



Supporting Early Connections

Program Evaluation of a Court and
Community Partnership Dedicated to
Improving the Lives of Maltreated Infants
and Toddlers in King County, Washington

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EXECUTIVE SUMMARY

Infants and toddlers are the largest group of children to enter, remain in and re-enter foster care and the least likely to reunify with their biological families. In Washington State, 36% of children entering foster care are under the age of three. Over a decade of research definitively shows that early relationships play a critical role in a child's brain development and future academic and social success. When these relationships become neglectful or abusive, the course of an infant's entire life is impacted. Young children who experience trauma and neglect are much more likely than their peers to develop mental health disorders and physical ailments; they are also at greater risk of having behavioral and educational problems. Moreover, dysfunctional relationships are often passed down through generations, further compounding the alarming issues that arise from early maltreatment.

From April 2008 to September 2011, the Center for Children & Youth Justice (CCYJ) coordinated a groundbreaking project in south King County, WA, called Supporting Early Connections (SEC). With funding from the Stuart Foundation, CCYJ developed an effective, multi-system, child-focused collaboration committed to addressing the social-emotional, mental health and relationship needs of infants, toddlers, and their biological parents who had child welfare cases heard at the dependency court in Kent, WA.

Through collaboration, cross-system training for professionals, and access to evidence-based treatment (Child Parent Psychotherapy) for babies and their families, SEC sought better outcomes for young children involved in the dependency system. This includes earlier exits from the child welfare system into permanent homes through reunification with biological parents, long-term placement with relatives, or adoption. By supporting healthy early relationships, SEC provided vulnerable babies a stronger foundation for their future physical, emotional and cognitive development. This critical early investment in maltreated children will ultimately reduce long-term costs to the community, particularly within the justice, child welfare and mental health systems.

Program Outcomes

A program evaluation of the three and a half year implementation of SEC has shown it to be a highly successful court-community collaboration. The goal of the evaluation was to determine if the SEC project could impact the awareness and practice of community professionals, and improve outcomes for babies and their families. With SEC in place, King County has made great strides in its efforts to meet the needs of infants, toddlers and their families who encounter the dependency court.

Highlights of SEC's success include:

- Created a **sustainable King County collaboration that includes on-going provision of treatment**, and is continuing post-grant. Referral information for ongoing access to SEC can be found at: www.kingcounty.gov/courts/JuvenileCourt/dependency/SEC.aspx
- King County's court, child welfare and mental health systems have demonstrated **real growth in their understanding of the social, emotional and relationship needs of maltreated young children and their families**.
- Created a series of resources, including sample forms and court order language, to **facilitate development of similar programs in other communities**.
- By focusing on family engagement, meeting with families in their homes and communities, and providing transportation, **SEC retained over 80% of parents for the full ten months of treatment**. This included parents who did not expect to be reunified with their children.
- Multiple measures of child-parent relationship functioning showed **statistically and clinically significant improvements for families in SEC treatment**.
- The mental health of participating children improved, indicated by a **substantial reduction in the number of children presenting with one or more mental health diagnoses by the end of treatment (87% vs. 47%).¹**
- Child welfare outcomes improved for participating children
 - **No children were re-referred to the child welfare system** during the pilot project period.
 - **Children in SEC achieved permanency faster** than typical when compared to both state and regional numbers (~18 vs ~24 to ~28 months). Ten months of foster care for an infant costs Washington \$4,200 in foster care payments alone, even without accounting for other costs to courts, child welfare, or families.
 - By the end of the pilot project, **55% of children had reunified with one or both of their biological parent(s)**.
 - By the end of the pilot project, **almost three quarters (71%) of children were living long-term with a family member (either their biological parent(s) or a relative caregiver)**.

"The attention and energy focused on having the different professionals sit down at the same table and understand each other's language, agendas and the scope of their roles in the process was really helpful."

- Navos Supervisor

"The awareness of the needs of young children affected the way court participants treat babies and toddlers in general, regardless of a family's participation in SEC. It resulted in a consciousness-raising that was wider than the SEC program."

- Commissioner

"SEC gets to the core of what's needed for families being served - helping parents understand and meet the child's needs. This can only be done in the context of the ongoing relationship between parent and child... More than any other service that I see being made available, Supporting Early Connections can fundamentally alter and strengthen that relationship."

-CASA Volunteer

"Having treatment occur in our home, in our natural environment, was great. The therapist was able to see the behaviors we see and help us learn practical, hands-on skills to be the best parents we can be."

- SEC Relative Caregiver

¹ Children were diagnosed using the Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood, Revised (DC:0-3R)

PROJECT OVERVIEW

Infants and toddlers are the largest group of children to enter, remain in and re-enter foster care and the least likely to reunify with their biological families. In Washington State, 36% of children entering foster care are under the age of three.² Over a decade of research definitively shows that early relationships play a critical role in a child's brain development and future academic and social success. When these relationships become neglectful or abusive, the course of an infant's entire life is impacted. Young children who experience trauma and neglect are much more likely than their peers to develop mental health disorders and physical ailments; they are also at greater risk of having behavioral and educational problems. Moreover, dysfunctional relationships are often passed down through generations, further compounding the alarming issues that arise from early maltreatment.

Many young children in the child welfare system experience multiple placements with biological parents, foster parents, and/or relative caregivers. The relationship changes and transitions these placements involve put these children at great risk both for immediate and long-term mental health challenges. All children need a primary, consistent relationship with an adult who can provide protection, stimulation and nurturance while fostering a strong sense of trust, stability and security. This experience is a critical foundation for both early brain development and future success in life with regard to relationships, academics, and a strong connection to their community. Unfortunately, court and child welfare systems, as well as foster and birth families, are often unequipped, or unaware of the need, to address the unique mental health and relationship needs of these very young children who experience significant trauma, loss and separations.

As more evidence is brought to the fore, it is clear that the environments in which infants and toddlers grow up drastically impact the course of their entire lives. Dr. Jack Shonkoff, pediatrician and editor of the Institute of Medicine's *From Neurons to Neighborhoods: the Science of Early Childhood Development*, has noted, "early life experiences are built into our bodies, for better or for worse."³ Despite this growing base of knowledge, early intervention initiatives to combat the mental health and developmental challenges experienced by maltreated infants and toddlers remain scarce. As the Center on the Developing Child, at Harvard University, puts it, "this field urgently needs treatment strategies that are age-appropriate, support the development of healthy relationships, and are consistent with scientific knowledge about early psychological development."⁴

² U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, Child Welfare Outcomes Report Data, "Child Maltreatment Data: Age of Child Victims." U.S. Department of Health and Human Services, 2009, <http://cwoutcomes.acf.hhs.gov>.

³ Shonkoff, JP (January 7, 2010) Symposium: Applying the Science of Early Childhood Development to State Policy. Seattle, WA.

⁴ Center on the Developing Child at Harvard University, *Working Paper 6*, 4.

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This report is a program evaluation of the three and a half year implementation of Supporting Early Connections. It is important to note that the evaluation was not intended as a research study. The evaluation looked at how effectively we could implement and integrate an evidence-based treatment, combined with cross-system education and collaboration. The goal of the evaluation was to determine if the project could impact the awareness and practice of community professionals, and improve outcomes for babies and their families.

Background

In early 2008, the non-profit Center for Children & Youth Justice was awarded a three-year, \$620,000 grant by the Stuart Foundation to implement an infant mental health court project in King County, WA. The project was informed by successful programs in other parts of the country, including the court-university partnership in Miami-Dade, Florida (part of the Florida Infant & Young Child Mental Health Pilot Program), that provides relationship-based treatment to maltreated infants and toddlers and their biological mothers. Supporting Early Connections launched in April 2008, with the first families receiving infant mental health services in August of that year. The evaluation looked at families who participated in SEC treatment between August 2008 and July 2011.

At the time of the grant award, King County had limited Medicaid-funded infant mental health treatment services available in the community. Navos (formerly Highline-West Seattle Mental Health) was the only community mental health agency in King County providing any infant mental health treatment. The county agency that allocates Medicaid funding for community mental health had previously approved use of a nationally recognized tool for diagnosing children under five, the DC:0-3R,⁵ to determine eligibility. However, there were no treatment services specifically designed for court- and child welfare-involved families.

Additionally, professionals in the court and child welfare systems had little understanding of the social-emotional and relationship needs of maltreated babies and toddlers. Leading up to the grant, Dr. Sheri L. Hill (at the time Faculty Lead on Policy for the University of Washington School

⁵ ZERO TO THREE, *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition*, 2005.

of Nursing, Center on Infant Mental Health and Development) provided several lunchtime trainings at the court. These trainings resulted from requests made by members of an interdisciplinary Infant Mental Health in the Courts workgroup, convened by Dr. Hill.⁶ However, no coordinated training in early childhood brain development and relationships existed for court and child welfare professionals.

KING COUNTY, WASHINGTON		
	Count	Percentage
Population	1,931,249 ⁷	
People below poverty level	183,468	9.5
Children under 5 years old	123,599	6.4
Race of children under 5 years old ⁸	White	56
	Black	8
	Asian	15
	Hawaiian/Pacific Islander	1
	Multi-Racial	13
	Other	7
Children under 5 years old identified as Hispanic	19,775	16

The four major components of the Supporting Early Connections project were:

- Coordination of a sustainable, multi-system collaboration that shares information about young children in care, and supports child-centered problem solving.
- Education and training for court, child welfare and mental health systems designed to develop a shared understanding of the mental health, developmental and relationship needs of infants and toddlers.
- Access to evidence-based, community infant mental health services for biological parents and their children.
- Targeted support designed to increase family engagement in treatment.

⁶ For more detail on the community process that preceded the grant, please see Sheri L. Hill, "Helping Policymakers See Through the Eyes of the Infant," *ZERO TO THREE Journal*, July 2009, 4-7.

⁷ US Census, King County QuickFacts <http://quickfacts.census.gov/qfd/states/53/53033.html>

⁸ 2010 Race by County, US Census Data file overview, Washington State Budget & Policy Center/Washington Kids Count. Data pull completed by Lori Pfingst, Senior Policy Analyst, on 8/12/2011. Note, US Census considered Latino/Hispanic an ethnicity, not a race.

Through this comprehensive program, CCYJ sought a variety of important outcomes for infants, toddlers, and their families, including:

- Increased placement stability, meaning fewer moves of babies among caregivers;
- Earlier permanency for children, including return home to a parent, or an alternate permanent plan with relatives or others;
- More children returning home to biological parents;
- Fewer recurrences of maltreatment and re-entry into the child welfare system;
- Improved child well-being; and
- Strengthened relationships between children and their biological parents or caregiver.

MULTI-SYSTEM COLLABORATION

CCYJ coordinated the work of the SEC Team, an effective, multi-system collaboration that brings together a variety of partners working to engage families and the community to meet the mental health and relationship needs of maltreated infants and toddlers. The multi-year nature of SEC and the group's steady leadership provided an excellent forum for embedding these relationships and a culture of infant mental health capacity building into the current system of care.

Building the SEC Team

At the start of the grant, collaboration and support were sought from key leaders in the court, child welfare and community mental health. An advisory group made up of decision makers from the various systems was formed and convened by Justice Bobbe J. Bridge (retired), Founding President and CEO of the Center for Children & Youth Justice. The group was provided with information about the scope of the project, grant requirements, and the need for a program focused on maltreated infants and toddlers. Each entity committed to participate in the project and identified one or more individuals to take part in implementing the program.

King County, Washington, has two courthouses that process dependency, or abuse and neglect, cases. After discussing the challenges of developing programs in two courts simultaneously, the advisory group decided that an infant mental health project pilot program should be sited in a single court, with the goal of eventually expanding to serve both courts. The Norm Maleng Regional Justice Center (NMRJC), in Kent, WA, was selected as the pilot site. Commissioner Richard Gallaher, the judicial officer assigned to the NMRJC dependency calendar, provided judicial support and leadership for implementation of the program.

The SEC Operations Team, or Ops Team, was created to support implementation of the program. CCYJ provided the Program Coordinator, Kelly Warner-King, who orchestrated the formation and on-going work of the SEC Ops Team. Representatives from the multiple systems that interact in dependency cases were invited to join the Ops Team. Despite budget cuts that impacted most of the agencies during the course of the project, SEC partners remained committed to the effort.

The Navos treatment team, including the Child and Family Services Supervisor, SEC Child-Family Therapists and the SEC Family Support Specialist, was actively involved in the work of the Ops Team. Inclusion of infant mental health treatment professionals provided opportunities for legal and child welfare professionals to ask questions and seek clarification about the treatment services provided to families.

Initially, the project partnered with the King South Division of Child and Family Services (DCFS) Office, located in Kent. The King South Office committed the time of the Area Administrator and two Child Welfare Supervisors to the project. Their participation in the collaboration and data collection efforts was essential to the development and sustainability of the program. King South social workers received training and worked closely with Navos therapists on SEC-enrolled cases.

In the second year of implementation, SEC expanded to provide treatment services to families with cases assigned to the White Center DCFS Office and those enrolled in the Family Treatment Court program at the NMRJC. The Family Treatment Court Coordinator joined the SEC Ops Team to support effective communication and information sharing with that court program. The Family Treatment Court judicial officer, attorneys and social workers all participated in infant mental health training.

In Washington State, DCFS is represented in dependency cases by the Attorney General's (AG's) Office. The AG designated one Assistant Attorney General (AAG) to serve as the liaison to SEC. Other AAGs assigned to dependency court attended SEC trainings and represented DCFS in cases with SEC-enrolled families.

The King County Dependency Court Appointed Special Advocate (CASA) Office also partnered with SEC. CASA provides volunteers who advocate for children's best interests in dependency cases. Volunteers are supervised by CASA Program Managers, and supported in legal matters by CASA attorneys. CASA dedicated one Program Manager and an attorney to help with implementation of SEC. Many CASA volunteers also attended SEC-sponsored trainings, and some served as advocates for children enrolled in SEC treatment services.

Parents' attorneys from the county's four public defense agencies were also invited to join the SEC Team. A core group of dependency supervisors and attorneys from three of the agencies participated in the collaboration to develop and implement the program. Many more independent and public defense agency attorneys took part in SEC trainings and referred clients to the project.

SEC infant mental health consultants, Dr. Sheri L. Hill and Dr. JoAnne Solchany, were also key members of the team. The participation of infant mental health system and treatment experts allowed all partners to learn more, on an on-going basis, about the developmental needs of maltreated young children.

THE SEC OPERATIONS TEAM	
Individual(s)	Affiliation
Dependency Commissioner and court staff	King County Superior Court, Norm Maleng Regional Justice Center
Child Welfare Area Administrator and Supervisors	King South DCFS Office
Supervisor and Program Attorney	King County Dependency Court Appointed Special Advocate (CASA)
Parents' Attorneys and Supervising Attorneys	Local public defense agencies
Assistant Attorney General	Office of the Attorney General, Dependency Division
Child and Family Services Supervisor, Child-Parent Therapists, Family Support Specialist	Navos
Family Treatment Court Coordinator	King County
SEC Project Coordinator	Center for Children & Youth Justice
Dr. Sheri L. Hill (www.earlychildhoodpolicy.com) Dr. JoAnne E. Solchany	Local early childhood mental health system and treatment consultants

Shared Ownership

SEC partners made substantial contributions of time and resources, fostering a sense of shared ownership in the project. At the start of the project, DSHS entered into a contract with Navos to reimburse costs involved in transporting children and parents in order to provide home- and community-based treatment. This enabled the therapists to go to the families, a critical component of the SEC model. The Commissioner made his courtroom available as the regular meeting location for the SEC Ops Team, and others offered space for additional meetings and trainings. Team members also worked together to present the project to a variety of audiences.

Relationship building was facilitated through monthly operations meetings with SEC Ops Team members. These meetings served multiple purposes, including the development of policies and procedures, problem-solving implementation issues, and informal educational opportunities where the systems exchanged information and resources. The Project Coordinator kept the team informed by providing regular updates on treatment enrollment and statistics. As the program developed, the team also focused on sustainability for all aspects of the program.

"It's all about the relationships. Strong relationships between professionals are key to supporting strong relationships between providers and families, which in turn support healthy relationships within families."

- Dr. Sheri L. Hill

In exit interviews, SEC Team members consistently reported that the collaboration exceeded their expectations, and was very important to the overall success of the program. After the initial implementation phase, the SEC Team decided to meet every other month, rather than monthly. However, by the second meeting on the less frequent schedule, the Team elected to return to monthly meetings. Partners felt that regular, monthly meetings were worthwhile and kept them more involved in the project.

“This was the first experience that I’ve had in a very adversarial legal system that was truly collaborative, including the court and all parties in a case. There was a new-found respect among the people sitting on the SEC Team, and I think it was helpful in developing our own relationships outside of court.”

- Parent’s Attorney

Team members often worked together to develop key aspects of the project and produce forms and written materials. For example, one of the first tasks the group undertook was selecting a name for the program via a nomination and ranking process. Members of the team also formed multi-disciplinary workgroups to create policies and agree upon procedures for implementing the program, such as standard court order language describing Navos’ treatment services.

“We could’ve just provided the therapy and it would’ve been good work. But the collaboration and system change efforts made SEC much more effective. They were essential components that were truly interconnected with treatment.”

- Navos Supervisor

Shared Information and Understanding

An important product of the collaboration was the development of shared language and a common basic understanding of the needs of infants and toddlers. Having the project consultants and treatment providers actively participate in operations meetings allowed for informal discussion about best practices and developmentally appropriate services for infants, toddlers and their families. Through general and case-specific discussions, partners also learned about the requirements, ethical obligations and challenges of each other’s roles. When disagreements arose in specific cases, SEC partners were often able to rely on their strong relationships and shared understanding of early childhood development to resolve differences.

Understanding Each Other’s Language

During one of the early SEC Ops Meetings, the Team discovered a language difference that clearly highlighted the need to better understand each other’s systems. A Navos therapist was looking ahead positively to a family’s “termination.” This elicited confused looks from court system partners, until someone realized that the word “termination” had vastly different implications in the court and treatment worlds. For the therapist, termination meant the successful completion of treatment. In the court context, the same word is used to describe the severing of a parent’s legal rights to their child.

“The awareness of the needs of young children affected the way court participants treat babies and toddlers in general, regardless of a family’s participation in SEC. It resulted in a consciousness-raising that was wider than the SEC program.”

- Commissioner

Decisions in a family’s dependency case were informed by the SEC therapist’s reports about how the child and family were progressing in treatment. For each child enrolled in the SEC program, the therapist provided regular reports about the family’s progress in treatment using a standard reporting format that is distributed to families and all parties to the case. As a result, the court, attorneys and child welfare social workers are able to make recommendations and decisions based on timely and reliable information about a child’s development, a family’s goals and needs, and the status of their relationship.

“Cases involved in SEC are resolving faster. Because everyone gets the same information about how the family is doing in treatment and what their strengths are, children are returning home sooner. And it’s by agreement of all parties, we’re not having to go into court to fight about it.”

- Parents’ Attorney

Project Coordination

The role of the Project Coordinator was key to supporting and maintaining the collaboration and integrating the various parts of the program into the whole. The Center for Children & Youth Justice employed the .5 FTE Coordinator, an attorney with experience in dependency court and a background in multi-system project management and evaluation. The Project Coordinator managed the work of the SEC Ops Team, which included scheduling and running meetings, convening workgroups, and keeping partners informed about the progress of implementation. Working with SEC Team members, she developed concrete tools and processes for referring families to treatment, sharing child and parent information among parties, and instituting best practices across systems.

“The attention and energy focused on having the different professionals sit down at the same table and understand each other’s language, agendas and the scope of their roles in the process was really helpful. The fact that CCYJ’s project leadership was able to bridge the different groups really helped us move towards something that was better for families.”

- Navos Supervisor

The Project Coordinator served as the main SEC spokesperson in the court and the community. An important function of the position was identifying opportunities to partner with other agencies and organizations in order to expand the reach of the project and sustain the work. The Coordinator made frequent presentations to educate various groups about the project. CCYJ staff also planned all SEC-sponsored events, including trainings and conference presentations.

Identifying and resolving differences as they arose between partners was critical to keeping the project moving forward. The Project Coordinator facilitated communication among parties by maintaining consistent contact with partners and demonstrating a willingness to listen to concerns. Regular meetings with the Navos treatment team enabled the Coordinator to provide technical support and monitor implementation of SEC treatment protocols. When conflicts arose between SEC partners, the Coordinator focused on respectfully communicating differences and seeking solutions as a group.

The Project Coordinator collected, analyzed and shared data to keep partners informed about the progress of implementation, and to evaluate the treatment and Child Welfare impacts of the program. The Coordinator and CCYJ staff worked closely with Navos and Child Welfare staff to insure that appropriate data was maintained and collected in the SEC database. CCYJ staff also collaborated with the SEC consultants and the contracted data analyst to process the data and describe the outcomes to various audiences. The Coordinator was also responsible for all grant reporting and conducting the project evaluation.

Embedding SEC in the Existing System

Throughout the implementation process, opportunities were identified to engage new partners and insure that SEC was integrated into the existing systems to the greatest extent possible.

Successful SEC parent graduates identified the important role that veteran parent partners could play in engaging and supporting families in the program. The SEC Project Coordinator worked with Parent-to-Parent, a court-supported peer mentoring and education program, to encourage parents with young children to consider SEC. Veteran parents, who have successfully completed the dependency process and had their children returned, now help recruit new families for SEC and provide support and encouragement to keep biological parents engaged in treatment. They also helped SEC develop a brochure, which is routinely distributed to biological parents as part of Parent-to-Parent's Dependency 101 orientation.

An unexpected result of the SEC project was an immediate, marked increase in the demand for infant mental health treatment services by child welfare and court partners. Infant mental health was relatively new to the King County community mental health system, and few providers had the staff with expertise to support the demand. Recognizing the need for more treatment options, the Stuart Foundation funded additional work to expand the capacity of South King County mental health providers to meet increased demand. Providers eagerly participated in training and supervision support, provided by Navos, and three additional community mental health agencies are in the process of developing the expertise to provide infant mental health services to families involved with the child welfare and court systems.

King County Superior Court participates in the Model Courts Project of the National Council of Juvenile and Family Court Judges. Part of a network of 36 courts around the country, the King County Model Court effort is a multi-system collaborative effort that aims to implement best practices and achieve improved outcomes for dependency cases. The SEC project has been integrated into the King County Model Court plan, and both the Coordinator and the Commissioner represent SEC at monthly meetings and workgroups.

SEC representatives also participated in a community-based workgroup called Connecting Over Infant Mental Health in King County. This group included representatives from mental health agencies, early intervention services, child welfare and others interested in developing a community of care to support the social-emotional and mental health of young children. Participation by SEC partners helped insure that the project was connected to the larger infant mental health work going on in the county. This helped SEC professionals access early childhood services for families, and generated interest in expanding treatment provider options.

IMPROVING UNDERSTANDING OF BABIES' MENTAL HEALTH AND DEVELOPMENTAL NEEDS

By providing high-quality, interdisciplinary early childhood training to all partners, SEC has changed the climate in which infants, toddlers and their families' dependency court cases are resolved in south King County. Through these trainings, professionals in the court, child welfare and mental health systems developed a shared understanding of infant development, the importance of early relationships and effective services available for families involved in the child welfare system. As a result, court parties reported that they are often more collaborative, creative and focused on the needs of infants who appear in the dependency court and on their caseloads.

SEC-Sponsored Trainings

SEC's interdisciplinary educational programming was centered on a basic introduction to the social, emotional and developmental needs of infants and toddlers, the brain science and data supporting the importance of relationships, and the impact of maltreatment on infants and toddlers. This key training, called "Through the Eyes of the Infant," was provided several times to different audiences by Dr. Sheri L. Hill. Training participants demonstrated a great deal of interest in the science of early childhood development, as well as the best practices and effective interventions available.

"You can learn about best practices at CLEs, but usually there is no real way to apply what you learn. SEC trainings were great because they provided practical education, in plain language, about young children, relationships and mental health. I was able to take what I learned and share it with my clients, my colleagues and the court."

- *Parents' Attorney*

As participants' knowledge base expanded, SEC developed new trainings to address issues that arose during implementation, including attachment theory, the impact of trauma on young children, and the intersection of the ethical and legal duties of various system partners.

"Because of the training provided by SEC, I think about cases differently than I did before. When I have a family with an infant or toddler in my courtroom, I ask more questions about placement and visitation. Before, it was easier to think of safety only. Now, my understanding of risk includes the impact of removing a child from their primary attachment relationship."

- *Commissioner*

Working with SEC infant mental health consultants, and local and national training programs, CCYJ provided a variety of on-going formal learning opportunities for professionals across multiple disciplines. Partnerships with the University of Washington's Court Improvement Training Academy (CITA) and the American Bar Association enabled SEC to share resources, provide professional education credits to participants, and bring internationally recognized infant mental health experts to King County. All trainings provided continuing education credits for judicial officers, attorneys, social workers and mental health counselors.

SEC conducted nine trainings, which had over 350 attendees.

Informal Learning Opportunities

SEC Team members found the informal access they had to the project's infant mental health consultants and therapists through Ops Meetings and associated work groups provided valuable learning opportunities. The consultants offered regular updates on the latest research and publications in the field, and they made it a priority to follow-up with the team when specific questions arose. Having the SEC therapists actively participate in the program implementation allowed for cross-system learning and greater understanding of the roles, responsibilities and constraints faced by different professionals.

SEC Ops Meetings provided important opportunities to discuss issues related to specific cases. One challenge that the team encountered was insuring that case-specific conversations happened without the Commissioner present. As the decision-maker in the case, the Commissioner was careful to avoid conversations that dealt with actual cases, as they could be considered prohibited *ex parte* communications. As a result, when concerns or questions related to SEC or Navos' treatment arose in a particular case, the Commissioner excused himself and the rest of the team discussed the issue. Many of the partners found this real-life, applied learning to be very helpful in developing a better understanding of how infant mental health treatment can address issues that brought families into dependency court.

Access to Infant Mental Health Research and Resources

Upon the suggestion of the Commissioner, Dr. Hill and the SEC Coordinator developed an infant mental health section of the King County Law Library. Dr. Hill compiled a list of key resources, including brain science research, court and policy recommendations, and infant mental health and development materials. The Stuart grant provided funding to purchase materials and publications. Library staff created a section where materials are available not only to attorneys and judicial officers, but to the general public, including social workers and CASA volunteers.

CCYJ developed an electronic newsletter to inform the larger community about the work of Supporting Early Connections. The periodic publication included updates on SEC activities and trainings, articles by SEC partners, and links to infant development resources for child welfare, mental health and legal professionals. Materials developed over the course of the project were also shared. The distribution list for the e-newsletter includes over 170 individuals from across Washington State and the nation. Dr. Hill regularly shares the e-newsletter with training audiences in other states and at national conferences. Past SEC newsletters can be downloaded from CCYJ's website at <http://www.ccyj.org/initiatives/supporting-early-connections/>.

Sharing the SEC Model and Lessons Learned

SEC sought to increase awareness of the mental health challenges facing young children in child welfare, and SEC as a model for addressing these challenges. SEC partners made formal presentations on the program model and results to a wide range of audiences. Presentations were offered at conferences and trainings at the local, state and national levels. Panels composed of different combinations of SEC partners served as presenters, demonstrating the importance of cross-disciplinary collaboration in the project.

SEC presentations were made at the following state and national conferences.

- Washington Behavioral Health Conference (statewide conference for mental health providers)
- ZERO TO THREE National Training Institute (national conference for early childhood professionals)
- Washington Children's Justice Conference (statewide conference for child welfare and court professionals)
- National Association of Counsel for Children (national conference for lawyers)

Conference materials developed for SEC presentations are available on Dr. Hill's website www.earlychildhoodpolicy.com/courttrain.html.

SEC was also featured in a 2011 national policy agenda published by a coalition of leading child welfare and early childhood development organizations. "A Call to Action on Behalf of Maltreated Infants and Toddlers" profiled SEC's therapy component as a model for providing comprehensive, relationship-based treatment to address the challenges faced by maltreated infants.⁹

⁹ American Humane Association, Center for the Study of Social Policy, Child Welfare League of America, Children's Defense Fund, and ZERO TO THREE, *A Call to Action on Behalf of Maltreated Infants and Toddlers* (2011) p. 19.

ACCESS TO EVIDENCE-BASED TREATMENT IN THE COMMUNITY

By linking families to evidence-based infant mental health treatment, SEC sought to increase the chances for a child to be reunified with at least one parent, with no further reports of abuse or neglect. SEC partnered with a local mental health provider, Navos, to provide ten months of community-based Child-Parent Psychotherapy (CPP), to mothers, fathers, and their infants and toddlers. Parents were referred to SEC by their attorneys, and participation was voluntary. Once a family enrolled in SEC, the treatment was included in the dependency court order as a service for the child.

Child Parent Psychotherapy (CPP)

The treatment provided to SEC families by Navos was CPP, an evidence-based treatment that works through the child-parent relationship. The rationale underlying CPP is that an infant or toddler who has experienced trauma in their relationship, through abuse and/or neglect, needs to be healed within that relationship. Maltreatment and multiple moves among caregivers can lead to attachment problems and trust difficulties in very young children, which is most effectively addressed by working with the parent to repair and move forward in a healthy manner.¹⁰

CPP is an evidence-based treatment for young children, birth through five years old, who have experienced domestic violence, physical abuse and/or neglect, and sexual abuse. CPP is one of the few empirically validated treatments for children under six years old, and it has been implemented extensively with ethnic minority populations. The California Evidence-Based Clearinghouse for Child Welfare has rated CPP as an intervention that is supported by research evidence and highly relevant to child welfare populations.¹¹ The National Child Traumatic Stress Network has also recognized CPP as an evidence-based, trauma-informed intervention.¹²

Developed by Alicia F. Leiberian, Ph.D.,¹³ and Patricia Van Horn, Ph.D., J.D.,¹⁴ CPP is increasingly being used to support the social, emotional and relationship needs of infants and young children in the United States and abroad. CPP integrates attachment, psychoanalytic and trauma theories with treatment strategies based in cognitive-behavior and social-learning approaches.¹⁵ Treatment focuses on enhancing the parent's awareness of, and responsiveness to, the child's needs through role modeling, emotional support, developmental guidance and case management.

¹⁰ Osofsky, et al. "The Development and Evaluation of the Intervention Model for the Florida Infant Mental Health Pilot Program." *Infant Mental Health Journal*, Vol. 28(3), 259-280 (2007). Published on line in Wiley InterScience (www.interscience.wiley.com).

¹¹ California Evidence-Based Clearinghouse for Child Welfare
<http://www.cebc4cw.org/program/10/detailed>.

¹² National Child Traumatic Stress Network
http://www.nctsn.org/nctsn_assets/pdfs/promising_practices/cpp_general.pdf

¹³ Dr. Leiberian is the Irving B. Harris Endowed Chair in Infant Mental Health at the University of California, San Francisco, and Director of the Child Trauma Research Project, at San Francisco General Hospital.

¹⁴ Dr. Van Horn is Associate Clinical Professor at the Department of Psychiatry, University of California, San Francisco, and Associate Director of the Child Trauma Research Project, at San Francisco General Hospital.

¹⁵ Osofsky, et al. "The Development and Evaluation of the Intervention Model for the Florida Infant Mental Health Pilot Program." *Infant Mental Health Journal*, Vol. 28(3), 271 (2007).

“SEC gets to the core of what’s needed for families being served - helping parents understand and meet the child’s needs. This can only be done in the context of the ongoing relationship between parent and child. Can parents arrive at an understanding of their child as a human being whose experience of the world is unique and of value? Do they understand how to meet the child’s needs and how to support the child’s development? More than any other service that I see being made available, Supporting Early Connections can fundamentally alter and strengthen that relationship.”

- *CASA Volunteer*

SEC Treatment Structure

The treatment component of SEC was sited at a community mental health agency, Navos, rather than at a university-affiliated research center. This choice was made in light of several considerations, including sustaining funding for CPP services and the ease of replication in other communities. A majority of children and families involved in the child welfare system in Washington State access behavioral health services through community mental health agencies. These agencies provide services that are reimbursed by federal and state Medicaid funds. By locating the CPP treatment in a community mental health agency, the project sought to build a program that could be replicated in other localities across Washington State.

Parents were referred to SEC by their attorneys, or they self-referred and their attorney was encouraged to discuss their participation with the parent. In part, participation was made voluntary for parents in the hope that they would be more likely to engage in and continue treatment if it was something they chose to do with their child. For the Navos therapists, who typically work with families who actively seek out services, it was extremely important that initial parent enrollment in CPP be voluntary and supportive of developing a therapeutic relationship between the family and the treatment team. Considering the needs of community mental health providers, as well as families and court parties, was key to the collaborative nature of the program.

Enrollment Requirements for the SEC Pilot Project

- *Family had an infant or toddler younger than 30 months at time of referral.*
- *The infant or toddler was placed in King County (placement could be in-home or out of home).*
- *One or both parents were motivated to improve their relationship with their infant or toddler.*
- *Parent(s) and infant were able to engage in the therapeutic process and willing to participate in weekly sessions.*
- *A dependency petition was filed within the past six months in King County Superior Court, and the case was heard at the Norm Maleng Regional Justice Center in Kent, WA, in Commissioner Gallaher’s court room or the Family Treatment Court.*
- *Assigned social worker worked in the King South (Kent) or White Center DCFS Office, or in Kent Family Treatment Court.*

Systemic issues also supported constructing the program as a voluntary service for parents. Wanting to engage families as early in the court process as possible, CPP treatment was offered to families while their court cases were in shelter care, before the dependency was legally

established. During shelter care, all services are voluntary for parents. Additionally, other successful models of voluntary court programs, including Family Treatment Court, informed the development of the SEC model. Finally, there was limited availability of CPP treatment under the grant, and the SEC Team wanted to maximize effective utilization of a limited resource. Ultimately, whether a parent voluntarily initiates a service or is ordered into it by the court, the reality is that parents' failure to fully participate, complete or comply with services is likely to have a negative impact on their dependency court case.

Enrollment was limited to families who were within six months of the start of their dependency court case. One reason for this was to provide the maximum opportunity for CPP treatment to impact the outcome of each dependency case. Federal law requires the development of a permanency plan for children within one year of being taken into care. SEC aimed to provide the system with critical information about babies and their child-parent relationships that would inform permanency planning. Another important reason for intervening early in the course of a dependency case was to support children's mental health by mitigating the negative impacts of trauma caused by maltreatment and their experiences in the child welfare system.

Once a family enrolled in SEC, CPP treatment with Navos was included in the dependency court order as a service for the child. The SEC Team chose to identify treatment this way for several reasons. First, because enrollment in SEC was voluntary for parents, defense attorneys did not want the court order to identify CPP treatment as a requirement for them. Second, the child was identified as a Navos client for therapeutic and financial purposes. If a biological parent became unavailable to participate in treatment, the therapist continued to work with the child and any new caregiver. This insured that the relationship between the child and therapist remained stable, providing continuity and support for the child during caretaker transitions. Third, identifying CPP as a service for the child required the department and the caregiver to make the child available to participate in treatment with the biological parent.

The SEC Team also agreed that because CPP was a service, the weekly treatment sessions would not be considered as visitation time. Visitation between parents and children is a right of the family when a child is placed in out-of-home care.¹⁶ Many parents reported that they were initially drawn to SEC because it provided additional time with their babies and toddlers, beyond court-ordered visitation time.

"Family Treatment Court parents rave about SEC and the support they felt they got from the therapists. They also really value the extra time they have to spend with their children."

- Family Treatment Court Coordinator

Navos provided ten months of community-based CPP to infants and toddlers and their biological parents. The typical case load for an SEC therapist was approximately ten children per FTE, as compared to 15 or more for standard, office-based CPP therapists.

¹⁶ RCW 13.34.136 (2) (b) (ii).

Individualized treatment plans were strengths-based, respectful of unique family culture, and created in partnership with the parent(s). Specific treatment goals were identified and progress toward the goals was regularly reviewed together by the therapist and parent(s). Therapists helped parents identify the strengths of their child(ren) and themselves, and used them to help families learn new skills.

“This wasn’t about setting an agenda for parents and having them be compliant. We were really engaging them in a different way – one that was non-judgmental and positive.”

– Navos Supervisor

Treatment plans often included referrals and coordination with other services and caretakers. Navos aimed to develop plans for optimal care of the infant or toddler. For example, SEC therapists frequently worked with Childhaven, a therapeutic child care center, to insure maximum coordination of services. Coordinated care is more efficient and effective for both families and communities. Therapists often engaged parents in this work to help them develop the capacity to advocate for their children’s needs.

In SEC, treatment also involved considerable communication and coordination with other professionals working with the child and family. On-going communication between Navos and child welfare social workers was essential to providing effective services. Considerable Navos staff time was required to coordinate transportation and identify appropriate locations for treatment to take place, particularly when a child was in out-of-home care.

SEC Treatment Reports – Sharing Information

SEC reports were developed primarily to share information about the child-parent relationship with the court and all parties to the dependency case. For each enrolled child, SEC therapists wrote and distributed three reports during the course of the treatment intervention. Parents signed releases of information for all parties and the court, and therapists distributed SEC reports to all parties in the case.

Parents signed releases of information for all parties and the court upon enrollment. Partnering with parents and their attorneys to ensure everyone had a clear understanding, from the beginning, about what and how information would be shared was essential for building trust and supporting family engagement.

Working with the SEC consultants and Project Coordinator, Navos developed a standard report format that includes:

- Summary of progress made toward treatment goals
- Screening and assessment results
- Status of the child-parent relationship, from the child, parent and dyadic perspectives
- Relevant strengths of the family
- Identified needs and challenges

“The reports were very helpful to me. They not only told me what progress was being made, but they told me which parents were, and were not, engaged. They also let me know what skills parents were learning and which of their child’s cues they were able to pick up on. I’d like the reports to stay as detailed as they are.”

- Child Welfare Social Worker

Partners found the SEC therapists’ reports helpful in developing family case plans, informing their own recommendations, and identifying children’s developmental and other needs. Judicial officers noted that the perspective provided by the therapists was important to forming their own assessment of the child-parent relationship. The report format was so well-received that non-SEC therapists at Navos have adopted it for use with clients who are involved with child welfare.

“Therapists provide regular and detailed written feedback to the parents and parties in the case, with specific suggestions about where progress is being made and where more work is needed. These reports document many hours of skilled observation of the family by the therapist, and provide very useful information to supplement my own observations.”

- CASA Volunteer

Navos therapists found the SEC reports were helpful in the treatment process. The report was designed to identify the unique strengths of the child, parent(s) and relationship, as well as areas of need and further work. In line with the basic values of CPP, this strengths-based approach enabled the therapist and family to identify what the child and parent already do well, and build on those strengths to develop new skills. Writing and reviewing SEC reports with parents at three distinct points during treatment provided therapists with structured opportunities to meet with parents and take stock of a family’s progress toward meeting treatment goals.

The reports also proved to be an effective engagement tool, as therapists provided parents with an opportunity to ask questions and give feedback. If a parent disagreed with a therapist’s report, the therapist included the parent’s point of view in the report. Parents reviewed and signed the reports before they were distributed to the court parties and CCYJ. Parent participants reported that having the opportunity to review and respond to the therapist’s report, prior to other court parties receiving it, helped them feel like a respected partner in the treatment process and developed trust with the therapist.

“The SEC reports helped the court see me as a three-dimensional person who has a healthy relationship with my child.”

- SEC Parent

Parents considered SEC reports meaningful because they gave the court positive information about the family, rather than focusing only on what wasn't going well. Families also found that these reports could be helpful in contexts beyond dependency. Some parents and caretakers used the reports to help other providers, such as pediatricians and early intervention services, understand their child's needs and support requests for additional services or evaluations. One father reported that he submitted copies of his family's SEC reports to a court that was deciding whether or not to lift a no-contact order between him and his older child.

SEC Participation in Child Welfare meetings

Navos therapists were available to take part in meetings to plan for the child and family. Child Welfare social workers, parents' attorneys and parents often asked SEC therapists to participate in meetings, such as Family Team Decision-Making and Child Protection Teams, where plans for placement, visitation and transitions were often developed.

SEC therapists provided the following kinds of information at these meetings:

- Family strengths and goals in treatment
- Ideas for supporting the developmental needs of the child(ren) during transitions
- Update on a family's progress in CPP treatment
- Identified developmental needs of the child(ren)
- Explanation of relevant child, parent and relationship screening results

Therapists were concerned that participation in meetings with child welfare and others might adversely impact their therapeutic relationship with the family. However, they also realized that the information and support they provided could be valuable to parents and professionals. As a result, SEC developed a policy that therapists would only participate in child welfare meetings if the parent(s) or caregiver treatment partners (when parents dropped out of treatment) were present. A one-page information sheet outlining what information therapists could contribute was also developed.

Engaging Families

A key component of the SEC treatment model is family engagement. Effective family engagement increases the likelihood that families will complete treatment, thereby improving the chances for successful reunification with no further reports of abuse or neglect, or decreasing the negative impact of maltreatment, even for families that do not reunify. To address engagement barriers identified by other projects, SEC developed a treatment program that was home- and community-based, and created a Family Support Specialist position to augment the treatment team.

Families who encounter the child welfare system can be difficult to engage and maintain in treatment, as they face many challenges, including poverty, drug addiction, lack of transportation, and the need to comply with multiple services ordered by the court. As a result, infant mental health projects in other communities have found it challenging to keep families enrolled in treatment. Florida's infant mental health court program considered a 50% retention rate to be a major success.¹⁷

¹⁷ Osofsky, et al., p. 277

SEC's goal for retention in treatment was 75% of parents. The project exceeded that goal. Out of the 49 parents enrolled in the program, 40 parents (81.63%) completed the full ten months of treatment. It is important to note that SEC retained parents in treatment, even in cases where the court decided that they would not be reunified with their children.

Parent Retention
81.63% of enrolled parents completed the full ten months of Child Parent Psychotherapy with their babies and toddlers.

Additionally, Navos did not end treatment with the child if a parent disengaged from SEC. SEC therapists continued to work with the child and a non-parent caregiver, while also keeping the door open for the biological parent to return to treatment. To let disengaged parents know that they were welcome to return to treatment with their child(ren), the therapists sent a monthly letter to the parent describing how their child was developing and inviting them to contact

the therapist. If a parent sought to return to treatment, Navos therapists would work with the parent to re-integrate them in a way that was safe and supportive for the child.

Going to the Family: Home- and Community-Based Treatment

Treatment took place in a parent or relative's home, or another location in the community that was comfortable for the family. In the early phases of treatment, biological parents often lacked a home environment where CPP could occur, since many families experienced homelessness and housing instability. As a result, Navos staff worked with parents, social workers, caretakers and others to identify appropriate locations for treatment. These included community centers, library activity rooms and child care centers.

"Children are parented in communities, not in offices."

- *Dr. Sheri L. Hill*

In addition to decreasing transportation barriers for families, working with families in their homes and community allowed for treatment to occur in a realistic setting.

"Having treatment occur in our home, in our natural environment, was great. The therapist was able to see the behaviors we see and help us learn practical, hands-on skills to be the best parents we can be."

- *SEC Relative Caregiver*

In the second year of the program, Navos acquired a small office in Auburn, WA, to provide an alternate location for treatment to occur in south King County. While a therapist's office was not the primary choice of treatment setting, some families had limited options for home or community meeting spaces. When treatment had to occur in an office, it was important to all involved that it not be a child welfare office, as that was not perceived as a neutral location.

Family Support Specialist

During the three and a half years of the SEC project, Navos employed two individuals in the Family Support Specialist role. Both employees had college educations in early childhood-related fields. At capacity, the SEC program operated with one Family Support Specialist supporting the work of three Navos therapists. The position was budgeted as a .75 FTE.

A majority of the Family Support Specialist's time, approximately 60%, was spent providing and arranging the transportation of SEC-enrolled children and their parents. Another 35% of their time was spent working closely with parents and professionals to engage and enroll families in treatment. The remaining time was spent on tasks that supported parents' full participation in treatment, including administering assessment tools, providing developmental information, and working with older children while a parent and infant participated in treatment.

Enrolling families typically took between five and seven weeks from Navos' receipt of a family's referral. Dogged persistence on the part of the Family Support Specialist was required in the beginning of these cases, as many parents were difficult to contact because they lacked a phone and stable housing. Parents were also frequently overwhelmed with other services required by the court, making scheduling of intake appointments a challenge. Considerable time and effort was also needed to coordinate children's participation in intake and on-going treatment. However, the patience and persistence provided by the Family Support Specialist during the enrollment process was critical to SEC's high parent retention rate.

The Family Support Specialist provided a child-centered approach to transporting infants and toddlers enrolled in SEC. Given the multiple separations and reunions that these children experienced with primary caregivers and biological parents, it was critical to have a consistent and supportive adult help them manage the resulting stress and its impact on their developing bodies and brains. The Family Support Specialist provided routine and stability to help children feel comfortable during transitions. Because of the long distances often traveled, the Family Support Specialist spent considerable time with child clients. As a member of the treatment team, the Family Support Specialist also provided a communication link between the therapists and caretakers about the child and their experience.¹⁸

"I want to make sure I am treating each infant and toddler as an individual person with different wants and needs, rather than as a package to deliver from point A to point B."

- *SEC Family Support Specialist*

Open communication and cooperation with Children's Administration social workers was essential to enrolling and retaining families in SEC. When children were placed in out-of-home care, support from the social worker assigned to the child's case was needed to coordinate the

¹⁸ More detail about Navos' child transportation philosophy can be found in the Fall 2010 SEC e-newsletter at <http://www.ccyj.org/uploads/SECMaterials/News%20from%20Supporting%20Early%20Connection%20Fall%202010.pdf>

child's participation in the Navos enrollment process. The Family Support Specialist and therapists found that on-going coordination with the Department was critical to arranging transportation for treatment and gaining support from relative and foster caretakers for a child's participation.

Transportation for Children, Parents and Treatment Staff

Conducting treatment in homes and the community required the expenditure of considerable transportation resources for babies, parents and therapists. In 2010, Navos staff reported driving almost 28,000 client related miles. Both therapists and FSS reported driving an average of 1,000 miles per month. The majority of these costs were covered by the transportation contract between Navos and the Department of Social and Health Services, with a small amount covered by the grant to reimburse for mileage related to participation in SEC collaboration and training activities. After staff costs, transportation was the single largest treatment-related expense, accounting for at least 6% of direct costs.

The geographical area that Navos staff covered turned out to be larger than expected. SEC enrollment criteria restricted services to families with dependency cases in the south King County court, who were also assigned to social workers in a DCFS office serving south and southwest King County or the Kent Family Treatment Court. Additionally, enrolled children had to be placed within the county. It turned out that these requirements included many children who were placed in communities in southeast King County, which is a considerable distance from Navos' office in West Seattle.

Transportation, while essential to the home- and community-based model, was identified as a hardship for the therapists and Family Support Specialist. Navos staff spent many hours a week in their cars, transporting children and parents, as well driving alone to and from treatment sessions. Navos therapists expressed frustration that so much therapy time was "lost" as a result of spending almost a quarter of their working hours alone in their cars. Additionally, Navos does not provide vehicles for staff use, so the therapists and Family Support Specialist were required to put many miles, and the consequent wear and tear, on their own cars.

As SEC moved into the sustainability phase, Navos sought to manage transportation costs and increase the ratio of treatment time to transportation by adjusting the SEC service area. SEC was expanded to serve families with cases heard in both of the King County dependency courts, but Navos identified specific communities that it would serve. Children and parents are now eligible for SEC if the child is placed in one of the selected communities, or if the child can be brought there weekly for treatment sessions. It is also anticipated that a smaller catchment area will enable therapists to maintain larger caseloads, generating more revenue.

Treatment Costs

The following outlines Navos' expenditures for participating in SEC. Analysis is based on Navos' budgetary categories.

- Direct Costs – 77.5%
- Program Administrative Costs – 10%
- Agency Administrative Costs – 12.5%

Staff costs and mileage accounted for over 90% of overall direct costs (staff costs 86%, mileage 6%). These should be the major budget items when planning this work in other locations. The grant covered 75% of therapist costs, with Navos providing 25% of the funding for the therapists. Additionally, Navos had to absorb some of the costs of training therapists and the Family Support Specialist, as well as some of the supervision and other on-going costs not fully covered by Medicaid reimbursement and the grant.

A notable cost that is not included in this analysis is expert consultation and supervision time provided by SEC clinical expert, Dr. JoAnne Solchany. This cost was covered entirely by the grant and managed by CCYJ. Reflective supervision is an additional cost that needs to be considered in any infant mental health program. If an agency does not have in-house expertise in working with court-involved young children, specific expert consultation in this area needs to be factored in as cost of providing effective services.

Therapists reported that they typically spent approximately 45-50% of their work week engaged in what would be considered “billable hours” in most circumstances including: face-to-face direct contact with families, phone or email contact/consultations with families, phone or email contact with collaterals in the case, and case team meetings.

Review of therapists’ billable time in the Navos data management system found that therapists spent their client-related time in the following ways (travel is excluded from this analysis)

- 62% face to face contact with children and families
- 23% meetings with collateral contacts
- 9% Intake
- 4% consultation with other MH providers
- 2% other

During the start-up/program development period of SEC, Navos managed a caseload of 10 children with one full-time therapist and one half-time Family Support Specialist. When the program was fully implemented, each child’s case received an average of .072 FTE of therapists’ time and .0167 FTE of Family Support Specialist time.

Screening and Assessment

Navos therapists conducted screening and assessment of all participating children and parents to identify child, parent and relationship needs, and to measure progress. Navos therapists also screened children for developmental concerns and recommended referrals to appropriate evaluation and services, as needed.

The SEC treatment team utilized a range of tools to assess functioning for the child, the parent(s) and the relationship. Information gathered through the assessment process was used to diagnose children and inform treatment; inform the court and parties about the needs and progress of SEC-enrolled children and families; and evaluate the program. Where indicated by individual screening results, SEC therapists also referred children for evaluation for Part C early intervention and other services.

The SEC assessment protocol was developed by Dr. JoAnne Solchany. Selection of the assessment tools was informed by similar programs across the country and variables such as cost, time required to administer, validity, and the capacity and training required to administer and score tools appropriately. A detailed description of each measure is provided when outcomes for the measure are discussed.

ASSESSMENT TOOLS

*The following assessment tools were administered
at the start and end of treatment.*

- Ages and Stages Questionnaire (ASQ)
- Ages and Stages Questionnaire – Social-Emotional (ASQ-SE)
- Navos Intake (pre-treatment only)
- SEC Parent information form (pre-treatment only)
- Behavioral Health Screen (BHS)
- NCAST Teaching Task (NCAST)
- Devereux Early Childhood Assessment (DECA)
- Denver II Developmental Screening Test (Denver)
- Parenting Stress Index (PSI)
- Center for Epidemiologic Studies Depression Scale (CES-D)
- Difficult Life Circumstances (DLC)
- Community Life Skills (CLS)

Screening and Assessment Measures: Challenges and Solutions

Several challenges emerged that should be considered for development of a similar program serving maltreated infants and toddlers. These challenges include:

- 1) the impact of dependency/court involvement on parent-report measures,
- 2) use of videotaped assessment tools within a child welfare population, and
- 3) concerns around screening parents for mental health needs.

Impact of Dependency-Involvement on Parent Reporting

SEC selected a combination of direct observation assessment tools and self-report measures. Generally speaking, assessments that rely on direct observation of child symptoms and behaviors are preferable, given the potential for inaccuracies and skewed perceptions that caregivers often report. SEC therapists encountered more challenges than expected when relying on parent-report measures when a family is involved in the dependency court, and where infants and toddlers may also be separated from their biological parents.

A key finding relating to working with dependency-involved parents is, understandably, the need and motivation to report that “things are going well,” whether about themselves as parents or about their children. Bias and defensive responding on self-report tools, while not unique in a community mental health setting, is a particular challenge for dependency-involved families. This may have occurred for several reasons: the parents were experiencing a traumatic reaction to having their child removed from their care and thus exhibited a sense of numbness. Conversely, some parents may have an understandable apprehension that acknowledgement of mental health symptoms or risks to the child-parent relationship would negatively impact the

parent's ability to have their child(ren) returned to their care. A third hypothesis is that parents may have reporting biases or inaccuracies simply due to the fact that they had little or no regular contact with their child(ren).

In order to gain an accurate picture of the child's functioning, SEC clinicians sometimes conducted assessments with a non-parental, primary caregiver, usually a foster parent or relative caregiver. However, even a foster or relative caregiver may have had only minimal experience with the young child because the placement was new; in these cases, relying on direct observation of the infant or toddler was more useful.

Because gathering information through assessment tools that require the child and/or parent to demonstrate actual skills is optimal, when a caregiver report is needed, working with the person in the primary caretaker role for child functioning measures is recommended. Regardless of which caretaker participates in the interview, where possible, have the child demonstrate their abilities. Most developmental screening tools based on parent report can be administered in a more interactive fashion with the child and parent in order to gain confirmation of child skills.

Impact of Dependency on Use of Videotaped Assessment Tools

Two of the key relationship assessment tools used in the SEC program, the NCAST and BHS, require video recording of the child and parent interacting with each other. Video recording is widely used in infant mental health treatment, and is an integral and clinically informative component of working with infant-parent dyads.

However, video recording of infant-parent play or structured interactions, such as asking a parent to "complete a task," caused considerable anxiety for some parents. Some SEC parents expressed worry that the video recording would be made a part of the court records and could be misinterpreted in decision-making about placement. Other parents exhibited a general sense of anxiety and nervousness about being videotaped, and this impacted their natural way of interacting with their infant or toddler.

SEC partners also expressed concerns about the videotaping of child-parent interactions. Parents' attorneys were especially worried about how video recordings might be used against their clients in the court process. To address these fears, partners needed to understand what the video assessments were, how they were used, and what they told clinicians. Education for SEC professionals included viewing actual video recordings of parent-child interactions (not clients in the program), and narration by SEC consultant Dr. JoAnne Solchany about behaviors she found instructive, what she was looking for, and how she would use the video in treatment.

Despite these challenges, the use of video-based tools provided the SEC program with confirmation of their value for assessment purposes and in ongoing treatment. Using video allows the clinician to watch an interaction unfold and analyze its components, rather than having to speculate after the fact. Often, a family's video recorded play interaction was later used in treatment with the goal of increasing reflective function in the parents, keeping the infant or toddler in mind, recognizing an infant's cues, and highlighting areas of strength and positive skills in the parents.

Screening Parents for Mental Health Issues

The assessment protocol for SEC included a measure, the CES-D, that screened parents for depression. Studies have found that parental depression is linked to child developmental and mental health outcomes. Chaffin and Bard describe parental depression as one of the common precursors to child removal as it is a risk factor for child maltreatment.¹⁹ Drake and colleagues found parental depression to be related to higher recidivism rates regarding child removal.²⁰ Leschied and colleagues found maternal depression to be related to increased risk of negative child outcomes in attachment, cognitive ability, social, emotional and physical development, and family isolation.²¹ Treatment recommendations suggest early screening and intervention for parental depression to promote better outcomes for children. Furthermore, decreased maternal depression has been found as a side-benefit to CPP.²²

Some therapists expressed serious concerns about using a formal depression screening measure with SEC enrolled parents. Since the child was the “client,” questions were raised as to the ethical nature of using any tool to formally identify mental health issues in the parent. Concerns were raised that the parents’ depression screening outcomes could be used against them in the dependency process. Compounding these concerns was the fact that mental health treatment for parents was often difficult to access, and therapists were worried about identifying a problem in the context of a dependency case, but being unable to address it.

Research indicates that parental depression plays a significant role in the developing parent-child relationship, as well as dependency outcomes. The issues raised by therapists highlight the need to insure that parents involved with child welfare get adequately assessed and have access to the mental health treatment and supports that they need. Some therapists’ concerns were strong enough that it was difficult to get compliance on completing measures, and parental depression data was incomplete.

¹⁹ Chaffin, M. & Bard, D. (2011) Changes in parental depression symptoms during family preservation services. *Child Abuse & Neglect*, 35, 448-458.

²⁰ Drake, B., Jonson-Reid, M., & Sapokaite, L. (2006). Rereporting of child maltreatment: Does participation in other public sector services moderate the likelihood of a second maltreatment report? *Child Abuse & Neglect*, 11, 1201-1226.

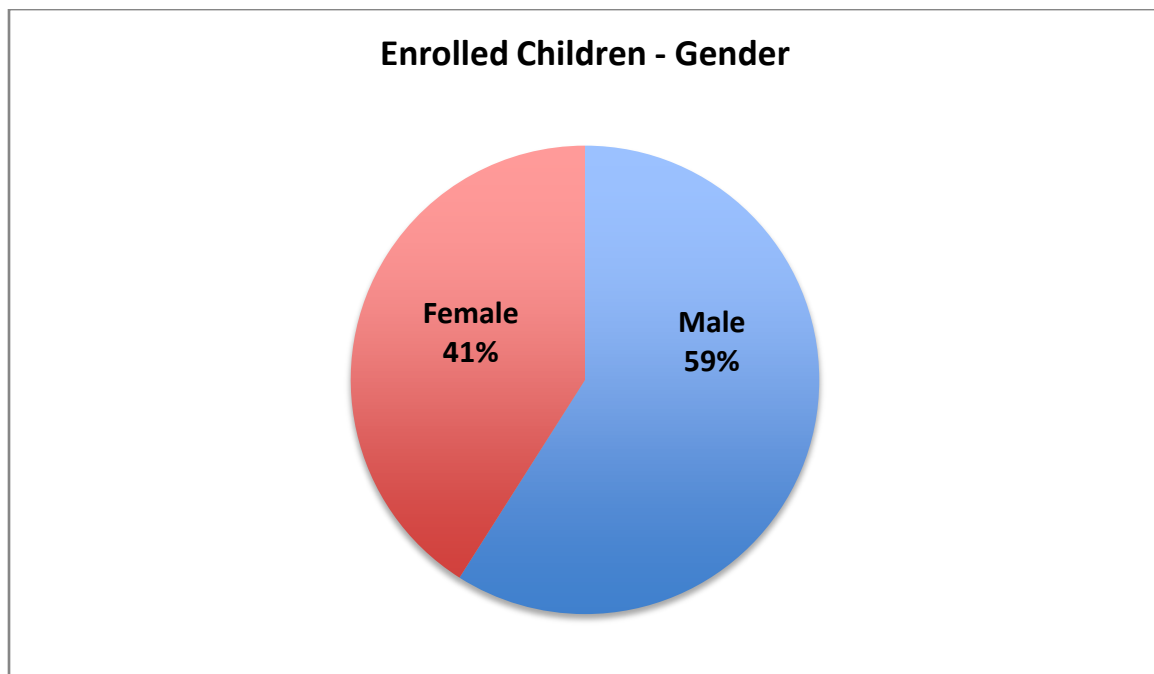
²¹ Leschied, AW, Chiodo, D., Whitehead, PC, & Hurley, D. (2005) The relationship between maternal depression and child outcomes in a child welfare sample: implications for treatment and policy. *Child and Family Social Work*, 10, 281-291.

²² Lieberman and Van Horn, 2008.

Who Were the Children and Parents Involved in SEC Treatment?

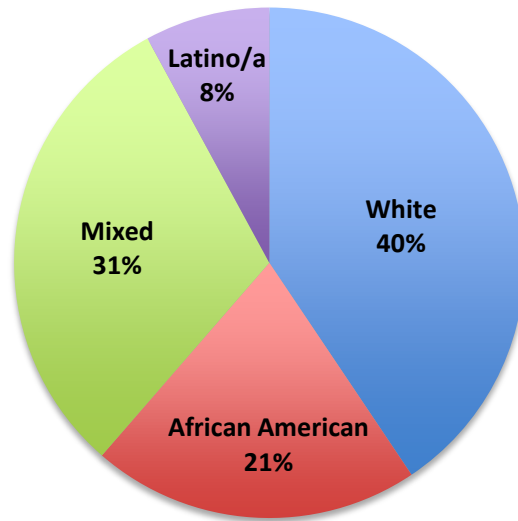
A total of 39 children and one or both of their biological parents were enrolled in treatment with Navos. Of the children, 38 completed treatment. The one child who did not complete treatment was enrolled with a presumed father. Genetic testing, required by the dependency court, later revealed that the father was not, in fact, the child's biological parent. As a result, no biological relatives were available to participate with the child in treatment, and the child's foster parent was unwilling to take part in SEC. This father completed SEC treatment with another child, who was his biological child.

The following data on enrolled children and parents reflects 39 children and their 49 biological parent(s), including the child who did not complete treatment. These families completed Navos' enrollment paperwork.



More boys than girls (23 vs. 16) participated in Child Parent Psychotherapy with Navos.

Enrolled Children - Ethnicity

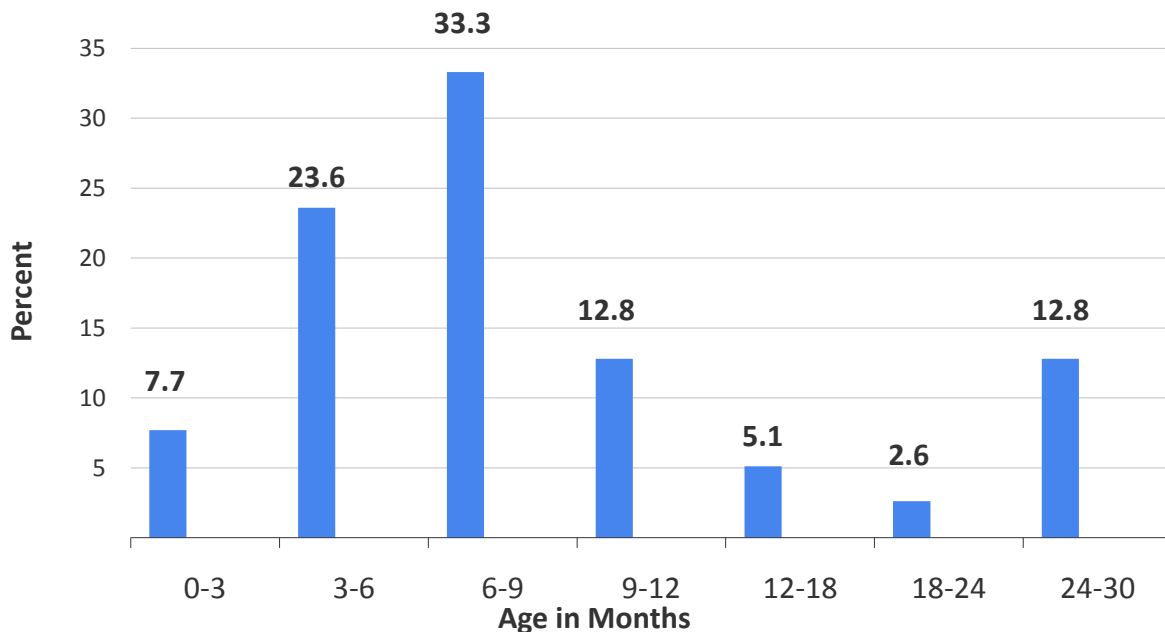


The mixed-ethnicity category included representation of the following groups:

- African American
- Latino
- Filipino
- Sudanese
- Cambodian
- Caucasian
- Unknown

No Native American children participated in the SEC pilot project because Indian Child Welfare Cases are not heard at the Norm Maleng Regional Justice Center in Kent. In the sustainability phase of the program, SEC expanded to serve families with cases assigned to either King County dependency court, making SEC participation available to this population.

Children – Age at Enrollment in SEC



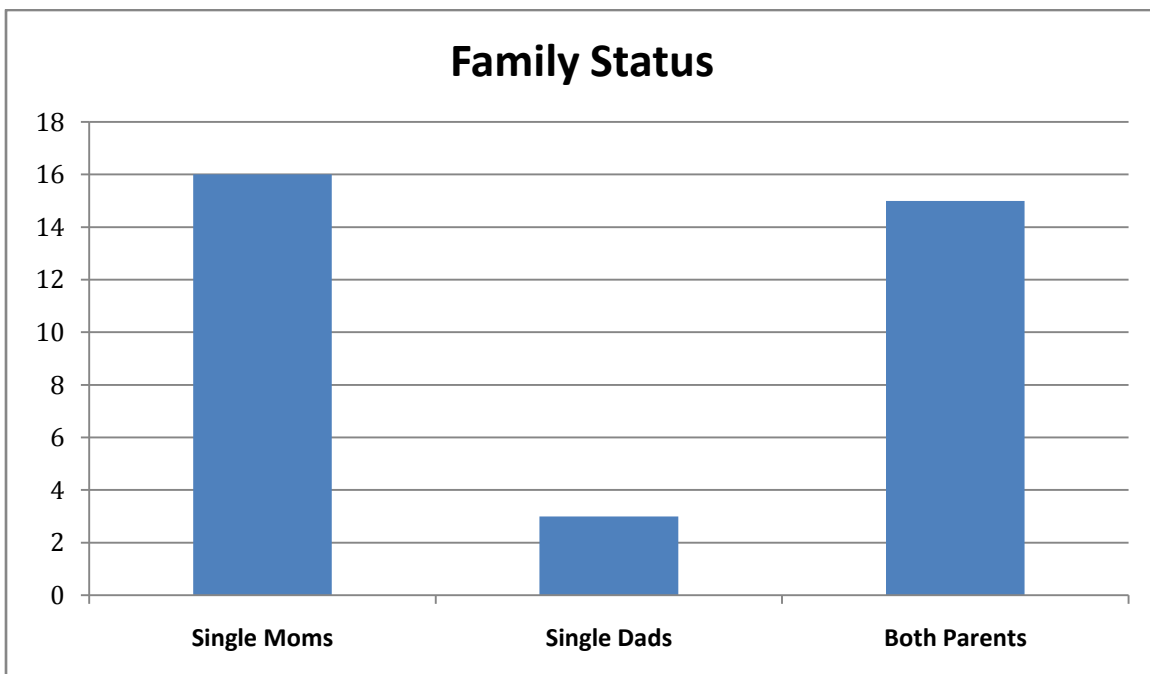
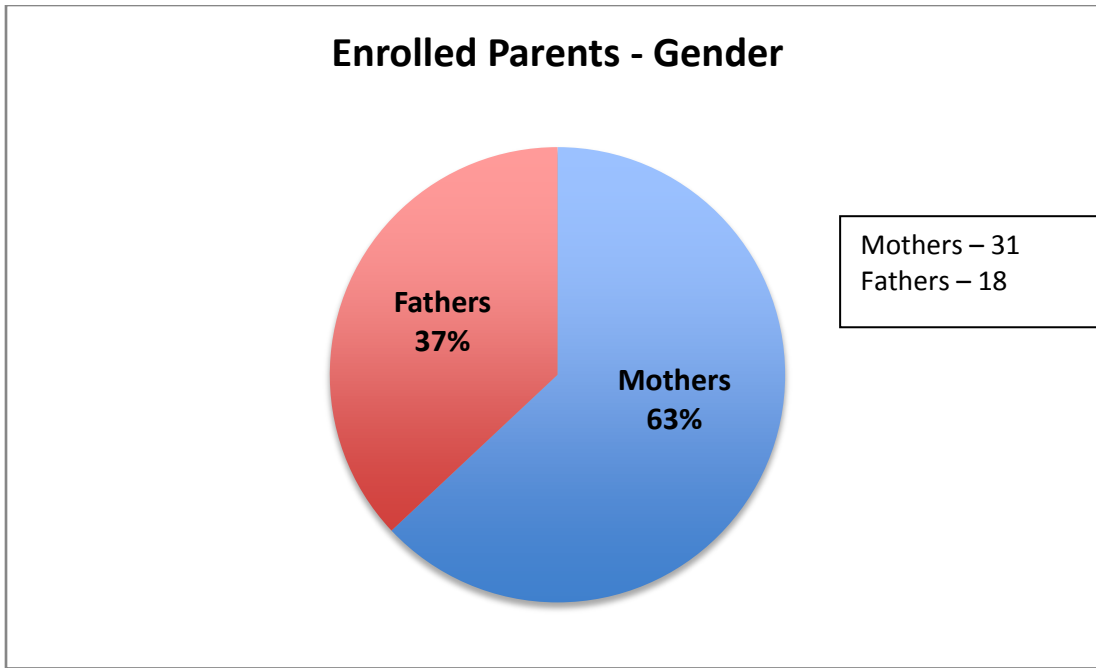
The SEC treatment component was designed for children 30 months or younger at the time of referral to Navos. Eighty percent of the children were under a year of age at referral, and over 50% were under seven months. The average age at enrollment for children was 9.8 months.

Compared to similar infant mental health court programs, the SEC program began working with the children at a much younger age. For example, the mean age of children for the Florida pilot project was 19 months.²³ It is important to note that many infant mental health programs do not enroll children until they are at least six months of age.

Beginning work with a very young group of infants allowed the SEC therapists to intervene early and support healthy parent-child relationships from the start. This early intervention orientation helped to minimize the development of child mental health impairments, supported stronger child-parent relationships, and contributed to better developmental outcomes for participating babies. Researchers at the Center for State Foster Care and Adoption Data at Chapin Hall, University of Chicago, clearly identify infants younger than 12 months as being at uniquely high levels of risk. “Children less than 1 year old at time of placement represent the most important population of foster children when viewed from any one of several policy, programmatic and fiscal perspectives.”²⁴

²³ Adams, Sandra, et al. *Florida’s Infant & Young Children’s Mental Health Pilot Project Final Report*, Florida State University Center for Prevention & Early Intervention Policy (2003), 13.

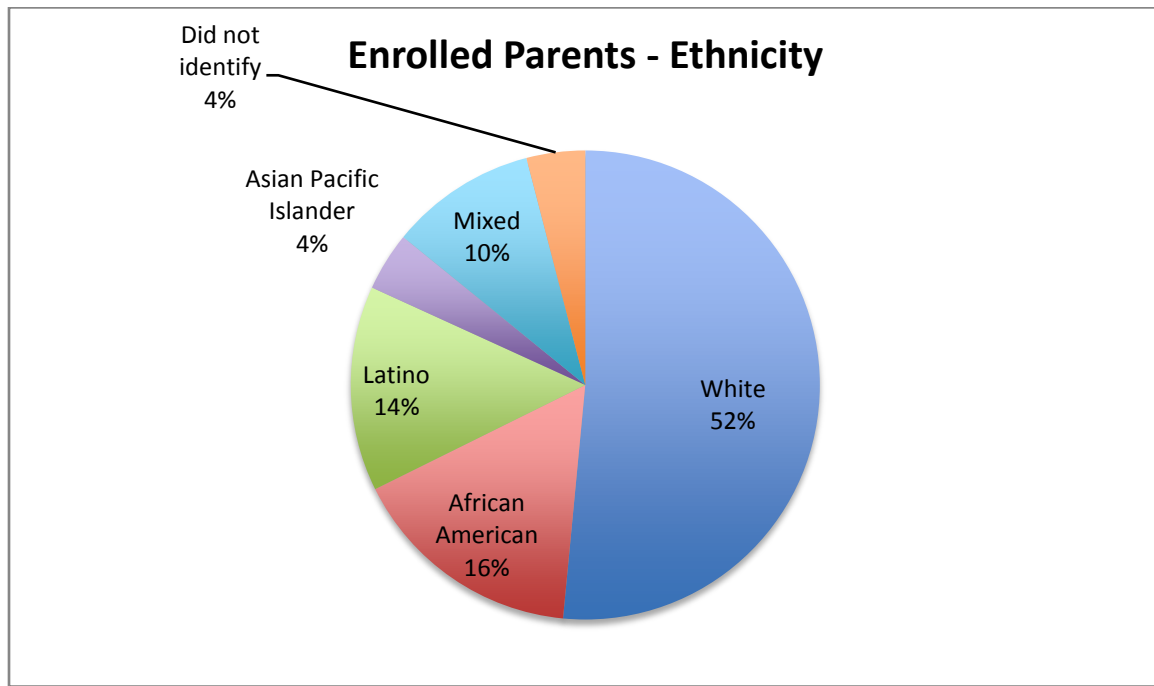
²⁴ Wulczyn, F, Chen, L, Collins, L & Ernst, M, *The Foster Care Baby Boom Revisited: What Do the Numbers Tell Us?*, *Zero to Three* (2011) vol. 31:3.



Unlike many infant mental health programs (including the Florida Infant Mental Health Pilot Project) that primarily serve mothers and their young children, SEC provided treatment to many fathers, both as single parents and as part of a couple. A total of 18 fathers enrolled in CPP with their children.

Almost a third of SEC children had parents who were separated or divorced. Almost two-thirds of parents reported discord in the family. And thirty percent of children came from families where domestic violence was an issue.

In some SEC families, both parents were enrolled in the program, but an order of protection required no contact between them. In these cases, the Navos therapist worked with each parent and their child separately from the other parent. When a protection order was lifted and the family requested it, the therapist worked with the child and both parents together.



Parents' Experiences

Navos administered three parent report measures to assess parental life experiences and stressors. These were:

- Community Life Skills Scale (CLSS)
- Difficult Life Circumstances (DLC)
- Parenting Stress Index – Short Form (PSI)

Community Life Skill Scale (CLSS)

The CLSS measures the use of community resources in six areas: transportation, budgeting support services, support involvement, interests and hobbies, and regularity of routines in daily life. The CLSS has 33 yes/no items, with a range of possible scores being 0-33. This measure has been used most frequently with pregnant and postpartum woman with limited social support.²⁵

Average scores on the CLSS (Entry: 25.69 Range 17.5-32; Exit: 27.1 Range 14 – 32) are similar to those other populations. For example, Barnard and others (1999) found an average score of 26.3 (Range = 15-33) in higher risk mothers with two month-old infants.²⁶

²⁵ http://steppingup.washington.edu/clinicians-corner/steppingup_community_life.pdf

²⁶ Barnard, K., Hilsinger, G. Patteson, D., Snyder, C., Solchany, J., & Shangle, M. (1999). Parent Protective Factors Project (1995-1999), Final Report. Seattle, WA: University of Washington.

Generally, SEC-enrolled parents struggled the most with budgeting, having a supportive community of friends, and maintaining interests and hobbies. Parents showed modest improvements on all subscale scores over time.

SEC did not target life skills as a focused portion of the intervention. However, both the Family Support Specialist and the therapists frequently addressed basic skills as they impacted a parent's capacity to be fully engaged in treatment and/or parenting their child.

These results suggest that families might benefit from focused life-skills support, in addition to other services focused strictly on parenting issues.

Difficult Life Circumstances (DLC)

The DLC measures chronic family problems, such as inadequate housing, long term debt, and unemployment. The 28-item scale is derived from clinical research experience with high-risk families during pregnancy and early infancy.²⁷

Scores for parents, when available, overall were generally similar at entry (M=4.55; N=31) and exit (M=5.03; N=30). A paired t-test, for those parents with entry and exit scores, indicated change over time was not statistically significant ($t(24)=1.578$; $p=.128$).

We did not expect to see substantial changes on this measure due to participation in SEC. Rather this measure was selected to provide a more structured mechanism for the therapist to identify the greatest challenges facing parents. However, therapists found that they gathered similar information through intake and the therapeutic process, making this measure somewhat redundant.

Parenting Stress Index – Short Form (PSI)

The PSI is designed to help identify levels of parental stress, family functioning and parenting skills. The tool is a 36-item self-scoring questionnaire that provides a Total Stress score from three subscales: parental distress, parent-child dysfunctional interaction and difficult child. The PSI includes a validity subscale to assess the amount of response bias, called defensive responding. The PSI is a measure used widely in programs aimed at early identification and prevention of family problems.

Scores on the PSI confirm therapists concerns that parents in SEC (similar to those who participated in the Florida IMH project) were highly dismissive of real stressors when responding to this measure. On the defensive responding scale, a score of 10 or lower indicates that the parent is responding in such a fashion that it calls into question the validity of their scores. This scale was completed at both time points by 22 of the 27 parents with pre- and post-treatment PSI scores. At the start of treatment, 11% of the assessments were considered invalid and another 11% had scores in the 15th percentile range, which is not considered invalid but falls well below normal. That means that up to 1 in 5 of the pre-treatment scores are questionable, at best. At the end of treatment, 14.8% of assessments were invalid and 11% fell below the 15th percentile, calling up to 1 in 4 protocols into question. Given the scoring issues, pre- and post-treatment scores on the PSI were not compared statistically.

²⁷ Barnard, K.E. (1989). *Difficult life circumstances (DLC)*. Seattle: NCAST Publications. Found at http://steppingup.washington.edu/clinicians-corner/steppingup_difficult_life.pdf.

Clinicians reported several difficulties in implementing the PSI, including parental discomfort with the measure. As a result, pre- and post-treatment data was only available on 67.50% of the parents who completed treatment. Additionally, the PSI scores at entry were available for less than half of the parents who started but did not finish treatment. These factors lead us to believe that the PSI substantially underestimated stress levels for this group of parents. Results should be considered with caution.

However, average post-treatment scores were substantially lower than pre-treatment scores. This indicates that it is likely that completion of therapy was associated with a reduction in stress experienced by parents in the child-parent relationship. Pre- and post-treatment scores are noted in the table below.

Scale (N=27 for all)	Pre Treatment Mean (SD)	Pre Treatment Median	Post Treatment Mean (SD)	Post Treatment Median
Total Percentile	46.16 (33.21)	45.00	35.46 (33.49)	20.00
Parental Distress Percentile	58.50 (32.93)	65.00	41.72 (33.66)	35.00
Parent-Child Dysfunctional Interaction Percentile	45.96 (31.31)	45.00	33.74 (29.54)	30.00
Difficult Child Percentile	33.39 (30.05)	25.00	29.89 (30.37)	22.50

Challenges Faced by SEC-Enrolled Families

A range of challenges experienced by SEC families were identified during intake for Navos services.

A quarter of the children enrolled in SEC with known physical trauma. Children's injuries included broken bones, shaken baby syndrome, brain injury and blindness.

Over half of the children enrolled in SEC had at least one parent suffering from some type of mental health challenge. In the majority of cases, parental mental health issues were untreated or inconsistently treated due to lack of resources and insurance coverage.

More than 40% of children had at least one parent involved in the criminal justice system. Parental involvement in the justice system included incarceration, awaiting trial and sentencing, and recently charged or arrested.

Substance abuse was also reported as a common issue for families in SEC. Over one-third of children had a parent struggling with substance abuse issues. Many of the parents working with SEC were also engaged in chemical dependency treatment.

11% of children had parents dealing with their own significant or chronic health issues.

11% of children had one or more parent who was under 18 years old.

Increased Parent Engagement in Other Required Services

While the SEC evaluation did not collect data on parents' level of engagement in court-ordered services, many partners noted that families who actively participated in CPP with Navos had a higher level of engagement across the board. Parents in dependency cases are frequently required to engage in services, such as substance abuse treatment, drug testing, mental health evaluation and treatment, domestic violence assistance and job training, "for the purpose of correcting any parental deficiencies identified in the dependency proceeding."²⁸

"I think SEC helped parents focus on the dependency and getting their kids back. Their progress shows – when they're meeting with the therapist and they start bonding with their baby, it really opens their eyes. They realize there's a lot more to this that they need to do."

- *Parents' Attorney*

"The therapy really helped parents stay connected to their child. That was a huge motivator in many other areas of their case."

- *CASA Supervisor*

²⁸ RCW 13.35.025 (2)

PROGRAM OUTCOMES

Child Well-Being Outcomes

“Infants and toddlers who have experienced abuse and neglect, or who have been exposed to prenatal maternal alcohol and/or substance abuse, have higher rates of physical and emotional problems. Of children under the age of 5 in foster care, it is estimated that between 23% and 61% are found to be significantly delayed when screened for developmental problems. Only 10% to 12% of children under age 5 in the general population are estimated to experience similar delays. If not addressed, these delays can have serious consequences for children as they age.”²⁹

A majority of children entered SEC treatment under 9 months old. In the general population, developmental delay is typically more difficult to identify in children younger than 9-12 months of age, due to their more limited repertoire of skills. Additionally, developmental delays in children involved in Child Welfare tend to emerge over time, as the negative impacts of stress and trauma to which they are exposed accumulate.

General Developmental Screening

Ages and Stages Questionnaire (ASQ)

The Ages and Stages Questionnaire (ASQ) is a series of questionnaires that correspond to age intervals from birth to 5 years. Each questionnaire contains simple questions for parents to answer about activities their child is, or is not, able to do. The answers are scored and help to determine whether the child's development is on schedule or whether the child should be referred for a developmental checkup with a professional.

The ASQ is designed to screen for concerns in the following developmental areas: communication, gross motor, fine motor, problem-solving, and personal-social. DCFS utilizes the ASQ for children under 5 who are assessed by the Child Health & Education Tracking (CHET) program.³⁰ Some ASQ results for SEC-enrolled children were taken from CHET screening reports. Because the ASQ is available in monthly increments, its value also lies in the ability to use it frequently, as clinicians recognize that things can change rapidly with infant and toddler development. SEC clinicians determined that the ASQ should be conducted with a child's primary caregiver and the child should be asked to demonstrate tasks in each skill area.

The ASQ was found to have informative value as it assesses for developmental delays and was useful in identifying the need for referrals to early intervention services.

Completed ASQs were available for 32 (84.21%) children at the start of treatment and 29 (76.32%) at exit. ASQ screenings were considered completed if they were missing no more than one sub-scale score. Percentages reported here are based on completed ASQs. Given concerns raised by the therapists' experiences with parent report, it is likely that this does not reflect the full range of developmental risk or need for this group.

²⁹ American Humane Association, Center for Study of Social Policy, Child Welfare League of America, Children's Defense Fund, and ZERO TO THREE. *A Call to Action on Behalf of Maltreated Infants and Toddlers*, (2011) 16.

³⁰ RCW 74.14A.050

At the start of treatment, one in three (34.4%) of the children with completed ASQs had an indicator of developmental risk in one or more areas. Scores that fell on or below the cut point were considered to indicate areas of developmental risk or concern. Concerns were evident in all aspects of development assessed by the ASQ, but more children had concerns related to fine motor skills than any other area.

At the end of treatment, 37.9% of children with completed ASQs had an indicator of developmental risk in one or more areas. Concerns were more evenly distributed across ASQ sub-scales at the end of treatment.

Denver-II Developmental Screening Test

The Denver II Developmental Screening Test is a widely used developmental screening tool that is used from birth to age six. As with the ASQ, the Denver focuses on infant/toddler development in areas such as: personal-social, gross motor, fine motor-adaptive, and language. In this way, Navos therapists found it useful in identifying young children in need of a referral for early intervention services. Results are predominantly measured by direct observation of a child's behavior and skills.

The Denver II provides a particularly good visual format for explaining and using results with families. Clinicians often reviewed the visual score profile with parents and caregivers in order to discuss developmental expectations, their child's particular strengths and needs, and what areas to provide support. Finally, the Denver II, unlike other screening measures, provides a clearer picture of a child's above age-level skills, which can offer clinicians information about strengths that might not be identified elsewhere.

The Denver II was added to the SEC assessment process after the program started receiving more referrals for infants under four months of age than anticipated. As a result, the Denver II was only completed on 21 (55.26%) children at entry, but increased to 28 (73.68%) at exit.

Children with Indicators of Developmental Risk		
	Pre Treatment	Post Treatment
Denver ³¹	47.6%	32.1%
ASQ	34.4%	37.9%

When they entered treatment, 33% of the children tested screened positive for a delay in one or more areas. If cautions are included as an indicator of risk, 47.6% had one or more areas of concern. These are relatively similar to the results found with the ASQ.

Upon exiting treatment, 17.9% of children tested screened positive for a delay, and 32.1% for either a delay or concern in one or more areas of development.

³¹ Includes children who screened positive or caution for a delay in one or more areas.

Social-Emotional Developmental Screening

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

This short screening was utilized with every child involved in SEC. The ASQ-SE is designed to conduct personal-social screening in areas such as: self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people. The ASQ-SE has been utilized with over 3,000 children ranging from 3 to 60 months. When using the ASQ-SE, clinicians found that it should be conducted with the child's primary caregiver, one who has had opportunities to observe the child in a range of situations and across time.

Although this tool is short and relatively easy to administer, and Navos was required by the King County RSN to use it as a part of intake for all children under 5 years old, clinicians found that it has overall low clinical value. This is largely because the domains are typically already assessed in treatment through a more informal, but nuanced, approach to developing social-emotional treatment goals.

Despite the clear social and emotional needs of SEC-enrolled children, as indicated by the large percentage of children with a mental health diagnosis at entry (see below), results on the ASQ-SE did not reflect these concerns. Only one child (3.1% of 32) screened positive for concerns upon entry. At exit, of the children tested, four (13.79% of 29) failed the ASQ-SE and one (3.45% of 29) fell on the cut-point. This further highlights the problems with parent-report measures.

Devereux Early Childhood Assessment I/T (DECA I/T)

The DECA I/T assessment captures positive behaviors and protective factors generally seen in young children, including initiative and attachment relationships. The infant version is used for children 1-18 months, and the toddler version is designed for children 18 - 36 months old. The toddler version of the DECA includes self-regulation as a factor. A total protective factor score is generated. The DECA is primarily a measure of protective factors, though it does identify some risk factors for mental health problems.

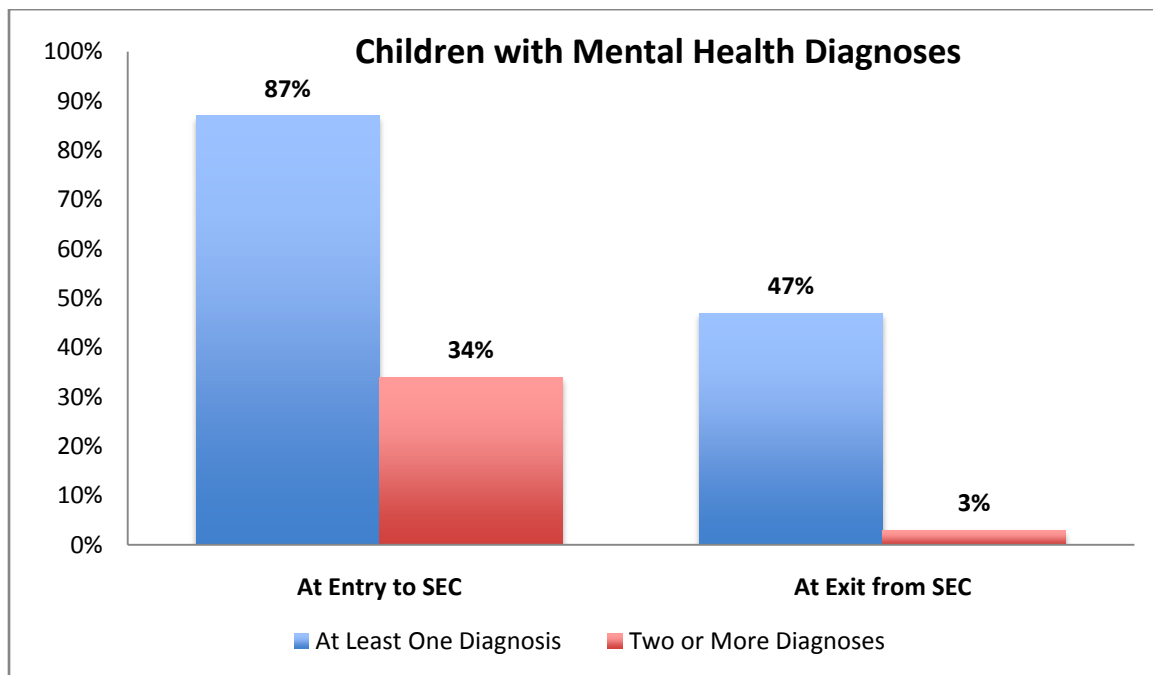
On the DECA, scores below 40 indicate an area of need, and scores above 60 reflect an area of strength. The table below contains data on the percent of children with identified needs and the percent of children with identified strengths/protective factors at entry and exit. For children in the child welfare system, it is important to consider both needs and strengths.

DECA I/T		
Pre-Treatment (N=35)		
	<i>Need</i>	<i>Strength</i>
Initiative	8.6%	14.3%
Attachment/Relationships	14.3%	17.1%
Total Problems	11.4%	14.3
Post-Treatment (N=30)		
	<i>Need</i>	<i>Strength</i>
Initiative	13.3%	26.7%
Attachment/Relationships	6.7%	20.0%
Total Problems	17.2%	27.6%

Mental Health and Well-Being

Children enrolled in CPP with Navos were diagnosed using the *Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood, Revised* (DC:0-3R). Children can have multiple diagnoses, as they can have diagnoses on Axis I, which are clinical disorders, and Axis II, which are relationship disorders.

Diagnosis of symptoms in early childhood is performed chiefly to inform clinical intervention, and not to assign a label to a long-term problem that is not expected to change. There were some children who did not receive a diagnosis at intake to SEC, but later were given one as their symptoms became apparent to the clinician.



It is important to note that many children no longer had any diagnoses at the end of treatment, and for those who did, their diagnoses were fewer in number and typically lesser in severity. This highlights how, in early childhood, mental health diagnoses should be viewed as transient in nature. The change in diagnoses over time can be due to many things including:

- improvements in the child, relationship, and/or environment;
- as the child matures some symptoms can become clearer and better understood; and
- over the course of treatment, some issues can be resolved, while others may become more prominent or apparent.

The most common DC: 0-3R diagnoses assigned to SEC-enrolled infants and toddlers were:

- Adjustment Disorder
- Relationship Disorder
- Depression of Infancy

The following chart represents all diagnoses given to SEC-enrolled children at the beginning and exit of the program.

Child Diagnostic Breakdown		
DC: 0-3 R Diagnoses	Time 1	Time 2
Posttraumatic Stress Disorder	2	
Deprivation/Maltreatment Disorder	2	2
Anxiety Disorder		2
Separation Anxiety Disorder	1	
Depression of Infancy	4	
Adjustment Disorder	23	9
Sensory Disorder	2	
Feeding Disorder	3	1
Multisystem Developmental Disorder		1
Relationship Disorder	13	4

Relationship Outcomes

A primary goal of the Supporting Early Connections project was to improve the quality and functioning of parent-child relationships. Recognizing that the caregiver-infant relationship “is key to both vulnerability and protection in early development,”³² the project utilized several tools to assess overall functioning, as well as important components of parent-child interactions. The assessments used in SEC were chosen to identify areas where the parent and child were struggling and to help target areas of intervention. Only time and developing an ongoing relationship with the parent and child help clarify the underlying issues and the long-term ability of an individual to parent.

Clinically and statistically significant improvement was found on multiple measurements of relationship functioning.

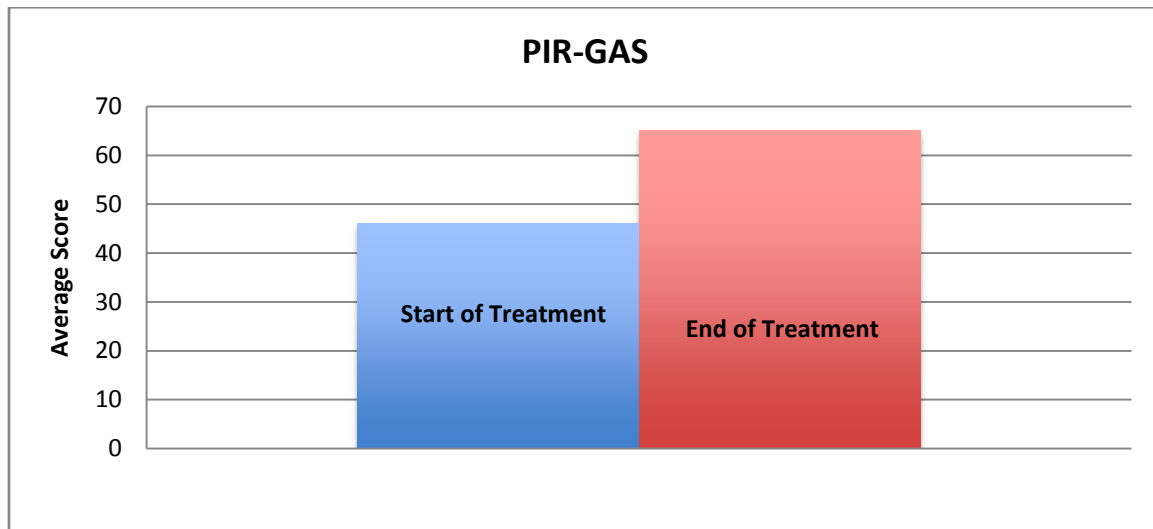
The measures employed by Navos were:

- Parent-Infant Relationship Global Assessment Scale (PIR-GAS)
- Behavioral Health Screen (BHS)
- NCAST Teaching Scale (NCAST)

³² Osofsky, et al. “The Development and Evaluation of the Intervention Model for the Florida Infant Mental Health Pilot Program.” *Infant Mental Health Journal*, Vol. 28(3), 263 (2007). Published on line in Wiley InterScience (www.interscience.wiley.com).

Parent-Infant Relationship Global Assessment Scale (PIR-GAS)

The Parent-Infant Relationship Global Assessment Scale (PIR-GAS) is a measure of the overall quality of a parent-child relationship, with scores ranging from 0 to 100, “severely impaired” to “well adapted.” Scores below 40 indicate a disordered relationship. Scores between 41 and 80 show features of a disordered relationship that may benefit from therapeutic intervention. Scores above 80 indicate relationships that are adapting to the challenges facing them.³³



Using the PIR-GAS, children were rated on their global relationship functioning when they entered and exited SEC. All children were assessed with their biological parents at entry. If the biological parents were not available at the end of treatment, the assessment was completed with the primary caregiver. Entry and exit PIR-GAS scores were available for 35 children.

A paired t-test found PIR-GAS scores at the end of treatment (M=64.97, SD=14.99) were significantly higher than scores at the start of treatment (M=46.00, SD=14.148); $t(34)=8.42$, $p<.001$. This 20% improvement in scores is both clinically and statistically significant.

The range of PIR-GAS scores recorded at the start of treatment went from the sub-category of Severely Disordered (21-30) to Adapted (81-90). The mean score for the start of treatment fell in the sub-category of Disturbed (41-50).

The range of PIR-GAS scores recorded at the end of treatment went from the sub-category of Disordered (31-40) to Well Adapted (91-100). The mean score for the end of treatment fell in the sub-

DEFINITIONS FOR PIR-GAS

“Disturbed” is defined as “the adaptive qualities of a disturbed relationship are beginning to be overshadowed by problematic features. Although not deeply entrenched, dysfunctional patterns appear more than transient. Developmental progress can still proceed, but may be temporarily interrupted.”¹

“Perturbed” is defined as “some aspect of the overall functioning of the relationship in this range is less than optimal: child and parent may experience transient distress lasting up to a few weeks. Nevertheless, the relationship remains characterized by adaptive flexibility. The disturbance is limited to one domain of functioning. Overall, the relationship still functions reasonably well and does not impede developmental progress.”¹

³³ ZERO TO THREE, *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition*, 2005, 42.

category of Perturbed (71-80), a full three categories above the average scores at the start of treatment.

The Behavioral Health Screen (BHS)

The Behavioral Health Screen (BHS) is scored from a 10 minute video segment of child-parent play. This assessment measures a number of dimensions that vary according to the age of the child. The BHS was developed by Dr. David Willis and colleagues at the Northwest Early Childhood Institute <http://www.hearingandspeech.org>. The BHS was selected because it was brief, allowed for a combination of structured and unstructured interaction between the parent and child, and provided scoring that would address a variety of behavioral and interactional items. The BHS was given at the beginning of treatment and again at the end of treatment.

Results of the BHS (on a paired t-test with parents who completed treatment) demonstrated that child-parent relationships improved an average of 22 percent ($M=22.37$, $SD=25.21$). This was both clinically and statistically significant; $t(38)=5.54$, $p<.001$. Additionally, improvement was clinically and statistically significant for all sub-scales.

Child-Parent relationship scores improved 22%, on average, on the BHS. This was both clinically and statistically significant.

At the beginning of treatment, parents' raw scores ranged from zero to six, out of a possible 10 points, with an average score of 3.24. By the end of treatment, parents' scores ranged from 4 to 10, with an average score of 7.5. The scores for parents increased an average of 4.25 points. These numbers reflect an improvement in parents over time in terms of their skills, which included engagement, positive affect, responsiveness, pacing and attention. These results suggest that even if the parent was not able to manage the daily stress and organizational demands of parenting their child, their ability to interact was much more positive and enjoyable for both the parent and child. The most growth was seen in the ability to share positive affect, which jumped from an average item score of 1.08 to 1.86. However, all individual items reflected a positive overall growth pattern.

NCAST Teaching Scale

The NCAST Teaching Scale was administered to better understand the relationship between SEC-enrolled parents and their children. This tool is widely used, often within Public Health Departments, to assess mothers, children and their interactions. The NCAST provides several subscales for caregivers, including sensitivity to cues, response to distress, social-emotional growth fostering, and cognitive growth fostering. For children, subscales include responsiveness to caregiver and clarity of cues. Total scores for the caregiver, child, and the dyad are also provided. Additionally, a set of contingency scores reflect groups of specific interactional items, where demonstration of that item is contingent on the actions of both parent and child within the interaction.

The NCAST was added to the initial Navos assessment protocol after treatment services were initiated with several families. It is important to note that one of the goals of SEC was to test specific assessment tools for the quality of relevant clinical information they could provide, family friendliness, and feasibility in future use. The NCAST Teaching scale can be administered easily, but requires scoring by someone with current certification. Identifying such a person was a challenge for Navos.

Teaching scores were available on 28 relationships at the start of treatment and 30 at the end of treatment. While these numbers did not allow higher level statistical analysis, a comparison of the mean scores at the beginning and end of treatment reflect patterns of improvement in all but one scale total and one subscale score. This suggests patterns of improvement in both parent and child, as well as within their interactions over the course of treatment. The only subscore that did not reflect growth was "caregiver response to distress," for which the post-treatment mean scores dropped about .75 of a point overall. Please refer to the table below for the pre- and post-treatment patterns.

NCAST		
Caregiver-Child Total		
	Pre-Treatment Score	Post-Treatment Score
Sensitivity to Cues	7.25	7.43
Response to Distress	8.54	7.73
Social Emotional Growth Fostering	7.75	8.73
Cognitive Growth Fostering	9.07	10.1
Caregiver Total	32.61	34.07
Clarity of Cues	7.36	8.3
Responsiveness to Caregiver	5.75	7.03
Child Total	13.11	15.33
Child-Caregiver Total	45.71	49.4
Contingency Scores		
	Pre-Treatment Score	Post-Treatment Score
Sensitivity to Cues	3.21	3.53
Response to Distress	3.61	2.93
Social Emotional Growth Fostering	1.71	2.07
Cognitive Growth Fostering	1.71	2.37
Caregiver Total	10.36	10.9
Responsiveness to Caregiver	5.29	6.7
Child Total	5.29	6.7
Child-Caregiver Total	16.96	17.23

Child Welfare Outcomes for Children Enrolled in SEC

An important goal of SEC was to improve the Child Welfare system outcomes for children and families enrolled in treatment. Specifically, the project sought the following for enrolled families and children:

- Increased placement stability, meaning fewer moves of babies among caregivers
- More children returning home to biological parents
- Earlier permanency for children, including return home to a parent, or an alternate permanent plan with relatives or others
- Fewer recurrences of maltreatment and re-entry into the child welfare system

Child welfare statistics for Region 4 and the rest of the state were prepared for SEC by Partners for Our Children (POC) to provide comparison points for the SEC evaluation. POC is a research and best-practice collaboration between the University of Washington School of Social Work and Washington State DSHS. The POC data was based on a sample of children experiencing their first placement in out-of-home care in Washington State from 1998 through 2007. Of note, the state estimates do not include data from Region 4. The data sample was drawn from the Children's Administration Case Management Information System (CAMIS), and included children less than 36 months of age who had a dependency petition filed within one year of placement.

The following data reflects outcomes for the 38 children who completed treatment with Navos. Child welfare data for these children was recorded by child welfare staff, based on case file information as of July 2011.

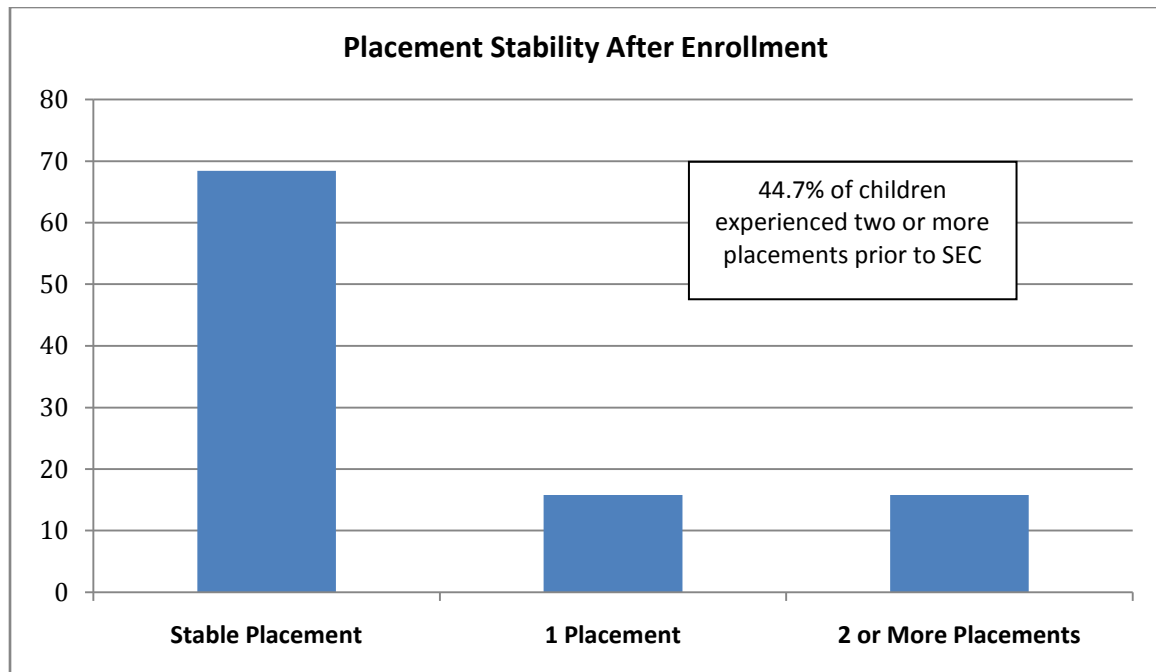
Stability

Keeping children in stable placements was a goal of SEC. Changing caretakers is stressful for babies and young children. Multiple moves among foster and/or relative homes decrease the opportunities for infants and toddlers to form attachments with a trusted adult, putting them at risk for developmental delays and future difficulties with learning, emotional regulation and mental health.

"We need to change the words we use.....when we move a baby in care from one home to another home...or one placement to another placement...what we are really doing is.....moving a baby from one relationship to another relationship."

Dorothy Henderson, LCSW³⁴

³⁴ Hill, SL (July 11, 2008) Through the Eyes of the Infant Presentation: Kent, WA.

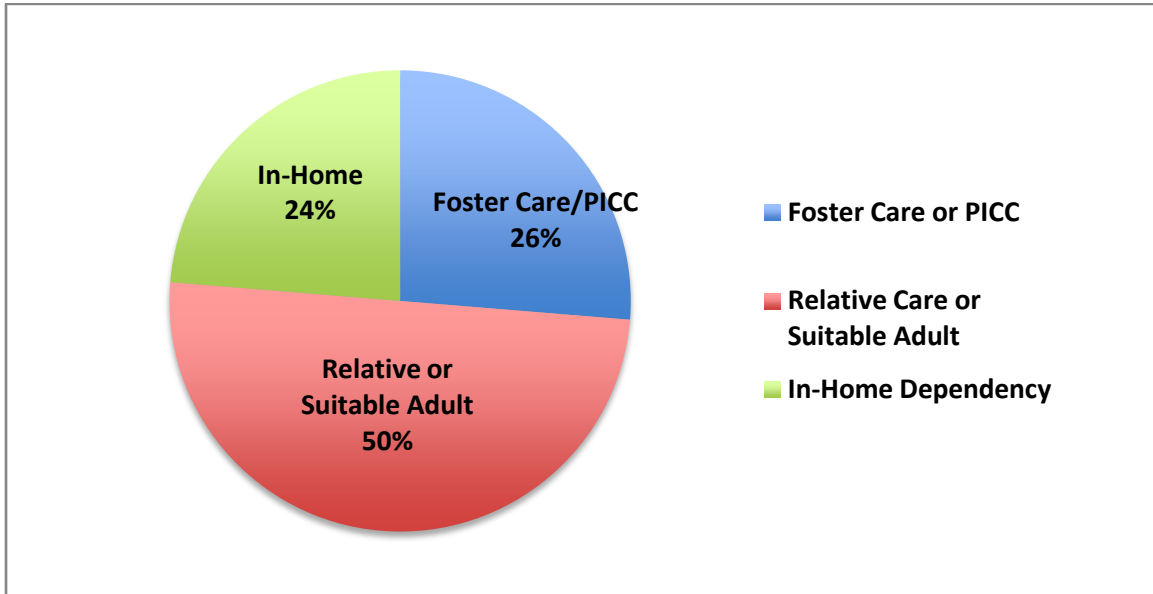


Definition of stable placement included return home to a parent

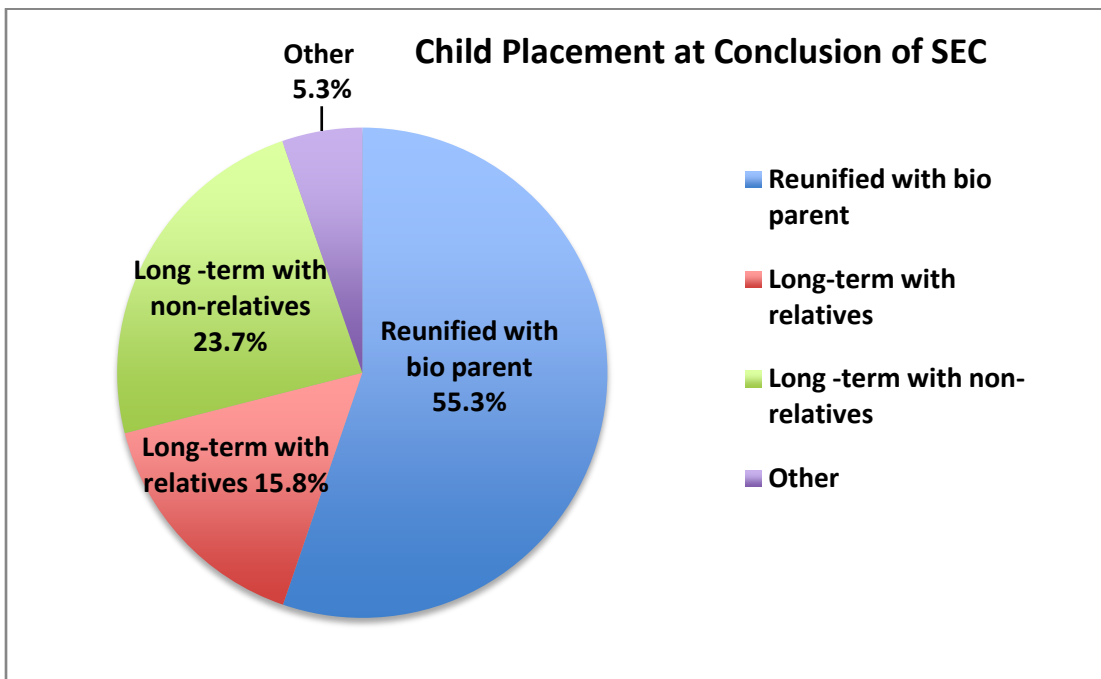
A review of records in the DCFS database, FamLink, showed that 44.7% of children experienced two or more placement changes prior to enrolling in SEC. Most children in SEC experienced more stability after enrolling in the program, with 68.4% remaining in stable placements or returning home. 15.8% of children experienced one change in placement (not including return home to a biological parent) after enrollment.

Despite participation in SEC, a small group of children, 15.8%, experienced two or three moves among caregivers after enrollment. To ameliorate the impact on children of multiple changes in caregivers, the Navos therapist continued to work with these children and their parent(s), when they were available, and helping each new caretaker learn about the children and their individual emotional and developmental needs.

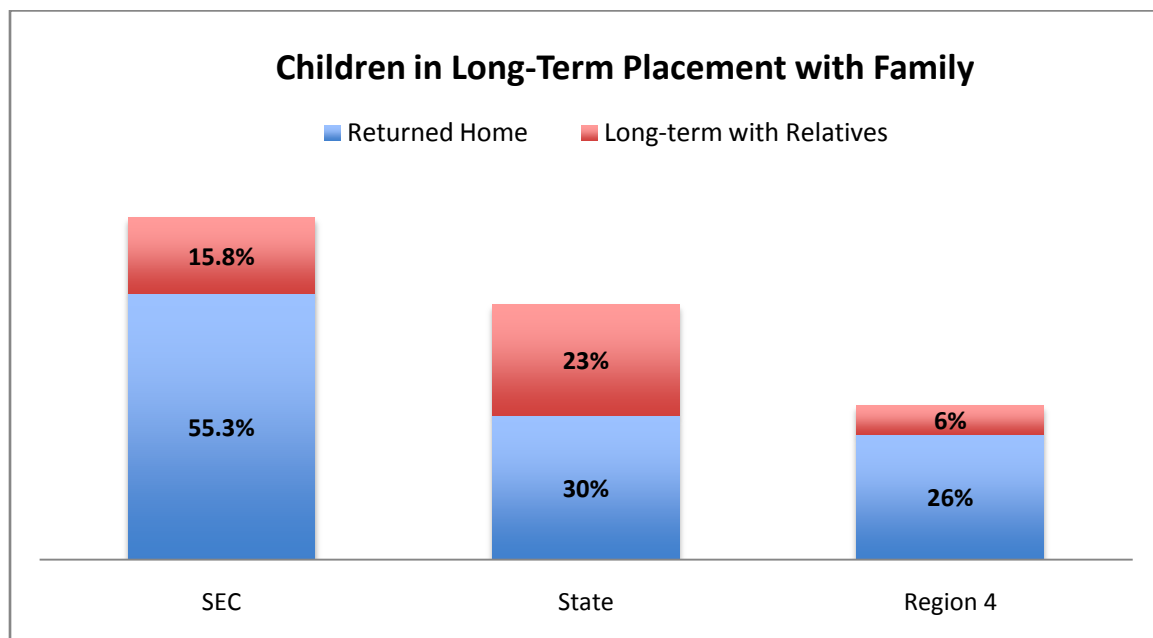
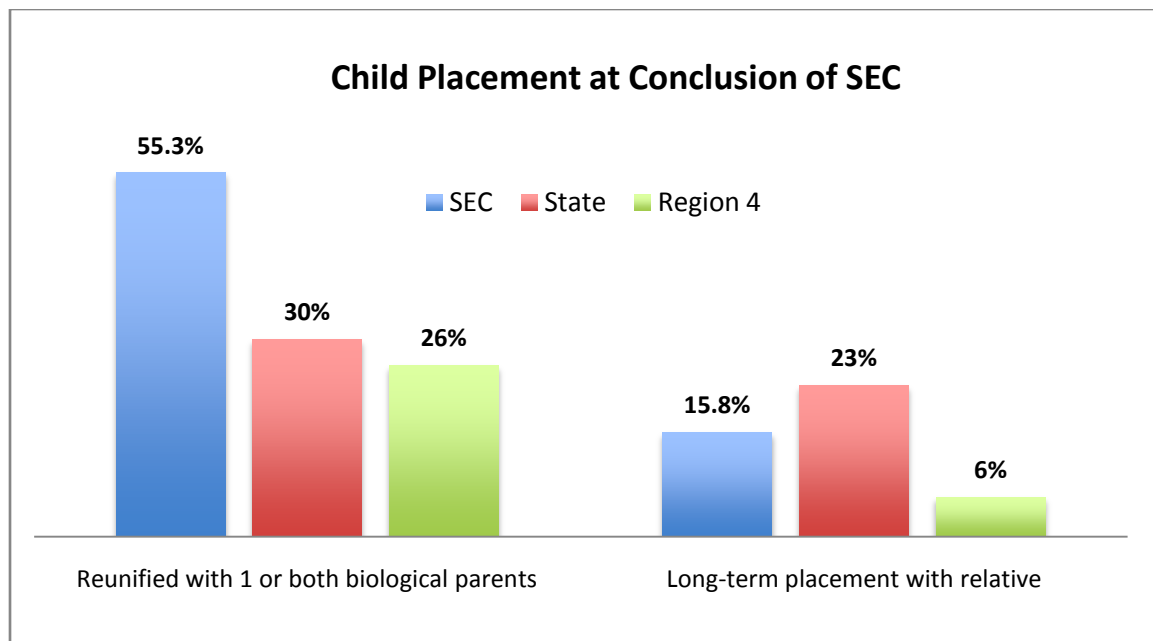
Child Placement at SEC Enrollment



Over 75% of children were placed out-of-home when they enrolled in SEC.



Child placement data reflects placement as of July 2011, when all children and families enrolled in the SEC pilot project had completed treatment.



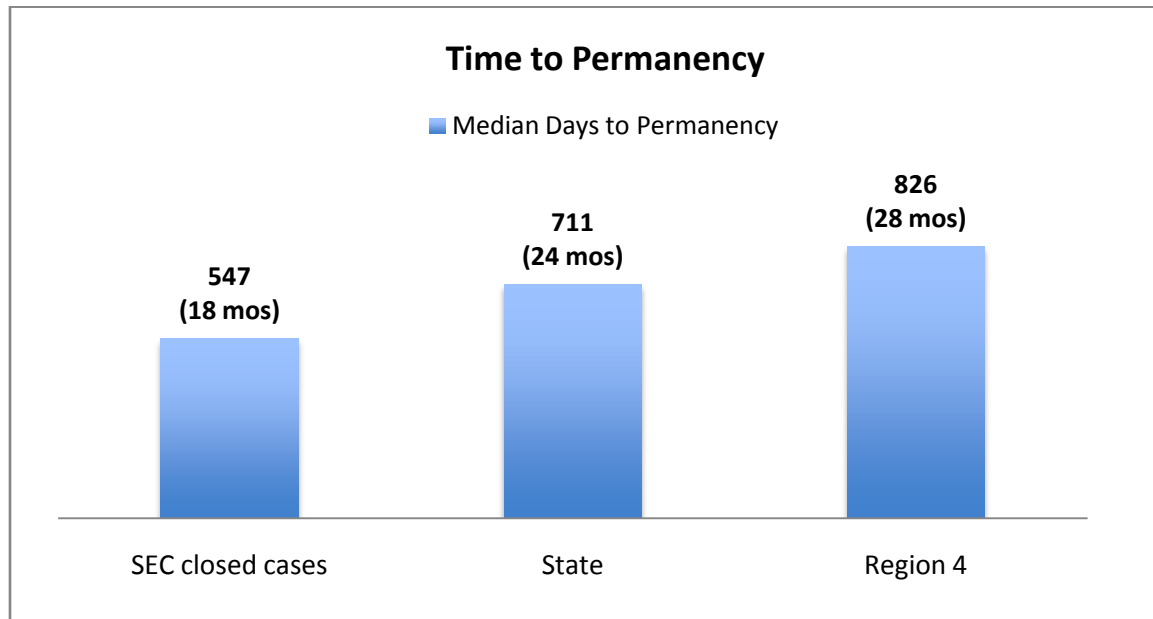
At the end of the evaluation period, 71% of children were either returned to their biological parents or in long-term placements with family members. 55.3% of children were reunified with one or both biological parents and 15.8% were in long-term relative placements.

Children in SEC reunified with biological parents at much higher rates than typical state or regional numbers. This is despite the young age of our sample. Nationally, reunification rates are lower for children under 12 months.³⁵

³⁵ Wulczyn, F., Chen, L., Collins, L., & Ernst, M. "The foster care baby boom revisited: What do the

Time to Permanency

SEC sought to decrease time to permanency by engaging families in CPP treatment with Navos within the first six months of their dependency case, and providing training and collaboration for professionals working with families.



N = 14 SEC Closed Cases

SEC closed cases were those where there was no longer an open dependency court case. SEC had 14 children who had completed CPP treatment and no longer had an open dependency case by July 2011, when data collection ended.

We took a conservative approach to analyzing time to permanency by looking only at SEC closed cases. This was to insure that the permanency event used to calculate time to permanency was in fact the child's final placement at dismissal of the case. SEC-enrolled children with closed dependency cases reached permanency at the following rates:

- 50% within 547.5 days (~18 months)
- 75% within 640 days (~21 months)
- 100% within 849 days (~28 months)

A majority of the children with closed cases in SEC achieved permanency at a rate substantially quicker than the median time to permanency for both the region and the rest of the state. The median time to permanency for Region 4 was 826 (~28 months), while the time to permanency for the rest of the state was 711 days (~24 months).

Most of the 24 children enrolled in SEC whose dependency cases were still open in July 2011, were on-track to achieve permanency in a shorter time than state and regional statistics indicate. The median time from the filing of dependency for those cases was 504.5 days. Many of these cases were approaching case dismissal with hearings scheduled in August and

numbers tell us?" *Zero to Three* (2011) 31(3) 4–10.

September. We anticipate that the time to permanency for these children would be similar to the results for the closed cases.

The difference between the median time to permanency for SEC-enrolled children and the median for the region and the rest of the state was approximately 6 to 10 months.

If we assume that shorter time to permanency results in a comparable reduction in time spent in foster care, then we could estimate that SEC produced an average savings of approximately \$4,200 in foster care payments per child, as compared to similar cases in Region 4. Compared to the rest of the state, the savings would be around \$2,600 per child. The current base payment rate for foster parents caring for children birth to five years old is \$423.60 per month. However, payments to foster parents are only a portion of the costs expended on children involved in the dependency system. A more detailed cost analysis, which is beyond the scope of this project, should take into account court and other child welfare-related costs.

Re-referral to Child Welfare

According to FamLink data retrieved by SEC Child Welfare partners, no SEC-enrolled children were the subject of a Child Protective Services report or other re-referral to the child welfare system by July 2011, when data collection ended.

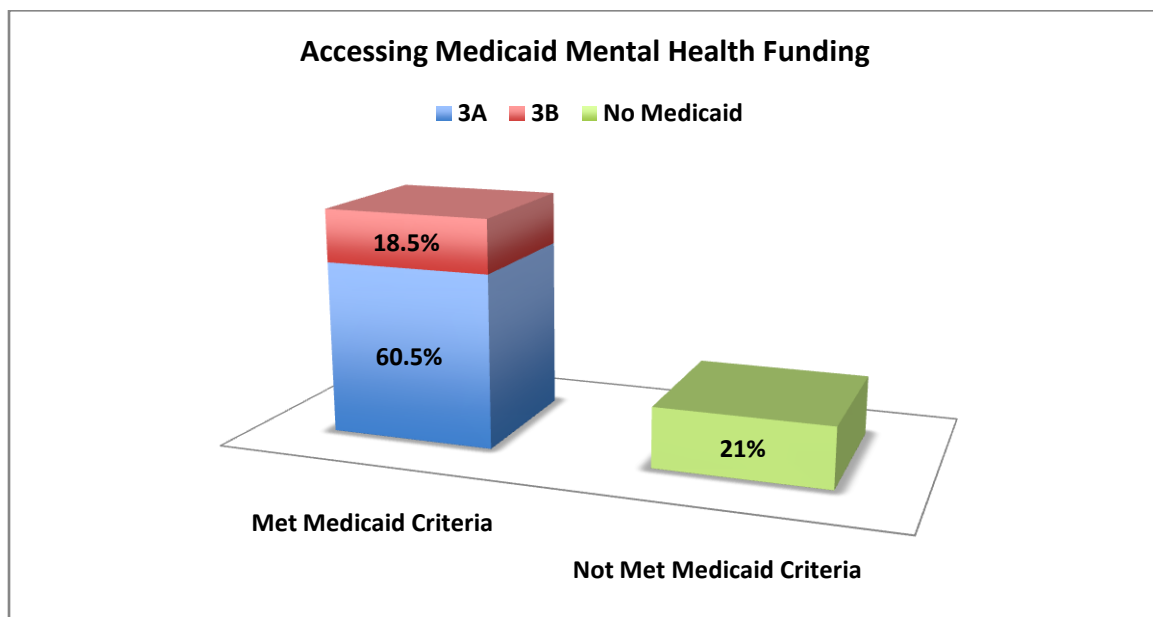
PROGRAM SUSTAINABILITY

Medicaid Reimbursement for Treatment Costs

A goal of the SEC pilot project was to identify a sustainable revenue source for dyadic treatment services. Enrollment in SEC treatment with Navos was free to families and not predicated on a child's diagnosis or qualification for Medicaid reimbursement. However, whenever possible, Navos sought Medicaid reimbursement for services from the King County Regional Service Network (RSN).

In order to access Medicaid funds, a child had to meet the county's definition of medical necessity. There are two levels of funding available in King County, identified as 3A and 3B funding. During the time of the SEC pilot, 3A rates ranged from \$7.95/day (\$2,902/year) to \$9.19/day (\$3,354/year), depending primarily on a child's minority status. Marginally higher rates are allocated for children who are considered "special populations," because additional cultural and other consultations are required when serving those children. Generally, 3B rates were between 3.5 and 4 times the 3A rate.

In the course of the pilot, Navos successfully accessed Medicaid funding for a significant portion of enrolled children. 79% of children enrolled in SEC met the RSN's medical necessity (or Access to Care) requirements to access funding. Some children were not able to access Medicaid funding until several months into treatment, while Navos worked with the county to clarify appropriate descriptions of these children's needs. Grant funds were critical because they paid for initial treatment services while the provider and RSN clarified access to Medicaid funding.



The majority of SEC-enrolled children qualified for the lowest level of Medicaid funding. Navos therapists believed that almost one third, or 12 children, should have met access to care standards for a higher level of care than they were granted. This may reflect an underestimate since, over time, therapists requested fewer 3B tiers because they had been unsuccessful in the

past. Additionally, there were two SEC cases where 3B was initially granted, then retracted and no funding, even at the lower 3A level, was provided.

Despite clear needs, one in five children, were deemed by the county not to meet medical necessity criteria. Fortunately, those children who did not qualify for Medicaid funding were provided treatment that was fully funded by the grant.

The challenges with enrolling very young infants were primarily systemic. Diagnosing a newborn or a child under four months of age with an infant mental health diagnosis, even using the DC: 0-3R, can be difficult, as they do not necessarily demonstrate typical mental health symptoms. Being removed from their primary caregiver created definite risks with regard to developing a healthy attachment, experiencing regulation disruptions, the emergence of withdrawn/unresponsive/depressed behaviors, and the physiological and emotional stress of separation and adjustment. The separation from caregiver establishes a foundation for the diagnosis for an Adjustment Disorder, but symptoms can be subtle.

In several instances, the county mental health agency argued that, due to the subtleness of symptoms, the work qualified as “prevention,” rather than “treatment,” and denied Medicaid payment for SEC-enrolled infants. Some very young infants did develop more potent disorders, such as feeding disorders and depression, and some had experienced significant trauma already due to abusive relationships with their caregivers. CPP services for these children were generally accepted as “treatment” and more easily qualified for Medicaid reimbursement.

The criteria for accessing Medicaid funding are not fully adapted to the unique needs of infants and toddlers, particularly those who have experienced the child welfare system. Given the increased risk and challenges facing babies and toddlers with families in dependency court, we anticipate all of these children could benefit from mental health intervention, regardless of whether they meet diagnostic criteria. However, young children often demonstrate a delay between when they experience trauma, and when they manifest mental health concerns severe enough to meet medical necessity standards. Most medical necessity criteria require more severe presentation of mental health symptoms than would be expected in very young children.

Also, medical necessity criteria require children to exhibit difficulties in multiple settings. Yet the science indicates that it is common for young children to manifest issues more clearly in some relationships and settings than in others. This is particularly challenging in child welfare cases, where biological parents may not be the primary caretakers for their children.

Sustaining and Expanding SEC Treatment Services

In the third year of the pilot project, SEC expanded therapeutic services to serve families with dependency cases assigned to the dependency court in Seattle. Now, families with cases in either court have SEC available as a voluntary service.

SEC is also working with treatment agencies in the community to expand the number of providers offering infant mental health services to children and families in the child welfare system. Wellspring Family Services, a private non-profit agency, has agreed to provide CPP to families that Navos is unable to serve because they do not meet Medicaid funding criteria, but who otherwise qualify for the SEC program.

Navos is committed to providing SEC treatment services to 15 children and their families, at a time. To make on-going treatment provision feasible, Navos changed some of the SEC enrollment criteria. These changes include:

- Restricting the home and community-based treatment catchment area, although the program is now available to families with cases in both King County dependency courts.
- Increasing the minimum eligible age for children from birth to four months old.
- Requiring that the child meet medical necessity criteria for Medicaid funding, or have private insurance, in order to receive treatment.

Additionally, Navos is working to identify therapist caseload requirements that will maximize revenue, while also supporting best practice and reducing the likelihood of staff burnout. Navos' infant mental health program for non-SEC cases currently requires therapists to carry a caseload of 18 children. Although best practice suggests that 15 is a more appropriate caseload, fiscal reality requires them to serve more. It is of note that cases that meet medical necessity criteria for 3B reimbursement are counted as 2-3 cases, depending on level of need and case complexity.

Navos therapists recommend mixed caseloads of SEC and non-SEC, non-child welfare cases. Ideally, with no more than six SEC cases and six to seven non-child welfare cases. Therapists assert that SEC clients require more time and effort than families who are not child-welfare involved. They feel that SEC cases require a similar level of effort similar to non-SEC 3B cases. The reasons given include:

- More driving
- Extensive collaboration with collateral contacts
- Data gathering requirements
- SEC report writing and distribution
- Complex scheduling, particularly when children are out-of-home
- Family engagement

It became clear over the course of the SEC pilot that sustaining the Family Support Specialist as a stand-alone position would be challenging in a community mental health setting. Medicaid does not provide a category of funding that would reimburse mental health agencies for the position, as originally conceived by SEC. For the time being, one of the Navos therapists has taken responsibility for enrolling families in SEC. Therapists will continue to provide as much transportation as possible for children and their parents.

Navos is exploring other options to provide the necessary family support services, including transportation, for SEC clients. One option that has been considered is dividing the Family Support Specialist position into two components, with separate funding sources, to provide the critical services that support engagement: enrollment and transportation. A peer partner with personal child welfare and/or infant mental health experience could provide enrollment and ongoing family support. Peer partner positions are becoming more common in community mental health settings, so an existing funding structure could be accessed.

Transportation for children and parents is crucial to the SEC model. Unfortunately, a peer partner who had been a parent involved in the Child Welfare system could not transport children, as DCFS regulations prohibit individuals with founded allegations of abuse or neglect to act in that capacity. Instead, Navos could hire or contract with a transportation provider who is consistent, trained in early childhood development, and integrated into the infant mental health treatment team. Funding for transportation could be funded by DCFS or another source.

Sustaining the SEC Collaboration

Under the leadership of Commissioner Gallaher, the Ops Team developed a plan to institutionalize the SEC collaboration. The sustainability plan has been proposed to the court and funding is being pursued to support its implementation. The proposed sustainability plan includes:

- Creating an SEC Advisory Subcommittee under the Model Courts Advisory Committee. The group will meet approximately quarterly to ensure that communications continue between the mental health professionals, social work professionals, legal professionals, CASA and the court. Commissioner Gallaher will chair the Subcommittee.
- Designating a court staff person as the court's contact for SEC-related matters, including acting as a conduit for updating the SEC page on the Juvenile Court web page, sending out the agenda for the Advisory Subcommittee, passing on information from Navos about the availability of slots for new children in the program and assisting Parent to Parent if necessary to obtain replacement SEC brochures.
- Future Reasonable Efforts Symposia will include a resource fair that will feature SEC, providing an opportunity for court and child welfare professionals to learn about the program.
- Sharing information about the number of openings for children in the SEC program at regular Dependency Ops meetings.
- Inviting David Johnson, Navos CEO, to present periodically at the Model Courts Advisory Committee about how the project is going. His first presentation will be in late fall 2011 and will describe how Navos is handling the transition from a grant-funded project to a self-sustaining service.
- Asking the Parent to Parent program to monitor the availability of SEC brochures and replenish them in the courtrooms.

CCYJ and SEC partners have worked together to identify funding opportunities to support the King County expansion of SEC and engagement of additional systems, including Part C Early Intervention services. In 2011, CCYJ was awarded a planning grant from King County United Way to support expansion of the program within the county.

Maintaining Cross-Disciplinary Infant Mental Health Education

The SEC Team recognizes the need for on-going training that brings together court, child welfare, mental health and early childhood professionals to better understand the social emotional and relationship needs of infants, toddlers and families who encounter the child welfare system. This is essential to insure that people across systems share knowledge and understanding, particularly as new professionals join the court and other agencies.

Over the next two years, CCYJ is collaborating with the Seattle University School of Law, Continuing Legal Education Program, and the Norlien Foundation to offer a series of six trainings in early brain development and best-interest decision-making in the courts. As part of this effort, a small group of leaders representing multiple systems (including SEC) will consult on the design of the trainings and explore ways that early brain science can inform policy and practice.

Additionally, the SEC Advisory Subcommittee plans to support on-going education in the following ways:

- Working with CITA to develop a training module for new attorneys rotating into dependency court, including not only information about SEC, but also other aspects of dependency that will enable attorneys to hit the ground running.
- Including occasional brown bags in the Unified Family Court Training program on infant mental health topics.

LIMITATIONS

Supporting Early Connections has shown that intensive, relationship-based treatment and cross-system education and collaboration can improve outcomes for maltreated infants and toddlers and their families. It is important to note that this is a program evaluation, not a research study. The evaluation looked at how effectively we could implement and integrate an evidence-based treatment, combined with cross-system education and collaboration. We wanted to know if we could make an impact on the community and improve outcomes for babies and their families. The evaluation was not designed to assess the efficacy of the treatment program or test the treatment modality itself.

The program evaluation findings have several important limitations. First, the number of children who enrolled in and completed treatment was 38. Because the sample size of children and their biological parents was small, the generalization of SEC's findings should be made with caution.

Second, parents enrolled in SEC on a voluntary basis. Therefore, it could be assumed that only motivated families entered and completed treatment. While this may be true, when working with such high-risk families, engaging and retaining over 80% of parents should be considered a success. Voluntary participation was selected, in part, to decrease barriers to family engagement and increase participation and buy-in from parents and their attorneys. As with any limited treatment resource, features that maximize client participation are cost-effective. It is important to note that, while it was technically voluntary, families were still challenging to engage, taking an average of five to seven weeks to enroll in the program.

Third, because the program was not structured as a formal research study, there was no control group against which to compare how the children and dyads would perform without the intensive treatment and cross-system education and collaboration.

KEY RECOMMENDATIONS

1. Expand SEC in King County to serve more families encountering the child welfare and dependency court systems. SEC should be a viable option for all families with young children in dependency court.
2. Implement the SEC model in other locales in WA State. It is particularly important to explore how this program could be implemented in rural communities, with their own unique needs and challenges.
3. Provide on-going, local and state interdisciplinary trainings that bring together court, child welfare, mental health and early childhood professionals to learn about the social emotional and relationship needs of infants, toddlers and families who encounter the child welfare system. Additionally, provide cross-training on understanding the roles, responsibilities and constraints faced by different systems.
4. Develop support and resources for local communities to create multi-system court-community partnerships dedicated to addressing the needs of maltreated infants and toddlers and their families.
5. Insure that all current local and state early childhood initiatives include the courts and child welfare in their existing partnerships.
6. Develop a state level interdisciplinary collaboration to review existing policies related to meeting the needs of maltreated infants and toddlers and their families.
7. Develop a cadre of community mental health providers who can provide Child Parent Psychotherapy.
8. Explore diverse funding options, including both Medicaid and Title IV-E funds, to provide Child Parent Psychotherapy.
9. Identify funding to support family engagement and transportation.
10. Adopt standardized assessment tools for relationship-based treatment. Create standards for data collection across infant mental health programs.

CONCLUSION

Overall, SEC has proven to be a very successful court-community collaboration. Over the past three and a half years of this project, King County has made great strides in its efforts to meet the needs of infants, toddlers and their families who encounter the dependency court.

Highlights of SEC's success include:

- Created a sustainable King County collaboration that includes on-going provision of treatment, and is continuing post-grant.
- King County's court, child welfare and mental health systems have demonstrated real growth in their understanding of the social, emotional and relationship needs of maltreated young children and their families.
- Created a series of resources, including sample forms and court order language, to facilitate development of similar programs in other communities.
- By focusing on family engagement, meeting with families in their homes and communities, and providing transportation, SEC retained over 80% of parents for the full ten months of treatment. This included parents who did not expect to be reunified with their children.
- Multiple measures of child-parent relationship functioning showed statistically and clinically significant improvements for families in SEC treatment.
- The mental health of participating children improved, indicated by a substantial reduction in the number of children presenting with one or more mental health diagnoses by the end of treatment (87% vs. 47%).
- Child welfare outcomes improved for participating children
 - No children were re-referred to the child welfare system during the pilot project period.
 - Children in SEC achieved permanency faster than typical when compared to both state and regional numbers (~18 vs ~24 to ~28 months). Ten months of foster care for an infant costs Washington \$4,200 in foster care payments alone, even without accounting for other costs to courts, child welfare, or families.
 - By the end of the pilot project, 55% of children had reunified with one or both of their biological parent(s).
 - By the end of the pilot project, almost three quarters (71%) of children were living long-term with a family member (either their biological parent(s) or a relative caregiver).