



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

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Disclaimer

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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	
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	
4 months clean	Acknowledgment by judge
Complying with court order	Case called early in court, small gift
Completion of Phase II	
4 to 6 months clean	Acknowledgment by judge, case called early in court, small gift
Completion of Phase III	
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 Act² (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 1 afternoon per week before a single judge. The program had approximately 60 participants as of late 2000.

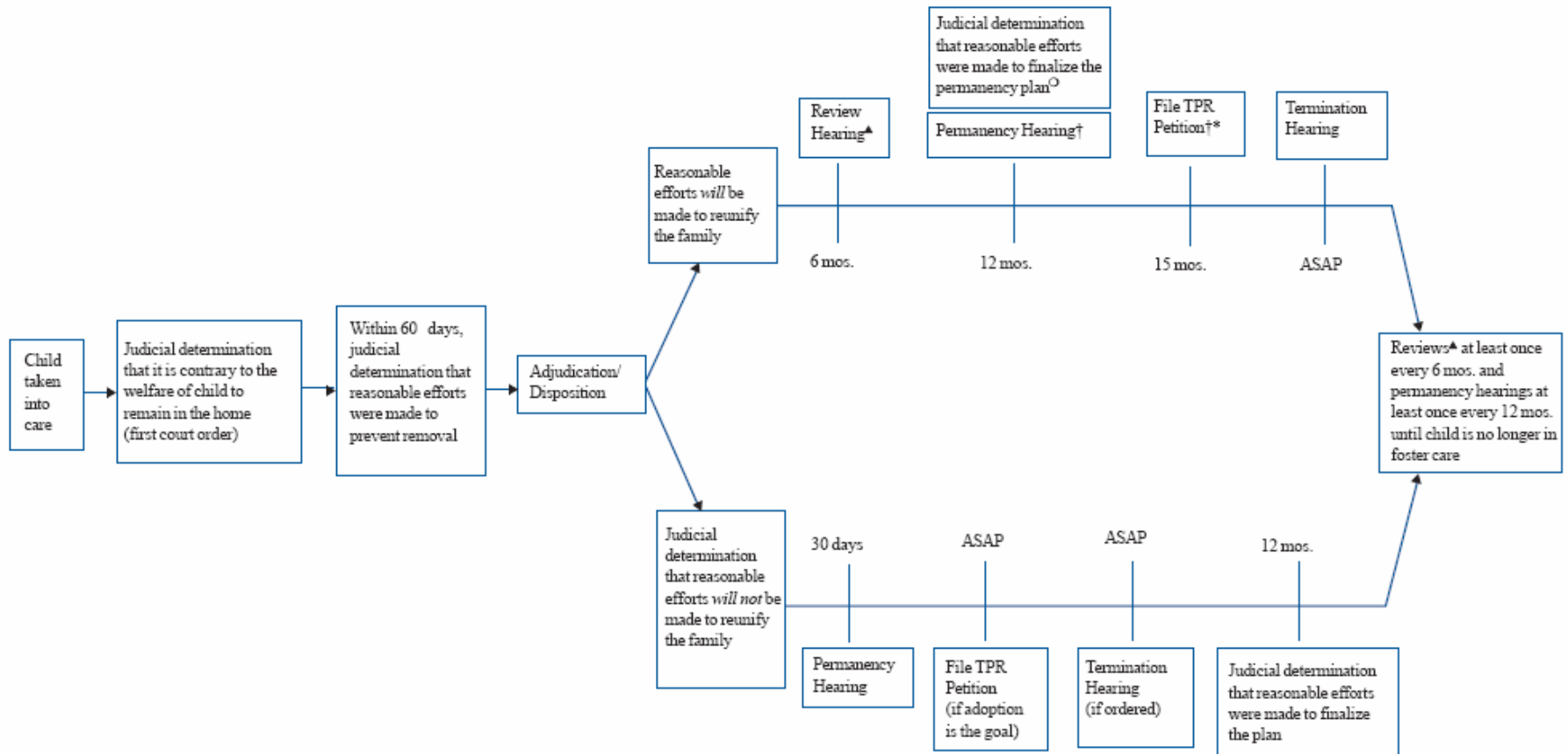
Preliminary Findings

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.

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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. Snavelly
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 FDTs. 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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