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Family Dependency Treatment Courts: Addressing Child Abuse and Neglect Cases Using the Drug Court Model

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Family Dependency Treatment Courts: Addressing Child Abuse and Neglect Cases Using the Drug Court Model

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Introduction

What Is a Family Dependency Treatment Court?

A family dependency treatment court is a court devoted to cases of child abuse and neglect that involve substance abuse by the child's parents or other caregivers. Its purpose is to protect the safety and welfare of children while giving parents the tools they need to become sober, responsible caregivers. To accomplish this, the court draws together an interdisciplinary team that works collaboratively to assess the family's situation and to devise a comprehensive case plan that addresses the needs of both the children and the parents. In this way, the court team provides children with quick access to permanency and offers parents a viable chance to achieve sobriety, provide a safe and nurturing home, and hold their families together.

The first family dependency treatment court (FDTC) opened in 1994 in Reno, Nevada, marking the beginning of a movement that has since taken hold in cities and counties across the United States. The ideas presented in this monograph are rooted in a 1999 gathering of teams from some of the most well-established FDTCs: Kansas City, Missouri; Reno, Nevada; San Diego, California; and Suffolk County, New York. This 2-day focus group was convened by the National Association of Drug Court Professionals (NADCP), the National Drug Court Institute (NDCI), and the Center for Substance Abuse Treatment (CSAT). Its purpose was to provide a forum where practitioners from this emerging field could share their experiences in planning and implementing FDTCs.

The focus group explored the pros and cons of various approaches to the development and operation of FDTCs, formulated a mission and overall goals for the court, and took the first steps toward devising a national strategy for advancing the FDTC concept. The group also considered a broader perspective on FDTCs, exploring their place within the American justice system as a whole. It compared the FDTC structure to both the adult drug court model and to the traditional family (dependency) court model, clarifying the FDTC's roots, special characteristics, and unique role.

Following the 1999 focus group, a number of projects—including training, technical assistance, and evaluation—were initiated to help other jurisdictions develop and implement family dependency treatment courts. Chapter 8 describes the specific resources offered to jurisdictions through these projects.

The Purpose of This Publication

This publication documents the ideas, discussions, and conclusions of the 1999 focus group. We caution, however, that because the FDTC is a model-in-progress, this document is not intended as a blueprint or "how-to" guide for establishing an FDTC. Nor is it meant to comprehensively address each area that is discussed. Instead, it is hoped that by consolidating the early experiences of the first courts, the stage will be set for other communities to make their own contributions to this exciting new collaboration among the judicial, child protection, and treatment fields.

Chapter 1
Background: History, Definition, Mission, and Goals of the Family Dependency Treatment Court

Why Family Dependency Treatment Courts?

Since the mid-1980s, a dramatic rise in cases of child abuse and neglect has overwhelmed the nation's courts and child welfare agencies. Each year, more than 1 million cases of child abuse and neglect are filed and substantiated; as of April 2001, the foster care system was responsible for more than 588,000 children (U.S. Department of Health and Human Services, 2001).

Many factors may account for the escalation in abuse and neglect, including poverty, domestic violence, and an increasing personal mobility that results in the loss of family support systems. However, the primary cause is clear: substance abuse and addiction. According to *Linking Child Welfare and Substance Abuse Treatment: A Guide for Legislators* (National Conference of State Legislatures, 2000), "a large percentage of parents who abuse, neglect, or abandon their children have drug and alcohol problems. . . . Although national data are incomplete, it is estimated that substance abuse is a factor in three-fourths of all foster care placements." Also, Kelleher et al. (1994) write that "children whose parents abuse drugs and alcohol are nearly three times more likely to be abused and more than four times likely to be neglected than children of parents who are not substance abusers."

It is not surprising that substance abuse and addiction are so frequently associated with the neglect and abuse of children. Parents battling substance abuse often put the needs created by their own alcohol or drug dependency ahead of the welfare of their families. At the same time, they—and their children—often have complicating physical or mental health problems. Unable to maintain employment or provide a stable and nurturing home environment, they are unable to care for their children.

The rapid increase of abuse and neglect cases due to parental substance abuse poses an immense challenge for dependency courts, child welfare systems, and treatment providers. Attaining treatment for families—especially treatment that is timely, accessible, and appropriate—has always been difficult. But with the burgeoning number of parents in need of treatment, courts and providers have been strained to capacity. Also, without a coordinated effort among them, these systems are not equipped to handle the specialized issues that permeate cases of abuse and neglect that stem from parental substance abuse. As a result, parents are likely to continue their addiction as their children, unable to return home, languish in foster care.

Recognizing that the complex web of problems affecting these families could be adequately addressed only through a coordinated approach to breaking the cycle of substance abuse and child maltreatment, a number of practitioners in juvenile dependency courts, child protective services, and substance abuse treatment systems began experimenting with a more holistic approach to intervention. In doing this, they looked to an earlier experiment in the coordination of judicial and treatment services—the adult drug court.

Adult Drug Courts: An Example To Follow

As far back as the 1950s, drug and alcohol abuse weighed heavily on the nation's court systems. By the 1980s, the burden was overwhelming. Offenders cycled in and out of court, their substance abuse problems either overlooked or left untreated—at times simply because the court lacked cooperative working relationships with providers. Those who entered treatment were often unmotivated and unmonitored, and they frequently dropped out unnoticed.

Because the adversarial nature of the justice system was failing to break the cycle of substance abuse, some jurisdictions began to reexamine the relationship between criminal justice processing and treatment services. It became apparent that treatment providers and criminal justice practitioners shared two common goals: stopping the use and abuse of addictive substances, and reducing crime. In 1989, Dade County, Florida used that realization to its advantage, opening the nation's first modern drug court. For more than a decade since then, adult drug courts have helped criminal offenders achieve sobriety and break the cycle of addiction and criminal behavior. These successes can be attributed to a set of key practices that include integrating treatment with justice case processing, a nonadversarial approach, early intervention, access to a continuum of services, frequent drug testing, use of a coordinated strategy to address behavioral change, ongoing judicial interactions, monitoring and evaluation of goals and outcomes, cross-disciplinary training, and partnerships among community organizations and agencies that generate support and enhance programming (National Association of Drug Court Professionals Drug Court Standards Committee, 1997).

The success of the adult drug court provided inspiration for professionals struggling with the onslaught of child abuse and neglect resulting from substance abuse by parents. They drew on the concept of collaboration between the criminal justice and drug treatment fields and combined this with the best aspects of family and juvenile court practices. What emerged were the family dependency treatment courts.

Four Early Family Dependency Treatment Courts

In September 1994, the Second Judicial District Court of Washoe County (Reno), Nevada, convened the first session of an FDTC. When the 1999 focus group met, 10 FDTCs were operating around the country, with approximately 10 more in the planning stages.

Like the adult drug courts that inspired them, the first FDTCs took a collaborative approach to therapeutic jurisprudence, building teams that included judges, treatment providers, child welfare specialists, attorneys (including the prosecution as well as those representing the protection agencies, the parents, and the child), and other key service providers. Together, these practitioners operated a formal program of early intervention and treatment based on a comprehensive needs assessment and case plan. Frequent court appearances held both the parents and the systems accountable for compliance and outcomes.

Definition, Mission, and Goals of the FDTC

As defined in *Juvenile and Family Drug Courts: An Overview* (Drug Court Clearinghouse and Technical Assistance Project at the American University, 1998), an FDTC is "a court that deals with cases involving parental rights, in which an adult is the party litigant, which come before the court through either the criminal or civil process, which arise out of the substance abuse of a parent."

An alternate definition crafted by the 1999 focus group emphasized the *process* through which the court responds to these cases:

> A family dependency treatment court is a collaborative effort in which court, treatment, and child welfare practitioners come together in a nonadversarial setting to conduct comprehensive child and parent needs assessments. With these assessments as a base, the team builds workable case plans that give parents a viable chance to achieve sobriety, provide a safe nurturing home, become responsible for themselves and their children, and hold their families together.

From its discussions, the focus group also developed the following mission and goals for the FDTC.

Mission

To protect children from abuse and neglect—precipitated by the substance abuse of a parent or caregiver—by addressing the comprehensive issues of both the parents and their children through an integrated, court-based collaboration among service providers who work as a team to achieve timely decisions, coordinated treatment and ancillary services, judicial oversight, and safe and permanent placements.

Goals

- To provide appropriate, timely, and permanent placement of children in a safe healthy environment.
- To stop the cycle of abuse and neglect in families.
- To provide children and parents with the services and skills needed to live productively in the community and to establish a safe, healthy environment for their families.
- To respond to family issues using a strength-based approach.
- To provide a continuum of family-based treatment and ancillary services for children and parents affected by substance use, abuse, and dependence.
- To provide continuing care and information that families need to access the services they may require to function responsibly.

- To develop cost-effective programming and interventions using the ongoing allocation of resources to support parents and their children.

- To provide gender-specific, culturally and developmentally appropriate treatment.

- To avoid delays in case processing by ensuring parental compliance with court orders and ancillary services, and by facilitating the court's ability to modify court orders as cases progress.

- To foster collaborative relationships among the systems operating in the community so they can effectively manage cases involving the abuse and neglect of children.

The next section examines FDTCs in the context of the broader justice system.

Chapter 2
How the Family Dependency Treatment Court Fits Into the Justice System

The family dependency treatment court (FDTC) draws on a rich judicial history, blending drug court practices with those of traditional family dependency courts. To clarify its place within the justice system, the focus group identified key factors from adult drug courts, traditional dependency courts, and family dependency treatment courts for comparison. The results of their discussion are shown in table 1.

Table 1. Comparison of Drug Court Models

	Adult Drug Court	**Traditional Dependency Court**	**Family Dependency Treatment Court**
Client	Adult or parent who is charged	Children who have been abused and or neglected	Both the adult and the children who are affected
Gender of Adult or Parent	Majority males	Majority females	Majority females
Type of Proceeding (Civil or Criminal)	Criminal	Civil (Parent may face criminal charges in another court)	All are civil, but some may also be criminal
Comprehensive Assessment	The treatment, skill-training, developmental, and health needs of the parent are assessed.	The health, safety, and developmental needs of each child are assessed.	The health, safety, and developmental needs of each child are assessed. The treatment, skill-training, developmental, and health needs of the parent are assessed.
Family Involvement	Nuclear and extended family members are often included in the case plan.	Extended family helps provide care and supervision of children.	The spouse, significant other, or father figure is often involved in the treatment process. Extended family is included in the case plan as appropriate.

	Adult Drug Court	Traditional Dependency Court	Family Dependency Treatment Court
Treatment	Parent- or adult-focused	Children are provided treatment if appropriate. Treatment of parent may be required by the court but occasionally is not provided through nor supervised by the court.	Treatment focuses on the parent but is also extended to the children, who are at risk for substance abuse, mental illness, developmental disabilities. Treatment may be provided to the family as a unit.
Services	Parent-/adult-focused; family unit may also be referred for services.	Children receive services. Parent may be referred to services.	The family unit receives a full range of services. Services for the parent and children are comprehensive and include areas such as parenting skills, domestic violence counseling, health care, and developmentally appropriate services.
Sanctions	Parent-/adult-focused	Not applicable. The child is not sanctioned. Accountability is focused on the parent.	Accountability is focused on the parent. The court must consider the impact of a parent sanction on the children and family as a unit.

	Adult Drug Court	Traditional Dependency Court	Family Dependency Treatment Court
Role of the Judge	Leader of a team; therapeutic	Determine best interest of the children; leader of a team	Leader of a team; nurturing with children; therapeutic
Objectives	Adult sobriety and reduced recidivism	A safe and permanent placement for the children	A safe and permanent placement for children through parent sobriety and the development of the skills and knowledge needed to become mature, responsible parents who can meet their children's developmental needs.
Role of Agencies and Organizations	Team members who represent criminal justice and treatment services who are empowered with increased accountability	Representatives of various entities (in traditional roles)	Team members who represent social services, treatment, and justice (criminal or civil) who are empowered with increased accountability and decisionmaking capacity
Time Constraints	Length of the program and treatment protocol	Movement toward safety and permanency as mandated by the Adoption and Safe Families Act (ASFA)	Movement toward safety and permanency as mandated by ASFA
Review Hearings	Frequent and regularly scheduled (varies from monthly to weekly)	As scheduled on court docket, mandated by state or federal statutes, or as needed in emergency situations	Frequent and regularly scheduled (varies from monthly to weekly)
Drug Testing	Frequent and random drug testing of parents	Drug testing done as ordered	Frequent and random drug testing of parents

Chapter 3
Common Characteristics of Four Early Family Dependency Treatment Courts

As discussions progressed during the 2-day focus group, participants identified characteristics shared by their programs. These are described below with notes about how each characteristic manifests itself in the progression from planning, through implementation, to the ongoing operation of the FDTC. Some descriptions are accompanied by program examples.

The first family dependency treatment drug courts—

- Integrated a focus on the permanency, safety, and welfare of abused and neglected children with the needs of the parents.
- Intervened early to involve parents in developmentally appropriate, comprehensive services with increased judicial supervision.
- Adopted a holistic approach to strengthening family function.
- Used individualized case planning based on comprehensive assessment.
- Ensured legal rights, advocacy, and confidentiality for parents and children.
- Scheduled regular staffings and judicial court reviews
- Implemented a system of graduated sanctions and incentives.
- Operated within the mandates of the Adoption and Safe Families Act (ASFA) of 1997 and the Indian Child Welfare Act of 1979.
- Relied on judicial leadership for both planning and implementing the court.
- Made a commitment to measuring program outcomes.
- Planned for program sustainability.
- Strived to work as a collaborative, nonadversarial team supported by cross training.
- Integrated a focus on the permanency, safety, and welfare of abused and neglected children and the needs of their parents.

  For most substance abuse programs, the adult is considered the primary client. Treatment providers focus on the adult in their therapeutic activities and although they may engage the family in the treatment process, treatment providers do not consider the interests of the children as a primary concern.

In contrast, the child is the primary focus of the intervention for the child welfare agency. Although the entire family may be "before the court," the child welfare specialist is required to put the child's need for safety and permanency first when a choice must be made in balancing children's needs and parents' needs.

A family dependency treatment court integrates the needs of *both* children and parents, encompassing the entire family as the client. Although decisions are always made in the best interest of the child, the court maintains a parallel focus on the interests of the parent. The operating procedures and decisions of the court reflect this dual focus. The court provides parents with an opportunity to address the issues in their lives—primarily substance abuse, sobriety, and recovery—and clears the way for them to establish a permanent, safe, and nurturing home environment. Family reunification is contingent on the parents' demonstrated ability to provide for the child's health, safety, and well-being. Timelines mandated by ASFA must be recognized and adhered to by the team throughout the life of a case.

- Intervened early to involve parents in developmentally appropriate, comprehensive services with increased judicial supervision.

  To meet the needs of parents, all of the first FDTCs intervened early to place parents in structured programs that included substance abuse treatment (often for 12 months), frequent court appearances, and drug testing; and training, education, counseling, and other ancillary services selected to meet each parent's specific developmental needs.

  The focus group identified two major challenges in providing these services to parents. First, the chronic shortage of treatment services—especially those for women and children—is a significant issue for all family dependency treatment courts. Participants noted that the shortage may get worse with the emergence of managed care. Because access to immediate treatment is a core tenet of FDTC, each court represented at the focus group had found a way to ensure that this treatment was available to its parents. (See sidebar for specific examples of how this was accomplished.)

  The second issue noted by the focus group was the conflict in timelines between substance abuse treatment programs and state and federal statutory mandates related to child welfare. Because relapse is common for a substance abusing parent, the long-term timeframes needed for recovery may not mesh with the shorter timelines mandated by statute and used by child welfare agencies to make child placement decisions. As a result, the child's needs for a permanent, safe home may conflict with the parent's need for extended treatment. It may be difficult for the child welfare professional to determine whether a parent is making appropriate progress in treatment.

  To reconcile these conflicting timelines, the FDTC coordinates treatment for parents with the deadlines for decisions about the placement of children. Through close ongoing communication among service providers, the court assesses the parent's response to treatment and ancillary services to make timely decisions in the best interest of the child.

Treatment for Parents: Examples From the First FDTC Programs

San Diego, California

To give its clients more immediate access to treatment, the FDTC in San Diego contracted for priority slots in San Diego County's network of alcohol and drug treatment providers. This initiative was funded through the San Diego County Board of Supervisors and the Alcohol and Drug Services Division of San Diego's Health and Human Services Agency.

Reno, Nevada

The Reno court has both an outpatient track and an inpatient track in which parents sometimes live with their children. Outpatient services are funded through a contract with the department of social services in addition to grants and donations. Inpatient services are funded through fees charged to participants on a sliding scale and supplemented by grants and donations.

Suffolk County, New York

The Suffolk County court uses existing community-based nonprofit and for-profit treatment facilities licensed by the New York State Office of Alcohol and Substance Services. Treatment modalities include an array of services: detoxification, short-term inpatient, long-term residential, day treatment, intensive outpatient, and outpatient. Treatment is provided by approximately 30 nonprofit agencies under contracts managed by the Suffolk County Department of Health, the Division of Community Mental Hygiene, Alcohol and Substance Abuse Services. This managing agency also serves as liaison between the treatment community and the family treatment court.

Kansas City, Missouri

The Kansas City program is specifically geared toward mothers and infants who have been exposed to drugs. Treatment, both residential and outpatient, is provided through an agency specializing in the services needed by this group. Funding may come through Medicaid, private insurance, or self payment on a sliding fee scale; it can be Community-Backed Anti-Drug Tax (COMBAT)-assisted; or it may be provided by the Missouri Department of Mental Health. The provider, a C-Star model for comprehensive services, has a noncompetitive contract but must offer an informal bid that binds it to the level of participation and collaboration required by the court. All needed services must be available to any participant accepted into the program.

- Adopted a holistic approach to strengthening family function.

  Many children and parents have specialized needs that affect their ability to thrive in an FDTC program. For example:

  - Children and parents with developmental disabilities may need the support of team members who are trained to work with the specific challenges of these conditions.

  - Children and parents with co-occurring mental health, substance abuse, and developmental disorders will need appropriate services to succeed in the program.

  - Women with histories of sexual abuse may be more comfortable in court if they can talk to a female judicial officer.

  - Parents diagnosed with HIV need additional medical services, and their children need a long-term permanency plan as well as a short-term plan.

  Domestic violence, in particular, presents numerous challenges to FDTCs. Many women and children coming into the courts are the victims of domestic violence—or have a significant other who is also involved with alcohol or drugs. In response, many courts have the authority to hold a significant other accountable. In some courts, this accountability is achieved through a signed contract requiring that the significant other comply with the court's conditions. Other courts may make a significant other's contact with the children contingent on program participation.

  In many cases, the FDTC's ability to respond to a family's special needs can mean the difference between success and failure. Unfortunately, the appropriate services are not always available. To implement a holistic approach to strengthening the family, the team must actively seek out resources to respond to these needs.

> "As a caseworker for the family dependency treatment court, you move furniture, take people to appointments, do whatever needs to be done. You work harder and provide more intensive services, but it's more rewarding because you're seeing success. You're more invested and have more information to work with because of communication with the team. The more contact you have with the family, the more success you see."
>
> —Child Welfare Specialist
> Family Dependency Treatment Court
> Reno, Nevada

- Used individualized case planning based on a comprehensive assessment.

  Both the children and the parents of each family entering an FDTC receive a comprehensive assessment to determine their developmental, mental, and physical health needs and their treatment. With this information, the team customizes a case plan to meet the family's needs, drawing on relevant disciplines and specialties.

Program Example: Kansas City

The Jackson County Family Dependency Treatment Court, which is designed to serve women with infants who have been exposed to drugs, intervenes after birth while mothers are still in the hospital. A social worker with a background in substance abuse conducts a crisis assessment of both mothers and newborns who have been identified by hospital staff as substance dependent. This immediate assessment helps the team determine how the case should be handled. By collaborating with hospital staff to develop the protocols for testing mothers and their newborns, the program has fostered good working relationships with staff members and heightened their concern for drug-exposed infants. Team members report that children clearly benefit from this cooperative, early intervention approach.

The Jackson County program has the backing of the Metropolitan Task Force on Drug-Exposed Infants. The task force is a long-standing workgroup that has met monthly for 10 years in Kansas City. This multidisciplinary team routinely reviews local issues and has spearheaded local and state system reforms.

The focus group devoted special attention to two components of an effective case plan: parenting programs and aftercare.

Parenting programs. Many types of parenting programs (sometimes called family-strengthening programs) are available to address a range of problems. Since 1990, the U.S. Department of Justice has funded efforts to synthesize research and practice information on these programs for wider use in the field. After reviewing 500 nominated programs, researchers selected the top 25 on the basis of evaluation results and ease of dissemination (Office of Juvenile Justice and Delinquency Prevention, 1994). (Several interventions that may fit within the FDTC model are described in appendix D.)

Typically, parenting programs define *family* as the constellation of adults or siblings who care for a child. Nontraditional family arrangements include single-parent families, divorced families with joint custody of the child, children living with extended family members, adoptive parents, protective custody (such as temporary or permanent foster homes), and stepparents (sometimes in blended families with children from two or more prior relationships).

Program Example: Miami

The Miami Dependency Drug Court, Family Dependency Treatment Court Initiative, implemented a family-strengthening curriculum that combines two proven family-focused interventions: Ages and Stages, which assesses children ages 0 to 4 for developmental delays; and Strengthening Families, which uses an adult/child/family systems approach for responding to family problems and improving chances for reunification. (A description can be found in appendix D.)

Aftercare. Aftercare is a complex issue when substance abuse treatment is provided in a civil justice setting—and even more complex when child abuse and neglect enter the picture. The FDTC team needs to devise strategies to prevent relapse, and they need to plan for child safety if relapse occurs. Because the risk of relapse is most likely during the first 3 months following treatment, it is recommended that child welfare officials continue monitoring families for at least 3 months after a parent leaves treatment and regains custody of the children. Although many child welfare officials say they cannot afford such support, it has been noted that they are already providing this followup by repeatedly reopening cases that have closed. Given the chronic nature of substance abuse, this cycle is likely to repeat itself many times if effective aftercare is not provided (National Center on Addiction and Substance Abuse, 1999).

Aftercare is a critical component of FDTC programs because there is always a danger that a parent will relapse and jeopardize the well-being of the child. Many parents are aware of their need for ongoing support. In fact, personal communication with a judge revealed that parents sometimes intentionally sabotage their graduation so they will not be left without services.

Providing for aftercare can be a challenge to the FDTC team, especially as time passes and the parents are no longer under the jurisdiction of the court. To ensure that resources are in place by the time of graduation, planning for aftercare should begin when the family first enters the program. The parent will need routine access to self-help groups, counseling sessions, and possibly other resources such as alumni events, support groups, and social functions.

The aftercare plan should also maintain services for children who may have been maltreated for a substantial period of time. When the plan addresses the needs of both the parent and the child, aftercare contributes to a healthy reunification process, growth of the family, and a permanent placement for the child.

- Ensured legal rights, advocacy, and confidentiality for parents and children.

Each member of the FDTC team must ensure that advocacy, confidentiality, and due process are maintained by advising the parents, children, and their representatives of the guidelines for participating in the drug court. Because parents are subject to sanctions by the court, it is essential that they be oriented to the conditions of participation. Some

judges use the jail sanction in an FDTC. In this situation, it is important that parents be notified upon entering the program that a jail sanction could be levied, and that they agree, in writing, to accept such a sanction.

The court should orient and provide written materials to participants and their families advising them of their rights and resources for advocacy.

Program Example: Suffolk County, New York

In Suffolk County, the obligation to be drug free is stated in a court order. Based on the facts of a particular event, the judge may find that the order was violated and then impose the jail sanction. The parent has an opportunity to know what the evidence is—usually a positive urinalysis—and to give an explanation before the judge makes a decision.

- Scheduled regular staffings and judicial court review.

  FDTC teams hold frequent staffings to review the progress of each child and parent and to update family case plans.

  Victims of child abuse and neglect come before juvenile and family court judges for protection from further harm and for timely decisionmaking for their future. In response, judges make critical legal decisions and oversee social service efforts to rehabilitate and maintain families, or to provide permanent alternative care for child victims. Frequent judicial review of cases in the FDTC—preceded by a team meeting (often called a *staffing*)—is an important component of the court's process. This is the opportunity for team members to give the judge vital information that will ensure that his or her decisions are based both on up-to-date assessments of the progress of parents and on the well-being and safety of their children.

  In the past, it has not been a standard requirement for a judge to build partnerships with other service providers or to develop nurturing relationships with the people who come into the court system. However, the FDTC's team approach changes those relationships. Participating judges, child welfare and substance abuse treatment systems, social service agencies, attorneys, law enforcement officials, and community groups all must become familiar with program policies and procedures, treatment procedures and issues, judicial system processes, and the mandates and legal issues affecting parents and children. Many issues must be resolved among the various disciplines to conduct effective meetings and make key decisions in response to parental compliance with court-ordered case plans. In some FDTCs, decisions about visitation and services for children are made during staffing hearings; in other courts, these decisions are made in separate child protection proceedings. If separate dependency proceedings occur, close coordination with the FDTC should take place.

Frequent judicial oversight of parents' progress in substance abuse treatment, compliance with conditions of court orders, and relationship and interaction with their children is a necessity to the FDTC process. Although the judge is considered the leader in the process, it is imperative that team members recognize that their knowledge and expertise can enhance the judge's ability to manage families in FDTC through staffing and court hearings.

Some courts allow children in the courtroom. The effort to create an atmosphere in the court that is welcoming to children is integral. The judges participating in the focus group described child-friendly courtrooms that include benches just for children. The children can work on puzzles, color with crayons, and play on the floor, or a court clerk may have a candy drawer with treats for the children. In this type of setting, children see the courtroom not as a scary place, but as a place that can help their families.

- Implemented graduated sanctions and incentives.

  FDTCs hold parents accountable through a graduated system of sanctions and incentives.

  Sanctions are used as a consequence for parents who miss a hearing date, test positive for drugs, skip a treatment session, or are otherwise noncompliant. Incentives are used to reward parents who achieve program milestones or perform admirably in the program. Practitioners generally agree that both sanctions and incentives have a therapeutic impact on parents and help them accept responsibility for their actions.

  Sanctions and incentives are also the key elements of the adult drug court model. In the adult court, the primary focus is on the adult offender. Therefore, when issuing sanctions, the judge needs to consider only the appropriateness of the sanction to the action and any written guidelines of the court.

  FDTC sanctions might include verbal admonitions from the judge, therapeutic essay writing, community service, fines, and increased frequency of urine testing. For significant acts of noncompliance, a judge may order an offender to jail for 2 days, a week, or longer. However, when considering a jail sentence for the parent, the FDTC first considers how this sanction might affect the safety and welfare of the children; every effort is made to avoid adverse effects. Jail time should not conflict with the parent's time with the child, even if the child is in foster care.

  The effect a parent's jail time has on children is just one of the serious issues this sanction raises for FDTCs. The other is due process. In the adult drug court, defendants must sign a contract—as a condition of entry to the program—acknowledging that jail is one of the sanctions for violating the program requirements. In doing so, defendants waive their right to advance notice and a full hearing prior to being jailed. This mechanism enables the judge to swiftly impose the sanction when necessary. Although this practice has been challenged, it still is the way most adult drug courts operate.

The Use of Jail as a Sanction: Focus Group's Perspectives

Focus group participants expressed varying opinions about the value of jail time as an FDTC sanction.

The Reno team reported that its judge sees a 48-hour jail stay as very motivating. In San Diego, jail time is used for parents who show a pattern of noncompliance over time. (In both jurisdictions, the incarcerated parent continues to receive treatment while in jail.)

Both the Reno and San Diego teams argued that jail time gets the attention of the parent very quickly—an advantage given the stringent time constraints of ASFA. Jail time also makes clear the seriousness of illegal drug use and forces parents to consider its detrimental effects on their children. Finally, they argued that parents in the courtroom who see another noncompliant parent go to jail are forewarned and may, in turn, take their responsibilities more seriously.

The majority of focus group participants agreed that there may be times when jail is an appropriate sanction. They pointed out that not all children are hurt by the sanction, and many parents learn a valuable lesson. The group concluded, however, that the welfare of the child should always be considered before a jail sanction is issued.

A dissenting opinion was voiced by participants from the Jackson County program. There, jail time is seen as demeaning to women in the program and detrimental to children who, when they see a parent being taken away, may perceive that they, the children, are being punished.

Program Example: Suffolk County Sanctions and Incentives—Levels and Phases of Dependency

Treatment courts often have written guidelines to govern the judge's issuance of sanctions and incentives. The guidelines shown in table 2 are used by the Suffolk County, New York, family court. The most serious infractions—Levels A and B—require an immediate court appearance, reevaluation of contact with children, and reassessment of the treatment level. In some cases, Level C infractions may result in more severe sanctions.

Table 2. Consequences and Rewards for FDTC Parents in Suffolk County, New York

Infraction	**Sanction**
Level A	
Leaving treatment with involuntary return to court	Reduction in phase
Violating a protection order	Termination from program
Filing of a new petition	Up to 6 months in jail
Level B	
Leaving treatment with voluntary return to court	Reduction in phase
Tampering with urine	Up to 2 full days in court, termination from program, up to 6 months in jail
Level C	
Testing positive or missing drug test	Reprimand from court
Missing treatment appointment	Therapeutic essay
Missing visit with child	Increased court appearances
Missing appointment for services	One or more full days in jail
Failing to keep recertification appointments	Increased case management contacts
Arriving late to court, breaking treatment program rules	Increased case management contacts
Achievements	**Incentives**
30 days clean	Acknowledgment by judge
Complying with court order	Reduced court appearances, case called early in court, small gift (book, keychain)
Completion of Phase I	**Phase Advancement Reward**
4 months clean	Acknowledgment by judge
Complying with court order	Case called early in court, small gift
Completion of Phase II	**Phase Advancement Reward**
4 to 6 months clean	Acknowledgment by judge, case called early in court, small gift
Completion of Phase III	**Graduation Ceremony**
6 months clean	Certificate of completion

- Operated within the federal mandates of the Adoption and Safe Families Act and Indian Child Welfare Act.

  The Adoption and Safe Families Act of 1997 (Public Law 105-89) was passed in response to the overwhelming number of children in the foster care system without permanent stable families and the pressing need to change how families that abuse or neglect their children are dealt with. The Indian Child Welfare Act of 1979 specifies procedures for state courts to follow in custody proceedings for Native American children identified as abused or neglected.

  Adults and children experience the passage of time very differently—physically, developmentally, and emotionally. An adult may be equipped to wait for an uncertain situation to resolve itself sometime in the future; however, a child's time is *now.* In recognition of the child's differing sense of time, ASFA reduces the deadline for permanency placement hearings for children in foster care from 18 months to 12 months.

  In dependency cases involving parental substance abuse, ASFA has made evident both the lack of access to treatment for substance abusing parents and the disconnects among courts, caseworkers, and treatment services—problems that often result in children continuing to live in unsafe conditions or in foster care placements for protracted periods of time. In some cases, this lack of service access and coordination for substance abusing parents has contributed to the termination of their parental rights.

  For the FDTC, the shortened timelines under ASFA mean that parents with substance abuse problems have much less time to enroll and participate in treatment and to demonstrate their capacity to provide a safe home for their children. The FDTC must operate within these constraints.

  The FDTC team—which includes many professional disciplines—brings a unique perspective to the issues surrounding the implementation of ASFA. FDTCs offer valuable insight regarding the protection of children and ideas to more effectively move the dependency court population through the FDTC process. The provisions of ASFA—and their full implications for the family dependency treatment court—are explored in greater depth in chapter 6.

- Relied on judicial leadership for both the planning and implementation of the court.

  The judge plays a key leadership role in the planning and implementation of an FDTC, encouraging team members to collaborate as they express their professional opinions. To be prepared for this leadership role, judges need training on the nature of substance abuse and recovery. They may also need orientation to the team approach—that is, the ways collaboration with other service systems can result in recovery for parents, reunification of families, and timely placements for children. The role of the judge is described further in chapter 5.

- Made a commitment to measuring outcomes of the FDTC program.

  Focus group participants agreed that ongoing evaluation is essential to FDTC success because it helps jurisdictions answer questions such as:

  - Is the program accomplishing what it intended to do? Is it meeting its goals and objectives?
  - Which components are effective? Which are not?
  - Is the program reaching its target audience?
  - Which services are most appropriate and useful for participants?
  - Is there a need to hire more staff?

  By documenting the positive outcomes for children and families, evaluation results can be used to gain support for FDTCs from policymakers and elected officials, and to change laws and policies to enable the expansion of FDTCs to and increase their acceptance in the community.

  The first step in planning an evaluation is to define success by asking "What is a successful outcome?" or "How will we recognize success?" The answer differs depending on the perspective of the practitioner. From the perspective of substance abuse treatment, successful outcomes are measured, in part, by the cessation of alcohol and drug use, decreased criminal behavior, and decreased need for health services. However, from the perspective of the child welfare agency, the child's safety and the permanency of the child's successful placement in the home define success. At times these definitions may be difficult to reconcile because, even when the parent's treatment goals have been met, child safety issues may remain.

  At the inception of the FDTC program, the team needs to develop a common definition of success. Using this as a starting point, it then should identify the variables to be studied and establish procedures to ensure the efficient and timely gathering of data. The evaluation should also be tailored to answer the questions of stakeholders who have decisionmaking power. When external evaluators are used, practitioners should become involved in the research design and methodology by providing information about the program's content and background (Tauber and Snavely, 1999).

  Beyond its benefits to individual programs, the accumulation of evaluation findings also benefits the field as a whole. In a review of FDTCs, the Urban Institute (1999) recommended a number of areas in which preliminary research is both needed and feasible in existing FDTCs. Those recommendations are presented in appendix C. Preliminary studies, such as those recommended by the Urban Institute, will lay the groundwork for more sophisticated studies on the larger impact of FDTCs. Future studies

should assess the long-term effects of the FDTC approach on child well-being and parent functioning in a range of life domains. Impact evaluations also need to be conducted to determine the effectiveness of specific service components and to identify the characteristics of cases most likely to benefit from the FDTC approach.

- Planned for program sustainability.

  Funding sources for FDTCs are limited. In some jurisdictions, a "tough-on-crime" stance narrows access to the available sources. In others, managed care constraints limit certain types of services. (In Jackson County, for example, inpatient days are severely curtailed.)

  However, focus group participants pointed out that FDTCs are not limited to moneys raised within the community. Program support can also come through nonmonetary resources and the reallocation of resources within communities. In addition, the group noted several important opportunities for states and local communities to expand treatment services for parents through the child welfare system. The following strategies were identified during the focus group meeting:

  - The Substance Abuse Prevention and Treatment Block Grant, managed by SAMHSA, is the largest source of treatment funding. This block grant to states provides funds for substance-abuse prevention and treatment services.

  - When treatment capacity is insufficient for a particular population (such as women and children), state and local agencies can apply for discretionary funds from SAMHSA's Targeted Capacity Expansion Program.

  - A number of states have expanded the provision of substance abuse treatment services through Medicaid in recent years. Additional states may want to consider this option as a way of expanding treatment capacity. Many child welfare parents are already eligible for Medicaid.

  - Some substance-abuse services can be paid for under Temporary Assistance for Needy Families (TANF) and welfare-to-work programs. Many families in the child welfare system with substance abuse problems receive welfare benefits. If parents' substance abuse interferes with their ability to care for their children, it may also interfere with their ability to work. States and counties can incorporate substance abuse treatment services as part of their parents' employment plans. Under these circumstances, TANF and welfare-to-work funds can be used for nonmedical aspects of substance abuse treatment if it is not otherwise available. [1]

  - The Administration for Children and Families is the lead agency in the U.S. Department of Health and Human Services for programs that promote the economic and social well-being of families, children, individuals, and communities. Different types of funding include the Court Improvement Program (a grant program to help state courts improve their handling of proceedings related to foster care and adoption), child abuse and neglect programs (a grant

program to help states improve and increase prevention and treatment activities), community service block grants (a grant program that provides states, territories, and Indian tribes with a flexible source of funding to help reduce poverty and address employment, education, housing assistance, energy, and health services), individual development accounts (a new program that empowers low-income individuals to save money for a home), social services research, and the Low-Income Home Energy Assistance Program.

- Title XX of the Social Security Act, also called the Social Services Block Grant, is a capped entitlement program. Block grant funds are given to states to help them achieve a wide range of social policy goals. Funds are allocated on the basis of population.

These resources may help FDTCs expand treatment capacity at the state and local levels. At the same time, programs can educate state and local leaders about the value of FDTC programs and urge them to expand resources to address the needs of children and parents involved in the child welfare system.

- Strived to work as a collaborative, nonadversarial team supported by cross training.

  Substance abusing parents are more likely to succeed when services are provided in a seamless, well-coordinated continuum. To achieve this, the FDTC teams represented at the focus group all strived to establish a nonadversarial, team-oriented environment. Teamwork enabled them to communicate with parents in one voice, thereby eliminating the confusion of contradictory messages, strengthening the relationship between the court and the family, and fostering the parent's motivation to change.

  However, the operation of an FDTC requires the efforts of individuals from a number of agencies—many of which have a history of unresolved turf issues and difficulties working in collaborative ventures. To create the nonadversarial, collaborative environment that is the foundation of effective teamwork, the FDTC must address the different philosophies and approaches that have traditionally separated the fields of substance abuse treatment, child welfare, and the judiciary. Every party in the FDTC system must step outside his or her traditional role, assume additional responsibilities, work harder and faster, and embrace perspectives he or she may not have considered previously. Some of the difficulties encountered in making these changes include:

  - Judges who reject the FDTC philosophy because they do not want to take on responsibilities that have traditionally been viewed as beyond the scope of judicial authority.

  - Substance abuse treatment providers who fear that parents will be taken out of treatment against their wishes and put in jail.

  - Child protective services caseworkers who are overwhelmed by additional demands and the close scrutiny of the multisystemic team

- Members of the substance abuse treatment community who see ASFA timelines as a threat and who need a better understanding of the FDTC system.

- Parent advocates and defense attorneys who fear the parents are not granted due process and who may encourage the parents not to cooperate.

- Child attorneys or representatives who worry that decisionmaking will focus more on the parent than on the child, that reunification will be rushed, and that visitation will be used as a sanction or incentive.

Although all these fields share the vision of permanent recovery for parents and permanent placement for children, safety for children, and healthy, functioning families, their differences have the potential to create misunderstandings, engender mistrust, and undermine cooperation. Each field has its own definition of who the client is, what outcomes are expected, what the timeline should be, and the appropriate response to setbacks. In addition, the legal and policy environments in which the agencies operate also affect their ability and willingness to work together. These environments are shaped by state and federal laws on child abuse and neglect, the sense of crisis under which many child welfare agencies work, the chronic shortages of substance abuse treatment services, and the confidentiality requirements that may prevent sharing information (Administration for Children and Families and the Substance Abuse and Mental Health Services Administration, 1999).

Focus group participants agreed that one of the best ways to bridge the gaps among those involved in the FDTC is to implement cross-system training. Their experience is supported by a paper from the National Center on Addiction and Substance Abuse (1999) at Columbia University, which recommends that certification and licensing of child welfare officials include training in the nature and detection of substance abuse and what to do when it is found. The report also states that judges and child welfare directors need to accept responsibility for training themselves and their staffs about the substance abuse problems that are driving their caseloads and about confidentiality laws for persons receiving treatment.

Cross training is also critical for substance abuse treatment providers. For many of these providers, participating in the legal arena may be a new experience. They need training in the court process, especially concerning open communication and frequent contact with the court. They must also become versed in the court's legal mandates—from both ASFA and the Indian Child Welfare Act. They also need orientation to the perspective of "the family as the client" with the best interest of the child as the paramount concern—a perspective that is not the traditional view of the treatment provider.

But cross training does more than impart information. It also helps build relationships and trust among team members. As a supplement to regular staffings, it allows time to discuss program procedures, identify gaps in service, consider how to improve outcomes for families in the program, and resolve problems as they develop.

Program Examples: Suffolk County, Reno, San Diego

Suffolk County, New York

To bridge the systemic barriers between substance abuse treatment and child welfare, the Suffolk county family treatment court develops a comprehensive service plan for each case, with input from both substance abuse treatment providers and child welfare representatives. The plan includes specific goals to meet the treatment needs of the parents and the service needs of the children. The team ensures speedy alcohol and drug assessment of the parents and identifies barriers to treatment. The members of child protective services conduct a risk assessment. A court-appointed special advocate is appointed for each child. The entire team reviews the service plan for consistency. The primary goal is preserving or reuniting the family and developing a permanency plan for the children.

Reno, Nevada

In Reno, substance abuse treatment efforts have improved because of the FDTC, where the individual issues of parents and their children are taken into consideration. The children benefit from the services received by their parents, such as intensified parenting classes, referrals to domestic violence centers, and sexual abuse treatment. Efforts are made to provide a variety of services in one location (one-stop shopping) to make it easier for the mothers. Rather than focusing only on getting the mother off drugs, the court also ensures that the needs of the children are met.

San Diego, California

In the San Diego court, the substance abuse treatment plan becomes part of the reunification plan, and representatives of all systems work toward the same goals. The social workers have a significant role in ensuring that services are delivered, and they work closely with the county-contracted Substance Abuse Recovery Management System (SARMS) recovery specialists (i.e., parents' substance abuse case managers who work with the treatment program under contract with the county).

Despite significant barriers to collaborative teamwork, many opportunities to more effectively serve families result from the shift in roles. Professionals in all systems have the opportunity to learn from one another and resolve turf issues. Therefore, it is necessary to train practitioners in ways that help them carry out these new responsibilities.

Chapter 4
Varying Approaches

Among jurisdictions across the country, the family dependency treatment court approach varies in a number of ways. The differences may result from a number of factors: the statutory framework within the state and local jurisdiction, the availability of resources, the degree of community support, the infrastructure of the local jurisdiction, and the ease of collaboration among systems. Below are five examples of how FDTCs may vary in their approach:

- **Type of case.** Most FDTCs accept only clients with civil cases. A few handle clients with both civil and criminal cases.

- **Court of jurisdiction.** FDTCs may operate under the jurisdiction of the family court, the juvenile court, or the general jurisdiction court.

- **Infrastructure of the local judicial jurisdiction.** Some FDTCs use a "one family, one judge" approach; all pending cases involving any member of the family are consolidated under the oversight of the FDTC judge. In other programs, families may deal with multiple judges—from the dependency court, the FDTC, and other criminal and civil courts in which family members may have matters pending.

- **Integrated or supplemental program.** Some FDTCs are fully integrated within dependency court. Other programs supplement the dependency court case process and step in at a particular point in the process to review parental compliance with court orders.

- **Target population.** Some programs focus on specific populations, such as mothers of drug-exposed infants. Others have a much wider focus and will consider any dependency case in which the initial investigation determines that parental substance abuse contributes to the abuse or neglect of children.

Each of the FDTCs represented at the focus group has its own individual approach, which is illustrated in the following overviews. For detailed descriptions of the focus group courts, see appendix A.

Suffolk County, New York

New York's Suffolk County Family Treatment Court enhances child protective services by providing case processing within civil family court proceedings and accepting cases of child neglect (but not child abuse) resulting from parental substance abuse. The family treatment court was developed in response to the escalating number of neglect cases involving parental substance abuse and the need to better integrate and coordinate services for children and families. The enhanced services offered by the program support the efforts of the department of social services by developing comprehensive service plans, facilitating access to treatment and ancillary services, and providing increased judicial monitoring of cases. The family treatment

court is designed to integrate chemical dependency and child welfare services for drug-addicted parents and their children.

The judge hears family treatment court cases on a separate docket—two mornings and three afternoons a week—and is assisted with monitoring and review by the treatment court team. Court staff members work jointly with members of a multidisciplinary case management team consisting of case managers, a court-appointed special advocate, drug and alcohol abuse specialists, and a liaison from the department of social services. The program provides a wide range of services to families, including parenting skills, mental health services, counseling on domestic violence issues, public health nursing services, and substance abuse treatment.

Reno, Nevada

The Reno court is an example of a program that works with both cases involving criminally charged parents and cases of child removal due to abuse or neglect. Respondents who appear before the family dependency treatment court judge are mostly women with substance abuse problems. The program provides for a minimum of 1 year of substance abuse treatment, linkage to social services, and a drug court team consisting of the judge, his or her staff, a case manager, the treatment provider, and a child welfare caseworker. Other team members may include the prosecutor, defense counsel, and probation officer. The program has uniquely used foster grandparents in a number of cases to provide support for the children and parent during their participation.

Jackson County (Kansas City), Missouri

The family dependency treatment court in the Sixteenth Judicial Circuit Court of Jackson County, Missouri, handles child abuse and neglect and other child endangerment cases. The court works directly with hospitals that identify new mothers who are substance abusers, and the program attempts to keep new mothers with their babies to ensure the critical early bonding of the newborns can take hold. Program proponents believe that the unique needs of each stage of child development must be met to protect the emotional stability of the child. Therefore, courts must move quickly to provide either a safe home with the parent or a stable and permanent living environment outside the parent's home. Delays in permanency decisions or frequent changes in placement can cause irreparable psychological damage to the child. To achieve these goals, the court works to stop substance abuse by parents when the substance abuse threatens the safety and welfare of their children. The court provides supervision and specialized treatment to parents who are abusing substances, led by a team that specializes in dependency cases.

San Diego County, California

The two-tiered approach used in the Dependency Court Recovery Project in San Diego County provides court supervision and substance abuse treatment through seven traditional dependency courts and three dependency drug courts. The dependency drug courts provide intensive supervision for parents who fail to comply with the requirements of the traditional dependency court. All parents who come before the traditional dependency court with evidence of an alcohol or drug abuse problem are screened and assessed for substance abuse. Any resulting treatment

plan becomes part of a court order, and violation of the court order results in escalating sanctions. The third occurrence of noncompliance may result in transfer to the dependency drug court, an intensified three-phase program of treatment with heightened supervision and judicial monitoring (each phase lasts 90 days). If the parent still does not meet treatment goals, a hearing to terminate his or her parental rights may be held. San Diego's program was developed in response to the estimated 80 to 90 percent of parents who come before the dependency court with substance abuse problems.

Chapter 5
Community Stakeholders

> "Stakeholders have a vested interest in the success of the family dependency treatment court and are likely to include parents, abused and neglected children, extended family members, judges, other members of the judiciary, prosecutors, defense attorneys, police and probation officers, jail administrators, public health practitioners, ancillary service providers, child protective service providers, school officials, transportation and daycare providers, employment and training specialists, welfare-to-work program specialists, local labor department officials, faith community leaders, county council members, State legislators, health care professionals, and the media."
>
> —Focus Group

Good processes and viable programs are important to the success of an FDTC. Equally important are the people who plan the processes and programs, support them, and participate in them. The focus group identified three groups of stakeholders who are critical to the success of their courts:

- Members of the steering committee.
- FDTC team members.
- Families appearing before the court.

This section specifies the key people and entities that need to be engaged in the work of an FDTC and describes the roles of principal team members. It also discusses the identification of a target population and offers a profile of the parent most often seen in an FDTC.

Steering Committee

Each of the focus group court teams identified a committee of key stakeholders, often organized at the inception of the project, as a steering committee. All the teams indicated that the support of their steering committee significantly contributed to their success. The list of key decisionmakers and community stakeholders is likely to vary from one community to another. Common to most of the lists are top-level officials and decisionmakers, treatment and ancillary service providers, policymakers, and community members.

The steering committee facilitates support for the drug court concept among high-level policymakers (e.g., elected prosecutor, presiding judge, and chief public defender) and commitment to supporting successful outcomes. In this manner, the planning team, which may include nonexecutive-level personnel, will be confident that the head of each participating agency has made the FDTC a priority, and has delegated to the team the authority to make implementation decisions. The steering committee should have as its clear purpose the support

and operation of the FDTC. It should meet regularly and establish a procedure for ongoing communication with the planning team to provide oversight and support.

The steering committee should comprise executive-level personnel from each agency involved in or affected by the FDTC. Members from noncourt-related community entities should also be considered. These members should be selected for the political support or potential resources that they may offer in support of the FDTC's planning process and operation. Potential members should reflect a broad cross section of the community. In this regard, members may include representatives of civic clubs (e.g., the Rotary Club or Lions Club), health agencies, local media outlets, vocational and educational services, the faith community, and private foundations.

At least two focus group teams noted that their steering committees have disbanded, and they urged other teams not to allow this to happen. Another court team supported this statement, pointing out that it has kept its steering committee in place and active throughout the life of the program, and that the committee has remained supportive and resourceful.

The FDTC Team

The purpose of the FDTC team is to ensure that every child's and parent's needs are met and that each receives every opportunity to be successful. Although each member of the FDTC team is accountable for his or her individual performance, team members work collectively, share critical information, and make collaborative decisions about every case before the court. Teams meet regularly—usually weekly—to share information regarding the children's and parents' progress, attendance at hearings, and participation in treatment. At these meetings, team members serve as sounding boards and listen closely to one another. Because the team is working together, no individual carries the entire burden for decisions that affect the family.

Team members often develop relationships with the parents and their children and observe every aspect of their lives. Therefore, each team member's insight and observations are important in making decisions. The entire team (depending on the jurisdiction) is usually present at court hearings. This is important for the presentation of a consistent message, which prevents parents from manipulating individual team members and ensures parent accountability.

Although the makeup of the FDTC teams represented at the focus group varied slightly, some positions were considered essential. Descriptions of the key members of an FDTC team follow:

Judicial officer. The primary role of the judge in abuse and neglect cases is to ensure the child's safety, permanency, and well-being. The judge oversees the progress of family members in treatment and serves as the team leader in bringing together various components of the program—including those within the family court system, the substance abuse treatment community, the child welfare system, mental health services, and other community organizations. The judge is also the central figure in the treatment and recovery of the participants, serving as a role model and authority figure to whom participants look for guidance and support. The judge provides leadership, and is in a position to influence related reform efforts and keep his or her colleagues and the community informed about the FDTC.

The judge is also obligated to educate team members and FDTC participants about courtroom policies, procedures, and the judge's role. He or she should remain open to learning from other team members about their systems. It is especially important for the judge to understand the cycle of substance abuse and relapse in addition to the various treatment options available. Judges also need specialized knowledge of child development, family violence, and other child welfare-related issues, including services for children and families available in the community.

Coordinator. The FDTC coordinator is the "hub of the wheel." He or she maintains the ongoing operation of program activities and ensures that the team works efficiently to provide services for the family. The coordinator is responsible for the overall monitoring services, ongoing scheduling of cases, maintenance of files, identifying and allocating resources, budgeting, and evaluating performance. The coordinator position may vary greatly from one jurisdiction to another. The scope of this position will be determined by the overall needs of the FDTC.

Substance abuse treatment providers. Treatment providers are critical to the success of the program and should be included in the program planning stage to help establish common goals, learn to "speak the language" of the child welfare and dependency court systems, and provide mechanisms for communicating the results of drug testing and other relevant information. It is the responsibility of the substance abuse professional to determine the appropriate substance abuse treatment and continuum of care for the parent and to educate the team on relevant issues regarding treatment modalities, relapse, and substances of abuse specific to their jurisdiction. In addition, treatment providers attend and participate in staffing and court sessions to offer information about the progress of FDTC participants.

Child welfare representative. Child welfare representatives are responsible primarily for the well-being of the children and are a key part of successful collaboration. Child welfare agencies and practitioners are responsible for protecting children's health and safety, advocating on behalf of the children's best interests, and ensuring that children and their parents receive necessary services in addition to substance abuse treatment. They, too, must learn to speak the language of the other team professionals, especially of substance abuse treatment providers, and understand substance abuse and the cycle of relapse and recovery.

Representative of supervision agencies. Those who function in a supervisory role, such as those in child protective services probation and parole officers, and treatment alternative to street crime (TASC) case managers maintain ongoing contact with the parents or offenders and provide frequent reports on their progress. This function is especially critical in linking offenders with community supervision, treatment, and law enforcement services.

Child attorney/representative (i.e. court-appointed special advocate and guardian ad litem). These separate legal representatives for children bring a necessary dynamic to the drug court team. They provide a voice for the children during the staffing hearing that might be absent in the general discussion. These attorneys often bring attention and focus to the needs of the children.

Parent attorney. The parent attorney ensures that the FDTC gives consideration to the parent's interests while at the same time guarding the welfare and safety of the child. This team member informs the parent about court procedures, makes the parent aware of the benefits of the program, and encourages the parent to participate. During team discussions of possible sanctions and incentives, the parent attorney may remind team members that in a family court setting, sanctions that separate a parent from a child are not always the answer. The parent attorney may also handle any related criminal charges against the parent.

Agency attorney/prosecuting attorney. The attorney responsible for bringing the case forward is integral in the identification of cases eligible for participation in the FDTC. The attorney attends all required hearings and files the motions and petitions necessary to initiate the parents' involvement in the FDTC. In addition, the agency attorney attends and participates in the staffing and court hearings to ensure ASFA timelines are met and the safety and best interest of the child are maintained. The attorney monitors the dependency court case, regardless of whether the family dependency court is fully integrated within, or is separate from, the family dependency treatment court.

> "Treatment providers have always been skeptical of how the court system treats clients. [It] has been focused on punitive measures that are intended to force people into socially appropriate behavior. As the treatment provider for the Kansas City Juvenile and Family Dependency Treatment Court, my perception has dramatically changed. We are witness to a system of attorneys, judges, and case managers who are passionately concerned about the welfare of our children. What makes this system so successful is a collaborative working relationship between the provider and the court. We are grateful for the opportunity to affect so many lives in a strength-based continuum of care."
>
> —Carla Ingram, CSACII, LCSW
> Program Manager
> North Star Recovery
> Kansas City, Missouri

Family Members

The children, parents, and other family members are also stakeholders in the FDTC. In the FDTC setting, parents have more opportunities to advocate for services to meet the needs of their children. They have the opportunity to bring their concerns before the court or to speak individually to team members. Children have a voice through their social worker, parents, or representatives, or they may speak directly to the court regarding their own safety, well-being, and permanency.

Program Example: Reno, Nevada

In Reno's family dependency treatment court, participants are encouraged to call staff members or the judge at any time. Frequent hearings in a more relaxed court atmosphere and face-to-face meetings with team members encourage parent participation in the process. Although some parents initially are not very communicative, they eventually begin to feel less threatened and speak openly about their views if they are listened to and treated with respect.

Program Example: San Diego, California

As part of a pilot project, the San Diego County dependency court sometimes uses family group conferences, which recognize the value of allowing families to participate in the decisionmaking process when the well-being of children is concerned. The conference includes parents, members of the extended family, and individuals who the family considers supportive or able to provide resources (e.g., neighbors, clergy, or tribal elders). The goal is to jointly develop an action plan in the best interest of the child. This approach actively engages the family and capitalizes on family strengths, allowing for an expression of culturally appropriate processes and solutions.

Families may have varying needs and interests depending on how the court defines its target population and, in particular, whether the court serves families struggling with more than substance abuse. The focus group broadly characterized the FDTC target population as substance abusing parents who are at risk of losing their children. When asked to consider the possibility of establishing more specific criteria, the focus group first examined the applicability of the dependency treatment court model to persons with problems other than alcohol or drug abuse and arrested maturity. The possibility of serving individuals with co-occurring disorders or those who are mentally impaired raised questions about the court's capacity to serve a broad population. The group agreed that the FDTC model probably could be applied to persons with special needs. The participants noted, however, that individual courts may want to explore the appropriateness of extending services to specific groups. Among the numerous factors to consider when making such a decision are the availability of resources and local services and the court's experience level.

With the exception of the Jackson County court, the courts participating in the focus group place no restrictions on cases in terms of gender or age. Nevertheless, they agreed that the parents they are most likely to see are females who are raising children alone (or with minimal support from the children's father or father figures). The typical parent's emotional and psychological maturation is likely to be arrested, and there is a good chance he or she will lack the skills to hold a steady job. The parent is also likely to need parenting training and may have mental or physical health issues. It is quite possible that the parent grew up in a dysfunctional family environment, is the product of multigenerational abuse and neglect, and is currently a victim of domestic violence.

Chapter 6
Permanency and Safety for Children: Implications of the Adoption and Safe Families Act of 1997

Historically, child welfare workers and the courts have struggled to provide substance abuse treatment that enables parents to retain or resume child custody without jeopardizing the safety of their children. Cases have often lingered in the courts for years, with no permanent resolution, as the parents cycled in and out of treatment. Their children were left in foster care for months or even years—a condition often called *foster care drift*. Since the 1997 passage of the Adoption and Safe Families Act (ASFA), a renewed emphasis on establishing permanency for children within federally mandated timeframes has accelerated the need to find effective responses to substance abuse and child maltreatment within families. The passage of ASFA is forcing courts and related services to take innovative approaches to helping substance abusing parents stabilize their lives and maintain their families.

Although ASFA may present challenges to FDTCs, its intent—to prevent foster care drift—is in line with the goals and operation of FDTC programs. Family dependency treatment courts, with their early and intensive delivery of services, have great potential to help meet ASFA goals. The common characteristics of the FDTC—immediately available services, collaboration among stakeholders, and frequent court reviews—are essential to the successful implementation of ASFA. The accelerated timeframes; the accountability by the parent, service providers, and the court; and the reduced duplication of services that are characteristic of FDTCs all further the goal of safely returning children to their families or finding permanent placements for children who cannot return home.

This chapter discusses the implications of ASFA for family dependency treatment courts.

A Summary of the Adoption and Safe Families Act of 1997

In 1997, President Clinton signed into law the Adoption and Safe Families Act[2] (Public Law 105-89). ASFA shortens the time children spend in foster care and specifies permanency options that lead to permanency, safety, and well-being for children. It calls on the nation's courts and social service agencies to make the health and safety of children the paramount concern in placement and permanency decisions.

Congress' intent in passing ASFA was to prevent foster care drift by moving children out of foster care and into safe and permanent placements as quickly as possible. ASFA places stringent requirements on the courts and the child welfare systems, holding them accountable for both the protection and permanent placement of children and for assistance with families—especially those in which substance abuse and addiction exist.

For the first time legislation, through ASFA, clearly states that the safety and welfare of children is paramount. Family dependency treatment courts adhere to this principle and are well positioned to work within the constraints of ASFA to provide parents with the tools they need to become nurturing, responsible adults who are ready to reunite with their children and able to provide them with a safe home environment.

Reasonable Efforts

ASFA mandates that child welfare agencies make "reasonable efforts" to preserve or reunite families. Specifically, the agencies must make reasonable efforts to:

- Prevent the initial removal of a child from his or her home (this applies only when keeping the family together does not endanger the health and safety of the child).

- Make it possible for a child who has been taken from the home to reunite with his or her parents (such efforts may occur during only the 12 months from the date the child entered foster care unless compelling reasons exist to extend the limit).

If reuniting a child with his or her parents is no longer the goal, the child welfare agency must place the child in a permanent, safe, and nurturing home.

When No Reasonable Efforts Are Required

To prevent children from languishing in the foster care system for extended periods of time, ASFA includes exceptions to the reasonable efforts requirement (National Council of Juvenile and Family Court Judges, 1998). The act acknowledges certain circumstances in which no efforts to preserve or reunite a family could be deemed reasonable. Specifically, reasonable efforts to preserve or reunite the family are not needed when any of the following circumstances exist:

- A child has been subjected to "aggravated circumstances" as defined by state law (e.g., abandonment, torture, chronic abuse, or sexual abuse).

- A parent has aided or abetted, attempted, conspired, solicited, or committed the murder or voluntary manslaughter of another of his or her children.

- A parent has committed a felony assault resulting in serious bodily injury to the child or to another of his or her children.

- A parent's rights to another child have been involuntarily terminated.

Permanency Hearings

ASFA requires that a permanency hearing to determine a child's permanent placement be held 12 months after a child enters foster care (starting from the date of adjudication or 60 days from the child's removal from the home, whichever is earlier) or within 30 days of a determination that no reasonable efforts are required.[3] At most, this leaves 14 months for a parent to succeed

under an established case plan before a permanency plan must be determined. (For an outline of the timelines required by ASFA, see appendix B.)

The permanency hearing involves significantly more than a review or an extension of placement. The hearing must determine the permanency plan for the child. Under federal regulations, the court must determine whether and when the child will be:

- Returned to the parent.
- Placed for adoption, with the agency filing a termination of parental rights (TPR) petition.
- Placed permanently with a fit and willing relative.
- Referred for legal guardianship.
- Placed in another planned permanent living arrangement (this final option is to be taken only in cases in which the agency has documented a compelling reason that none of the first four options would be in the child's best interest).

Termination of Parental Rights Requirement

ASFA requires that a child protection agency file or join a TPR petition when a child under its protection has been in foster care for 15 of the past 22 months; the court determines that the child has been abandoned; or the court, following ASFA guidelines, determines that no reasonable efforts to preserve or reunite the family are required. There are three exceptions to the TPR requirements:

- The child is being cared for by a relative.
- The agency has documented compelling reasons that TPR would not be in the best interest of the child.
- The agency has not provided necessary services in a period consistent with the case plan (in cases where reasonable efforts are required).

The Reasonable Efforts Provision: Implications for the FDTC

At various points in the court proceedings, the judge must decide whether the agency has in fact made reasonable efforts—in light of a child's current and future health and safety needs—to prevent removal, provide adequate services to reunite the family, or to diligently locate and secure an alternate permanent placement for the child. According to the National Council of Juvenile and Family Court Judges et al. (1987), reasonable efforts may consist of providing direct services, financial or in-kind benefits, or counseling assistance.

The FDTC model, with frequent and regularly scheduled hearings, is well positioned to ensure these efforts are made and to provide the judge with frequent opportunities to make a determination. Yet, making this determination is no small challenge. According to a 1999 analysis of data on child abuse and neglect—which included a survey of 916 professionals in the field and numerous indepth interviews with those on the front lines of child welfare—

> Determining whether "reasonable efforts" have been exerted is practically and emotionally very difficult. Parents almost always oppose efforts to terminate rights to their children. Child welfare officials, many of them trained in social work and focused on "helping families," are generally reluctant to recommend breaking up families. With an uncoordinated and often inconsistent delivery of services from various agencies and providers to assist families, family court judges often find defining "reasonable efforts" an elusive goal, especially since substance abuse is a factor in most cases and most child welfare workers and juvenile dependency court judges have little or no understanding of the nature of substance abuse or addiction, or the process of treatment and recovery (National Center on Addiction and Substance Abuse, 1999).

The challenge of defining "reasonable efforts" is potentially diminished in the FDTC due to the coordinated service delivery plan and a team approach to case management.

When No Reasonable Efforts Are Required: Implications for the FDTC

It is the court's responsibility to inquire at each hearing whether any of the reasonable effort conditions outlined in ASFA apply. If so, and the judge agrees that no reasonable efforts are required, the court must hold a permanency hearing within 30 days. The agency must make reasonable efforts to place the child in accordance with the new permanency plan, including placing the child for adoption or with a legal guardian.

In the FDTC model a number of questions emerge: Is past history of failed drug treatment a circumstance in which no reasonable efforts should be required? Should a parent whose rights to a child previously were involuntarily terminated as a result of an inability to achieve sobriety while in treatment—which was inadequate or inconsistent—be prevented from participating in the FDTC's program?

Anecdotal evidence from existing FDTCs suggests that even parents who might otherwise be considered a poor risk are able to succeed in a program of early and intensive treatment, and can reunite with their children. However, ASFA mandates that the child's health and safety always be considered paramount. These and other questions will be answered as the research on successful graduates informs the field about identifying appropriate FDTC parents.

Permanency Hearings: Implications for FDTCs

For parents battling substance abuse—as well as the courts and substance abuse treatment providers—the 12-month timeframe for the permanency hearing has important implications. Even parents who are committed to achieving sobriety often require more than 12 months in substance abuse treatment before making significant progress, and one or more relapses during treatment are common. Responding to concerns from the field, the U.S. Department of Health and Human Services (HHS) entered the following commentary into the federal regulations:

> "[P]arents dealing with substance abuse issues may require more than 12 months to resolve those issues. However, a parent must be complying with the established case plan, making significant measurable progress toward achieving the goals established in the case plan, and diligently working toward reunification in order to maintain the goal of a permanency plan at the permanency hearing. Moreover, the state and court must expect reunification to occur within a timeframe that is consistent with the child's developmental needs."[4]

For an FDTC parent or participant, reunification may continue to be the goal of the permanency plan if the parent meets these HHS conditions. However, the child's safety must remain paramount. Although drug treatment services may be required for more than 12 months, this need should not be used to justify extending reunification efforts. Rather, reunification should be safely accomplished within the 12 months, with drug treatment continuing after reunification.

It is also essential that agencies promptly provide substance abuse treatment services. Historically, treatment service providers have lacked sufficient capacity to help parents who seek it—but the short timeframe imposed by ASFA increases the need for court systems to ensure close judicial supervision of, and coordination and accountability among, service providers. FDTCs are model programs that incorporate these vital components for meeting ASFA's mandates.

Termination of Parental Rights Requirement: Implications for the FDTC

A substance abusing parent who complies with and makes substantial progress toward the goals in his or her case plan, and who diligently works toward reunification, may fall under the "compelling reasons" exception to ASFA's TPR requirements. If the agency believes this is the case, the caseworker should document the specific reasons that make the parent's progress a compelling reason not to file a TPR petition.

Because FDTCs are designed to provide early and intensive services, the third exception—when the agency has not provided necessary services in a period consistent with the case plan (in cases where reasonable efforts are required)—should not apply to alcohol and drug treatment services.

Chapter 7
Recommendations of the Focus Group

Family dependency treatment courts remain a new concept, but initial reports from the field indicate that the justice, child welfare, and substance abuse treatment systems are finding effective ways to collaborate. As a result, many allegedly abusive and neglectful parents who have substance abuse problems are receiving the services they need to make safe and stable homes for their children.

Although FDTCs currently exist in a limited number of jurisdictions, this new breed of family court has shown significant potential. To facilitate the efforts of court planners and to ensure that new court teams benefit from the experience of the first courts, the focus group proposes the following elements as a national strategy for validating and advancing the FDTC movement:

- **Set minimum standards for family dependency treatment courts by which they can be defined and judged.** As the field gains experience and research findings become available, these standards should be codified to guide the development and refinement of FDTCs.

- **Develop gender-specific treatment and longer treatment programs.** The lack of treatment programs that are longer and specifically designed for women is a serious concern in a court setting in which most parents are women.

- **Develop effective aftercare programs that will keep graduates on their recovery and growth paths.** Program graduates need a transitional link from the courts to the community that will provide the continued support and treatment they need. Aftercare should be available following graduation and, ideally, should be supplemented with a mentoring program or alumni association for long-term support, recovery, and ongoing healthy child development.

- **Secure ongoing support from policymakers, community leaders, and the public.** Support is necessary at every level of government, from the local community to state and federal representatives. Education and awareness among the general public are also needed so communities can appreciate FDTC efforts to promote child safety and parents' recovery from substance abuse. Media attention can play a significant role in this process.

- **Foster a clear understanding of the purpose of the family drug treatment court and the roles of the FDTC team among team members and other court and agency personnel.** This is especially important for court personnel, for it is only through understanding that they will support the FDTC movement.

- **Provide interdisciplinary cross training for FDTC team members on a local level.** To sustain and improve on the efforts of existing FDTCs, the cross training of practitioners must be widely implemented. Sharing knowledge and skills across systems is necessary not only for optimizing the day-to-day operations of the court but for

establishing trusting relationships. Training must be ongoing, with representatives of FDTC organizations continually building their understanding of the team's components and the strength that is possible through collaboration.

- **Realign resources for service delivery, education, and outreach.** Collaboration is an essential component of effective FDTC programs. Agencies and organizations must coordinate their efforts to frontload services, maximize resources, and build program capacity and sustainability.

- **Identify funding sources and means to raise funds without breaching ethical standards.** In each jurisdiction, it will be necessary to investigate the financial resources available through local, state, and federal avenues.

- **Identify venues for education and training, and use them to increase understanding among stakeholders, legislators, the judiciary, the bar, and the public of the FDTC mission, goals, and process.** A public information campaign is needed to educate the public and stakeholders about the promise and vision of FDTCs. Current leaders in the field need to use national and state conferences, forums, newsletters, and publications to mobilize decisionmakers and communities.

- **Form collaborations of national organizations around dependency issues.** Such organizations include, but are not limited to, the National Association of Drug Court Professionals, the National Drug Court Institute, the American Bar Association, the National Council of Juvenile and Family Court Judges, the Child Welfare League of America, and the National Association of the State Alcohol and Drug Abuse Directors.

- **Establish measurements and basic data elements to evaluate FDTCs.** The research community needs to establish the effectiveness of FDTCs. Programs need to incorporate evaluation components from the outset, develop uniform data elements, and demonstrate effective outcomes. The complexity of the FDTC approach makes it difficult to determine the type of data that should be measured. As evaluation procedures and models are developed, the field must collaborate effectively to share approaches to research and evaluation.

- **Expand substance abuse treatment capacity and allocate resources for early intervention and treatment.** Each community needs to develop a full continuum of resources. These services might include residential care, outpatient services, day treatment, individual and group counseling, and education.

- **Recognize the distinctions between civil and criminal FDTCs in establishing program plans.** Each program should be aligned with the legal and statutory requirements for its jurisdiction. Procedures and processes must account for the limits and authority of the court.

- **Break down barriers.** When barriers to collaboration exist between the court system, the child welfare system, and the substance abuse treatment community, they can prevent effective service delivery to families. Although federal agencies recognize and address these barriers and provide funding for some initiatives that attempt to break down barriers, much of the work necessary to change established systems must be done on state and local levels. New roles must be taken on at all levels—by social workers, treatment counselors, agency administrators, political leaders, and judges. Although the challenges are substantial, the potential rewards are even greater.

Chapter 8
Current Initiatives

Training for Family Dependency Treatment Courts

Training is critical to the implementation of an FDTC. However, because the FDTC differs significantly from the adult criminal and juvenile delinquency drug court models, a new approach to training is needed.

Responding to this need, in 2001 the Drug Court Planning Initiative (DCPI) began to offer training for jurisdictions planning a family dependency treatment court. During the first year, 42 jurisdictions participated in a two-part training. They first visited at least two host family dependency treatment courts and then attended a 4-day conference workshop. The workshop addressed the unique characteristics of FDTCs; provided substantive, topic-specific information in a practitioner-focused manner; and guided participants through the development of an implementation plan.

By 2002, the DCPI had refined and expanded the initial training conference into a series of three programs: introductory training, skills-based training, and operations training. Each program builds on the preceding program in the series. Together the programs lead participants through the process of designing and planning a family dependency treatment court, paying particular attention to implementation and institutionalization. A total of 68 jurisdictions participated in the training program in its first 2 years.

To ensure the planning teams that attend training represent the critical disciplines involved in FDTCs, each participating team is required to include a:

- Judicial officer.
- Child protective service or welfare service representative.
- Substance abuse treatment provider.
- Drug court or planning coordinator.
- Parent attorney.
- Agency attorney.
- Child attorney, guardian ad litem, or child representative.
- Evaluator.
- Management information systems specialist.

The DCPI training program is interactive, and it provides opportunities for teams to discuss, analyze, and plan for an FDTC. Specifically, jurisdictions are encouraged to examine issues that will affect the design of their FDTC, identify how the key leaders will address those issues, and work as a team to ensure the integrity and efficiency of the planning process.

The following description is excerpted from the training program series announcement:

Introductory Program

Purpose

To identify leadership roles in the planning process, to provide a foundation of information about how to apply the drug court concept within a dependency court practice, and to assist participants as they begin to plan for an FDTC.

Goal

To introduce the drug court concept and build common knowledge of its application in a dependency court setting, and to further develop the leadership skills essential to effectively implement an FDTC plan, particularly the skills of the judicial officer, child welfare representative, and coordinator.

Characteristics

- First in the series.
- Three-day training for judicial officer, child welfare representative, and coordinator.
- Observations offered by the host FDTC based on its experience (both the court staffing and courtroom).
- Substantive topics include:
    - Implementation of ASFA.
    - Implementation of the National Council of Juvenile and Family Court Judges' *Resource Guidelines* (1995) and *Adoption and Permanency Guidelines (2002).*
    - Family dependency treatment court characteristics.
    - Sustainability and community resources.
    - Responsibility to children and the evolution and promise of FDTCs.
    - Judicial and team leadership responsibilities.

Skills-Based Program

Purpose

To educate the planning team about issues, practices, and processes unique to FDTCs; to assist team members from each discipline as they examine the impact of the FDTC on their roles and responsibilities.

Goal

To begin drafting an FDTC policy-and-procedures manual by applying the knowledge and insight acquired as a result of the presentations; to determine how team members will collaborate to plan the FDTC.

Characteristics

- Second in the series.
- Four-day training for entire planning team.
- Observations offered by the host FDTC based on its experience (both the court staffing and courtroom).
- Substantive topics include:
    - ASFA.
    - Indian Child Welfare Act.
    - Cultural competency.
    - Team building.
    - Intergenerational issues in substance use, abuse, and dependence.
    - Development of an FDTC mission statement.
    - Basics of substance abuse and dependence.
    - Management of information.
    - Targeting and eligibility.
    - Screening and assessment.
    - Management information systems.
    - Evaluation.

Operations Program

Purpose

To create the framework and policy for the FDTC, defining specific roles within the team and the jurisdiction.

Goal

To define treatment services and continuing care models, develop a program structure, identify sanctions and incentives, examine community resources, formulate an action plan, and finalize a policy and procedure manual.

Characteristics

- Third and final program in the series.
- Three-day training for entire planning team.
- Substantive topics include:
  - Assessment and treatment services.
  - Definition of your treatment services and continuing care models.
  - Case management, process and structure.
  - Management of participant behavior through incentives and sanctions.
  - Quality assurance and sustainability.
  - Ethics and confidentiality.
  - Ensuring team consensus.
  - Intergenerational issues related to substance use, abuse, and dependence.

Family Dependency Treatment Court National Cross-Site Evaluation Project

A significant project sponsored by the Center for Substance Abuse Treatment is now underway. This evaluation comprises five FDTCs. It examines whether the revised procedures, intense supervision, and early treatment interventions are instrumental in achieving the courts' desired outcomes.

Funding for FYs 2002 and 2003

Funding streams and grants have changed since the focus group meeting in 1999. As noted in program sustainability, FDTCs are not limited to the actual dollars raised within the community. Program support can also come through nonmonetary resources and the reallocation of resources within communities. The following items identify potential funding opportunities for FDTCs:

- Fiscal Year (FY) 2002 appropriations for the Substance Abuse Prevention and Treatment Block Grant increased by $60 million from the FY 2001 funding level. It was estimated that FY 2003 appropriations would again be increased over FY 2002. This block grant to states provides funds for substance abuse prevention and treatment services.

- When treatment capacity is insufficient for a particular population (such as women and children), state and local agencies can apply for discretionary funds from SAMHSA's Targeted Capacity Expansion Program.

- SAMHSA's drug treatment court grant in FY 2002 provided more than $10 million in funding for 28 community drug treatment courts to provide substance abuse treatment for

juveniles, parents charged with abuse and neglect of their minor children, and substance abusing adults charged with criminal offenses. These grants will expand these courts—which provide targeted treatment services to break the cycle of child abuse, criminal behavior, alcohol or drug abuse, and incarceration—by funding alcohol and drug treatment and additional services that support substance abuse treatment. The grants, which are part of the SAMHSA drug courts initiative, will allow SAMHSA to support the goals of the Adoption and Safe Families Act. ASFA sets strict timelines for courts that have jurisdiction over parents who have neglected or abused their children.

- A number of states have expanded the substance abuse treatment services available through Medicaid in recent years. States may fund substance abuse treatment in many forms through the mandatory benefits required by the Health Care Financing Administration and may wish to consider this as an option for expanding treatment capacity. Many parents involved in the child welfare system are already eligible for Medicaid.

- Some substance abuse services can be paid for under Temporary Assistance for Needy Families (TANF) and welfare-to-work programs. Many families in the child welfare system that also have substance abuse problems receive welfare benefits. If parents' substance abuse is interfering with their ability to care for their children, it may also be interfering with their ability to work. States and counties can incorporate substance abuse treatment services as part of their parents' employment plans. Under these circumstances, TANF and welfare-to-work funds could be used for nonmedical aspects of substance abuse treatment if the treatment is not otherwise available. [4]

- The Administration for Children and Families (ACF) is the lead HHS agency responsible for programs that promote the economic and social well-being of families, children, individuals, and communities. The FY 2002 budget requested $44.4 billion, a net increase of $1.2 billion, or 2.9 percent, from the FY 2001 funding level. Of these funds, $12.6 billion was allocated for discretionary programs, and $31.8 billion was earmarked for entitlements. The programs covered with this money include the Court Improvement Program (a grant program to help state courts improve how they handle foster care and adoption proceedings), child abuse and neglect programs (grants for states to improve and increase prevention and treatment activities), Community Service Block Grants (a program that provides states, territories, and Indian tribes with a flexible source of funding to help reduce poverty and address employment, education, housing assistance, energy, and health services), individual development accounts (a new program that empowers low-income individuals to save for a home), social services research, developmental disabilities, entitlement programs (TANF), childcare, and the Low-Income Home Energy Assistance Program.

- Title XX of the Social Security Act, also referred to as the Social Services Block Grant, is an entitlement program with funds capped at $2.8 billion. Block grant funds are given to states to help them achieve a wide range of social policy goals. Funds are allocated on the basis of population.

These resources may help FDTCs expand treatment capacity at the state and local levels. At the same time, FDTC programs can educate state and local leaders about the value of FDTCs and urge decisionmakers to expand resources that address the needs of children and parents involved in the child welfare system.

Appendix A: Focus Group Participant FDTC Program Descriptions

Family Treatment Court, Suffolk County, New York

In Suffolk County, New York, the number of child abuse and neglect cases continues to escalate. Parental substance abuse is believed to contribute to the majority of cases, placing children at substantial risk for out-of-home care. Despite the prevalence of cases involving substance abuse, neither the child welfare system nor the dependency system has been able to effectively meet the multifaceted needs of chemically dependent parents and their children. This has resulted in the fragmentation of services and poor coordination among service delivery systems. The Honorable Nicolette M. Pach, a family court judge in Suffolk County, responded to this need by researching the connection between substance abuse and child maltreatment. She assembled key stakeholders to further explore the problem and formulate a plan to address the needs of children and families.

Implementation of the Family Treatment Court

With the support of the Office of Court Administration and the Suffolk County District Administrative Judge, a steering committee composed of key court personnel, county leaders, and representatives from numerous county and community-based agencies was developed to explore resources, funding sources, policy concerns, and implementation issues. After a yearlong planning period, the Suffolk County Family Treatment Court (FTC) became operational on December 10, 1997.

The multidisciplinary, interagency effort integrates chemical dependency and child welfare services for alcohol- or drug-addicted parents and their children. The overall purpose of the program is to ensure the safety and well-being of children, to facilitate reunification efforts, and to expedite permanency planning. The program uses a comprehensive and integrated case management approach to meet the needs of chemically dependent parents and their children, including the developmental and health care needs of children. The program was the state's first family drug court and initially relied on county and state funding, as well as in-kind contributions from participating agencies. The court later received a grant from the State Division of Criminal Justice Services and an additional grant from the Robert Wood Johnson Foundation.

Eligibility

FTC identifies substance abusing parents who have neglected their children by screening all of the original neglect petitions filed by the Department of Social Services (DSS) through local child protective services agencies. Parents who are alleged to have neglected or abused their children, who abuse alcohol or drugs, and who meet the established criteria will have their cases heard before the designated treatment court judge. Eligible parents are notified of the program and its requirements during their initial court appearance and are offered the opportunity to meet with staff to further discuss the program. Parents who are willing to admit neglect due to their substance abuse and who voluntarily opt to participate in the program sign an agreement and are scheduled to meet with members of the court-based case management team for an alcohol and drug family assessment.

Court Procedures and Operations

FTC emphasizes early intervention through the immediate assessment and referral to appropriate treatment and ancillary services of substance abusing parents who are charged with child abuse or neglect. Within 2 to 3 weeks of their initial court appearance, eligible parents are assessed and referred to the appropriate treatment, which includes an intake appointment with a treatment provider. This provider addresses the parent's specific needs, including transportation and daycare services. Approximately 6 weeks following the parent's initial court appearance, a dispositional order based on the service plan is entered. This order details the specific services designed to address the needs of the family. The goal of the court is to develop a comprehensive service plan that meets the needs of both the parents and the children.

Intensive case monitoring and frequent status reviews before the judge keep the court apprised of safety issues pertaining to the children, the parents' progress in treatment, and progress toward permanency planning goals. This monitoring, which continues throughout the duration of the court order, enables the court to make informed decisions regarding placement issues.

FTC places increased emphasis on accountability. Parents are rewarded for progress in treatment and for meeting the requirements of the drug court. Conversely, they are sanctioned for noncompliance or failing to meet the needs of their children. Onsite alcohol and drug testing provides an effective measure of abstinence. Positive drug tests result in the reevaluation of treatment levels and other therapeutic interventions, as well as increased monitoring by the court. Willful contempt of court orders may result in up to 6 months' incarceration. Progress is acknowledged through the three phases of the program, each of which addresses specific recovery and child welfare issues. Graduation is achieved after a minimum of 1 year of participation in the program, including 6 consecutive months of sobriety and a court-approved permanency plan. Aftercare services include ongoing supervision by child protective services.

Case Management, Treatment, and Related Services

Through its team approach to case management, FTC integrates chemical dependency and child welfare services, ensuring the delivery of coordinated services for the entire family. Court-based case management services enhance the efforts of DSS, and frequent case conferencing ensures that critical information is exchanged among service delivery providers. The development of a comprehensive plan that addresses the needs of the entire family is one of the foundations of the family treatment court. The strong assessment components leading to the development of this plan are also critical to ensuring that permanency planning efforts begin early in the process.

The enhanced assessment components of FTC are also integrated with the risk assessment conducted by DSS. This results in a more comprehensive and coordinated plan and a more inclusive court order. For example, in addition to placement and visitation issues, service plans frequently include services to address alcohol and drug issues, domestic violence, the mental health issues of parents, and the developmental and health care needs of children. Intensive monitoring of the service plan is key to the family treatment court. The team also serves as a resource for linkages to public assistance, housing, transportation, and other ancillary services.

As of late 2000, FTC was held 3 half-days per week before one judge. There are approximately 46–60 active cases at any time.

Preliminary Findings

FTC recently began evaluation efforts; however, some benefits of the program can already be seen. Parents have been able to access appropriate treatment in an expedited manner. Intensive monitoring is identifying family needs and problems early so that assistance can be provided and the safety of children can be ensured. The court receives comprehensive status reports, enabling informed decisions concerning the placement of children. Also as a result of integrating services, new relationships are developing among treatment providers, child welfare professionals, and the court.

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Dependency Court Recovery Project, San Diego, California

San Diego County receives approximately 90,000 reports of suspected child abuse or neglect each year. Of these cases, approximately 2,400 come under the jurisdiction of the dependency court. In such cases, the court may remove supervisory authority or custody of the child from the family and transfer custody to the county child protection agency (there are approximately 9,000 children in the county's dependency system). In San Diego County, the Superior Court Juvenile Division's seven dependency courts and the Health and Human Services' Children's Services Division handle the cases.

Before 1997, San Diego County's dependency system had tremendous difficulty making timely permanent placement decisions for children. A review of the case files indicates that 80 percent of dependency cases involved alcohol or drug abuse by one or both parents. However, many parents in the court system were not receiving prompt and effective substance abuse treatment, which forced the dates for reunification plans and placement decisions to be extended. As a result, the county was not able to resolve cases within the state's statutory guidelines. In 1994, case resolution averaged 34 months. Children spent significant time in foster care, often with three changes in placement, which led to further trauma and psychological problems among these children.

A Systems Approach

In response to this situation, the presiding judge of the juvenile court, the Honorable James R. Milliken, brought together a team of key stakeholders in the dependency system to collaboratively implement a series of rapid reforms designed to achieve either family reunification or the timely and permanent placement of children outside the home. Stakeholders included the San Diego County Board of Supervisors, judges, court and county administrators, attorneys, social workers, foster parents, substance abuse treatment providers, parents, and juveniles. A policy group was also established to provide a forum for the discussion and development of policies on how dependency cases should be handled from beginning to end.

The resulting Dependency Court Recovery Project emphasizes compliance with statutory timelines for decisionmaking in all dependency cases. Eight major court-reform measures address both the general court reforms and the specific alcohol and drug concerns. Directly addressing these concerns is a two-tiered system of court supervision and substance abuse treatment.

The First Tier: Dependency Court

Within the dependency court, each parent against whom an abuse or neglect petition is filed is subject to the requirements of the dependency court. If alcohol or drugs are an issue, the parent is also subject to the requirements of the Substance Abuse Recovery Management System (SARMS). Through SARMS, Mental Health Systems, Inc. (a nonprofit organization under contract with the county) provides case management services to help parents address their substance abuse problems and encourages sobriety. The SARMS recovery specialist conducts the substance abuse assessment, enrollment, alcohol and drug testing, and progress monitoring and reporting. He or she also works with the participant to prepare a Recovery Services Plan that identifies the required treatment. Dependency parents attend counseling, therapy, education sessions, and recovery support groups through community-based treatment programs and submit to frequent alcohol and drug tests. SARMS reports to the court and Children's Services Division on a twice-monthly basis regarding parents' progress in treatment and the results of the alcohol and drug tests. In addition to the normal dependency review hearing schedule, 30- and 60-day SARMS review hearings are required, and the parent is encouraged to seek treatment before the 30-day hearing.

A social worker from the Children's Services Division remains the principal case manager and is responsible for the overall dependency case management. The addition of the SARMS recovery specialist provides case management for the parents' substance abuse issue only.

SARMS recovery specialists initially work actively with participants toward compliance with their recovery services plans, which are an automatic condition of the court order. Violation of the order results in sanctions of increasing severity: first, a reprimand from the judge; second, jail time and/or a fine; third, jail time and/or a fine or referral to the dependency drug court.

The Second Tier: Dependency Drug Court

The dependency drug court, a major component of the Recovery Project, is designed for dependency court parents who fail to meet the SARMS recovery services plan treatment goals. The dependency drug court operates an intensified three-phase program of treatment and heightened supervision, with each phase lasting 90 days. In Phase 1, a court appearance is required once a week. In Phase 2, a court appearance is required every 2 weeks. In Phase 3, a court appearance is required once a month. The parent is expected to cooperate fully with the conditions of the recovery services plan and to submit to random alcohol and drug tests in conjunction with dependency drug court appearances. If the parent is uncooperative and repeatedly fails to meet the recovery service plan goals, a permanency hearing to terminate parental rights may ensue.

Case Management, Treatment, and Related Services

SARMS is an extensive case management system that uses a broad range of treatment options to address the needs of parents in both tiers of the dependency court system. Through funding from the San Diego County Board of Supervisors and activities of the Health and Human Services Agency's Alcohol and Drug Services, the county network of contract treatment providers has been expanded to serve the immediate needs of the dependency population. The recovery services plan developed by the SARMS recovery specialist may include counseling, therapy, education sessions, and attendance in support groups. In addition to traditional inpatient and outpatient services, programs that can house parents (usually mothers) with their children are sought. Such facilities provide a "SAFE (sober and friendly environment) house" for the care and well-being of the family as parents progress through the recovery process. When possible, necessary services, such as parent-skills training, employment, and mental health and medical treatment, are within walking distance. The expectation is that a continuum of services and early intervention will strengthen the family and result in increased chances for success. However, the best interest of the child always remains the paramount consideration, and dedicated foster parents are valued for their role in making the dependency system work when the child cannot safely stay with the parent.

Dependency courts sometimes use family group conferences to allow families to participate in the decisionmaking process concerning the protection and safety of their children. This process involves parents as well as members of the extended family. With the guidance of the Children's Services Family Unit, meeting staff who are trained as family group conference facilitators, family members, and the participating support groups meet to formulate a plan for the child, which is then presented to the Health and Human Services Agency. This approach capitalizes on family strengths, allows for the expression of culturally appropriate solutions, and engages the whole family in accepting responsibility for the children.

As of late 2000, the dependency drug court was in session 3 days a week before one judge. Approximately 60 cases are active at a given time.

Preliminary Findings

The majority of clients are responding well to the program. Preliminary progress reports reflect an 81 percent compliance rate with the recovery services plan. More than 1,200 parents have received SARMS case management services.

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Family Drug Court, Jackson County (Kansas City), Missouri

The family drug court was established in the Sixteenth Judicial Circuit Court of Jackson County, Missouri, in 1998 to address an increasing number of problems associated with alcohol and drugs. The court's goals are to stop parental substance abuse that threatens the safety and permanency of their children and to stop substance abuse by delinquent juveniles or their parents that places the juveniles at risk of further delinquent behavior. The overall mission of the court is "to provide judicially managed, community-based, close supervision and specialized treatment to parents and juveniles whose substance abuse places their children or themselves at risk of substantially increased intervention by the justice system." The court was initially a participant in a pilot project under the auspices of CSAT and, in October 1998, received an implementation grant from the U.S. Department of Justice's Drug Court Programs Office.

Eligibility

Eligibility is based on established written criteria, and eligible clients are identified immediately after charges are filed. Clients are promptly advised about family drug court requirements and the merits of participating. Eligible individuals are screened both for substance abuse problems and their suitability for treatment by trained professionals, must appear promptly before the drug court judiciary, and are enrolled in a treatment program. Jackson County has a combined court system that facilitates case processing in cases when both abuse or neglect issues and juvenile delinquency exist. However, the focus of this description is on cases related to child dependency or child endangerment, including:

- Child dependency cases, defined as abuse or neglect civil cases, including any case filed pursuant to child abuse or neglect statutes when parental substance abuse is the primary or underlying cause for the neglect or abuse of the child.

- Child endangerment or criminal cases (diversion), including criminally filed child endangerment cases in which the defendant or mother has had at least one drug-exposed child with a subsequent baby testing positive for any abused substance at the child's birth, or a criminal defendant eligible for the adult drug court who also has a child who is the subject of a dependency proceeding in the family court.

Court Procedures and Operations

To address these civil and criminal child dependency cases, the family drug court uses a team approach, which includes the family drug court commissioner, the family drug court manager, the attorney for the juvenile officer, the defense attorney, the adult prosecutor, the guardian ad litem, treatment providers, social service providers, family members, and other interested parties. The court has also established relationships with private and public community-based organizations, public criminal justice agencies, law enforcement, and substance abuse treatment delivery systems that can provide linkages to education, housing, vocational rehabilitation, and other services. These relationships have expanded the continuum of services available to clients and helped educate the community about family drug court concepts.

In this approach, the roles of the child dependency/juvenile justice practitioners and substance abuse treatment providers are very different from those in a traditional court. The judge is the central figure on the team, focusing on sobriety, lawful behavior, accountability, and engaging clients in treatment. The court's focus remains on the best interest of the child. Treatment providers keep the court informed of each client's progress so that incentives and sanctions can be appropriately applied. The court operates a coordinated, systemic approach to the substance abuser through comprehensive planning that includes a method for data collection and program evaluation.

Case Management, Treatment, and Related Services

The period immediately after charges are filed is a critical window of opportunity for intervention, and the value of substance abuse treatment is emphasized during this time. It is critical that the referral to the family drug court be immediately followed by a court appearance for the intervention to be effective. Treatment is unique to the individual, taking into account his or her biopsychosocial and cultural needs. The model uses a holistic approach to the client and family treatment plan and incorporates medical and mental health needs, financial issues, housing, vocational needs, and family and legal issues. Comprehensive services include individual and group counseling, relapse prevention, self-help groups, preventive and primary medical care, general health and nutrition education, parenting skill training, domestic violence education, and treatment for the long-term effects of childhood physical and sexual abuse. Case management ensures an uninterrupted continuum of care and monitoring of client progress.

Abstinence is monitored by frequent urinalysis. Sanctions are imposed for continued substance abuse, and the severity of sanctions increases for continued noncompliance. The overriding focus is always the best interest of the child.

The family drug court is in session three afternoons a week and has approximately 60 active cases at any given time.

North Star Recovery Services

North Star Recovery Services provides a range of program and treatment services for women, men, and children. It is the family drug court's partner for the provision of services for mothers or babies who test positive for drugs. North Star offers residential, day outpatient, intensive outpatient, and continuing care treatment services. A multidisciplinary team includes counselors, community support workers, a family therapist, a child therapist, nurses, psychiatrists, child development teachers, and vocational counselors. A great emphasis is placed on empowering women as they rebuild their self-esteem and develop healthy relationships. Through the program's child development center, mothers can develop the skills to foster healthy, nurturing relationships with their children.

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Family Drug Court, Reno, Nevada

The family drug court in Reno, Nevada, began in 1995 in response to the rising number of child abuse and neglect cases involving parental substance abuse. Heavy caseloads prevented social service caseworkers from meeting with parents more than once a month, and because of a backlog in the judicial system, children languished for years in foster care. In addition, the same families often cycled repeatedly through criminal and family courts because of problems related to substance abuse. Judge Charles McGee of Washoe County, Nevada, became motivated to try a new approach to help children and parents with substance abuse problems.

In 1995, Judge McGee, who had 17 years of experience as a general jurisdiction, juvenile court, and family court judge, designed the first family drug court. He used information about criminal drug courts obtained from a colleague to develop the court's approach and launched the program with a budget of $15,000. The court now operates with funds from participating agencies, the overall county court administration budget, and a grant from a private foundation; it has also secured funds from the county child welfare agency to pay for substance abuse treatment.

Eligibility

Families are eligible for the program if their children are placed at risk by their parents' involvement in substance abuse. They may be identified by criminal activity on the part of a parent or because children are being removed from the home as the result of abuse or neglect. The respondents who appear before the family drug court judge are mostly women with addiction problems. Many are victims of domestic violence, have histories of physical and sexual abuse, and are often in destructive relationships with men. The families are normally referred by child protective agencies or drug treatment programs. However, this is a voluntary program, and families may elect not to participate or to discontinue participation and have their cases revert back to the traditional court docket.

Each parent must make a commitment to (1) refrain from alcohol and drug use, (2) meet with the judge twice a month for progress hearings, and (3) accept sanctions for failure to comply with any ordered obligations. In exchange, the program provides a minimum of 1 year of substance abuse treatment, increased social services, and a support system consisting of the judge, his staff, a case manager, the treatment provider, and a child welfare caseworker. On acceptance of these conditions, families enter into a yearlong program of intensive intervention with the goal of reuniting as a healthy, stable family unit.

Court Procedures and Operations

Parents must appear before the judge every other week for a hearing. Before this hearing, the judge confers with staff members involved in the case to discuss the parents' progress and related issues. Staff members may include the treatment provider, child welfare caseworker, case manager, prosecutor, defense counsel, probation officer, and foster grandparents. All staff from each agency that has contact with the parents must attend the conference. At the hearing, success is reinforced through praise and encouragement, but parents are held strictly accountable for failed drug tests or missed treatment appointments. Failure to appear for a drug test or a positive

test usually results in 2 days in jail. Caseworkers make arrangements for the care of the child. For participants further along in the program who relapse, community service may be allowed, or jail time may be deferred to the weekend to prevent employment conflicts. Other parent participants in the court program may sit in the gallery during these hearings.

The Reno family drug court is a 12-month program, and the participant must be entirely sober and drug free for 3 consecutive months before graduation. The graduate may be required to attend 3 months of aftercare, which consists of attendance at monthly hearings and aftercare treatment. During this time, the graduate's progress in recovery is monitored, and appropriate parenting of the children is ensured. The strength of the court is based on the fact that the judge, the court staff, the caseworkers, prosecutors, defense counsel, and the treatment professionals are personally involved with the families.

Case Management, Treatment, and Related Services

A comprehensive assessment is conducted immediately to identify family needs. Services provided include drug treatment, coping and life-skills development, parenting skills education, and integrated services case management. Participating agencies give their appraisal of the family and recommend a course of action. Each agency is asked to honor the goals of the others, work through turf issues, and identify gaps in service provision. Through this collaborative approach, an individualized plan with specific goals is developed. The judge in Reno hired a service coordinator, based in his court, to ensure that participants receive all necessary services.

Two treatment programs provide assessment and treatment. One program, an inpatient track called Step II, is designed for women only. Step II allows children to live with their mothers; it also provides drug testing for women twice a week. The other track, an intensive outpatient program called CHOICES, is designed for both men and women, and all the couples in family drug court participate in this track. The outpatient track monitors clients by conducting drug tests three times a week. A nonprofit group, Tru Vista, can also provide family group conferencing services. Court staff members monitor the capacity of each program and accept new participants in the drug court only if treatment openings are immediately available.

Family drug court is in session 1afternoon per week before a single judge. The program had approximately 60 participants as of late 2000.

Preliminary Findings

Although no formal evaluation has been done, 74 participants have graduated from the program since 1999. Screening for substance abuse has improved because of the social services caseworkers' close involvement in the family drug court. Access to ancillary services has greatly improved because of the efforts of the service coordinator. Program staff members believe that the clear case plan and close monitoring of progress allow for informed decisions on the part of the judge concerning child custody and better quality of service for families.

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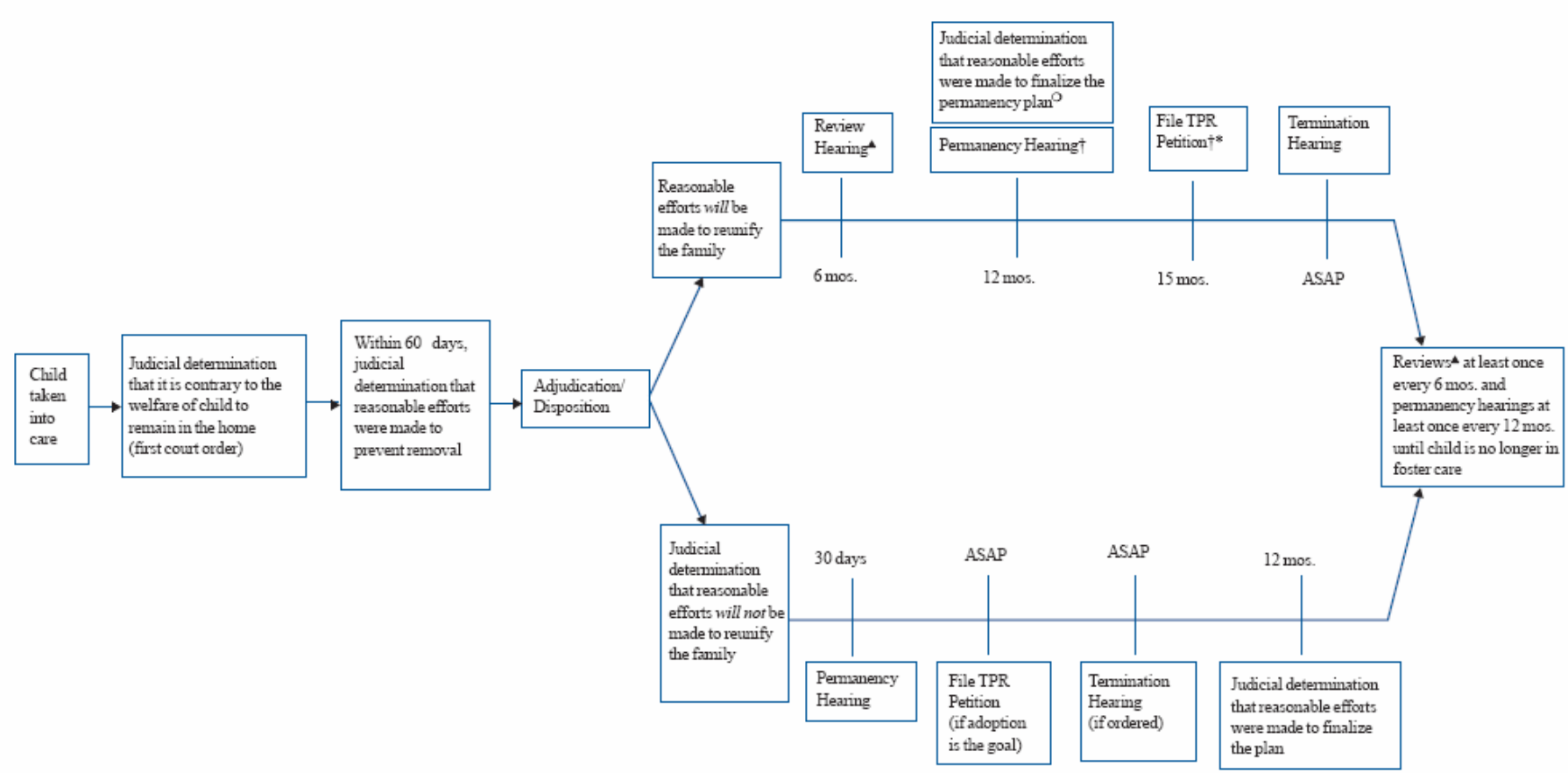
Appendix B. Adoption and Safe Families Act Timeline



▲If the review hearing is held by the court, it must be held at least once every six months.
○ The determination that reasonable efforts to finalize the plan be made is often made at the permanency hearing, although it can be made at another point in the proceedings as long as the 12 month deadline is met.
† When calculating when to have the permanency hearing or the 15 of 22 months, use the earlier of the date of adjudication OR 60 days after the child is removed from the
* Unless one of the following exceptions is documented: child is being cared for by a relative, agency has not provided services it has deemed necessary to rehabilitate the family, or a compelling reason exists.
Source: This timeline was originally prepared by Mimi Laver and published in ABA Child Law Practice, Vol. 17(8), p. 119. It was updated and amended by the authors for this book.

Appendix C: Recommendations for Research and Evaluation

In its *Review of Specialized Family Drug Courts: Key Issues in Handling Child Abuse and Neglect Cases*, the Urban Institute (1999) made the following recommendations regarding the research and evaluation of family drug treatment courts:

Process evaluation. Studies need to document the policies and procedures developed by courts around the country. Issues that should be examined include confidentiality, staffing patterns, interagency collaboration, sanction and incentive practices, and advocates' concerns regarding civil rights of parents and children.

Service needs of parents and children. These address substance abuse treatment, legal issues, health, employment, housing, domestic violence, and other areas.

Outcomes for children. Short-term outcomes include the duration and number of foster care episodes and the final placement decision. Long-term outcomes for those placed with their parents include the percentage named in subsequent abuse or neglect petitions, and when parental rights are terminated, the percentage of children adopted.

Outcomes for parents. Short-term outcomes include graduation or failure to graduate from treatment, participation in aftercare following case termination, perceptions of fairness of the court process, effects of the process on treatment motivation and retention, and assessment of the relationship between FDTC services and reduction in problems faced by parents.

System impacts. For courts, these include the duration of cases, the number of hearings, the demands for resources, the net-widening effects of encouraging early intervention, the potential efficiencies of combining multiple petitions for multiple children in a family in a single case, and the potential for linking drug court cases with active cases in other courts. For other systems, these include the effect on demand for staff and services, requirements to change procedures, and barriers to participation based on agency mandates or funding.

Direct expenditures and in-kind contributions. These include those paid for by existing agency funds, insurance, special government programs, private funds, and funding received from agencies and community groups. This information is needed for a comparison with the costs of existing procedures for handling these cases.

Appendix D: Family Intervention Programs

Contact information for each of these programs can be found at www.strengtheningfamilies.org.

HOMEBUILDERS Program

The HOMEBUILDERS Program is one of the best documented family preservation programs in the country. It is designed for the most seriously troubled families referred by child service agencies. Populations served include newborns to teenagers. The program is designed to break the cycle of family dysfunction by preventing foster care, residential, and other out-of-home placements, and to strengthen the family. Program goals include improving family functioning, increasing social support, increasing parenting skills, improving school and job attendance and performance, improving household living conditions, establishing daily routines, improving adult and child self-esteem, helping clients become self-directed, and enhancing motivation for change while decreasing family violence.

The program includes 4 to 6 weeks of intensive in-home services to children and families. A practitioner provides counseling and other services, spending an average of 8 to 10 hours per week in direct contact with the family; the practitioner is on call 24 hours a day, 7 days a week for crisis intervention. Therapeutic processes used include skills building, behavioral intervention, motivational interviewing, relapse prevention, rational emotive therapy, and other cognitive strategies.

HOMEBUILDERS has been evaluated both formally and informally since it began in 1974, and results have shown repeated positive findings on a variety of measures focusing on placement prevention and on child and family functioning.

Strengthening Families Program

The Strengthening Families Program (SFP) is a family-skills training program designed to reduce risk factors for substance use and other problem behaviors in high-risk children of substance abusers, including behavioral, emotional, academic, and social problems. SFP builds family relationships and parenting skills and improves the children’s social and life skills. It is designed for families with children 6 to 10 years old and has been modified for African-American families, Asian and Pacific Islanders in Utah and Hawaii, rural families, Hispanic families, and early teenagers in the Midwest.

SFP participants attend 14 weekly meetings, each 2 hours long. SFP includes three separate courses: Parent Training, Children’s Skills Training, and Family Life Skills Training. Parents learn to increase desired behaviors in children by using attention and reinforcements, communication, substance use education, problem solving, limit setting, and maintenance. Children learn about communication, understanding feelings, social skills, problem solving, resisting peer pressure, and complying with parental rules. The meetings also include opportunities for questions and discussion about substance use. Families practice therapeutic child's play and conduct weekly family meetings to address issues, reinforce positive behaviors,

and plan activities together. SFP uses creative strategies—such as providing transportation, child care, and family meals—to retain families in treatment.

Positive outcomes have been found in a number of independent program evaluations. Parents reported significant decreases in drug use, depression, and use of corporal punishment, as well as increased parental efficacy. Children became less impulsive, improved their behavior at home, and exhibited fewer problem behaviors in general. Children also reported fewer intentions to use tobacco and alcohol.

Treatment Foster Care

Treatment Foster Care (TFC) is a parent training program that works with foster parents to provide 6-month placements for 12- to 18-year-old adolescents referred to the program because of chronic delinquency. The teenagers' biological parents or guardians are involved intensively both during the placement period and a 12-month aftercare period. Youth are referred by the juvenile justice system.

The treatment goals for the referred youth's parents are to increase their parenting skills, particularly the ability to supervise and use effective discipline strategies, to increase their level of involvement with their child, and to help them engage in prosocial activities in the community. Treatment goals for the referred youth are to reduce criminal behavior and substance use, improve school attendance and grades, reduce association with delinquent peers, and become better able to live successfully in a family setting.

After intensive preservice training, TFC parents are contacted daily to monitor their children's progress and problems, and they attend a weekly meeting to receive supervision and support. TFC parents implement a daily behavior management program that is individualized for each TFC adolescent. Each day, youth participants have the opportunity to earn and lose points that translate into long- and short-term privileges. As they progress through the program, the level of supervision and control over their activities is reduced. Youth also participate in weekly, skills-focused individual therapy. The youth attend public schools, where their attendance and performance are tracked on a daily basis. Twenty-four-hour-a-day, 7-day-a-week on-call support is provided to TFC parents and parents or guardians during home visits and in aftercare.

The effectiveness of the TFC program has been demonstrated in several studies. TFC boys reported significantly fewer psychiatric symptoms, had better school adjustment, returned to their family homes after treatment more often, and rated their lives as being happier than boys in group care placements. This model is now being adapted for adolescent girls who are referred by the juvenile justice system but who have serious mental health problems.

Functional Family Therapy

Functional Family Therapy's (FFT) primary goal is to improve family communication and supportiveness while decreasing the intense conflicts so often characteristic of troubled families. Other goals include helping family members identify what they desire from each other, identifying possible solutions to family problems, and developing powerful behavior change strategies.

The program is conducted by family therapists working with each individual family in a clinical setting, which is standard for most family therapy programs. More recent programs with multiproblem families involve in-home treatment. The model includes four phases: introduction/impression, motivation (therapy), behavior change, and generalization (more multisystem focused). Each phase includes assessment, specific techniques of intervention, and therapy goals. The intervention involves a strong cognitive/attributional component that is integrated into systemic skills training in family communication, parenting skills, and conflict management skills. The FFT model has been evaluated many times since its inception in 1971, and its effectiveness has been repeatedly demonstrated.

Effective Black Parenting

Effective Black Parenting (EBP) is a cognitive behavioral program created to meet the specific needs of African-American parents. It facilitates efforts to combat child abuse, substance abuse, juvenile delinquency, gang violence, learning disorders, behavior problems, and emotional disturbances. It seeks to foster effective family communication, a healthy sense of African-American identity, and healthy self-esteem. The program emphasizes the importance of extended family values and provides information on child growth and development. It is grounded in basic parenting strategies and offers information appropriate for all socioeconomic levels, but it is especially effective for parents of children 2 to 12 years old.

The program is taught in two formats. In one format, program participants attend 15 3-hour training sessions that emphasize role playing and home behavior projects. The second format is a 1-day seminar version for large groups of parents. Black educators and mental health professionals teach a series of basic child-management skills using African proverbs and African-American linguistic forms and emphasize African-American achievement and competence. In addition, the interactive groups address respectful and rulebreaking behaviors, traditional and modern discipline, black pride, black self-disparagement, coping with racism, African-origin family values, preventing drug use, and single parenting. Two companion parent training programs are also available: Confident Parenting, for the general parent population, and Los Niños Bien Educados, for Latino parents.

Evaluations of the program have shown a significant decrease in parental rejection, an increase in the quality of family relationships, and improved child behavior outcomes. Both formats have been well received in African-American communities nationwide, and 2,000 instructors have already been trained and are using the program in schools, community agencies, churches, mosques, and Urban League affiliates.

Nurturing Parenting

The Nurturing Parenting programs are family-centered programs designed to build nurturing skills as alternatives to abusive parenting and child-rearing attitudes and practices. The ultimate desired outcomes are to stop the generational cycle of child abuse by building nurturing parenting skills; reducing the rates of recidivism, juvenile delinquency, and alcohol abuse; and lowering the rate of teenage pregnancies.

Nurturing Parenting is based on a reparenting philosophy. Parents and children attend separate groups that meet concurrently, with cognitive and affective activities designed to build self-awareness, positive self-esteem, and empathy. The program teaches alternatives to shouting and hitting and enhances family communication and awareness of individual needs. It attempts to replace abusive behaviors with nurturing ones, promote healthy physical and emotional development, and teach appropriate role and developmental expectations.

Thirteen different programs address specific age groups (infants, preschool through middle school age, and teenagers), cultures (Hispanic, Southeast Asian, African-American), and needs (special learning needs, families in alcohol recovery). Programs can be implemented in group or home sites from 2 to 3 hours a week for 12 to 45 weeks. The program includes parenting skills, self-nurturing activities, home practice exercises, family nurturing time, and infant, toddler, and preschool activities. The program has been adapted for Hmong, Hispanic, and African-American families. The initial Nurturing Program for Parents and Children 4 to 12 Years has been field tested extensively, and significant positive increases were found in parenting attitudes and the personality characteristics in parents, children, and family interaction patterns.

Health Start Partnership and CARES Parenting Program

The Health Start Partnership and CARES Parenting Program are promising parenting programs that grew out of one agency's prenatal and pediatric services unit. The overall goal is to foster secure mother-infant attachments by encouraging responsive parenting. This is accomplished through by helping new or expectant mothers understand child development, form realistic expectations, learn to respond to infant cues, gain perspective on their own childhood issues and roles as a parent, and find and learn to use social supports. It is rooted in attachment theory and includes three essential components: home visits, support and education groups, and medical care. Risk factors that indicate a need for project services include a personal history of maltreatment or out-of-home placement; conflicts, including abuse by a partner or spouse; negative feelings about the pregnancy; limited support; social isolation; economic stress; unmet personal needs; and chaotic family systems.

Women are enrolled in late pregnancy or as early in the postpartum period as possible. The partnership program is designed for a group of 8 to 12 women with infants born within a few months of each other. Clients meet every other week, with home visits on alternate weeks, for about 2 years. The CARES group is always open to new members. Enrolled children range in age from newborn to 5 years, and families graduate when the last drug-exposed child is enrolled

in kindergarten. CARES provides regular home visits and weekly support groups, with medical care and lunch provided onsite. Transportation is provided for all groups.

Evaluation data for this program indicate a decline in abuse and neglect rates. In addition, all children who remained with the project until its completion were fully immunized by 30 months of age or were up to date on immunizations when the project ended.

Multisystemic Therapy

Multisystemic Therapy's (MST) primary goals are to reduce out-of-home placements and antisocial behavior in adolescents, and empower families to resolve future difficulties. MST is an intensive family-based treatment addressing the known determinants of serious antisocial behavior in adolescents and their families. On a highly individualized basis, treatment goals are developed in collaboration with the family, and family strengths are used as levers for therapeutic change. MST treats factors in the youth's environment that contribute to behavior problems. Such factors might pertain to individual youth characteristics (e.g., poor problem-solving skills), family relations (e.g., inept discipline), peer relations (e.g., association with deviant peers), and school performance (e.g., academic difficulties). Specific MST interventions are based on the best empirically validated treatment approaches, such as cognitive behavior therapy and pragmatic family therapies.

Several programmatic features are crucial to the success of MST. First, the use of the family preservation model of service delivery (i.e., low caseloads, home-based services, time-limited duration of treatment) removes barriers to access to care and provides the high level of intensity needed to successfully treat both youth who present serious clinical problems and their multineed families. Second, the philosophy of MST holds service providers accountable for engaging the family in treatment and for removing barriers to successful outcomes. Such accountability clearly promotes retention in treatment and attainment of the treatment goals. Third, outcomes are evaluated continuously, and the overriding goal of supervision is to facilitate clinician attempts to attain favorable outcomes. Fourth, MST programs place great emphasis on maintaining treatment integrity so considerable resources are devoted to therapist training, ongoing clinical consultation, and service system consultation. Rigorous evaluation that demonstrates the program's effectiveness is a hallmark of MST.

Brief Structural/Strategic Family Therapy

Brief Structural/Strategic Family Therapy (BSFT)[5] evolved from a program involving Cuban-American families with youth who abused drugs and exhibited behavior problems. It is currently applied to families from other Hispanic-American groups and to African-American families. Therapy is tailored for and delivered to individual families, sometimes in their homes. A basic premise of BSFT is that families' maladaptive ways of relating are an important factor in the development of problems such as substance abuse. Therapists seek to change these maladaptive interaction patterns by choreographing family interactions during therapy sessions and creating the opportunity for new, more functional interactions to emerge. Therapists are trained to assess and facilitate healthy family interactions based on the cultural norms of the

family being helped. Structural Ecosystems Therapy, a variation of BSFT, is currently being applied and tested in the families of HIV-positive African-American women, caregivers of patients with Alzheimer's disease, and drug-abusing youth.

BSFT has been rigorously evaluated in a number of studies. The approaches have been found to be an effective means to improve family relationships, improve youth behavior, and reduce recidivism among youthful offenders.

Center for Development, Education, and Nutrition

The Center for Development, Education, and Nutrition (CEDEN) provides comprehensive services that promote and strengthen families in need of prenatal, early childhood, and parenting education. The agency's programs seek to improve the outcomes of pregnancies among adolescents and at-risk women by providing information on reducing the incidence of premature and low-birthweight babies. The agency also provides services to prevent and reverse developmental delays, increase positive parenting behaviors, reduce injuries, and ensure timely immunizations. CEDEN serves primarily low socioeconomic families and parents with children 0 to 5 years old who have developmental delays or are at risk of becoming developmentally delayed.

CEDEN's home-based programs accommodate family needs by working with children at childcare centers, relatives' homes, shelters for homeless or battered women, and other community shelters. The frequency of home visits is based on the family's needs and may range from weekly to monthly. Parent educators deliver a series of educational materials, including early childhood stimulation activities, age-appropriate activities, basic health and nutrition care, home safety, and a profamily curriculum focusing on child development, behavior, and skills building.

Program evaluations demonstrate CEDEN's ability to improve the status of young children with developmental delays. Children participating in the program maintain up-to-date immunizations at a higher-than-average level for the community. Parents report satisfaction in learning and using alternative disciplinary methods; they also feel they understand their children better after participating in CEDEN's programs. In addition, parenting classes and support groups help reduce the social isolation of mothers by facilitating friendships and boosting self-esteem.

Home-Based Behavioral Systems Family Therapy

Home-Based Behavioral Systems Family Therapy is based on the Functional Family Therapy model but targets families with lower educational levels and higher levels of pathology than the original model. Intermediate objectives include decreased family conflict and increased cohesion; improved family communication; improved parental monitoring, discipline, and support of appropriate child behavior; improved problem-solving abilities and parent-school communication; improved school attendance and grades; and improved child adjustment. Long-range objectives include reductions in the child's involvement in the juvenile justice

system, self-reported delinquency, teen pregnancy, and special class placement, along with increased graduation rates and employment.

The program is delivered in five phases: introduction/credibility, assessment, therapy, education, and generalization/termination. In the program's early phases, therapists are less directive and more supportive and empathic than in the later phases—when the family's cooperation and lowered resistance allow for increased therapist directiveness.

Evaluations have indicated robust treatment effects that are not the result of chance.

Appendix E: Strengths, Challenges, Opportunities, and Threats

In a series of exercises designed to both assess the state of family drug treatment courts and build a strategy for the future, the focus group identified the courts' perceived strengths and the challenges, opportunities, and threats facing them.

Strengths

- Early assessment and service plans.
- Judicial leadership (albeit a challenge to keep everyone on the bench in step with change).
- Courtroom style—proactive judicial involvement in the case.
- Collaboration among service providers and a nonadversarial approach.
- Careful documentation of activity, leaving no doubt as to whether reasonable efforts (as defined by the Adoption and Safe Families Act of 1997) have been made.
- Frequent contact with parents, regular meetings, and routine hearings.
- Ability to avoid being in violation of ASFA requirements by providing services early and achieving a positive outcome.
- Ability to identify truly abandoned children early on.
- Coordination and integration of services.
- More efficient case management over long periods of time.
- Motivated clients.
- Early identification of clients who are likely to succeed and those who are not likely to succeed.
- Clients with similar characteristics (screening criteria).
- Ability to identify inconsistencies in the child welfare system.
- Policy of treating clients with dignity and respect.
- Dedicated staff, which leads to consistency in approach and indepth understanding of clients.
- Clients' positive perception of legal system.
- Family drug treatment court parents who help each other succeed.

Challenges

- Tendency to associate a court with the personality of a particular judge; incumbent on judge and team to groom their replacements.
- Fragility of clients in the first 30 to 90 days.
- Tendency to objectify all standards for admission into FDTC (intuition must play a part in determining whether someone is ready).
- Immediate aftermath of an arrest or a child's removal from the home.
- Limited number of spots in the program.
- Territoriality issues among the collaborators.
- Limited time for inpatient treatment due to managed care rules.

- Decline in Medicaid patients (as clients lose children, they lose access to Medicaid, and it happens more quickly under ASFA).
- Obtaining buy-in from other members of the judiciary.
- Locating housing for parents (after children are removed).
- Limited treatment capacity; the need to work with the treatment community to increase sensitivity to the needs of this population.
- Getting systems to work with one another and to treat the client as one person, not several individual parts.
- HIV-positive clients.
- Ex parte nature of some communications in other forums (e.g., divorce cases).
- Resistance among parents' attorneys (though this is beginning to change as attorneys begin to understand the court); need to educate attorneys about FDTC.
- Confidentiality.
- Ethical issues.
- Due process issues.
- Deferring to the skills and knowledge of other team members.

Opportunities

- To use ASFA as a motivational tool.
- To provide cross training or multidisciplinary training.
- To work together to find ways to help parents and families and keep children safe.
- To learn the important roles that other people play in the lives of recovering families and to recognize court professionals' own limitations.
- To initiate reforms in related areas.
- To learn how other people perceive our clients.
- To learn from collaborating professionals at staffings.
- To give healthy, safe, clean, and sober parents back to their kids.
- To expose the underfunding of child welfare systems and the need to redirect money into those efforts.
- To learn how a client's arrest creates opportunity out of crisis.

Threats (External)

- Damaged relationship with foster care community due to time limits imposed by ASFA.
- Threats by parent advocates who maintain that parents should not cooperate with FDTCs (i.e., parent advocates, not a parents' attorney).
- Placement of a child in kinship care as an excuse not to go forward with a permanency plan. (This is akin to placing kids in a black hole and forces us to focus only on kids in paid foster care. Parents are in and out of their lives; nothing changes for them.)
- Political risk of taking persons with questionable backgrounds, such as drug dealers, into the program.
- Lack of understanding of FDTCs and the accountability that is essential to their success.

- Potential for issues to become political.
- Funding (funding is often subject to the political climate).
- Lack of education about FDTCs among professionals and the community at large.
- Perceived lack of good outcome data.

Appendix F: Focus Group Participants

Participating Family Drug Treatment Court Practitioners

Jackson County Family Court
Kansas City, Missouri
Judge

The Honorable Molly M. Merrigan
Commissioner
Jackson County Family Drug Court
Treatment Specialist

Carla Ingram
Program Manager
North Star Women and Children
Child Welfare Specialist

Penny Howell
Drug Court Program Manager
Jackson County Family Drug Court
Guardian Ad Litem

Kyla Grove
Jackson County Family Drug Court

San Diego County
Superior Court
Juvenile Court Division
San Diego, California
Judge

The Honorable James R. Milliken
Presiding Judge, Juvenile Division
San Diego Superior Court
Treatment Specialist

Kimberly Bond
Chief Operating Officer
Mental Health Systems, Inc.
Deputy Alternate Public Defender

Rosalind Gibson
Alternate Public Defender's Office
Project Manager

Andrea Murphy
San Diego Superior Court

Second Judicial District Court
Reno, Nevada
Judge

The Honorable Charles M. McGee
Judge
Second Judicial District Court
Treatment Specialist

Kristen O'Gorman
Director of Administration and Counselor
CHOICES
Child Welfare Specialist

Elise Henriques
Social Services Practitioner
Washoe County Social Services
Deputy Public Defender

Cynthia Lu, Esq.
Washoe County Public Defender's Office

Suffolk County Family Treatment Court
Central Islip, New York
Judge

The Honorable Nicolette Pach
Family Court Judge
Suffolk County Family Treatment Court
Treatment Specialist

Eileen Davies
Case Manager
EAC
Child Welfare Specialist

Christine L. Olsen
Project Director
Suffolk County Family Treatment Court
Attorney

Kathy Phillips, Esq.
Legal Aid Society

Other Participants

Lolita R. Curtis
Vice President
National Association of Drug Court Professionals

Bruce Fry, J.D.
Social Science Analyst
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration

Robin Kimbrough, J.D.
Research Associate/Professor
Institute on Family and Neighborhood
Clemson University

Eva Klain, J.D.
Director
Court Improvement Project
American Bar Association

Marilyn Roberts
Former Director
U.S. Department of Justice
Office of Justice Programs
Drug Courts Program Office (now part of BJA)

Kathleen R. Snavely
Director of Research
National Drug Court Institute
Consultant

Betsy Earp
Consultant/Writer
ROW Sciences, Inc.

Deborah Kaufman
Research Associate
ROW Sciences, Inc.

Ali Manwar, Ph.D.
Social Science Analyst
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration

Shirley Rhodus
Division Manager
El Paso County Department of Human Services
Colorado Springs, Colorado

Steve Zentz, Esq.
Colorado Springs, Colorado

Appendix G: Other CSAT Resources

The following documents include other CSAT publications (treatment improvement protocols and companion products based on them) that may be of help to FDTCs. These documents can be obtained from the Substance Abuse and Mental Health Services Administration's National Clearinghouse for Alcohol and Drug Information (NCADI) at 800–729–6686 (TDD 800–487–4889) or from CSAT's Web site at www.csat.samhsa.gov. The NCADI publication number is provided.

TIP 12, Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System, BKD144

- *Quick Guide for Clinicians Based on TIP 12,* QGCT12
- *KAP Keys Based on TIP 12,* KAPT12

TIP 17, Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System, BKD165

- *Quick Guide for Clinicians Based on TIP 17,* QGCT17
- *KAP Keys Based on TIP 17*, KAPT17

TIP 21, Combining Alcohol and Other Drug Abuse Treatment With Diversion for Juveniles in the Justice System, BKD169

- *Quick Guide for Clinicians and Administrators Based on TIP 21,* QGCA21

TIP 23, Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing, BKD205

- *Quick Guide for Administrators Based on TIP 23,* QGAT23

TIP 25, Substance Abuse Treatment and Domestic Violence, BKD239

- *Quick Guide for Clinicians Based on TIP 25,* QGCT25
- *KAP Keys Based on TIP 25*, KAPT25

TIP 30, Continuity of Offender Treatment for Substance Use Disorders From Institution to Community, BKD304

- *Quick Guide for Clinicians Based on TIP 30,* QGCT30
- *KAP Keys Based on TIP 30*, KAPT30

TIP 36: Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues, BKD343

Quick Guide for Clinicians Based on TIP 36, QGCT36
KAP Keys Based on TIP 36, KAPT36

Notes

[1] Nonmedical services are performed by those not in the medical profession, such as counselors or social workers, and include services not provided by a hospital or clinic. The welfare-to-work program specifically targets individuals who require substance abuse treatment for employment and allows nonmedical substance abuse treatment as an activity under job retention and support services.

[2] P.L. 105-89, signed into law on November 19, 1997, amending Titles IV–B and IV–E of the Social Security Act.

[3] The DHHS document *Permanency for Children: Guidelines for State Legislation* (in development) recommends that the deadline be clarified in state statute as 12 months from the date of adjudication.

[4]Commentary to Section 1355.20, *Federal Register*, vol. 63, no. 181, September 18, 1998, p. 50072.

[5]One Person Family Therapy, Family Effectiveness Training, Bicultural Effectiveness Training, Structural Ecosystems Therapy, and Structural Ecosystems Prevention have all been developed based on the BSFT model.

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National Council of Juvenile and Family Court Judges. 1998. *Judge's Guidebook on Adoption and Other Permanent Homes for Children*. Reno, NV: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

National Council of Juvenile and Family Court Judges. 1995. *Resource Guidelines: Improving Court Practice in Child Abuse and Neglect Cases*. Reno, NV.

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AMERICAN UNIVERSITY
WASHINGTON, DC

BUREAU OF JUSTICE ASSISTANCE (BJA) DRUG COURT CLEARINGHOUSE

Subject: Comments From Four Family Drug Court Judges Regarding Goals and Evaluation Criteria for Family Drug Courts
Prepared by: Caroline S. Cooper, Director, OJP Drug Court Clearinghouse
Date: October 23, 2002

The following are comments from four family drug court judges regarding two commonly asked questions:

(1) What appear to be the primary motivations for participants to enter family drug courts?

(2) What are the principal criteria – from the court's perspective -- that should be used to evaluate the effectiveness of family drug courts?

It is evident that all of the judges appear to be in very close agreement on both issues while, at the same time, approach them from diverse perspectives.

The judges responding were:

Judge Jeri Cohen, Dade County (Miami), Florida
Judge Charles McGee, Washoe County (Reno), Nevada
Judge Nicolette Pach, Suffolk County (Central Islip), New York
Judge John Parnham, Escambia County (Pensacola), Florida

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1. Based on your experience, what do you feel is the primary motive(s) for participants to enter the family drug court?

Judge Cohen: "I think that the primary motivating factor for parents entering drug court is to get children back. Although they can do this without drug court, I believe their lawyers tell them that the services in drug court are outstanding and that without drug court they will not be successful. In addition, our DC&F is terrible. The attorneys have seen over the years how DC&F actually works to hinder the parents rather than help them. Our addiction specialists essentially babysit these parents for 12 months. In addition, drug court helps parents get preferred placement in maternal addiction centers and, because we have so many eyes on the parents, quicker reunification. For example, I can put my parents into sober housing after treatment with children because I have a structured and monitored environment."

Judge McGee: "I feel the primary motive for participants entering the Family Drug Court is the assurance of getting their children back if they get clean and sober and satisfy the case plan."

Judge Pach: Based on my telephone conversation with Judge Pach, she cited the following factors which she felt motivated parents to participate: fear of losing their child; and actually losing their child. She also cited the encouragement which the defense bar gives for participation. Under ASFA, the family drug court presents the parents' best hope of reunification with or maintaining custody of their child; the service plan developed is consistent with ASFA requirements. If a parent doesn't participant, their case will go into the neglect docket with only the support of an overworked case worker, with minimal services. When they come back for a permanency hearing, little will have been accomplished.

Judge Parnham: Based on my telephone conversation with Judge Parnham, he indicated that, under the new system applicable to the Escambia County Family Drug Court – which makes program participation voluntary -- the primary motivating factor for parents' entry appears to be the desire to regain custody of their children. However, he also noted that, under the previous "semi-coercive" system in which a jail sentence could be imposed for a finding of contempt for failure to comply with a dependency court order, which sentence would be suspended if the participant agreed to participate in the family drug court, the desire to avoid jail appeared to be the primary motivating factor. He also noted that, with the shift to a purely voluntary program, far fewer participants now enter the family drug court since all entities involved in the case (defense, case workers, the Department of Social Services, etc.) need to support the family drug court option; if one entity doesn't support that option, the client doesn't enter the program.

3. What are the principal criteria you would use to assess the effectiveness of the family drug court (from the court's perspective, that is)?

Judge Cohen: "The success of a particular case should be judged not so much based on whether a parent gets all of his/her children back, but rather whether the parent can make good decisions with the drug court on safe permanent placements for the children. This would include giving some children up for relative/stranger adoption; leaving some/all children with relatives but being a helper; getting custody of the children and breaking the cycle of violence, substance abuse and neglect. The primary goal is safe, permanent and nurturing homes within the statutory time frames."

Judge McGee: "The principle criterion to assess the effectiveness of the court will be the longitudinal study to show whether or not these people are able to maintain their sobriety and their parenting skills. In another sense, however, the Family Drug Court is even a success as it fails to reunify children with parents. If the intensive efforts at reunification don't work, then the

judge can at least honestly and with good faith certify reasonable efforts at reunification before proceeding to a termination of parental rights."

Judge Pach: Based on my telephone conversation with Judge Pach, she noted that the primary criteria she would look at is the outcome for the child and, particularly, the length of time that elapses until a permanent plan for the child is in place when the child is in a permanent safe and stable home. She would also look at how long it takes to complete assessments and get meaningful services delivered. She, too, noted that the focus can't simply be on reunification or parental sobriety. While reunification is the preferred permanency plan, the court must focus on timely permanency for children.

Judge Parnham: Judge Parnham indicated that he agreed with Judge Cohen's comments in this regard. He also noted that, because of the bifurcated design of the Escambia County Family Drug Court, "the best interests of the child" aren't addressed in the *family drug court* component of the dependency process. These are addressed in a separate, traditional adversarial dependency hearing, in which parties are represented, with prior notice given, etc.. The "best interests of the child" are therefore always the consideration and the reason the case is in the dependency court. However, decisions that affect dependency issues (e.g., termination of visitation, reunification, placement of the child, etc.) are made in the *dependency* component of the proceedings. The focus of the family drug court component of the dependency case process is upon assisting the parent in changing his/her lifestyle that necessarily affects the child –not making decisions regarding the placement of the child or reunification – decisions which remain in the traditional dependency process. Given the context in which the family drug court operates in Escambia County, Judge Parnham therefore cited as the primary criteria he would use to evaluate the success of the program is the degree to which the parent makes lifestyle changes that affect the child -- becoming clean and sober; securing/maintaining employment; developing parenting skills, etc.

Judicial Perspectives on Family Drug Treatment Courts

BY JUDGE LEONARD P. EDWARDS AND JUDGE JAMES A. RAY

ABSTRACT

Family Drug Treatment Courts are a specialized calendar or docket that operates within the juvenile dependency court. These courts provide the setting for a collaborative effort by the court and all the participants in the child protection system to come together in a non-adversarial setting to determine the individual treatment needs of substance-abusing parents whose children are under the jurisdiction of the dependency court. This article is intended to give judges and others a judicial perspective on FDTCs, and to offer some assistance for those who are operating or who are considering creating one.

Family Drug Treatment Courts (FDTCs), also known as juvenile dependency drug treatment courts, are a specialized calendar or docket that operates within the juvenile dependency court.[1] FDTCs are not courts in the traditional sense because they do not adjudicate. Instead they provide the setting for a collaborative effort by the court and all the participants in the child protection system to come together in a non-adversarial setting to determine the individual treatment needs of substance-abusing parents whose children are under the jurisdiction of the dependency court. The participants in the FDTC work with these parents in an effort to rehabilitate them so that they can become competent caretakers and have their children safely returned to their care.[2] FDTCs are one of the newest arrivals in the drug court world.[3] The first FDTC was created in the mid-1990s and several other FDTCs were started a few years later.[4] Today they are one of the fastest growing types of drug courts in the United States.[5]

We are two juvenile court judges who started our FDTCs in the late 1990s and have presided over them ever since. We believe we have enough experience with these courts to describe how FDTCs work, what the critical issues are for their creation and maintenance, and where they are going. We also believe that there is enough evaluative information to declare them a success. This article is intended to give judges and others a judicial perspective on FDTCs, and to offer some assistance for those who are operating or who are considering creating one.[6]

The article will first describe what juvenile dependency courts do and the need and purpose for FDTCs within the context of dependency courts. Second, it will discuss the creation of FDTCs. Third, we will discuss how FDTCs typically operate and some of the issues all FDTCs must resolve. Fourth, we will address what we believe makes these courts effective. Fifth, we will discuss some of the promising innovations that have been developed in FDTC practice. Sixth, we will address the difficult challenge of sustaining recovery for clients after they leave the FDTC. Seventh, we will examine some evaluative data indicating how successful these courts have been, and eighth, we will conclude with some thoughts on the future of FDTCs.

I. NEED AND PURPOSE OF FDTCS

A. Juvenile Dependency Courts

Juvenile dependency courts[7] oversee state intervention in the lives of abused and neglected children and their families. When the state intervenes in a family to protect a child from abuse or neglect, the law requires the judicial branch to review the decision to remove that child from parental care, the decisions concerning

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the provision of services to parents whose child has been removed, and the decisions relating to the permanent placement plan for the child (return to the parent, termination of parental rights, guardianship, placement with a fit and willing relative, or in another planned permanent living arrangement).[8]

Child protection and child welfare issues are governed by federal and state laws.[9] These laws describe the different roles that the executive and judicial branches play in the protection of children, the efforts to preserve families, and the timely determination of permanency plans for children. One of the unique aspects of these laws is that they are sensitive to children's developmental needs. For example, they declare that a permanent plan for a child must be determined in a short period of time, not to exceed one year from the time the child is placed in foster care.[10] This time frame reflects children's pressing need to live in permanent home as soon as possible so they can develop normally,[11] and also seeks to avoid "foster care drift," the movement of children from one foster home to another.[12]

Child protection and children's services agencies are faced with significant challenges in implementing these federal and state laws. These agencies must respond to reports of child abuse and neglect and determine whether children can safely remain in their homes.[13] If the case is serious, the family may be offered services or the child may be removed from parental custody. In removal cases, these agencies must then determine what service plan should be offered to the parents to give them a fair opportunity to be rehabilitated and safely reunited with their children. In a few very serious cases, the court may not order family reunification services (reasonable efforts) for the parents to reunify with their child.[14] Finally, child protection and children's services agencies must find a permanent home for removed children within a specific time frame. The juvenile dependency court must oversee all of these events to determine whether agency actions have a factual and legal basis.[15]

B. The Need for a Family Drug Treatment Court

Children come before the juvenile dependency court for a number of reasons. Some are physically abused, and some sexually abused. Some have parents who abandon them or are so neglectful that the children do not receive the basic necessities of life. Our experience, and that of the colleagues with whom we have consulted, is that the foremost presenting problem for abusive and neglectful parents is substance abuse. Research confirms our experience. Estimates are that from 50% to 90% of all child protection cases have substance abuse as a problem facing the parent or parents.[16] Substance abuse includes abuse of street drugs, prescription drugs, over-the-counter drugs, or alcohol. Usually it is substance abuse that leads to neglect of the child, although on occasion it leads to harm of the child as, for instance, when drugs are sold in the child's home, when the fetus is exposed to drugs during pregnancy, or when the child accidentally ingests drugs.[17] Other social and familial problems such as domestic violence, mental health issues, developmental disabilities, and lack of parenting and caretaking skills often plague families, but substance abuse clearly is the most frequently identified issue facing parents in juvenile dependency court.[18] We should add that in many cases substance abuse is the presenting problem, but by no means the most significant issue facing the parent. Often sobriety is achieved in a reasonably short period, but other problems such as domestic violence, mental health problems, and housing needs are the issues on which the FDTC court process will spend the majority of its time working with the parent.[19]

Because of the pervasiveness of substance abuse among dependency court clients, we learned early in our work as juvenile court judges that if we were going to be successful in our courts, we would have to manage substance abuse assessment and treatment issues effectively. We learned that our juvenile courts would have to develop a system that could assess substance abuse levels, design case plans, and have the resources to engage parents in effective substance abuse treatment. As judges, each of whom has been sitting on the bench for more than 25 years, it took us a rather long time to realize that our children's services agencies and we as judges did not have the expertise to assess for substance abuse, design treatment plans, or monitor treatment effectively.[20] We knew that the parents were unlikely to be able to assess their own needs because in most cases they resist acknowledging the extent of their addiction. Thus, it was a logical step for us to reach out to the substance abuse treatment community and invite

them into our courts to create a process in which they would advise us about our clients' substance abuse treatment needs and then provide that treatment.

All parents whose children come before the juvenile dependency court are subject to the stringent timelines set by the Adoption and Safe Families Act. When ASFA was written, some thought that the one-year timeline for family reunification was too short to give parents a fair opportunity to rehabilitate themselves and have their children returned. After all, many of these parents had been using drugs for more than 10 years.[21] We have learned that the FDTC has the capacity to start treatment quickly and thereby give the parent a chance for recovery even within ASFA timelines.[22] In our FDTCs, parents can start treatment almost the first day their child's case appears in the court for the initial hearing.[23] We believe that for a juvenile dependency court to deal competently with substance-abusing parents, the court and child protection and children's services agencies must have continuous access to substance abuse expertise. This expertise must be available so the court and the other FDTC members will understand the seriousness of the parent's substance abuse problem, order a treatment plan that will best meet the parent's addiction problems, and gain better perspective on the progress the parent is making in her recovery efforts.

C. Purposes of a Family Drug Treatment Court

We believe an FDTC has three purposes. The first is to provide a substance abuse assessment and treatment plan in the context of juvenile dependency proceedings so a parent will have a fair opportunity to recover from addiction and correct the conditions that necessitated removal of the child, making it possible for the parent to reunify with his or her child within the strict ASFA timelines. The second purpose of an FDTC is to utilize the strengths of the drug court process to improve a parent's chances of success in treatment and recovery.[24] The third purpose is to provide the client with a new vision of life, one that will lead to long-term stability, and to help each client realize that vision.[25]

D. FDTCs Save Time and Money

Many foster children do not reach permanency in a timely fashion. ASFA declares that a child should be placed in a permanent home in a year after removal from his or her parent and that any child who has been in out-of-home care for 15 of the past 22 months should have a permanent home established immediately. Sadly, national statistics show that many children linger for years in foster care, some never finding a permanent home.[26]

We believe that FDTCs shorten a child's time to permanency. This happens for several reasons. First, the substance abuse issue is identified early and treatment starts early. Second, because of the individualized case plan and the drug court team's close monitoring, the parent is more likely to succeed. If the parent fails the program, there is usually no question that reasonable efforts have been provided. As a result, the child can find permanency in a more timely fashion.[27]

Just as adult criminal drug courts have been shown to save money,[28] substantial evidence supports the assertion that FDTCs also save money. To the extent that an FDTC shortens the time that a child remains in the foster care system, savings in foster care dollars can be realized.[29] Judge James Milliken (ret.) of the San Diego County Juvenile Court has evaluated the cost savings of the FDTC he started more than five years ago, the Dependency Court Recovery Project (The Project). The evaluations conducted by the federal Center for Substance Abuse Treatment found that The Project "made a dramatic impact on reducing the use and cost of foster care in San Diego."[30] The study showed a 58% cost savings when The Project was compared to traditional child welfare models.[31] Evaluations of other FDTCs have demonstrated similar savings.[32]

Additionally, we recognized that an FDTC could order the most effective preventive intervention that a court is capable of providing to addicted parents. Not only is the court working with parents (mostly mothers) and their children, but most of those mothers are still in their childbearing years. We have observed that our FDTCs often resemble a nursery, with new births occurring regularly within the client population. Success in an FDTC helps prevent babies from being born to a substance-abusing mother.

II. CREATION OF FAMILY DRUG TREATMENT COURTS

We started our Family Drug Treatment Courts after hearing reports from colleagues regarding the few FDTCs that had been created. We were influenced

by the success of the criminal drug courts that were started in the early 1990s and that have grown and expanded quickly across the country.[33] Word of innovations spreads quickly in the juvenile judiciary and particularly among those of us who are involved with Court Improvement efforts[34] and the Model Courts Project of the National Council of Juvenile and Family Court Judges.[35] We have had great success improving our courts by adopting the best practices that have been developed by colleagues. FDTCs appeared to be another very promising innovation.

A. Learning from Existing FDTCs

We learned that several of our colleagues across the country had started an FDTC in their jurisdictions. We discussed FDTCs with some of our local judges and with professionals who regularly appear in our juvenile dependency court, including the attorneys representing each of the parties, representatives from children and family service agencies, service providers, court administrators, and substance abuse treatment providers. We were interested. In Santa Clara County (San Jose), California, the local court team visited one of the first FDTCs in the country, the court that Judge Charles McGee started in Reno, Nevada (Washoe County). The trip included 10 people, including a judge, several representatives from the children's services agency, attorneys who represented the children, attorneys who represented social workers, attorneys who represented parents, substance abuse treatment providers, and a court administrator. Each person was able to talk with his or her counterpart in the Reno FDTC. Everyone came away believing that from their perspective the FDTC would be an improvement over what we had been doing before.

In Lucas County (Toledo), Ohio, the Administrative Judge led a multidisciplinary team to another of the nation's first FDTCs in Escambia County (Pensacola), Florida. Each person returned from the trip awed by the amount of effort required to make the FDTC a success, but inspired by the possibilities offered by this new court structure. The Toledo team immediately started planning for its own FDTC.

B. Learning from Criminal Drug Courts

We also turned to our local criminal drug courts for guidance. Criminal drug courts started before FDTCs and have become the fastest growing type of court in the United States.[36] We visited criminal drug courts, attended their graduations, and discussed their operations with the criminal court judges, the professionals, and the drug court case managers.[37] We learned that there are significant similarities and differences between the two types of drug courts. Some of the similarities are as follows:

- Both follow the 10 principles of drug courts.[38]
- Both develop an individualized plan for each client who appears in court.
- Both monitor the progress or lack thereof made by each client.
- The judges in each court praise those who are doing well, sanction those who are not following the case plan, and encourage all participants.
- Both courts address issues other than substance abuse, including housing, employment, and living stable lives in the community.

There are significant differences between the two types of drug courts. We stress that these differences must be acknowledged in the operation of a FDTC. Put another way, an FDTC is not a criminal drug treatment court in a dependency context. Some of the differences between the two types of courts are as follows:

- The juvenile dependency court focuses on children—criminal drug courts do not.
- The primary reasons for creating adult drug courts were: (1) reduction of jail and prison populations and (2) the "revolving door" reflecting adult offenders return to court time after time without ever rehabilitating.[39] On the other hand, the primary reasons for creating FDTCs were the pressure for timely permanency dictated by the passage of ASFA,[40] and the spirit of the court improvement movement in the nation's juvenile dependency courts.
- The juvenile dependency court must adhere to strict timelines—the criminal drug courts have no similar statutory scheme. The juvenile dependency court must follow the federal time guidelines established under ASFA.[41] Pursuant to this law and the state laws implementing it, a child who has been removed from parental care by the state in child protection proceedings must be given a permanent home within one year of the date the child entered foster care. This time frame creates a great deal of pressure on all participants in the child protection system, and particularly on the judge,[42] to move the process

along quickly and to conclude the permanency process in the one year time frame. This time frame means that there is a sense of urgency in all juvenile dependency matters, including the time by which a substance abusing parent must be rehabilitated. Treatment must start early and it is time limited.[43]

- The criminal drug courts utilize jail as a primary sanction. Some FDTCs use jail, while others do not. Moreover, the purpose of jail may be different in the two courts.
- The "ultimate sanction" in the criminal court is incarceration while the "ultimate sanction" in juvenile dependency court is loss of parental rights. This distinction may make all the difference in terms of a parent's motivation to comply with court orders.[44]
- Most criminal drug court clients are male while women comprise more than 85% of the clients in most FDTCs.[45] This gender difference has significant treatment implications. Women's treatment needs are different from men's, and this has meant that our treatment services have had to be structured to meet women's specific needs. Drug-dependent women often have low self-esteem and little self-confidence and may suffer from depression.[46] They often have suffered childhood trauma, and their drug use may be a form of self-medication.[47] They are more likely than men to have co-occurring mental health disorders or be domestic violence victims.[48] Being a victim of violence may increase the likelihood they will engage in substance abuse.[49]

  As a result of these characteristics, women have different treatment needs than men.[50] The research indicates that the most effective substance abuse treatment for women must be comprehensive, should emphasize the "mother-child relationship,"[51] and should include the children, particularly infants, in treatment.[52] Research has demonstrated that men and women relapse at different rates and for different reasons.[53] In our FDTC practice we have found that often a woman's case plan must include separation from a significant other in her life, usually a man.[54] We have also found that treatment can be more effective if there are gender-specific services for women such as programs for mothers with their children and AA/NA groups for women only.[55]
- The drug court team is comprised of a different set of professionals in each court. The criminal drug court team is made up primarily of professionals from the justice system, while the FDTC will have many professionals from the social service, mental health, domestic violence, and public health sectors.[56]
- An FDTC is much more complex than a criminal drug court because all aspects of the client's life and relationships, as well as the ultimate consideration of child safety, are part of the rehabilitative process. For example, the Center for Substance Abuse Treatment has identified ten kinds of services that a drug-dependent mother needs for rehabilitation. These include: (1) comprehensive screening and assessment; (2) medical intervention for women and their children (e.g., gynecology, HIV, TB); (3) linkages to federal and state supplementary programs (e.g., Head Start, legal aid, job training, TANF); (4) substance abuse and psychological counseling; (5) health education and prevention; (6) educational and vocational training; (7) transportation; (8) housing; (9) child care; and (10) continuing care.[57] Based on our experience, we would add (11) access to parenting classes and (12) domestic violence services to this list.
- Participation in the criminal drug court can be mandatory, but participation in FDTCs is usually voluntary.[58]

Considering the factors listed, we realized that the FDTCs could borrow much from the criminal drug court, but that the FDTC process had to be designed to address the different social and legal aspects of child abuse and neglect cases as well as the special needs of dependency court clients and their children.

C. Learning from Juvenile Courts

We also relied upon our own experience as juvenile court judges. Juvenile court judges have long been performing drug court-like functions in their traditional roles as judges. The FDTC requires judicial leadership to bring the court system and service providers together and to create a collaborative environment. This has been the traditional role of the juvenile court judge, that of convenor of court systems and communities on behalf of children.[59]

From our years as juvenile court judges, we knew that the FDTC would work well in the context of the juvenile dependency court's goal orientation. Rehabilitating substance-abusing mothers would result in better outcomes for children, and the FDTC appeared to offer great hope for improving outcomes for substance-abusing mothers. Juvenile court judges have always been goal oriented. Indeed, the juvenile court is

the original problem-solving court, and juvenile court judges have always attempted to identify services and strategies to rehabilitate children and family members.[60] This oversight and review-of-services role is consistent with juvenile court law.[61]

D. Starting a Family Drug Treatment Court

Starting an FDTC requires several elements, but judicial leadership is the first and most important.[62] If the judiciary, or at least one member of the judiciary, is not interested in a FDTC, it will not be created. After judicial leadership has been identified, that person needs to do some strategic planning. At the outset, it is important to get permission or a "blessing" from the Presiding Judge or Supervising Judge of the juvenile court and, depending on the structure of the judicial branch in a particular district, possibly from the Presiding Judge of the entire court system. Because of the success of most drug court efforts in the United States, that permission should not be difficult to obtain. Once a judicial officer has an interest and permission from the local judicial branch to create an FDTC, organizational steps must follow. These steps may include the following:

1. The judicial officer should convene the participants in the juvenile dependency court system and discuss the creation of the FDTC. In our jurisdictions we regularly have meetings that bring together representatives of all professionals who participate in the juvenile dependency court process. We believe that such meetings are beneficial to the administration of the juvenile court and that they provide an ideal place to introduce new ideas concerning court improvement.[63] We introduced the idea of an FDTC at these meetings and the discussion that followed led to investigation of other FDTCs as well as to consultation with professionals involved in those courts. Additionally, the judicial officer can distribute information about FDTCs during these meetings. Helpful information and technical assistance are available from several sources.[64] It may also be useful to show a film about FDTCs.[65]
2. Because FDTCs are collaborative courts, the judicial officer must be prepared to create a collaborative environment within the juvenile court. A growing body of literature describes collaborative or problem-solving courts.[66] These courts operate under a different philosophy and with different rules than traditional courts.[67] The collaborative court approach stresses addressing each client's individualized needs, the efforts of a team of professionals assisting the court, and intense court oversight of progress (or lack thereof) by each client. Breaking from the traditional adversarial process, collaborative courts utilize team input into judicial decision making and focus upon reaching individual goals for each client. They also emphasize a new role for the judge, that of problem solver.[68] These courts have been given significant recognition and praise by the Conference of Chief Justices and the Conference of State Court Administrators.[69]
3. The FDTC must create a system in which substance-abusing parents are identified, assessed, given case plans, monitored during their time before the court, and given sanctions and encouragement as appropriate during the drug court process. Each of these stages needs to be developed by a team of professionals (the Team).[70] The assessment and determination of a treatment plan should come from substance abuse treatment providers. Case management can be provided either by social workers or substance abuse treatment professionals. The monitoring, sanctions, and encouragement can be provided by the court process.
4. We have found that frequent cross-training on substance abuse and other issues relevant to the operation of the drug court and the services needed for drug court clients has assisted in improving everyone's knowledge about the dynamics of addiction and recovery and about the need to have substance abuse professionals as an integral part of the juvenile dependency court process. This cross-training also helps the substance abuse assessors and treatment providers understand the strict timelines for family reunification dictated by federal and state law. Cross-training is particularly effective because it brings professionals from different disciplines together around issues of common interest.[71] It aids in the process of truth finding in the juvenile dependency court and reduces some of the adversarial feelings intrinsic to the court process.[72]
5. We believe that the judicial officer must take a leadership role in contacting and convening the critical participants as the FDTC is created. For example, the judicial officer must be ready to reach out to the substance abuse treatment provider community to identify what resources are available and who will be willing to come to the table and be part of the FDTC. In Santa Clara County, the judge went to the local Director of the Department of Alcohol and Drug Services and asked him what he believed would be necessary to have adequate resources for an FDTC. Since he had already been working with the criminal

drug court, he had little difficulty agreeing to work with our juvenile dependency court plans.

In Lucas County, a "joint venture" involving Children's Services and Alcohol and Drug Addictions Services (the policy making and funding board) existed before creation of the FDTC. The joint venture provided assessment and treatment referral on demand for parents whose children had been removed or were at risk of removal. Since most referrals for services from Children's Services were women, most of the needed resources were in place, especially treatment capacity and housing for women. Those service providers were eager to engage with the FDTC because they soon learned that compliance with the service requirements was far better among FDTC participants. As a result, everyone enjoyed greater success.

We have discovered that the FDTC has required a different array of services than those used by the criminal drug court. As we pointed out earlier, most FDTC clients are women. Thus, the FDTC services must focus on pregnant and parenting mothers, and all service providers must have the capacity to work with the child and the mother. Housing resources must meet the needs of mothers and their children, substance abuse classes should have a mother-child component, and parenting classes likewise must address the needs of young mothers.

6. No drug court will be successful unless it has adequate assessment and treatment services (outpatient and inpatient) for the participants.[73] Our team meetings often address potential sources of support for treatment services and FDTC operational issues. We discovered that it was necessary for each of us to become advocates for substance abuse services and for women in recovery, in particular, as women have different treatment needs than men.[74] We discovered that a majority of the substance abuse treatment services in our communities focused upon men in recovery. Thus it was necessary to approach our local elected officials and service providers and ask for some new services for women and a redistribution of existing services so that women and children were more equitably treated. For example, housing resources must have the capacity to serve women in recovery and their children. Traditional housing for men in recovery does not allow for children in the living situation. We need to add that advocating for mothers and infants is much more politically attractive than the more traditional judicial branch requests, such as asking for a new courthouse or additional court clerks.

7. An important step in creating an FDTC involved working with child protection and children's services agencies. As dependency court judges, we have always worked with these agencies collaboratively regarding the administration of justice.[75] This collaboration has continued in the creation and operation of our FDTCs and has been important for several reasons. First, children's service agencies are very interested in any efforts to improve outcomes for children and families. These agencies have struggled for years with the problems presented by substance-abusing parents,[76] and for the court to create a system that produces better results for families and in a timely fashion is consistent with agency goals. Second, these agencies are under a legal mandate to provide "reasonable efforts" to prevent removal of children, to provide services so that separated families can be reunited, and to provide timely permanency for removed children.[77] The FDTC has proved to be an effective means of providing "reasonable efforts" in providing services to families separated from their children. Third, the children's service agencies in both of our jurisdictions had experienced difficulties communicating and working with professionals who provide substance abuse services in our communities. The FDTC provided a vehicle for establishing productive, working relationships between the children's services agency and substance abuse treatment professionals. As judges, we played an important role in bringing the children's services agency together with the substance abuse service community in each of our jurisdictions. By keeping the focus on the FDTC's operations, we helped to avoid turf wars and finger pointing.[78]

   Finally, there is another important reason for children's service agencies to be involved in the FDTC—resources. To the extent that these agencies accept responsibility for providing effective substance abuse treatment services, they may provide the resources to ensure that those services are present. In Santa Clara County, the agency is paying for substance-abuse experts to provide assessments for substance-abusing parents as they enter the dependency process and also for housing for substance-abusing mothers and their children. Since the children's service agency has access to federal and state funding to provide such services, the juvenile court should not miss the opportunity to work closely with it to maximize the substance abuse treatment resources available for FDTC clients.

   There are other sources of funding for drug treat-

ment and services for FDTC clients. These include grants from the federal government, Medicaid, TANF, and Title XX of the Social Security Act.[79] Additionally, state and local resources can support substance abuse treatment and even the creation and operation of an FDTC.[80]

8. Each of us spent considerable time with our drug court teams determining how the FDTC would operate. We believe we may have spent too much time and energy on these issues, but we did not have the benefit of technical assistance from many other courts or national organizations. We believe the process for starting an FDTC today has been made much easier.[81] Some of the issues that the judicial officer and the team must address include eligibility for the FDTC (which clients will participate in the FDTC and who will not be eligible), when the FDTC cases (calendar) will be heard, who will be a member of the FDTC team, how information will be communicated among the various parties and agencies,[82] what sanctions and rewards will be offered to clients, whether entry into the FDTC will be voluntary or mandatory, and what the relationship between the FDTC and the underlying dependency process will be. Some of these issues are discussed below.
9. At some point in the process of creating a new FDTC, the judicial officer and the team must decide that it is time to start the court process. We found that our FDTCs started slowly. Only a few clients were interested in the FDTC at the start, probably because it was new and the attorneys representing parents (and the parents themselves) were cautious about what benefits the FDTC would offer their clients. As the FDTC matured, the attorneys for parents understood the benefits of the court to their clients and urged them to join. Social workers also saw the benefits of the FDTC and advocated that their clients participate. Expanding an FDTC will depend on whether all parties, and particularly the parents and their attorneys, perceive the court to be beneficial to their interests. Regular team meetings should ensure that all concerns about the court and the processes are heard and addressed. Failure to have such meetings and to permit all professionals to air their concerns could result in creation of an FDTC which has few or no client participants.
10. Some jurisdictions, including both of ours, have found it useful to develop memoranda of understanding (MOUs) regarding the roles, responsibilities, duties, and authority among the entities involved with the FDTC. MOUs can be particularly helpful when working with agencies that do not have a history of collaboration.[83]
11. We should add that it can be very helpful to have a federal or state grant to support the start-up of an FDTC. Neither of our jurisdictions benefited from such a grant when we started our FDTCs because grants were not being offered to FDTCs in those days (only to criminal drug courts). Fortunately, times have changed, and both federal and state governments are beginning to support start-up FDTCs, as well as provide enhancement grants for courts already in existence.[84]

III. STRUCTURE, PROCEDURES, AND OPERATIONS

A. How an FDTC Operates [85]

The typical operation of an FDTC involves a substance-abusing parent whose child is before the juvenile dependency court. After the court has sustained a petition alleging abusive or neglectful behavior, the client may apply to the court to become a member of the FDTC. The client will be assessed by a substance abuse treatment assessor to determine the best treatment plan for him or her.[86] If the client is accepted by the court or by the FDTC Team, [87] the client may sign an agreement[88] concerning treatment steps he or she will make and the conditions attached to entry into the FDTC. During the next months (usually a year), the client will appear before the court on numerous occasions with progress reports on treatment successes or setbacks, and the court will provide encouragement, rewards, and sanctions for the client's actions. After a year (or other specific time period) of successful participation, the client will complete the drug court process and will receive some recognition either through a certificate or graduation ceremony. There may be a period of time after graduation during which the client reports back to the court to ensure continued sobriety.

B. Structure

FDTCs have many similarities, but they are not identical. They vary in a number of significant ways, many of which were mentioned in the preceding section. Some FDTCs include all substance-abusing parents whose children are before the juvenile dependency court.[89] In some FDTCs, the same judge hears criminal and juvenile dependency cases, thus giving the judge additional power (the criminal sanction) over the client.[90] Some FDTCs utilize two judges to hear the calendar.[91] The length of participation in various FDTCs can

vary from a few months to over a year. The relationship between the dependency process and the FDTC also differs from court to court. Some juvenile courts hear the dependency case simultaneously with the FDTC, while others hold separate hearings. In some, the same judge hears the dependency proceeding and the FDTC session, while in others different judges hear the dependency and FDTC sessions. Another structural variation involves whether there will be a pre-hearing administrative meeting before the FDTC calendar is called. Both of our FDTCs utilize this type of meeting. We have found that such meetings are useful to exchange information about the progress or lack of progress by each client, and to address general administrative issues. Moreover, by having representatives from all participants in the FDTC proceedings present at these meetings, there is no ethical issue regarding *ex parte* communications.

C. Procedures and Operations

For a number of operational issues, FDTCs around the country have developed different policies and procedures. A discussion of some of these issues follows.

1. *Determining Eligibility for the FDTC.* There is some variation around the country on this issue. Some FDTCs admit only women.[92] In Santa Clara County, the parent must be receiving family reunification services to be eligible for participation in the FDTC. This means that a parent who was not offered family reunification services (reasonable efforts to reunite parent and child) is ineligible for the FDTC. The court would not offer reunification services if it found the client ineligible because of aggravated circumstances.[93]
2. *Signing an Agreement or Contract upon Entry to the FDTC.* Should the applicant sign a contract at the time of entry into the FDTC? Most FDTCs are voluntary—that is, the participant agrees to enter into the more intensive FDTC by agreeing to participate in the FDTC activities and to follow the directions of the court and the Team. We have found that it is helpful to have a written contract that the participant, the participant's attorney, and the court each sign at the time of entry. This contract or agreement indicates what the court's expectations are concerning the client's actions while in the FDTC. It lays the foundation for monitoring the client's progress and outlines the possibility and severity of sanctions.[94]
3. *Determining the Client's Treatment Plan.* All clients entering our FDTCs must undergo a substance abuse assessment conducted by substance abuse treatment providers. Our substance abuse assessors have informed us that based on their philosophy and training, they will try to work with a client at the treatment level the client is willing to accept. If a client believes that he or she can be successful with outpatient treatment, but the assessor believes that residential treatment is necessary, some assessors will accept the client's plan and try to work with him or her at that level of treatment.[95]

   We suggest that the FDTC should not permit the client's assessment of his or her treatment needs to determine the court-approved treatment plan. We insist that the assessor inform the FDTC Team on both the treatment plan the client is willing to participate in and the plan the assessor believes the client needs to recover from his or her addiction. The FDTC Team almost always adopts the latter assessment.
4. *Content of the Treatment Plan.* What should the FDTC case plan include? Should it address only substance abuse treatment issues? What if domestic violence or other relationship issues are impacting the client? What if housing issues or mental health issues face the client? How far should the FDTC Team create a case plan beyond the substance abuse issues?

   We believe that the case plan must start with substance abuse services the experts determine are appropriate for recovery. They may be outpatient or inpatient treatment, chemical testing, AA/NA meetings, obtaining a sponsor, completing the 12 steps, and other appropriate substance abuse treatment interventions.

   Additionally, we believe that effective case planning must include a holistic approach to the client and her situation. We have learned this from operating our FDTCs. Clients would appear in court and state that they were clean and sober, but that they had no place to live or that their boyfriends were beating them or that they needed counseling. As a result, we learned that to be effective, the treatment plans had to go far beyond substance abuse issues. We now ask about domestic violence, mental health, housing, employment, education, driver's licenses, old criminal and traffic warrants, and other aspects of the client's life that might bear upon her ability to succeed in life.

   If an issue is important to the client, the Team needs to hear about it and decide whether it will be included as a part of the case plan. For example, in a typical situation, the client (a mother) may be willing to engage in outpatient treatment, but unwilling to leave her boyfriend. The Team will investigate

to determine whether that living environment will be supportive of the case plan and goals. When the Team learns that the boyfriend has inflicted domestic violence or that he is still using drugs and is not in treatment, the case plan will likely direct the mother to move from that residence, probably to a sober living environment (SLE). The plan may also place restrictions on her contact with her boyfriend.[96]

5. *Voluntary Entrance into the FDTC.* Should clients be able to choose whether to enter and participate in the FDTC, or should participation be mandatory? In Santa Clara County, participation in the original FDTC was by application. In the past two years the Team has decided to change the model to include all substance-abusing parents in the FDTC. Some participants choose to participate in a more intensive track of the FDTC, and they do so voluntarily, but every substance-abusing parent is assessed and given a case plan that becomes a part of the court-ordered service plan.[97] In Lucas County, parents can choose to enter the FDTC. Once a participant has chosen to enter the FDTC, however, continued participation is mandatory. Participation is also voluntary in Washoe County, New York City's Family Treatment Court, the Escambia County (Florida) Drug Treatment Court, the Miami-Dade Drug Treatment Court, and the Erie County (New York) Family Court.[98]

6. *Responses to Client Participation.* One unique characteristic of the FDTC is an emphasis on frequent reviews of a client's progress, which includes rewards for success in following the treatment plan and sanctions for failures to follow that plan.

   a. *Rewards.* Courts are not noted for praising or rewarding parties who appear in legal proceedings. One does not often hear about judges praising criminal defendants or civil litigants. Yet, rewards are a basic ingredient in the FDTC. Once the treatment plan has been established, at each review hearing the judge and other Team members will discuss the progress (or lack thereof) that a participant has demonstrated during the time between court appearances. Different FDTCs around the country have developed a variety of rewards from verbal praise to tokens to tickets to local community events. From our perspective, these rewards, and particularly the words of praise from the judge, support positive change and provide an effective incentive to continue compliance with the treatment plan.

   b. *Sanctions.* Clients sometimes are not successful following the treatment plan. Most FDTCs will impose sanctions when setbacks occur. Perhaps the most discussed issue among FDTC judges is whether jail should be used as a sanction for lapses in treatment.[99] When a client relapses or fails to follow the case plan, all FDTCs agree that some sort of sanction is appropriate, but the nature of that sanction is the issue. Most FDTCs use incarceration as a sanction. Those who favor the use of incarceration argue that it works.[100] They further declare that the dependency process and reunification of parents with their children is so important that the juvenile court has an obligation to get the parent's attention.[101] They state that a few days in jail is a trivial consequence when compared to the permanent loss of a child. They also point out that failure to follow a court order is subject to the court's contempt power. A number of those judges have reported to us that parents have thanked them for "waking them up" by putting them in jail and getting them back on track for reunification. Moreover, a California appellate court recently upheld use of jail as a sanction through the court's contempt power.[102]

   If jail time is utilized, it is important to consider the framework in which it is being utilized. How does the participant view the time in jail? Is the jail term punishment for failure to comply or is it an opportunity to reflect about what has happened and to plan how to accomplish personal goals? Used in the latter sense, it can be more of a "retreat" than a punishment. One judge refers to the jail sanction in his jurisdiction as "therapeutic incarceration."

   We caution that when using jail as a sanction, the judge must understand clearly the purpose for any jail sentence and use it only for that purpose. Most drug court participants are not dangerous in the community and do not need to be detained for anyone's safety. Moreover, just because the jail sanction is utilized extensively and successfully in the criminal drug court does not mean that it should be used as widely in the FDTC.

   Other courts prefer positive reinforcement and milder sanctions for clients who relapse or otherwise get off track.[103] They argue that jail is not necessary. They believe that with the proper balance of other sanctions and rewards, parental motivation can be maximized. Some reflect that jail is an unjust consequence for failing to follow the drug treatment plan. They state that parents do have the right to choose whether they will reunite with their children

and can walk away from the dependency process, so the judge should not put them in jail for choosing not to participate. They point out that jail can be seen as demeaning to women in the FDTC and detrimental to their children who see their parent in jail.[104] They also point out that contempt is not utilized for parents who fail to go to parenting classes, who do not appear for visitation, or who otherwise do not participate in the court-ordered case plan. They argue that failure to engage in substance abuse treatment should not be treated any differently. Finally, they suggest that jail is a tempting sanction and will probably be over-utilized by the FDTC judicial officer because it is easy. On the other hand, they argue, creative sanctions can be just as effective as incarceration.

Whether jail is utilized or not, FDTCs use many other sanctions when clients are not compliant with the treatment plan. In Pima County, Arizona, for example, the court uses the following sanctions: (1) restrictions on associations and travel; (2) community service; (3) written essays; (4) increased treatment sessions; (5) increased court appearances; (6) increased 12-step meetings; (7) increased drug testing; (8) up to 48 hours in jail; (9) residential treatment; (10) delay in graduation to the next level or from the program; and (11) dismissal or suspension from the FDTC.[105] Both of our FDTCs also utilize these sanctions.

7. *Discussion of Dependency Issues at the FDTC Hearing.* The relationship between the FDTC and the underlying juvenile dependency case is an issue that all FDTCs must address. Should visitation or aspects of the court-ordered case plan be open for discussion and court decision during the FDTC hearing? One of our courts has made the decision that only treatment issues will be discussed at FDTC hearings.[106] The reasoning is that the team is addressing treatment issues with a unified voice and that only treatment issues are before the court. To inject other issues and the possibility of adversarial positions would detract from the collaborative nature of the court process. Other courts may handle this issue differently.[107]

8. *The Use of Information Gathered in the FDTC Process in Juvenile Dependency Proceedings.* Is the parent's failure to follow the drug treatment plan evidence that can or should be admissible in the juvenile dependency case? This issue must be addressed at the outset of the creation of the drug court. Otherwise, unresolved legal issues may arise in the dependency proceedings. This issue has implications for successful and unsuccessful parents. The successful parent would like to have her progress admitted in the dependency proceedings while the unsuccessful parent would not. We have concluded that treatment success or lack thereof is admissible in the dependency case.

9. *Graduation from FDTC.* Should the FDTC acknowledge completion of the program? In both of our FDTCs we have a celebration for clients who have completed a year of recovery in the program. The ceremony is the culmination of successful participation in the drug court experience. For many of our clients it is one of the most important moments in their lives. Friends and family attend and there are speeches and tears. It is a wonderful event. In Santa Clara County, we refer to the event as a graduation. The Lucas County FDTC celebrates completion of the drug court program with a Commencement. The court explains to the client that the Commencement marks the beginning of the client's life and that it will be the next phase in the client's recovery process.

   Should the drug court honor a client who has participated in the FDTC, but who has not followed the treatment plan successfully? We recommend that they not graduate, but be given some acknowledgment of their efforts. One of us offers those clients a Certificate of Completion rather than a graduation certificate. The Certificate of Completion is not given at a ceremony, while Graduation/Commencement Certificates are awarded as a part of a graduation ceremony.

10. *The Relationship of Graduation from FDTC and the Juvenile Dependency Case.* Does graduation from the FDTC guarantee that a child will be returned to the parent? Some courts explain at the outset of the case that graduation will guarantee a reunification with the child—others do not. We suggest that the two issues (recovery from substance abuse and reunification with the child) remain separate and not be connected. We tell our clients that their chances of reunification will be enhanced by participation in the FDTC, but that the return of the child is a separate issue.

11. *Honesty.* Should the Team be concerned about participant honesty regarding recovery? Yes! Addiction and drug use are closely linked to dishonesty. Addicts lie in order to maintain their lifestyles and avoid detection and punishment. We both stress to FDTC participants the importance of honesty. The honesty issue arises regarding all aspects of the participant's life from treatment issues, to drug testing, to contact with old friends, to daily living. We discuss honesty

when the client appears on the FDTC calendar and praise clients who admit to transgressions, especially when they have not been detected by the Team. We believe that a client's honesty is one of the criteria that will indicate that recovery is taking place.

12. *Separate Court File.* Should the court system create and maintain a separate file for FDTC cases? In both of our courts, our clerks maintain FDTC records in the existing dependency file. Other FDTCs create a separate file for the treatment court. Creating a separate file obviously involves more time and expense, but it also separates the treatment plan and progress from the dependency issues. Some courts find this separation useful.
13. *Confidentiality Issues.* FDTCs must be prepared to address the issues surrounding confidentiality. Just as juvenile dependency court proceedings are usually confidential,[108] federal law protects information regarding substance abuse treatment.[109] Thus it is important for the Team to spend some time developing information-sharing protocols including releases. Examples of these protocols and release forms are available from the authors as well as from most existing FDTCs.[110]

IV. THE REASONS FAMILY DRUG TREATMENT COURTS WORK

We have spent considerable time and energy starting and maintaining our local FDTCs. We believe they are effective in what they attempt to accomplish: (1) to provide the appropriate level of treatment services for substance-abusing parents in the juvenile dependency court so that those parents will have a fair opportunity to reunite with their children in a timely fashion; and (2) to provide a unique and effective type of support and encouragement for these parents. We also believe that we have some perspective on why these courts work and why they will continue to grow.

We believe that FDTCs work because, like criminal drug courts, the judge and the other FDTC participants treat clients with respect and dignity, fashion individual plans for each person, and listen and respond to each client's problems and concerns. Unlike the ordinary court process where the judge makes orders, tells clients what to do, and deals with them on a more or less impersonal basis, the FDTC starts from the premise that each client has individual needs and problems, and that success in treatment is integrally connected to an understanding of the client's unique situation in life.[111]

To learn about a client's situation, the FDTC takes the time to learn the details of the client's substance abuse history, including previous treatment episodes, preferred drugs, sponsor status, clean and sober date, and use patterns. The Team inquires about significant relationships to determine whether they might impact recovery or lead to relapse. The Team also inquires about the client's living situation and learns about locations in the community where the client has used in the past as well as the people the client has used drugs with. Additionally, we have learned that it is important to learn about a client's family of origin, including those who have substance abuse problems and those who will be good supports for the client during recovery. Throughout the treatment process, the Team will ask what problems, if any, the client is facing in her efforts to remain clean and sober.

The FDTC judge, like the criminal drug court judge, takes time to talk with each client and to develop a personal relationship with him or her. For most clients, this is the first time that a powerful person has shown an interest in their well-being. The impact of the judge-client interaction when it is personalized, as it is in the FDTC, results in greater compliance with the treatment plan than in court proceedings when the court-client interaction is less personal.[112] From our experience as well as from the literature,[113] we conclude that this interaction is one of the most significant motivators for the client to change behavioral patterns. The comments we receive include "I have never felt so supported," "I couldn't have made it without you," and "You really care about what happens to me."

We also believe that frequent appearances before the judge and the Team provide an important continuity and support for the FDTC client. The federal and state child protection laws[114] mandate hearings every six months to review parental progress toward family reunification and child welfare. FDTC clients return to court on a weekly, biweekly, or monthly basis depending on their treatment progress. Knowing that one is returning for a progress report seems to be a strong motivator to comply with the FDTC case plan. Clients return to court because they have developed a strong relationship with the judge and the Team.[115]

We also have some strategy regarding the frequency of hearings. At the beginning of the case, the Team

holds hearings more frequently, often every week. The goal at this stage of the treatment process is to get the client into the appropriate housing situation, have her engaged in treatment, and have her regularly testing, attending AA/NA meetings, and securing a sponsor. Once the client demonstrates that she is fully engaged in the treatment plan, the hearings can be less frequent, perhaps every two weeks. When the client has demonstrated that she is fully engaged in treatment and is working to structure a new life, the hearings may be even less frequent, perhaps every three weeks. If there is a relapse or some problems in the treatment plan, the meetings increase in frequency.

Additionally, the frequent hearings also permit the court to hold the service providers accountable for the services promised to the FDTC participant. If the Team concludes that a service is important to a participant's success, then it is expected that the service will be provided. A review in a week or two enables the court to see that the provider has addressed the issue.

The FDTC also ensures collaboration and coordination among all service providers in the client's life. This collaboration is critical to successful service delivery and, ultimately, to client rehabilitation.[116] As we have mentioned, while substance abuse is usually the presenting problem in FDTC, we have discovered that domestic violence, mental health concerns, poverty, housing, employment, and other social problems can be equal or greater hurdles for the parent. Without identification of these additional problems and coordination among the service providers addressing all of the client's challenges, success may not be possible. FDTC brings all these providers before the court, whose authority ensures that they work together collaboratively.[117]

The FDTC approach to rehabilitation recognizes that there are no easy answers to the enduring problems of substance abuse, domestic violence, and mental health issues. But we also realize that bringing together a group of experts and service providers in the juvenile dependency court with a problem-solving mentality can build the strongest foundation for the recovery process. The dialogue between the Team and the client creates the opportunity for all problems and concerns to be addressed. This interaction builds trust and confidence between the client and the Team. It also means that each perspective (that of the social worker, the attorney/guardian *ad litem* for the child, the attorney for the parent, the substance abuse expert, the other service providers, the judge, and the client) will be presented and discussed. Everyone in the process acknowledges that this is hard work, that it takes more time than the ordinary management of court cases, and that it can be exhausting. We are convinced that, given the enormity of the social and personal problems facing most FDTC clients, the extra effort is necessary and appropriate.

Success of the FDTC also reflects the importance of the underlying issue in all juvenile dependency court cases—reunification with one's children. We rarely discuss family reunification issues during client appearances in the FDTC, but everyone knows that success in the FDTC will maximize a parent's chances of reunifying with his or her children. The criminal court uses jail as the ultimate sanction—the juvenile dependency court's ultimate sanction is more significant, the permanent loss of one's children.

V. PROMISING INNOVATIONS IN FAMILY DRUG TREATMENT COURTS

Our FDTCs are not static. None of them looks anything like what they were when we started operations in the 1990s. Moreover, we believe that our FDTCs will continue to evolve as we learn better ways to engage clients and motivate them to make significant changes in their behaviors. In this section, we will discuss some of the most promising innovations we have discovered.

A. Mentor Moms Program (Santa Clara County)

One of the most challenging issues for any FDTC is persuading a client to engage in treatment. Many clients are in an early stage of readiness to change their pattern of substance use. They deny that they have a substance abuse problem—even if their children have been removed from them. Often they focus on their anger against law enforcement, social workers, or the court system and are unable to face the reality that their substance abuse was a major contributor to their problems in the child protection system. Others simply do not believe they have a substance abuse problem at all and that their use of drugs is something that they "can handle" without help. They are in denial.

One program that has assisted mothers in understanding and accepting their predicament, and has assisted them in engaging in substance abuse treatment,

has been the Mentor Moms Program operating in Santa Clara County. The attorney office representing parents hired several of the first graduates from the FDTC and asked them to work with new female clients. Instead of hearing about the FDTC from an attorney, the new female client will be introduced to a mentor who will explain the program and offer herself as a support.[118] The fact that the mentor, who is neither a social worker nor an attorney, can tell the new client that she, the mentor, has been through the system has had a significant impact on most clients and has helped persuade them to engage in substance abuse treatment and the FDTC.[119] The Mentor Mom model has been adopted by the Lucas County FDTC and has been recommended in the literature.[120]

B. Foster Grandparent Program (Washoe County)

In this program, foster grandparents volunteer and provide support to families in the program. By tapping into the vast resources of the elder community, Washoe County has brought an important group of persons into the recovery process. By providing almost daily contact with drug court participants, the grandparents mentor excellence in parenting behaviors that many parents have never experienced before.[121] "Families need aftercare options when the program is over and it's difficult for a court to stay involved with the family. This relationship fills some of that void, and [the bonds] can go on forever."[122]

C. Celebrating Families Parenting Class (Santa Clara County)

Utilizing the resources of a SAMHSA grant, Santa Clara County instituted a parenting class created by experts in substance abuse and child development. Celebrating Families is a 15-week parenting class that brings parents and children together in an enriched environment that includes a neurological assessment for each child, Head Start and Early Start for all the young children, and a curriculum carefully designed to address the special needs of substance-abusing parents. The objectives of the classes are to: (1) break the cycles of chemical dependency and violence/abuse in families by increasing participant knowledge and use of healthy living skills; (2) positively influence family reunification by integrating recovery into daily family life; and (3) decrease participants' use of alcohol and other drugs and to reduce relapse by teaching all members of the family about the disease of chemical dependency and its impact on families. Celebrating Families has been evaluated and the results demonstrate a high degree of success. The program has been replicated in several other sites around the country and in several foreign jurisdictions.[123]

D. Specialized Social Workers (Santa Clara County)

After a few years of working with the FDTC, the Santa Clara County Department of Family and Children's Services concluded that the structure of their agency should be modified to reflect the importance of substance abuse expertise on the social worker staff. The director created a new Substance Abuse Unit of eight social workers, two social worker assistants, and a supervisor. Each of these workers specializes in cases involving parents with substance abuse problems. Each social worker in this unit sees the parent on an as-needed basis which often means weekly contact. They have also learned about effective techniques to motivate parents toward recovery from addiction.[124] The recognition of the importance of substance abuse as a problem for the agency's clientele has been tempered by the realization that the juvenile dependency system has so many substance-abusing parents that the Substance Abuse Unit cannot handle all of the cases coming before the FDTC.[125] Nevertheless, the substance abuse expertise developed by the social workers in this unit has benefited the entire agency. Lucas County Children's Services has also developed a specialized social worker unit.

E. CASA Involvement

Many jurisdictions utilize Court Appointed Special Advocates (CASAs) in the FDTC process. CASAs are trained, court-appointed volunteers who work with abused and neglected children in juvenile dependency cases. The first CASA program was started by a juvenile court judge in 1977, and at last count there are over 940 CASA programs in 49 states.[126] Many FDTCs use CASAs to support the children of FDTC clients as well as the clients.[127]

The FDTC can use CASA volunteers in numerous creative ways. In the District of Columbia Family Treatment Court, CASA volunteers support children and their mothers as they move from residential treatment into aftercare.[128] With the aid of an enhancement grant, the Santa Clara County CASA[129] program has identified a number of experienced child advocates who have been provided

additional training in issues relating to the FDTC process, substance abuse and recovery, and maintaining appropriate roles. These advocates are assigned to children under seven years of age and work with the child and the mother to help her understand her child's developmental needs and support children as they transition into life with their substance-free family. The advocates spend time with the mother and child (usually one child at a time) and mentor them regarding parenting skills. Thus far, all participants are enthusiastic about the results.[130]

F. Dedicated Mental Health Services (Santa Clara County)

After five years of operation, the Santa Clara County Team concluded that FDTC clients must have dedicated mental health services. With at least 50% of FDTC clients having co-occurring mental health difficulties, the Team applied for and received grant monies that will provide mental health assessments, medication assessments, medications, and therapy. The Team is convinced that integration of these mental health services into the case plans of FDTC clients will significantly improve the outcomes for dual diagnosis participants. The Lucas County FDTC team came to the same conclusion and added mental health services for dual diagnosis participants.

G. Transportation Support (Santa Clara County)

Getting around from one program to another, from drug testing to visitation, can be a significant challenge for a parent with few or no resources. Transportation can be particularly challenging in a large county. In Santa Clara County, the Team discovered that many mothers were struggling with transportation. On occasion, the children's services agency is able to provide bus passes for the clients, but sometimes the clients found themselves unable to get around the county to complete their treatment programs. The FDTC applied for and received an enhancement grant that included a modest sum for bus passes for FDTC parents. These have proved to be a small but effective investment in the client's successful completion of treatment plans.

VI. SUSTAINING RECOVERY—AN ENDURING PROBLEM

We have learned a great deal about substance abuse, recovery, and family dynamics. However, we recognize that we are still learning and that our FDTCs have been unable to address many problems. For example, some of our clients relapse. They relapse during the drug court treatment process, they relapse after they have had their children returned to their care, and they relapse after they have graduated from FDTC and have had their dependency cases dismissed from court jurisdiction. Substance abuse experts state that relapse is sometimes a part of the recovery process, but relapses are nevertheless significant disappointments for the clients and for all members of the FDTC Team. Their occurrence has led us to examine the issues of relapse and sustaining recovery and to start to make changes in our operations to address these issues.

We know that after the case has been dismissed, relapse can occur in many circumstances, but that several situations reoccur more frequently. Some mothers find themselves isolated and alone (albeit with their children) after the intensive support provided by the FDTC has been removed. Some of these mothers become depressed and turn to drugs for self-medication and their lives begin to deteriorate. Some mothers return to boyfriends or to the fathers of their children, and these relationships do not support their recovery. The boyfriend/father is sometimes using drugs, may be violent toward the mother and children, or, at times, creates such significant problems in the lives of the mother and children that the mother cannot maintain her sobriety or the lifestyle she developed during her recovery.

The FDTC response in Santa Clara County has been to try to create connections for drug court clients that will last even after the court case is dismissed. This is not an easy task as the court loses jurisdiction over the child once it dismisses the case, and there are no legal means of holding the parent accountable for his or her behavior. The first step we took was to utilize our Mentor Moms as contact persons for FDTC graduates.[131] Part of the Mentor Moms' responsibilities is to keep track of graduates and offer themselves as supports and contacts should the graduate want help of any kind. The fact that many clients have developed a good relationship with the Mentor has made this a successful effort.

The second step has been to create a number of events during the year to which graduates are invited to attend. The FDTC sponsors a summer picnic and a Thanksgiving dinner. Both have been well attended by

clients, their children, and by members of the Team. Many graduates also attend. Additional annual events include a Winter Holiday dinner sponsored by Rainbow House, a network of homes providing a sober living environment (SLEs).[132] With the assistance of an enhancement grant, the leadership at Rainbow House is also starting a weekly movie night to attract clients and graduates to meet in an enjoyable setting. The FDTC is now creating a calendar of events to identify activities throughout the year for clients and graduates. The purpose is to provide opportunities for clients and graduates to meet on a regular basis throughout the year in a safe and supportive environment. The FDTC Team believes that by forming positive new relationships with women, FDTC clients will have greater success in recovery in the years to come.

The third step has been to identify treatment programs that last beyond graduation from the FDTC and dependency court. At first, we relied upon Alcoholics Anonymous and Narcotics Anonymous as the foundation for lifetime sobriety.[133] After time we realized that more supports in the community would increase the opportunities for positive connections for clients. As a result, we worked to create some AA/NA groups that were comprised of FDTC clients and graduates. Additionally, the FDTC has identified statewide AA/NA conferences and provided scholarships for clients and graduates to attend these conferences.

Finally, at graduation the judge invites the graduates to return to the FDTC at any time to meet with the Team and to keep in contact. In some cases the judge orders the graduate to return as a part of the graduation process. This happens only in cases with special issues where the Team is concerned about the client following through with a specific task. Other FDTCs around the country have structured post-graduation contacts with the court.[134] Their existence reflects an acknowledged need for client support after the formal drug court process has officially ended.

In Lucas County, the population is small enough that those in recovery and those who have graduated from the FDTC get to know each other. They see each other in their daily lives and participate in meetings together. The court also invites them to return to the FDTC at any time. The result is that community contacts support recovery even after commencement.

Sustaining sobriety in our jurisdictions is a work in progress, but there is hope that these strategies will be successful. At graduation and dismissal, our clients are doing better in their lives than they have for many years. They are highly motivated, are focused on the well-being of their children, and have opportunities for successful lives. We believe that our efforts to provide supports for them in the community and in connection with continued drug court activities will increase their chances of lifetime success.

VII. EVALUATION OF FAMILY DRUG TREATMENT COURTS

A. Evaluation of Results

The evaluative data confirms that drug addiction treatment is worth its cost.[135] Both of our sites have been involved in evaluation of the effectiveness of our FDTCs. One of our sites (Santa Clara County) is a part of the national study of the effectiveness of FDTCs being conducted by NPC Research.[136] There are many positive findings from this research, including the conclusion that FDTCs are having considerable success in supporting parents to enter and remain in substance abuse treatment.[137] The evaluation confirms that parents in FDTCs are significantly more likely to have at least one treatment entry and have significantly more treatment entries than comparison parents. FDTC parents enter treatment earlier and spend more days in treatment than non-FDTC parents.[138] Additionally, FDTC parents reunified faster than comparison group parents, and FDTC cases reached permanency sooner than the comparison group cases.[139]

Other evaluations are equally positive. From a national perspective, all FDTCs report a very significant decrease in drug use by participants once they enter the program.[140] Additionally, almost all persons completing the FDTC have been able to improve their legal relationships with their child or children; approximately one half of the participants have been able to retain or obtain employment, almost 90% receive treatment for mental health, and approximately one half have developed alumni groups.[141] As pointed out above, studies have demonstrated that FDTCs can save substantial foster care dollars by reaching permanency sooner.[142] Research has also demonstrated that drug courts have increased the number of drug-free babies born to FDTC

mothers. We know that many of the mothers who enter the FDTC will have additional children. The FDTC increases the probability that these babies will be born drug free.[143]

One difficulty with the evaluative efforts has been the fact that FDTCs are evolving—they are moving targets. Each of our courts has discovered new and better ways of treating substance-abusing parents, and these changes have been incorporated into our courts. Our FDTCs operate better today than ever before and they continue to improve. As FDTCs expand across the country and as judges and other team members exchange ideas, improvements in court operations should continue to accelerate.

An additional challenge for evaluators has been to identify a control group that can be compared to participants in the FDTC. The judge and other members of the Team are understandably reluctant to permit random assignments of services to different clients in the same court system in order to determine whether one strategy works better than another. Evaluations are currently underway to compare similarly sized juvenile court jurisdictions where one juvenile court utilizes an FDTC and the other does not.[144] Such evaluations should give further insight into the effectiveness of FDTCs.

We recommend that any new FDTC integrate evaluation from the outset. Each of our courts can provide technical assistance on the steps to take for evaluation of FDTC outcomes, just as the resources mentioned earlier can assist.[145]

B. Judicial Satisfaction

Judges gain great personal and professional satisfaction from their participation in all drug courts and from FDTCs in particular. As we wrote above, drug courts have grown very rapidly over the past 15 years.[146] One reason for this growth has been the sharing of satisfactory results among judges around the country. Just as we learned about the possibilities of greater success for families in the dependency court from reading about and then visiting other FDTCs, so have hundreds of colleagues taken similar steps.

When visitors from other jurisdictions come to visit our courts, they can see that the FDTC environment is conducive to change, and that parents are fully engaged in recovery. As one teenager said in the Santa Clara County Drug Court Video, "Some people say this is about mothers getting their kids back. I think it's more about kids getting their mothers back."[147] We can testify that working in our respective FDTCs has been the most positive professional experience of our careers. Indeed, we believe that the FDTC process we have described offers an example of the juvenile court at its best.

VIII. THE FUTURE OF FAMILY DRUG TREATMENT COURTS

For several reasons, we predict that FDTCs will continue to grow and flourish.[148] First, FDTCs work. The evaluations demonstrate that substance-abusing parents engage in treatment earlier, they participate in more treatment events, and they sustain their sobriety longer than any other treatment model we have used. Second, juvenile and family court judges across the country are actively engaged in court improvement efforts, and the FDTC is an innovation that will continue to attract more and more attention. Third, the FDTC's holistic approach is well suited to the juvenile and family courts, where judges are concerned about each client's success and well-being of the entire family. The FDTC problem-solving style ensures that all issues facing the client and the family will be addressed. Fourth, it is clear that investing in recovery for women benefits not only the women themselves, but also the children they have and will be caring for. This investment also benefits families and the community as a whole.[149] Fifth, the FDTC team approach maximizes collaboration among service providers, which ensures that all of the necessary persons will be able to participate in creating solutions. Sixth, the FDTC model seeks to engage the community in efforts to sustain success after the court case is dismissed. Seventh, technical assistance for creating and expanding FDTCs is readily available for all jurisdictions, and eighth, FDTC results will continue to bring great personal and professional satisfaction to the judges and all members of the Team.

America's juvenile and family courts address the problems facing our most vulnerable children and their families. Substance abuse may be the most pervasive of these problems, but in reality, each of these families faces many complex issues regarding numerous aspects of their lives. Hundreds of families come before our juvenile and family courts each day with a

myriad of problems.[150] Successful resolution of these problems will turn on the creative models our courts design for their responses, the collaboration they maintain with service providers, and the positive connections they can encourage between family members and others who share the desire to live healthy, sober, productive lives.

Our nation's juvenile and family courts weave the fabric of our society, giving protection, hope and opportunities to our most at-risk families, while at the same time holding them accountable for their behaviors. To the extent that juvenile and family courts can effectively address the problems facing substance-abusing families by turning to the FDTC process, these courts will continue to create and expand FDTCs. Given the stringent time limits required by federal law, FDTCs offer the possibility that substance-abusing parents can successfully address their treatment issues and have their children returned to their care within statutory time limits. FDTCs have become the most effective process available to the juvenile dependency court to achieve success in cases involving parental substance abuse. We urge our judicial colleagues to consider creating an FDTC in their jurisdiction.

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1 In this article, an FDTC does not include all civil drug courts, but only those that operate in the juvenile dependency court. Thus, a drug court in the Domestic Relations Court would not be considered an FDTC.

2 A Family Drug Treatment Court has been defined as "a drug court that deals with cases involving parental rights, in which an adult is the party litigant, which come before the court through either the criminal or civil process, and which arise out of the substance abuse of a parent." *Juvenile and Family Drug Courts: An Overview*, Office of Justice Programs Drug Court Clearinghouse and Technical Assistance Project. (1998), *available at* http://www.ncjrs.org/html/bja/jfdcoview/dcpojuv.pdf [hereinafter *Juvenile and Family Drug Courts*]; "A family dependency treatment court is a collaborative effort in which court, treatment and child welfare practitioners come together in a non-adversarial setting to conduct comprehensive child and parent needs assessments. With these assessments as a base, the team builds workable case plans that give parents a viable chance to achieve sobriety, provide a safe nurturing home, become responsible for themselves and their children, and hold their families together." *Family Dependency Treatment Courts: Addressing Child Abuse and Neglect Cases Using the Drug Court Model*, Bureau of Justice Assistance, December 2004, at 4 [hereinafter BJA-2004].

3 There are 132 FDTCs in the United States according to the most recent data. *Drug Court Activity Update*, Jan. 1, 2005, OJP Drug Court Clearinghouse, BJA Drug Court Clearinghouse, Justice Programs Office, School of Public Affairs, American University [hereinafter *Drug Court Activity*].

4 For information on the creation of the first FDTC, see Judge Charles M. McGee, *Another Permanency Perspective*, 48 JUVENILE AND FAMILY COURT JOURNAL 4, at 65-68, (1997).

5 *Drug Court Activity*, *supra* note 3.

6 In the preparation of this article, we consulted with other judges who operate FDTCs, but the opinions expressed herein are our own. We must confess that we and all judges operating these courts owe an enormous debt of gratitude to Judge Charles McGee (ret.) who created one of the first FDTCs, has written extensively about these courts, and inspired many others to start their own.

7 These courts are also referred to as Family Courts, Children's Courts, Child Protection Courts, and Abuse and Neglect Courts. We will use the term juvenile dependency courts throughout.

8 According to federal statutes, there are five possible permanent plans for children: return to a parent, adoption, guardianship, permanent placement with a fit and willing relative, or placement in another planned permanent living arrangement (in a foster home or in a group home). Return to a parent and adoption are the preferred permanent placements, while placement in another planned permanent living arrangement is an option only to be taken when the agency has documented a compelling reason that none of the other options would be in the child's best interest. The Adoption and Safe Families Act of 1997, 42 U.S.C.A. sections 675(5)(C) and 1305 [hereinafter ASFA].

9 The federal laws include the Child Abuse Prevention and Treatment Act of 1974 (CAPTA), 42 U.S.C. section 5103(b)(2)(G), The Adoption Assistance and Child Welfare Act of 1980 (AACWA), 42 U.S.C. section 670 et. seq., ASFA, Pub. L. No. 105-89, Sec. 103 Stat. 2115 (codified as amended in scattered sections of 42 U.S.C.), and the Indian Child Welfare Act (ICWA) Title 25, U.S.C. sections 1901-1963. Each state has its own statutes that implement the federal law and integrate it into existing state statutory schemes.

10 ASFA, *supra* note 8. In some states, the time for family reunification has been reduced to six months for children under three years of age at the time of the filing of legal proceedings. California Welfare and Institutions Code section 361.21(d), (West, St. Paul, 2005).

11 David Arredondo & Leonard Edwards, *Attachment, Bonding and Reciprocal Connectedness: Limitations of Attachment Theory in the Juvenile and Family Court*, 2 JOURNAL OF THE CENTER FOR FAMILIES, CHILDREN & THE COURTS, at 109-127, 113-114 (2000); Terry M. Levy & Michael Orlans, ATTACHMENT, TRAUMA, AND HEALING: UNDERSTANDING AND TREATING ATTACHMENT DISORDER IN CHILDREN AND FAMILIES 1 (Child Welfare League of America, 1998).

12 Foster care drift describes the situation of children lost in the child welfare system who move from foster home to foster home, from placement to placement, without ever achieving permanency. See Marsha Garrison, *Why Terminate Parental Rights?* 35 STANFORD LAW REVIEW 423 (1983).

13 This is no small task. There are over 3,000,000 reports of child abuse and neglect each year. NO SAFE HAVEN: CHILDREN OF SUBSTANCE ABUSING PARENTS 1 (National Center on Addiction and Substance Abuse, Columbia University, NY, 1999) [hereinafter NO SAFE HAVEN].

14 *Aggravated circumstances*, (National Conference of State Legislatures, August 1999), Retrieved Feb. 2, 2004 from http://www.ncsl.org/programs/cyf/aggravat.htm; California Welfare and Institutions Code section 361.5 (West, St. Paul, 2005).

15 For a more thorough description of the juvenile dependency process, refer to RESOURCE GUIDELINES: IMPROVING COURT PRACTICE IN CHILD ABUSE & NEGLECT CASES (National

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Council of Juvenile and Family Court Judges, 1995) [hereinafter RESOURCE GUIDELINES].

16 "…a large percentage of parents who abuse, neglect, or abandon their children have drug and alcohol problems…. Although national data are incomplete, it is estimated that substance abuse is a factor in three-fourths of all foster care placements." LINKING CHILD WELFARE AND SUBSTANCE ABUSE TREATMENT: A GUIDE FOR LEGISLATORS (National Conference of State Legislatures, 2000); Laura Feig, DRUG-EXPOSED INFANTS AND CHILDREN: SERVICE NEEDS AND POLICY QUESTIONS (U.S. Department of Health and Human Services, 1990); Kelly Kelleher et al., *Alcohol and Drug Disorders Among Physically Abusive and Neglectful Parents in a Community Based Sample*, 84 AMERICAN JOURNAL OF PUBLIC HEALTH, 1999, at 1586, 1588; Alcohol and Other Drugs Division, National Council of Juvenile and Family Court Judges, available at http://www.ncjfcj.org/content/view/256/352/; Norah Lovato & Kelly Mack, *Courts That Heal*, CHILDREN'S VOICE (Child Welfare League of America, 2003) available at http://cwla.org/articles/cv0303courts.htm at 1 [hereinafter *Courts That Heal*]; NO SAFE HAVEN, *supra* note 13, at 2; *Alcohol and Other Drug Survey of State Child Welfare Agencies*, (CWLA, 1997) available at www.cwla.org/programs/bhd/1997stateaodsurvey.htm [hereinafter *AOD Survey*]; José Ashford, *Treating Substance-Abusing Parents: A Study of the Pima County Family Drug Court Approach*, 55 JUVENILE AND FAMILY COURT JOURNAL, Fall 2004, at 27-37, 28.

17 "The national incidence for fetal alcohol syndrome is 1.9 per 1000 births. Each year, at least 1 in 10 or 375,000 babies born in the United States have been exposed to illegal drugs taken by their mother during pregnancy." Child Abuse and Neglect Statistics from the National Committee to Prevent Child Abuse, 1995, at 2; and see *FACTS: Substance Abuse and Child Welfare*, New York State Office of Alcoholism & Substance Abuse Services, available at http:/www.oasas.state.ny.us/pio/publications/fs22.htm; Peter Boylan, *Court Asked to Overturn Ruling*, HONOLULU ADVERTISER, July 6, 2005.

18 "Any judge, warden or other person involved in the criminal justice system will tell you the primary underlying reason for the incarceration of a majority of people is involvement with drugs or alcohol." McGee, *supra* note 4, at 65.

19 The Santa Clara County FDTC has been keeping data on its clientele for several years. These data show that 69.6% of the clients have domestic violence issues, 34.5% have mental health issues, and 58.5% have housing issues. On occasion, the FDTC team will conclude that "this is not a substance abuse case—this is all about domestic violence." Data on these and other issues relating to the client profiles are available from the authors.

20 We knew that we were not alone. National data reveal that most state child welfare agencies do not make it standard procedure to determine if substance abuse is present when investigating child maltreatment cases. NO SAFE HAVEN, *supra* note 13 at 2, 5, 31. We also knew that parents in these cases did not normally receive referrals for substance abuse treatment. NO SAFE HAVEN, *supra* note 13 at 5, 31; *AOD Survey*, *supra* note 16.

21 The ASFA timelines can be "an insurmountable barrier for addicted parents unable to enter treatment due to waiting lists, or for parents in treatment who relapse." *Family Drug Courts: An alternative approach to processing child abuse & neglect cases*, (Family Drug Practitioner Fact Sheet of the National Drug Court Institute, 1999).

22 "The first step is to ensure that all parents with allegations of alcohol/drug use receive a thorough standardized assessment (preferably onsite at the court ASAP)." Kathleen West, *Substance Abuse and Permanency Planning: Implementing ASFA When Parental Substance Abuse is a Factor*, 21-22, THE JUDGE'S PAGE, February 2005, available at http://www.nationalcasa.org/download/Judges_Page/0502_newsletter_0036.pdf; *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues, Treatment Improvement Protocol (TIP) Series*, (Center for Substance Abuse Treatment, U.S. Department of Health and Human Services, 2004), at xvii [hereinafter *Substance Abuse Treatment*].

23 This is often referred to as the Shelter Care Hearing or the Preliminary Protective Hearing. It usually takes place one or two days after removal of the child from parental care. See RESOURCE GUIDELINES, *supra* note 15, at 29-44. In some FDTCs, the court accepts clients whose children have not been the subject of formal state intervention; conversation with Judge John Beliveau from Lewiston, Maine. Clearly, the difficulties with ASFA would not occur in cases in which no legal proceedings have been initiated.

24 Each of our FDTCs has written a Mission Statement. They are available from the authors. Other Mission Statements are available from the NCJFCJ where the Permanency Planning for Children Department has created a clearinghouse of information concerning FDTCs. Contact the NCJFCJ's PPCD at (775) 784-5300 or the Alcohol and Other Drugs Division at (775) 784-8078.

25 "I believe that implementation of a redemptive type of justice system for drug addicts who are parents has staggering potential." McGee, *supra* note 4 at 65; "Goals of family drug courts…include helping the parent to become emotionally, financially, and personally self-sufficient and to develop parenting and 'coping' skills adequate for serving as an effective parent on a day-to-day basis." *Juvenile and Family Drug Courts*, *supra* note 2, at 5.

26 As late as 2001, the average length of time a child remained in foster care was 33 months. THE AFCARS REPORT, (Children's Bureau, U.S. Department of Health & Human Services 2003), available at www.acf.hhs.gov/programs/

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cb/publications/afcars/report8.htm; M. Corrigan, *Delays Deny Justice to Foster Care Kids*, Detroit Free Press, May 25, 2005; *Foster Care National Statistics*, at 4 (National Clearinghouse on Child Abuse and Neglect Information, National Adoption Information Clearinghouse, June 2003); Fostering the Future: Safety, Permanence and Well-Being for Children in Foster Care, at 12 (The Pew Commission on Children in Foster Care, 2004).

27 James Milliken & Gina Rippel, Dealing With Our #1 Problem in Dependency Cases: Parental Substance Abuse, (2005, available from authors); James Milliken, The Dependency Court Recovery Project—A Joint Project of the Superior Court and the County of San Diego, (March 2001—copy on file with the San Diego Juvenile Court and available from the authors); and see, generally, Ashford, *supra* note 16.

28 C.W. Huddleston, K. Freeman-Wilson, & D. Boone, *Painting the Current Picture: A National Report Card on Drug Courts and Other Problem Solving Court Programs in the United States*, May 2004, at 2 (National Drug Court Institute); Adult Drug Courts: Evidence Indicates Recidivism Reductions and Mixed Results for Other Outcomes, (U.S. Government Accountability Office, February 2005), available at www.gao.gov/new.items/d05219.pdf; S. Belenko, N. Patapis, & M. French, *Economic Benefits of Drug Treatment: A Critical Review of the Evidence for Policy Makers*, (Treatment Research Institute, University of Pennsylvania, February 2005); *California Drug Courts Save Millions*, Guardian Unlimited, April 16, 2003.

29 For an analysis of foster care savings resulting from reducing a child's time in foster care by implementing improved court procedures and policies, see Gregory Halemba, Gene Siegel, Rachael Gunn, & Susanna Zawacki, *The Impact of Model Court Reform in Arizona on the Processing of Child Abuse and Neglect Cases*, 53 Juvenile & Family Court Journal, Summer 2002, at 1-20, 17.

30 James R. Milliken, Healing Dysfunctional Dependency Courts: An Overview, (copy available from the author). In San Diego County, for example, from April 1998 to July 2002, the average time from the assumption of jurisdiction to a permanent placement plan was 16.2 months and the average time to reunification was 8.8 months. These figures compared favorably to the previous time of 45.7 months to permanency prior to the Project. James Milliken & Gina Rippel, *Effective Management of Parental Substance Abuse in Dependency Cases*, 5 Journal of the Center for Families, Children & the Courts, 2004, at 95-107.

31 D. Crumpton, S. Worcel, & M. Finigan, *Analysis of Foster Care Costs from the Family Treatment Drug Court Retrospective Study – San Diego County, California* (NPC Research, 2003). Available from the San Diego County Juvenile Court and from the authors. See also Milliken & Rippel, *id*.

32 See Section VII of this article, page 16.

33 As of December 2003, there were 1,667 problem-solving courts including 666 adult drug courts, 268 juvenile drug courts, and 112 FDTCs. Huddleston et al., *supra* note 28 at 9. For a full description of problem-solving courts, see G. Berman & J. Feinblatt, Good Courts, (The New Press, 2005).

34 Court Improvement programs were started as a result of federal legislation. The Family Preservation and Support Act (Omnibus Budget Reconciliation Act of 1993, P.L. 103-66) provided for limited federal monies to be distributed to each state in order to improve the operation of juvenile dependency courts. Although the grants to each state were relatively modest, court improvement efforts have resulted in remarkable changes in juvenile dependency courts across the country. *See Court Improvement Progress Report: 2004*, (American Bar Association, Child Welfare Court Improvement, National Child Welfare Resource Center on Legal and Judicial Issues, 2004).

35 The Model Courts Project is formally called "Improving the Juvenile and Family Courts' Handling of Child Abuse and Neglect Cases: A Model Training and Technical Assistance Program Development Project." Currently, the Model Courts Project has identified 28 courts nationwide and works with them to improve practice in juvenile dependency cases. Both Lucas and Santa Clara counties are Model Court sites. See *Model Courts: Improving Outcomes for Abused and Neglected Children and Their Families*, January 2004, (National Council of Juvenile and Family Court Judges).

36 On the history of criminal drug treatment courts, see P. Hora, W. Schma, & J. Rosenthal, *Therapeutic Jurisprudence and the Drug Treatment Court Movement: Revolutionizing the Criminal Justice System's Response to Drug Abuse and Crime in America*, Notre Dame Law Review, January 1999, 1-85, 7.

37 In Santa Clara County, a visit to the criminal drug court persuaded the juvenile court judge of the necessity of a FDTC. He discovered that the criminal drug court was much slower than the juvenile court process. Two mothers who had already lost their children permanently to the child protection system were graduating from the criminal drug court. Clearly, this was not the kind of success that the justice system should applaud. See Leonard Edwards, *Santa Clara County Dependency Drug Treatment Court*, 33 Journal of Psychoactive Drugs, Oct.-Dec. 2001, also found in B.J. Winick & D.B. Wexler (eds.) Judging in a Therapeutic Key: Therapeutic Jurisprudence and the Courts, (Carolina Academic Press, 2003), at 39-42, and Juvenile and Family Justice Today, Summer 2001, at 16-17.

38 Huddleston et al., *supra* note 28 at 5; and see Principles of Drug Addiction Treatment, National Institute on Drug Abuse, NIH Publication No. 99-4180, at first four pages [hereinafter Principles of Drug Addiction].

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39 Judge Charles McGee & Caroline Cooper, *Shipping Oars and Going to Sails: The First Ten Years of Dependency Drug Courts*, THE JUDGES' PAGE, at 3, available at http://www.ncjfcj.org/publications/JMdrugcourtarticle.pdf.

40 *Id.*

41 ASFA, *supra* note 8; on whether it is possible to reunify safely with a substance-abusing parent within ASFA timelines, see J. Larsen & C. Lederman, *Drug-Exposed Infants and the Miami Criteria for Judicial Decisions in Dependency Cases*, INTERNATIONAL JOURNAL OF LAW, POLICY AND THE FAMILY, Oxford U. Press, 2000, at 86-106.

42 ASFA requires the judge to make reasonable efforts findings regarding the agency's actions to ensure that a child reaches timely permanency.
"(C) if continuation of reasonable efforts of the type described in subparagraph (B) is determined to be inconsistent with the permanency plan for the child, reasonable efforts shall be made to place the child in a timely manner in accordance with the permanency plan…" ASFA, *supra* note 8, Section 101(a)(C).

43 Edwards, *supra* note 37.

44 "With the success I had seen in the general jurisdiction drug court, where the potential sanction was imprisonment, I felt there would be even greater success where the potential consequence of failure was loss of one's children. I have found this thought borne out time and time again; with appropriate support and services, most parents will do anything they can to get their children back." McGee, *supra* note 4 at 65-66.

45 Nationally, as of 2001, 87% of FDTC graduates were women and 13% were men. Caroline Cooper, *Viewing Family Drug Courts from a National Perspective*, JUVENILE AND FAMILY JUSTICE TODAY, Summer 2001, at 19. Some FDTCs are operated exclusively for women including the District of Columbia and Jackson County (Kansas City), Missouri. *See* Judge Anita Josey-Herring & Jo-Ella Brooks, *District of Columbia Family Treatment Court Partners with CASA Program*, THE JUDGES' PAGE, available at http://www.nationalcasa.org/download/Judges_Page/0502_newsletter_0036.pdf; *see* also BJA-2004, *supra* note 2 at 29.

46 D.L. Haller & D.R. Miles, *Personality Disturbances in Drug-Dependent Women: Relationship to Childhood Abuse*, 30 AMERICAN JOURNAL OF DRUG AND ALCOHOL ABUSE, 2004, at 269-86; A.S. Landheim, K. Bakken, & P. Vaglum, *Gender Differences in the Prevalence of Symptom Disorders and Personality Disorders Among Poly-Substance Abusers and Pure Alcoholics*, 9 EUROPEAN ADDICTION RES., 2003, at 8-17.

47 Lisa Najavits, *Numbing the Pain: The Link Between Trauma, Posttraumatic Stress Disorder, and Substance Abuse*, 5 COUNSELOR MAGAZINE, THE MAGAZINE FOR ADDICTION PROFESSIONALS, 2004, at 12-17, available at http://www.professionalcounselor.com/pfv.asp?aid=oct04PTSDSUD.htm; "…research indicates that up to 70 percent of drug abusing women report histories of physical and sexual abuse." *NIDA InfoFacts: Treatment Methods for Women*, available at http://www.drugabuse.gov/Infofacts/TreatWomen.html (National Institute on Drug Abuse); Patrick Zickler, *Childhood Sex Abuse Increases Risk for Drug Dependence in Adult Women*, 17 NIDA NOTES 1, available at http://www.drugabuse.gov/NIDA_Notes/NNVol17N1/Childhood.html.

48 U. S. Department of Health and Human Services (2002), *Mental Health: A Report of the Surgeon General*, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health; *Understanding Substance Abuse and Facilitating Recovery: A Guide for Child Welfare Workers*, (U.S. Department of Health and Human Services, 2005) [hereinafter *Understanding Substance Abuse*]; *Blending Perspectives and Building Common Ground: A Report to Congress on Substance Abuse and Child Protection*, (Department of Health and Human Services, April 1999), Chapter 5, 1-2 [hereinafter *Blending Perspectives*].

49 S.L. Martin & L.L. Kupper, *Substance Use Before and During Pregnancy: Links to Intimate Partner Violence*, 29 AMERICAN JOURNAL OF DRUG AND ALCOHOL ABUSE, August 2003, at 599-617; M. Tuten & H.E. Jones, *A Partner's Drug-Using Status Impacts Women's Drug Treatment Outcome*, 70 DRUG ALCOHOL DEPENDENCY, June 2003, at 327-330; *Parenting Issues for Women with Co-Occurring Mental Health and Substance Abuse Disorders Who Have Histories of Trauma*. (Coordinating Center, SAMHSA Women, Co-Occurring Disorders and Violence Study), available at http://www.prainc.com/wcdvs/pdfs/Fact%20Sheets/Other%20Fact%20Sheets/Parenting%20Fact%20Sheet%20Final.pdf [hereinafter *Parenting Issues for Women*].

50 Glen Hanson, *In Drug Abuse, Gender Matters*, 17 NIDA NOTES 2, 2002, available at http://www.drugabuse.gov/NIDA_Notes/NNVol17N2/DirRepVol17N2.html; *Intensive Outpatient Treatment for Alcohol and Other Drugs Abuse, Treatment Improvement Protocol (TIP) Series 8, Chapter 5: The Treatment Needs of Special Groups*, NCADI, available at http://www.health.org/govpubs/bkd139/8g.aspx; *NIDA InfoFacts: Treatment Methods for Women*, NIDA, available at: http://www.nida.nih.gov/infofacts/treatmentwomen.html; *Substance Abuse Treatment*, *supra* note 22 at 122.

51 West, *supra* note 22, at 21; the discovery that women have specific treatment service needs than men is a recent development. Prior to the 1970s, research did not focus on issues specific to women. Andrea Barthwell, *Treatment of Women*, (Presentation at National Conference on Drug Addiction Treatment: From Research to Practice, National

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Institute on Drug Abuse), available at http://www.drugabuse.gov/MeetSum/TX/TXinfo3.html.

52 "…true recovery for a mother usually works only when it includes her children." Norma Finkelstein, Ph.D., quoted in *Parenting Issues for Women*, *supra* note 49 at 1; R. Mathias, *NIDA Expands Its Research on Addition and Women's Health*, 10 NIDA NOTES 1, Jan./Feb. 1995; S. Blumenthal, *Women and Substance Abuse: A New National Focus*, (U.S. Department of Health and Human Services, Office of Women's Health); R. Mathias, *Mental Health Problems of Addicted Mothers Linked to Infant Care Development*, 12 NIDA NOTES 1, Jan./Feb. 1997; L. Beckman & H. Amaro, *Patterns of Women's Use of Alcohol Treatment Agencies*, in ALCOHOL PROBLEMS IN WOMEN, 319-348 (S. Wilsnack & L. Beckman, eds., Guilford Press, 1984) [hereinafter ALCOHOL PROBLEMS IN WOMEN].

53 S. Stocker, *Men and Women in Drug Abuse Treatment Relapse at Different Rates and for Different Reasons*, 113 NIDA NOTES 4, Nov. 1998; M. Vanicelli, *Treatment Outcome of Alcoholic Women: The State of the Art in Relation to Sex Bias and Expectancy Efforts*, in ALCOHOL PROBLEMS IN WOMEN, *supra* note 52 at 369-412; *Understanding Substance Abuse*, *supra* note 48 at 19.

54 As one domestic violence expert stated, "Mixing men and women in treatment groups will reduce the effectiveness of the treatment. There are several compelling reasons to have gender based interventions. In our FDTC, 75-80% of clients have been victims of domestic violence in at least one relationship. Any conjoint services prior to both parties completing domestic violence education/therapy programs potentially can increase the power and control tactics, including violence. Women who have been victims of domestic violence can be easily triggered for flashbacks and for relapse, by comments, facial expressions and voice tones of other perpetrators they have contact with even if they have no previous history with those individuals. There are also socialization differences between men and women which mixed gender groups are not able to address as effectively as gender based group." Nancy Marshall, M.S., L.M.F.T, to one of the authors in June 2005; See also, *Understanding Substance Abuse*, *supra* note 48 at 19.

55 "Women in women-only drug abuse treatment programs were more than twice as likely to complete treatment as women in mixed-gender programs." C. Grella, *UCLA Study Looks at Women in Treatment*, 14 NIDA RESEARCH FINDINGS 6, March 2000.

56 For example, the Santa Clara County FDTC includes a public health nurse, a mental health expert, and a domestic violence expert. See A. Somervell, C. Saylor, & C. Mao, *Public Health Interventions for Women in a Dependency Drug Court*, 22 PUBLIC HEALTH NURSING 1, at 59-64 (discussing the Santa Clara County FDTC from a public health nursing perspective). On the need for mental health participation, see R. Rawson, R. Gonzales, & P. Brethen, *Treatment of Methamphetamine Use Disorders: An Update*, 23 JOURNAL OF SUBSTANCE ABUSE TREATMENT, 2002, at 145-150, 147.

57 Center for Substance Abuse Treatment, U.S. Health and Human Services, *Practical Approaches to the Treatment of Women Who Abuse Alcohol and Other Drugs*, (1994); P. Budetti & M. Haack, *An Analysis of Resources to Aid Drug-Exposed Infants and their Families*, George Washington U., (1993); C.M. McGee, J. Parham, T.T. Merrigan, & M. Smith, *Applying Drug Court Concepts in the Juvenile and Family Court Environment: A Primer for Judges*, at 2, (C. S. Cooper ed., prepared by American University for State Justice Institute, Washington, D.C., 1997).

58 McGee & Cooper, *supra* note 39 at 4.

59 Leonard Edwards, *The Juvenile Court and the Role of the Juvenile Court Judge*, 43 JUVENILE AND FAMILY COURT JOURNAL 2, 1992, at 25-32; Standard of Judicial Administration 24, California Judicial Council, (West, 2005) [hereinafter SJA 24]; it has not been the traditional role of the criminal or civil court judge. See G. Berman, *What is a Traditional Judge, Anyways*, 84 JUDICATURE 2, 2000, at 78-85.

60 See generally, Edwards, *id.*, at 26-27; for more on problem-solving courts, see Berman & Feinblatt, *supra* note 33, at 31-58; see http://www.ncsconline.org/D_Research/Problem-Solving.html and http://www.ncsconline.org/WC/Education/KIS_ProSolRefLstGuide.pdf and links contained therein.

61 "Juvenile court judges are encouraged to…[2] Investigate and determine the availability of specific prevention, intervention and treatment services in the community for at-risk children and their families; and [3] exercise their authority by statute or rule to review, order and enforce the delivery of specific services and treatment for children at risk and their families." SJA 24, *supra* note 59 at subsection (e).

62 S. Inada, *How to Start A Family Drug Court: Advice From Judge James R. Milliken*, 18 CHILD LAW PRACTICE 1, at 10; D. Marlowe, D. Festinger, & P. Lee, *The Judge is a Key Component of Drug Court*, 4 DRUG COURT REVIEW 2, at 1-34, 25.

63 Holding these administrative meetings has been identified as a best practice. See Leonard Edwards, *Improving Implementation of the Federal Adoption Assistance and Child Welfare Act of 1980*, 45 JUVENILE AND FAMILY COURT JOURNAL 3, 1994, at 3-28, 18; M. Hardin, H.T. Rubin, & D. Baker, *A Second Court That Works: Judicial Implementation of Permanency Planning Reforms*, at 39, (ABA Center on Children and the Law, 1995); Leonard Edwards, *Improving Juvenile Dependency Courts: Twenty-Three Steps*, 48 JUVENILE AND FAMILY COURT JOURNAL 4, 1997, 1-23 at 9-10.

64 Judges can contact the National Center on Substance Abuse and Child Welfare, NCJFCJ's Permanency Planning for Children Department, (775) 784-6012; also the

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National Institute of Drug Court Professionals or Caroline S. Cooper, Director of the BJA Drug Court Clearinghouse, Justice Programs Office, School of Public Affairs, American University (202) 885-2875, http://spa.american.edu/justice/drugcourts.php; National Institute on Drug Abuse (NIDA) at http://www.nida.nih.gov; Center for Substance Abuse Treatment (CSAT) at http://csat.samhsa.gov/; and the National Drug Court Institute, http://www.ndci.org/.

65 A copy of a video of the Santa Clara County FDTC is available from the authors.

66 *Building a Better Collaboration: Facilitating Change in the Court and Child Welfare System*, 8 TECHNICAL ASSISTANCE BULLETIN 2, (National Council of Juvenile and Family Court Judges, April 2004) [hereinafter *Building a Better Collaboration*]; Greg Berman & John Feinblatt, *Problem-Solving Courts: A Brief Primer*, 23 LAW AND POLICY 2, 2001, also available at www.courtinnovation.org.

67 *Id.*

68 *Id.*, and for a detailed discussion of the role of the juvenile court judge in building a collaboration, see *Building a Better Collaboration*, *supra* note 66.

69 *In Support of Problem Solving Courts*, Conference of Chief Justices CCJ Resolution 22 and Conference of State Court Administrators, COSCA Resolution 4, Adopted August 3, 2000.

70 The Team in our jurisdictions includes the judicial officer (two in Lucas County), representatives from the Department, CASA, attorneys for parents, attorneys for the Department, attorneys/guardians *ad litem* for children, a public health nurse (Santa Clara County), a mental health expert (Santa Clara County), a domestic violence expert (Santa Clara County), an employment specialist (Lucas and Santa Clara counties), and a housing expert. Others may come and participate in the drug court activities on an as-needed basis.

71 Edwards, *Improving Implementation*, *supra* note 63 at 11.

72 *Id.*; and see BJA-2004, *supra* note 2, at 27.

73 "The law requires that we provide reasonable services. The Court has the authority to order services and must do so or parents will not get access to treatment and children will remain in foster care." Judge James Milliken, in S. Inada, *How to Start a Family Drug Court*, 18 CHILD LAW PRACTICE 1, at 10-12, 11.

74 See the references and text at notes 45-55, *supra*.

75 Edwards, *Improving Juvenile Dependency Courts, supra* note 63 at 9-10.

76 *Blending Perspectives*, *supra* note 48, Introduction, at 2.

77 For a discussion on the "reasonable efforts" requirement, see Edwards, *Improving Implementation*, *supra* note 63 at 19-21.

78 Collaboration between child welfare agencies and substance abuse treatment providers has been difficult in many jurisdictions. See *Blending Perspectives*, *supra* note 48 at 4.

79 BJA-2004, *supra* note 2, at 24-25.

80 In California, Judge Stephen Manley, one of the leaders in the adult drug court movement, was instrumental in securing state funding to support the creation and expansion of FDTCs in the state. Building on the success of adult drug courts in California, Judge Manley argued persuasively to the California State Legislature that FDTCs will be as effective as adult drug courts and will save the state foster care dollars.

81 For example, technical assistance is available from The Drug Court Planning Initiative, *Family Dependency Treatment Court Skills-Based Training Program*, Bureau of Justice Assistance and OJJDP, OJP, U.S. Department of Justice in collaboration with the National Criminal Justice Reference Service and the National Association of Drug Court Professionals. Additional technical assistance is available from the National Council of Juvenile and Family Court Judges, www.ncjfcj.org; see also M. Wheeler & J. Siegerist, *Family Dependency Court Planning Initiative Training Curricula*, (National Drug Court Institute, 2003). See also the organizations and technical assistance resources mentioned in note 64.

82 This was a particularly challenging issue for both of our FDTCs. The confidentiality laws for substance abuse treatment providers are different from the laws governing confidentiality of child welfare agency records, and the juvenile court's confidentiality laws are different from both of those. Additionally, the attorneys have their own confidential relationships with their clients. We worked through all of this carefully and now believe that a start-up court will be able to adopt policies and procedures that ensure the flow of necessary information without violating any of these laws. See further discussion *supra* at Section III, C 13.

83 Upon request, the authors can provide copies of the MOUs developed in their jurisdictions.

84 OJJDP and SAMHSA have offered grant funding for start-up and enhancement of FDTCs. See http://ojjdp.ncjrs.org/funding/funding.html.

85 This is a composite sketch of the workings of a "typical" FDTC. Variations exist regarding almost every structural and operational detail, but this sketch attempts to capture a general picture of the FDTC.

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86 The substance abuse assessment is a critical first step. Without an accurate assessment, the treatment plan may not be sufficient to ensure recovery. Both of our jurisdictions rely on substance abuse experts and not upon social workers to complete the assessment. Additionally, the sooner the assessment is complete, the sooner the treatment can begin. For this reason, attorneys for parents often have their clients complete the assessment before the court has reached the jurisdictional stage of the legal proceedings. San Diego County uses a similar assessment protocol through the Substance Abuse Recovery Management System (SARMS). See Milliken & Rippel, *supra* note 30 at 99.

87 The Team usually consists of one or two judicial officers, a coordinator, substance abuse treatment providers, one or more representative from the Department, and attorneys for the parent, the social workers, and the child. See BJA-2004, *supra* note 2 at 32-34. The Santa Clara County FDTC team has never had a coordinator. The Lucas County Team does have a coordinator as do most FDTCs we are aware of. For the other members of each team, see note 70 *supra*.

88 Copies of the Santa Clara and Lucas County client agreements are available from the authors.

89 San Diego and Santa Clara counties in California are examples of this model.

90 Washoe County, Nevada, is an example of this model.

91 Lucas County utilizes two judges to hear the FDTC.

92 The District of Columbia and Jackson County, Missouri, are two examples.

93 See the references to "aggravated circumstances" *supra* at note 14.

94 Copies of the contracts for Santa Clara and Lucas counties are available from the authors.

95 The outpatient/inpatient treatment decision is one of the most important that the FDTC Team must make. Research indicates that inpatient treatment may be necessary for a successful outcome particularly in clients who are methamphetamine users. Rawson et al., *supra* note 56, at 147.

96 A strategy that one of us has used is to invite the boyfriend to come to the FDTC and talk with him about the situation facing the mother. The court will ask if he considers himself to be an important person in the mother's life and in the child's life. If he says "yes," the court explains that he may have a significant impact on the outcome of the child welfare proceeding. The court will state that if he is using drugs or is being violent toward the mother, it is unlikely that the child would be returned to that environment. The court then asks whether he would be willing to engage in services that would demonstrate to the court that he can be a safe parent figure. The court may also explain that the court is ordering the mother to live in a sober living environment (SLE) and ask for his support of this plan. This approach has been successful in the majority of cases in which it has been employed. Judge James Milliken (ret.) has also written in a similar vein about the issue of boyfriends/girlfriends. See Inada, *supra* note 73 at 12.

97 In this regard, Santa Clara County adopted a modification of the San Diego model. In San Diego County, every parent with substance abuse issues is assessed by the treatment experts (SARMS), and their progress is reviewed by the judicial officer on a regular basis. If the client relapses or fails to follow the treatment plan, the case may be referred to the Presiding Judge for sanctions, including jail. For a more complete description of the San Diego Recovery Project, see the articles in notes 30, 31, and 73, *supra*.

98 McGee, *supra* note 4, at 66; G. Sosa-Lintner, *New York City's Family Treatment Court*, JUVENILE AND FAMILY JUSTICE TODAY, Summer 2001, at 22; *Program Manual*, at 4, (Erie County Family Court, Family Treatment Court, 2001), available from the Erie County (New York) Family Court, or from the authors.

99 C. Cooper, *Use of Jail Sanctions in Family Drug Courts, Frequently Asked Questions*, (BJA Drug Court Clearinghouse, 2005); BJA-2004, *supra* note 2 at 20.

100 T. Maugh & D. Anglin, *Court Ordered Drug Treatment Does Work*, THE JUDGE'S JOURNAL, Winter 1994, at 10; S. Satel, *Drug Treatment: The Case for Coercion*, 3 NATIONAL DRUG COURT INSTITUTE REVIEW 1, at 1-9 (both of these articles refer to criminal drug courts).

101 The San Diego and San Joaquin FDTCs in California, Suffolk County in New York, Escambia County (Pensacola) and Miami-Dade in Florida, Lucas County in Ohio, and the Washoe County, Nevada, FDTCs all utilize jail as a sanction.

102 In re Olivia J. (2004); 124 Cal.App.4th 698, 21 Cal. Rptr.3rd 506 [The California Supreme Court has granted review in this case].

103 Santa Clara County, California, Manhattan Treatment Court in New York City, and Jackson County, Missouri, do not utilize jail as a sanction, and the Presiding Judge of the newly created FDTC in Omaha, Nebraska, announced at the opening ceremony that jail will not be used as a sanction except in rare cases. (Remarks of Judge Douglas F. Johnson, Douglas County Family Drug Treatment Court, Omaha, Nebraska, May 26, 2005, available from the author and from Judge Johnson); *Nebraska's Courts Celebrate May as National Drug Court Month With Proclamation Signing by Chief Justice at the Opening of the First Family Drug Treatment Court in Omaha*, (Office of Public Information, Nebraska Supreme Court, May 24, 2005).

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104 This is the position taken in Jackson County (Kansas City), Missouri. See BJA-2004 *supra* note 2 at 20.

105 Ashford, op. cit. note 16 at 30. The list of sanctions for the parents in the Suffolk County FDTC can be found at BJA-2004, *supra* note 2 at 21.

106 In Santa Clara County, the judge presides over both the dependency calendar and the FDTC. However, if there is a contested issue (whether the child should be returned home or whether services should be terminated), a different judge will hear the case.

107 The Pima County FDTC is a separate calendar from the dependency calendar. The FDTC judge provides oversight of treatment progress, not of the dependency case. Ashford, *supra* note 16 at 29.

108 42 U.S.C. section 671(a)(8) (2001); Leonard Edwards, *Confidentiality and the Juvenile and Family Courts*, 55 JUVENILE AND FAMILY COURT JOURNAL, Winter 2004, at 1-25.

109 42 U.S.C. section 290dd-2 (2001); 42 C.F.R. section 2.1 (2001).

110 For a more complete discussion of the confidentiality issue in FDTCs, see C. Lu, *Family Drug Court: An Alternative Answer*, 21 CHILDREN'S LEGAL RIGHTS JOURNAL Spring 2001, at 32, 28; *Substance Abuse Treatment*, *supra* note 22 at 151-163.

111 "It is essential that each case plan be individualized and that all services be provided to deal with all problems facing the family." McGee, *supra* note 4 at 66.

112 The evaluative data show that participation in the FDTC increases the number of treatment episodes as well as the probability of successful family reunification. (see Section VII, pages 16-17).

113 Experiences in other disciplines confirm the conclusion that personalizing the professional-client relationship increases client compliance with professional advice. In medicine, personalizing the doctor-client relationship results in higher compliance with medical instructions. E. Sellers, H. Cappell, & J. Marshman, *Compliance in the Control of Alcohol Abuse*, in COMPLIANCE IN HEALTH CARE, chapter 14 (R.B. Haynes, D.W. Taylor, & D. Sackett eds., The Johns Hopkins University Press, 1979); D. Falvo, EFFECTIVE PATIENT EDUCATION: A GUIDE TO INCREASED COMPLIANCE, 2-3, 7, 18-22, 65, 128-134, 175-182 (Aspen, 1985). The development of a positive relationship between a social worker and a parent in treatment also results in better compliance with the program expectations and a reduction in the likelihood of future child abuse or neglect. J. Littell, *Client Participation and Outcomes of Intensive Family Preservation Services*, 25 SOCIAL WORK RESEARCH 2; J. Altman, *A Qualitative Examination of Client Participation in Agency-Initiated Services*, 84 FAMILIES IN SOCIETY: THE JOURNAL OF CONTEMPORARY HUMAN SERVICES 4, at 471-479. In the school setting, studies show students with caring and supportive relationships in the school environment report more positive academic attitudes and values and more satisfaction with school. These students also are more engaged academically. A. Klem & J. Connell, *Relationships Matter: Linking Teacher Support to Student Engagement and Achievement*, 74 JOURNAL OF SCHOOL HEALTH, Sept. 2004, at 262.

114 AACWA, CAPTA, and ASFA, and state laws implementing these statutes, *supra* note 9.

115 E. Pyle, *Addicts Can Change When Someone Cares, Judges Say*, THE COLUMBUS DISPATCH, June 2, 2002, News 01B.

116 Inger Sagatun-Edwards & Coleen Saylor, *A Coordinated Approach to Improving Outcomes for Substance-Abusing Families in Juvenile Dependency Court*, 51 JUVENILE AND FAMILY COURT JOURNAL, Fall 2000, at 1-16, 14.

117 "'[T]eamwork' is the hallmark of the Family Drug Court," McGee, *supra* note 4 at 67.

118 S. Lafferty, *Experience Invaluable in Making Mothers See the Light*, THE RECORDER (San Jose, CA), Oct. 10, 2000; *'Mentor Moms' Voted Best New Model Court Idea*, JUVENILE AND FAMILY JUSTICE TODAY, Fall 2000, at 18.

119 For further information on Mentor Moms, contact Gary Proctor, (408) 442-0442.

120 *Understanding Substance Abuse*, *supra* note 48, at 19.

121 Charles McGee, *The Washoe County (Reno) Family Drug Court*, JUVENILE AND FAMILY JUSTICE TODAY, Summer 2001, at 21.

122 Judge Charles McGee, quoted in *Courts That Heal*, *supra* note 16 at 2; for further information about the Foster Grandparent Program, write to Foster Grandparent Program, 1552 C Street, Sparks, NV 89431 or call (775) 358-2768.

123 T. Tisch, *Celebrating Families: An Innovative Approach for Working With Substance Abusing Families*, 14 THE SOURCE 1, 6-10, (The National Abandoned Infants Assistance Resource Center). For further information, contact Rosemary Tisch, PPI Director at (408) 406-0467 or Deborah Dohse, MSW, (408) 975-5174.

124 *Understanding Substance Abuse*, *supra* note 48 at 14.

125 For further information, contact Social Worker Supervisor Joyce McEwen Crawford at Joyce.McEwen-Crawford@ssa.sccgov.org.

126 Leonard Edwards, Ernestine Gray, & J. Dean Lewis, *The Judicial Role in Creating and Supporting CASA/GAL*

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Programs, JUVENILE AND FAMILY JUSTICE TODAY, Spring 2005 at 16-19, 17.

127 For a summary of some of the FDTCs that utilize CASA volunteers, see *The Impact of Parental Substance Abuse in Dependency Cases*, THE JUDGES' PAGE, February 2005, available at http://www.nationalcasa.org/download/Judges_Page/0502_newsletter_0036.pdf; "A CASA worker assigned to the participant can make the difference needed for success." McGee, *supra* note 4 at 67.

128 Josey-Herring & Brooks, *supra* note 45.

129 CASA stands for Court Appointed Special Advocate. In Santa Clara County, the CASA program is called the Child Advocate Program.

130 For further information about the Dependency Drug Treatment Court Pilot, contact Melissa Santos at Melissa@cadvocates.org.

131 See Mentor Moms Program, section V-A, pages 13-14.

132 Rainbow Houses are another model deserving attention. Working with the Santa Clara County Department of Alcohol and Drug Services (DADS), Nancy Wilson, an enterprising woman, has created a network of homes for substance-abusing women in the county. With five converted houses and a capacity of 50 beds, Rainbow Houses offer a sober living environment for FDTC clients and their children for up to one year. Typically the client will enter a Rainbow House alone, and as she progresses, her children will be returned to her care. The Rainbow Houses include a number of services for clients and graduates. For further information, contact Nancy Wilson at Rainbow Recovery Foundation, Inc, 2147 Lincoln Avenue, San Jose, CA 95125, nwilson@rainbowrecovery.org; on the importance of housing for women, see *Substance Abuse Treatment*, *supra* note 22 at 85.

133 In addition to AA and NA, the clients may go to Cocaine Anonymous (CA), Marijuana Anonymous (MA) and similar groups. All use a form of the 12 steps and sponsors to address addiction. It is usually required that the client obtain and work with a sponsor. In Santa Clara County, the FDTC also accepts Health Realization as a substitute for AA/NA.

134 Examples include the FDTCs in Florida's Escambia County and Miami-Dade, and the Manhattan Family Treatment Court in New York City.

135 See *Principles of Drug Addiction Treatment*, *supra* note 38; Berman & Feinblatt, *supra* note 33 at 155-158.

136 There are four sites involved in this five-year study: Washoe County (Reno), Nevada; Santa Clara County (San Jose), California; San Diego, California; and Suffolk County, New York.

137 *Draft Interim Report—Family Treatment Drug Court Retrospective Outcome Evaluation Update II, Santa Clara County*, at p. II (NPC Research, Portland, Oregon, September 2004); Rawson et al., *supra* note 56 at 149.

138 *Id.*

139 N. Young, *Findings from the retrospective phase family drug court national cross-site evaluation*, (presented at the National Association of Drug Court Professionals 4th Annual Conference in Washington, D.C., 2003).

140 Cooper, *supra* note 45 at 20; see also Ashford, *supra* note 16 at 33.

141 Cooper, *supra* note 45.

142 See Section I-D, page 3.

143 C.W. Huddleston, K. Freeman-Wilson, D. Marlowe, & A. Roussell, *Painting the Current Picture: A National Report Card on Drug Courts and Other Problem Solving Court Programs in the United States*, May 2005, at 8-9 (National Drug Court Institute).

144 For further information, contact Northwest Professional Consortium, Inc., 4380 SW Macadam Ave., Suite 530, Portland, Oregon 97239.

145 See notes 64 and 81.

146 *Drug Court Activity*, *supra* note 3.

147 See note 65 *supra*, regarding the Santa Clara County drug court video.

148 There are 153 FDTCs in the United States according to the most recent data. Huddleston et al., *supra* note 143 at 3.

149 *Substance Abuse Treatment for Women*, November 2004, (United Nations, Office on Drugs and Crime, V.04-53297).

150 Leonard Edwards, *President's Message*, JUVENILE AND FAMILY JUSTICE TODAY, Summer 2003, at 3; Leonard Edwards, *Remarks of Leonard P. Edwards on the Occasion of William H. Rehnquist Awards Presentation—November 18, 2004*, 56 JUVENILE AND FAMILY COURT JOURNAL, Winter 2005, at 45-51, 46.

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Drug Court Practitioner

Fact Sheet

Family Dependency Treatment Court: [1] Applying the Drug Court Model in Child Maltreatment Cases [2]

By Meghan M. Wheeler, M.S. and Carson L. Fox, Jr., J.D.

Introduction

A number of family courts [3] across the nation are successfully applying the drug court model to child welfare cases that involve an allegation of child abuse or neglect related to substance abuse. "Family Drug Courts" or "Family Dependency Treatment Courts" (FDTC), which began in Reno, Nevada, in 1995, seek to do what is in the best interest of the family by providing a safe and secure environment for the child while intensively intervening and treating the parent's substance abuse and other co-morbidity issues. The FDTC approach has resulted in better collaboration between agencies and better compliance with treatment and other family court orders necessary to improve child protection case outcomes. Through December 2005, the number of operational FDTCs has grown to 198 (Huddleston, Freeman-Wilson, & Marlowe), with an additional 188 in the planning stage.

The Link Between Child Maltreatment and Substance Abuse

Each year in the United States, nearly 1 million cases of child abuse and neglect are filed and substantiated (Administration on Children, Youth, and Families [ACYF], 2006). Of those filings, approximately 1,490 cases involved the deaths of children (ACYF). The national rate of referrals to child welfare agencies increased to 42.6 referrals per 1,000 children in 2004 from 39.1 referrals per 1,000 children in 2003. The number of children in out-of-home placement has nearly doubled in the last two decades (ACYF). Currently, more than half a million children live in foster care, with nearly 126,000 awaiting adoption (ACYF). Of the estimated 281,000 children who exited foster care during Fiscal Year (FY) 2003, 50 percent had been in care for more than 12 months, with the time children spent in foster care changing little between FYs 1998 and 2003 (National Clearinghouse on Child Abuse and Neglect Information, 2005).

The correlation between parental substance abuse and child maltreatment is well-documented (National Center on Addiction and Substance Abuse, 1999).

The FDTC approach has resulted in better collaboration between agencies and better compliance with treatment and other family court orders necessary to improve child protection case outcomes.

In 80 percent of confirmed child abuse and neglect cases, experts identify parental substance abuse as a precipitating factor, which further complicates these already difficult and complex cases (Child Welfare League of America, 2001).

A parent's inability to maintain a drug-free lifestyle and make other significant changes delays reunification with his or her children and may ultimately lead to the termination of parental rights. Families with parents who face alcohol and drug dependency face additional challenges, including poor housing, mental and physical health problems, transportation issues, lack of appropriate child care, educational challenges, and lack of stable employment. Under the more traditional family court system, a disconnect often exists between the family court, child protection caseworkers, and drug treatment services, leading to uncoordinated and limited services, which further leads to children spending prolonged time in foster care.

A parent's inability to maintain a drug-free lifestyle and make other significant changes delays reunification with his or her children and may ultimately lead to the termination of parental rights.

The Adoption and Safe Families Act

Congress passed the Adoption and Safe Families Act (ASFA) in 1997 to strengthen the performance of child welfare systems. Specifically noted, "The passage of this new law gives us an unprecedented opportunity to build on the reforms of the child welfare system that have begun in recent years in order to make the system more responsive to the multiple, and often complex, needs of children and families" (Child Welfare League of America, 2001). ASFA's primary goal is to provide for the safety, permanent placement, and well-being of children and families (1997). To promote efficiency in permanency planning[4], based on the best interests of the child, ASFA mandates that courts finalize permanent placement no later than 12 months after a child enters foster care. In addition, in most cases, ASFA requires courts to begin termination of parental rights after the child has been removed from the home for 15 of the last 22 months (Office of the Federal Register, 2000). Child welfare and clinical experts have expressed concern that the timeframes imposed by ASFA are unrealistic, given the time necessary for effective treatment and sustained recovery of substance-abusing parents. This concern is particularly troubling, considering that waiting lists at treatment facilities are not uncommon.

Without access to appropriate treatment, comprehensive case planning, and structured and frequent visitation, parents often struggle to comply with complex court orders. Furthermore, while ASFA mandates more frequent case reviews by the court, the first review hearing commonly occurs 6 months after the disposition of a case, leaving the parent very little time to complete the case plan and comply with court requirements. After the initial hearing in a child maltreatment case, parents typically leave the courtroom angry at the system for intruding in their lives, unclear about the court's expectations, unaware of how to access community services, and unmotivated or unable to follow through.

The complexity of child abuse and neglect cases and the requirements of ASFA have created a great challenge for family courts, child welfare systems, and treatment providers. Representatives from all disciplines within these systems must reevaluate the way in which child abuse and neglect cases are handled, including their approach to supervision and family services.

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Family Dependency Treatment Courts: Family-Focused Practices

The planning, implementation, and operation of a family dependency treatment court is not as simple as taking the adult criminal or juvenile delinquency drug court model and placing it in the family court setting. The focus, structure, purpose, and scope of a FDTC differ significantly from the adult criminal or juvenile delinquency drug court models. FDTC applies the drug court model to cases entering the child welfare system that include allegations of child abuse or neglect. FDTC draws on best practices from both the drug court model and dependency court practice to effectively manage cases within ASFA mandates. By doing so, they ensure the best interest of children, while providing every imaginable service to the parent(s). Without these services, the parent(s) will more than likely lose custody of their children and put future children at risk. FDTC partners include the court, child protective services, and an array of service providers for parents, children, and families.

Since an FDTC focuses on cases of child abuse and neglect that involve parental substance abuse, FDTCs' goals are to protect children and to reunite families by providing drug-abusing parents support, treatment, and access to services. In the more traditional family court system, professionals from child protective services, treatment providers, and public health systems separately report to the court, making requests that can be inconsistent with each other and ultimately leading to results that may not be in the best interests of the child or parent. Using the drug court model, FDTC brings these professionals together on an interdisciplinary team, which works to address the complex array of issues impacting families-including addiction, child abuse, and child neglect.

The expertise of each FDTC team member is critical to the success of families entering the system. While team members must adhere to individual ethical and professional standards, they also respect and understand the roles of their fellow team members in the FDTC process. Ongoing cross training among team members is essential to this interdisciplinary approach. This exchange of information helps team members gain a better understanding of each other's roles and how they can work together to reduce institutional or programmatic barriers to better serve families.

Since an FDTC focuses on cases of child abuse and neglect that involve parental substance abuse, FDTCs' goals are to protect children and to reunite families by providing drug-abusing parents support, treatment, and access to services.

Because the judge focuses treatment resources on the parent, FDTC improves outcomes for children and families.

The lasting collaborative partnership of an FDTC team requires strong leadership. Though the development and ongoing operation of an FDTC team may be shared among many individuals and systems, the judge is the team's natural leader in the FDTC process because of the court's legal responsibility to make judgments about the best interests and safety of children. Because the judge focuses treatment resources on the parent, FDTC improves outcomes for children and families. Parents who abuse substances are much less likely to effectively provide for the basic needs of children, often resulting in neglect and increasing the likelihood of long-term emotional, intellectual, and physical problems for children (National Clearinghouse on Child Abuse and Neglect Information, 2003). FDTC provides an elaborate support network for families to ensure the safety of children, while simultaneously assisting the parent in making significant life changes.

The FDTC review session is a valuable opportunity for the judge to interact with each parent on a regular basis, providing immediate responses to compliance and noncompliance with both support and re-direction.

In an FDTC, child protective services and treatment providers join forces to identify, assess, and provide immediate access to substance abuse treatment and other services for substance-abusing parents. Based on comprehensive assessments, the FDTC team develops service and treatment plans that address the needs of the entire family. In the traditional family court process, child protection case plans and substance abuse treatment plans often are developed in a vacuum, out of touch from other services with which the family is involved. In contrast, the FDTC team agrees on the needs of the parent and child and determines the pace and order of each requirement in the case and treatment plans. The team regularly reviews and modifies these plans, as necessary.

FDTCs also heighten the judicial oversight of children and families by increasing the number of times a parent is required to report before the court. Weekly or bi-weekly drug court review sessions are common, and a team meeting typically precedes these court sessions. In this pre-court meeting, the team reviews progress in each case to be called before the FDTC that day. Team members may recommend modifications to the unified treatment and case plans. Team members also make recommendations to the judge for sanctions or incentives to encourage positive behavior and discourage noncompliance. To ensure the best use of time and personnel, the court receives a uniform report in advance of the team meeting. This meeting prepares the judge and team by providing accurate, timely information on each case brought before the court that day.

The FDTC review session is a valuable opportunity for the judge to interact with each parent on a regular basis, providing immediate responses to compliance and noncompliance with both support and re-direction. The courtroom, traditionally adversarial, is transformed into an opportunity for judges to constructively address problems. In an FDTC, parents are empowered to be involved in decision making and are acknowledged for their accomplishments. They also must face their problems and accept the consequences for noncompliance. Although the participant in FDTC court appearances is the parent, the focus of the

team meeting and court hearing are on the progress and obstacles facing both parents and children.

The FDTC team monitors the progress of families and continuously facilitates access to services through the exchange of information and coordination across systems. The identification of services in the FDTC extends far beyond substance abuse treatment. Abstinence from drugs and alcohol, although a significant accomplishment for parents involved in child welfare services, is not the only factor that determines whether a child is reunified with a parent. Issues such as domestic violence, mental and physical health, pending criminal charges, housing, child care, and employment are factors that can delay the reunification process and ultimately increase the time children remain in out-of-home placements. By providing greater coordination and access to services, FDTCs support and encourage the development of healthy parent-child relationships.

FDTC Research

Preliminary data from a federal cross-site study to evaluate the effectiveness of FDTC, conducted by the Northwest Professional Consortium, Inc. (2005), indicate positive child welfare, court, and treatment results:

> ***On average across sites, parents enrolled in family treatment drug courts were more likely than parents in traditional child welfare case processing to be reunified with their children and less likely to have terminations of parental rights. Furthermore, on average, family treatment drug court cases were shorter than traditional child welfare cases. The strongest results were in the treatment arena: family treatment drug court parents were more likely to enter treatment, had more treatment episodes, spent more total days in treatment, and were more likely to complete treatment than comparison group parents (B. Green, personal communication, January 2, 2005).***

These evaluation findings demonstrate the value and benefit of the drug court model to address the intergenerational cycles of substance abuse and child maltreatment.

In an FDTC, parents are empowered to be involved in decision making and are acknowledged for their accomplishments.

Final Thoughts

FDTCs have enhanced the ability of the family court, child protection agencies, and treatment systems to respond to families in crisis. Not only must parents in FDTC take responsibility for their substance abuse and recovery, but they must also be held accountable to provide their children a safe, stable, drug-free home environment. When FDTCs function well, their promise is extraordinary. FDTCs afford substance-abusing parents a genuine opportunity for family reunification with support and treatment and strengthen the community response to child abuse and neglect by decreasing the risk of physical and emotional harm to children.

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FDTCs have enhanced the ability of the family court, child protection agencies, and treatment systems to respond to families in crisis.

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Endnotes

1. In this document, the term "Family Dependency Treatment Court" (FDTC) is used throughout, although locally an FDTC may be referred to as Family Drug Court, Dependency Drug Court, Family Treatment Court, and the like. The name Family Dependency Treatment Court was coined during a joint meeting of the Office of Justice Programs, Bureau of Justice Assistance, National Council of Juvenile and Family Court Judges, National Association of Drug Court Professionals, and National Drug Court Institute to define more specifically the drug court model applied in child abuse and neglect case processing.
2. In this document, the terms "child maltreatment" and "child abuse and neglect" are used interchangeably.
3. In this document, the term "Family Court" is used throughout to refer to the state court, which has jurisdiction over child abuse and neglect cases.
4. Permanency planning is defined as a process through which planned and systematic efforts are made to ensure that children are in safe and nurturing family relationships expected to last a lifetime. (See: http://www.cwla.org/newsevents/terms.htm .)

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Fact Sheet Quiz: What Did You Learn?

Test your new knowledge. Answer these true and false questions based on the Fact Sheet text.

T F 1. FDTC is integrated in the existing family dependency court structure.

T F 2. The multidisciplinary team exclusively focuses on substance abuse treatment and recovery for parents.

T F 3. FDTC is simply taking the adult criminal or juvenile delinquency drug court model and placing it in a family court setting.

T F 4. The operational structure of the FDTC draws on best practices from both the drug court model and dependency court.

T F 5. A parent's abstinence from drugs and alcohol is the only factor that determines whether a child is reunified with a parent.

T F 6. The FDTC team monitors the progress of families and facilitates access to services for parents and children.

Answers: *1. True; 2. False; 3. False; 4. True; 5. False; 6. True*

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AN OVERVIEW OF OPERATIONAL FAMILY DEPENDENCY TREATMENT COURTS

By Judge Nicolette M. Pach (ret.)

The intent of this article is to lay the groundwork for a national conversation about Family Dependency Treatment Courts (FDTCs). While FDTCs are in many ways similar to drug courts, they have their own set of complications that render NADCP's 10 key components necessary, yet insufficient, to guide the establishment, maintenance, and improvement of FDTCs. Questions about best practices surround such issues as child welfare, the Adoption and Safe Families Act (1997) timelines, the civil court arena, and the scope of the intervention. When the best interests of the child are paramount, sanctions and incentives for an alcohol and other drug (AOD)-involved parent must be carefully handled. Federal timelines must be fully considered by FDTCs in their planning. Sanctions in particular are complicated by the fact that FDTCs occur in a civil arena rather than the criminal one like traditional drug courts. Finally, a court must decide whether the FDTC intervention will consider a full range of psychosocial and legal problems facing a particular family, or if it will concentrate solely on AOD involvement. This article should serve as a focal point through which those professionals involved in FDTCs can create their own components necessary for FDTCs.

Nicolette M. Pach, a Judge of the Family Court of the State of New York from 1993 to 2002, presided over New York State's first Family Treatment Court which opened in 1997. She initiated and oversaw the development of this court, which was designed to address the needs of the children who are neglected as the result of parental substance abuse. Judge Pach is an independent consultant to national organizations. Her expertise lies in helping to develop Family Dependency Treatment Courts and assisting states and localities to address issues concerning the coordination of family courts with child welfare systems and

substance abuse treatment providers. Judge Pach has gained national recognition for her innovative work. In 2000 she received the Howard Levine Award for Excellence in Juvenile Justice and Child Welfare from the New York State Bar Association, and in 2001 she received the Adoption MVP Award from the Dave Thomas Center for Adoption Law in Ohio.

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ARTICLE SUMMARIES

ESTABLISHING FDTC BEST PRACTICES

[9] While Family Dependency Treatment Courts can use NADCP's 10 key components for guidance, they require their own guiding principles.

NECESSARY PARTNERS AND ROLES

[10] FDTCs are based on collaboration between the courts and various agencies, including Child Protective Services.

DEFINING THE MISSION OF THE FDTC

[11] The authoritative scope of a specific FDTC can range from monitoring AOD compliance to addressing all psychosocial and legal problems facing a particular family.

COURT CALENDARING PRACTICES

[12] Some courts sub-divide the matters related to specific families, while others maintain a "one family/one judge" style practice that enables a single judge to hear all matters related to a family.

PHASE STRUCTURE AND MANAGEMENT OF CLIENT BEHAVIOR

[13] While phase advancement is an important incentive, contact with the child must be conducted with the child's best interest in mind, not simply as a court response to the parent's behavior.

STRUCTURE OF THE FDTC

[14] Successful FDTCs tend to have a steering committee, a planning team, and a therapeutic team.

CASE MANAGEMENT

[15] There are numerous ways to approach case management for FDTCs. Issues to be addressed include assessment, case planning, linkage to services, monitoring, and advocacy.

QUESTIONS TO BE ANSWERED

[16] Ultimately, what ought to be the mission of FDTCs? How ought FDTCs interface with the Adoption and Safe Families Act?

INTRODUCTION

Communities have developed family dependency treatment courts (FDTCs) in response to the overwhelming increase in the number and complexity of dependency cases involving child abuse and neglect where parental drug or alcohol abuse is a factor. These courts are designed to quickly identify and assess substance-abusing parents; provide immediate access to substance abuse treatment and related services; remove barriers to successful completion of treatment; and provide ongoing judicial supervision and reliable monitoring of parental sobriety. FDTCs use a system of sanctions and incentives to help increase accountability on the part of the parents. By using informed judicial decision making, these specialized courts allow for the safe reunification of families or the finding of alternative permanent homes for children in a timely manner where reunification is not possible (New York State Commission on Drugs and the Courts, 2000). The design of these courts, therefore, requires a coordinated, collaborative approach.

FDTCs are not a new or separate legal entity and they operate within their respective state's existing legal structure. These courts address social problems associated with parental substance abuse in the legal context of the family court, which has jurisdiction to hear child protective proceedings as set forth in state constitutions or statutes.

FDTCs serve families that are disrupted by parental drug or alcohol abuse in which neglected children must be protected. In child protection proceedings, these family courts focus first on child safety, and then on remediation of the issues that brought the family before the court. The court's ultimate legal requirement is to assure that children have a safe, stable, and permanent home within a developmentally appropriate time frame.

[9] FDTCs are modeled structurally after drug courts, which were developed in the late 1980s to focus on adult substance-abusing criminal offenders. By 1997, a consensus was reached among drug court professionals and *Defining Drug Courts: The Key Components* was published by the National Association of Drug Court Professionals (NADCP, 1997). The key components identified for criminal drug courts are informative for FDTCs but must be reformulated to suit dependency courts, as these courts have considerations well beyond those of the criminal drug courts. The primary focus of the FTDC is the safety and well being of the child. The goal is to maintain the family unit if possible and, if the child must be removed from the parent's custody, to reunify the family promptly as soon as the parent can safely care for the child. If timely reunification is not possible following reasonable efforts, the court is required to devise an alternative permanent plan for the child. As part of this plan, Child Protective Services (CPS) is required to begin proceedings to terminate parental rights and, if no relatives are available to raise the child, find an appropriate adoptive home. The court must assure that these goals are accomplished in a way that is least harmful and most beneficial to the child.

In the context of developing key components for FDTCs, a discussion of the questions posed by Jane M. Spinak (2002) in her article "Adding Value to Families: The Potential of Model Family Courts," is warranted. First are the questions that must be addressed in any family court reform effort:

> ...[T]he breadth of potential authority by a judge fully exercising her discretion within such a structure inevitably raises a question of the scope of the court's power. This question, which has been at the heart of every effort to create or reform Family Court, has been posed in a variety of ways. (Spinek, 2002, p.336)

Beyond addressing the scope of the court's power, additional questions must be asked, including:

- What role is appropriate for the court?
- How far should the court go in administering access to services, service delivery, and supervision of those services?
- How does each court assure that they actually are adding value to the lives of the families under their care? (Spinek, 2002, p.340)
- Does the court take into account established exemplary family court practices, the practices of the Model Courts developed under the auspices of the National Council of Juvenile and Family Court Judges Permanency Planning for Children, and the emerging work of the National Center on Substance Abuse and Child Welfare? (Victims of Child Abuse Project, 1995; Schecter, 2001)
- How well does the court meet the Adoption and Safe Families Act's comprehensive Permanency Planning requirements?
- How well do Model Courts assure reasonable efforts are made to identify and assess substance abuse, engage and retain parents in treatment, and assess and address the extraordinary needs of their children?

This paper will describe some of the ways family courts across the country have adapted criminal drug court components and simultaneously developed other features to address and meet the complexities of child protection cases. In addition, common features of existing FDTCs, as well as differences in the ways in which they carry out their basic mission, will be described. The overarching mission of FDTCs is to achieve timely permanency of a stable home life for children in dependency cases where parental substance abuse is a factor, by promptly addressing parental substance abuse issues, and identifying and addressing the children's needs through a court-based collaboration of agencies to

promote reunification where possible and if necessary, an alternative safe and stable home.

This paper is not intended to assess which are the best practices for a FDTC, but rather to serve as a way to open the discussion among FDTC professionals so they can begin to reach a consensus on the goals, objectives, and operational practices of FDTCs. In addition, this paper will examine how the key components derived from the adult drug courts apply to FDTCs and identify additional attributes that are essential to the mission of FDTCs. Overall, the intent of this paper is to identify issues and raise questions yet to be resolved by the field as FDTCs continue to evolve.

This paper is based on the review of policy and procedure manuals from fourteen operational FDTCs across the country (see Appendix B when referenced) as well as on observations of FDTCs in several states. It also is informed by the author's experience participating in the creation of the Suffolk County, New York Family Treatment Court and presiding over that court for five years.

BACKGROUND

Parental Substance Abuse in Child Abuse and Neglect Cases

In the last decade, family courts have experienced a large increase in child protection cases, an increase that appears to be driven by the co-occurrence of parental substance abuse and neglect case filings. Experts estimate that in 40 to 80 percent of confirmed child abuse and neglect cases, parental substance abuse is a factor (Child Welfare League of America, 2001). Consequently:

> [Family courts] have suffered serious strain from a vast expansion in the number of drug-related filings in recent years. Such

> cases typically involve allegations of parental abuse and neglect of children, where there is an indication that the abuse and neglect stems from a parent's drug addiction. Such cases often result in the removal of children from their homes, and the effects…on children and families—and, eventually, society at large—is severe. The high cost of foster care ensures that such cases are extremely expensive, too. (New York State Commission on Drugs and the Courts, 2000, section III)

Permanency Planning in the Best Interest of Children

In 1997, coinciding with the rise in substance abuse driven child neglect cases, Congress passed the Adoption and Safe Families Act (ASFA). This has greatly affected family court practices and must be factored into any consideration of attributes essential for FDTCs. At that time, growing numbers of children, neglected by their parents, were lingering in foster care after initial court intervention to assess and address immediate child safety concerns. They were being raised by "the system" instead of by families in safe, stable, and permanent homes. ASFA was intended to remedy that situation by requiring timely permanency.

Specifically, ASFA requires the courts and the child welfare system to resolve dependency cases by implementing a plan for permanency in a timely fashion. In keeping with children's developmental needs, this legislation imposed strict time limits within which the court was to establish permanent, safe, and stable homes for children who are the subject of a dependency case. ASFA time frames are significantly shorter than the usual time it takes, under the best of circumstances, for an addicted parent to establish a sober, stable lifestyle (Young, Gardner, & Dennis, 1998, p. 20). However, while the impact on family court proceedings

has been great, legally, ASFA "…is merely an attempt to refine the law concerning permanency planning for children in foster care so that [the] law more fully and expeditiously accomplishes its pre existing goals." (*In re Marino S.*, 1999/2002/2003)

ASFA requires the court to hold a "permanency hearing" to approve or modify the permanent plan proposed by CPS for a family within 12 months of the finding of neglect, or within 14 months of the child's removal, whichever is the earlier, although some states have enacted even stricter time frames. The preferred permanent plan is a safe and stable home with the child's natural parent. But there are provisions requiring that a petition to terminate parental rights (TPR) be filed if the parent is not ready for reunification with a child who has been in foster care 15 out of the last 22 months.

In addition, ASFA has expanded the role of the courts. The courts must judge the sufficiency of the efforts made by CPS to assist families at several key junctures. ASFA requires CPS to make "reasonable efforts" to prevent the removal of children in the first instance and to reunify families where children have been removed. There are financial consequences to states, in the form of the loss of federal funds for foster care, if they do not meet ASFA requirements. The court also is placed in the unfamiliar position of judging the CPS case plan and developing its own alternative case plan if the CPS plan is not deemed adequate.

All of these requirements are in addition to the court's pre existing duty to hear the evidence, determine if there is enough evidence to establish a case, and assure due process for the parents, children, and families (Spinak, 2002, p. 331). It is also the responsibility of the court to assure the safety and due process of children and their families by "ensur[ing that] reasonable efforts were made to assist the family in remaining a unit and remaining free of unnecessary

state intervention." (Spinak, p. 341) Accordingly, the strict ASFA time frames create additional strain on already overburdened family courts.

ASFA has, however, provided an additional impetus for communities to develop FDTCs. Under ASFA, all states must conduct their own statewide self-assessment of child and family services and then submit to a Child and Family Service Review conducted by the federal government. Included in the Review are assessments of outcomes concerning child safety, well-being, and permanency. Findings concerning systemic factors in need of improvement are included in the state's proposed Program Improvement Plan, which must gain federal approval in order for the state to continue to receive certain federal funding. Federal findings, particularly those concerning deficiencies in the array of services, often could be addressed by establishing a FDTC.

FDTCs can be structured to help jurisdictions operate within the ASFA time frames. These courts can aid community interagency collaboration by providing sufficient services constituting "reasonable efforts" to assist families in reunification. FDTCs can assure due process, timely case processing, and permanency hearings. The frequent judicial and case management monitoring yields a clear record of a parent's progress toward providing a safe and stable home, and of CPS's efforts to assist the family with reunification. Most importantly, FDTCs can improve outcomes for children and families by providing a motivated parent with optimal opportunity to establish a stable recovery in time to regain custody of his or her child.

NECESSARY PARTNERS AND ROLES

> **[10]** The complexities within child welfare agencies and substance abuse treatment agencies, coupled with the different perspectives and

> world views, make cooperation between service systems difficult to establish and harder to maintain. But now more than ever, collaboration between these agencies is essential if families are to be given real opportunities for recovery and children are to have the chance to grow up in healthy family situations. (Department of Health and Human Services, 1999)

FDTCs bring together various community agencies and professionals who work with child welfare cases as a team to develop a unified plan. The commitment and participation of community stakeholders is integral to the success of FDTCs. Stakeholders include the court, CPS, alcohol and other drug agencies, substance abuse treatment providers, and the attorneys representing the family and CPS, as well as the families themselves. Some FDTCs also include ancillary service providers such as mental health services, the public health nurse, providers of early childhood intervention services, and domestic violence services. Of the fourteen courts reviewed for this paper, all included, at a minimum, a judge willing to take on a leadership role, CPS representatives, treatment providers, a representative of court administration, and a court coordinator. Coordinator is a particularly important role, as he or she manages court operations and effectuates the changes FDTCs make in court calendaring practice, including the accommodation of more frequent court appearances and staff meetings within the courthouse. Finally, information management experts are frequently included to assist in the effective monitoring of cases, sharing of information, and collection of data sufficient to evaluate the program. By establishing these interdisciplinary teams, FDTCs facilitate access to all of the services that are necessary to reunite families.

The support of the agency responsible for child protective services is particularly critical to the success of the FDTC. CPS has the obligation to investigate cases of child

neglect and abuse, assure child safety, and determine if court intervention will be sought to ensure the cooperation of the parents. The operation of CPS has been greatly impacted by the passage of ASFA, and some FDTCs are planned and operated in a way that assists CPS in meeting the demands of ASFA. For example, the FDTCs surveyed for this paper assist CPS in "making reasonable efforts" to engage and retain parents in substance abuse treatment.

Of course, for a FDTC to be successful, appropriate substance abuse treatment services must be available. Treatment providers and/or the local governmental agency responsible for overseeing the contracts and/or licensing of treatment providers must participate in the planning and support of the FDTC. In localities where treatment is relatively plentiful and many providers have clients who are participants in the FDTC, the local governmental agency with authority to license or contract with treatment providers can help to negotiate provider participation agreements. In other jurisdictions with only one or two treatment providers, the providers themselves participate directly in the collaboration. The inclusion of treatment providers in the planning process also enables these providers to bring information to the table regarding funding options and opportunities, as well as to help assess appropriate treatment needs for individual clients and available resources in the community to meet those needs.

FDTC coordination occurs at both the administrative and operational levels, which avoids the duplication of efforts. Coordinators are employed by various participating agencies or directly by the court system. Policy makers and team members come from many agencies and each answers to their own chain of command, which poses an inherent challenge to coordination. On an operational level, it is essential to coordinate the work of all the participating agencies; assure that quality information is communicated to the court and CPS; and keep a consistent presentation to

participants and families. If a court is not well coordinated on an operational level, the participants inevitably play one team member, including the judge, against the other. This enables the participant to continue his or her addictive behaviors. FDTCs, like adult drug courts, attempt to minimize the adversarial nature of court proceedings, and try to avoid enabling participants to continue the manipulative behavior that is characteristic of substance abusers.

Suffolk County, for example, has broken the coordination function into two parts. The Director, a court employee with guidance from the administrative oversight team, is responsible for administering, coordinating, developing, and implementing policy. She also maintains interagency relationships by organizing cross training events between CPS, treatment providers, and other FDTC staff as a way to enhance and develop the array of services available.

On an operational level, the Clinical Coordinator, also an employee of the court system, is responsible for coordination and collaboration on individual cases. She convenes the team members for staffings before each court appearance and assures that the reports sent to the judge are complete. She is also responsible for presiding over quarterly comprehensive case review meetings for each family with all providers and team members requested to participate. This is in addition to the statutorily mandated case planning that is required of CPS. The Clinical Coordinator invites all service providers and the CPS worker to join the operational team members at this meeting. Progress on service plan goals is assessed as well as client progress through the phases of the FDTC. Written reports of these meetings are submitted to the judge and all attorneys.

Since the operating FDTC requires communication within a multidisciplinary group, an effective means of information sharing must be developed. Ideally, this calls for the ongoing participation of information management experts

from the earliest possible point in the creation of the FDTC. Since FDTCs have not yet been systematically evaluated, the team member with management information expertise must incorporate evaluation issues into the planning of the court from the ground up. However, should the appropriate technology not be available, FDTCs must maintain records in written case files, phone call logs, and staff meeting minutes.

DEFINING THE MISSION OF THE FDTC

[11] The court's definition of its mission may impact its design. The mission may be narrowly drawn to provide prompt access to treatment services and judicial monitoring of abstinence for a particular family member. Alternatively, the mission may be broadly defined to address all the needs of the family. Some FDTCs are intimately involved in the delivery of child welfare services, while others have opted not to become involved with providing direct services and simply provide close judicial monitoring of compliance with services ordered and offered in the community.

The CPS intervention begins upon receipt by child welfare officials of a report of child abuse or neglect. In some communities, collaborative systems are available to access substance abuse treatment in child welfare cases at the inception of CPS intervention well before court intervention is contemplated. In other communities, the FDTC is the first opportunity for clients to participate in a structured protocol to access substance abuse services.

In light of these various issues, jurisdictions that create a FDTC must examine the role of the FDTC judge. In particular, it must be determined:

> Whether the role of the Family Court judge is primarily adjudicative or administrative: is her primary purpose to decide specific disputes or to manage the larger, more complex issues that the

> family brings with it to the courthouse? ...[I]f the court is assuming the larger, managerial role, is that role primarily preventive or primarily remedial? That issue leads to two collateral questions. First, should the court subsume some or all of the services provided directly under its control, or should it maintain the traditional division between the executive and judicial functions? Second, if the judge does assume a broader role, does this necessarily include a leadership role for the court in the larger community it serves? (Spinak, 2002, p. 336)

Additionally, in some jurisdictions, family courts administer services for litigants such as probation and mediation. In other states, courts have not traditionally provided services directly and have served only the adjudicative function. San Diego County, CA, engaged in comprehensive community systemic reform to facilitate access to and delivery of substance abuse treatment services called the Substance Abuse Recovery Management System (SARMS). Long before court intervention, at the initiation of a child protective case, SARMS assists CPS workers in assessing whether substance abuse is present; coordinates a substance abuse assessment; and provides parents with immediate access to substance abuse treatment. The SARMS model is designed to winnow out the more compliant parents giving them an early and effective opportunity to address substance abuse, thus permitting them to avoid court. The assessment, referral, and case management are conducted in the community rather than the courthouse. San Diego has a multi-tiered and increasingly intensive continuum of intervention culminating in referral to the FDTC (locally known as the Dependency Court Recovery Project) if the parent has not responded to earlier SARMS intervention (Milliken, 2001). The FDTC is the strongest measure available to induce parental cooperation (Young & Gardner, 2002). Court resources therefore are reserved for the most difficult cases. Suffolk County, on the other hand, did not

develop formal pre-court protocol to access treatment services already in place. Thus, facilitated access to treatment along with coordinated case management becomes available only after the parent has been brought to court.

EXERCISING LEGAL JURISDICTION AND INTAKE

Civil and Criminal Jurisdiction

FDTCs are limited by the jurisdiction conferred on them in their own states. Some FDTCs may be empowered to hear both dependency cases and criminal cases, while others will be limited to dependency cases only. This, therefore, impacts the design of the FDTC. In New York State, for example, dependency matters and criminal matters are handled in separate courts. New York FDTCs cannot entertain related or unrelated criminal matters. While the family court judge and the judge presiding over the criminal matters may become aware of the other proceedings, there is no formal mechanism that would allow a single judge to preside over both cases.

In Jackson County, Missouri, the judicial officer who presides over the dependency case has limited criminal jurisdiction and may preside over certain aspects of related criminal charges of child endangerment. The court also may take jurisdiction when the parent is eligible for criminal drug court on an unrelated criminal matter and has a child who is the subject of a dependency proceeding in the family court. This design necessitated the development of protocols with law enforcement, the prosecutor, and the criminal court so that appropriate cases can be transferred to and from the family drug court. In the event of parental failure, the criminal case is returned to criminal court for further proceedings. Conversely, in Washoe County, Nevada, the court exercises both civil and criminal jurisdictions in admitting parents to FDTC. Parents may come to the court's attention due to criminal activity or the removal of children

by CPS. Referrals typically come from CPS or other treatment providers and non-CPS cases may be referred and may be accepted upon approval by the team.

WHEN TO TAKE JURISDICTION: TIMING OF FDTC INTERVENTION

In the jurisdictions reviewed, FDTC intervention is sought at differing points along the continuum of the dependency case court process. When structuring the timing of admission of a family's case into FDTC, courts must be mindful of the ASFA requirements. Since the purpose of FDTCs is to promote the safe reunification of families, parents must be admitted to FDTC with enough time remaining to beat the ASFA clock (Victims of Child Abuse Project, 1995; Schecter, 2001).

Admission to FDTC can be as early as the parent's arraignment with a conditional enrollment at an uncontested adjudication. Enrollment also may occur further on in the process, at the disposition proceeding, when the order reflecting the service plan for the case is issued. Another option is to offer enrollment in FDTC after a finding that the parent is in contempt when the parent has been noncompliant with court-ordered treatment services or has not remained abstinent. Identification of the target population and eligibility criteria impacts the timing of admission as well. A focus on newborns, for instance, requires admission early in the dependency case, while a focus on repeated treatment failures by parents results in later admission to the court process.

Early enrollment in FDTC occurs in Kansas City, Missouri, where most cases are referred at the initiation of the court process through the Newborn Crisis program. Babies born with positive drug screens and their parent(s) are referred for acceptance in the FDTC immediately so the

mothers can be promptly enrolled in treatment and separation of mother and child can be avoided.

In Mecklenburg County, North Carolina, parents have the option of being admitted to the FDTC early in the court process if they acknowledge substance abuse problems. However, they have further opportunities for later enrollment in the FDTC and may elect to participate after a petition has been filed, and the court has made a formal finding of willful contempt of court. A jail sentence is imposed but suspended on the condition that the parent enter the FDTC within 24 hours.

COURT CALENDARING PRACTICES

[12] Family courts differ in their calendaring practices. In some jurisdictions where there are multiple judges sitting in the family court, judges specialize in certain types or aspects of cases. For instance, one judge may hear juvenile delinquency cases while another judge may hear dependency cases. Dependency cases may be further divided into sub categories, with one judge hearing emergency removal (or shelter care) hearings and then a different judge conducting the adjudication (fact finding) and disposition. Yet another judge may preside over the permanency hearing and another over the termination of parental rights.

Model Court practice, as developed by the National Council of Juvenile and Family Court Judges, recommends "direct calendaring" practice. That is, courts that observe "one-family/one-judge" (Victims of Child Abuse Project, 1995, p. 19) take jurisdiction over the entire dependency case, from referral (usually at the initial "shelter" hearing) through adjudication, disposition, permanency hearing, and finally through reunification or TPR.

Court calendaring practices in FDTCs vary as well. Some FDTC judges preside over the entire family's case,

overseeing both the dependency case and monitoring the parents' compliance with child welfare case planning, abstinence, and treatment. In other courts, the practice is to leave the dependency case and the monitoring of the children's issues in the "home court" with one judge, while referring monitoring of the parent's abstinence and treatment compliance to a second "drug court" judge. The choice of design may be a reflection of any of several reasons, including strongly held judicial philosophy, the level of pre-existing cooperation across the court, child welfare and drug treatment systems, and the availability of judicial and community resources to assist the families.

Using the one-family/one-judge model, a FDTC judge monitors the parent's compliance with court-ordered substance abuse treatment and progress in recovery. The same judge is also responsible for assuring that the child's need for timely permanency and ancillary services are met. The court uses the parents' desire for reunification to leverage compliance with treatment and to encourage the parent to maintain abstinence. The FDTCs in Miami/Dade County, Kansas City, Billings, and Suffolk County are examples of one-family/one-judge calendaring practice.

In other jurisdictions, the original dependency action is handled by one home court judge from inception through reunification, or TPR and adoption, while a second judge presiding over the drug court monitors only the parents' compliance with the portion of the court order requiring abstinence and substance abuse treatment. The focus is on parental sobriety with speedy intervention, assessment, referral to substance abuse treatment, and frequent judicial monitoring of a parent's progress in recovery. The dependency judge will receive evidence of the parent's compliance with substance abuse treatment during drug court participation in the dependency proceedings.

In Durham County, the decision to have one judge for the FDTC and a second judge preside over the dependency case was deliberate (P. Baker & A. Stith, personal communication, June 10, 2003). The Presiding Judge was cognizant of the fact that FDTC judges receive a wealth of information during staffings and at FDTC appearances, and that unsuccessful FDTC cases may result in TPR. Decisions at a TPR proceeding must be based solely on evidence presented at the TPR proceeding itself. In this jurisdiction, one judge presides over the entire dependency case (from inception through TPR), while another judge oversees compliance with alcohol and other drug (AOD) treatment and abstinence. This particular model was designed to avoid the appearance that the TPR outcome was influenced by the information presented at the FDTC reviews (Baker & Stith). However, this does not mean that the FDTC judge is blind to Permanency Planning and ASFA issues; in fact, she discusses them with participants as part of drug court reviews. The judge in the dependency case is kept apprised of the parents' progress by receiving copies of the bi-weekly reports on participants in the FDTC (Baker & Stith).

PHASE STRUCTURE AND MANAGEMENT OF CLIENT BEHAVIOR

[13] The surveyed FDTCs delineate program phases as a means of measuring participant progress and providing guidance to parents in meeting both treatment and service plan goals. There are usually three to four phases with stated goals and requirements for advancement and completion or graduation. Passage from phase to phase is rewarded with tokens of advancement. In some FDTCs, the court responds to both the participant's progress toward abstinence and also toward establishing a lifestyle that is consistent with providing a safe, stable, and permanent home for their children. In these courts, phase advancement is tied to both

abstinence and compliance with a comprehensive service plan. In other courts, the phase requirements are limited to monitoring parents' sobriety and addressing issues with their children, with parental contact with children remaining the province of the dependency home court judge.

The initial phase includes the process of assessment, service planning, and admission to treatment and other services. Next, there is a period of commencing services, meeting parental responsibilities within the limits of the court order, maintaining abstinence, and receiving education. This is followed by a period of practicing sobriety skills, obtaining other life skills, taking increased responsibility for meeting children's needs, and sustaining a sober lifestyle. Finally, there is a period of solidifying gains and accomplishing concrete goals so that children and families may be reunited. Ultimately, following a period of aftercare, child protective and court supervision may be safely removed. The final phase in FDTC requires close monitoring since it is at that point children's safety is primarily in the hands of their parents and is at great risk if parents are unable to maintain sobriety.

FDTCs have developed systems of responses consisting of incentives and sanctions. These are developed in the context of due process, limits on jurisdiction, substance abuse treatment protocols, judicial philosophy, local culture, and the best interest of the child. These responses range from judicial praise or reprimand, incarceration, reunification with children, and termination of parental rights.

The language used in court reflects the goal of family reunification and consciousness of the fact that FDTC is a civil proceeding, rather than a criminal one. The court wants to give parents the "incentive" to take the steps necessary to be able to safely care for their children. There are "consequences," favorable and unfavorable, of a parent's compliance and of a child's condition. When there is a

relapse, the court may not wish to "punish" a parent, since substance abuse is a disease of which relapse is a predictable part; the court may choose to "respond" therefore, not with a punishment, but rather, by requiring an increase in the intensity of treatment level.

Contact with children, while some times termed a "reward," is determined on the basis of the child's safety and best interest. The parent's progress, or lack thereof, will have an impact on this decision, but is not the only consideration. For instance, if a child can safely visit with a parent who can behave appropriately during the visit, the parent's unexcused absence from treatment should not impact on the children's right to visit with their parent. On the other hand, some children have been hurt by their parent's behavior when the parent was abusing substances to such an extent that they may not be in a condition to visit a parent, even if the parent is maintaining sobriety. Again, the interest of the child must govern this decision. Successful completion of treatment is not a guarantee of return of custody. The focus of the system of sanctions and incentives is on the child's safety, best interest, and permanency, not on punishing the parent.

Westchester County's family treatment court has a fairly typical practice of using incentives and sanctions, with progress acknowledged by the judge in open court. The importance of this as an incentive is sometimes underrated. Parents who find themselves in dependency proceedings often have had conflicted relationships with, and have not received a great deal of praise from, authority figures throughout their lives. The importance of praise from a person with as much authority and power over the respondent as the judge is significant.

Other rewards include hearing the case early in the docket and excusing the parents from the remainder of the FDTC proceeding, or a reduction in the frequency of required court appearances. As a response to the parent's progress, the

court anticipates an increase in contact or visitation with the child. In Kansas City, for example, tangible rewards, such as $10 vouchers from local stores, are awarded for every 30 days of abstinence. Participants eagerly anticipate the days they are due for a voucher, as they use them to purchase household necessities or treats. Some individuals "bank" their vouchers to purchase needed items when they are ready to establish a household. Generally speaking, FDTCs have become innovative in inventing incentives to encourage responsible behavior and discourage violations of court orders.

Securing participant compliance is a critical issue in criminal and family drug courts. There are times when the punitive connotation of a "sanction" is warranted—for instance, when a parent tampers with a urine sample or lies to the court. Sanctions, therefore, do have a place in FDTC. Kansas City's policy and procedure manual describes sanctions that include a reprimand from the bench in open court for a first noncompliance. For a second violation, the participant may be required to increase treatment activity, watch a specific educational video, write a report to the court, or write a letter to their children if they missed a visit (which is reviewed by a therapist). In lieu of a report, the parent may be required to create a work of art to express their emotions, participate in community service, sit in court for an entire day, return to a previous phase. A third violation could result in the above sanctions, but also may result in home detention/electronic monitoring or brief incarcerations. Some family courts have the authority to issue bench warrants as a means of assuring attendance at court proceedings and use it to secure parental compliance.

Many FDTCs also have the capacity to incarcerate for civil or criminal contempt. Those FDTCs with criminal jurisdiction can impose sentences of incarceration for criminal offenses. In the criminal court, the use of incarceration as a sanction is clearly acceptable. One of the

motivations for participation is the avoidance of jail by the defendant. The client contract clearly stipulates that failure to comply can result in incarceration.

In family courts, the motivating factor is the parent's desire to maintain or regain custody of his or her child. Using the power of a contempt proceeding to incarcerate a parent in a dependency case is a controversial philosophical decision. However, jail is not an anticipated outcome of the usual dependency case. The anticipated consequence of failure to comply with an order in a dependency case is the curtailment or loss of parental rights, not the loss of personal liberty.

While some FDTCs have concurrent criminal jurisdiction, most do not. Many family courts, however, may exercise contempt powers to secure compliance with court orders. Thus, it is technically possible to incarcerate a parent for failure to comply with a court order to attend substance abuse treatment and remain abstinent. In the civil court context, a jail sentence for contempt is designed to secure obedience to a court order. In using this power, the courts take stock of whether the use of incarceration is reasonably calculated to do that. If it appears that the parent's compliance will not be forthcoming in a time frame where reunification is still possible under ASFA, then often the time for incarceration has past. The court must then turn its focus to an alternate permanent plan for the child.

In the Mecklenburg County Family Treatment Court, the use of incarceration is available. If the parent fails to participate in the court ordered substance abuse assessment, or fails to enter the substance abuse treatment as recommended, an order to show cause why the parent should not be held in contempt may be filed. Upon a finding of contempt, the parent may be incarcerated. There is a schedule of sentences from 24 hours up to 30 days of incarceration. The parent may avoid incarceration by

agreeing to enter FDTC in exchange for a suspension of the jail sentence.

STRUCTURE OF FDTC

[14] In reviewing 14 FDTCs, it was found that three groups of players emerge as part of the court development process: a steering committee, a planning team which often evolves into an ongoing administrative oversight team, and the operational or "therapeutic" FDTC team. Some steering and planning/administrative committees had overlapping or identical memberships. Committee/team composition varied from jurisdiction to jurisdiction based on the range of legal and social issues each court needed to address, as well as the extent to which local law enforcement and social service providers were available and willing to participate in the collaborative effort that FDTCs require.

Generally, agency directors or high level administrators who participate on the steering committee provide the leadership and authority for their organization to engage in FDTC planning and operations (NADCP, 1997). They determine what resources are available to the FDTC, and whether a reconfiguration of existing services, new funding, or collaborative agreements are required, and how those should be secured. Some steering committees agree on core values and principals underlying the creation of the FDTC before engaging in concrete planning activities.

The planning/administrative oversight team usually comprises representatives of the same agencies that participate in the steering committee. They oversee the development and implementation of policy and procedures as the FDTCs become operational. They try to resolve those agency conflicts that inevitably arise. To do this, the representatives need sufficient authority and experience to approve policy and procedures as well as authority over others in their agency who will eventually work on the

operational team. The planning/administrative oversight committees meet either regularly or as the needs of their FDTC dictate (NADCP, 1997).

The operational FDTC team consists of the individuals who perform the day-to-day tasks of the FDTC. Operational team members perform case management functions; depending on the breadth of the FDTCs mission, case management functions can be expanded. This team uses a non-adversarial collaborative approach to coordinate the identification, engagement, and retention of substance-abusing parents in a variety of services (NADCP, 1997). It includes, at a minimum, the judge, CPS representatives, attorneys for all parties, members with substance abuse expertise, and someone to perform appropriate case management functions. FDTCs differ in the extent to which other agencies are included on the operational team. This is partly determined by how broadly or narrowly the FDTC has defined its mission. In the overall dependency case, parents must participate not only in a substance abuse treatment plan, but also in a broader case plan in an attempt to maintain or regain custody of their children.

A variety of agencies may participate in a FDTC to reach beyond parental sobriety and holistically encompass all aspects of the family's functioning. For instance, if early childhood developmental issues are included in the FDTC's mandate, then the participation of the community agency responsible for those services will participate. With the high incidence of trauma issues and domestic violence among the participant population (up to 80 percent of participants), agencies that address domestic violence and victim assistance often are included. Due to the co-occurrence of criminal activity and arrests with substance abuse, cooperation from the probation department and law enforcement also may be sought.

CASE MANAGEMENT

[15] A significant feature of FDTCs is case management, which includes the following (Siegal, 1998):

- Assessment
- Case planning
- Linkage to services
- Monitoring of participants, families, and case plans
- Advocacy

FDTCs have been creative in finding personnel to provide case management under such structural limitations as funding, court design, and pre-existing agency relationships. In some courts, case management oversight is limited to parental participation in treatment, while in others, it includes service planning for families and children and a broad array of services including housing aid, vocational, educational, and employment planning, and various services to address the children's specific needs. A single team member assigned to work with a single family may perform case management functions, or functions may be shared among various team members.

Credentials for case management also vary. In some FDTCs, case managers are required to have drug and alcohol counseling credentials, but in other courts they are not. In Miami, for example, there are four case managers, called Dependency Drug Court (DDC) Specialists. Their credentials are commensurate with their comprehensive duties. Three of them have master's degrees and the other has a bachelor's degree. They are responsible for:

> Alcohol and drug abuse screening and assessments, referrals to and enrollment in treatment services, alcohol and other drug testing, progress monitoring, crisis and therapeutic intervention, to engage and retain the

> parent in the dependency court process, advocating for the parent, and keeping the parent motivated to treatment and recovery throughout the long DDC process. Specialists report to the court…on treatment progress, health issues, housing issues, employment issues, and dependent children's issues. DDC Specialists collaborate with Division of Children and Families (DCF) counselors to develop the substance abuse screening/evaluation/treatment and aftercare portion of the Children and Families Case plan…review the plan with the parents and their attorney's…staff cases weekly with other team members including DCF counselors, representatives from the Linda Ray Intervention Center, and the nurse practitioner. (Juvenile Court 11th Judicial Circuit, Miami-Dade County, FL, Policy and Procedure Manual, p. 9. See Appendix B)

Given the breadth of their responsibilities, they also are provided with professional weekly clinical supervision and therapeutic training from the University of Miami Department of Psychiatry and Behavioral Sciences.

ASSESSMENT

All FDTCs require a substance abuse assessment of the participating parent to determine the appropriate level of treatment and to establish treatment goals. Courts often make use of existing resources in arranging for substance abuse assessments. Suffolk County was able to outsource a psychiatric social worker from the health department to conduct assessments at the courthouse. The social worker then referred participants to local treatment providers. Other courts depend on treatment providers to conduct assessments. Child welfare, mental health, and other assessments also are conducted by FDTCs, depending on the breadth of their missions.

Comprehensive assessments of the family, parents, and children are important to assure that the problems that brought the family into the FDTC are addressed. Rarely is substance abuse the only problem facing these families:

> Children of substance abusing parents generally, and children in foster care particularly, possess, almost by definition, many of the risk factors and few of the protective factors associated with a host of negative outcomes. For instance, children exposed to severe substance abuse in the home often experience mental, emotional, and developmental problems, as well as severe trauma, which may result from physical or sexual abuse or chronic neglect. (Department of Health and Human Services, 1999)

In addition,

> Usually parents who abuse alcohol and drugs and maltreat their children suffer many problems at once. They tend to be socially isolated, to live chaotic lives, to suffer from depression and other chronic health problems, to be struggling with drained financial resources, and to be unemployed. (National Center on Addiction and Substance Abuse at Columbia University, 1999, p. 14).

The Yellowstone County Family Drug Court utilizes a lengthy neurological/psychosocial evaluation of both parents and children being served by the Family Drug Court to identify the multiplicity of issues facing the family. This 8 to 9 hour evaluation, performed by a doctor, is completed during Phase 1 of FDTC participation and is repeated every 90 days. Staff and parents are afforded a comprehensive view of the issues to be addressed. The completed evaluation informs service planning and intervallic administration allows participants and staff to assess progress on an regular basis.

It also is used to identify needed services, and has been provided to parents who, accompanied by their Child and Family Services (CFS) social worker, are requesting services for their children in the local school district.

Such an extensive assessment is usually not available in other jurisdictions. Most FDTCs use a standard instrument for initial substance abuse screening, such as the Addiction Severity Index, administered by substance abuse counselors either at the courthouse or at the treatment facility to determine appropriate treatment levels. Other assessments are obtained through community resources, such as developmental screens of children conducted by public health nurses.

CASE PLANNING

In dependency cases where parental substance abuse is a factor, multiple case plans may be developed. For instance, treatment providers are required to have a treatment plan for the substance abusing parent, while CPS has statutory responsibility to develop a comprehensive service plan for each case to assure child safety and well being and to promote the reunification of families. Service plans must be developed to assist parents to gain the skills necessary to meet the needs of their children, and these plans must meet the child's needs, such as developmental delays and physical and mental health problems and may be developed by the service provider or an independent diagnostic assessment agency.

Where the FDTC has jurisdiction over the dependency case, all developed plans come under court scrutiny. Dependency courts have the responsibility under ASFA to initially rule on the sufficiency of the original service plan and, subsequently, whether reasonable efforts have been made to carry it out. The court reviews and approves or modifies permanency plans several times over

the life of a case. These multiple service-planning efforts are enhanced by coordination in the FDTC process.

Communities differ to the extent that parents or family members are included in developing the case and service plan. As an example of inclusion, in Yellowstone County, the FDTC coordinator, treatment provider, CFS worker, and client sit down at regular intervals for "roadmapping" sessions to review progress toward long and short-term goals and to make adjustments in the plan and goals as necessary. A roadmap may address substance abuse treatment, physical and medical concerns, mental health treatment, and parenting issues, as well as meeting lifestyle issues such as housing, employment, and outstanding criminal matters. The initial roadmap, which follows the CFS plan, is completed shortly after acceptance into FDTC, and the parents sign off on the plan. The Yellowstone court finds client participation essential as it invests in them by providing treatment, while getting feedback from parents as to their needs, requests, concerns, and priorities.

LINKAGES TO SERVICES

Some of the FDTCs surveyed have sought or developed resources to address the full range of issues which impact families where children have been abused or neglected as a result of parental substance abuse. These families require an array of services such as physical and mental health treatment of the entire family, parenting skills instruction, early childhood intervention to address developmental delays, and services to assist in ameliorating co-occurring issues such as domestic violence and trauma history.

The Miami/Dade County Dependency Drug Court assures that their families have access to comprehensive services by reaching out into the community to preexisting organizations willing to work closely with the court and tailor

their programs to meet the families' needs. Additionally, by developing a strong relationship with the University of Miami, the court has secured additional services. As an example, The Linda Ray Intervention Center associated with the University, provides developmental assessments for children. The Center also provides services for the younger children, at the Center or at home, and moves the children on to Head Start when the children graduate from the Center. The Center offers FDTC parents innovative parenting skills curricula that are scientifically based and use pre- and post-testing to evaluate progress. Additionally, at the Center, under the auspices of the University of Miami School of Nursing, the FDTC operates a health clinic. Parents are referred to the clinic upon entering the court and referrals are made for the full range of health services including family planning. The Center's services are court ordered and their staff participates in the court process by attending hearings and offering written reports.

MONITORING

FDTCs become involved in monitoring parents' participation in planned services to the same extent that they are exercising jurisdiction over the matter. Where the FDTC has taken jurisdiction over only substance abuse treatment and abstinence issues, its efforts are limited to monitoring these issues. Where the court has taken a more holistic approach, monitoring occurs across many more domains.

Frequent judicial monitoring of participants was a central feature of every FDTC reviewed. Parents appeared in court regularly and the judge reviewed their progress with them in open court. The judges develop a rapport with the participants and are an integral part of the participant's support system. Participants must account for their behavior directly to the judge. To keep the judge and child protective services well informed of the participant's progress, there is additional monitoring outside the court session.

There is a great variety among FDTCs as to who monitors service and compliance. Some FDTCs rely directly on treatment and service providers, child protective workers, and probation officers dedicated to the FDTC to amass and report information. In others, independent case managers track client's progress. Some FDTCs have personnel to monitor whether children's need and service requirements are being met. Case monitoring conducted by an entity independent of the service or treatment provider may enhance system accountability and relieves the service provider of the burden of preparing for court appearances, staffings, and reports. While relying directly on providers for information may reduce the number of personnel necessary to run the treatment court, it also reduces the number of personnel able to provide first hand reports.

In Suffolk County, case management functions are distributed among several participating agencies. A local not-for-profit agency employs drug and alcohol case managers and court-appointed special advocate case managers. The drug and alcohol case managers monitor compliance with substance abuse treatment, perform drug testing at the courthouse, and provide some concrete services. When issues are identified or raised by participants, these case managers engage in limited crisis intervention while referring the participant back to their treatment counselor. Special advocate case managers monitor child welfare issues that are addressed by a combination of CPS workers, public health nurses, schools, and other specialized service providers. In Kansas City, Department of Family Services (DFS) workers are assigned specifically to the FDTC to provide case management, although when their caseloads are full, other DFS workers help handle the overflow. In Pensacola, the primary counselor from the treatment agency provides case management in combination with other team members. This primary treatment counselor is responsible for written reports to the judge.

Virtually every FDTC utilizes some form of drug and alcohol testing to monitor sobriety. Where funding is available, FDTCs require frequent testing, initially as often as multiple times per week. Other courts test on a less frequent and random basis, requiring clients to call in daily and submit to random testing immediately upon request. Since dependency proceedings are civil in nature and there is a lower standard of proof required for court hearings, some FDTCs have moved away from the stringent "chain of custody" protocols required for drug testing in criminal proceedings and utilize less expensive forms of testing, saving the more rigorous and expensive procedures for situations in which the results are contested or contempt proceedings are contemplated.

ADVOCACY

Developing Resources to Meet the Complex Needs of Families

"Advocacy is one of case management's hallmarks. While a professional conducting therapy may speak out on behalf of a client, case management is dedicated to making services fit clients, rather than making clients fit services," (Siegal, 1998). FDTCs serve as an example of this kind of advocacy. Miami's Dependency Drug Court has reached out to other community agencies to provide needed services. Aftercare services, ordered at the graduation, are provided by the Project Safe program. They provide peer support, urine testing, and employment assistance. Given the prevalence of traumatic history in their client population, the Miami court also has made arrangements for therapeutic and educational services through another local agency, Victims Services Center.

The Suffolk County court has found that agencies are very willing to adjust their services and service delivery methods to meet the needs of the FDTC participants. Project

Outreach, a substance abuse treatment program, had a specialized women's unit when the court began referring clients there. Soon, Project Outreach altered its transportation zones to accommodate the court participants. As participants stayed in treatment longer and domestic violence issues began to emerge, Project Outreach collaborated with the Victims Information Bureau (VIB). VIB provided domestic violence counseling at the Project Outreach treatment facility, rather than have participants attend at the VIB facility some distance away. This accommodated the client's limited transportation and time constraints, which were already impacted by such responsibilities as parental obligations, 12-step programs, vocational/educational programs, and jobs.

QUESTIONS RAISED

Determining What Model Will Meet the Needs of Families in the Local Community

[16] Family dependency treatment courtswere born out of adult criminal drug courts, a concept so compelling and successful that its application to family court cases was inevitable. After implementing their own versions of these courts, FDTC practitioners' mantra has become "but it's not the same as drug court—it's not just about substance abuse."

In criminal courts and criminal drug courts, the primary objective is fairly straightforward: stop drug-driven criminal behavior by stopping drug use. In family court dependency cases, however, the objectives are: keep the child safe and give the child a safe and stable permanent home in a child-friendly timeframe by reunifying the child with a sober parent if possible or, if not, by finding an alternate safe, permanent placement with relatives or in an adoptive home. The priority of family reunification can only occur if the underlying problems which brought the family to the attention of CPS and the court are addressed and resolved.

These issues often extend beyond substance abuse. It is within this context that FDTCs show their divergence from DUI and drug courts.

Is the scope of the FDTC something that lends itself to a national consensus, or is it a matter that must be resolved in local jurisdictions? In deciding the scope, there needs to be agreement about the objectives of FDTCs. Is the focus to secure parental abstinence, and/or to promote family reunification, and/or to assure safe and stable permanent homes for the children in a timely fashion? Should FDTC teams identify and address children's special needs as part of promoting child well being and family reunification, or should they focus only on parental abstinence?

The first main question to be resolved is: What is the mission of the FDTC? When family courts develop a family dependency treatment court, a pivotal decision is whether its function is to address parental abstinence issues only, or whether the FDTC should address the entire range of issues present in the dependency case. The extent to which they choose to address the range of issues in the dependency case within the FDTC proceedings affects their scope, characteristics, and profile. Jurisdictions choose to be either limited or expansive in their programs for a variety of philosophical, ethical, and practical reasons, and there is wide variation across the country.

Ancillary questions that must be asked include: Is FDTC one feature of a community-wide collaboration of agencies and service providers tasked with meeting the needs of families affected by substance abuse in the child welfare system? Should the FDTC be integrated into the dependency case process or should it stand alone? On one end of the spectrum, there are courts that limit the FDTCs involvement to addressing adult substance abuse with the balance of the dependency case issues being resolved before a different judge in a separate proceeding. On the other end, there are

courts where the entire dependency case comes under FDTC jurisdiction—while adult substance abuse is the precipitating event that makes the case eligible for FDTC, the myriad of other family difficulties, adult and child, are identified, addressed, and monitored by the FDTC as well.

In addition, calendaring practices vary. In FDTCs where the dependency case remains in the home court, the parent's compliance with substance abuse treatment and abstinence is monitored in the drug court. All decisions on the dependency case, such as increased visitation or return of children, are made in the home court, while contempt of court orders regarding attendance at treatment and remaining abstinent are attended to by the drug court judge. In other courts, a single judge in a single proceeding hears dependency and sobriety issues. Routine case reviews include both parental compliance and dependency case plan progress, including children's issues and service needs. In the middle are courts where the dependency case and parental compliance with substance abuse conditions of court orders are monitored by the same judge in the same courtroom, but are heard in separate proceedings. For instance, if at a drug court appearance a parent is in compliance and requests additional visitation, that issue is deferred for determination at a separate proceeding in the dependency case where all parties and attorneys may be present and have an opportunity to respond to, and be heard on, the request.

In deciding the scope of the FDTC, jurisdictions must decide whether to follow a one-family/one-judge calendaring practice, or whether there are legitimate logistical or ethical constraints to this practice. Should the same judge who presides over the intense level of judicial monitoring of the FDTC also preside over TPR or other proceedings that may result in the temporary or permanent loss of custody? Is it possible to have all appropriate parties and attorney's present at every court proceeding or review so that all issues may be resolved as they arise?

The second main question that must be asked is: How should FDTC interface with the Adoption and Safe Families Act? That is, should FDTCs be mindful of ASFA time frames when structuring their programs? Or should they concentrate on the parent's sobriety, admitting parents regardless of their dependency case status? ASFA requires the family court to rule on the adequacy of the CPS case plan for reunification. Accordingly, should the FDTC have that responsibility? Should FDTCs have a role in formulating that plan? Should FDTCs be in the business of assessing parent, child, and family difficulties and service needs? At permanency hearings, family courts have to decide if child welfare agencies have made "reasonable efforts" to reunify families. What is the proper role of FDTCs in informing the permanency hearing?

Under ASFA, all states undergo Children and Family Service Reviews. Upon failure to meet federal standards, the state's department of social services is required to enter into a Program Improvement Plan (PIP) approved by the federal government. FDTCs have a potential impact with respect to whether "[f]amilies have enhanced capacity to provide for their children's needs,"[1]. Does the FDTC have a role in meeting the state's PIP requirements by enhancing that capacity? Does the judicial branch, more particularly, the family court, have a stake or a role in assuring that their state meets the requirements of the PIP? Does FDTC have a role in assuring that needed services are available in their community? Is that role limited to the individual families that come before the FDTC or is that role more expansive in terms of assuring that the community's array of services is adequate to avoid the financial consequences to the taxpayers if the jurisdiction does not meet the mandates of the PIP? Should FDTCs promote collaboration among the many

[1] CFSR Well Being Outcome 1 (Administration for Children and Families, 2007).

service providers who have members of FDTC families as their clients? Moreover, what are the implications of these choices? Can an "abstinence only" drug court be successful in the absence of a broad based community protocol for addressing parental substance abuse? Can an "integrated" drug and dependency court have a positive impact on collaboration across community agencies and services? Finally, what about the many non drug-related dependency cases where outcomes also would be improved if given the level of services and scrutiny afforded FDTC cases? Why should this level of assistance be denied the mentally ill or developmentally disabled parent family? Should FDTCs limit themselves to parental difficulties or should they address the difficulties and obstacles confronting the entire family in their quest for reunification?

This review and posing of questions is intended to promote discussion and debate among FDTC practitioners. The time has come to examine the consequences of choices made in the development of FDTCs to determine which processes and protocols have successfully met the needs of families and children within the context of their individual communities. Furthermore, other more specific operational questions must be addressed in each jurisdiction as they plan. Some of the operational questions raised by each section of this article are contained in Appendix A.

CONCLUSION

Family court has been greatly impacted by parental substance abuse and the rise of caseloads containing parents with co-occurring problems. Simultaneously, the 1997 Adoption and Safe Families Act created additional pressure on the system by requiring the courts and child welfare systems to resolve dependency cases within strict time limits. ASFA also has thrust upon the courts the role of judging the adequacy of efforts made by state departments of social services to assist families and the role of approving or

modifying the case plan. All this is in addition to the court's preexisting duty to hear the evidence, determine if there is enough evidence to establish a case, and assure due process to parents, children, and families.

Jurisdictions have been seeking to develop new ways to meet these demands. To that end, family dependency treatment courts have emerged as one solution. FDTCs were adapted from the practices of adult criminal drug courts. While *Defining Drug Courts: The Key Components* (NADCP, 1997) can provide valuable guidance to FDTCs as well as to adult drug courts, additions and changes must be made to comport with the best dependency court practices and to meet the complex needs of families. The court practices discussed above are some jurisdictions' attempts to adapt the best features of adult criminal drug courts to dependency court use. Several basic issues still need to be resolved, however, and questions still need to be answered by practitioners in the field, including: Of the practices reviewed, what can be determined about the consequences of the different approaches to the participant families and to practice and procedure in the different FDTC models? Do they respect long held, well thought out, philosophical and ethical jurisprudential considerations? Do they take the best advantage of local resources and opportunities? Are vestiges of historical practices hindering their development? Do they help family court professionals in their jobs and enable the system to function more efficiently? Most importantly, (how) do they benefit families?

Spinak (2002) warns that FDTCs must be vigilant in protecting families: "This commitment to ensuring family integrity must permeate the court's oversight role for the court to be distinguished from the child welfare agency's role," (p. 341). Additionally, she notes that up until now Model Courts and FDTCs have served only a small percentage of dependency cases using their own criteria to include or exclude cases. The time has come to try to take

these pilot projects and expand them to meet the overwhelming demands of child protective cases. Can the design be replicated in all family dependency courts? What modifications will be necessary to enable communities to provide these services to all dependency cases?

As FDTCs evolve and are reproduced across the country, it is time for the leaders of child welfare, the courts, and substance abuse treatment to come together to exchange information on FDTC practices and to build a framework for integrating the best of these practices into all family dependency treatment courts. In so doing, we should not disregard Spinak's (2002) admonishment that "the purpose that will justify the court's expanded authority—thus adding value to the family's life—is the rigorous enforcement of the constitutional principles that recognize the importance of children being raised by their families and not by the state." (p. 340)

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APPENDIX A

There are many practical questions raised in planning and launching a new FDTC in individual jurisdictions. They must be answered in the context of local resources and practices. Some of those considerations are suggested below. They have been structured to track the sections of the foregoing article.

Permanency Planning in the Best Interest of Children

How should FDTCs interface with ASFA? First and foremost, FDTCs will want to assure their practices are focused on the ASFA priority of the safety and best interest of children. Individual courts already may be following calendar practices tailored to individual state ASFA statutes. If these practices have not yet been employed, planning courts should consider what impact the FDTC could have on improving compliance with ASFA time frames and permanency hearing requirements and factor that into the planning process. Courts may build in protocols to assure the work of the FDTC program is recognized when making reasonable efforts determinations. They also may assure that the progress reported in FDTC court reviews is considered when determining the appropriateness of proposed permanency goals and case plans. Finally, planning courts may wish to review their state's federally required CFSR and PIP to determine if the local FDTC can respond to some of the requirements to improve their state's practice.

Necessary Partners

In every jurisdiction, there are partners who must be brought to the table. Since FDTC clearly involves the court, CPS, and treatment, appropriate representatives from those entities must be present. The array of local treatment resources will inform the decision to include the governmental licensing agency and/or the substance abuse

treatment providing agencies. A determination of which other agencies in the community are providing services to the families who will participate in the FDTC and consideration of including them in the planning process will be required.

In this process, the court and stakeholding agencies will examine and question their appropriate role. Judges will consider how their role as a community leader in this effort is shaped by judicial and ethical considerations. Similarly, determinations will be made concerning the nature and extent of judicial and court leadership in developing the FDTC and securing services necessary to assist the families involved. Other partners will examine how to maximize their participation in shaping the treatment court to best benefit families as well as individual agencies and parties they represent, while maintaining appropriate role boundaries once the FDTC becomes operational.

In engaging and maintaining collaboration with partners in the FDTC, cross-systems communication is critical to its success. Localities will have to develop communications protocols that comport with state and federal confidentiality requirements. Once appropriate waivers of confidentiality have been agreed upon, FDTCs must then develop protocols for timely and reliable communication systems. Not only must information be communicated, responses to that information must be coordinated. FDTCs will determine which agencies or individuals will be responsible for managing the information exchange and coordinating the team's response to events. In the course of developing these protocols, teams must take into account the dynamics of addiction and recovery and avoid practices that permit participants to manipulate team members who may then inadvertently enable addictive behaviors.

Defining the Mission of FDTCs

As local jurisdictions define the mission of their FDTC, they will determine the range of case issues that will come under its umbrella. The FDTC may be expansive in scope to include not only parental substance abuse, but also all of the issues that brought the family before the court in the dependency case. Or, the FDTC may be limited to parental substance abuse issues only, with the dependency case issues being addressed elsewhere. The mission and case issues included in the scope of the FDTC will impact case management and identification of necessary partners.

The team will determine the location of the hub of coordination, collaboration, and communication concerning the case plan. It may be court based, centered in CPS, or contracted out to a not-for-profit agency or substance abuse treatment provider. Deciding both which entity has the capacity to perform various functions and the appropriate roles for the court and other agencies will entail practical as well as philosophical considerations.

Exercising Legal Jurisdiction and Intake

State law dictates the type of jurisdiction for FDTCs. In some states, FDTCs will be limited to dependency cases only. In states where the court has broader jurisdiction, a determination must be made as to what other types of cases (i.e., criminal matters) involving the same family will be heard by the FDTC judge and incorporated into the case plan.

The second question regarding jurisdiction is at what point in the life of a case a parent should be considered for FDTC. Some courts will admit the parent as early as the first court appearance, while others may decide it is appropriate to wait until the parent has failed to comply with court orders to engage in AOD treatment and remain abstinent. Jurisdictions

also will need to consider the status of the case relative to ASFA time frames.

Court Calendaring Practices

Some FDTCs utilize the direct one-family/one-judge calendaring practice, keeping all issues in one courtroom and the focus on timely permanency for children. Other jurisdictions maintain the dependency case before one judge and send the parent to another judge or magistrate for the monitoring of compliance with substance abuse treatment and abstinence. This latter practice sometimes develops based on logistical considerations or concerns over whether it is appropriate for one judge to hear the FDTC status hearings as well as modification (such as return or removal of children) and TPR proceedings.

Phase Structure and Managing Client Behavior

FDTCs generally measure parental progress through the program by phases. Movement from one phase to the next is based on the achievement of certain milestones. Accomplishments should be agreed upon across disciplines and, depending on the structure of the court, may include milestones in the permanency/dependency service plan requirements, meeting parental obligations, lifestyle changes to support abstinence along with substance abuse treatment participation and progress. Whether these milestones are divided into three, four, or five phases is a matter of local preference.

Sanctions, incentives, and consequences are integral to motivating parents to comply. Teams will need to discuss a schedule of sanctions and incentives and determine how they can be consistently applied. Jurisdictions will have to explore what rewards are available within their community. With respect to determining appropriate sanctions, courts will first be guided by local law. While incarceration for

contempt may be legally available, local custom or judicial preference may dictate whether or not it will be employed. Teams also will need to educate themselves about relapse to determine when a "response" to address the circumstances of the relapse is more appropriate than a sanction.

Structure of the FDTC

Three levels of support are needed for FDTCs. First is acceptance and support of the FDTC mission and overall policy from the highest level of leadership of each entity involved. Second is agreement by supervisory personnel on protocols and practices that will be used in the FDTC. Third comes from the individuals who will actually be carrying out the work of the FDTC when it becomes operational. These levels of support may be garnered in a steering committee of high ranking officials, a planning and administrative oversight committee of managerial personnel with sufficient authority to agree to protocols and practices on behalf of their agencies/entities, and finally an operational team who is trained to utilize the protocols and practices while working directly with the families. Depending on the size of the community, these may be three distinct groups of individuals or membership may overlap completely or in part. Identifying the right individuals to fulfill these functions will have long lasting impact on the success of the FDTC.

Case Management

FDTCs will have to determine how case management will operate. Initial screening to determine eligibility for participation must occur and clinical and programmatic criteria will need to be developed. For instance, teams will have to assess their ability to work with parents with co-occurring disorders, such as mental illness.

FDTCs require the availability of assessments in order to plan appropriate services. Beyond looking at levels

of AOD use and abuse, FDTCs, depending on their scope, must consider assessments of co-occurring disorders, the presence of domestic violence, mental health concerns, family service needs, and children's health and developmental issues. After deciding what should be assessed, the team will have to agree on the assessment process including what instruments will be used and which team members will be responsible for what parts of the assessment.

The next logistical concern is formulating a case plan to meet the identified needs. The overall case plan must be developed and the multiple service plans of individual entities (CPS, treatment, children's services) must be coordinated.

Families must be linked to services. Not every parent will need the same level of substance abuse treatment, so a continuum of levels will have to be sought. As families will need other services, FDTCs will have to decide how extensive the services under its auspices will be. The court may or may not decide to address housing, vocational training, child development, child health, parent health, day care, and transportation.

A team member will need to be designated to "broker" services or refer cases. Service providers must be selected and their responsibilities to FDTC delineated. Written reports or attendance at staffings may be required, and participants, families, and case plans must be monitored. The team must decide whether CPS, a treatment provider, an independent agency, or a court employee will take responsibility for the monitoring. Depending on the scope of the FDTC and the information to be monitored, this responsibility may include substance abuse issues only or may embrace the entire case plan.

Drug and alcohol testing must be incorporated into FDTC operations. Frequency, payment for testing,

individuals to administer the test, testing protocols including test kits, what substances are tested for and how to assure tests are random and reliable, are all problems to be solved by the team.

FDTCs often engage in some form of advocacy on behalf of their families and programs. FDTCs role in developing resources to meet the complex needs of its families and the roles of the professional staff and the judge in developing resources are other questions to be debated. Other issues for planning FDTC teams to ponder include their ability to bring the program to scale to serve all parents in the community charged with neglect where substance abuse is an issue. Planning jurisdictions should maintain their focus on adding value to the lives of families while serving to reorganize the process for enhanced professional collaboration. In the excitement of developing a program that will increase success in reuniting children with sober parents, FDTCs also must assure they are sufficiently safeguarding parents' and children's due process rights.

APPENDIX B

POLICY AND PROCEDURE MANUALS REVIEWED

Albany County Family Treatment Court
Gerard E. Maney, Judge
David B. Cardona, Chief Clerk
One Van Tromp Street
Albany, NY 11207
(518) 427-3592

Durham County Family Treatment Court
Elaine O'Neal, Judge
Office of Trial Court Administration
Durham County Judicial Building
201 E. Main Street, Suite 278
Durham, NC 27701
(919) 564-7210

El Paso Family Dependency Treatment Court Program
Alfredo Chavez, Judge
Annabell Casa-Mendoza, Coordinator
65th District Court
500 E. San Antonio, Suite 1105
El Paso, TX 79901
acasas@co.el-paso.tx.us
(914) 834-8216

Erie County Family Treatment Court
Margaret O. Szczur, Judge
Erie County Department of Social Services
478 Main Street, Room 604
Buffalo, NY 14202
(716) 858-7954

Or

Erie County Family Court
1 Niagara Square
Buffalo, NY 14202
(716) 858-4764

Escambia County Family Focused Parent Drug Court
John J. Parnham, Judge
2251 N. Palafox Street
Pensacola, FL 32501

Or

Robin Wright, Sr. Deputy Court Administrator
100 W. Maxwell St.
Pensacola, FL 32501
Robin_wright@co.escambia.fl.us
(850) 595-3055

Idaho 7th Judicial District Child Protection and Parent Drug Court
P.O. Box 389
Rexburg, ID 83440
(208) 656-3243

16th Judicial Circuit Jackson County Family Drug Court
Molly Merrigan, Commission
Penny Howell, Administrator
625 E. 26th Street
Kansas City, MO 64108
(816) 435-4757

Manhattan Family Treatment Court/New York County Family Court
Gloria Sosa-Lintner, Judge
60 Lafayette Street
New York, NY 10013
(212) 374-2526

Mecklenburg County Family Treatment Court/ F.I.R.S.T. (Families in Recovery Stay Together)
800 East Fourth Street, Suite 211
Charlotte, NC 28202
(704) 358-6216

Miami-Dade County, Florida Dependency Drug Court
Jeri B. Cohen, Judge
Paul Indelicato, Director
3300 NW 27 Avenue
Miami, FL 33142
(305) 638-6102

Suffolk County Family Treatment Court
Nicolette M. Pach, Judge
Joan Genchi, Judge
Christine Olsen, Director
400 Carleton Avenue
Central Islip, NY 11702

Washoe County, Nevada Family Drug Court
Charles McGee, Judge
P.O. Box 30083
Reno, NV 89520
(775) 325-6769

Westchester County Family Treatment Court
Westchester County, NY

Yellowstone County Family Drug Court
Susan Watters, Judge
Becky Bey, Coordinator
Child and Family Services Building
2525 4th Avenue North
Billings, MT 59101
(406) 657-3156

Family Drug Treatment Courts:

A Place for Judicial Activism?

by the Honorable Angela Edwards Roberts

Socrates asserted four traits belonging to a judge: to hear courteously, to answer wisely, to consider soberly and to decide impartially.[1] The tug-of-war between judicial restraint and judicial activism was probably not part of Socrates's thinking, but has become a political concern over recent decades. In the midst of hot-button politics, however, family court judges nationwide have been responding to the nature and number of cases overwhelming their dockets. Chief Justice Judith S. Kaye of New York described in *Newsweek* exploding caseloads fueled by drug abuse, domestic violence and family dysfunction: "The flood of cases (into the courts) shows no sign of letting up. We can either bail faster or look for new ways to stem the tide."[2] Chief Justice Leah Ward Sears of Georgia wrote about it in the *Washington Post*: "Fragmented families are flooding our court dockets.... For judges they represent a difficult workload.... For children, they are a tragedy."[3]

This onslaught of family dysfunction has dramatically changed the role of the family court judge, and, more than ever, Socrates's observation must be heeded. Like our colleagues in other states, Virginia's Juvenile and Domestic Relations District Court (J&DR) judges are responding to this deluge by assuming judicial roles and trying approaches that may appear unorthodox, even activist, in nature. One of these is the family drug treatment court (FDTC).

The objective of this article is to inform lawyers and judges about these new courts and to encourage judges to be involved in this innovation. This article asserts that family drug treatment courts allow for collaborative intervention without breach of judicial ethics when a team of professionals, led by the J&DR court judge, works collaboratively to help families effectively deal with substance abuse.

Further Identifying the Problem

With the passage of the federal Adoption and Safe Families Act of 1997 (ASFA) (Public Law 105-89), Congress mandated that children in the foster care system have a permanent placement within twelve months of entering the system.[4] For parents who were substance abusers, this presented a particular challenge. Assuming they wanted addiction treatment, waiting lists were long, court dockets were crowded, and the likelihood of relapse could easily place them outside the twelve-month time frame. Could a law whose intent was to place children in loving, permanent homes rather than allowing them to languish in the foster care

system for years have the unintended effect of separating families that might reasonably be reunited?

Fearing this reality and searching for a solution to the problem, child welfare proponents borrowed principles from adult drug courts started in 1989, and applied the principles to create FDTCs.
These courts are a juvenile or family court docket of which selected abuse, neglect, and dependency cases are identified where parental substance abuse is a primary factor. Judges, attorneys, child protection services, and treatment and other social and public health personnel unite with the goal of providing safe, nurturing, and permanent homes for children while simultaneously providing parents the necessary support and services to become drug and alcohol abstinent.[5]

These courts are civil in nature and have a sense of urgency to rehabilitate participants within the mandated time frame. The ultimate sanction for failure is not incarceration as in adult drug court, but loss of parental rights. Because alcohol and drug abuse have been identified as the cause of seven out of ten child abuse and neglect cases, the need for these courts is critical.[6]

In 2004, the Conference of Chief Justices and the Conference of State Court Administrators adopted a national joint resolution committing all fifty state chief justices and state court administrators to "take steps, nationally and locally, to expand and better integrate the principles and methods of well-functioning drug courts into ongoing court operations."[7]

Family Drug Treatment Courts in Virginia

Virginia established its first drug treatment court in 1995 as a result of the judiciary's efforts to find more effective methods to handle the escalating number of drug offenders on Virginia's court dockets. This reflected the philosophy that more effective handling of drug treatment for addicts would result in higher recovery rates and reduced criminal behavior.[8] Initially starting with one adult drug treatment court, today the number of operational drug treatment court programs in the state has grown to twenty-nine. There are sixteen adult felony courts, one adult driving-under-the-influence drug treatment court, eight juvenile drug treatment courts and four family drug treatment courts. These four FDTCs are currently making a difference in Alexandria, Charlottesville/Albemarle County, Newport News and Richmond.

Virginia has strong judicial, legislative and executive support for the continuation and expansion of drug treatment courts. Because these programs represent the most successful and cost-effective approach to dealing with drug-addicted offenders. advocates continue to seek permanent and stable sources of funding.[9] Chief Justice Leroy R. Hassell Sr. commented in his address to the Virginia Drug Court Association, September 30, 2005:

> As I review the preliminary data, as I receive letters from graduates of drug courts, as I interact with participants in drug court programs and listen to their life stories, as I see families reunited, marriages restored, and jobless, unproductive people who were once, through their own fault albeit, existing in a cycle of despair, as I observe these people being transformed into productive, taxpaying citizens, I conclude that, yes, drug courts work. I conclude that, yes, drug courts are needed.[10]

Indeed, this thinking is consistent with that of Thomas Jefferson, who stated, "The care of human life and happiness, and not their destruction, is the first and only legitimate object of good government."[11] If alcoholism and drug addiction are accepted as treatable and preventable diseases, states should address them through a public health strategy with the goal of long-term recovery.[12]

How Family Drug Treatment Courts Operate

Common practices and key components adopted by the National Association of Drug Court Professionals are essential to every drug court.[13] (See sidebar.) These include requiring early case screening and assessment; prompt referral and access to a continuum of treatment and rehabilitation services; a coordinated strategy to govern responses to participants' compliance; partnerships with public agencies, treatment providers, attorneys, community-based organizations and others; and regular and active judicial supervision.[14]

FDTCs normally use a team approach to handle cases. Judge, attorney, social worker, substance abuse/mental health worker, court appointed special advocates and others are all a part of the team of professionals that provide support needed to deal with addiction. The court convenes on a weekly basis. The team of professionals keeps participants accountable by ordering various evaluations, urine screens, Alcoholics Anonymous or Narcotics Anonymous meetings, job searches or whatever else the court may

Defining Drug Courts:
The Key Components

1. Drug courts integrate alcohol and other drug treatment services with justice system case processing.
2. Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.
3. Eligible participants are identified early and promptly placed in the drug court program.
4. Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.
5. Abstinence is monitored by frequent alcohol and other drug testing.
6. A coordinated strategy governs drug court responses to participants' compliance.
7. Ongoing judicial interaction with each drug court participant is essential.
8. Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.
9. Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.
10. Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness.

(NADCP, 1997).

deem appropriate. Inpatient services and detoxification programs are often absolutely necessary.

In some cases, children of recovering parents are removed from their homes. In other cases, children are able to remain with a parent or guardian. As long as a participant is in the FDTC, he or she gets credit for working toward reunification, with the incentive being a desire to not lose custody of his or her children. Therefore, the time period may extend beyond the twelve-month ASFA-mandated period. The key is to provide community resources along with the accountability the law requires.

If a community determines that family drug treatment court would be a welcomed alternative to traditional procedures but the number of participants who would take advantage of such an opportunity is small, a regular J&DR docket could feasibly handle the cases with an intensive team approach. Clearly though, larger numbers of waiting participants who could encourage judges and family law practitioners to check into starting one in their community. For further information on Virginia drug treatment courts, please visit **www.courts.state.va.us/dtc/home.html**.

Judicial Ethics

The key to the success of any drug court rests on the professional role of the judge as leader in the drug court process. The role of the judge changes from the traditional passive one to a more active one. "No longer are courts and judges uniformly shying away from these issues because they may entail 'social work.' Instead many judges are becoming knowledgeable about substance abuse causes, symptoms, behaviors and treatments, as well as issues relating to recovery, relapse, and family dysfunctions."[15] As drug courts are becoming more accepted in the legal community, the issue of the proper ethical role of judges in the process continues to be debated. "In all judicial proceedings, the judge bears the ultimate responsibility for ensuring that the parties receive a fair hearing in a dignified forum."[16] Each of Judicial Canons 1 through 5 raises unique ethical concerns for the drug court judge. I will only focus on four of the most common.

As noted previously, a coordinated strategy governs court responses to compliance. This strategy used by all drug courts involves "staffing," in which members of the drug court team meet in advance of the participant's hearing to discuss the participant's progress in treatment and to reach consensus about rewards and sanctions. As a judge becomes part of this collaborative decision-making team that includes treatment providers, court personnel and attorneys, the judge's involvement may appear to undermine perceptions of judicial independence and impartiality. Canon 1(A) states:

> An independent and honorable judiciary is indispensable to justice in our society. A judge should participate in establishing, maintaining and enforcing high standards of conduct, and shall personally observe those standards so that the integrity and independence of the judiciary will be preserved.[17]

It is submitted that the collaborative decision-making process, however, does not violate the judge's duty of independent judgment so long as the final decisions remain with the judge. The judge may not delegate this final decision making to other members of the drug court team.[18]

All drug courts require the judge's personal engagement with each participant throughout the drug court experience. This dynamic is crucial to the successful completion of treatment and other program requirements. The ethical concern here is that of avoiding the appearance of impropriety. The judge's personal engagement must not conflict with the judge's position as a detached arbiter who is blind to the parties before the court.[19] Canon 2(A) states:

> A judge shall respect and comply with the law and shall act at all times in a manner that promotes public confidence in the integrity and impartiality of the judiciary.[20]

The Code requires impartiality, not disengagement. A judge can show concern about a participant's progress in recovery, yet can also extend the same quality of engagement and concern to all participants to avoid the appearance of impropriety.[21] If the judge maintains an active, supervising relationship throughout treatment, the likelihood increases that a participant will remain in treatment and improve the chances for reaching sobriety and family reunification.

All drug courts should forge partnerships among drug courts, public agencies and community-based organizations to generate local support and enhance drug court program effectiveness. Ethical concerns are raised when the independence or impartiality of the judiciary comes into question. As long as the focus of collaborative work in this area is to educate about drug court practices and procedures, there should be no ethical problems. Caution should be taken when partnering with law enforcement so as to not appear to be acting as an instrument of law enforcement. Where court-community partnerships cooperate in the exchange of information, ethical concerns should be minimal or nonexistent. Community organizations that educate the court about available resources merely serve to aid the court's disposition of cases. Partnerships should never include discussion of specific cases that are pending in the court, nor should they cast any doubt on the judge's capacity to act impartially.[22]

Finally, certain concerns about impartiality and dignity may arise from a judge's conduct both inside and outside of the courtroom in drug courts. Praising, hugging and clapping for participants are inconsistent with normal courtroom behavior, but quite common in drug courts. Likewise, judges attending social gatherings (like a picnic) with parties before the court is not customary, but is common in drug courts. Canon 3(B) states:

> A judge shall require order and decorum in proceedings before the judge.[23]

Realizing that a drug court's goal is to actively promote the successful treatment of participants rather than to mediate a dispute between two litigants, a judge may participate in these activities to promote the objectives of the drug court. The judge must, however, remain impartial and dignified and treat all participants equally; not discuss or transact business with participants outside of the courtroom; keep outside gatherings open to all participants; and never be alone with a single participant.[24]

The Benefits of Family Drug Treatment Courts

Family drug treatment courts have been shown to benefit families, courts and the community. They shorten a child's time in foster care by identifying substance abuse issues early and starting treatment. Also, because of the individualized case plan and the drug court team's close monitoring, the participant is more likely to succeed. If the participant fails the program, there is usually no question that reasonable efforts to rehabilitate have been provided and the case can move toward permanency. Because the time in foster care is shortened, communities save money. Family drug courts can serve as an effective preventive intervention for addicted parents by preventing babies from being born to a substance-abusing mother.[25]

Socrates's wisdom is alive in Virginia's FDTCs as the J&DR judge utilizes a team of community-based professionals to hear courteously, answer wisely, consider soberly, and decide impartially in an area of life and law where solutions are very difficult to harness. Rather than being a model of judicial restraint, family drug courts represent judicial activism to confront the onslaught of family dysfunction brought on by drug abuse. Virginia's J&DR judges are responding to the nature and number of cases overwhelming family court dockets, and the family drug treatment courts are making a difference in the lives of Virginia's children and their families. ⚖

Endnotes:

1 Quoted in Wright, *Courtroom Decorum and the Trial Process*, 51 JUDICATURE 378, 382 (1068).

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3 Hon. Leah Ward Sears, *A Case for Strengthening Marriage*, THE WASHINGTON POST, Oct. 30, 2006, at A17.

4 *Applying Drug Court Concepts in the Juvenile and Family Court Environments: A Primer for Judges* (June 1998) at 16 [hereinafter PRIMER].

5 *Painting the Current Picture: A National Report Card on Drug Courts and Other Problem Solving Court Programs in the US*, Bureau of Justice Assistance (BJA), National Drug Court Institute (NDCI)(May 2005), at 12 [hereinafter Report Card].

6 National Center on Addiction and Substance Abuse at Columbia University, New York, NY (1999). *No safe haven: Children of substance abusing parents.*

7 Report Card, *supra* note 5, at 9. See also *Therapeutic Jurisprudence and the Drug Treatment Court Movement: Revolutionizing the Criminal Justice System's Response to Drug Abuse and Crime in America,* 74 NOTRE DAME L. REV. (Jan. 1999).

8 Virginia Drug Treatment Courts Program (VDTCP) Web site at **www.courts.state.va.us/dtc/home.html**

9 For further discussion of policies to improve the ways states organize and deliver alcohol and drug prevention and treatment see "Blueprint for the States: Findings and Recommendations of a National Policy Panel. Join Together." 2006 (hereinafter Blueprints) at **www.jointogether.org**.

10 VDTCP, *supra* note 8.

11 Quoted in *Therapeutic Jurisprudence*, supra note 7 at 439.

12 "Blueprint," *supra* note 9 at 8.

13 *Defining Drug Courts: The Key Components* (National Association of Drug Court Programs, 1997)

14 *See* Report Card, *supra* note 5 at 10. 10 Key Components.

15 Primer, *supra* note 4, at 6. *See also* Pamela M. Casey and David B. Rottman, Problem-solving Courts: Models and Trends, paper presented to the National Center for State Courts (NCSC) July 8, 2003.

16 *Ethical Considerations for Judges and Attorneys in Drug Court*, National Drug Court Institute (May 2001) at 1.

17 Rules of the Virginia Supreme Court of Virginia, Part Six, Section III, Canons of Judicial Conduct for the State of Virginia. Canon 1 (A) (hereinafter Canons)

18 Ethical Considerations, supra note 15 at 3.

19 Ethical Considerations, *supra* note 15 at 5.

20 Canon 2(A), supra note 16.

21 Ethical Considerations, supra note 15 at 5.

22 Ethical Considerations, supra note 15 at 5.

23 Canon 3, *supra* note 16.

24 Ethical Considerations, *supra* note 15, at 8.

25 The Honorable Leonard Edwards, *Judicial Perspectives on Family Drug Treatment Courts*, 56 JUVENILE & FAM. CT. J. 3 (Summer 2005).

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Juvenile and Family Drug Courts: An Overview

Prepared by the
Office of Justice Programs Drug Court Clearinghouse and Technical Assistance Project

The Office of Justice Programs Drug Court Clearinghouse and Technical Assistance Project (DCCTAP) at American University, sponsored by the Drug Courts Program Office of the Office of Justice Programs, U.S. Department of Justice, compiles operational and evaluative information on adult, juvenile, and family drug court programs throughout the United States. Summary reports of drug court activities are published and updated periodically by the DCCTAP, to reflect current developments, emerging issues, experiences reported by local drug court officials, and observations of staff during the course of providing technical assistance to local jurisdictions. Juvenile and Family Drug Courts: An Overview updates our Preliminary Report on juvenile drug courts published in November 1996 and reflects information provided by juvenile and family drug courts operating in 17 States as of January 1, 1998, including one tribal court.

This report was prepared by the Office of Justice Programs Drug Court Clearinghouse and Technical Assistance Project at the American University, Washington, DC. This project is supported by Grant No. 95-DC-MX-K002 awarded by the Drug Courts Program Office, Office of Justice Programs, U.S. Department of Justice. Points of view or opinions in this document are those of the authors and do not necessarily represent the official position or policies of the U.S. Department of Justice.

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Background

As most juvenile justice practitioners know only too well, the populations and caseloads of juvenile and family court dockets have changed dramatically during the past decade. The nature of both the delinquent acts and the dependency matters being handled has become far more complex, entailing more serious and violent criminal activity and escalating degrees of substance abuse. Practitioners in the juvenile justice system also recognize that the situations that are bringing many juveniles and parents under the court's jurisdiction are often closely linked with substance abuse and with complicated, and often multigenerational, family and personal problems. These associated problems must be addressed if the escalating pattern of youth crime and family dysfunction is to be arrested. Many justice system practitioners are also recognizing that, insofar as substance abuse problems are at issue, the "juvenile," "family," and "criminal" dockets are increasingly handling the same types of situations, and often the same litigants.

The juvenile court traditionally has been considered an institution specifically established to address the juvenile's needs holistically. However, many juvenile court practitioners have found the conventional approach to be ineffective when applied to the problems of juvenile substance-abusing offenders. During the past several years, a number of jurisdictions have looked to the experiences of adult drug courts to determine how juvenile courts might adapt to deal with the increasing population of substance-abusing juveniles more effectively. The recently enacted Adoption and Safe Families Act of 1997[1] has added impetus to the establishment of juvenile and family drug courts by calling for States to initiate termination of parental rights proceedings for children who have been in foster care for 18 of the previous 22 months. This short timeframe for dealing with issues of this magnitude increases the need for court systems to develop mechanisms to ensure judicial supervision, coordination, and accountability of the services provided to juveniles and families in crisis.

Development of juvenile and family drug courts is proving to be a much more complex task than development of the adult drug court. These drug courts require the involvement of more agencies and community representatives than adult drug courts. Among the unique challenges presented are:

- Developing strategies to motivate juvenile offenders to change. Juvenile substance abusers often lack the "hitting the bottom" motivation that adult long-term substance abusers experience and often respond to in their recovery process. Juvenile offenders also frequently present a sense of invulnerability and a lack of maturity, and are at different developmental stages. Treatment and rehabilitation plans for juveniles need to take these factors into account;

- Counteracting the negative influences of peers, gangs, and family members;

- Adequately addressing the needs of the family, especially families with substance abuse problems, some of which may have gone on for generations;

- Complying with confidentiality requirements for juvenile proceedings while at the same time, obtaining necessary information to meaningfully address the juvenile's problems and progress; and

[1] *Public Law 105-89. Sec. 103.111 Stat. 2115.*

- Responding to the numerous developmental changes that occur in the lives of the juveniles while they are under the court's jurisdiction.

The development of juvenile and family drug courts has, therefore, required special strategies to address these and other issues that emerged during the course of program planning and implementation. While the hallmark of juvenile drug courts operating to date has been flexibility, the following characteristics are common to their approaches:

- Much earlier and more comprehensive intake assessments for both juveniles and adults;
- Much greater focus on the functioning of the family, as well as the juvenile and/or parent, throughout the period of participation in the drug court program;
- Much closer integration of the information obtained during the intake and assessment process with subsequent decisions made in the case;
- Much greater coordination among the court, the treatment community, the school system, and other community agencies in responding to the needs of the juvenile, the family, and the court;
- Much more active and continuous judicial supervision of both the juvenile and/or family member's progress in treatment and compliance with other program conditions *and* the various treatment and other rehabilitation services being provided;
- Immediate judicial use of both sanctions applied for noncompliance and incentives to recognize progress by the juvenile and the family.

Because juvenile and family drug court programs are relatively new and are still evolving, they need to continually "retool" if they are to stay abreast of the needs of their target populations. Most programs, for example, characterize the extent of drug use among the participating juveniles as increasingly more severe. Most also report the age at first use among participants to be commonly between 10 and 14 years, although earlier use is being detected. During 1995 and 1996, when the first juvenile drug courts developed, the primary drugs used by juvenile participants were reported to be alcohol and marijuana. More recently, however, there appears to be increasing use of other substances, particularly methamphetamine, crack/cocaine, heroin, and toxic inhalants.

Defining Juvenile and Family Drug Courts

For the purpose of this report, a *juvenile* drug court is defined as a drug court that focuses on juvenile delinquency (e.g., criminal) matters and status offenses (e.g., truancy) that involve substance-abusing juveniles. A *family* drug court is defined as a drug court that deals with cases involving parental rights, in which an adult is the party litigant, which come before the court through either the criminal or civil process, and which arise out of the substance abuse of a parent. These cases can include: custody and visitation disputes; abuse, neglect, and dependency matters; petitions to terminate parental rights; guardianship proceedings; and other loss, restriction, or limitation of parental rights.

Goals of Juvenile and Family Drug Courts

Juvenile and family drug courts provide immediate *intervention* in the lives of children and parents using drugs or exposed to substance addiction through family members, as well as *structure* for the litigants through the ongoing, active involvement and oversight of the drug court judges. Common goals of juvenile drug courts therefore include providing children with an opportunity to be clean and sober, constructive support to aid them in resisting further criminal activity, support to perform well in school and develop positive relationships in the community, and skills that will aid them in leading productive, substance-free, and crime-free lives. Most programs recognize that to accomplish these goals, the court may need to have a continuing involvement with each child beyond the period traditionally required by the adversarial process. Goals of family drug courts are similar and include helping the parent to become emotionally, financially, and personally self-sufficient and to develop parenting and "coping" skills adequate for serving as an effective parent on a day-to-day basis.

Juvenile and family drug courts use a variety of strategies to achieve these goals. They are developing systems of triage applied at intake to better utilize community services, recognizing and responding to the cultural diversity of children and parents involved in court proceedings and the environments in which they live, and treating children and families holistically. For example, they have worked to overcome the dichotomy (for management purposes) between juvenile delinquency and family/dependency matters and to provide substance abuse treatment that addresses family issues.

Juvenile and Family Drug Courts vs. The Traditional Court Process

Most juvenile court professionals who are establishing juvenile drug courts are initiating these programs to provide the intensive judicial intervention and supervision of juveniles and families involved in substance abuse that is not generally available through the traditional juvenile court process. In part because of high caseloads and in part as a result of a lack of comprehensive treatment resources, the proponents of juvenile drug courts feel that the traditional juvenile court is becoming a forum focusing more on the determination of guilt than on the court's original mission of rehabilitation. With the ever-growing prevalence of substance abuse among juveniles and the complexity entailed in their treatment, which must necessarily involve both the child and his/her living environment, the traditional juvenile justice process may be unable to deal effectively with the whole problem.

The juvenile and family drug court is designed to fill this gap by providing immediate and continuous court intervention that includes requiring both the child and the family to participate in treatment, submit to frequent drug testing, appear at regular and frequent court status hearings, and comply with other court conditions geared to accountability, rehabilitation, long-term sobriety, and cessation of criminal activity. Enhancements introduced by the juvenile and family drug court to the traditional court process for handling these types of cases include:

- ❑ Immediate intervention by the court and continuous supervision of the progress of the juvenile and his/her family by the judge;
- ❑ Development of a program of treatment and rehabilitation services that addresses the *family's* needs, not simply the child's;
- ❑ Judicial oversight and coordination of treatment and rehabilitation services provided to promote accountability and reduce duplication of effort;
- ❑ Immediate response by the court to the needs of the child and his/her family and to noncompliance by either the child or the family with the court's program conditions; and
- ❑ Judicial leadership in bringing together the schools, treatment resources, and other community agencies to work together to achieve the drug court's goals.

Juvenile and Family Drug Court Structure

The Judge

The judge is the key leader for the juvenile and family drug court programs. The judge not only oversees the child's performance and progress and that of his/her family but also must bring together all parts of the program, those within the criminal justice system as well as those associated with community, educational, public health, mental health, and other resources needed to support the child and his/her family's progress.

Operational Process

Most existing juvenile drug courts are post-adjudication programs that operate after the guilt of a child has been determined, through either trial or plea. Many advocate using a post-adjudication, rather than diversion, model because of the more extensive authority available to the court and the options available if the child fails to complete the program. The case disposition process, however, can entail suspending a sentence of commitment, deferring sentencing, or striking the guilty finding and dismissing the charge, pending the child's performance in the program.

Eligibility Requirements

For each jurisdiction, the process of determining the juvenile drug court's target population has, in effect, centered upon determining how best to make use of limited available resources. As in adult drug courts, there is concern that the populations targeted for participation not be dictated by desires to achieve high "success" rates, focusing on children who present minimal risks rather than those with more serious problems who can truly benefit from the drug court program. Given this concern, most juvenile drug courts, at least initially, focus on juveniles with moderate to heavy substance abuse who are not dangerous to the community. Determining a child's potential danger to the community has presented more complex screening and assessment tasks for the juvenile drug court than its adult counterpart because little history regarding a child's propensity for violence is available for many of the children brought before the court. Confidentiality requirements further complicate this task by inhibiting exchange of information regarding a child's prior activities, including acts of violence.

Program Design

Populations and Situations Targeted

Most juvenile drug courts are targeting juveniles with nonviolent drug or drug-related offenses, although some programs include certain assault cases where substance use is involved, such as fighting at school. Many feel that children of participants in adult drug courts also should be targeted—particularly if they are involved in the juvenile justice system—because they are already exposed to drug use through their parents or other family members, even if they are not themselves before the court.

There is debate as to whether children involved in gang activity should be permitted in a juvenile drug court. Some feel, at least initially, a juvenile drug court should exclude children involved in gangs; others, however, are concerned about "labeling" children as "gang-involved" without taking into account the nature of their involvement, the role of gangs in their community, and whether any of these children might really need to be helped and could profit from the program.

Most family drug courts are targeting abuse and neglect cases, many of which enter initially as civil actions but quickly become criminal matters as the court's criminal contempt powers are relied upon for enforcement of court orders. Most programs characterize the extent of substance addiction among the participating adults as severe and long-term.

Treatment

As with the adult drug court, juvenile and family drug court treatment services do not end with the treatment provider. All activity generated by the juvenile drug court is designed to have a therapeutic value, including the ongoing interaction between "treatment" and "court" processes. Among the special attributes of treatment services offered by juvenile drug courts are: (1) assessing the juvenile and his/her family situation early and continually (2) providing treatment programs that are developmentally based, gender specific, and culturally competent; (3) incorporating an "outreach" component to the assessment and treatment process that includes periodic visits to the home to assess the family situation; and (4) addressing the school performance, peer relationships, and self-esteem issues of each juvenile participant, in addition to his/her family situation. It is also recognized that treatment services for participants in juvenile and family drug court may need to be provided beyond the sanction period (e.g., the period of the court's jurisdiction), so the availability of aftercare services is vital.

Sanctions and Incentives

Like adult drug courts, sanctions in the juvenile drug court must be structured to promote each juvenile's ability to take responsibility for his/her actions. Positive rewards and incentives for compliance with program conditions are as important as negative sanctions for program noncompliance. Most drug court professionals agree that the hallmark of any sanctioning scheme must be consistency and predictability.

As noted above, juvenile drug courts commonly impose sentences of detention that can be stayed pending participation in the drug court but can still be maintained for leverage with a noncompliant drug court participant. There is some concern about the use of detention in cases before the determination of

guilt; in these instances the nature of the detention facility must be considered. Short-term incarceration is generally viewed as much more effective than long-term.

The positive incentives valued most highly by drug court participants, both juvenile and adult, seem to be the handshake and words of encouragement from the judge and the accolades of the other drug court participants. Specially designed point systems and contracts between the drug court and the participant provide both positive and negative reinforcement and help to develop the participant's internal sense of accountability. Some juvenile drug court programs require participants to keep a daily journal or maintain a "thinking log," as a key requirement for program participation. One judge maintains a drug court library from which all participants must read and has designated a portion of the courtroom wall to display artwork produced by the participating juveniles.

Management and Evaluation

The need to maintain adequate information on both participants and the overall operation of the juvenile drug court is critical. Like their adult counterparts, most juvenile drug courts are encountering difficulties in integrating the various databases that contain essential information (e.g., court, school, public health, social services, law enforcement, treatment provider) but are frequently incompatible with one another. In addition, jurisdictions that are integrating existing systems for juvenile and family drug court purposes must comply with Federal and State confidentiality requirements. All agree that juvenile and family drug courts must produce objective and measurable outcome data that can serve as a guideline for monitoring program operations and against which the effectiveness of the program can be assessed. The first step in developing useful information systems for juvenile and family drug courts, however, requires that representatives of the key agencies involved identify the critical data elements needed to make decisions and measure outcome, and then determine how this data can be compiled, maintained, and accessed on a regular basis.

Critical Issues Unique to Juvenile and Family Drug Court Programs

Adequately Assessing Family Needs and Problems

Most juvenile and family drug court practitioners observe a high correlation between a juvenile's drug abuse and that of a parent or other family member and feel it important to address the family's problems to deal effectively with the child's. It is unlikely, therefore, that the court can deal with the "delinquency" issue and not get involved with "dependency" issues as well, even if no formal dependency action is pending. Conversely, it is considered likely that if family issues are not addressed, the child will continue to come back to court with the same problems. Recognizing that it is counterproductive to draw a line between what is needed for the child and what's needed for the family, the juvenile drug courts' challenge is to assess family needs fully and to engage the family in the child's recovery.

Compelling Involvement of Parents of Juvenile Drug Court Participants

A key issue for juvenile drug court judges in particular is how to constructively respond to noncompliance by parents of juvenile drug court participants. Even if incarceration or other sanctions are within the power of the court to impose on noncomplying parents, the question remains whether such action will actually help or harm the relationships between the parent and the child or the court and the child. Incarceration of parents or removal of a child from the home are certainly viewed as last resorts. A number of juvenile drug court programs require parents to participate in special parent groups that provide both support and the opportunity to develop parenting skills. Most juvenile and family drug court judges are coming to realize that their ultimate effectiveness, in the long term, will depend upon their achieving parental compliance with drug court program requirements through ***persuasion*** rather than coercion.

In some States, families are required to participate in court proceedings involving their children, and in some (Indiana, for example) this requirement extends to anyone living in the child's household. In others, however, there does not appear to be clear authority to compel the participation of parents in a juvenile drug court program. Although the privilege of confidentiality is usually considered to be the child's, it is generally the parent or guardian who must waive it. While most juvenile drug courts are using existing legal authority to compel parental participation, strategies for dealing with a truly noncompliant parent, such as appointment of a guardian *ad litem*, need to be further explored.

Addressing the Ramifications of Adults' Substance Abuse for Children

Most agree that drug use by adults has a direct effect on children with whom they are in contact, either by example, by involvement, or in utero. (See also "Populations and Situations Targeted" above.) In jurisdictions where both adult and juvenile drug courts operate, it has been suggested that the adult drug court refer children of participants to the juvenile drug court for special educational and prevention services. Even jurisdictions that do not have an adult drug court can be alert to the potential

ramifications of parents' substance addiction for children, whether the parents come before the court through criminal, domestic, or other civil proceedings.

Defining the "Family" of Juvenile and Family Drug Court Participants

One special issue many juvenile courts must address is how to define the child's "family." The immediate "family" of a child may not be nuclear; it may be godparents, step-parents, other relatives, live-in friends of parents, neighbors, or other caretakers. Juvenile drug court programs are therefore finding it necessary to identify an adult figure in the child's life to work with him or her, recognizing that this adult figure may change during the period of the court's jurisdiction. Another family dynamic that must be addressed is the juvenile who either is or becomes a parent during the period of program participation.

Some programs are using peer groups composed of juveniles who are further along in the juvenile drug court process to reinforce positive family influences and overcome negative ones. The dynamics of drug courts, both juvenile and adult, frequently take on the characteristics of an extended family. Drug court programs, while focusing on family issues, also operate with the recognition that some families involved with the program are dysfunctional and, despite the program's best efforts, will not change sufficiently to support the juvenile's needs. Juvenile drug courts, therefore, must equip participants with life and coping skills and, if necessary, strive to find alternative adult role models.

The School System Connection

Most juvenile drug courts make a special effort to develop a close relationship with the schools because it is in everyone's best interest that the children involved in juvenile and family drug courts succeed in school. In a number of jurisdictions, school systems, which previously expelled children arrested for substance offenses, have begun working with the court to keep these children in school. They also have provided support services for the juvenile drug court, such as making available basketball courts after school hours. Jurisdictions are finding that the juvenile drug court benefits the school system in that the rigid supervision elements of the programs can reinforce school policies, and provide an immediate mechanism for addressing school-related problems as they occur. Because a number of juvenile drug court participants are often not in traditional schools at time of program entry, special efforts are also being made to develop relationships with alternative schools as well. Most recent information from juvenile drug courts indicates that more than 80 percent of participants have returned, or remained, in school full-time as a result of program participation—a significantly higher rate than would have been expected if the juvenile drug court had not been established.

Important Collaborations

Community Organizations

All of the juvenile and family drug courts are making concerted efforts to actively involve the schools, faith communities, business community, recreation services, and a diversity of additional resources, including public health agencies, community anti-drug coalitions, local universities, and retired citizens. Many judges are personally seeking the support and involvement of these local organizations.

Public Health

Critical to the juvenile and family drug court process is addressing the public health needs of the participating children, including assessment, treatment, prevention, and other components. Among the most frequent public health problems being addressed are HIV infection, sexually transmitted diseases, and the presence of mental disorders, such as attention deficit disorders.

Local Bar

Significant efforts are being made to educate the local bar regarding juvenile court processes, school procedures, and the needs of children to be addressed, as envisioned by the juvenile and family drug courts. Some jurisdictions are seeking to attract members of the young lawyers divisions of local bar associations to participate in the local juvenile or family drug court process, which can also provide these attorneys with courtroom experience.

Law Enforcement

The relationship between the juvenile and family drug courts and local law enforcement agencies is vital, and their involvement in the planning and implementation of these programs has been considered critical. In some jurisdictions, the police officer assigned to the juvenile drug court knows the participants and can also explain the drug court process to other officers. The liaison officers also "keep an eye on" the participants, particularly if they are seen in a drug area. If the participant fails to appear at treatment or in court, police officers familiar with the program and the participant can also execute an immediate bench warrant. Community policing can also be a very important component of juvenile drug court programs. In at least one jurisdiction, a local sheriff's department has provided direct support for the juvenile drug court initiative by contributing funds for treatment.

Conclusion

Because juvenile and family drug courts are relatively new, there has not been a sufficient period of operation to document significant results over the long term. Juvenile and family drug court judges are reporting, however, that their initial experience confirms remarkable sustained turnaround by juveniles and adults in the program who were otherwise at high risk for continued, escalating criminal involvement and illegal substance use. Such indicators as recidivism, drug usage, educational achievement, and family preservation, either through retention or regaining of custody, indicate that juvenile and family drug courts hold significant potential. All involved with these programs also agree that the juvenile and family drug courts are exercising much more aggressive supervision over the juvenile offender and adult litigant than would be provided in the traditional court process. They also believe that the rigorous monitoring of participants, along with the treatment and rehabilitation requirements imposed, promotes a far greater likelihood of success in reducing drug use and criminal activity than can be achieved through the traditional court process.

For Further Information

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State	Operating Over 2 Years	Recently Implemented	Being Planned	Total
ALABAMA	**Jefferson Co.** -Birmingham (fam) **[1 fam]**	**Franklin Co.** -Russellville (juv/ad) **[1 cmb]**	**Butler/Lowndes/Crenshaw Cos.** -Greenville/Haynesville (ad/juv) **Calhoun Co.** -Anniston (juv) **Cullman Co.** -Cullman (juv) **Madison Co.** -Huntsville (fam) **Shelby Co.** -Columbiana (juv) **Tuscaloosa Co.** -Tuscaloosa (juv) **[4 juv, 1 fam, 1 cmb]**	4 juv 2 fam 2 cmb 8 TOTAL
ALASKA			**Tribal** -Napskiak(ad/juv) **[1 cmb]**	1 cmb 1 TOTAL

State	Operating Over 2 Years	Recently Implemented	Being Planned	Total
ARIZONA	**Maricopa Co.** -Phoenix (juv) **Pima Co.** -Tucson (juv) **Yavapai Co.** -Prescott (juv) -Prescott (fam) **Tribal** **Hualapai Tribe** - Peach Springs(juv/ad) **Pascua Yaqui Tribe** -Tuscon (juv) **[4 juv, 1 fam 1 cmb]**	**Tribal** **Havasupai** -Havasupai (ad/juv/fam) **Kaibab Band of So. Paiute** [- Redhill Village- Pipe Springs/ Kaibab (juv)] **Sacaton/Gila River** -Sacaton (juv) **Salt River Tribe** -Scottsdale (juv) **[2 juv, 1 cmb** + *1 inactive juv* **]**	**Cochise Co.** -Bisbee (juv) **Maricopa Co.** -Phoenix (fam) **Pima Co.** -Tuscon (fam) **Yuma Co.** -Yuma(juv) **Tribal** **Pascua Yaqui Tribe** -Tuscon (fam) **[2 juv + 3 fam]**	8 juv 4 fam 2 cmb 13 TOTAL
ARKANSAS			**Saline Co.** -Benton (juv) **[1 juv]**	1 juv 1 TOTAL

State	Operating Over 2 Years	Recently Implemented	Being Planned	Total
CALIFORNIA	**Butte Co.** -Oroville (juv) **El Dorado Co.** -Placerville (juv) **Fresno Co.** -Fresno Sup.(juv) **Kern Co.** -Bakersfield (juv) **Kings Co.** -Hanford (juv) **Los Angeles Co.** -Sylmar (juv) **Mendocino Co.** -Ukiah, (juv) **Napa Co.** -Napa (juv) **Orange Co.** -Santa Ana (juv) **Placer Co.** -Auburn (juv) **Riverside Co.** -Riverside(Juv) **San Diego Co.** -San Diego (juv) -San Diego (fam) **San Francisco Co.** -San Francisco (juv) **San Joaquin Co.** -Stockton (juv) **Santa Clara Co.** -San Jose (fam) -San Jose (juv) **Stanislaus Co.** -Modesto (juv) **Tulare Co.** -Visalia (juv) **Ventura Co.** -Ventura (juv) (cont.)	**Contra Costa Co.** -Richmond (juv) **Los Angeles Co.** -Long Beach (juv) **Marin Co.** -San Rafael (juv) **Merced Co.** -Merced (juv) **Plumas Co.** -Quincy (juv) **Riverside Co.** -Riverside (fam) **Sacramento Co.** -Sacramento (fam) **San Luis Obispo Co.** -San Luis (juv) **San Mateo Co.** -Redwood City (juv) **Santa Barbara Co.** -Lompoc (juv) -Santa Barbara (juv) -Santa Maria (juv) **Siskiyou Co.** -Yreka (juv) **Sonoma Co.** -Santa Rosa (juv) **[12 juv, 2 fam]**	**Contra Costa Co.** -Walnut Creek (juv) **Fresno Co.** -Fresno (fam) **Glenn Co.** -Willows (juv) **Los Angeles Co.** -East Lake (juv) **Madera Co.** -Madera (fam) **Nevada Co.** -Nevada City (juv) **Placer Co.** -Tahoe (juv) **Santa Cruz Co.** -Santa Cruz (juv) **Shasta Co.** -Redding (juv) **Siskiyou Co.** -Yreka (fam) **Solano Co.** -Fairfield (juv) **Trinity Co.** -Weaverville (juv) **Tulare Co.** -Visalia (fam) **[9 juv, 4 fam]**	41 juv 9 fam 50 TOTAL

OJP Drug Court Clearinghouse and Technical Assistance Project
Summary of Drug Court Activity by State and County
JUVENILE & FAMILY DRUG COURTS
January 29, 2002

State	Operating Over 2 Years	Recently Implemented	Being Planned	Total
CALIFORNIA (cont.)	**Yolo Co.** -Woodland dep (fam) -Woodland (juv) **Yuba Co.** -Marysville (juv) **[20 juv, 3 fam]**			
COLORADO	**Larimer Co.** -Fort Collins (juv) **[1 juv]**	**Denver Co.** -Denver (juv) **[1 juv]**	**El Paso Co.** -Colorado Springs (fam) **Tribal** **Southern Ute/La Plata** -Ignacio (fam) **[2 fam]**	2 juv 2 fam 4 TOTAL
CONNECTICUT	**Hartford Co.** -Hartford (juv) **[1 juv]**			1 juv 1 TOTAL
DELAWARE	**Kent Co.** -Dover (juv) -Wilmington (juv) **Sussex Co.** -Georgetown (juv) **[3 juv]**			3 juv 3 TOTAL
DISTRICT OF COLUMBIA		**District of Columbia** -D.C. Superior (juv) **[1 juv]**	**District of Columbia** -D.C. Superior (fam) **[1 fam]**	1 juv 1 fam 2 TOTAL

FDC Literature Review: Annotated Bibliography

Drug Court Overview and Approaches/Models

Ashford, J.B. (2004). Treating substance-abusing parents: A study of the Pima County family drug court approach. *Juvenile and Family Court Journal, 4,* 27-37. doi: 10.1111/j.1755-6988.2004.tb00171.x

A geographical comparison-group design was used to examine the effectiveness of the Pima County (Arizona) Court Assisted Treatment Services (CATS) program and its drug court intervention. The study compared the summary statistics for the volunteers to the family drug court (n=33) with a treatment-refusal group (n=42) and a treatment-as-usual group (n=45) from a matched geographical area. The findings of this study indicate that the family drug court group had higher engagement and completion rates of residential treatment than was true of the other comparison groups. In addition, the volunteers to the family drug court group had fewer parental rights severed, a higher percentage of permanency decisions reached within one year, earlier permanency decisions, and a higher percentage of children placed with their parents. The implications of this study's findings for future evaluations of the components of a family drug court intervention are discussed.

BJA. (2004). *Family dependency treatment courts: Addressing child abuse and neglect cases using a drug court model.* Rockville, MD: U.S. Dept. of Health and Human Services. Center for Substance Abuse Treatment

Bryan, B. & Havens, J. (2008). Key linkages between child welfare and substance abuse treatment: Social functioning improvements and client satisfaction in a family drug treatment court. *Family Court Review, 46,* 151-162. doi: 10.1111/j.1744-1617.2007.00189.x

This article summarizes earlyfindings regarding social functioning and client satisfaction from a longitudinal study of women receiving treatment in a family drug treatment court located in the Midwestern United States (N= 33). Drug treatment court participants were interviewed at program entry and when they had completed 6 months of treatment. Family drug court participants reported significant improvements in employment status and increases in earned income after 6 months of treatment. Respondents also reported improved social functioning and high overall levels of satisfaction with treatment. Findings and implications for future research are discussed.

Cannavo, J.M., &Nochajski, T.H. (2011). Factors contributing to enrollment in a family treatment court. *The American Journal of Drug and Alcohol Abuse,37*(1), 54-61. DOI:10.3109/00952990.2010.535579

The literature has shown that standard drug courts have had some success in reducing recidivism. As a result of drug court success, there has been an extension of therapeutic courts into other areas, including family courts. Characteristics that identify those who

are likely to refuse entering a Family Treatment Court (FTC) can provide insight into how refusal rates may be decreased. This study evaluated FTC enrollment to identify predictors that may aid in the development of interventions to decrease refusal rates. A total of 229 referrals to the FTC were included in this study. Comparisons were made across a number of factors between those who chose to enroll in the FTC and those who did not. Binary logistic regression modeled the effect of independent variables on the probability of enrollment. There were high rates of mental health problems, with high rates of trauma exposure in the sample, consisting mostly of females. Race, government assistance, severity of substance use problems, motivation to change substance use behavior, and parent–child interactions were significant predictors of enrollment. The results for the study point out the need for possible specialized treatments and a need to consider how motivational elements may be addressed during the intake assessment to aid in decreasing refusal rates. Additionally, the results point toward a need for consideration of family system approaches when working with FTC participants as well as the need for further work with motivational elements and drug court participants.

Dakof, G.A., Cohen, J.B., & Duarte, E. (2009). Increasing reunification for substance-abusing mothers and their children: Comparing two drug court interventions in Miami. *Juvenile and Family Court Journal, 60,* 11-23.

This study provides a quasi-experimental test of 80 consecutive enrollments in the Miami-Dade (Florida) Dependency Drug Court in order to examine the impact of a family-based and gender specific intervention, Engaging Moms Program (EMP), on drug court graduation and family reunfication. We compared EMP with case management services (CMS). Results indicated that 72% of mothers in the EMP graduated from drug court, and 70% were reunified with their children. In contrast, 38% of mothers receiving CMS graduated from drug court, and 40% were reunited with their children. EMP, then, appears to be a promising family drug court intervention.

Dakof, G.A., Cohen, J.B., Henderson, C.E., Duarte, E., Boustani, M., Blackburn, A., Venzer, E. & Hawes, S. (2010). A randomized pilot study of the Engaging Moms Program for family drug court. *Journal of Substance Abuse Treatment, 38,* 263-274. doi: 10.1016/j.jsat.2010.01.002

In response to the need for effective drug court interventions, the effectiveness of the Engaging Moms Program (EMP) versus Intensive Case Management Services (ICMS) on multiple outcomes for mothers enrolled in family drug court was investigated. In this intent-to-treat study,mothers (N = 62) were randomly assigned to either usual drug court care or the Engaging Moms drug court program. Mothers were assessed at intake and 3, 6, 12, and 18 months following intake. Results indicated that at 18 months post drug court enrollment, 77% of mothers assigned to EMP versus 55% of mothers assigned to ICMS had positive child welfare dispositions. There were statistically significant time effects for both intervention groups on multiple outcomes including substance use, mental health, parenting practices, and family functioning. EMP showed equal or better improvement than ICMS on all outcomes. The results suggest that EMP in family drug court is a viable and promising intervention approach to reduce maternal addiction and child maltreatment.

DeMatteo, D., Filone, S., & LaDuke, C. (2011). Methodological, ethical, and legal considerations in Drug Court research. *Behavioral Sciences & the Law, 29*(6), 806-820.

Since their inception in the late 1980s, drug courts have become the most prevalent specialty court in the United States. A large body of outcome research conducted over the past two decades has demonstrated that drug courts effectively reduce drug use and criminal recidivism, which has led to the rapid proliferation of these courts. Importantly, drug court research has flourished despite the many challenges faced by researchers when working with a vulnerable population of justice-involved substance users. In this article, we highlight the most common methodological, ethical, and legal challenges encountered in drug court research, and discuss ways in which researchers can overcome these challenges to conduct high-quality research. Drug court research exemplifies how rigorous empirical investigation can be accomplished in the criminal justice system, and it can serve as a useful model for researchers working in other parts of the judicial system.

Dice, J.L., Claussen, A.H., Katz, L.F., & Cohen, J.B. (2004). Parenting in dependency drug court. *Juvenile and Family Court Journal, 55*(3), 1-10.

This article discusses the underlying approach and philosophy of the Miami-Dade Dependency Drug Court (DDC), which addresses the needs of families affected by substance abuse through a comprehensive and therapeutic approach. The DDC works with community agencies to provide services that effectively treat the family as a unit. The DDC provides a model approach to addressing risk factors associated with substance abuse in families and a model approach to collaboration with community stakeholders. This article discusses the process of adapting a parenting program to meet the needs of families in the DDC.

Family court and outpatient treatment hoped to lead to more reunification. (2008). *Alcoholism & Drug Abuse Weekly*, *20*(20), 1-6.

The article reports on the joint effort of the Department of Human Resources (DHS) and the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) to improve parent reunification in the state. The two agencies believe that the problems in the state's foster care system could be solved by expanding the family court program, which aims to reunify parents who are substance-dependent. They funded the assessment and treatment for these parents. [PUBLICATION ABSTRACT]

Kuhn, J.A. (1998). Seven-Year Lessons on Unified Family Courts: What We Have Learned since the 1990 National Family Court Symposium. *Family Law Quarterly, 32, 67-93.*

In October 1990, the National Council of Juvenile and Family Court Judges conducted "a first of its kind" symposium that addressed the topic of unified family courts. Teams of three to five judges, court professionals, legislators, and service providers from over twenty states attended the program to identify and offer to state courts a series of

recommendations for implementation of a model family court. The product of this symposium, Recommendations for a Model Family Court, l also known as the "Redbook," has been heavily relied upon during the last seven years by persons all over the country who have sought to improve the justice system's response to children and families by creating a unified family court.

Lesperance, T., Moore, K.A., Barrett, B., Young, S., Clark, C., &Ochshorn, E. (2011). Relationship between trauma and risky behavior in substance-abusing parents involved in a family dependency treatment court. *Journal of Aggression, Maltreatment & Trauma 20*(2), 163-174.

This exploratory study examined participants in a Family Dependency Treatment Court (FDTC), designed for substance-abusing parents whose children were removed from the home. Twenty-five participants were interviewed one year after FDTC enrollment to assess retrospectively the relationship between trauma history and risky behaviors. Treatment compliance rates were found to be high, and most participants had negative urinalysis results. Qualitative analyses revealed that approximately half of the participants attributed decreases in risky behaviors to the FDTC program. This study increases understanding of the effect of substance abuse and trauma on high-risk behaviors and might help to improve services for substance-abusing parents involved in the child welfare system. Finally, the future success of reducing child abuse and neglect and parental substance use could hinge on the partnership between judicial and substance abuse treatment through FDTCs. Findings from this exploratory pilot study should be replicated with more representative and larger samples.

Malbin, D.V. (2004). Fetal alcohol spectrum disorder (FASD) and the role of family court judges in improving outcomes for children and families. *Juvenile and Family Court Journal, 55*(2), 53-63.

The purpose of this article is to support increased recognition and efficacy of services for people with Fetal Alcohol Spectrum Disorder (FASD) in the legal system. FASD is under-reported, under-diagnosed, and over-represented in juvenile justice. Prenatal alcohol and other drug exposure causes brain damage that affects behaviors, e.g., poor judgment, impulsivity, difficulty learning from experience, and difficulty understanding consequences, leading to multiple diagnoses such as Attention Deficit Disorder, Conduct Disorder, Oppositional Defiant Disorder and Emotionally Disturbed. FASD is an invisible physical disability; most people with FASD have no observable physical characteristics. The courts are in an important position to increase awareness of this problem by simply asking whether FASD is a factor that needs to be considered. This article includes: (1) an overview of FASD diagnostic criteria and current terminology; (2) exploration of FASD as a physical disability with behavioral symptoms; (3) a case example illustrating common patterns of behaviors in children and adults with FASD without identification and improved outcomes following identification and implementation of appropriate treatment; and (4) recommendations for family court judges. The courts are in an important position to increase awareness of this problem by

encouraging advocates and professionals to learn more about FASD and to take it into account when making recommendations to the court.

National Center on Substance Abuse and Child Welfare (2011*). Introduction to cross-system data resources in child welfare, alcohol and other drug services, and courts.* US Department of Health and Human Services: Rockville, MD.

This guide was developed for use by management and administrative officials at the State, county, and tribal level who wish to develop cross-system relationships in child welfare, alcohol, and other drug services, and court systems. The guide presents detailed information on five child welfare data-reporting systems, three other child welfare data systems, five alcohol and other drugs system data, two court system information sources, two tribal child welfare data systems, and one tribal health system data source. The child welfare data-reporting systems are the Statewide Automated Child Welfare Information System, the Adoption and Foster Care Analysis and Reporting System, the National Child Abuse and Neglect Data System, the National Youth in Transition Database, and the Child and Family Services Review. Other data systems discussed include the Longitudinal Studies of Child Abuse and Neglect, the Center for State Foster Care and Adoption Data, the National Data Analysis System, the Treatment Episode Data Set, the National Survey of Substance Abuse and Treatment Services, the Inventory of Substance Abuse Treatment Services, the National Survey on Drug Use and Health, and the National Outcome Measures for Co-Occurring Disorders. Additional systems include the National Consortium on State Court Automation Functional Standards, Dependency Court Performance Measures, child welfare data from the Bureau of Indian Affairs and the HIS Resource and Patient Management System, and tribal health system data from the Resource and Patient Management System.

Oliveros, A., & Kaufman, J. (2011). Addressing substance abuse treatment needs of parents involved with the child welfare system. *Child Welfare, 90*(1), 25-41.

The goal of this paper is to synthesize available data to help guide policy and programmatic initiatives for families with substance abuse problems who are involved with the child welfare system, and identify gaps in the research base preventing further refinement of practices in this area. To date, Family Treatment Drug Court and newly developed home-based substance abuse treatment interventions appear the most effective at improving substance abuse treatment initiation and completion in child welfare populations. Research is needed to compare the efficacy of these two approaches, and examine cost and child well-being indicators in addition to substance abuse treatment and child welfare outcomes.

Osofsky, J.D. (Ed.) (2011). *Clinical Work with Traumatized Children*. Cohen, J.B., Dakof, G.A., & Duarte, E. (Ch.13) *Dependency Drug Court: An Intensive Intervention for Traumatized Mothers and Young Children*.The Guilford Press: New York, NY.

Although research on DDC is limited, a small number of studies indicate that drug court has promise. Most DDCs share key elements, including a non-adversarial relationship

among the participating partners, comprehensive assessment of service needs, frequent court hearings and drug testing, intensive judicial supervision, enrollment in substance abuse treatment programs designed to improve parenting practices and other necessary services, and the administration of judicial rewards and sanctions. In order to graduate from DDCs, participants must have successfully completed substance abuse treatment, remain compliant with mental health services, have a specified period of continuous abstinence, show evidence of a safe and stable living situation, spend a substantial period of time adequately performing the parental role, and have a life plan initiated and in place (e.g. employment, education, vocational training). DDCs frequently include drug court counselors, who refer clients to substance abuse treatment and other court-ordered services, develop a recovery service plan, and monitor and report clients' ongoing progress to the court. Although there are numerous components to DDCs, the contributions of the drug court judge and counselors to the effectiveness of drug court are undeniable.

OJJDP. (1998). *Juvenile and family drug courts: An overview.* Rockville, MD: US Dept of Justice, Office of Justice Programs.

For the purpose of this report, a juvenile drug court is defined as "a drug court that focuses on juvenile delinquency matters and status offenses that involve substance-abusing juveniles." A family drug court is defined as "a drug court that deals with cases involving parental rights, in which an adult is the party litigant, which come before the court through either the criminal or civil process, and which arise out of the substance abuse of a parent." Juvenile and family drug courts provide much earlier and more comprehensive intake assessment for both juveniles and adults and have a much greater focus on the functioning of the family as well as the juvenile and parent than traditional courts. There is a closer integration of the information obtained during the intake and assessment process with subsequent case decisions. There is also greater coordination among the court, the treatment community, the school system, and other community agencies that respond to the needs of juveniles, families, and the court. Because juvenile and family drug courts are relatively new, there has not been a sufficient period of operation to document significant results over the long term. Juvenile and family drug court judges are reporting, however, that their initial experience confirms remarkable sustained turnaround by juveniles and adults in the program who were otherwise at high risk for continued, escalating criminal involvement and illegal substance use. Such indicators as recidivism, drug usage, educational achievement, and family preservation indicate that juvenile and family drug courts hold significant potential. An enclosure provides summary data on juvenile and family drug court activity.

Rittner, B., & Dozier, C.D. (2000). Effects of court-ordered substance abuse treatment in child protection cases. *Social Work, 45*(2), 131-140.

Courts often play active roles in the lives of families supervised by child protective services (CPS). Judges adjudicate dependency, mandate services, determine placements of children, and order continued supervision or termination of parental rights or services. This study examined the effects of court orders in preventing recurrence of substance

abuse in the cases of 447 children in kinship care while under CPS supervision. In addition, the effects of court orders on duration of service and on numbers of placements were studied. Results suggested that court interventions had mixed outcomes. Levels of compliance with mandated substance abuse and mental health treatment did not appear to influence rates of re-abuse or duration of service. Court orders appeared to affect both the number of caretakers and placements the children experienced. Children adjudicated dependent were more likely to have multiple caretakers than those under voluntary supervision. This study suggests that further research is needed to determine how compliance with court-ordered treatment should be used by workers in making decisions about continued supervision. In addition, the authors highlight the importance of adequate substance use and abuse screening in good case planning.

Sanford, J.S. & Arrigo, B.A. (2004). Lifting the Cover on Drug Courts: Evaluation Findings and Policy Concerns. *International Journal of Offender Therapy and Comparative Criminol.*2005; 49: 239-259. doi: 10.1177/0306624X04273200

Drug treatment courts emerged in 1989 as a court-based solution to an enormous increase of drug-related arrests. Since their inception, drug treatment courts have been subject to empirical and process evaluations to provide quantitative and qualitative data regarding their effectiveness. This article reviews the extant literature on the effectiveness of drug treatment courts and discusses findings regarding various components of the criminal justice system. It is argued that based on empirical evaluation findings, drug treatment courts have achieved success in lowering rates of recidivism among drug offenders, despite problematic methodological and analytical concerns. This article also presents key components and agents of drug treatment courts and discusses their impact and relevance to policy creation and adaptation. It is suggested that when combined with empirical evaluations, process evaluations provide great insight into the drug-treatment-court dynamic. This article concludes with a discussion of the implications of drug treatment courts for justice policy.

Somervell, A.M., Saylor, C., & Mao, C.L. (2005). Public health nurse interventions for women in a dependency drug court. *Public Health Nursing, 22*(1), 59-64.

There are an increasing number of children placed in foster care due to abuse and neglect. Parents of these children often have difficult drug abuse problems leading to the removal of their children. The cost of caring for these children is staggering, reaching an estimated $24 billion. One program in Northern California that has been created to assist parents is dependency drug court. This research utilized qualitative and quantitative data to identify the perceived needs of women who have graduated from this dependency drug court (n = 50) and what they think the public health nurse (PHN) could do to intervene in the difficult process of going through dependency drug court and reunifying with their children. In addition, select interviews were conducted with former drug court recipients who were functioning as "mentor moms" (n = 4). Themes relating to successful strategies emerged from the interviews. They included respect, validation, empowerment, understanding, and support. Common barriers such as overwhelming feelings of anger, denial, and hopelessness contributed to stress during recovery. Among strategies

recommended by the mentor moms was a suggestion for PHNs to bridge the information gap through regular reports on the development and health of their children during the time they reside in foster care.

Sparks, S., Risch, R., & Gardner, M.E. (2011).*¡CelebrandoFamilias! An innovative approach forSpanish speaking families at high risk for substance abuse disorders.*Prevention Partners.

*¡Celebrating Families! (CF!)*is one of the few evidence-based practices listed on SAMHSA's National Registry of Evidence Based Practices focusing on families affected by substance abuse disorders. The program has been successfully administered in English with English evaluation instruments indicating significant impact in four of the five family outcomes (cohesion, communication, family strengths and resilience and organization) measured and one small positive reduction (family conflict). Likewise, four of the five parenting outcomes (parent involvement, supervision, efficacy, and positive parenting style) improved with medium effect size (d = .50 to .60), along with a small positive improvement in parenting skills (LutraGroup, 2007). To evaluate the program in Spanish-speaking populations, the curriculum was translated into Spanish, culturally adapted and piloted at three different sites: Latino Community Development Center (LCDA) Oklahoma City, OK; EMQ-Families First (Dorsa Elementary School) San Jose, CA; and Mexican American Community Services Agency (MACSA) Collaborative in Gilroy CA. Retro-before/after evaluation instruments were completed by 41 mono-lingual (Spanish) parents and 23 bi-lingual youth participants. Responses to open-end questions by the parents about the impact of the program were highly positive. Group leaders were all bi-lingual Spanish from the communities served. They completed evaluation instruments for three age groups of youth at the completion of the 16 weeks program. In addition to the quantitative analysis, the Dorsa school principal was interviewed to obtain an informal observation. Findings: Results were consistent with the findings of the English version, although instruments varied from the English instruments. *¡CelebrandoFamilias!* evaluation instruments were under development at the time of the pilot. Therefore some questions were consistent and others differed in wording between the three sites. Adults reported significant satisfaction with the program. Results were consistent with the LutraGroup (2007) findings for English speakers with parents also indicating significant impact on family organization, cohesion, communication, conflict solving, strengths and resilience; positive parenting, parent involvement, improvement in parenting skills, and alcohol and drug use reduction. Group leaders for youth observed very significant positive changes with 96-99% confidence levels. Youth were highly satisfied with the program but not as strongly positive as were adults and youth group leaders. Cognitive scores for the factual material were lower for youth than for adults. Additionally, an unexpected finding was the program's effectiveness as a primary prevention program at Dorsa Elementary School, one of the pilot sites. At this site five families were referred from Dependency Drug Courts. The additional 16 families voluntarily participated after learning of the program from the Dorsa school principal. These families were from a high risk community but without identified substance abuse problems.

Spartaro, R.M. (2011). Nipping it in the bud®: Adopting a family drug court approach to fighting the cycle of alcohol addiction for children when parents are convicted of DUI. *Family Court Review, 49*(1), 190-206. DOI: 10.1111/j.1744-1617.2010.01361.x

Many states have implemented Drug Courts in recent years by combining drug and alcohol treatment with ongoing judicial supervision. Through the use of incentives such as reduced and dismissed charges and fines combined with supervised treatment, Drug Courts have been shown to be very effective in helping to break the cycle of addiction, crime, and repeat incarceration for those involved. However, these courts do little to address situations in which the addict is the custodial parent of a minor child, who is exponentially more at-risk for future alcohol addiction simply by being the child of an alcoholic, due to both environmental and biological factors. Thus, while the parent's addiction is theoretically being addressed by the courts, little is being done, absent a showing of abuse or neglect, by the judicial system to combat the seeds of addiction that have already been planted in these children. Therefore, this Note advocates for states to include an alcohol education and counseling program aimed at children of alcohol-related offenders based on the Drug Court Model. Participation in this program would then act as a mitigating factor for the addicted offender when receiving their final sentence. This proposed program would then serve as a model for other states to adopt in the near future.

Wheeler, M. & Fox, C.L. (2006). *Drug court practitioner fact sheet: Family dependency treatment court: Applying the drug court model in child maltreatment cases.* National Drug Court Institute. Alexandria, VA

Evaluation/Outcome Studies

Boles, S. M., N. K. Young, Moore, T., & DiPirro-beard, S (2007). The Sacramento dependency drug court: Development and outcomes. *Child Maltreatment, 12*, 161-171.

Dependency Drug Courts (DDCs) are a growing method of addressing the functional status and reunification success of families involved in child welfare and affected by substance use disorders. Despite widespread interest in DDCs, few evaluations have appeared in the literature to help inform the discussion about their effectiveness. This article provides a description of various types of DDCs and reports 24-month reunification rates from the Sacramento DDC. Results indicated that DDC participants had higher rates of treatment participation than did comparison participants. In addition, at 24 months, 42% of the DDC children had reunified versus 27.2% of the comparison children. There were no differences in treatment completion or child reunification rates by parent's primary drug problem. Rates of recidivism were extremely low for both the DDC and comparison groups and did not differ significantly. The results of the present study are encouraging and suggest that rigorous, controlled studies are merited to further evaluate the effectiveness of DDCs.

Bruns, E.J., Pullmann, M., Wiggins, E., & Watterson, K. (2011).*King County Family Treatment Court Outcome Evaluation: Final Report.* Division of Public Behavioral Health and Justice Policy: Seattle, WA.

There is growing research comparing outcomes for parents in regular dependency courts parents in FTCs. Existing research consistently finds a positive impact of FTCs. A study of four FTCs in several sites across the United States found that FTC participants enrolled in treatment more quickly, received treatment services for a longer mean duration, and were more likely to complete treatment successfully than parents in regular dependency courts. The study also found that FTC participants had their children placed in permanent living situations more quickly and were more likely to reach reunification with their children. Similarly, other research on FTCs has found that participants have a higher number of treatment entries, enroll in treatment earlier, spend more time in treatment, and reach reunification faster than participants in regular dependency court. Boles, Young, Moore, and DiPiroo (2007) found that families receiving FTC services had substantially higher reunification rates than families in regular dependency court. At 24 months after entry, 42% of the FTC children had reunified versus 28% of children whose parents had received standard services, and there were no differences between the groups in subsequent maltreatment reports. This suggests FTCs have a positive impact on reunification without posing additional risks of harm or neglect to children. However, none of these studies have featured random assignment into court types. These outcomes are encouraging, and they fit with the theoretical model of change, which suggests that more timely and intensive supports, coupled with consistent oversight and appropriate sanctions, provide parents with a greater likelihood of success – and a greater chance of being reunified with their children – than regular dependency court procedures. However, few studies have examined the inner workings of FTCs and established direct connections between elements of FTCs and specific outcomes. One area that has been studied is the association between timely access to substance use treatment, successful treatment outcomes, and successful child welfare outcomes. In a study of over 1,900 substance-abusing women who had at least one child placed in out-of home care during a six year period, researchers found that women who entered treatment faster remained in treatment longer and were more likely to successfully complete treatment, and their children spent less time out-of-home and were more likely to be reunified. Timely access to treatment may result in successful case outcomes by placing parents on a positive trajectory for behavior change.

Burrus, S.W., Mackin, J.R., &Finigan, M.W. (2011). Show me the money: Child welfare cost savings of a Family Drug Court. *Juvenile and Family Court Journal, 62*(3), 1-14.

Family drug courts are programs that serve the complex needs of families involved with the child welfare system due to parental substance abuse. This article summarizes the results of outcomes and selected costs of a system-wide reform located in Baltimore, Maryland. Results from this study found that parents served by the program entered treatment faster, stayed in treatment longer, and completed treatment more often than non-served parents. Children in program families spent less time in foster care and were more likely to be reunified with their biological parents. These outcomes resulted in cost

savings, including reduced foster care expenditures.The relationship between parental substance abuse and child welfare involvement is well evidenced in the literature. Between 25% and 80% of child welfare cases involve alcohol and other drugs indicated on the child welfare. In the best interests of the child, child welfare and the substance abuse treatment community must work together to address the challenging needs of parents involved with child welfare who have substance abuse issues. Parents involved with child welfare due to substance use are least likely to be reunified with their children, and these same children are likely to stay in substitute foster care longer. Effectively serving these families is challenging, thereby demonstrating the importance of creative interventions focused on their unique needs. Finally, according to a new U.S. Department of Health and Human Services report, spending on foster care services is steadily increasing nationally each year, a circumstance that underscores the policy implications for addressing the needs of these families.

Carey, S.M., Finnigan, M., Crumpton, D., & Waller, M. (2006). California drug courts,: outcomes costs, and promising practices: A overview of phase II in a statewide study. *Journal of Psychoactive Drugs, SARC Supplement 3,* 345-356.

The rapid expansion of drug courts in California and the state's uncertain fiscal climate highlighted the need for definitive cost information on drug court programs. This study focused on creating a research designthat can be utilized for statewide and national cost-assessment of drug courts by conducting in-depth case studies of the costs and benefits in nine adult drug courts in California. A TransactionalInstitutional Costs Analysis (TICA) approach was used, allowing researchers to calculate costs based on every individual's transactions within the drug court or the traditional criminal justice system. This methodology also allows the calculation of costs and benefits by agency (e.g., Public Defender's office, court, District Attorney). Results in the nine sites showed that the majority of agencies save money in processing an offender though drug court. Overall,for these nine study sites, participation in drug court saved the state over $9 million in criminal justice and treatment costs due to lower recidivism in drug court participants. Based on the lessons learned in Phases I and II, Phase III of this study focuses on the creation of a web-based drug court cost self-evaluation tool (DC CSET) that drug courts can use to determine their own costs and benefits.

Carey, S.M., Sanders, M.B., Waller, M.S., Burrus, S.W.M, & Aborn, J.A. (2010). *Marion County Fostering Attachment Treatment Court Process Outcomes and Cost Evaluation, Final report.* Submitted to Oregon Criminal Justice Commission.

This evaluation was funded under the Edward Byrne Memorial State and Local Law Enforcement Assistance Grant Program: Byrne Methamphetamine Reduction Grant Project 07-001. This summary contains process, outcome and cost evaluation results for the Marion County Fostering Attachment Family Treatment Court (FATC).

Carey, S.M., Sanders, M.B., Waller, M.S., Burrus, S.W.M, & Aborn, J.A. (2010). *Jackson County Fostering Attachment Treatment Court Process Outcomes and Cost Evaluation, Final report.* Submitted to Oregon Criminal Justice Commission.

This evaluation was funded under the Edward Byrne Memorial State and Local Law Enforcement Assistance Grant Program: Byrne Methamphetamine Reduction Grant Project 07-001. This summary contains process, outcome and cost evaluation results for the Jackson County Community Family Court (CFC).

Green, B.L., Furrer, C., Worcel, S., Burrus, S., & Finigan, M.W. (2007). How effective are family treatment drug courts? Outcomes from a four-site national study. *Child Maltreatment, 12*(1), 43-59.

Family treatment drug courts (FTDCs) are a rapidly expanding program model designed to improve treatment and child welfare outcomes for families involved in child welfare who have substance abuse problems. The present study examines the effectiveness of the FTDC in improving treatment and child welfare outcomes for parents. This study compares outcomes for 250 FTDC participants to those of similar parents who did not receive FTDC services in four sites. Results show that FTDC parents, compared to comparison parents, entered substance abuse treatment more quickly, stayed in treatment longer, and completed more treatment episodes. Furthermore, children of FTDC parents entered permanent placements more quickly and were more likely to be reunified, with their parents, compared to children of non-FTDC participants. Finally, the FTDC program appears to have a "value added" in facilitating positive child welfare outcomes above and beyond the influence of positive treatment experiences. The authors note that one important aspect of the FTDC context that has been seen as important to its success is the increased information sharing between treatment, child welfare, the courts, and the regular contact between judges and participants. The study also suggests that FTDCs are supporting parents who may struggle with treatment.

Green, B.L., Furrer, C.J., Worcel, S.D., Burrus, S.W., & Finigan, M.W. (2009). Building the evidence base for family drug treatment courts: Results from recent outcomes studies. *Drug Court Review, 6 (2),* 53-82.

Family Drug Treatment Courts (FDTCs) are an increasingly prevalent program designed to serve the multiple and complex needs of families involved in the child welfare system who have substance abuse problems. It is estimated that over 301 FDTCs are currently operational in the United States. Few rigorous studies of FDTCs have examined the effectiveness of these programs. This paper reviews current FDTC research and summarizes the results from four outcome studies of FDTCs. Results suggest that FDTCs can be effective programs to improve treatment outcomes, increase the likelihood of family reunification, and reduce the time children spend in foster care. However, further research is needed to explore how variations in program models, target populations, and the quality of treatment services influence effectiveness.

Gyudish, J., Wolfe, E., Tajina, B., & Woods, W.J. (2001). Drug court effectiveness: A review of California evaluation reports. *Journal of Psychoactive Drugs, 33,* 369-378.

Over the past two decades, drug courts have emerged as a viable alternative for addressing drug cases within the criminal justice system. In California, the Drug Court Partnership Program (DCPP) was created in 1998 and has supported and funded the development of drug courts throughout the State. This article reports on a review of California drug court evaluations through January 2000 conducted as part of an evaluation of the California DCPP. A total of 23 evaluations were collected. Seventeen were reviewed in detail, and six were excluded because they were internal reports rather than evaluations. A standardized review process was initiated which led to a scored rating of the evaluation reports. Results of this review support previous findings that drug court participants may experience reduced re-arrest rates by 11% to 14%compared to nonparticipants. The largest reduction in re-arrest rates appears among graduates. The graduation rates were between 19% and 54%. Costs and savings associated with drug courts were discussed but no conclusions were possible based on the findings from these evaluations. The evaluation of the effectiveness of drug courts presents unique challenges. This review concludes with a discussion of evaluation methods (e.g. standardizing rate calculations, term definitions) that would strengthen drug court research.

Harwin, J., Ryan, M., Tunnard, J., Alrough, B., Matias, C., Momenian-Schneider, S., &Pokhrel, S. (2011).*The family drug & alcohol court (FDAC) evaluation project*. Brunel University, FDAC Research Team: Final Report.

This report presents the findings from the evaluation of the first pilot Family Drug and Alcohol Court (FDAC) in **Britain**. FDAC is a new approach to care proceedings, in cases where parental substance misuse is a key element in the local authority decision to bring proceedings. It is being piloted at the Inner London Family Proceedings Court in Wells Street. Initially the pilot was to run for three years, to the end of December 2010, but is now to continue until March 2012. The work is co-funded by the Department for Education (formerly the Department for Children, Schools and Families), the Ministry of Justice, the Home Office, the Department of Health and the three pilot authorities (Camden, Islington and Westminster). The evaluation was conducted by a research team at Brunel University, with funding from the Nuffield Foundation and the Home Office. FDAC is a specialist court for a problem that is anything but special. Its potential to help break the inter-generational cycle of harm associated with parental substance misuse goes straight to the heart of public policy and professional practice. Parental substance misuse is a formidable social problem and a key factor in around a third of long-term cases in children's services in some areas. It is a major risk factor for child maltreatment, family separation and offending in adults, and for poor educational performance and substance misuse by children and young people. The parents' many difficulties create serious problems for their children and place major demands on health, welfare and criminal justice services. For these reasons, parental substance misuse is a cross-cutting government agenda. FDAC is distinctive because it is a court-based family intervention which aims to improve children's outcomes by addressing the entrenched difficulties of

their parents. It has been adapted to English law and practice from a model of family treatment drug courts that is used widely in the USA and is showing promising results with a higher number of cases where parents and children were able to remain together safely, and with swifter alternative placement decisions for children if parents were unable to address their substance misuse successfully. The catalysts for the FDAC pilot were the encouraging evidence from the USA and concerns about the response to parental substance misuse through ordinary care proceedings in England: poor coordination of adult and children's services; late interventions to protect children; delays in reaching decisions in court; and soaring costs of proceedings, linked to the cost of expert evidence.

McCoy, C. (2010). Do drug courts work? For what, compared to what? Qualitative results from a natural experiment. Victims and Offenders, 5, 64-75. doi: 10.1080/15564880903423102.

This is an outcome study of addicts who were sentenced to treatment in a drug court which began operations in 1997. Ten years later, we located and interviewed 25 people from three groups: (1) drug court clients, (2) addicts rejected from drug court and imprisoned, and (3) addicts accepted into drug court but who instead entered traditional drug treatment programs. We explored measures of success such as ability to stay off drugs, hold jobs, maintain family relationships, and the more typically-used outcome variable: recidivism. Drug court clients had better life outcomes than offenders who went to prison, but those who participated in traditional in-community drug treatment were equally successful. Lack of recidivism as indicated in criminal records may be an inaccurate measure of success, since the study found that some subjects' records were clean because they had died. The number of study subjects is too small to draw broad conclusions about program effectiveness, but the results raise concerns about the methodology of many drug court evaluations.

Pach, N.M. (2008). An overview of operational family dependency treatment court outcomes. *Drug Court Review,* 67-122.

The intent of this article is to lay the groundwork for a national conversation about Family Dependency Treatment Courts (FDTCs). While FDTCs are in many ways similar to drug courts, they have their own set of complications that render NADCP's 10 key components necessary, yet insufficient, to guide the establishment, maintenance, and improvement of FDTCs. Questions about best practices surround such issues as child welfare, the Adoption and Safe Families Act (1997) timelines, the civil court arena, and the scope of the intervention. When the best interests of the child are paramount, sanctions and incentives for an alcohol and other drug (AOD)-involved parent must be carefully handled. Federal timelines must be fully considered by FDTCs in their planning. Sanctions in particular are complicated by the fact that FDTCs occur in a civil arena rather than the criminal one like traditional drug courts. Finally, a court must decide whether the FDTC intervention will consider a full range of psychosocial and legal problems facing a particular family, or if it will concentrate solely on AOD involvement. This article should serve as a focal point through which those professionals involved in FDTCs can create their own components necessary for FDTCs.

Worcel, S., Furrer, C., Green, B.L., & Rhodes, B. (2006). *Family treatment drug court evaluation final phase I study report*. Portland, OR: NPC Research.

This report presents the final analysis of Phase I of the Family Treatment Drug Court (FTDC) Evaluation. The FTDC Evaluation, funded by the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment, is a 4-year study conducted by NPC Research aimed at investigating the short- and long-term child welfare and treatment outcomes for families involved with these innovative programs. There are four study sites participating in this evaluation: San Diego County, CA; Santa Clara County, CA; Suffolk County, NY; and Washoe County, NV. The Phase I design collected archival administrative data on past participants in the FTDCs and similar comparison group cases, and included information about placement changes, types of placements, treatment services and outcomes, case lengths and resolutions, and demographic and background information about the families involved with the cases. Results indicated that rapid entry into drug court and treatment services appear to be related to a number of positive outcomes, including more treatment completion, shorter times to permanent placement, and shorter case closure. In addition, parents who entered treatment faster, stayed in treatment longer, and completed treatment were more likely to graduate from drug court and were more likely to have faster time to permanent placement.

Worcel, S. D., Furrer, C. J., Green, B. L., Burrus, S. W. M., & Finigan, M. W. (2008). Effects of family treatment drug courts on substance abuse and child welfare outcomes. *Child Abuse Review, 17*(6), 427-443.

This paper presents results from the first large-scale outcome study of American Family Treatment Drug Courts (FTDCs)—specialized courts designed to work with substance-abusing parents involved with the child welfare system. The paper examines whether court, child welfare and treatment outcomes differed for 301 families served through three FTDCs as compared to a matched sample of 1,220 families with substance abuse issues who received traditional child welfare services. Propensity score weights were used to account for measured differences between the FTDC and comparison groups. Child welfare outcomes were analyzed using analytical techniques that controlled for these inherently nested data (i.e. children within a family). Overall, the study found that FTDC mothers had more positive treatment outcomes than similar mothers who were not served by the FTDC. FTDC mothers were more likely to enter substance abuse treatment services than were non-FTDC mothers, entered treatment more quickly after their initial court petition than did non-FTDC mothers, spent twice as much time in treatment than did non-FTDC mothers and were twice as likely to complete at least one treatment episode than non-FTDC mothers. In addition, data from the study indicate that FTDCs influence a key child welfare variable of interest: FTDC children were significantly more likely to be reunified with their mothers than were un-served children.

Judicial Perspectives: Sanctions and Rewards

Bolt, R. & Singer, A. (2006). Juristocracy in the trenches: Problem-solving judges and therapeutic jurisprudence in drug treatment courts and unified family courts. *Maryland Law Review, 65,* 82-99.

This article explores the role of judges on two types of "problem-solving courts": drug treatment courts and unified family courts. It compares the behavior these "problem-solving" judges to more traditional models of judicial behavior and to activist judging at the appellate level. The authors conclude that the judges who serve on these problem-solving courts have largely repudiated the classical judicial virtues of restraint, disinterest and modesty in favor of a more activist and therapeutic stance. However, the causes and consequences of this role-shift are complex. In particular, the authors suggest that the proliferation of problem solving courts and judges is not primarily a "trickle-down" effect of activist judging at the appellate level; rather, these developments are a response to powerful political and institutional forces outside the judicial system. Legal scholars who seek to understand "juristocracy in the trenches" should therefore broaden their analytic focus to include the ways in which these institutional forces shape the behavior of state trial court judges.

California Supreme Court bars jailing parents for treatment non-compliance. (2009). *Alcoholism & Drug Abuse Weekly, 21*(14), 3-3.

The article discusses a court case wherein a parent cannot be put to prison for not complying with substance abuse treatments. A ruling from the California Supreme Court allows parents to regain custody of their children without attending ordered treatments. According to Judge Carol Corrigan, parents cannot be forced by the court in participating in such treatments. Prior to the ruling was a woman's release after the termination of her parental rights when her child was positive for methamphetamine.

Edwards, L. (2010). Sanctions in family drug treatment courts. *Juvenile and Family Drug Treatment Court Journal, 61,* 55-62.

We all know that sanctions and rewards are essential parts of the success of Family Drug Treatment Courts (FDTC), but no one is clear about what these sanctions and rewards should be. Each local court has its own set of sanctions and rewards, many borrowed from criminal drug courts, some created by available resources within the community. Now the California Supreme Court has made the decision about sanctions more complex with its decision in In re Nolan W.1 holding that imprisonment cannot be used as a sanction in the FDTC. What are permissible sanctions in an FDTC? After In re Nolan W., are fines or community service permissible? What about a reduction in visitation? What guidance has the California Supreme Court given trial courts in these areas? This article will try to bring some clarity to these questions and also offer a framework for trial courts to consider regarding the most effective use of sanctions in FDTCs. The article concludes that imprisonment is an unnecessary sanction in FDTCs, and that sanctions in these courts should be guided solely by treatment considerations.

Edwards, L.P., & Ray, J.A. (2005). Judicial perspectives on family drug treatment courts. *Juvenile and Family Court Journal, 56*(3), 1-27.

Family Drug Treatment Courts are a specialized calendar or docket that operates within the juvenile dependency court. These courts provide the setting for a collaborative effort by the court and all the participants in the child protection system to come together in a non-adversarial setting to determine the individual treatment needs of substance-abusing parents whose children are under the jurisdiction of the dependency court. This article is intended to give judges and others a judicial perspective on FDTCs, and to offer some assistance for those who are operating or who are considering creating one.

Linquist, C.H., Krebs, C.P., & Lattimore, P.K. (2006). Sanctions and rewards in drug court programs: Implementation, perceived efficacy, and decision making. *Journal of Drug Issues, 36,* 119-145.

Utilizing several Florida drug court programs, results indicate that the number of sanctions used by the drug court programs greatly exceeded those used by traditional courts or probation. Key stakeholders identified numerous behaviors (18 distinct behaviors) likely to result in sanctions. The extensiveness of sanctions used was substantially greater than that of the rewards used, with only half as many rewards as sanctions identified to encourage compliance. Lastly, derived from a qualitative analysis, the drug court programs appeared to emphasize tailoring the sanction to the individual participant, rather than applying sanctions in a uniform manner. However, it is recommended that additional research be conducted to address how drug court programs' sanctioning systems related to program effectiveness. This study addressed several research gaps in the drug court literature regarding implementation, perceived effectiveness, and decisionmaking pertaining to sanctions and rewards. In selecting five Florida judicial circuits, this process evaluation examined the use of rewards and sanctions to reinforce compliance and to compare linkages among the courts, treatment, and probation in drug courts and traditional courts. Tables and references

Meyer, W. (2007). Developing and delivering incentives and sanctions. *National Drug Court Institute.*

Traditionally, responses by the criminal justice system to offender behavior exact retribution for what the offender has done and/or punish the offender with the hope that the behavior will not be repeated. Research demonstrates this approach has been totally inadequate to stem drug abuse and related crime in the United States. Deterrence theory posits that the decision to commit a criminal act is influenced by the perception that the certainty, severity and celerity (swiftness) of the consequences. Conventional criminal case processing relies heavily on severity of the consequences and ignores the importance of certainty and swiftness. Drug courts utilize scientifically accepted behavioral modification tools of certainty, swiftness and graduated severity coupled with incentives to permanently change offender behavior. This chapter assists the drug court team in developing the necessary responses to shape offender behavior and identifies the skills

for delivering effective response

Whiteacre, K.W. (2007). Strange bedfellows: The tension of coerced treatment. *Criminal Justice Policy Review, 18*, 260-273. doi: 10.1177/0887403407300088

The use of sanctions in drug treatment courts (DTCs) to enforce participant compliance with treatment represents the convergence of two different, sometimes opposing, correctional philosophies, punishment and rehabilitation. Though the literature on DTCs tends to treat this merging of ideologies unproblematically, it could present a possible source of conflict within DTCs and other coercive treatment programs. Exploratory interviews with staff and participants in a juvenile drug court (JDC) (n□37) uncovered two types of tension resulting from the sanctioning system. First, staff members often disagreed with each other over the appropriateness of rewards versus punishments and punishment severity to motivate compliance. Second, staff members experienced personal ambivalence over the efficacy of sanctions as a therapeutic tool, particularly when faced with some juveniles' continued noncompliance despite the sanctions. Staff neutralized this tension by attributing noncompliance to the juveniles' lack of motivation, concluding coerced treatment only works for those who are "ready" for treatment. This would appear to pose a paradox for coerced treatment, which is meant to induce compliance specifically among those who are not motivated. Future research should investigate the implications this ideological contradiction among staff has for the therapeutic outcomes of coerced treatment settings.

Ten Science-Based Principles of Changing Behavior Through the Use of Reinforcement and Punishment

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1. SANCTIONS SHOULD NOT BE PAINFUL, HUMILIATING OR INJURIOUS.

   a. Research on offender perceptions and specific deterrence effects on offenders subject to sanctions report that:

      1. Certainty of sanctions does exert a specific deterrent effect on future behavior.

      2. Perceived severity, if certainty is present, does not exert a deterrent effect on future behavior. Harrell, A., & Roman, J. (2001). "Reducing Drug Use and Crime Among Offenders: The Impact of Graduated Sanctions." *Journal of Drug Issues*, 31 (1), 207-232.

      3. Exploratory studies report that drug court participants who perceived a more certain and meaningful connection between their own conduct and the imposition of sanctions and rewards tended to have better outcomes than individuals who did not perceive such a connection. Douglas B. Marlowe, David S. Festinger, Carol Foltz, Patricia A. Lee, Nicholas S. Patapis, "Perceived deterrence and outcomes in drug court", *Behavioral Sciences and the Law,* v.23: 181-198 (2005)

   b. While research on animals indicate that severity of punishment is directly related to behavior extinguishment, the same is not necessarily true for criminal offenders.

Research reports that controlling for age, socioeconomic status, and time of incarceration the risk that the offender would re-offend was not related to the prior sanctions imposed irrespective of whether the sanction was probation, a fine or prison. The one exception to this finding is when first and second time offenders received prison instead of a fine or probation, they were more likely to re-offend. Brennan, P and Mednick, S., "Learning Theory Approach to Deterrence of Criminal Behavior," Vol. 103 *Journal of Abnormal Psychology,* pp. 430-440 (1994).

c. In controlled studies, participants tend to choose heavy future punishment over smaller immediate punishers. As it relates to substance abusers, they tend to discount the future consequences. The immediacy of the effect is the best predictor of whether there will be a change in the status quo. Murphy, J. G., Vuchinich, R. E., & Simpson, C. A. (2001). "Delayed Reward and Cost Discounting." *The Psychological Record*, 51, 571-588.

d. Multi-disciplinary research posits that defiant behavior results when sanctions are perceived as unfair punish the individual not the act, imposed on individuals poorly bonded to the community and on individuals who fail to feel shame or contrition for their acts. Sherman, L. W. (1993). "Defiance, Deterrence, and Irrelevance: A Theory of the Criminal Justice Sanction." *Journal of Research in Crime and Delinquency*, 30 (4), 445-473.

2. <u>RESPONSES ARE IN THE EYES OF THE BEHAVER</u>.

a. Contrary to expectations, incarceration is not necessarily viewed by the criminal offender as the harshest punishment. In a comparison of alternative sanctions to prison time, 6-24% of inmates surveyed preferred 12 months incarceration compared to sanctions ranging from a halfway house (6.7%), probation (12.4%) or day fines (24%). Those inmates desiring alternative sanctions seemed to have better

connections with the community, for example children, job, etc. Wood, P. B., & Grasmick, H. G. (1995). "Inmates Rank the Severity of Ten Alternative Sanctions Compared to Prison." Oklahoma Department of Corrections: www.doc.state.ok.us/DOCS/OCJRC/OCJRC95/950725j.htm See also Petersilla, J. and Deschanes, E., "What Punishes? Inmates Rank the Security of Prison v. Intermediate Sanctions?" *Federal Probation*, Vol. 58, No. 1 (March 1994).

b. Research also indicates that punishment or the possibility of punishment as a sanction tends to be a greater motivator of behavior for those addicts who have a lot to loose. For those addicts who have nothing to lose, the threat or actual imposition of punishment causes them to withdraw from treatment or drop out. The use of positive reinforcement has been shown to be particularly effective in motivating abstinence in this population. See Higgins, S. T., & Silverman, K. (1999). *Motivating Behavior Change Among Illicit-Drug Abusers.* Washington, D.C.: American Psychological Association; particularly Chapter 17, Crowley, T., "Clinical Implications and Future Directions," pp. 345-351.

c. An extensive study focusing on whether criminal sanctions reduce, increase or have no effect on future crimes found the following:

1. Similar sanctions have completely different effects depending upon the social situation and offender type.

2. Treatment can increase or decrease criminality depending on offenders' personality type.

3. Criminal sanctions decrease criminality in employed offenders but increase criminality in unemployed offenders.

4. Threat of criminal sanctions deters future criminality in people who are older.

5. People obey laws more when they believe laws are enforced fairly. See Sherman, L. W. (1993). "Defiance, Deterrence, and Irrelevance: A Theory of the Criminal Justice Sanction." *Journal of Research in Crime and Delinquency*, 30 (4), 445-473.

d. The concept of the perception of fairness and its effect on the behaver may have greater importance than previously believed. Behavioral economic research suggests that people will react to perceived unfairness by engaging in activity that will "punish" the person perceived as being unfair even to the extent of punishing themselves to get back at that person. Andreoni, J., Harbaugh, W., & Vesterlund, L. (2001). "The Carrot or the Stick? Rewards, Punishments and Cooperation." Unpublished paper, National Science Foundation Grant.

e. Just as a sanction may be misperceived, so can a system of rewards. Providing such things as appointment books, pencils or even increasing monetary rewards as a bonus may even jeopardize continued abstinence. Higgins, S. T., & Silverman, K. (1999). *Motivating Behavior Change Among Illicit-Drug Abusers.* Washington, D.C.: American Psychological Association., pp. 334-335.

f. As drug court professionals we must be particularly cognizant of the participant perception that a response of increased drug treatment imposed upon therapeutic recommendation will be perceived by the participant as a punishment. To the extent we can persuade the participant that treatment is in their best interest, we should do so. See Center for Substance Abuse Treatment, "Combining Substance Abuse Treatment with Intermediate Sanctions for Adults in the Criminal Justice System." Rockville, Maryland: Center for Substance Abuse Treatment, U.S. Department

of Health and Human Services publication SMA 94-3004; 1994 d. *Treatment Improvement Protocol (TIP) Series 12*.

3. RESPONSES MUST BE OF SUFFICIENT INTENSITY.

a. Animal Research has demonstrated that punishment must be of sufficient intensity to motivate the change in behavior. If the punishment is of not sufficient consequence, the behaver is not motivated to change or becomes habituated to the punishment Azrin, N. and Holz, W. "Punishment" in Honig W. (ed). *Operant Behavior: Areas of Recidivism and Application*. (Meredith Publishing 1966) pp. 381-447. Particularly p. 426 and 433. Using animal testing, authors answer whether punishment is effective in eliminating undesirable behavior and what has to be present to heighten efficacy.

b. Research also indicates that graduated sanctions work in the drug court context. Using the DC drug court, a positive drug test sanction group was compared with a group not sanctioned for positive urine testing. The graduated sanction group had significantly fewer arrests than the non-sanctioned group. Harrell, A., & Roman, J. (2001). "Reducing Drug Use and Crime Among Offenders: The impact of Graduated Sanctions." *Journal of Drug Issues*, 31 (1), 207-232.

c. Research on graduated rewards demonstrates that participants receiving graduated reinforcement achieved greater mean levels of abstinence than participants receiving fixed reinforcement. Roll, J., Higgins, S. and Badger, G. "An Experimental Comparison of Three Different Schedules of Reinforcement of Drug Abstinence Using Cigarette Smoking as an Exemplar." *Journal of Applied Behavioral Analysis*, Vol. 29, p. 495-504 No. 4 (Winter 1996).

d. A word of caution to practitioners: Some rewards may actually interfere with a person's intrinsic motivation. (See unintended

consequences below). Deci, E. L., Koestner, R., & Ryan, R. M. (1999). "A Meta-analytic Review of Experiments Examining the Effects of Extrinsic Rewards on Intrinsic Motivation." *Psychological Bulletin*, 125 (6), 627-668.

4. <u>RESPONSES SHOULD BE DELIVERED FOR EVERY TARGET BEHAVIOR</u>.

a. Early animal research pointed out that punishment is only effective if it is delivered for every targeted behavior. Azrin, N. and Holz, W. "Punishment" in Honig W. (ed). *Operant Behavior: Areas of Recidivism and Application*. (Meredith Publishing 1966) pp. 381-447. Particularly p. 426 and 433.

b. Outcomes in the criminal justice context is in line with animal-based research. In work by Brennan & Mednick, those offenders who received sanctions on a continuous schedule evidenced a significantly lower arrest rate than those offenders who received intermittent sanctions. Brennan, P. and Mednick, S. "Learning Theory Approach to the Deterrence of Criminal Recidivism." Vol. 103, *Journal of Abnormal Psychology*, pp. 430-440 (1994).

c. Experts in contingency management suggest that reinforcers be used for every target behavior. Higgins, S. T., & Silverman, K. (1999). *Motivating Behavior Change Among Illicit-Drug Abusers.* Washington, D.C.: American Psychological Association. (Particularly see Kirby and Crowley pp. 334 and 349). Recent research indicates the mere opportunity to participate in getting an immediate reward can be effective in changing behavior. Participants who had clean urine tests were given an opportunity to draw paper slips from a fishbowl. Prizes indicated on the slips ranged from nothing to a dollar to a TV set. Results showed group drawing for reward was more likely to complete treatment (84% vs. 22%) and significantly more likely to be abstinent. Petry, N. M., Martin, B., Cooney, J. L., & Kranzler, H. R. (2000). "Give Them Prizes and They Will Come:

Contingency Management for Treatment of Alcohol Dependence." *Journal of Consulting and Clinical Psychology*, 68 (2), 250-257. Petry, N. M. (2001). "Contingent Reinforcement for Compliance with Goal-related Activities in HIV-positive Substance Abusers." *The Behavior Analyst Today*, 2 (2), 78-85.

d. Rewards need not be something tangible to be effective in motivating behavior, praise when delivered both immediately and continuously for achieving target behavior is very effective. Deci, E. L., Koestner, R., & Ryan, R. M. (1999). "A Meta-analytic Review of Experiments Examining the Effects of Extrinsic Rewards on Intrinsic Motivation." *Psychological Bulletin*, 125 (6), 627-668.

5. **RESPONSES SHOULD BE DELIVERED IMMEDIATELY.**

a. In laboratory settings, a one hour delay in imposition of punishment has been demonstrated to decrease the sanctions' ability to change behavior. Delay in imposition of sanctions can allow other behaviors to interfere with the message of the sanction. Marlowe, D. B., & Kirby, K. C. (1999). "Effective Use of Sanctions in Drug Courts: Lessons from Behavioral Research." *National Drug Court Institute Review*, II (1), 11-xxix.

b. Similarly, experts in contingency management recommend that the uses of positive and negative reinforcements are more efficacious when imposed immediately. Griffith, J. D., Rowan-Szal, G. A., Roark, R. R., & Simpson, D. D. (2000). "Contingency Management in Outpatient Methadone Treatment: A Meta-analysis." *Drug and Alcohol Dependence,* 58, 55-66. Higgins, S. T., & Silverman, K. (1999). *Motivating Behavior Change Among Illicit-drug Abusers*, Washington, D.C.: American Psychological Association, pp. 334. Burdon, W., *et al.* "Drug Courts and Contingency Management." *Journal of Drug Issues*, 31(i), pp. 73-90 (2001).

c. What we have learned about the schedule of reinforcement from behavioral research is now being confirmed by the biomedical brain research. The effects of reinforcement appear to be exerted in the brain areas that are part of the dopamine reward system. From brain research, scientists conclude, "rewards and punishments received soon after an action are more important than rewards and punishments received later." Dayan, P., & Abbott, L. F. (2001). *Theoretical Neuroscience: Computational and Mathematical Modeling of Neural Systems*. Cambridge, MA: MIT Press.

6. UNDESIRABLE BEHAVIOR MUST BE RELIABLY DETECTED.

a. Early studies by Crowley and others demonstrated in a contingency management situation, abstinence must be reliably detected. Higgins, S. T., & Silverman, K. (1999). *Motivating Behavior Change Among Illicit-Drug Abusers.* Washington, D.C.: American Psychological Association. (Particularly see Kirby's chapter, pp. 330-332 and Crowley's chapter, p. 339).

b. Failure to reliably detect drug use in effect puts a person on an intermittent schedule of rewards and sanctions which is ineffectual in changing behavior. Marlowe, D. B., & Kirby, K. C. (1999). "Effective Use of Sanctions in Drug Courts: Lessons From Behavioral Research." *National Drug Court Institute Review*, II (1), 11-xxix.

c. Random and frequent scheduling of urine testing that is both quantitative and qualitative can make detection relatively foolproof. See Higgins, S. T., & Silverman, K. (1999). *Motivating Behavior Change Among Illicit-Drug Abusers.* Washington, D.C.: American Psychological Association, pp. 283-308.

d. The credibility of an intermediate sanction program is dependent upon reliable drug use detection. Torres, S. (1998). "A Continuum of Sanctions for Substance-abusing Offenders." *Federal Probation*, 62 (2), 36-45.

7. RESPONSES MUST BE PREDICTABLE AND CONTROLLABLE.

a. Early research in contingency management provided patients with clear, usually written agreements or contracts. Higgins, S. T., & Silverman, K. (1999).,*Motivating Behavior Change Among Illicit-Drug Abusers.* Washington, D.C.: American Psychological Association, p. 348-349.

b. Abstinence based research indicates that perceived certainty of consequence does have a deterrent effect. Obviously, this perception is based not only on what does occur but what the participant expects will occur. See Harrell, A., & Roman, J. (2001). "Reducing Drug Use and Crime Among Offenders: The Impact of Graduated Sanctions." *Journal of Drug Issues*, 31 (1), 207-232.

c. Using a contingency management protocol "requires clear articulation of behaviors that further treatment plan goals," Burdon, W., *et al.* "Drug Courts and Contingency Management.", *Journal of Drug Issues*, 31(i), pp. 73-90 (2001).

d. Failure to specify particular behaviors that are targeted and the consequences for non-compliance can result in a behavior syndrome known as "learned helplessness where a drug court participant can become aggressive, withdrawn and/or despondent." Marlowe, D. B., & Kirby, K. C. (1999). "Effective Use of Sanctions in Drug Courts: Lessons from Behavioral Research.", *National Drug Court Institute Review*, II (1), 11-xxix.

8. <u>RESPONSES MAY HAVE UNINTENTIONAL SIDE EFFECTS</u>.

a. Punishments that are too excessive or used inappropriately may cause unanticipated side effects like learned helplessness. Marlowe, D. B., & Kirby, K. C. (1999). "Effective Use of Sanctions in Drug Courts: Lessons from Behavioral Research.", *National Drug Court Institute Review*, II (1), 11-xxix.

b. Applied research in behavior analysis suggests that negative side effects from punishment contingencies include behavioral supervision, fear, anger, escape and avoidance. Higgins, S. T., & Silverman, K. (1999). *Motivating Behavior Change Among Illicit-Drug Abusers.* Washington, D.C.: American Psychological Association p. 330.

c. Even the application of positive reinforcements can have negative unexpected consequences – the addition of bonus payments to an escalating pay schedule actually reduced weeks of cocaine abstinence. Higgins, S. T., & Silverman, K. (1999). *Motivating Behavior Change Among Illicit-Drug Abusers.* Washington, D.C.: American Psychological Association p. 335.

d. Frequency of contacts between the judge and drug court participant can actually have a negative impact on successful program completion. However, this does not apply to ASPD participants and those participants with substantial substance abuse problems. Marlowe. D. B., Festinger, D.S., & Lee, P.A. (2003), "The Role of Judicial Status Hearings in Drug Court", *Offender Substance Abuse Report*, 3, 33-46. Marlowe. D. B., Festinger, D.S., & Lee, P.A. (2004), "The Judge is a Key Component of Drug Court, *Drug Court Review*, 4, 1-34. Marlowe, D. B., Festinger, D. S., Lee, P. A., Dugosh, K. L., Beansutti, K. M., (2006) "Matching Judicial Supervision Hearing to Client's Risk Status in Drug Court", *Crime & Delinquency*, 52-1, 52-76,

e. Behavioral research strongly suggests that extrinsic rewards for behavior that is intrinsically motivated can actually reduce the motivation to continue that behavior. Thus, additional economic rewards for a person who intrinsically likes their work can actually reduce desire to work. Motivation by praise is the most effective way of heightening participants intrinsic motivator. Deci, E. L., Koestner, R., & Ryan, R. M. (1999).,"A Meta-analytic Review of Experiments Examining the Effects of Extrinsic Rewards on Intrinsic Motivation." *Psychological Bulletin*, 125 (6), 627-668.

9. <u>BEHAVIOR DOES NOT CHANGE BY PUNISHMENT ALONE</u>.

a. Punishment has the drawbacks pointed out under other principles (See 8(a) and (b) above.)

b. Controlled comparisons of reinforcement and punishment report that clients in the reinforcement contingency stayed in treatment while those in the punishment contingency did not. Higgins, S. T., & Silverman, K. (1999). *Motivating Behavior Change Among Illicit-Drug Abusers.* Washington, D.C.: American Psychological Association, p. 330.

c. Effects of punishment are temporary and the punished behavior returns when the punishment contingency terminates. Higgins, S. T., & Silverman, K. (1999). *Motivating Behavior Change Among Illicit-Drug Abusers.* Washington, D.C.: American Psychological Association, p. 330.

d. Punishment is most effective when used in combination with other behavior notification techniques such as positive reinforcement. Marlowe, D. B., & Kirby, K. C. (1999). "Effective Use of Sanctions in Drug Courts: Lessons from Behavioral Research." *National Drug Court Institute Review*, II (1), 11-xxix. Higgins, S. T., & Petry, N. M. (1999). "Contingency Management: Incentives for Sobriety." *Alcohol Health & Research*, 23 (2), 122-127.

f. Recent contingency management research involving stimulant abusers found that the use of prize based incentive reinforcers resulted in improved treatment retention and abstinence. Petry, N., Pierce, J. and Stitzer, M. *et. al.* "Effect of Prize-Based Incentives on Outcomes in Stimulant Abusers in Outpatient Psychosocial Treatment Programs", *Archives of General Psychiatry,* v. 82: 1148-1155 (Oct. 2005)

10. <u>THE METHOD OF DELIVERY OF THE RESPONSE IS AS IMPORTANT AS THE RESPONSE ITSELF.</u>

a.. If the participant feels that the process is unfair either to him or to others, the participant will be defiant. Andreoni, J., Harbaugh, W., & Vesterlund, L. (2001)., "The Carrot or the Stick?: Rewards, Punishments

and Cooperation.",Unpublished paper, National Science Foundation Grant. Sherman, L. W. (1993). "Defiance, Deterrence, and Irrelevance: A Theory of the Criminal Justice Sanction." *Journal of Research in Crime and Delinquency*, 30 (4), 445-473. Thus, the drug court judge must articulate the differences in two apparently similar situations where there is a different judicial response. Otherwise a perception of unfairness will be projected.

b. Research based upon patient physician communication has demonstrated that interpersonal skills and empathic communication can improve patient satisfaction. Hubble, M. A.,Duncan, B. L., & Miller, S. D. (Editors) (1999). *The Heart & Soul of Change: What Works In Therapy.* Washington, DC: American Psychological Association, p. 274-275.

c. Psychiatrists who are enthusiastic about the effectiveness of a prescribed course of treatment and communicate same to the client obtain a significantly higher success rate (77% to 10%). Hubble, M. A.,Duncan, B. L., & Miller, S. D. (Editors) (1999). *The Heart & Soul of Change: What Works In Therapy.* Washington, DC: American Psychological Association, p. 277.

d. Research has consistently demonstrated that the psychoactive effects of a drug can vary based upon how the physician described the expected effect. Hubble, M. A.,Duncan, B. L., & Miller, S. D. (Editors) (1999). *The Heart & Soul of Change: What Works In Therapy.* Washington, DC: American Psychological Association, p. 300-309.

e. Certain styles of participant - therapist interaction result in more compliant behaviors. For instance, in parent training, confrontational and teaching oriented approaches tended to result in non-compliant responses whereas when support and facilitation were used compliant behaviors resulted. Patterson, G. A., & Forgatch, M. S. (1985). "Therapist Behavior as a Determinant for Client Noncompliance: a Paradox for the Behavior Modifier." *Journal of Consulting and Clinical Psychology*, 53, 846-851.

f. Research involving substance abuse (alcohol) using the two styles above confrontative vs. client centered (motivational interviewing - MI) approach resulted in reduced alcohol use in MI group and less resistance to change. Lawendowski, A. L. (1998).,"Motivational Interviewing with Adolescents Presenting for Outpatient Substance Abuse Treatment.", Unpublished doctoral dissertation, University of New Mexico;. "Dissertation Abstracts International," 59-03B, 1357;. Miller, W. R., Benefield, R. G., & Tonigan, S. (1993).,"Enhancing Motivation in Problem Drinking: A Controlled Comparison of Two Therapist Styles." *Journal of Consulting and Clinical Psychology*, 61, 455-461.

g. Motivational interviewing techniques shown to be successful include (1) let client do talking; (2) open-ended questions; (3) no more than two playbacks of what client said per main question; (4) complex reflections (playbacks) should be used at least 50% of the time when summarizing totality of clients statements; and (5) do not move beyond clients level of readiness. Do not warn confront or give unwelcome advice. Miller, B. (1999). Kaiser. "Motivational Interviewing Newsletter for Trainees," 6 (1), 1-2; Rollnick, S., & Miller, W. R. (1995). "What is Motivational Interviewing?" *Behavioral and Cognitive Psychotherapy*, 23, 325-334.

h. Even brief motivational interventions can be efficacious. Six months after enrolling in a comparison study, 22% oof those who received a brief motivational intervention tested negative for cocaine use and 40% of the opiate abusers tested negative for opiates, compared with 16% and 30% ,respectively who did not receive the intervention. Bernstein J., Bernstein E., *et. al.*, "Brief Motivational Visit at Clinic reduces Cocaine and Heroin Use", *Drug and Alcohol Dependence* v.77(1):49-59 (2005)

i. Recent research confirms that motivational interviewing techniques are effective in the drug court context. When a judge uses positive reinforcement with a participant, the number of positive urine tests is lower than when neutral or critical comments are employed. Scott Senjo &

Leslie Leip, *Testing Therapeutic Jurisprudence Theory: An Empirical Assessment of the Drug Court Process*, 3 WESTERN CRIMINOLOGY REVIEW 1-21 (2001) also available at http://wcr.sonoma.edu/v3n1/senjo.html

To: **Nancy K. Young**
From: **Nicolette M. Pach**
Re: **RESPONDING TO PARTICIPANT BEHAVIOR**
Date: **July 1, 2009**

In Family Drug Courts the goal is safe and stable permanent reunification of children with a parent in recovery within the time frames established by ASFA and matching the child's developmental tolerance. The FDC field is moving away from the criminal drug court vocabulary of "sanctions" toward a model of "responses" appropriate to the family court dependency cases, designed to assist the parent to ameliorate the issues which brought the family into the child protective system in the first place. The purpose of responding is not to punish the parent, but to enhance the likelihood that the family can be reunited before the ASFA clock requires an alternate permanent plan for the child.

FDC must set and communicate clear concrete expectations for participants so they know what is desirable (acceptable) and undesirable (unacceptable) behavior as they move through the phases of the FDC. FDC must develop clear responses to participant behavior to be used by the team to promote compliance. Responses should be consistent in FDC in so far as is possible, but must be flexible enough to account for the unique individual circumstances of each parent.

With this in mind the FDC should consider the goal of each response to a participant's compliant or non-compliant behavior. Responses should be designed to achieve a specific clinical (therapeutic) result for the parent in treatment; a protective response if the parent's behavior puts the child at risk; or a motivational response designed to teach the parent how to engage in desirable behavior and achieve a stable lifestyle.

The FDC must always take into account the impact of a response may have on a child. Parent/child custody or contact should be determined solely on the basis of the child's safety and best interest, not as a parental sanction or reward. Incentives can be structured to enhance the parent child relationship. Similarly, clinical decisions as to a parent's treatment may be made in response to behavioral indicators that the current clinical approach is insufficient, but must be determined by treatment professionals as clinically appropriate, not as a punitive sanction

Responses should be strength based focusing on parent's successes however minor rather than focusing on failings. This encourages parents to use their own resources to overcome difficulties. FDC should avoid using responses that appear punitive merely for the sake of punishment. Incarceration should be avoided in FDC, but where the judge determines it is appropriate, all procedural and due process safeguards must be observed.

Responses should be applied using scientifically based behavioral modification practices to achieve the desired effect. Research indicates that the "Ten Science-Based Principles" as conceptualized by Judge William Meyer (ret.) promote behavioral change by stressing certainty and swiftness in court responses. Responses should be informed by ongoing clinical assessment, motivational strategies, cognitive-behavioral interventions and the development of continuing care strategies. (See http://www.georgiacourts.org/duidoc/developing%20and%20Delivering%20Incentives%20and%20Sanctions%204-3-07.pdf)

Responding to Participant Behavior in Family Drug Courts

October 21, 2011

Presented by:
Linda Carpenter
Program Director
Alexis Balkey
Program Associate
Children and Family Futures

This project is supported by Award No. 2009-DC-BX-K069 awarded by the Office of Juvenile Justice and Delinquency Prevention,
Office of Justice Programs

Introductions

- **Linda Carpenter M.Ed.**
  Program Director
  Children and Family Futures
  Irvine, California

- **Alexis Balkey BA, RAS**
  Program Associate
  Children and Family Futures
  Irvine, California

Agenda

- Welcome and Opening Remarks
- 3 Essential Elements of Responses to Behavior
- Responses to Behavior in Family Drug Court
- 10 Science-Based Principles
- Rethinking Sanctions and Incentives
- Questions and Discussion
- Next Steps

Children and Family Futures

Mission:

Improve the lives of children and families, particularly those affected by substance use disorders.



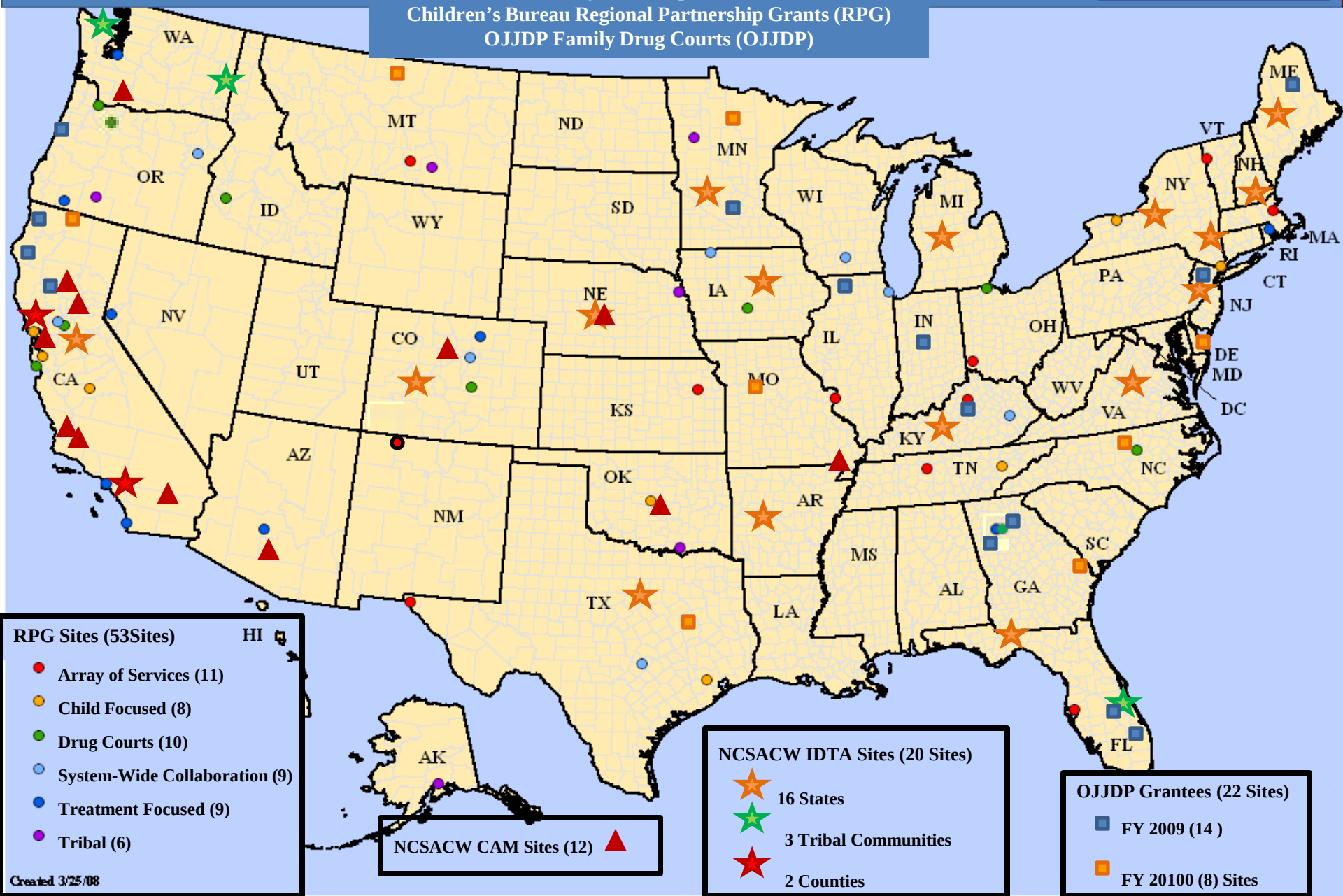
CFF Primary Technical Assistance Programs

- **Children and Family Futures (CFF)**
  - **SAMHSA & ACYF**
    National Center on Substance Abuse and Child Welfare
    - In-Depth Technical Assistance
    - Children Affected by Methamphetamine
  - **ACYF**
    Regional Partnership Program
  - **DOJ**
    Office of Juvenile Justice and Delinquency Prevention

http://www.cffutures.org

US DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Administration for Children and Families
www.samhsa.gov

NCSACW In-Depth Technical Assistance Sites (IDTA)
Children Affected by Methamphetamine Sites (CAM)
Children's Bureau Regional Partnership Grants (RPG)
OJJDP Family Drug Courts (OJJDP)



RPG Sites (53Sites)

- Array of Services (11)
- Child Focused (8)
- Drug Courts (10)
- System-Wide Collaboration (9)
- Treatment Focused (9)
- Tribal (6)

Created 3/25/08

NCSACW CAM Sites (12)

NCSACW IDTA Sites (20 Sites)

- 16 States
- 3 Tribal Communities
- 2 Counties

OJJDP Grantees (22 Sites)

- FY 2009 (14)
- FY 20100 (8) Sites

3 Essential Elements of Responses to Behavior

Linda Carpenter



3 Essential Elements of Responses to Behavior

1. Addiction is a brain disorder
2. Length of time in treatment is the key. The longer we keep someone in treatment, the greater probability of a successful outcome.
3. The purpose of sanctions and incentives is to keep participants engaged in treatment.

ASAM Definition of Addiction

"Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors."

Adopted by the ASAM Board of Directors 4/12/2011

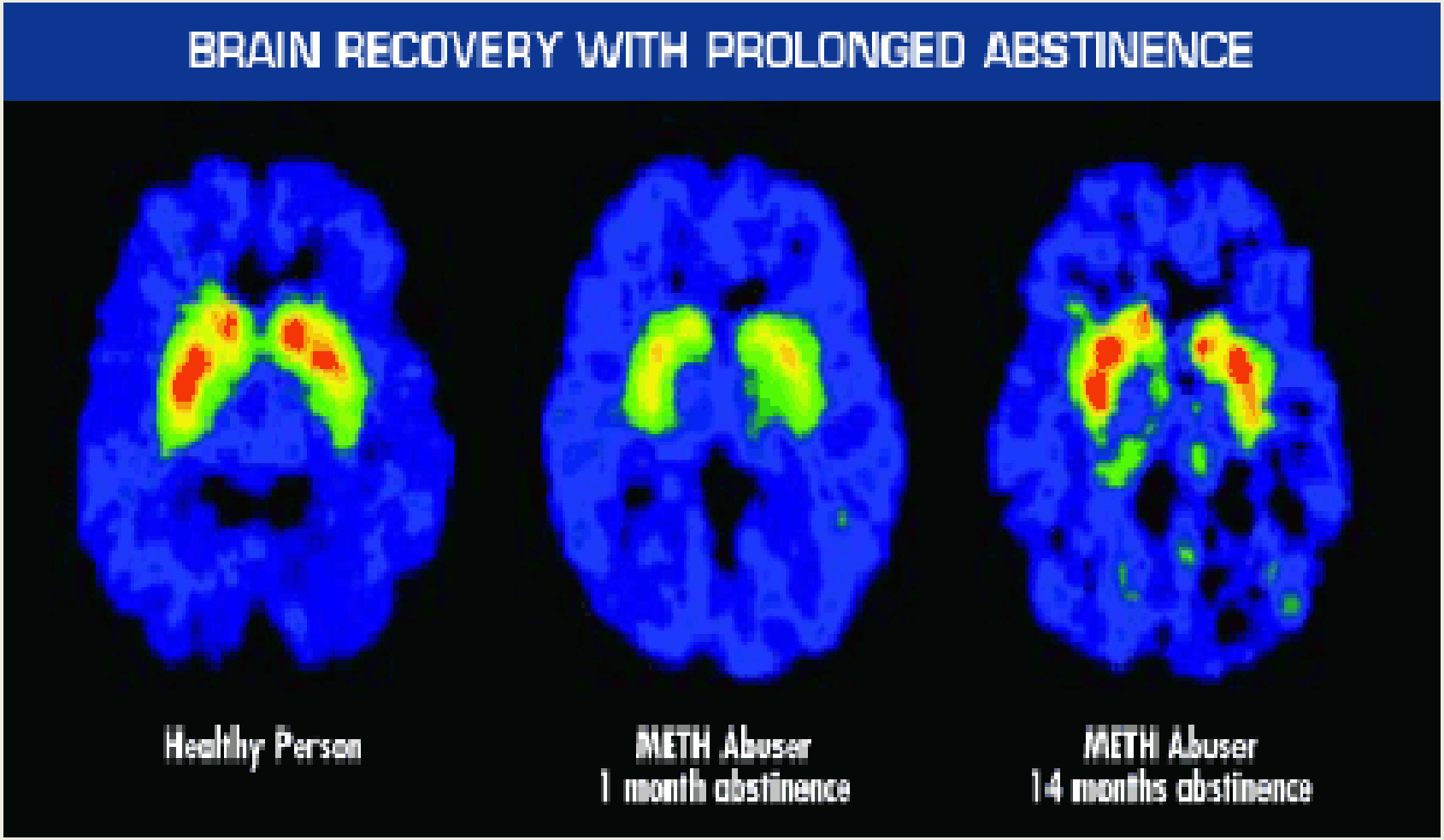


ASAM Definition of Addiction

- Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response.
- Like other chronic diseases, addiction often involves cycles of relapse and remission.
- Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

Adopted by the ASAM Board of Directors 4/12/2011

Addiction affects the brain





Proximal vs. Distal Responses

- Timing is everything; delay is the enemy; how can you as a team work on this issue?
- Intervening behaviors may mix up the message.
- Brain research supports behavioral observation; dopamine reward system responds better to immediacy.



Frequency of Responses

- Responses should be delivered for every target behavior.
- Undesirable behavior must be reliably detected
- Frequency of contact with a Judge needs to be matched with the offender's needs. High-end need more, low-end need less.

Responses to Behavior as an Engagement and Retention Principle

- Treatment dropout is one of the major problems encountered by treatment programs; therefore, motivational techniques through appropriate responses to behavior can keep patients engaged and improve outcomes.
- Good outcomes are contingent on adequate treatment length.

http://www.drugabuse.gov



What is Success in FDC? Key Outcomes

Safety (CWS)

- Reduce re-entry into foster care
- Decrease recurrence of abuse/neglect

Permanency (Court)

- Reduce time to reunification
- Reduce time to permanency
- Reduce days in care

Recovery (AODS)

- Increase engagement and retention in treatment
- Increase number of clean UA's
- Increase number of graduates
- Decrease Recidivism

AFSA Clock

- FDC's goal is safe and stable permanent reunification with a parent in recovery within the time frames established by ASFA.
- Responses aim to enhance the likelihood that the family can be reunited before the ASFA clock requires an alternative permanent plan for the child.

Three Clocks: Competing Requirements

AFSA

Treatment Recovery

Child's Developmental

Responses to Behavior in Family Drug Courts

Alexis Balkey



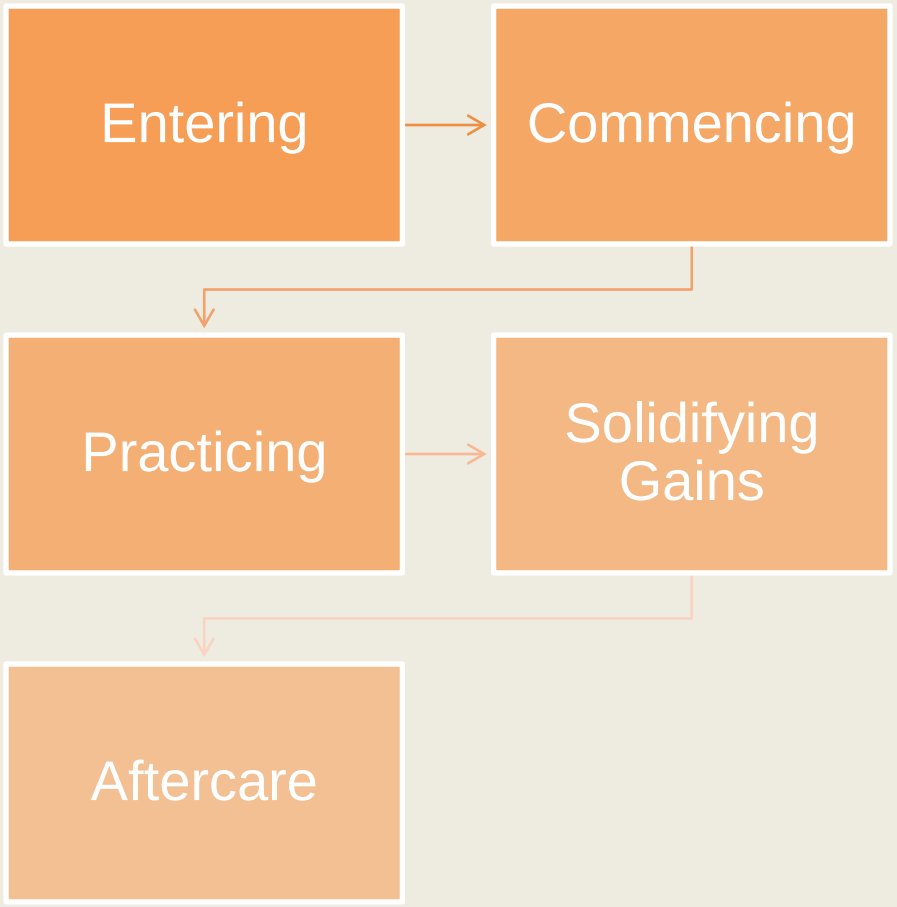
FDC Framework

FDC focus is on treatment

Responses are thus based on treatment

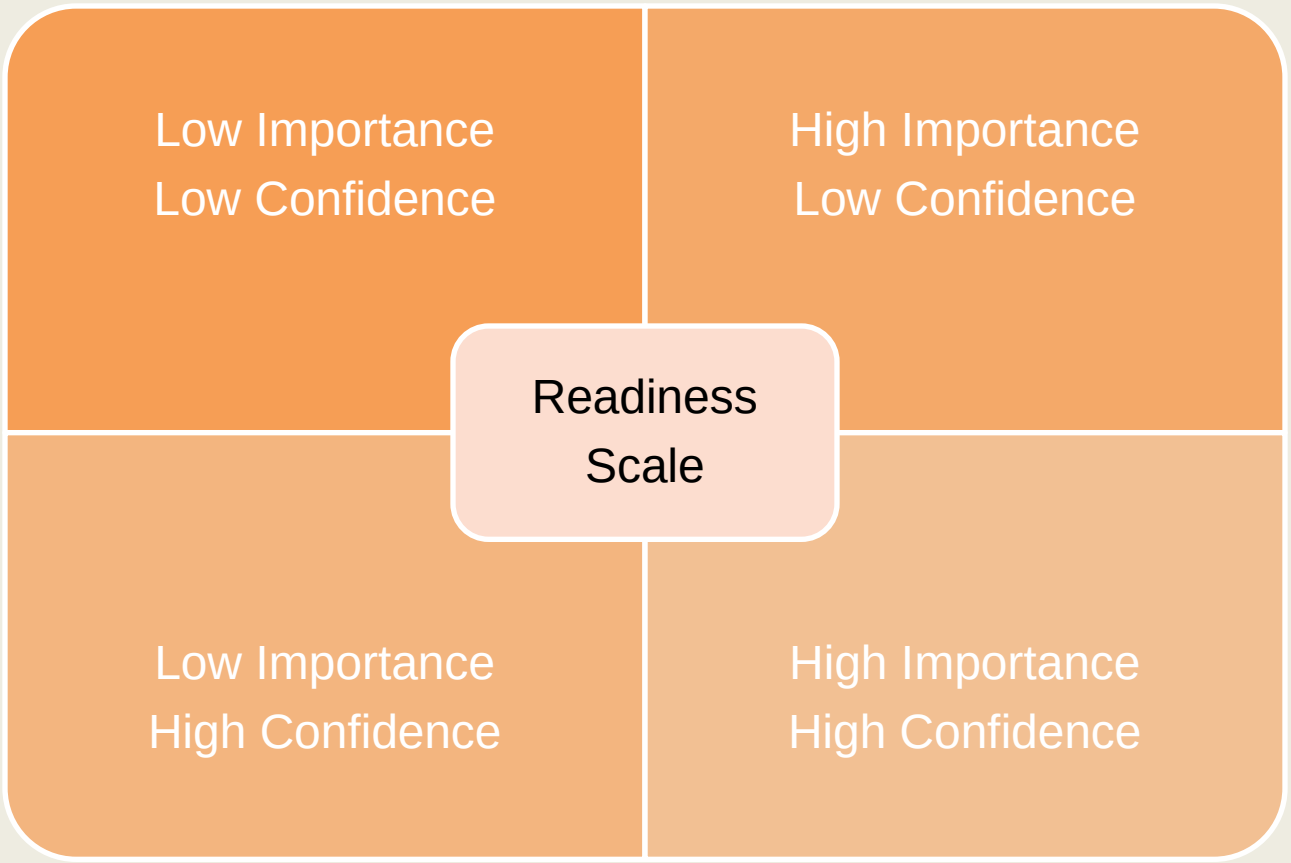
Long-term success is based on achieving compliance through persuasion rather than coercion

Phases and Benchmarks

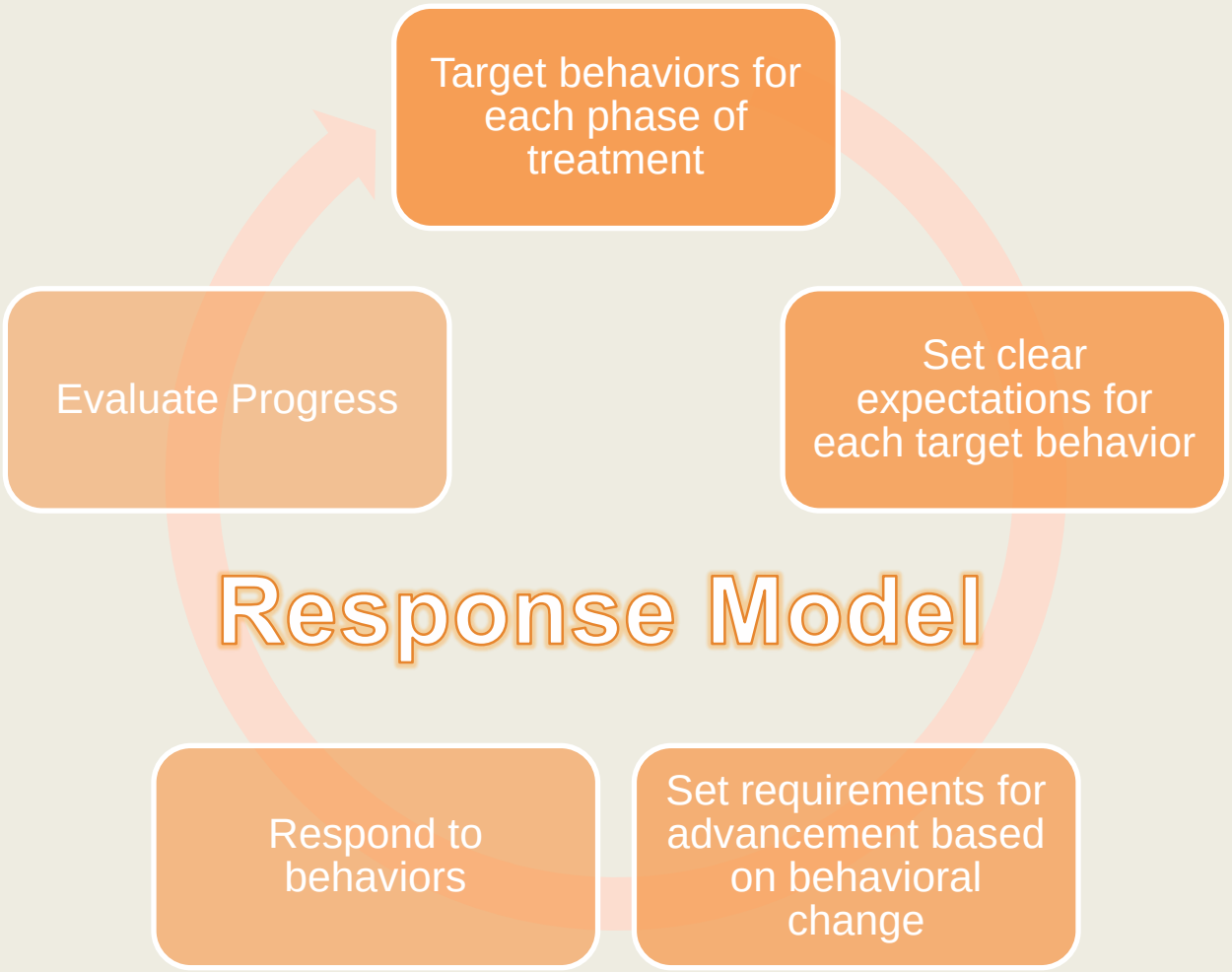


- Set target behaviors for each phase
- Establish clear expectations for every targeted behavior
  - desirable
  - unacceptable
  - concrete
  - reasonable
  - agreed upon
- Set requirements for advancement based on behavioral change

Client Readiness



Model for Responding to Behavior





Reinforcement is how substance abuse problem began and is maintained

- Positive reinforcement – it feels good to use.

  Examples:
  - Actual effects of the drug (i.e., “the high”)
  - Social outlet / time with peers
  - More energy / confidence / self-assurance
- Negative reinforcement – it feels bad NOT to use.

  Examples:
  - Increased anxiety
  - Physical withdrawal symptoms
  - Boredom
  - Demands made by others *(when I’m sober, my husband and I argue constantly; leaving for the bar or passing out is an escape!)*

10 Science-Based Principles



10 Science-Based Principles

1. Sanctions should not be painful, humiliating, or injurious.
2. Responses are in the eye of the behaver.
3. Responses must be sufficient intensity.
4. Responses should be delivered for every target behavior.
5. Responses should be delivered immediately

Meyer, William's Ten Science-Based Principles of Changing Behavior Through the Use of Reinforcement and Punishment (National Drug Court Institute)



10 Science-Based Principles

6. Undesirable behavior must be reliably detected.

7. Responses must be predictable and controllable

8. Responses my have unintentional side effects

9. Behavior does not change by punishment alone

10. The method of delivery of the response is as important as the response itself.

Responses to Behavior

Safety

- A protective response if a parent's behavior puts the child at risk

Therapeutic

- A response designed to achieve a specific clinical result for parent in treatment

Motivational

- Designed to teach the parent how to engage in desirable behavior and achieve a stable lifestyle



Setting Range of Responses

- FDC team should develop a range of responses for any given behavior
- Avoid singular responses, which fail to account for other progress
- Aim for “flexible certainty” – the certainty that a response will be forthcoming united with flexibility to address the specific needs of the individual
- NDCI Tool



Techniques

- Contingency Management
- Motivational Interviewing
- Teachable Moments
- Fishbowl

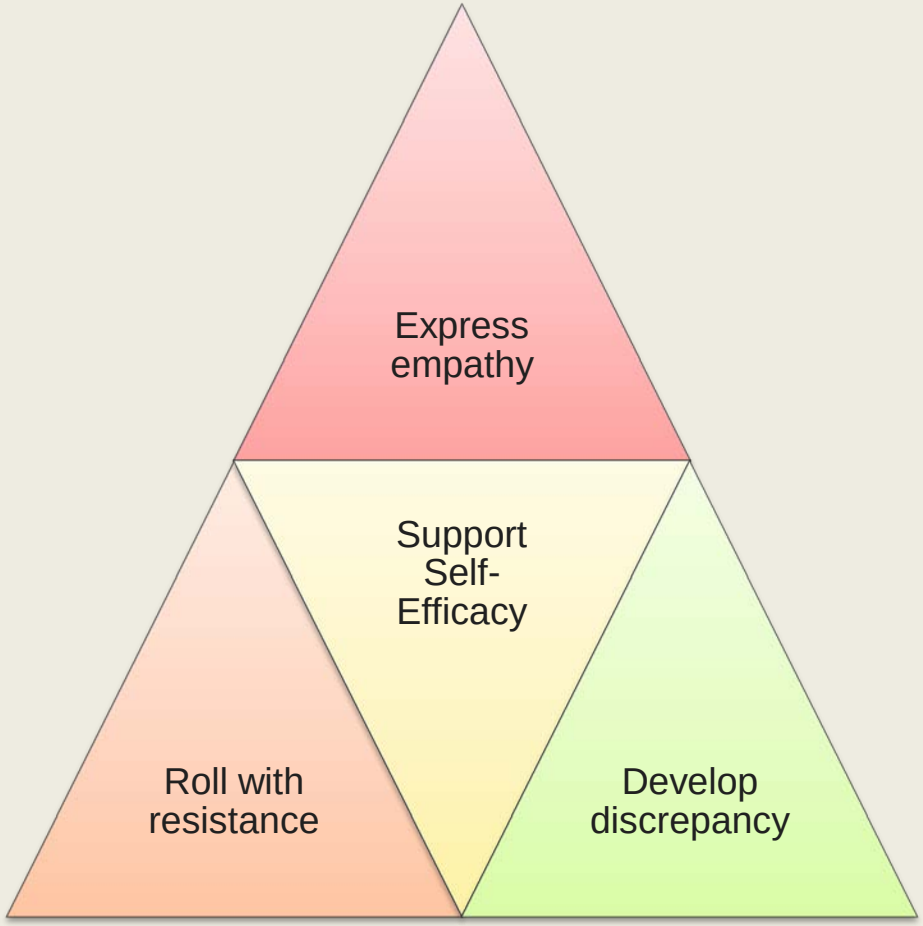
Contingency Management

JSTEPS

- Clarify Expectations
- Clarify Steps
- Reinforce positive behaviors
- Shapes behaviors
- Small steps are recognized by the system
- Technique to replace “drug-using rewards” with structure
- Behavior contract – binding agreement

Small Steps recognized by the system

Motivational Interviewing Four General Principles



Change Talk

Desire: *I want to change.*

Ability: *I can change; You know, I'm starting to feel like this just might work out.*

Reason: *I should change because……I think that using may be causing problems.*

Need: *I need to change; I'm kind of worried that things might be getting out of hand.*

Commitment: *I am going to change; I'm definitely going to do something about that.*



Behaviors that Promote Resistance Talk (and discourage change talk)

- Arguing for change – the counselor directly takes the pro-change side of the argument
- Assuming the expert role – lecturing; the counselor has the answers
- Criticizing or blaming
- Labeling – proposing acceptance of a specific label or diagnosis
- Being in a hurry – perceived shortness of time leads counselor to believe that he or she must be more forceful and directive
- Claiming preeminence – “I know what’s best for you.”



Methods for Evoking Change Talk

- Ask evocative questions
  - What strengths do you have that would help you beat this, if you decide to stop?
- When client offers a reason for change, ask for elaboration.
  - *My mother hounds me about my drinking all the time.*
  - Tell me more about that. What are her concerns?
- Query extremes
  - If you were to keep drinking, what is the worst thing you can imagine happening?

Rethinking Sanctions and Incentives

Linda Carpenter



Why use rewards to address substance abuse?

- Reinforcement is the main mechanism through which all "natural" behaviors are developed – i.e., "learned."

  Examples:
  - Infancy: comfort and food teach infants to bond to parents
  - Childhood: praise/approval from adults, time spent with peers make child more likely to go to school
  - Adulthood: societal respect, status, and money keep adults working

- We are all products of our learning history
  - B.F. Skinner: *"The organism is always right."*
  - Everyone behaves so as to maximize the reinforcement they receive



Why use rewards to address substance abuse? (cont'd)

- 75 years of research, consistent results: Reinforcement is ***by far*** the best way to change behavior
  - Rewarding desired behavior is more effective than punishing undesirable behavior
  - Teaches what to do, not what NOT to do
- Reinforcement is the main technique used in thousands of successful interventions - examples:
  - Parent training approaches
  - Developmental disabilities (e.g., autism)
  - Depression and anxiety treatment
- NIDA (2010) review of the literature: *"Combining medications (when available) with behavioral therapy is the best way to ensure success for most patients."*



Ideas for Positive Reinforcement

- If you meet FDC targets, lots of good things happen
- Small things:
  - Ceremonial acknowledgement of successes – e.g., certificates, an announcement in the court room
  - Letter or phone call to someone the client cares about, praising the client
  - A toy that the client can give to his/her child(ren) and take credit for
- Big things:
  - Help finding a job or a better job
  - Housing assistance
  - Transportation assistance
  - Letters of recommendation
  - Giving the client a role in the court – e.g., engaging the client as a peer leader, to be part of a focus group to discuss ways of improving the court, etc.



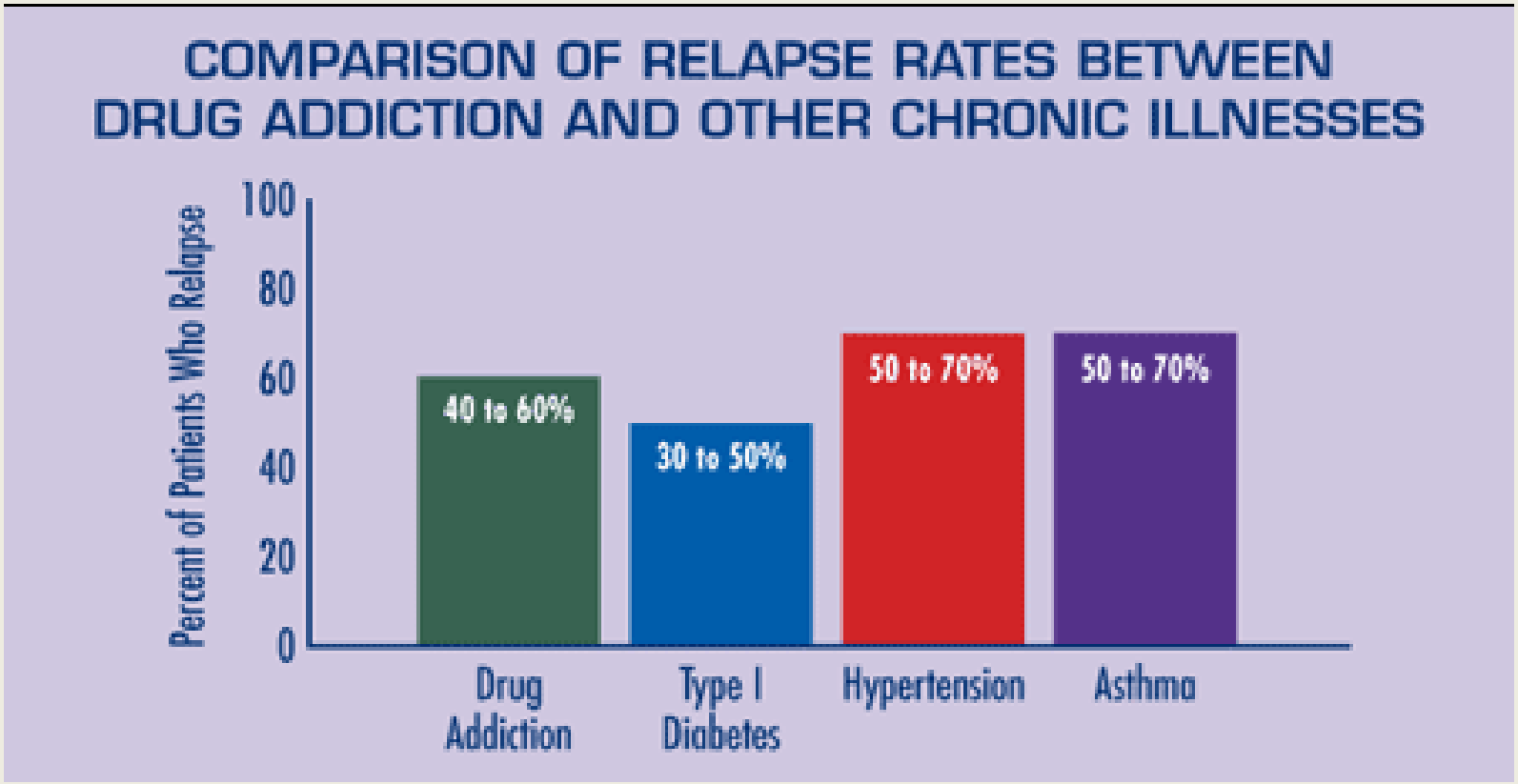
Ideas for Negative Reinforcement

- If you meet FDC targets, some bad things (may) go away
- Small things:
  - Less frequent or less aversive (e.g., with more privacy) drug testing
  - Fewer appointments and requirements
  - Children's foster parent not treating the parent disrespectfully
- Big things:
  - Using voucher money for something client truly needs – e.g., to pay off a debt
  - No longer need someone monitoring visits with children
  - Court personnel advocate for client (e.g., that client can obtain methadone in a more desirable setting)

Rethinking Relapse

- Relapse is not the same as treatment failure
- Relapse is not an isolated event, but rather a process
- Relapse presents a therapeutic opportunity
- Re-engagement after relapse
- Relapse prevention plan and strategies
- Client relapse leads to collaborative intervention to reengage client in treatment and reassess child safety.
- Relapse vs. lapse

Addiction and other Chronic Conditions



Rethinking Sanctions

Use of “sanctions” is not recommended:

- Weekend jail (work detail)
- Short term jail sentence
- Fines
- Tough physical labor
- Clean jail
- Electronic surveillance or monitoring
- GPS monitoring
- Electronic bracelet

Rethinking Termination

- FDC keep abusers in treatment
- FDC should make termination almost impossible to achieve
- The longer we keep someone in treatment, the greater probability of a successful outcome.
- Grounds: behavior threatens public safety or undermines program integrity

Treatment Responses

- Response & treatment alternatives can be discussed in staffing
- How are final decisions made?
  - Treatment by treatment provider
  - Consequences by the judge



Impact on Children and Families

- Accountability is focused on parent
- Court must consider impact of a response on children and family as a unit
- Visitations should be determined solely on basis of child's safety and best interest (vs. parent sanction or reward)

Role of the FDC Team in Responding to Participant Behavior

- Target behaviors for each phase of treatment
- Set clear expectations for each target behavior
- Reports to judge; includes progress, highlights successes

Critical Questions

- What are the proximal and distal behaviors you are trying to shape? Have you prioritized your target behaviors depending upon the participant's risk and need over the time period of your program in the phases you have established?

- Do you know the population you serve? Have you assessed for risk and need? Are the responses for addicts of a different magnitude than for abusers considering the proximal and distal target behavior goals for that individual?

Critical Questions

- Have you used available local and national resources to expand your range of consequences? Does your list of responses reflect the importance of incentives?
- Has team sat down and memorialized the range of responses for compliant and non-compliant behavior? Will NDCI's Building Consensus tool help?
- Are you using the 10 science-based principles in your responses?
- Are treatment decisions being made by treatment providers?
- What are your grounds for termination?

Questions?

Technical Assistance

- How do I access technical assistance?
  - Visit the Children and Family Futures website for resources and products at **www.cffutures.org**
  - Email us at **fdc@cffutures.org**
  - Call us: 1-866-493-2758



Contact Information

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Sanctions

Sanctions shall not be imposed for the purpose of punishment.
All sanctions imposed shall be gradual in severity and only that necessary to change behavior consistent with treatment.

Sanctions should be designed to change future behavior, not punish past actions!

Sanctions Should be Delivered For Every Infraction

- No sin should go unpunished
- "for every action, there is an equal and opposite reaction"
- Forgiveness is NOT a drug court concept
- All Sanctions and Incentives are determined on a case by case basis

SANCTIONS

Program

- Interim sanctions and/or interventions will be imposed at treatment to provide immediate response to relapse.
- Honesty will be rewarded with a lesser/reduced sanction

TYPICAL BEHAVIOR : DRUG TESTING

- FAILURE TO TEST
- CLIENT IS UNABLE TO PRODUCE A URINE SAMPLE OR FAILS TO PRODUCE (20ML) AMOUNT DURING NORMALTESTING TIME.
- NO SHOW FOR TESTING (ns)
- NO SHOW FOR TESING WHEN ANNOUNCED ON A SATURDAY, SUNDAY, OR HOLIDAY.
- UNACCEPTABLE TEST TEMPERATURE
- POSITIVE UA/ALCOHOL TEST
- RELAPSES: FIRST
  SECOND
  THIRD
- DILUTED SAMPLE
- POSSESSION OF ANY TYPE OF ADULTERATION/FLUSHING SUBSTANCES USED FOR MASKING RESTS, INCLUDING BUT NOT LIMITED TO LIQUIDS, POWDERS, PILLS, DYES, DEVICES, ETC. (SEE PAGE 7)

Tier I	Tier II	Tier III
FIRST OFFENSE	SECOND OFFENSE	THIRD OFFENSE
Delayed Admit to formal program	Detox	Residential (min 30 days)
Increased Testing	Community Services	Graduation eligibility delayed
Increased Treatment	Written/verbal apology to team/group	Termination
Community Service	Increased treatment	Increased treatment
Increased court appearances	**Verbal warning from Judge**	**Order from Judge**
Open apology to team/Group		
No Phase change for 30 days		
Verbal warning from Judge		

SANCTIONS

Program

- HONESTY MAY BE REWARDED WITH A LESSER/REDUCED SANCTION

TYPICAL BEHAVIOR : SELF HELP RESPONSIBILITY

- FAILURE TO TURN IN SELF HELP MEETING SLIPS BY DATE DUE
- MEETING SLIPS ARE TURNED IN WITH LESS THEN REQUIRED NUMBER OF MEETINGS.
- FORGED MEETING SLIPS (SEE PAGE 7)
- FAILURE TO OBTAIN IN 12 STEP SPONSOR

Tier I	Tier II	Tier III
FIRST OFFENSE	SECOND OFFENSE	THIRD OFFENSE
Warning and or 7 meetings in 7 days plus any sanction from sanction pool Increased self help meetings Other writing assignments Journaling Increased court appearances Open apology to Group No Phase change Essay to Court	14 meetings in 14 days, plus any sanction from sanction pool Write Essay Outline pages 1-83 of NA basic Text Spend day observing court Community Service Written/verbal apology to team/Group Peer review **Verbal warning from Judge**	Graduation eligibility delayed Termination **Order from Judge**

SANCTIONS

Program

- HONESTY MAY BE REWARDED WITH A LESSER/REDUCED SANCTION

TYPICAL BEHAVIOR : MISCELLANEOUS

- INAPPROPRIATE COURTROOM BEHAVIOR
- NEW DRUG OR ALCOHOL USE PRIOR TO COURT
- CONTINUOUS RULE VIOLATIONS
- ABSCONDING FROM PROGRAM (3 DAYS NO CALL NO SHOW)
- DISHONEST STATEMENT TO JUDGE, TEAM AND/OR TREATMENT
- QUITTING PROGRAM AFTER PROBATIONARY PRIOD AND BEFORE COMPLETION
- OBTAINING NEW DRUG CHARGES
- FAILING TO COMPLY WITH SANCTIONS
- LEAVING RIVERSIDE WITHOUT PERMISSION
- ASSOCIATING WITH/LIVING IN A HOME WHERE DRUGS ARE USED/PRESENT

Tier I	Tier II	Tier III
FIRST OFFENSE	SECOND OFFENSE	THIRD OFFENSE
Writing assignments		Repeat each phase/specified time
Journaling	Written/verbal apology to team	Graduation eligibility delayed
Increased court appearances	De-phasing	Structured Sober Living Requirement
Open apology to team	Additional drug testing	Termination
Increased Treatment	Community Service	**Order from Judge**
Essays for Court	Round Table W/Team	
Community Service	**Verbal warning from Judge**	

SANCTIONS

Program

TYPICAL BEHAVIOR : Non-compliance

- CONTINUALLY FAILS TO MEET REQUIREMENTS IN ONE OR MORE AREAS, OR CONTINUALLY COMMITS RULE VIOLATIONS
- FAILURE TO PROVIDE CURRENT ADDRESS OR CHANGE OF ANY PERSONAL INFORMATION WITHIN 24 HOURS OF CHANGE. (ADDRESS, PHONE, EMPLOYMENT, SPONSOR, ETC)
- LEAVING DETOX OR A RESIDENTIAL CARE PROGRAM PRIOR TO COMPLETION WITHOUT THE TEAMS PERMISSION
- FAILURE TO OBTAIN SOBER LIVING
- FAILURE TO MEET EMPLOYMENT/SCHOOL MILESTONES
- OBTAINING NEW DRUG CHARGES
- USE OF PRESCRIPTION AND/OR OVER THE COUNTER MEDICATION WITHOUT FIRST OBTAINING PERMISSION FROM TREATMENT.

Tier I	**Tier II**	**Tier III**
FIRST OFFENSE	SECOND OFFENSE	THIRD OFFENSE
Increased court appearances		Graduation eligibility delayed
Delay in promotion of phase	Placement in structured Sober Living	Termination
Increased Treatment	Community Service	**Order from Judge**
Increased Drug Testing	Written/verbal apology to team	
Verbal warning from Judge	**Verbal warning from Judge**	

SANCTIONS

TREATMENT

- ALL TREATMENT SANCTIONS ARE TO BE IMPOSED BY TREATMENT AND REPORTED TO THE FPC TEAM

TYPICAL BEHAVIOR : TREATMENT

- NO CALL – NO SHOW (NC/NS)
- CLIENT FAILED TO CALL AND SHOW FOR GROUP. CLIENT FAILED TO SHOW PROOF OF AN EMERGENCY.
- FAILURE TO CALL AND SHOW FOR 3 CONSECUTIVE DAYS
- CLIENT DID CALL PRIOR TO THE START OF G

Tier I	Tier II	Tier III_____
FIRST OFFENSE	SECOND OFFENSE	THIRD OFFENSE
Writing assignments		Repeat each phase/specified time
Journaling	Written/verbal apology to team	Graduation eligibility delayed
Increased court appearances	De-phasing	Structured Sober Living Requirement
Open apology to team	Additional drug testing	Termination
Increased Treatment	Community Service	**Order from Judge**
Essays for Court	Round Table W/Team	
Community Service	**Verbal warning from Judge**	

SANCTIONS

Program

- BEHAVIORS THAT WILL RESULT IN IMMEDIATE TERMINATION ARE DISHONEST AND PRECALCULATED ACTIONS.

TYPICAL BEHAVIOR : IMMEDIATE TERMINATION

- POSESSION OF ANY TYPE OF ADULTERATION/FLUSHING SUBSTANCES USED FOR MASKING TESTS, INCLUDING BUT NOT LIMITED TO LIQUIDS, POWDERS, PILLS, DYES, DEVICES, ETC.
- SUBSTITUTING, ALTERING OR TYRING IN ANY WAY TO CHANGE BODY FLUIDS FOR PURPOSES OF TESTING.
- FORGED MEETINGS
- DISHONEST STATEMENT TO JUDGE, TEAM AND/OR TREATMENT
- OBTAINING NEW DRUG CHARGES

Tier I	Tier II	Tier III
FIRST OFFENSE	SECOND OFFENSE	THIRD OFFENSE
Residential	Residential	Termination from program Assessment for reentry after 30 days if approved by team.

REWARDS

MOST OF TODAY'S CLINICAL TEXTBOOKS CONCLUDE THAT POSITIVE REINFORCEMENT IS FAR PREFERABLE FOR CHANGING BEHAVIOR [THAN PUNISHMENT].

A good incentive will evoke good feelings in the participant . . . They may feel important, accomplished, liked, respected, or simply recognized.

REWARDS SHOULD BE IMMEDIATE

REWARDS

Program

- GIFT CERTIFICATES SHOULD BE AWARDED FOR EXTRAORDINARY BEHAVIOR
- TREATMENT MAY ADD THEIR OWN REWARDS.

EXTRAORDINARY BEHAVIOR :

Maintianing sobriety Stayed away from using partner/users Maintain sobriety during stressful life experience (death in family, loss of job, etc) Doing more then is required Telling the truth/being honest about non-compliant event Helping another client with transportation Helping another client with _____ Volunteering time	Share home with others Obtaining employment/GED/finishing school Being a mentor or role model Moving from one phase to another Completion of Nurturing Families Program Graduating Program

Tier I	**Tier II**	**Tier III**
Certificate of Promotion Praise from the judge Early call list Recognition from the team	Travel privileges Excused from court early Reduced court appearance Clothes/hosehold items Connect with community for speical needs (dental, haircuts, mentoring, employment)	Housing Voucher Program token Graduation Certificate Gift Certificate (relevant to need) Tattoo removal Legal assistnace with felony/misd Reduce fines