect the opinions from each other’s perspective, but be able to work together for the benefit of the family. I also see myself as the reminder that we are not traditional dependency court…We’re going to make sure that we distinguish ourselves, and that we are a problem-solving court. We’re an ECC court and we don’t do it the way that traditional dependency court does it.

Community Coordinators

Among those who provided a response (n = 135), 98.5 percent of survey respondents reported their ECC has a dedicated community coordinator. Community coordinators (n = 17) reported an average length of ECC service of 23.21 months (SD = 14.42), or approximately two years. Qualitative participants described the community coordinator as having a broad role in terms of facilitating and managing the collaboration of multiple team members. The CEBC notes that a local community coordinator “works with the judge to lead the [Safe Babies Court Team].”

In the present survey sample, the mean community coordinator leadership score was 35.69 (SD = 9.85) on the 0-44 scale. A one-way ANOVA was conducted to determine differences in community coordinator leadership scores by participant role. Data were normally distributed, as assessed by examination of Q-Q plots. Inspection of boxplots indicated several outliers, though these cases were retained in analysis. The data violated the assumption of homogeneity of variance, as assessed by Levene’s test of homogeneity of variance (p = .045). Results indicate that there were no significant differences in perceived community coordinator leadership by role, Welch’s \( F(7, 31.13) = 1.37, p = .254 \).

Community coordinators take on many responsibilities including attending hearings, facilitating meetings, explaining ECC to families, addressing team conflict, and linking to community resources. Survey respondents provided more specific perceptions of how much they agree that their community coordinator completes specific duties. Table 4 lists these duties in descending order of how many participants strongly agreed with the statement. Responses indicate that, in general, ECC team members agree their community coordinator carries out their responsibilities well. Notably, there was much missing data for several of the responsibilities listed, up to nearly one-third of participants. For example, 30 percent of participants did not provide a response to the item: “The community coordinator works to represent our ECC team in the national ECC learning community.” While we cannot confidently ascertain why this is the case, it is possible some ECC team members were unsure of how to answer the question (e.g., they are unfamiliar with that particular duty).

<table>
<thead>
<tr>
<th>Table 4. Perceptions of community coordinators (N = 150)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please indicate how much you disagree or agree with the following statements. The community coordinator works to:</td>
</tr>
<tr>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>Act as a liaison between the judge and the ECC team</td>
</tr>
<tr>
<td>Identify potential resources for families</td>
</tr>
<tr>
<td>Track data about the families served by our ECC team</td>
</tr>
<tr>
<td>Represent our ECC team in the local community</td>
</tr>
<tr>
<td>Identify potential resources for caregivers/foster parents</td>
</tr>
<tr>
<td>Represent our ECC team in the national ECC learning community</td>
</tr>
<tr>
<td>Secure community partnerships to benefit families served by the ECC</td>
</tr>
<tr>
<td>Recruit new ECC team members</td>
</tr>
</tbody>
</table>

Successful community coordinators were described as being good collaborators, being problem solvers, and having a good understanding of the ECC’s roles and model. One coordinator described their role:

For me, my role is to advocate and be a liaison between the court system and the unit. There are treatment providers, the therapy services. I act as that middleman between everybody to keep the case focused on ECC and to make sure that we are approaching it with an ECC model. Caseworkers have their tasks and service providers have their tasks, but one of my roles is to bring that all together to really hone in on the ECC model and to make sure that we are child-focused, that we really are thinking of the child first.
Infant Mental Health Specialists/Child-Parent Psychotherapy Providers

Thirteen Infant Mental Health Specialists and Child Parent Psychotherapy providers (IMHS/CPP) reported an average time on their ECC team of 17.40 months (SD = 13.81), or about 1.5 years. Qualitative participants described CPP providers as focused on parent-child attachment and being trauma-informed in their approach. An administrator/policy expert shared:

"The child-parent psychotherapy provider is essentially the primary clinician for each individual case... [they are] a central provider of the most intensive therapeutic intervention. It is the heart of helping parents recognize how trauma has affected them and how it affects their relationship with their child and helping them change the patterns towards something more helpful.

These providers perform a multitude of assessments with parents and their child(ren), help the parent feel supported, and help move the family toward permanency through communication, training, and helping parents identify parental habits that are not effective or trauma-informed. CPP providers also educate the courts and team members about attachment, and advocate for secure attachment of the child with both the caregivers and parents. As one community coordinator explained:

"For us, CPP is huge. We have not seen a successful case if the parent does not get engaged in CPP... they really start acknowledging, "Wow, I wasn’t parenting correctly," or "I can do better." For [my] county, we have not seen a successful parent that has not engaged with CPP. That’s usually a big identifier to us that this parent may not succeed.

Attorneys

Attorneys participating on ECC teams represent various agencies and clients. The present evaluation includes the perspectives of parent attorneys, CLS/Assistant State’s Attorneys/Assistant Attorney Generals, and Guardian ad Litem attorneys. Twenty-six attorneys reported an average time on their ECC team of 17.40 months (SD = 13.81), or about 1.5 years. Qualitative participants described attorneys as prioritizing the law over the more therapeutic approach taken by other team members. Attorneys described their role as ensuring that the letter of the law is followed as in all proceedings. They explained that their accountability to the law may be interpreted by other members of the team as aggressive, antagonistic, or not family-centered. One community coordinator corroborated this, saying, "Attorneys, by nature, by career track are... aggressive. Our family team meetings are very therapeutic. They’re very calm...We try to be very therapeutic and our attorneys don’t come from a therapeutic approach." Attorneys themselves also perceived that others do not understand their role within the ECC team and may struggle with feeling that their opinions are not respected by team members:

"I’m the bad person in the room, I’m the bad guy. I’m the one taking your kids, I’m the one telling you you’re not doing your job—and that applies to everybody whether it’s a case manager, whether it’s the parents. I’m the one giving, basically, the bad information. In a system that’s meant to be very kumbaya. I am the wrench...in the system because I still have to hold them accountable to my legal standards, and when you want to do something with the parent or you need more time, I still have state and federal guidelines I have to meet.

Child Welfare Workers

Twenty child welfare workers reported an average time on their ECC team of 18.14 months (SD = 12.22), or 1.5 years. Notably, qualitative participants did not discuss the role of GALs.

Guardians ad Litem

Twenty-one GALs reported an average time on their ECC team of 17.69 months (SD = 14.90), or about 1.5 years. Notably, qualitative participants did not discuss the role of other service providers, despite much discussion about the co-morbid issues they encounter among ECC-participating families (e.g., substance abuse, domestic violence).

Caregivers

Though there were no current relative or non-relative caregivers in the survey sample, the importance of caregivers was discussed in interviews and focus groups. Caregivers are required to work with the ECC team and be able to bring the child to court, visitations, and therapy, or the team may consider an alternative placement. One case manager/supervisor shared:

"We will not keep a kid in a home if the caregiver is not involved. We will tell them, "If you do not get on board with this and you do not get involved, we will find a new placement for that child."

Caregivers need to interact with the biological parents and are expected to appropriately bond with the child in a trauma-informed manner, which, according to a foster parent/parent partner, should transfer to positive attachment with the permanent caregiver:

"I think that the foster parents need to be mentoring the biological parents because that’s ultimately what is helping the children more long-term. A lot of the biological parents have never seen appropriate parenting behaviors."
Other Team Members

Several survey respondents are in other roles, such as community partners and administrators. Six of these individuals reported an average time on their ECC of 53.83 months (SD = 20.90), or about 4.5 years. Among qualitative participants, other team members discussed included court bailiffs and parent partners. Although not explicitly a part of the ECC team, bailiffs were described as important people in the courtroom, as one community coordinator shared:

[The bailiffs provide] a sense of safety. They develop relationships with the families as well because the families are coming so often. Sometimes the bailiffs will talk to families after and provide some influence or guidance, like young fathers.

I’ve seen our bailiffs have very nice conversations about, “Young man, this is why this is so serious.” It’s not taken as a threat. I mean, they really, again, are developing a relationship.

Parent partners, or peer-to-peer specialists, are individuals who have been through the child welfare system and can share their experience working through a case plan and achieving permanency. Their role is designed to be supportive for parents who may be afraid and overwhelmed by the ECC process. One judge explained:

[The parent partner is] ...a person that’s already kind of gone through the system successfully because they are actually finding that in terms of studies that some of the greatest support for the parent is to be able to reach out to somebody else. It’s kind of like your AA support group.

Notably, while ECC-involved parents attend monthly team meetings and regularly attend court, they are generally not perceived as a member of the team. Some providers talked about getting the whole team in agreement and then presenting a potential plan to parents or of the team being comprised of professionals. One CPP provider said:

…I think that we [professionals on the team] need to come together more as a team before we had our family team meetings…because it’s like everybody’s in there with their own agenda. We don’t know what each other’s agenda was… So, it would be helpful if we’re all communicating more. So that when we’re presenting things to the family, we’re as a united front...

The parent was described as working closely with the CPP provider and case manager, as well as a close relationship with the community coordinator and engaging with other caregivers. Judges ensure that the court environment is supportive of the parents, while the attorneys focus on legal standards and related accountability and progress.

TRAINING

Among 143 survey respondents, two thirds (67.8%, n = 97) indicated they participate in ECC-related training at least once per year. A chi-square analysis indicated there were no significant differences in annual training participation by role, as determined with a Bonferroni adjusted p value of .002; however, there was a large range, from 46.7 percent of attorneys to 100 percent of other team members reporting annual participation. ECC team members receive training from a variety of sources, including Zero to Three (60.4%), OCI (34.0%), the National Council of Juvenile and Family Court Judges (13.9%), other Florida ECC teams (13.9%), ECC teams outside of Florida (4.2%), and other sources (e.g., employing agency, DCF Child Protection Summit, the Florida Bar; 27.1%). Respondents reported that they had received and needed training on various topics relevant to ECC (See Tables 5 & 6). Many respondents across roles expressed a desire for more training on various topics, with frequencies varying by role. Notably, many participants across roles expressed a desire for more training in Neonatal Abstinence Syndrome, specifically.

In terms of best practices, 75.7 percent of respondents (n = 109) said they were familiar with Florida’s draft ECC Best Practice Standards, and, of those, 75.2 percent (n = 82) had read them. Survey respondents noted several resources they would seek out if they had questions about ECC best practices. Beyond reviewing the draft Best Practice Standards, ECC team members said they would reach out to their local community coordinator, their peers (either within their ECC team or their respective roles), OCI, their supervisor, and other ECC experts (e.g., Zero to Three, Miami Child Well-Being Court, Dr. Mimi Graham, Dr. Joy Osofsky).

Table 5. Topical training received by role (N = 144)

<table>
<thead>
<tr>
<th>Topical training received</th>
<th>Judge (n = 15)</th>
<th>Community Coordinator (n = 14)</th>
<th>WHC/ CPP (n = 14)</th>
<th>Attorney (n = 30)</th>
<th>Child Welfare (n = 22)</th>
<th>GAL (n = 22)</th>
<th>Other Service Providers (n = 24)</th>
<th>Other Team Members (n = 5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe Babies Court Team Approach</td>
<td>76.9%</td>
<td>92.3%</td>
<td>86.7%</td>
<td>50.0%</td>
<td>77.3%</td>
<td>68.2%</td>
<td>50.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Table 6. Topical training needed by role (N = 144)

<table>
<thead>
<tr>
<th>Topical training needed</th>
<th>Judge (n = 15)</th>
<th>Community Coordinator (n = 14)</th>
<th>WHC/ CPP (n = 14)</th>
<th>Attorney (n = 30)</th>
<th>Child Welfare (n = 22)</th>
<th>GAL (n = 22)</th>
<th>Other Service Providers (n = 24)</th>
<th>Other Team Members (n = 5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social work</td>
<td>23.1%</td>
<td>15.4%</td>
<td>20.0%</td>
<td>30.0%</td>
<td>22.7%</td>
<td>18.2%</td>
<td>61.1%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Childhood sexual abuse</td>
<td>46.2%</td>
<td>53.8%</td>
<td>6.7%</td>
<td>23.3%</td>
<td>27.3%</td>
<td>18.2%</td>
<td>29.2%</td>
<td>40.0%</td>
</tr>
</tbody>
</table>
FUNDING
As ECC operations vary from team to team, so does funding for the community coordinator position. In some circuits, community coordinators span multiple teams; in others, they only work part-time, or their time is split across other duties. As of November 2018, over half of the community coordinator positions (55.6%, \( n = 10 \)) were funded by the local community-based care agency; the remaining coordinator positions are funded by a local courthouse (22.2%, \( n = 4 \)) or social service agency (22.2%, \( n = 14 \)).

Funding appears to affect ECC team members’ overall perceptions of community context. Qualitative participants shared that funding sources could create confusion in terms of who is running the program. An administrator/policy expert shared:

“The thing that I really don’t like about the process... [some community-based care organizations fund] the community coordinator positions. Philosophically, I don’t believe it should be with the CBCs...they should be court programs. I feel very strong like that’s where we need to go, because these are court-based programs...I think it’s hard to manage because I think the staff struggle. Is it a CBC program, or is it a court program?”

Similarly, a community coordinator described a situation of different funding sources causing confusion about responsibilities:

“When you’re funded by different sources, your responsibilities, most of the time it’s not just this is what you’re doing, it’s, “Okay, we need you to do X, Y and Z in conjunction with all of this stuff right here and then attend these meetings and go here, go there.” You get further and further away from the purpose of what you’re supposed to be doing because they just keep adding to it late.

Two other community coordinators identified the funding security of their own positions as directly influencing and delaying program progress. One said:

“I also think that having confidence in the funding for the position of community coordinator [is necessary] because that allows your team to think about growth and long-term strategies versus just the immediate because we want to grow and we want to know that this is going to continue.

Survey respondents shared similar sentiments in an open response prompt soliciting additional feedback about their community coordinator. The issue of neutrality came up several times with one participant explaining, "The community coordinator is in a difficult position. The coordinator position is funded and supervised by the local community-based care organization. This situation does not provide the position with an ability to be neutral in matters related to ECC..." Another said, “This position really needs to be independent of case management with the community-based provider so [they] can hold team members accountable." This perception is shared by at least one coordinator working under a CBC, saying, “It is difficult at times to be a neutral party when your supervisor is also the supervisor of case management.”

How does an Early Childhood Court Operate?
According to qualitative participants, although knowledge of the ECC model varied among team members, there was a general focus on maintaining fidelity to the program despite it being new to some people. Furthermore, the program was sometimes slightly adapted to fit the particular circuit. Factors that helped in maintaining fidelity were having experienced team members, team members performing their roles using a trauma-informed approach, and collaborative team efforts. Challenges to maintaining the fidelity of the program included staff turnover and a need for comprehensive training, including provision of information, resources, and other tools needed for proper implementation. As shown in Figure 3, most qualitative participants, regardless of role, felt that the ECC model was being mostly or fully implemented by their team.

ACTIVITIES
Team Meetings
ECC team members meet regularly and frequently to address the needs of their clients. Both family team meetings and court hearings are major aspects of the ECC model. Among the survey respondents who provided an answer (\( n = 138 \)), 98.6 percent reported their ECC team hosts at least one family team meeting per month, with meetings (regardless of frequency) typically led by the community coordinator (81.8%, \( n = 121 \)). Though a few respondents said meetings are led by others (e.g., community-based care agency; 7.4%, \( n = 11 \)), or that they did not know who led their meetings (10.8%, \( n = 16 \)). During these meetings, the majority of participants (\( N = 150 \)) reported that their teams:

- Assess progress with case plans (83.3%)
- Consider additional needs of the families (82.7%)
- Assess treatment progress (82.7%)
- Consider strengths of the parents (79.3%)
- Ensure placement stability (76.7%)
- Address concurrent planning (68.7%)
- Monitor transitions in placement (67.3%)
ECC team members also participate in regular court hearings. Among 143 responses, 85.3 percent indicated hearings are held once per month, with few being held less (5.6%) or more (9.1%) often. Table 7 provides a breakdown of survey respondents’ perceptions of ECC hearing-related activities.

Table 7. ECC hearing-related activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes (%)</th>
<th>No (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consistent team member attendance (n = 130)</td>
<td>95.4%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Team members contribute relevant information and recommendations for court’s consideration (n = 134)</td>
<td>95.5%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Issues resolved and recommendations crafted prior to hearings (n = 127)</td>
<td>86.6%</td>
<td>13.4%</td>
</tr>
</tbody>
</table>

In addition to the family team meetings and court hearings, ECC teams convene to discuss ECC-related issues. Among 126 respondents, the majority (74.6%) reported meeting at least quarterly; several participants reported their team meets semi-annually (2.4%), annually (0.8%), or never (7.1%). Some respondents noted that their team met “as needed” or that they were “unsure.” Others said that, while they may not meet in person, they communicate in other ways (e.g., e-mail, text). During these additional meetings, the majority of participants (n = 150) reported that their teams discuss available services in the community (62.7%), identify gaps in services (58.7%), and discuss issues and patterns observed in the cases being monitored by the team (66.7%). Fewer participants reported that they conduct a review of data (46.7%).

Family Time and Support

One major tenet of ECC is allowing ECC-involved families to have family time, which is intended to be both frequent and meaningful.1 The majority of survey participants who provided a response to those items agreed that family time is, indeed, frequent and meaningful (see Table 8). Notably, many team members utilize virtual meeting methods to help facilitate family time. Though it is ideal for caregivers to transport child(ren) to visitation sessions, fewer than half of the respondents who answered that item agreed this is happening. Because visitation plans are not meant to be static, best practices call for regular review and tailoring of the plan,3 which among 110 survey participants, 87.3 percent reported this occurred.

Table 8. Team member perceptions of family time

<table>
<thead>
<tr>
<th>How often do ECC parents have “family time” with their child(ren)?</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is frequent (n = 116)</td>
<td>1.7%</td>
<td>5.2%</td>
<td>16.4%</td>
<td>55.2%</td>
<td>21.6%</td>
</tr>
<tr>
<td>It is meaningful (n = 107)</td>
<td>0.9%</td>
<td>3.7%</td>
<td>20.6%</td>
<td>59.8%</td>
<td>15.0%</td>
</tr>
<tr>
<td>Virtual methods (e.g., FaceTime) are utilized when needed and available (n = 101)</td>
<td>1.0%</td>
<td>12.9%</td>
<td>12.9%</td>
<td>55.4%</td>
<td>17.8%</td>
</tr>
<tr>
<td>Caregivers transport the child(ren) to visitation (n = 99)</td>
<td>4.0%</td>
<td>18.2%</td>
<td>31.3%</td>
<td>38.4%</td>
<td>8.1%</td>
</tr>
</tbody>
</table>

In addition to the services provided prior to reunification, teams are meant to provide post-reunification support as well. Participants reported offering families support groups (36.0%), home visitation (63.3%); ongoing counseling (66.0%); Head Start/early childhood education or child care (57.3%); and early intervention (Early Steps, or developmental therapies/services; 62.0%).

**PERCEPTIONS OF THE JOB**

**Caseload Size**

Among the 114 survey respondents who provided complete information about their caseload size, the average ECC caseload size among all workers was 9.27 (SD = 8.45), representing approximately 34.98 percent (SD = 37.44%) of their total caseload. A one-way ANOVA was conducted to assess differences in the number of ECC cases by role. Data were normally distributed, as assessed by examination of Q-Q plots. Inspection of boxplots indicated several outliers, though these cases were retained in analysis. The data violated the assumption of homogeneity of variance, as assessed by Levene’s test of homogeneity of variance (p = .001). Results indicate that the number of ECC cases is statistically significantly different by role, Welch’s F(7, 29.487) = 3.916, p = .004 (Table 9). Results of a Games-Howell post-hoc analysis indicate that other service providers have significantly fewer ECC cases than community coordinators and child welfare workers. There were no other significant differences in caseload size by role.

A one-way ANOVA was conducted to assess differences in ECC cases as a percent of total caseload between roles. Data were normally distributed, as assessed by examination of Q-Q plots. Inspection of boxplots indicated several outliers, though these cases were retained in analysis. The data violated the assumption of homogeneity of variance, as assessed by Levene’s test of homogeneity of variance (p < .001). Results indicated ECC cases as a percent of total caseload was statistically different by role, Welch’s F(7, 29.365) = 10.770, p < .001 (Table 9). Results of a Games-Howell post-hoc analysis indicates that ECC cases make up more of the total caseload for community coordinators compared to judges/magistrates, attorneys, and other service providers. Similarly, ECC cases make up more of the total caseload for child welfare workers compared to judges/magistrates, attorneys, and other service providers. These results suggest that, although community coordinators and child welfare workers in this sample do report a similar number of ECC cases to nearly every other role, ECC cases make up a majority of their workload. Comparatively, ECC cases make up a minority of the workloads of judges, attorneys, and other service providers, indicating these roles have higher total caseloads (i.e., regardless of case type). However, these results are likely due to the varying job responsibilities of these roles and cannot speak to actual time and effort spent on ECC cases.

Table 9. ECC Caseload Size (n = 114)

<table>
<thead>
<tr>
<th>Role</th>
<th>Judge (n = 11)</th>
<th>Community Coordinator (n = 13)</th>
<th>IMHS/Stockton (n = 14)</th>
<th>Child Welfare Worker (n = 12)</th>
<th>GAL (n = 19)</th>
<th>Other Service Providers (n = 17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>M (SD)</td>
<td>M (SD)</td>
<td>M (SD)</td>
<td>M (SD)</td>
<td>M (SD)</td>
<td>M (SD)</td>
<td>M (SD)</td>
</tr>
<tr>
<td>Number of ECC Cases</td>
<td>14.18 (11.44)</td>
<td>15.31 (11.44)</td>
<td>7.58 (3.35)</td>
<td>6.14 (3.47)</td>
<td>10.54 (4.47)</td>
<td>8.32 (4.63)</td>
</tr>
<tr>
<td>Other Cases as Proportion of Total Caseload</td>
<td>0.26% (6.65%)</td>
<td>0.62% (22.07%)</td>
<td>44.83% (40.69%)</td>
<td>12.43% (11.38%)</td>
<td>61.57% (43.97%)</td>
<td>38.06% (37.56%)</td>
</tr>
<tr>
<td>Number of Cases</td>
<td>13.66 (11.44)</td>
<td>14.67 (11.44)</td>
<td>7.58 (3.35)</td>
<td>6.14 (3.47)</td>
<td>10.54 (4.47)</td>
<td>8.32 (4.63)</td>
</tr>
<tr>
<td>Other Cases as Proportion of Total Caseload</td>
<td>12.43% (11.38%)</td>
<td>22.07% (22.07%)</td>
<td>43.97% (43.97%)</td>
<td>37.56% (37.56%)</td>
<td>50.26% (50.26%)</td>
<td>57.45% (57.45%)</td>
</tr>
</tbody>
</table>
Of the 114 survey participants who provided complete caseload data, 61.4 percent think their number of ECC cases is "about right." Notably, few participants (8.8%) reported their number of ECC cases to be "too high," while nearly one-third (29.8%) reported the number to be "too low." See Table 10.

### Table 10. Perception of ECC Caseload Size (n = 114)

<table>
<thead>
<tr>
<th>Judge (n = 14)</th>
<th>Community Coordinator (n = 10)</th>
<th>MWA CPP (n = 12)</th>
<th>Attorney (n = 9)</th>
<th>Child Welfare (n = 14)</th>
<th>GAL (n = 10)</th>
<th>Other ES Workers (n = 12)</th>
<th>Other Team Members (n = 6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Too High</td>
<td>0.0%</td>
<td>18.8%</td>
<td>33.3%</td>
<td>0.0%</td>
<td>7.1%</td>
<td>5.3%</td>
<td>5.9%</td>
</tr>
<tr>
<td>Too Low</td>
<td>36.4%</td>
<td>37.5%</td>
<td>33.3%</td>
<td>42.9%</td>
<td>35.7%</td>
<td>15.6%</td>
<td>5.9%</td>
</tr>
<tr>
<td>About Right</td>
<td>63.6%</td>
<td>43.8%</td>
<td>33.3%</td>
<td>57.1%</td>
<td>57.1%</td>
<td>78.9%</td>
<td>88.2%</td>
</tr>
</tbody>
</table>

### Time Pressure

A one-way ANOVA was conducted to determine if time pressure differed by role. Data were normally distributed, as assessed by examination of Q-Q plots, and there was homogeneity of variances, as assessed by Levene’s test of homogeneity of variance (p = .387). Inspection of boxplots indicated several outliers, though these cases were retained in analysis. The mean time pressure score was 8.78 (SD = 4.61) on the 0-20 scale, and there were no significant differences in score by role, F(7, 120) = 1.528, p = .164. The results indicate that, in general, ECC team members feel neutral about time pressure, regardless of role.

### Self-Efficacy and Empowerment

A one-way ANOVA was conducted to determine if self-efficacy differed by role. Data were normally distributed, as assessed by examination of Q-Q plots, and there was homogeneity of variances, as assessed by Levene’s test of homogeneity of variance (p = .356). Inspection of boxplots indicated several outliers, though these cases were retained in analysis. The mean self-efficacy score was 16.04 (SD = 2.64) and ANOVA results indicated significant differences by role, F(7, 122) = 2.299, p = .031; however, results of a Tukey post-hoc analysis revealed no significant differences in self-efficacy by role. The results indicate that, in general, ECC team members feel self-efficacious, regardless of role.

In addition to self-efficacy, as shown in Figure 4, most qualitative participants, regardless of role, felt empowered in their role. The relationship among team members was described overall as one where everyone felt respected. Most team members felt that they had power within the team, but there were some observed power discrepancies, with some team members holding more decision-making ability than others. For example, the judge was often seen as the person with ultimate power to decide which cases would be selected for ECC and what the outcome of each case would be. However, most team members felt equally heard and that they were working towards a common goal. This is further explored in the next section (How does the ECC Operate).

### Figure 4. Perception of empowerment in ECC role

**PERCEPTIONS OF TEAMMATES**

In general, survey respondents agree that their teammates have had adequate training, are qualified to work on the team, and reflect the diversity of the families served (see Table 11).

### Table 11. Perceptions of teammates

<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>
</tr>
</thead>
<tbody>
<tr>
<td>Receive adequate ECC-related training pertinent to their role (n = 125)</td>
<td>1.6%</td>
<td>14.4%</td>
<td>12.8%</td>
<td>43.2%</td>
<td>28.0%</td>
</tr>
<tr>
<td>Are qualified to work on the team (n = 133)</td>
<td>0.8%</td>
<td>4.5%</td>
<td>6.8%</td>
<td>53.4%</td>
<td>34.6%</td>
</tr>
<tr>
<td>Reflect the diversity of the families we serve (e.g., race, ethnicity, gender identity, language) (n = 133)</td>
<td>0.8%</td>
<td>11.3%</td>
<td>12.8%</td>
<td>45.1%</td>
<td>30.1%</td>
</tr>
</tbody>
</table>

Among those who provided a response (n = 118), nearly one-third (31.4%) reported that turnover is problematic for their ECC team. When prompted for more explanation, participants spoke to turnover generally, noting that it “causes inconsistencies and delays,” while another said it has resulted in them not having a “set team.” Still another shared their perception that the time commitment of ECC results in some team members deciding to leave: “ECC is very time consuming. People leave due to this and the feeling that nothing is truly addressed in staffings.” However, most often, survey respondents cited child welfare, and case management in particular, as the source of the turnover (e.g., “the case managers in this area are constantly turning over”). Described as a “revolving door,” many survey respondents described how this turnover negatively impacts their ECC, from slowing down the team because “there is a learning curve upon a new caseworker being assigned” to causing “a lapse with the progress of cases.” One participant spoke about recent high turnover among service providers and case managers, saying, “Families are having a lapse in services and [are] reluctant to work and open up to new providers.”

Regardless of role, qualitative participants similarly noted that turnover was challenging because new hires have to be educated in a seamless manner that does not disrupt the family support or the ECC process. Perhaps more problematic is when turnover creates situations in which there are no providers, or the remaining providers lack cultural competency. For example, one attorney shared, “We’ll be like, ‘This is our provider,’ so we now got to roll with it, even though we’re all cringing like, ‘This isn’t the best.’”

### AGENCY CONTEXT

Qualitative participants spoke to the importance of agency context. Specifically, a supportive agency was described to include instances where the ECC agency provides reflective supervision that addresses secondary traumatization of staff; appraises team member performance and makes changes to improve performance; and has strong relationships with the community. Participants felt having a supportive agency was crucial to the successful implementation of ECC. Factors that contributed to enhancing this support included adequate coordination of services between agencies, availability of...
resources (e.g., sufficient providers, transportation options), and necessary funding. As previously reported, funding source can also limit support if the source of funding was a real or perceived conflict of interest (i.e., lack of neutrality of the community coordinator). Perceptions of support varied, with some team members not feeling optimally supported by their agencies. Factors that negatively impacted support were high caseloads, which burdened team members, and supervisors’ lack of awareness of team members’ activities. A CPP provider shared:

I think for clinicians, we have to have support from our agency and if our agency doesn’t support us because—all of us in this process have such hype for secondary traumatization because of what we’re listening to all the time. If we don’t have support not only within the system, but within our organization to support us, then it’s not going to go well. It’s going to look bad and we’re going to end up traumatizing our parents, instead of supporting our parents and their children.

Agency Context was also described in positive terms, in particular with how it relates to developing relationships and teams. As one administrator/policy expert said, “Their CEO is always so positive. As an agency, they are so focused on the strengths that I think they’ve helped the team focus on that, so that’s been really helpful [for team building].”

COLLABORATION
Qualitative participants’ responses were more mixed in reporting on perceptions of ECC team cohesion than on empowerment and implementation (see Figure 5).

Figure 5. Perceptions of ECC cohesiveness

Based on 106 survey participants, the mean synergy score was 27.94 (SD = 7.00) on a 0-36 scale. A one-way ANOVA was conducted to assess differences in perceived team synergy by role. Data was normally distributed, as assessed by examination of Q-Q plots. Inspection of boxplots indicated several outliers, though these cases were retained in analysis. The data met the assumption of homogeneity of variance, as assessed by Levene’s test of homogeneity of variance (p = .117). Results indicate that team synergy was not statistically significantly different by role, F(7, 98) = 2.018, p = .060.

Communication
Qualitative participants perceived that communication between team members and between the team and parent(s) enhanced outcomes of ECC. Team collaboration was commonly associated with clear and frequent communication, as well as understanding the roles of each member of the ECC team. A CPP provider highlighted the importance of each team member communicating their perspective:

A good team means everybody’s doing their job… You want diversity, and you want different opinions… I want good conversation. I don’t want us always to agree. That wouldn’t be a good team. I don’t know if that makes sense or not, and some people think I’m weird, but I want somebody else’s eyes. I see a very controlled [therapy] environment right here for one hour a week, and I need somebody else to tell me what does it look like in another venue or another environment, in another system. I can report to this, but I need your trust and full faith that you’re going to report on the other stuff.

Team members generally communicated in a respectful manner even when they did not agree with each other. The ideal was to have open communication between all team members, where parents’ progress was discussed openly, and feedback was sought from team members before parent- or program-related decisions were made. However, lapses in communication among team members sometimes occur, particularly when team members are unaware of the activities other team members were carrying out with the families. This situation impacts optimal provision of services and can lead to the team presenting a less than united front to the families, and results in confusion. In addition, there was a perception that, in some instances, information was “filtered” when being passed on from one team member to another. A CPP provider shared an example of a time they nearly overrode the goal of a clinician working with a parent because they did not have all the information. Upon learning the clinician’s goal, the CPP provider said, “Oh my god. That’s all you had to say. [Laughter] So, I will not [do this]. I’ll just leave it alone.”

In addition to a lack of open communication, communication that is interpreted as harsh or potentially adversarial has created conflict, particularly when communicating with parents. Qualitative participants noted that frequent communication with families enabled the team to address emerging issues in a timely manner and oftentimes other family members received services that enhanced their relationship with the child. However, situations were mentioned where communication between team members and parents took a negative tone, which can impact the parents’ processes and outcomes. A community coordinator explained:

We have one or two [GALs] that… probably need to go through some training on how to be nice, but you can tell they have the best intentions. It’s just they don’t know how to say it in a way that’s not offensive and so then our parents don’t like them. They wonder why the parents don’t like them, but they don’t get, “Well, you ringed mom out or you just showed that you were so judgmental of mom and dad’s life, all because it’s not how you would live your life.”
Conversely, in cases with parents that were perceived to be less engaged, team members focused on transparent communication aimed at identifying challenges the parents were having and possible solutions to these challenges. In those instances, it was also helpful to leverage situations where a team member had the “best relationship” with the client. A CPP clinician said:

You are able to be more on top of the parents, catch things when there is a barrier. We’re all able to kind of catch it as a team and jump on it right away, versus on a regular case, you’re there every six months. So, if something happens, the case manager may feel that they don’t need to urgently work on it because, “I’ve got three months…” So then by the time it’s time to come to court, they’re just now working on those things and could have been resolved previously.

One case manager/supervisor identified how communication between team members and parents can be challenging but can also lead to greater transparency and open communication within the team:

I would say one of the challenging things—also going back to just the providers and case managers—sometimes the manipulative tactic that sometimes the clients would use, they’ll play it both sides. They’ll tell providers things that are not necessarily great about their case manager and they’ll tell the case manager things that are not so great about the providers, and so with us just having a cohesive group would be, it keeps communication open, we are aware of what’s going on.

Conflict

When qualitative participants spoke of conflict, it was often within the context of team members having differing foci, which can slow the progress towards permanency. For example, one case manager/supervisor explained that team members will say, “This is what we need to do to get it going on, and then the clinician is like, ‘Oh, no, wait. We want to process this. We want to talk about this.’” An attorney similarly noted that CPP providers are “given a lot of weight in this system,” and that their sole opinion can hinder reunification, even if it is in direct conflict with the law, as “…legally, there’s no reason not to reunify. That home is safe. You can work on the relationship once you get them in the home.”

Even among those who work directly with the children, there can be disagreement. For example, the CPP provider works to improve the parent-child relationship; the GAL advocates for the child; and the case manager oversees the whole case, gathers information, and makes decisions. A CPP provider explained:

Well, I think clinically, we come in a little bit differently, so far as we’re with the parent and the child, and we’re observing the relationship. We’re giving that feedback, which doesn’t necessarily agree with what the Guardian ad Litem might see…or what the case manager and the case manager’s team in terms of projecting the future [is thinking], like, “This will never work. Look at this history.” But… things change.

Decision-making

Despite these challenges around varying foci and the weighting of certain team members’ opinions, survey respondents reported that they are generally satisfied with the decision-making process of their team (see Table 12). The majority of those who provided a response were comfortable with and support team decisions. Still one-quarter of participants report they feel left out of the decision-making process.

Table 12. Perceptions of ECC team decision-making

<table>
<thead>
<tr>
<th>Please indicate how much you disagree or agree with the following statements. In general...</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am comfortable with the way decisions are made on the team (n = 131)</td>
<td>3.8%</td>
<td>8.4%</td>
<td>16.8%</td>
<td>53.4%</td>
<td>17.6%</td>
</tr>
<tr>
<td>I support the decisions made by the team (n = 131)</td>
<td>0.0%</td>
<td>6.1%</td>
<td>15.3%</td>
<td>62.6%</td>
<td>16.0%</td>
</tr>
<tr>
<td>I feel I am left out of the decision-making process (n = 130)</td>
<td>13.1%</td>
<td>39.2%</td>
<td>22.3%</td>
<td>16.9%</td>
<td>8.5%</td>
</tr>
</tbody>
</table>

Overall, qualitative participants described a culture of collaboration, frequent and open communication, and problem solving in their process, a cultural shift from the traditional dependency court model. Trusting relationships between members of the team can enhance their ability to serve families. Open communication and mutual respect were deemed important for building trust among team members. A case manager/supervisor provided an example:

I would say I have a very good relationship with our coordinator. I can trust her, depend on her, and vice versa. She can call me up about a case. We can talk about it, chat about it, discuss any type of issues that we may be having together.

Among survey respondents who completed the satisfaction with participation scale (n = 130), a mean score of 14.09 (SD = 4.17) indicates they are generally satisfied with their involvement on their ECC team. A one-way ANOVA was conducted to assess differences in satisfaction with ECC participation by role. Data was normally distributed, as assessed by examination of Q-Q plots. Inspection of boxplots indicated several outliers, though these cases were retained in analysis. The data met the assumption of homogeneity of variance, as assessed by Levene’s test of homogeneity of variance (p = .291). Results indicate that satisfaction with ECC participation does not significantly differ by role, F(7, 122) = 1.781, p = .097.
Who Does Early Childhood Court Serve?

In general, families (i.e., biological parents) participating in ECC were consistently described across respondents. Common issues include substance abuse, domestic violence, and mental health conditions. These three risk factors were often co-occurring, as described by one CPP provider, "Gosh. Substance abuse, mental health, domestic violence. Trauma, trauma, trauma, trauma. The parents really, really, really need a lot of support." Additional common characteristics of families include young age of parents and intergenerational involvement with the court system. As one community coordinator explained, "Ours, it’s very intergenerational trauma. Our judge has seen… like this is her fifth generation of this family that’s coming in." This section provides a description of 1) ECC inclusion criteria, 2) assessments used with ECC-involved families, 3) characteristics of ECC-involved families, and 4) common comorbidities of ECC-involved families.

INCLUSION CRITERIA

Of the survey respondents who provided a response (n = 111), 90.1 percent reported their ECC teams limit the number of families accepted into ECC. Some participants noted that while they know there is a limit, they are not aware of what that limit is, while others said their team’s limits are more dependent on the number of total children on cases, rather than cases themselves. However, 65 respondents reported that, on average, their team limits the number of cases to 19.56 (SD = 11.04). Of 115 survey respondents, 98.3 percent reported their ECC team has criteria for eligibility and exclusion for participation. Sixty-eight participants who said their team had eligibility criteria responded to the item assessing if criteria are specified in writing, with 85.3 percent (n = 58) responding “yes”. Table 13 provides further details about how criteria are used and communicated.

Table 13. Implementation of ECC eligibility criteria

<table>
<thead>
<tr>
<th>Criteria are specified in writing (n = 68)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>85.3%</td>
<td>14.7%</td>
</tr>
<tr>
<td>ECC team relies on written criteria for family eligibility (n = 48)</td>
<td>89.6%</td>
<td>10.4%</td>
</tr>
<tr>
<td>Criteria are communicated to potential referral sources (n = 49)</td>
<td>98.0%</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

Though survey findings indicate that ECC sites do have eligibility criteria in place and, according to qualitative participants, they are generally being implemented, the actual inclusion/exclusion criteria varied widely across ECC circuits. Some respondents reported that their ECC restricted participation based on many criteria, often rationalized as wanting to enroll families with the best chance of success. Restrictions on type of abuse, severity of substance abuse, and unavailability to participate in a fast-moving timeline due to mental health, substance abuse treatment, or incarceration were common across several circuits. One judge shared, “No sexual abuse, no contact orders…If there’s severe, non-treatable mental health… we also don’t take families that have a parent who’s incarcerated.” Some additional exclusion criteria are unexplained physical injuries and large, complex families with multiple children. The following example quote from an attorney illustrates this:

"Yes, if there’s an unexplained injury […] those are cases that don’t come in… the child has to be zero to three, that’s the goal here, but what we’ve been doing is taking cases that have a child that’s zero to three, but there’s six other children that range in age, 16 to newborn, and we think it’s really been a barrier because when you bring in that many other children, you have that many other parents and it’s really time boggling… and we feel like we spend so much time on children that aren’t even zero to three children, but you have a 15-year old that’s running away every week, that takes up majority of your staffing, majority of your court time…"

There are also ECCs that do not have specific exclusion criteria (e.g., “we don’t exclude anyone”) or those that intentionally seek more complex cases, with the reasoning that this intensive approach will result in a better outcome. A case manager/supervisor explained:

"See, our judge is really big about the [families who have been in the dependency system before]… she was like, “That’s the kind of person we want, the person that’s been through this so many times, but they haven’t gotten these services, so this time will be different for them.”

Some respondents identified an important middle ground by setting limits around meaningful participation. One participant shared their team’s process:

"Yes, we take any birth to fives. We’ve had parents with previous terminations… mental health, substance abuse, and domestic violence usually on all of our cases… We have first-time involvement with the Department of Children and Families. We have four or five kids previously removed and terminated. So, we’re very wide… the only thing that we’ve ever talked about is just kind of making sure that we don’t have parents that are so low developmentally that they can’t understand. We don’t want to set people up for failure. So, that’s been our only [exclusion criterion]—other than that, send them. We’ll do what we can.

ASSESSMENTS

Families who are accepted in ECC receive a plethora of assessments from their team members, from trauma to dental screenings (see Table 14). In addition to the assessments listed in Table 14, several participants noted that substance abuse evaluations are also conducted, and ACE scores are recorded. Note, sample sizes vary as data could have been missing or respondents could have selected “I don’t know.”

Table 14. Assessments conducted with ECC families

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental screening (child) (n = 109)</td>
<td>98.2%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Parent-child relationship assessment (n = 114)</td>
<td>98.2%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Infant mental health assessment (n = 105)</td>
<td>98.1%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Medical exam (child) (n = 104)</td>
<td>98.1%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Assessment of other needed resources (n = 107)</td>
<td>97.2%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Mental health assessment (parent) (n = 108)</td>
<td>95.4%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Dental exam (child) (n = 81)</td>
<td>93.8%</td>
<td>6.2%</td>
</tr>
<tr>
<td>Trauma assessment (child) (n = 103)</td>
<td>93.2%</td>
<td>6.8%</td>
</tr>
<tr>
<td>Trauma assessment (parent) (n = 100)</td>
<td>91.0%</td>
<td>9.0%</td>
</tr>
</tbody>
</table>
Those in an IMHS/CPP provider role were specifically asked about the Progress in Treatment Assessment (PITA). Of the 12 IMHS/CPP providers who responded, 75 percent reported they use the PITA, with six out of seven (85.7%) reporting that they update it regularly. These providers also reported using several other assessments with their ECC-involved families, such as Ages and Stages questionnaires and depression inventories.

CHARACTERISTICS

Characteristics of biological parents enrolled in ECC often included young age; previous exposure to risk (i.e., previous judicial involvement, previous involvement with the child welfare system in their own childhoods and/or as a parent); mental health issues; substance abuse; and intimate partner violence (IPV). More complex characteristics of parents that were described included emotional immaturity, need for mentoring and parenting coaching, and use of “manipulative tactics” among some in efforts to regain custody of their child(ren). A foster parent/parent partner spoke about an ECC-involved mother, saying, “She’s also very immature and needs a lot of support, and she’s 22. She needs a mom herself.” This same participant went on to add, “I think that the foster parents need to be mentoring the biological parents because that’s ultimately what is helping the children more long-term. A lot of the biological parents have never seen appropriate parenting behaviors.”

Qualitative participants often noted intergenerational involvement in the child welfare system, specifically describing parents (typically mothers) who were involved in the dependency system previously, including as current or former foster youth. This was mentioned across participants and described as an additional aspect of complexity. One CPP provider described how these parents may not trust the system: “This mother is severely traumatized. She was in the dependency system herself for years...So, it’s very difficult to get her to trust you.” A judge validated this belief, describing this intergenerational involvement as an indicator of system failure: “Some of mine were children that were in the system...I have apologized to them. I’ll say, ‘I’m sorry I didn’t know then what I know now.’” An administrator/policy expert shared a similar sentiment: “The kids who go through multiple foster placements, then come back into the system as parents with two or three more kids because we failed them when they were little.”

Despite some challenging characteristics, there were several descriptions of motivation and potential for growth among biological parents. In the words of one of the judge, “That knowledge of growth that they themselves have, to me, indicates that we’ve done something right, and so hopefully they’ll do better in the [bigger] picture, and society, they’re going to do better.” Another judge made a similar comment: “I think as we work with [parents], they would be listening. They’re going to be, ‘Well they are trying to get me educated. You really are trying to get my car back on the road.’ They can really try.” A case manager/supervisor provided more depth about the parents’ motivation and potential for engagement as a key factor in their case:

“I guess what made it successful is more—one is the parents’ motivation, the sense of that collaboration between everyone. They felt like, “Everyone is cheering for me to push forward to get my children back.” Just having that supportive role that the parent helped them to say, “Okay. Well, I’m not just doing this because you’re telling me to follow the case. I’m doing this because there’s a purpose. There’s a reason and I’m gaining insights from there. I’m learning from that.”

Interestingly, characteristics of the specific children in cases were not frequently mentioned by qualitative participants as affecting the ECC process in the same way that characteristics of the biological parents were described as important factors that influenced the overall ECC process. Other providers did not typically talk about children’s health or developmental needs in the context of ECC services, even though it is well known that young children who have experienced trauma are likely to need such services.

In terms of equity, survey respondents tended to agree that marginalized groups have both equivalent access to ECC services and receive equivalent treatment within ECC services compared to non-marginalized groups (see Table 15). Still, in terms of racial equity specifically, qualitative participants described ECC-involved families as predominantly White, which could be due to system distrust by other racial groups. More research is needed to explore this issue, though one attorney explained their perspective, saying “I don’t know if it’s just the fact that there’s the distrust of DCF within certain communities and they want as little involvement as possible.”

Table 15. Equivalence of participation between marginalized and non-marginalized groups

<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>
</tr>
</thead>
<tbody>
<tr>
<td>Equivalent access</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n = 107)</td>
<td>1.9%</td>
<td>2.8%</td>
<td>8.4%</td>
<td>37.4%</td>
<td>49.5%</td>
</tr>
<tr>
<td>Equivalent treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n = 110)</td>
<td>0.9%</td>
<td>2.7%</td>
<td>7.3%</td>
<td>36.4%</td>
<td>52.7%</td>
</tr>
</tbody>
</table>

COMMON FAMILY ISSUES (COMORBIDITIES)

Intimate Partner Violence

Among 125 survey respondents, nearly all of them (94.4%) consider IPV/domestic violence to be a concern among the families they work with on their ECC team. Corroborating this, qualitative participants described IPV as a common element in ECC cases, often described as deeply connected with parental mental health and/or substance abuse. One community coordinator explained it in terms of dependency, “They’re either dependent on the drugs or they’re dependent on the domestic violence partner.” Intimate partner violence was also linked to physical space, in that ECC staff accommodated IPV situations by keeping the parents a safe distance from each other.
A coordinator shared: “The bailiff will allow or the court will have the mother leave [and] clear [out] first and quietly hold the father back if there’s [sic] issues of DV so that the mom can leave safely without being followed or intimidated.” Notably, the majority of participants who perceive IPV to be problematic agree or strongly agree that their ECC team and community is prepared to address IPV (see Table 16).

Table 16. Preparedness to address IPV

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our ECC team has received training on intimate partner/domestic violence</td>
<td>2.0%</td>
<td>12.1%</td>
<td>9.1%</td>
<td>57.6%</td>
<td>19.2%</td>
</tr>
<tr>
<td>(n = 99)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Our ECC team is knowledgeable about intimate partner/domestic violence</td>
<td>0.0%</td>
<td>8.4%</td>
<td>10.3%</td>
<td>62.6%</td>
<td>18.7%</td>
</tr>
<tr>
<td>(n = 107)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Our community has the resources it needs to serve clients with intimate</td>
<td>2.7%</td>
<td>10.0%</td>
<td>13.6%</td>
<td>53.6%</td>
<td>20.0%</td>
</tr>
<tr>
<td>partner/domestic violence concerns (n = 110)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Substance Abuse

Similar to IPV, substance abuse was often mentioned in connection with other issues, such as mental health and IPV, and was described as a common issue among ECC-involved families across respondents. Substance abuse among ECC participants was primarily talked about in three ways. First, the range of substances involved, from marijuana and alcohol to opiates and methamphetamine, were discussed. One foster parent/parent partner noted their perception of substance prevalence among ECC cases, saying, “Honestly, it’s not like we’ve had 20 cases with cocaine. It is marijuana and alcohol.” Second, substance abuse was viewed as a challenge within ECC’s relatively short time requirement. A case manager/supervisor explained this challenge as “moving the cases too fast when you have a parent that have been dealing with substance abuse for over a long history, and you’re giving them 12 months to get it together.” Finally, qualitative participants spoke about an intergenerational cycle of drugs, violence, and victimization. A CPP provider shared:

They’re giving [drugs] to children so they will sleep... Some moms with that violence are more low functioning, not just uneducated, but maybe don't have the cognitive abilities, a little dull. Maybe that dullness comes from being so victimized for so long or maybe using substances for so long. The victimization probably started with them when they were children.

Evaluators asked the survey respondents specifically about opioids. Among 119 respondents, most (88.2%) consider opioid-related issues to be a concern among the families they work with on their ECC team. Notably, while a majority of participants who think opioid-related issues are problematic agree or strongly agree that their ECC team and community is prepared to address opioid-related issues, there are still many who disagree. For example, nearly one-third do not believe that their community has the necessary resources to address opioid-related issues (see Table 17).

Table 17. Preparedness to address opioid-related issues

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our ECC team has received training on opioid-related issues (n = 81)</td>
<td>3.7%</td>
<td>18.5%</td>
<td>17.3%</td>
<td>40.7%</td>
<td>19.8%</td>
</tr>
<tr>
<td>Our ECC team is knowledgeable about opioid-related issues (n = 91)</td>
<td>1.1%</td>
<td>13.2%</td>
<td>16.5%</td>
<td>52.7%</td>
<td>16.5%</td>
</tr>
<tr>
<td>Our community has the resources it needs to serve clients with opioid-</td>
<td>7.4%</td>
<td>23.2%</td>
<td>16.8%</td>
<td>35.8%</td>
<td>16.8%</td>
</tr>
<tr>
<td>related issues (n = 95)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PARENTAL PARTICIPATION

Empowering ECC team members, including families, was a key emerging theme across roles in the qualitative data. ECC centers around the family, and the relationship within the team is one that encourages empowering the parents and giving them a voice regarding what happens to their child. For example, one judge said, “I think also, by letting [parents] have a voice, it lets people hear what they’re learning and [lets the parents] practice what they’re learning...It’s so good for them to be able to articulate it.” Similarly, a case manager described the positive aspect of ECC parents having more of a voice in court:

The parents themselves who were successful, they gained a lot of empowerment when we do go to court where they are actually noticed and they actually have a voice and they’re allowed to speak up for themselves on things that they want.

Survey respondents tended to perceive that parents are engaged and included in the ECC process. Among 117 respondents, 43.6 percent reported that 76-100 percent of parents actively participate in the process, while another 39.3 percent reported that 51-75 percent of parents participate. A minority of participants reported that fewer than half of parents actively participate (17.1%). Similarly, participants (n = 116) perceive that parents are included in the ECC process: the mean score on the parental inclusion scale was 17.44 (SD = 3.47), on a 0-20 scale. A one-way ANOVA was conducted to assess differences in perceived parental inclusion by role. Data was normally distributed, as assessed by examination of Q-Q plots. Inspection of boxplots indicated a couple of outliers, though these cases were retained in analysis. The data met the assumption of homogeneity of variance, as assessed by Levene’s test of homogeneity of variance (p = .325). Results indicate that team members’ perceptions of parental inclusion does not significantly differ by role, F(7, 108) = 1.210, p = .303.

However, some qualitative participants felt that, despite the focus on parent empowerment, this was not always the case, as parents may sometimes believe that they had no control over what is being taken from them or that they had to do as they were told to attain a specific outcome. Some team members described...
being involved in parent advocacy during the ECC case process. Several members of the team discussed their advocacy efforts on behalf of parents in some instances; however, in other instances, team members had to be firm with the parents in order to advocate for the child. An attorney explained:

They’re either going to get reunified or you’re going to have that whole team pushing for an alternative goal, so it’s really up to what the parent does. They have a lot more control over what happens to their case versus a traditional case, where no one’s watching and then everyone else is going to make the decision based upon what happens during a very large period [of time] versus—I feel like the [ECC] parents have a lot more say [as] to what happens going to happen to their kids.

A case manager/ supervisor corroborated this, saying:

We have a parent that’s like, “Well, if you just tell the judge to give me my babies back, she’ll give them back,” and we’re like, “That’s too much. We’re not stupid. She’s not going to just give your kids back.” We joked like, “Who’s the enemy number one this week?”

Qualitative participants noted the importance of trust and attachment between team members and parents. A trusting relationship between the team and families enabled engagement of parents who were subsequently eager to receive services and get involved. According to team members, some parents find it difficult to trust the team because of trauma and previous negative experiences within the system. They also reported that some parents find it difficult to trust themselves to adequately provide for their child. Team members tried to build trust with parents through transparent communication and leveraging situations where the parents felt connected to a particular provider or team member. The structure of the ECC itself promoted trust and attachment between families and the team because the team spends time with families until permanency is achieved. In addition, helping parents deal with trauma and enhancing attachment between the child and their family is often part of the services that are provided to families involved in ECC.

**CAREGIVER PARTICIPATION**

Similar to parental participation, survey respondents tended to agree that caregivers are included in the ECC process: the mean score on the caregiver inclusion scale was 16.91 (SD = 3.00), on a 0-20 scale. A one-way ANOVA was conducted to assess differences in perceived caregiver inclusion by role. Data were normally distributed, as assessed by examination of Q-Q plots. Inspection of boxplots indicated a couple of outliers, though these cases were retained in analysis. The data met the assumption of homogeneity of variance, as assessed by Levene’s test of homogeneity of variance (p = .405). Results indicate that team members’ perceptions of caregiver inclusion do not significantly differ by role, F(7, 91) = 1.006, p = .432.

**Lack of Resources**

Qualitative participants shared concerns regarding the lack of availability of resources for ECC-involved clients within their communities, such as transportation and access to healthy food, education, and housing. Among these, the biggest issues were transportation and housing. An administrator/policy expert explains:

Transportation’s an issue. Housing’s an issue. We’ve been feeding the families. We’re trying to transition that from the case workers and the community coordinators and those folks doing that out of their pockets. Two Baptist foundations have now said that they were doing it. You know we’ve got to make that more systematic.

These limitations, attributed to insufficient family income and system-level issues such as lack of viable public transportation or affordable housing, were also exacerbated or caused by the presence of a criminal record, limiting parents’ abilities to qualify for housing or employment. These issues strongly impacted families’ participation in ECC. In some communities with limited resources, there was concern about the case worker and community coordinator spending considerable time assisting families with these issues, emphasizing a need to have a more systematic way of handling them. An attorney described some of the many barriers these families face when attempting to access resources:

We have a lot of families with substantial history, with prior removals. I’d say there’s definitely a lot of trial history for the individuals involved. A lot of involvement in criminal justice system and that’s the type of barrier for housing and things like that. Substance abuse is present in probably 90% of our cases. Domestic violence is an aspect in almost all of our cases as well, of either current or prior. A lot of our families have various levels of housing insecurities and employment inconsistency.

The ECC tries to address some of these challenges when possible, such as by providing bus passes for parents or offering information on where to access programs and services within the community.

In addition to housing and transportation barriers, some counties have a lack of service agencies or providers, such as domestic violence centers, substance abuse treatment centers, mental health services, child parent psychotherapy, and foster homes. Even in locations where these services existed, there were sometimes barriers to accessing them. For example, because they were inconveniently located (i.e., long distance from the family’s home) coupled with a lack of transportation. In some situations, there was concern about the quality of services provided by these agencies. Those living in urban areas generally had greater availability of services than those living in rural areas, though even in urban areas, limited access via public transportation is a major barrier.
What are the Outcomes of Early Childhood Court?
Similar to cohesion, qualitative participants’ responses were more mixed in reporting on perceptions of ECC team effectiveness (see Figure 6).

![Figure 6. Perceptions of ECC team effectiveness](image)

Successful outcomes were discussed in one of several ways: 1) success for the child; 2) success for the parent; and 3) factors influencing success. As safety and permanency are important outcomes for all dependency cases, participants shared that a child arriving at these statuses is successful—which does not necessarily require reunification. As one community coordinator said, “The children, they’re in safe environments. Either way, they’re in a safe environment where they’re well-nurtured and set up for success.” Participants spoke to parental success within ECC, and across respondent roles, parental motivation and transformation or improvement was seen as success for parents. In terms of what facilitates success, team members again spoke about how this parental motivation, as well as the team-based approach, is important in achieving success. Regarding the latter, one administrator/policy expert spoke to why they believe the team-based model makes a difference for these high-risk families—especially those who have already experienced failures in traditional dependency court:

*If you look at the risk conditions of the families [coming in] site to site, they’re no different, and these families have tremendously high levels of social risk trauma, substance abuse, and domestic violence... It’s not the case. It’s the team.*

The idea that the ECC approach is more compelling than any individual characteristic is supported by comments about unexpected successes: A judge shared, “I’ve worked with probably 20 families so far. The outcomes have been really good although, we had a couple of good outcomes of people that I never, never would’ve believed would ever be unified.”

Though there are successes, challenges also exist, and were described as those elements that impede the ECC process, such as parent insincerity or manipulation. For example, one attorney said, “We have a lot more re-removals and when those families come back again, a lot of times they admit that they were successfully able to deceive the team and their providers about, say, drug use.” Participants said that sometimes parents faced insurmountable issues that made it difficult to fully participate in ECC. For example, challenges were described in relation to social determinants of health (e.g., housing, employment, basic needs), with one judge sharing, “We live in areas where the transfer—public transportation is virtually non-existent.” Moreover, a foster parent/parent partner pointed out that the removal of a child often means an end to public assistance that parents need in order to provide a safe and secure home environment:

*Their Medicaid is taken away, their food stamps, their housing and so we’ve kind of tied their hands behind their back like... “Show all of these things. Get a job even though we’re requiring eight hours of your time every week, and then even more so on ECC weeks and do that with no housing funding, no food.”*

Discussion

The present evaluation phase focused heavily on the process of ECC implementation. Exploring ECC processes allows the evaluation team to more fully understand how teams are operating, which will be useful in contextualizing the eventual examination of outcomes. Namely, it provides information on how well ECC teams across Florida are implementing ECC with fidelity (i.e., adhering to best practices). When assessing outcomes in the future, evaluators can be more confident that outcomes are reflective of the model as it is intended to be implemented. The next phase of evaluation (Spring 2019) will include more nuanced analysis of individual ECC teams, when possible, to help better assess fidelity by team and tailor recommendations for improvement. In addition, pending data availability from OCI, the evaluation team may be able to associate outcomes with varying levels of fidelity to the model. For example, evaluators could explore if and how certain aspects of ECC (e.g., team synergy, caseload limits, community coordinator position funding) impact outcomes. These analyses could support or inform changes to the current best practices.

Summary of Findings

The current findings indicate that, in general, ECC teams in Florida are implementing the process in accordance with best practices, as reported by ECC team members. Though there is some variation in how teams operate, there were very few statistically significant differences by role in the implementation processes measured. This gives the evaluators more confidence that team members are in agreement with the state of implementation across roles. In general, participants reported feeling both self-efficacious and empowered in their individual roles. They look to their judges and magistrates to “set the tone” as the leaders of their teams. Judges’ and magistrates’ self-reports indicate they have received training in major ECC topics (e.g., ACES, trauma-informed care) and their fellow ECC team members corroborate this, perceiving their judges to exhibit therapeutic jurisprudence in the forms of appropriate judicial demeanor and decision-making, and providing parental and caregiver support.

Nearly all ECC teams have a dedicated community coordinator, who participants generally perceive to demonstrate leadership on the team. Though many participants agreed that their community coordinator fulfilled many of their responsibilities (e.g., act as a liaison between the judge and the ECC team, secure community partnerships to benefit families served by ECC), there was a large amount of missing data on those items. This could
indicate that participants are unaware of the responsibilities of their coordinator and/or how well he or she completes them—a potential disconnect in communication between roles. Notably, a major point of turmoil for many participants is the funding of the community coordinator position. A number of participants voiced concerns about the neutrality of the coordinator when they are funded by and housed in the local community-based care lead agency. This is an area of inquiry that the evaluation team will be explored further in Spring 2019.

The majority of participants are familiar with Florida’s draft ECC Best Practice Standards, and of those, most have read them. Participants have received training on a variety of topics, but across roles, appear most interested in learning more about Neonatal Abstinence Syndrome. Many participants receive training from ZTT and OCI, so those entities might consider creating additional training content on this topic. Though many participants reported needing more training on one or more topics, they generally agreed that their peers are well-trained in ECC topics and qualified to work on the team.

Participants reported that their teams do attempt to maintain fidelity to the ECC model by having experienced team members, taking a trauma-informed approach, and working collaboratively. The majority of participants reported that their teams do hold the standards-suggested monthly team meetings, and many are engaging in activities that are aligned with best practices. Court hearings are also held regularly—at least once per month for 94.4 percent of the sample. Team members are generally happy with their ECC caseload size, though nearly one-third perceive it to be too low, indicating a desire to expand program capacity. A primary challenge for team dynamics was turnover, with one-third reporting it to be problematic for their team. Case management in particular was cited as having high turnover and slowing down ECC case progress.

Though perceptions of team cohesion were somewhat mixed, participants reported good synergy across roles. Even when team members do not agree, communication was typically described as respectful. When lapses in communication occur, it can impede service provision and result in a divided front when engaging with ECC-involved families. Conflict was most often discussed in terms of team members having differing foci or goals, slowing down the progress toward permanency. Some team members perceived certain roles to have elevated power within the team. Though a quarter of participants feel left out of their team’s decision-making, they tend to feel comfortable with and support their team’s decisions. Agency context is important to creating a supportive environment for team members, which can include offering reflective supervision, providing performance feedback, and having strong connections with the local community. Overall, participants across roles tended to report satisfaction with their participation in ECC.

Eligibility criteria for ECC-involved families varies widely by team, but in general, criteria exist in writing and are relied upon when selecting families to participate. Most teams do have a limit to the number of families they can serve, and typically that limit is about 20 families, in accordance with best practices.1 ECC-involved families served were described consistently as having issues related to IPV, substance abuse, or mental health, and often these were co-occurring. In terms of diversity, most survey participants perceived that their team reflects the diversity of the families they serve, and report both equivalent ECC access and treatment for marginalized and non-marginalized groups. Team members report that clients receive a variety of assessments and have frequent and meaningful family time. Notably, caregivers are not uniformly transporting children to visitation sessions. Though caregiver transport is ideal,1 and was noted in the qualitative data as a reason for placement change, at a minimum, there should be confirmation of who is responsible for transportation.14 This does not necessarily need to be the caseworker, but should be someone with whom the child has a relationship.14 Another area of potential growth for ECC teams is in post-reunification support. For example, only about one-third of survey participants reported that support groups are available to families.

Though parents were described as having many challenges, team members also spoke to their potential for growth. Still, parents were not typically discussed as members of the team and the point-of-view of the child was minimally discussed. Interestingly, qualitative participants also did not discuss the role of the GAL, who serves as the child’s best-interest advocate. This may indicate that the child, and those who represent the child, are not afforded as much voice on the team as other roles. This is an area that requires further research.

Finally, though the present evaluation phase did not focus on ECC outcomes, participants did share their perceptions of what constitutes success on an ECC case. Safety and permanency for the child, regardless of placement, was considered a successful case. While participants shared that parent insecurity or manipulation can impede success, they conversely spoke of how parental motivation and transformation is a success in and of itself, as well as helps lead to successful outcomes.

**HOW DOES EARLY CHILDHOOD COURT COMPARE TO TRADITIONAL DEPENDENCY COURT?**

In general, descriptions of how ECC differs from traditional court included aspects of a more respectful culture and emphasis on teamwork and relationship-building. For example, a CPP provider shared, “It’s very different. Just the way you’re spoken to, the way that you’re treated, and kind of what your position is within the system is very different.” Specific aspects of how the ECC model was described as unique include time and timeline, a child-centered focus, accountability and physical space. Time was most often mentioned as a differentiating factor, including the time spent with the parent and meeting as a team, as well as the shorter timeline to permanency. An administrator/policy expert explained, “...in traditional dependency court, hearings are every three-plus months. In Early Childhood Court, [it is] every month plus a family team meeting every month.” This results in noticeable differences for the families. A CPP provider commented, “It’s night and day compared to regular dependency versus the ECC. I think a lot of it has to do with us being in court so often.” Similarly, an attorney expanded on this:

> I think that certainly our ECC parents get a lot more time in front of Judge [name]. They get a lot more contact with their attorneys and their attorneys are a lot more involved in staffings that take place... and they also build a stronger relationship with Judge [name].

However, it was not only the team meetings and court hearings that required more time, and sometimes time was problematic.
For example, the frequency of services and time commitment expected of parents and professionals was described as a primary characteristic of ECC compared to traditional dependency court—one that could present logistical challenges. Participants also spoke about how time can impact cases with substance abuse, in particular, because the quick timeline expectation was often viewed as incompatible with addressing long-term parent substance abuse, creating complexity in the process. A case manager/supervisor explained their concerns:

Moving the cases too fast when you have a parent that [has] been dealing with substance abuse for over a long history, and you’re giving this parent 12 months to get it together, and within six months she is sober. Her sobriety is gained and we’re reunifying and then we move 10 steps back and now we have a child that’s involved that sometimes have to come back into care because the mom has now relapsed.

Related, participants shared that ECC requires more accountability from both parents and professionals given the numerous ECC commitments (e.g., “I think it’s 100% more accountable on everybody’s parts”—case manager/supervisor). Parents are held more accountable compared to traditional court because of the frequent meetings and close follow-up. A foster parent/parent partner shared that ECC-involved parents “are usually working their case off because they know they’re held accountable.” However, expectations of parents can vary from team member to team member. One attorney pointed to accountability as a potential source of conflict when parents are not held accountable enough in ECC: “Some of our ECC providers are very big enablers. They’re not very good at helping the parents or helping the team hold the parents accountable to change.” Some ECC teams have created ways to try to improve parental accountability, such as implementing a tracking sheet that contains parents’ upcoming appointments and goals.

Finally, participants spoke of the difference in physical space between ECC and traditional dependency courtrooms. They recounted stories of judges “coming down” from the bench and sitting with the group or choosing not to wear their judicial robes. Because children are so frequently present in ECC courtrooms, teams try to make them child-friendly, by providing comforts like snacks, books, and toys.

**GENERAL ANSWERS TO RESEARCH QUESTIONS**

Based on the qualitative findings, we offer initial answers to the overarching research questions of the evaluation. It is important to note that these answers will evolve over time as more data collection and analysis is conducted. The data collected in the current phase of the evaluation will inform our next steps in order to more specifically answer these questions.

**RQ1: How does ECC differ from standard dependency court in terms of implementation and outcomes?**

The primary differences mentioned across respondents were the greater time commitment, frequency of meetings, and services involved with ECC. Early Childhood Court was also described using a child-focused, trauma-informed lens, and empowering biological parents, giving them more of a voice in the process compared with traditional dependency court. Finally, the team-based and supportive approach was often contrasted with the more adversarial culture of a courtroom environment.

**RQ2: Are some ECC teams more successful in their implementation; and if so, what factors lead to being successful?**

Respondents described elements for facilitating program implementation such as effective, frequent, clear communication among all team members and families, and establishing trusting relationships among all participants. Judicial leadership was another key element in ECC model implementation, because judges ‘set the tone’ for how meetings and hearings are conducted. In terms of broader context, agencies and community capacity had potential to provide additional support for following the ECC model.

**RQ3: What challenges and successes have been encountered in Florida’s ECCs?**

Common challenges reported by participants include conflict or communication barriers among team members, working with deeply traumatized populations including intergenerational trauma and dually-involved families, establishing and maintaining consistent funding, and accessing community resources.

Successes were described across ECCs in several ways. The first conceptualization of ECC success was establishing a team-based culture of respect and inclusion with effective communication among all team members. Respondents described effective team processes as important elements of success in ECC cases. Secondly, successes also were often described in terms of parent motivation and characteristics; engaging with a parent, tapping in to their motivation, and partnering with them to come to a plan for safety and permanency for the child were often described as a success. Importantly, success was not always defined as reunification, but rather safety and permanency for the child.

**RQ4: Are there particular circumstances in which ECC may be significantly more effective than standard dependency court?**

Respondents talked about both parent and caregiver engagement as key elements of ECC effectiveness. Parents had to be willing to commit to numerous meetings and services, more than in standard dependency court, in addition to making changes in their case plans to provide safety and permanency for the child. Caregivers had to be ‘on board’ with the ECC model in terms of really mentoring the biological parent and being willing to foster the entire family and provide positive role modeling.

There were also situations in which the ECC case outcome was surprising, in that either the family was not expected to reunify but then they did, or a biological parent that was doing well in the process and was expected to ‘succeed’ but then did not. These surprising outcomes indicate that it may not be possible to know at the beginning of the process which families will benefit most. There was wide variation in the types of families targeted by ECC circuits. Overall, the faster timeline and greater frequency of meetings and services in ECC were described as universally more effective than standard dependency court given the young age of the child(ren).
Limitations

There are several important limitations to note regarding the present evaluation. Participation in evaluation activities was voluntary and, therefore, self-selection bias is a concern. It is possible that those who participated have had different ECC experiences or have specific motivations for participation. Thus, their points of view may not be reflective of all ECC team members. In a similar vein, our recruitment strategy did not include former ECC team members, who likely have important insight to consider. In addition, there was very little participation from parent partners and caregivers, and no participation from parents. Given that parents are central to the ECC model, the evaluation team plans to increase efforts to include them in future evaluation activities. Some of the quantitative variables had missing data, and although the evaluators assessed for missingness patterns by role prior to numerous analyses, it is possible that those who did not respond to particular items differ in other important ways from those who did provide a response. For example, though 113 survey respondents said their team has eligibility criteria, only 68 indicated whether or not these criteria were written. Because the present findings are not generalizable, they should be interpreted with caution. However, the evaluators are encouraged that qualitative and quantitative findings generally corroborated one another.

Recommendations

Despite these limitations, the evaluation team offers several initial recommendations based on the current findings. It should be noted that these recommendations are based on data collected from all participating ECC team members and may not be applicable to individual teams. The Institute’s Spring 2019 evaluation activities will continue to refine and tailor these and other recommendations.

Given that numerous participants did not evaluate how well their community coordinator carried out their responsibilities, community coordinators should work to ensure that they are engaging with all members of the team. Particularly when new team members are on-boarded, the community coordinator should consider meeting with the new member individually to explain their role and the resources they can provide to team members. In addition, coordinators should consider providing updates on their responsibilities at quarterly team meetings, such as apprising team members of any conferences attended or new community partnerships secured. Related, the community coordinator should promote team building and communication and help their members better understand one another’s roles and the ECC process. Participants recommended the provision of continuing education, as well as training and on-boarding of new staff. Though team members understand that lack of funding can impede training opportunities, they might be willing to get creative with solutions, exemplified by this CPP provider’s idea:

…I started thinking about the players in the system, “Well, the new case manager’s coming on. How do I get them up to speed really quick?” Not where it’s like, “Hey, guess what? You’re going to another training,” and you’re going, “Oh, my God. How long do I have to sit through this one?” So, probably come up with - what is it? Like little 30-minute segments or something that is simple, somebody can just put on the podcast and listen while you’re driving to your visitation or whatever.

Participants did not just speak to training dollars but suggested more ECC funding is needed in general. Specific funding recommendations were generally about pay for clinical non-billable time, the lack of which deters participation from many CPP providers, which was discussed as one aspect of the lack of ECC-related resources many communities face. An administrator/policy expert shared:

…We have some tremendous CPP providers, but they’re not going to do the program because the money won’t work. So what you need is a way to support non-billable time which isn’t about the therapy that something would happen otherwise. You need ongoing supervision, a way to support time, and then you need agency directors or team leaders that understand this work.

In addition to needing more funding for appropriate staffing, ECC teams should work to secure additional supports for families that span the length of the case and possible outcomes. Team members made several suggestions about what to include in the case plan, including: helping clients gain access to basic needs (e.g., assistance with housing applications, addressing transportation issues); engagement of parent partners from the onset of the case; in-home support services beyond six-months post-case closure; and including child care activities, such as diapering and feeding. One community coordinator shared:

…If we could get them engaged with a peer specialist from day one, I think that would make a dramatic change. To put someone right there in their face that have the same circumstances they have because I—when they come to meet with me, as much as I care and I want them to succeed, I’ve never done drugs…so I’m not really able to empathize with them from that level.

On a macro level, since parents may lose public assistance (e.g., housing, WIC) following removal, many parents may struggle with accessing funds for their basic needs, such as food, housing, and transportation. A foster parent/parent partner suggested families who are making progress on their case plan retain eligibility some of these assistance programs, saying “How about if you participate in ECC, those things are there...as long as you continue to put your feet in this and move forward then these things are going to be in place.”

Whether it be increased resources or changes to policy, additional supports for families will likely require new collaborations and the recruitment of more community partners. Strengthening engagement with health care providers and Early intervention programs would be beneficial to children and families, improve compliance with CAPTA, and ensure that children are enrolled in appropriate supports prior to entering school. This is primarily the responsibility of the community coordinator, as outlined in the best practices, though coordinators might consider helping other team members leverage their professional connections to secure new partnerships.

Given that turnover was noted as being problematic, particularly within case management, ECC teams should consider exploring new case management operations to potentially help reduce turnover and streamline processes for the team. This could come in the form, as suggested by one judge, of having a case manager and supervisor dyad that is solely dedicated to the ECC. It might also include condensing job responsibilities.
For example, case managers and supervisors being trained as adoption specialists would allow for them to work with families through permanency for those whose case plan includes adoption. Pending resources, this is something the evaluation team plans to explore in Spring 2019.

Conclusion and Next Steps

From the perspective of ECC team members, as a whole, Florida ECC teams do appear to be implementing the model with some degree of fidelity to the Best Practices\(^1\) and the California Evidence-Based Clearinghouse.\(^2\) Judges exercise therapeutic jurisprudence. Community coordinators co-lead the ECC teams and carry out their responsibilities. Teams are regularly and frequently coming together for family team meetings and court hearings. Team members report a fair amount of collaboration and feel self-efficacious in their roles. Still, many questions remain based on the present findings, which will be addressed in Spring 2019 through the following evaluation activities:

1. **Compare ECC processes and outcomes by coordinator funding source.** Given the concerns about community coordinator funding, and how that might affect (perceptions of) neutrality, the evaluation team will create a coordinator funding source variable in the present quantitative dataset based on the lead judge/magistrate. This variable will be examined to see if ECC team processes (e.g., team synergy) vary by funding source. We will also work with OCI to compare outcomes (e.g., re-removals) by coordinator funding source, if possible, using OCI administrative data.

2. **Explore fidelity to the model by individual ECC teams.** While the present analysis focused on ECC implementation generally, with attention to the perspectives of specific roles, we will next explore fidelity to the model by individual teams. While the present analysis indicates that team members are generally in agreement on the status of implementation across roles, this may or may not hold true across ECC teams. This will involve quantitative analysis of the extant survey data.

3. **Cost Effectiveness Analysis.** In Fall 2018, the evaluation team sent a brief survey to ECC team members regarding their workload and salary information. In total, 123 participants engaged at least partially with the survey. This data will be supplied to Dr. Troy Quast, who will conduct a cost effectiveness analysis of ECC.

4. **Conduct focus groups and individual interviews with parents and caregivers (resources permitting).** Given their near complete absence from the Fall 2019 data collection, it is important that we make a targeted effort to recruit both parents and caregivers into the evaluation activities. Their voice is integral to evaluating this program.

5. **Explore case management models of ECC teams (resources permitting).** 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,\(^16\) 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 CBCs have a dedicated ECC case manager, while others have multiple case managers taking on ECC cases as part of their overall caseload. This exploration might include, but is not limited to, qualitative questions included in data collection with parents and caregivers; a new, brief survey of case managers’ perspectives of their role; and a comparison of case outcomes by case management model.

Pending funding, subsequent annual evaluations might examine:

- Highly successful vs. less successful ECCs
- The role of ECCs in promoting racial equity in the dependency court system
- Longitudinal outcomes
- Client characteristics or circumstances most likely to benefit from the ECC model (e.g., cases with co-occurring issues [substance abuse/mental health/IPV], particular substance use, housing safety/stability, repeat cases)

Additional variables may also be added to improve quantitative analysis in subsequent years, such as including implementation data, additional child and family characteristics, and services utilization.
Appendices

Appendix A — Logic Model

<table>
<thead>
<tr>
<th>INPUTS</th>
<th>OUTPUTS/ACTIVITIES</th>
<th>OUTPUTS/TARGETS</th>
<th>OUTCOMES: SHORT</th>
<th>OUTCOMES: MEDIUM</th>
<th>OUTCOMES: LONG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel</td>
<td>Development of MOUs</td>
<td>Abused and/or neglected children ages 0-36 months who are removed and placed in out-of-home care (relative, non-relative, foster care)</td>
<td>Professionals: Increased knowledge and skills re: trauma-informed practice</td>
<td>Professionals: Improved communication</td>
<td>Clients: Increased rates of reunification</td>
</tr>
<tr>
<td>Training</td>
<td>Family Team Meetings</td>
<td>Parents</td>
<td>Professionals: Trauma-informed practice</td>
<td>Professionals: Trauma-informed practice</td>
<td>Reduced recidivism (i.e., re-entry to CW system)</td>
</tr>
<tr>
<td>Funding</td>
<td>Specialized Dockets</td>
<td>Out-of-Home Caregivers</td>
<td>Professionals: Increased cultural competence</td>
<td>Professionals: Concurrent case planning</td>
<td>Increased court system satisfaction</td>
</tr>
<tr>
<td></td>
<td>EBP Child-Parent Therapy</td>
<td></td>
<td></td>
<td>Professionals: Improved service coordination</td>
<td>Improved trust between caregiver and parent (regardless of outcome)</td>
</tr>
<tr>
<td></td>
<td>Identification of and Service Coordination for Co-Morbid Issues</td>
<td></td>
<td></td>
<td>Professionals: Improved understanding of cases from multiple perspectives</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Completion of Progress in Treatment Assessment (PITA)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Case Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Family Time/Visitation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Post Re-Unification Support</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Coordinator Led Quarterly Meetings with Additional Stakeholders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Additional Stakeholder Activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Monitoring and Evaluation of ECCs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INPUTS: RESOURCES</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td>Community Coordinators</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Judges Magistrates</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Minimum 2-year term</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Infant Mental Health Specialists</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Attorneys</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>GALs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dependency Case Managers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Child-Parent Therapy Treatment Providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Supervision and/or case consultation support for fidelity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other Treatment/Social Service Providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Supervision and/or case consultation support for fidelity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Additional Stakeholders (i.e., anyone whose professional life involves young children and families—law enforcement, child welfare, advocates, healthcare providers)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td>Content: trauma-informed care, adverse childhood experiences, impact of trauma</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Initial and continuing education (annual basis)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Funding</td>
<td>Infant Mental Health Specialists</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Expanded Logic Model Elements

INPUTS: RESOURCES

Personnel
- Community Coordinators
- Judges Magistrates
  - Minimum 2-year term
- Infant Mental Health Specialists
- Attorneys
- GALs
- Dependency Case Managers
- Child-Parent Therapy Treatment Providers
  - Supervision and/or case consultation support for fidelity
- Other Treatment/Social Service Providers
  - Supervision and/or case consultation support for fidelity
- Additional Stakeholders (i.e., anyone whose professional life involves young children and families—law enforcement, child welfare, advocates, healthcare providers)

Training
- Content: trauma-informed care, adverse childhood experiences, impact of trauma
- Initial and continuing education (annual basis)

Funding
- Infant Mental Health Specialists
OUTPUTS: ACTIVITIES

Development of MOUs (with participants’ voluntary and informed consent)

Family Team Meetings (monthly, except judge/magistrate)
• Address concurrent planning
• Ensure placement stability
• Monitor transitions in placement
• Assess treatment progress
• Assess compliance with case plans
• Consider additional needs

Judicial Elements/Activities (Specialized Docket)
• Consistent docket
• Monthly status hearings
  o Pre-notification (unless notice is waived) required for all issues considered at hearing (e.g., visitation, sibling contact, services to parents, reunification, case plan amendments, goal changes)
• Therapeutic judicial decision-making
• Permanency planning
• Professional and supportive demeanor

Evidence-Based Child-Parent Therapy Activities
• Assessment/Recommendations by Infant Mental Health Specialist
• Treatment Sessions (intensity and duration per model standards)
• Monitoring of ongoing substance abuse and domestic violence

Identification of and Service Coordination for Co-Morbid Issues
• Developmental assessments and ensuing case plans for children
  o Medical exam with developmental screening
  o Comprehensive Behavioral Health Assessment (CBHA)
  o Developmental screening with 45 days of entry into childcare
• Substance Use Treatment
• Mental Health Treatment
• Additional Supports (e.g., transportation, housing assistance, medical and dental treatment, vocational/educational programs)
• Parenting reflection models/services (e.g., Circles of Serenity)

Completion of Progress in Treatment Assessment (PITA)

Case Management

Family Time
• “Frequent and meaningful”
• Use of virtual methods, as needed and available (e.g., FaceTime)
• Prioritization of child’s comfort and well-being
• Judge’s avoidance of out of town placements, when feasible
• Caregivers transport of child to visitation
• Regular review/tailoring of visitation plan

Post Re-Unification Support
• Support groups
• Home visitation
• Ongoing counseling
• Head Start/early childhood programming

Community Coordinator Led Quarterly Meetings with Additional Stakeholders
• Identify services
• Review data
• Note gaps in services
• Discuss issues raised by cases

Additional Stakeholder Activities
• “Help galvanize funding”
• Use data to promote quality improvement
• Use leadership to ensure long-term sustainability

Monitoring and Evaluation of ECCs
• Annual remedial action plan and timetable
• Community coordinator enters programmatic and service-related data into ECC tracking system
• Monthly data reviews (i.e., of permanency, safety, well-being)
OUTPUTS: TARGET POPULATION

Abused and/or neglected children ages 0-36 months who are removed and placed in out-of-home care (relative, non-relative, foster care)

Parents

Out-of-Home Caregivers

OUTCOMES: SHORT-TERM (CHANGES IN KNOWLEDGE, SKILLS, ATTITUDE, MOTIVATION, AWARENESS)

Professionals
• Increased knowledge and skills re: trauma-informed practice
• Increased cultural competence

Clients
• Increased understanding of past trauma on parenting
• Improved parenting capacity
• Improved caregiver motivation

Process
• Timely connection to necessary services

OUTCOMES: MEDIUM-TERM (CHANGES IN BEHAVIORS, PRACTICES, POLICIES, PROCEDURES)

Professionals
• Improved communication between stakeholders
• Trauma-informed practice by all multidisciplinary team members
• Concurrent case planning (for permanency)
• Improved coordination of services
• Improved understanding of cases from multiple perspectives

Clients
• Reduction of re-abuse
• Consistency of supportive placement for child
• Improved parent-child relationship
• Increased parent engagement and trust in court system/process
• Promotion of co-parenting relationship between parents and caregivers
• Reduced time to permanency

OUTCOMES: LONG-TERM (CHANGES IN SITUATION: ENVIRONMENT, SOCIAL CONDITIONS, ECONOMIC CONDITIONS, POLITICAL CONDITIONS)

Clients
• Increased rates of reunification
• Reduced recidivism (i.e., re-entry to child welfare system)
• Increased court system satisfaction (among clients)
• Improved trust between caregiver and parent (regardless of outcome)

Process
• Cost-savings
Dear Early Childhood Court team members,

We look forward to meeting with you in Asheville at the Zero to Three Cross-Sites Meeting! Our evaluation team from the Florida Institute for Child Welfare and University of South Florida will be meeting with you at the times listed below for a 1 hour focus group conversation about your role and your community’s implementation. Focus groups will be held at the conference hotel and specific locations will be e-mailed to you later this week. We hope you will join us!

**Sunday 8/26**
3:30-4:30 pm: Case Managers and Clinicians, Child Wellbeing Specialists, & GALs

- Swannanoa Villa  Group 1: Case Managers
- Swannanoa Villa  Group 2: Clinicians, Child Wellbeing Specialists, & GALs

**Tuesday 8/28**
9-10:00 am: Attorneys (CLS/ASA/AAG attorneys, parent attorneys, GAL attorneys)

- Swannanoa Villa  Group 1: Early Implementation (Please plan to attend this focus group if you feel that less than 50% of your ECC team is implementing ECC with fidelity and good outcomes.)
- Swannanoa Villa  Group 2: Full Implementation (Please plan to attend this focus group if you feel that at least 50% of your ECC team is implementing ECC with fidelity and good outcomes.)

11am-12:00 pm: Judges and Magistrates

- Blue Ridge  Group 1: Early Implementation (Please plan to attend this focus group if you feel that less than 50% of your ECC team is implementing ECC with fidelity and good outcomes.)
- Blue Ridge  Group 2: Full Implementation (Please plan to attend this focus group if you feel that at least 50% of your ECC team is implementing ECC with fidelity and good outcomes.)

**Schedule interviews at your convenience during the meeting 8/26-8/29:**

- Caregivers: Foster Parents, Parent Partners
- Administrators and Funders: (CBC, DCF, Trial Court, Juvenile Welfare Board)

**Community Coordinators** – We will meet in October in Tampa!
Appendix C — Focus Group Semi-Structured Interview Items

1. Tell us about your role as a ____________ INSERT ROLE HERE ____________.
   a. How did you become involved with your ECC team?
   b. What are your major ECC-related responsibilities?

2. Tell me about the families that have been involved in your circuit’s ECC?
   a. What are their case profiles like (e.g., charges, family issues, level of complexity)?
   b. What are the eligibility criteria for a family’s participation in ECC?

3. How does the ECC process compare to a traditional process?
   a. Tell me about how the steps of the two court processes differ.
   b. Tell me about the difference in workload for your role.
   c. Describe the differences, if any, you’ve noticed in working your interactions with the families/children.
   d. Describe the differences, if any, you’ve noticed in family/child outcomes.

4. I’d like you think of ECC cases that have gone exceptionally well. What were those cases like?
   a. What were some of the commonalities of those cases?
   b. Why do you think these cases went so well?

5. Now I’d like you to think of ECC cases that have been exceptionally challenging. What were those cases like?
   a. What were some of the commonalities of those cases?
   b. How did you work through those challenges?
   c. What would have helped you to better navigate those challenges?

6. Tell me about your ECC-related collaborations.
   a. What does collaboration look like in the courtroom?
   b. Thinking outside the courtroom, what are your interactions like with other ECC team members?
   c. Can you describe to me any ECC collaborative relationships that you consider to be challenging?
   d. Can you describe to me any ECC collaborative relationships that you consider to be exceptionally strong?

7. What is most needed in the role of ____________ INSERT ROLE HERE ____________ in order to be successful in ECC implementation?
   a. Describe the skill set needed to do your job.
   b. Describe what helps to facilitate carrying out your role successfully.
   c. What, if any, resources are you lacking that you think would help you to do your job better?

8. How does your community’s context (political, social, services landscape) impact your ECC?
   a. Describe any challenges or negatives you’ve experiences in trying to implement ECC in your community.
   b. What infrastructure supports are needed to help your ECC succeed or expand (e.g., physical space, staffing, processes)?

9. Before we end our conversation today, is there anything else you’d like to share with me about your ECC team or your thoughts on ECC in general?
Appendix D — A Priori Codes and Emergent Themes

A priori themes were derived from the interview/focus group questions. These general themes included: Roles and Responsibilities of each participant (e.g., Judge, CCP Provider, etc.) described from their own and from others’ perspective; Characteristics of ECC Families describes typical qualities of biological parents and family member involved in ECC, such as age of parents, previous experience of trauma and potential for growth; Team Processes includes how teams described their processes for managing both conflict and collaboration between and among ECC team participants; ECC vs. Traditional describes how ECC is unique compared to traditional dependency court, such as having a faster timeline and using a team-based approach; and Outcomes included both successes and failures, in whatever way the respondent conceptualized ‘success’ and ‘failure’ within the ECC context.

Additional themes emerged from the responses using a grounded theory and constant comparison approach. Emergent themes were: Power/Empowerment refers to parents in ECC having more of a voice in the process and more egalitarian relationships across the program because of the team-based approach; Communication that was open and transparent was described as important for the ECC team’s processes; Trust/Attachment could be seen across relationships between team members and also between the ECC team and biological parents. Biological parents having a hard time establishing trusting relationships with the many ECC team members sometimes found a primary relationship with one team member that facilitated the process; Agency Context, which describes elements of support—or lack thereof—from a respondent’s home agency; Similarly, Community Context describes how aspects of a community could influence an ECC case process. Community Context issues include transportation, housing and employment for ECC families. Racial Equity includes the different racial or ethnic groups involved in ECC, with some respondents implying that White families may be more likely to participate; Knowledge of the Model, showing that some respondents were aware of and implementing elements of the national Early Childhood Court model from Zero to Three; Recommendations included suggestions for program improvement, such as more secure and appropriate funding and billing processes, better communication among team members, reducing staff turnover and supporting biological parents/families; and finally, ECC Best Practices includes unique concepts mentioned by individuals that could be useful across ECCs in the state, such as ideas for team building activities, supporting parents, and program improvement strategies.
Appendix E — Project Information Sheet for Quantitative Survey

Early Childhood Court Evaluation
Project Information Sheet
Pre-Conference Survey

EARLY CHILDHOOD COURT EVALUATION

The Florida Institute for Child Welfare, in collaboration with the University of South Florida College of Public Health, is conducting a one-year, state-wide evaluation of Florida’s Early Childhood Courts (ECCs). This statewide evaluation will examine the implementation processes and outcomes among ECCs across Florida, as well as child and family outcomes. In addition to determining the impact that the ECC model has on recidivism, permanency, and reunification of families, the goal of the evaluation is to track the broader implementation/replication of the ECC model across the state, while identifying successful strategies for implementing the model and challenges encountered during implementation. Recommendations generated from the statewide evaluation will inform program improvements.

EARLY CHILDHOOD COURT SURVEY

If you choose to participate in this portion of the evaluation, you will complete a survey about your experiences with and perceptions of your ECC team. The survey will cover various topics pertinent to your role. The survey should take approximately 30 minutes to complete. If you serve on more than one ECC team, we will ask that you complete the survey for each ECC team separately.

Participating in this survey is completely voluntary. Even if you decide to participate now, you may change your mind and stop at any time. You may choose not to answer any question for any reason, which you are not required to share with us.

The evaluation team will store all data in password-protected electronic storage to keep your information safe throughout this study. Your individual identity will be kept private when information is presented or published about this evaluation. We are not requesting your name at this time and we are the only individuals who will have access to your individual data. The data you provide will be stored for five years following the completion of the study.

QUESTIONS

The Co-Principal Investigator overseeing this evaluation is Dr. Jennifer Marshall with the University of South Florida College of Public Health. If you have any questions or concerns, please reach contact Dr. Marshall at (813) 396-2672 or jmarshal@health.usf.edu. If you need to contact the University of South Florida Institutional Review Board, you can do so at (813) 974-5638.

Dr. Marshall’s Co-Principal Investigator is Dr. Jessica Pryce with the Florida Institute for Child Welfare. You can contact Dr. Pryce at (850) 645-0976 or jpryce@fsu.edu. If you need to contact the Florida State University Institutional Review Board, you can do so at (850) 644-7900.

Please take all the time you need to read through this document and decide whether you would like to participate in the survey.

Please keep this form for your records.
References


