GUIDANCE TO STATES:

Recommendations for Developing Family Drug Court Guidelines

OJJDP

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INTRODUCTION

Family drug courts (FDCs) offer an important and effective way to address substance use disorders and parenting within the child welfare and court systems. In existence since 1994, with more than 300 programs in operation today, FDCs grew out of the adult criminal drug court movement that began in Miami in 1989. In the mid-1990s, the adult criminal drug court model was described by the National Association of Drug Court Professionals (NADCP) in *Defining Drug Courts: The Ten Key Component*s,[1] which offered a framework to develop and refine adult drug courts.

Several States have developed FDC standards by which they monitor local jurisdictions and that provide direction on specific needs and issues related to child welfare such as child development, trauma experiences and child safety concerns, however most States have not. This poses challenges as States and individual FDCs seek guidance in planning, implementing, and monitoring their programs and in turn makes program evaluation and quality assurance more difficult. There have been considerable efforts to identify the characteristics of FDCs in the past decade that incorporate practice changes to address the needs of children and their families. Building on those efforts, this document has been developed to provide assistance to the field in further defining FDCs' best and promising practices so that States can issue their own guidelines for FDCs or enact standards by which FDCs are held accountable.

As a component of the Technical Assistance program of the Office of Juvenile Justice and Delinquency Prevention, Children and Family Futures partnered with the National Drug Court Institute, Federal, State, and other stakeholders to create these recommendations. It is hoped that the document will be used by States to develop their own recommendations but also by local FDCs as a tool for courts and administrative agencies who are beginning an FDC or seek to improve their operations. This document provides the description of each recommendation, the supporting evidence, and examples of effective strategies on how that recommendation can be implemented. The guidance also provides a common vocabulary to begin the collaborative effort to implement an FDC, including specific direction to maximize collaboration efforts for States.

WHAT'S NEW IN 2.0

Guidance to States: Recommendations for Developing Family Drug Court Guidelines was first published in May 2013 and since that time, more than 20,000 copies have been downloaded from the internet and another 500 were distributed in hardcopy. In the past few years, there have been a number of new and important contributions to the FDC literature, such as the SAMHSA publication on the lessons from the Children Affected by Methamphetamine grant program,[2] the development of Adult Drug Court Best Practice Standards[3,4] and new evaluation literature on FDCs.[5] There have also been significant advances from research on topics such as trauma, case management and recovery support, and mental health. This updated publication includes this research and has consequently increased the number of citations in the document from 55 in the 2013 version to over 100 in Guidelines 2.0. This bolstering of the research base and summarizing of the evidence supporting the guidance to States is a significant contribution to present and future FDCs.

BACKGROUND

During the more than twenty years that FDCs have been in operation, significant work has been done to develop an operational model that addresses the unique needs of families affected by substance use disorders in the child welfare system. The Family Dependency Treatment Court Characteristics were described in the seminal publication *Family Dependency Treatment Courts: Addressing Child Abuse and Neglect Cases Using the Drug Court Model*.[6] The characteristics were refined during the Drug Court Planning Initiative: Family Dependency Treatment Court training that was created and conducted by the National Drug Court Institute. These Characteristics became the foundation of many FDCs as they developed program policy and practice.

At the same time, the National Center on Substance Abuse and Child Welfare published a 10 Element Framework[7] that focused on improving practice and policy linkages between substance use disorder treatment services, child welfare, and dependency courts. There was also growing concern about the placement of Indian children involved with child welfare and Tribal-State relationships. Congress passed the Indian Child Welfare Act (ICWA) in 1978 in response to the disproportionally high number of Indian children being removed from their homes.[a] In 2003, the Tribal Law and Policy Institute published the *Tribal Ten Key Components*[b] to adapt and generalize NADCP's key components to specifically address the critical issues and challenges faced by Tribal Healing to Wellness Courts.

CREATION OF THE RECOMMENDATIONS

Creating this Recommendations document began with a diverse group of subject matter experts from across the country who contributed their knowledge and expertise from the field of FDCs. These individuals represented the same disciplines found on an FDC team: substance use disorder treatment and other service providers, child welfare, and the courts. As the next step, the Recommendations were presented and discussed with a broader group of stakeholders, including State drug court coordinators, and their input was incorporated.

To determine the relevancy of the Recommendations and to assure they are representative of the complex implementation and operational issues faced by FDCs, a qualitative review and quantitative analyses of 13 source documents and 32 individual FDC research articles and evaluation reports was conducted. Documents included numerous State FDC standards and guidelines; the adult drug court Ten Key Components;[8] the juvenile delinquency 13 Strategies in Practice;[9] the National Council of Juvenile and Family Court Judges' publications: Resource Guidelines[10] and Adoption and Permanency Guidelines;[11] and the National Center on Substance Abuse and Child Welfare 10 Element Framework.[12] These documents, selected for their applicability to FDCs and child welfare, were qualitatively reviewed for references to the topic areas included in the draft Recommendations. A quantitative analysis followed by determining the frequency that a topic related to a specific Recommendation was referenced.

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[a] The purpose of ICWA is "...to protect the best interest of Indian Children and to promote the stability and security of Indian tribes and families by the establishment of minimum Federal standards for the removal of Indian children and placement of such children in homes which will reflect the unique values of Indian culture... "(25 U.S. C. 1902). ICWA provides guidance and sets minimum standards to States regarding the handling of child abuse and neglect and adoption cases involving Indian children. ICWA Guidelines were published in 1979 to provide guidance to States and more recently, the Bureau of Indian Affairs is soliciting feedback on whether these Guidelines need to be revised. See "Guidelines for State Courts; Indian Child Custody Proceedings," Bureau of Indian Affairs (Nov. 1979), *available at* http://www.nicwa.org/policy/regulations/icwa/ICWA_guidelines.pdf.

[b] See "Tribal Ten Key Components," Bureau of Justice Assistance (Apr. 2003), *available at* https://www.ncjrs.gov/pdffiles1/bja/188154.pdf.

Evidence-Informed Practices

As States, courts and programs strive to use evidence-based or evidence-informed practices in their service delivery, determining which practices are the best match for their programs and unique population can be challenging. There are decades and volumes of research involving child welfare services and substance use disorder treatment outcomes, but the studies conducted on specific practices in the FDC setting are more recent and fewer. Significant research has been conducted on the drug court model, but much of what has been studied has been from adult criminal drug courts. So although there is growing evidence that FDCs improve outcomes, there is not a large research base on the exact practices that contribute to their success. As noted in the recent Research Update on Family Drug Treatment Courts publication, "evaluators are beginning to uncover the specific practices within Family Drug Treatment Courts that can optimize their outcomes and cost-benefits for taxpayers."[13]

This document provides a summary of the relevant research to assist jurisdictions in selecting and improving practices that affect children and families. FDC literature, adult drug court research, and research in the fields of child welfare and substance use disorders were scoured to find practices that improve outcomes for parents, children, and families. These identified practices have been synthesized and categorized into the ten Recommendations.

To assure that the research cited in this document is thorough, but cognizant of the inherent differences between family drug courts and adult drug courts, the adult drug court research findings have been examined for their relevancy and application. Specifically, this document makes the assumption that because there are similarities between adults with substance use disorders in criminal drug court and parents with substance use disorders in family drug court, some of the research findings and identified practices would apply to both Courts and could be expected to produce similar improved outcomes in both settings. Non-FDC research cited in this document has undergone a thorough review to verify its applicability in the FDC setting.

Conducting randomized, controlled trial studies is challenging in the court setting, and therefore there are few published evaluations using quasi-experimental or experimental design conducted with an FDC. The studies that do exist identify that a number of common practices in FDCs fall into the category of a promising practice or practice-based evidence. Additional research will be required to determine the effectiveness of these practices and their application among various population groups. However, if the practice was supported by the expert contributors to this document, it is included in the Effective Strategies section with each Recommendation.

Systems Impact

One of the intents of this document is to assist States and local communities to create systems change that will have a lasting impact on the FDC and on the policies of the court, child welfare and treatment service systems, and community-based organizations serving parents, children, and families. Children and Family Futures defines systems change as "a permanent shift in doing business that relies on relationships across systems and within the community to secure needed resources to achieve better results and outcomes for all children and families."

Therefore, a set of Recommendations that address both FDC scale and scope allows systems change to occur. In fact, no decision made by an FDC team is more important than the one to examine the scale and scope of its operations and its targeting. The term "scale" refers

to the extent to which an FDC can serve the eligible child welfare population affected by a substance use disorder. "Scope" is demonstrated by how completely an FDC can respond to the full range and multiple needs among the child welfare population: housing, mental illness, family violence, family income, employment issues, and children's needs such as developmental delays.

Family drug courts cannot function in isolation and must understand how they relate to the larger systems of which they are a part (e.g., the child welfare or substance use disorder treatment population in a given jurisdiction). An FDC may serve a very small or large percentage of the eligible child welfare population in their community, but decisions about what percentage they could and should serve must not be determined solely by the amount of outside funding that is available. Failing to address the number in need versus the percentage served as a foundational policy issue may result in an FDC becoming a "boutique court,"[c] unable to influence the rest of the dependency court's operations or the larger population in need of services.

Scope is equally as important as scale. FDCs must be sure that the needs of each family member are assessed and met through the development of comprehensive service plans and partnering with a wide range of service providers. It is through these relationships with service providers that systems change occurs. Developing and strengthening relationships with these and other stakeholders lead to the identification of the broad array of resources needed to meet the needs of families, thereby increasing the likelihood of long-term recovery and improving child welfare related outcomes.

COLLABORATION

Family drug courts are a collaborative effort of the court, child welfare, substance use disorder treatment systems, and community partners. No single system or set of workers has the authority, capacity, resources, or skills to respond to the array of challenges faced by families affected by substance use disorders, but collectively, multiple systems and agencies do have those capacities and skills. And regardless of the model—Integrated or Parallel[d]—FDCs can take the responsibility to assure that service needs for parents, children and families are met, whether through direct service provision by team member agencies or facilitated brokerage of services in the community. Working with partnering agencies and the operational team, FDC judges have a unique opportunity to lead this systems change.

Although collaboration among child welfare, substance use disorder treatment, and court systems is required for true systems change and is necessary if families are to succeed, effective collaboration at all levels of each system can be very hard to accomplish. For example, a caseworker assigned to the FDC team may be invested in the process of cross system collaboration, but without the support of the managing child welfare supervisor, the caseworker may not be allowed to spend sufficient time on those activities. The same can be true in the reverse whereby a child welfare director is supportive and invested in FDC but an assigned caseworker is not.

[c] "Boutique Court"- refers to an FDC or other specialty court that serves a very small percentage of the overall population.

[d] "Integrated" refers to a "one judge, one court" model where dependency hearings and drug court progress hearings are heard by the same judge; "Parallel" refers to the dependency and drug court progress hearings being heard by two different judges. Caution is offered that even in a Parallel Model FDC, it is imperative that information is integrated and the needs of the entire family are met.

While challenges are present at every level, a focus on collaborative strategies can allow systems change to be achieved. Specifically, as the State partners begin the process of changing systems, they can assess whether the Family Drug Court Model is embraced as an important initiative by all partners and at all levels. Where there is resistance, outreach and education efforts can be implemented. When new protocols are developed, a consideration to pilot them in one or two existing FDCs before implementing Statewide can help to identify ways of strengthening them. Ultimately, the team—whether State or local—should look to tie important decisions to specific principles of collaboration that are detailed in memoranda of understanding.

THE CHALLENGE

The barriers to building successful collaboration between the substance use disorder treatment and the child welfare systems are well known and have been described in several publications.[14,15,16,17,18] Adding the court system to the mix complicates the challenges. In the FDC setting, the expectation of a non-adversarial approach, particularly among the attorneys, can be a challenge when assuring that due process is given to all parties. However, there are numerous opportunities for all team members to share their differing opinions, and for the court to fully provide due process. FDC team staffing meetings, especially those occurring on a weekly or bi-weekly basis, are a place where specific details can be shared from each team member's perspective and often in greater detail than the dependency status/permanency hearings allow. This teaming allow staff to collaboratively focus more deeply on the parent's recovery efforts as well as the child's and family's needs. Many parents in FDC may also have legal matters being heard in the criminal court and may be on supervised probation. Their children may also be involved with the juvenile justice system. This requires an even greater level of collaboration within the court system and related agencies, but presents clear opportunities for judicial decision making to be family-focused.

Indeed, outcomes for children and families depend on informed decisions by teams of people who work in disparate systems that are driven by unique funding, philosophical, and legislative mandates. Structural and philosophical differences among the substance use disorder treatment, child welfare, and court systems exist that tend to highlight their differences, in reality however, staff from these systems can successfully collaborate in ways that show they hold several important core values in common.[19]

HOW TO USE THIS DOCUMENT

This is guidance for States to develop FDC guidelines or standards to monitor FDCs within their State as well as for local jurisdictions to implement the recommendations. It is intended to frame many of the important questions that must be addressed to plan, operate, and evaluate FDCs. It also identifies common challenges and the approaches that an FDC team can use to resolve them.

The term "guideline" is meant as a suggested course of action or policy based on research or practice-based evidence.

The term "recommendation" is used in this document to identify a set of specific practices based on research or practice-based evidence.

Finally, the term "standard" here means a requirement, often set forth by a State agency that outlines specific practice.

Each section of the document describes a specific recommendation, presents available research that supports the recommendation and identifies effective strategies for specific practice for States and local FDCs.

THE TEN RECOMMENDATIONS ARE:

1. Create Shared Mission and Vision
2. Develop Interagency Partnerships
3. Create Effective Communication Protocols for Sharing Information
4. Ensure Interdisciplinary Knowledge
5. Develop Protocols for Early Identification and Assessment
6. Address the Needs of Parents
7. Address the Needs of Children
8. Garner Community Support
9. Implement Funding and Sustainability Strategies
10. Evaluate for Shared Outcomes and Accountability

The strategies are statements of how some FDCs have taken action to implement these recommendations. The task for State policymakers as well as for local jurisdictions is to determine which of these strategies in each category of recommendations best fit with their community and to develop action plans to implement those prioritized strategies.

There are five appendices at the conclusion of the document. The *Guide to Compliance with the Indian Child Welfare Act* is found in Appendix A. Appendix B provides the specific steps needed to generate the collaborative structures for developing State guidelines or standards. The "Facilitator's Guide" in Appendix C provides exercises and tools to assist States and communities in creating their set of guidelines and/or standards. It proposes that administrators create a Steering Committee or similar governing body to direct the initiative and describes the specific functions of the Steering Committee. Appendix D provides a checklist for States and local jurisdictions to focus on specific evidence-informed practices. The complete list of the research articles and evaluations can be found in Appendix E.

Although this document presents ten separate recommendations, a careful reading will reveal that the recommendations are closely intertwined. Discussions of mission and vision are linked to the team's decisions about shared outcomes, which must be based on good information systems and strong evaluations. Those evaluations support sustainability planning and provide the evidence that other agencies need to become genuine partners of the FDC. Effective screening and assessment tools and client engagement and retention practices can also provide evidence that clients who enter the program have a good chance of completing it which has been demonstrated to reduce recurrence of maltreatment and return to foster care.[20]

The 10 recommendations are interconnected, however, it does not mean an FDC can or should devote equal attention to all ten immediately. Rather, a phasing of strategic priorities needs to be implemented. An FDC's decisions about which recommendations need priority emphasis will be some of the most important choices made by the governing body. Further, the State or local FDC may choose to use the recommendations exactly as provided in this document or they may select to modify them to accomplish their goals and meet their own unique needs. Identifying priorities and the State crafting FDC guidelines should be in the context of its own standards if they exist, other pertinent State or Federal legislation, resources and the strengths and abilities of the providers in the State.

It is expected that implementing all of the recommendations will be an ongoing effort of quality assurance. FDCs should strive for improvement, noting that each community has its own strengths, challenges, and unique needs. FDC teams should keep in mind that an important part of the process is to determine how to meet the Recommendations by implementing the effective strategies as fully as possible.

States should determine how the guidelines or standards they create will affect their existing FDCs. Based on these determinations, each State should work with existing programs to generate creative solutions that provide the best process for adopting the new guidelines or standards. The existing FDCs can provide the context and a range of strategies for effective implementation, and identify particular challenges such as gaps in services in rural jurisdictions or limited employment options. These strategies can then be documented in future publications that strengthen the lessons learned from the field.

RECOMMENDATION 1: CREATE SHARED MISSION AND VISION

FDC partners must have a shared mission and vision that defines how they work together. The discussion of values and agreement on common principles is an essential foundation for FDC collaborative relationships.

DESCRIPTION:

A shared mission and vision are important for the long-term success of an FDC. Mission and vision statements articulate why and for whom the FDC exists. The process of developing a collaborative mission and vision statement is equal in importance to the sentences that will eventually be contained in that statement. The discussions required to agree upon a system-wide mission tend to reveal shared and discrepant goals across systems. Recognition of common goals and resolution of discrepancies results in a shared mission and vision that will act as the foundation of the collaborative effort and can be revisited in times of disagreement.

Each partner enters the FDC collaboration with its own perspective, assumptions, and values about the mission and mandates of the FDC and other partners. Unless these differences are identified and addressed, the FDC will find it difficult to reduce the adversarial nature of the court process and reach agreement when practice or systems issues arise. Acknowledging that addiction is a brain disease that affects the entire family and that recovery and well-being occurs in the context of families may be new concepts to some team members. Although the newly formed FDC team may certainly agree that trauma and substance use disorders affect a family dynamic and that treating only parents or only children is not sufficient, it is often the values and definitional issues (such as who is viewed as the primary client) that affect the ways in which staff can work within the boundaries of multiple professional ethics, mandates and responsibilities. While no team member is expected to relinquish his individual values, a shared set of values that demonstrates common ground and incorporates the views of the entire team is necessary to work together effectively. In fact, the first two issues that a newly formed team must address is whether an Integrated or Parallel model will be put into place and to clearly identify a target population. Some team members may have very strong opinions about the benefits of one model over the other, while other team members may not understand the differences. Although this decision may ultimately be made by the court, involving all team members in this discussion may reveal valuable individual vision and values. These differences of opinion may also come to light during the discussion of what population to serve. Beyond constructive discussion, however, the FDC's critical task is to develop its mission based on goals and principles held in common so the agencies and staff can work together to best ensure safety, permanency, and well-being of children and parents in recovery.

While no team member is expected to relinquish his individual values, a shared set of values that demonstrates common ground and incorporates the views of the entire team is necessary to work together effectively.

Once FDC partners have defined a shared mission and vision, they must establish a governance structure including an Oversight Committee, Steering Committee, and a core operational team. The Oversight Committee includes the most senior officials from each system. These officials are willing, whenever appropriate, to change their own agencies' policies when those policies impede the ability to serve families. A multi-disciplinary Steering Committee will direct the initiative and focus on the FDC program policies, protocols, monitoring, and evaluation. The operational team will oversee day-to-day functions of the FDC and will provide and receive feedback on current program policies and protocols.

RESEARCH FINDINGS:

Despite structural and philosophical differences among the substance use disorder treatment, child welfare, and court systems, in reality, staffs from these systems hold several important core values in common such as the primacy of child safety. Effective practices across child welfare, substance use disorder treatment and the court systems include communicating clearly and frequently with parents, and in collaboration across the three systems. When these areas of effective practice are in place, parents are perceived to be better able to make timely progress toward recovery and completion of their child welfare case plan.[21]

The importance of a mutually agreed upon program structure and consistency in practice has been examined closely in adult drug courts. Carey and colleagues found that teams with a shared vision generate better outcomes generally when they develop an agreed upon set of practices. These practices can include written guidelines for responses to participant behavior (incentives and sanctions), the importance of receiving drug test results within forty-eight hours and drug testing at least twice per week, the need for status reviews every other week, and the use of immediate sanctions. These factors ensure that participants are learning about structure, accountability, safety, and dependability.[22]

EFFECTIVE STRATEGIES FOR CREATING SHARED MISSION AND VISION:

The list of effective strategies is provided in a self-assessment format to allow readers to determine the degree to which their FDC has implemented the strategies. For each strategy, indicate the number that most closely corresponds to the description of the FDC's status.

1= Not Yet Considered; 2= Exploration; 3= Installation; 4= Initial Implementation; 5= Full Implementation; 6= Sustained Practice

- ☐ Judicial leadership ensures planning, implementation and operations of the FDC.
- ☐ Judicial leadership helps to promote teamwork and to facilitate better working relationships among agencies.
- ☐ The FDC has included the judicial officers, attorneys, child welfare, substance use disorder treatment providers, as well as other service providers as partners in understanding core values and the development of the shared mission and vision.
- ☐ The FDC has used a formal values assessment process such as the Collaborative Values Inventory[e] or the Partnership Self-Assessment Tool[f] to determine how much consensus or disagreement exists about issues related to substance use disorders, parenting, and child safety.
- ☐ The FDC revisits mission, vision and values, as well as policies and procedures, on an annual basis and has established meaningful orientation and assimilation of new team members.
- ☐ The FDC has negotiated shared principles or goal statements that reflect a consensus on issues (e.g. target population, eligibility criteria, parallel or integrated FDC model) related to families affected by substance use disorders in child welfare and the dependency court.
- ☐ The FDC has negotiated priority access to substance use disorder treatment for child welfare clients.
- ☐ Other problem solving courts (e.g. criminal, delinquency, veterans, and mental health) have been included in the planning process to address potential overlap of participants and to assure consistency where appropriate across case types.

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[e] Collaborative Values Inventory was developed by Children and Family Futures. The Collaborative Values Inventory (CVI), a self-administered questionnaire that provides jurisdictions with an anonymous way of assessing the extent to which group members share ideas about the values that underlie their collaborative efforts. The CVI is simple and short, but it identifies areas of commonality and difference that are easily overlooked either because people feel uncomfortable discussing values or because they move directly to program and operational issues. Retrieved from http://www.cffutures.org/files/cvi.pdf.

[f] The Partnership Self-Assessment Tool measures a key indicator of a successful collaborative process - the partnership's level of synergy. The Tool also provides information that helps partnerships take action to improve the collaborative process. Retrieved from http://partnershiptool.net/.

- ☐ The FDC has discussed and developed responses to the conflicting time frames associated with child welfare/Adoption and Safe Families Act (ASFA), Temporary Assistance to Needy Families (TANF), substance use disorder treatment and child development. The entire FDC team understands the mandates and demands placed on child welfare to close the dependency case and balances this with the parent's recovery needs. The team understands the relationship between the FDC and the underlying legal dependency case and has agreed upon policies and procedures that protect due process and accounts for the ethical obligations of team members.

- ☐ The FDC has selected a model—either parallel or integrated—after considering the benefits and challenges of each. Regardless of the model selected, the FDC demonstrates an understanding that both models underscore the importance of integrated information sharing.

- ☐ The FDC team has developed detailed policies and procedures, agreed upon by all, covering operations and policy issues such as clients' voluntary or involuntary participation in the program. These policies and procedures are reflective of the team members' values and shared mission and vision.

- ☐ The FDC has decided whether or not jail will be used as a sanction and through discussion, all team members understand the effect of and the rationale behind the decision. If jail is an available sanction, the FDC has agreed upon protocols with respect to due process and the impact of this and other sanctions on children. FDC team members understand that the ultimate determination to use jail as a sanction rests solely with the judicial officer.

RECOMMENDATION 2: DEVELOP INTERAGENCY PARTNERSHIPS

Family drug courts are structured within the legal framework of the court and child welfare systems and the restorative nature of treatment services. However, they require partnerships with additional agencies to provide a range of services and support for family stability, parents' recovery, and the permanency, safety and well-being of children and their families. To fully provide these services and supports, FDCs must form relationships with mental health, domestic violence, primary health, child development, and other agencies that result in collaborative practice.

DESCRIPTION:

Many parents in FDC require services in addition to treatment and child welfare to address the complex issues impeding the healthy functioning of their families. Among others, these services include mental health, domestic violence, Court Appointed Special Advocates (CASA) for children, primary and oral health, child care, housing, transportation, and employment-related services. The FDC team and service providers engage in coordinated case planning, along with the parent, to prioritize and sequence services so the demands on the parent are manageable and clinically appropriate. It is important to remember in developing case plans and requirements of the court that as these individuals attempt to navigate these systems, they are dealing with the effects of substance use on their brain chemistry. A parent who is still using substances or has attained only a minimal period of abstinence is not likely able to comprehend or act on the multiple, simultaneous tasks characteristic of child welfare case plans and substance use disorder treatment plans. The core operational team must include the court/judge, agency attorney, parent's attorney, child's attorney, child welfare worker, and substance use disorder treatment provider. However, to fully meet the needs of families, the FDC team must also include representatives from a wide range of agencies that can provide essential services. Partnerships can also enhance the capacity of the FDC to sustain their program after grant or time-limited funding ends. In the first round of Children's Bureau's Regional Partnership Grant Program, which consisted of 53 projects, grantees achieving higher levels of collaboration among their partners had higher rates of sustaining various aspects of their program model than did those grantees with lower levels of collaboration.[23]

RESEARCH FINDINGS:

Research results suggest a need to consider family system approaches when working with FDC participants.[24] In one study of 1,940 families in 11 family drug courts, researchers found that comprehensively addressing families' needs is associated with better outcomes than those in a contextual group.[g,25] Child safety and permanency, parental recovery, and family well-being improve when

Research results suggest a need for consideration of family system approaches when working with FDC participants.

Cannavo & Nochajski, 2011

[g] Contextual Group: contextual information is included for indicators where state or county-level measures are similar in definition and publicly available.

agencies work together to address the complex needs of families at the intersection of substance use disorder treatment and child welfare.[26] In one FDC study, children in the treatment group had longer stays in child welfare custody but were substantially less likely to experience future incidents of maltreatment than those in families with parental substance use disorders without FDC services.[27] Better outcomes for women have resulted when substance use disorder and child welfare services are integrated. When services are coordinated and integrated, women remain in treatment longer and are more likely to reduce substance use and be reunified with their children.[28] Progress in resolving co-occurring issues such as domestic violence, housing and mental health increases the likelihood of achieving family reunification.[29] In another study, collaborative strategies for addressing issues of child safety, substance use, and family stability were implemented with families affected by substance use disorders, and these strategies were found to have a positive effect on parents' and children's sense of hope. This change in hope correlated positively with changes over the same time period in problem severity, general functioning, and mental health symptomology.[30]

One of the cornerstones of drug court is the coordinated efforts of the multi-disciplinary team working with other services providers and professionals to meet the varied needs of families. When these partners work together, outcomes are improved. In one study, FDC graduates demonstrated significant decreases in domestic violence and overall case risk ratings.[31] In two additional studies, results showed that FDC participants are more likely to initially enter treatment, enter treatment faster and were also more likely to complete treatment than their non-FDC counterparts.[32,33] In a recent study of families referred by child protective services to a specialized outpatient treatment program, clients assigned a peer recovery coach were assessed and initiated services in less time than participants without a peer recovery coach. Parents assigned a recovery coach also stayed in treatment significantly longer than their counterparts without a recovery coach.[34] A coordinated team approach is key. Research from adult drug courts suggests continuous input from several professional disciplines may be necessary to even minimally intervene effectively with high-risk,[h] drug-involved offenders.[35] Programs utilizing a single case coordinator who actively collaborated with multiple service providers have been found to be particularly effective with court-referred clients and their families to increase family functioning and child well-being and decrease family danger and conflict.[i,36]

A study of a residential treatment program serving women with co-occurring disorders and their children revealed that significant improvements in recovery, including reduced mental health symptoms, reduction in risk behaviors, and longer program retention occurred when certain interventions were in place. These interventions included Celebrating Families! and an improved integrated case management system that focused on five protective factors: (1) concrete support in time of need; (2) knowledge of parenting and child development; (3) social and emotional competence of children; (4) parental resilience; and, (5) social connections.[37]

[h] The term "high risk" is used here by the author to denote likelihood of behavior change with standard interventions, high risk of failing without more intensive services.

[i] The Intimacy, Conflict, and Parenting— Family Functioning Scale was used to measure these items before and after the intervention. Noller, P. ICPS Family Functioning Scales (ICPS-FFS) in Handbook of Family Interventions (2001) Vol. 2.

Nationally, 85 percent of children in the child welfare system stay home or return home,[38] so FDC teams must consider services and supports for parents *and* children to address trauma exposure and other needs. Those who are exposed to trauma have a greater risk for substance use disorders.[39] As demonstrated in one FDC study, the best prevention for children is effective treatment for their parents and recognizing that family stress and trauma can contribute to relapse.[40]

Adult programs with wraparound services, including efforts to secure safe and stable housing, avert re-arrests and save taxpayer money in the long run. These benefits occur when programs engage a wide range of partners to specifically address participant needs such as relapse prevention, gender-specific services, mental health treatment, parenting classes, family counseling, programs designed to address the perpetration of domestic violence, health and dental services, and residential care.[41] Another example of this type of partnership resulting in improved outcomes is a study in which women who received gender responsive programming were found to have better in-treatment performance and trends indicating reductions in post-traumatic stress disorder symptomology.[42] It is reasonable to extrapolate these findings as applicable to parents in the FDC setting.

Effective Strategies for Developing Interagency Partnerships:

The list of effective strategies is provided in a self-assessment format to allow readers to determine the degree to which their FDC has implemented the strategies. For each strategy, indicate the number that most closely corresponds to the description of the FDC's status.

1= Not Yet Considered; 2= Exploration; 3= Installation; 4= Initial Implementation; 5= Full Implementation; 6= Sustained Practice

- ☐ The FDC has established a collaborative structure composed of stakeholders diverse in responsibilities including an Oversight Committee, Steering Committee, and a core operational team.
- ☐ Clinical services to address mental health and trauma issues for drug court participants and their children are coordinated. These services are also included in comprehensive assessments and case plans for all families participating in the FDC.
- ☐ Domestic violence prevention and intervention services are included in comprehensive assessment and case plans for all families participating in the FDC. When possible, the team includes a representative from a domestic violence service agency.

> ***In Chatham County, Georgia, a domestic violence services advocate is part of the operational team, attending every staffing and court session.***

- ☐ The FDC ensures that primary healthcare, dental care, child care, and transportation are available for families participating in the FDC.
- ☐ Specialized health services for parents with a substance use disorder regarding HIV/AIDS, Hepatitis C and other diseases frequently transmitted among intravenous drug users are accessible for all families participating in the FDC.

- ☐ The FDC uses a family system approach and a multidisciplinary team monitors the number of referrals made to other programs and services and tracks the number of participants who initiate and complete clinical and supportive services needed by families. The FDC also monitors barriers that prevent access to these services. The process includes a "warm handoff," which is an in-person connection made between the person making the referral and the service provider.

- ☐ The FDC has substance use disorder support/recovery groups that include a special focus on child welfare and child safety issues.

- ☐ The FDC has a process for developing and maintaining interagency partnerships, including linkage agreements or memoranda of understanding, and includes these agencies in an advisory group.

- ☐ The FDC has established a communication protocol to share clinical and case information (e.g. treatment success or relapse) among collaborative partners. The protocol addresses confidentiality issues.

- ☐ The FDC has coordination agreements and information sharing policies with the child welfare system, criminal and juvenile justice systems, law enforcement, and community supervision professionals to meet the needs of participants and their children who are in the criminal or juvenile justice system (e.g., visitation for children with incarcerated parents, treatment while parents are incarcerated).

RECOMMENDATION 3: CREATE EFFECTIVE COMMUNICATION PROTOCOLS FOR SHARING INFORMATION

Effective, timely, and efficient communication, and information sharing dramatically improves individual case monitoring and provides the guideposts that gauge the effectiveness of the FDC. Shared information is the prerequisite to joint accountability that promotes child safety, parent engagement, and retention in treatment and recovery.

DESCRIPTION:

Efficient communication is critical to ensuring child safety and FDCs' role in engaging and retaining parents in treatment and promoting recovery. This communication occurs at the case level and at the systems level. At the case level, an information sharing protocol is required that conforms to confidentiality laws and regulations and meets the information needs of the FDC team members so they can serve parents and families appropriately and effectively. Protocols should limit the sharing to information that is critical for informed decision-making and treatment planning, while protecting the privacy and due process rights of the parents. Without efficient communication protocols, the staff may duplicate efforts, or expend scarce resources to obtain information. Information sharing at the systems level is of equal importance. Shared information at the systems level is the foundation of mutual accountability in the pursuit of cross-agency goals. Efficient data management, the use of existing databases and coordination across databases are needed for reliable program monitoring.

RESEARCH FINDINGS:

Research has shown that increased information sharing between treatment, child welfare, the courts, and the regular contact between judges and participants is important to FDC's success, specifically in improving the quality of case monitoring, relapse support and team members' ability to provide resources to parents.[43] Research also suggests that promising collaborative models between the child welfare system and the substance use disorder treatment system typically include using protocols for sharing confidential information.[44] Areas of effective practice that were found to be consistent across court, treatment and child welfare systems were: communicating clearly and frequently with parents; collaboration across the three systems; and, knowledge and experience with substance use disorder issues and with ASFA.[45] One study conducted in the juvenile court setting found that the vocabulary used by judges and others in the courtroom was typically at a reading level above both the youth and many adults (parents) coming before the court, underscoring the importance of clear and appropriate communication in such settings.[46]

Research has shown that increased information sharing between treatment, child welfare, the courts, and the regular contact between judges and participants is important to an FDC's success.

Green, et al. 2007

Collaboration, while not synonymous with communication is necessary for effective information sharing and has been shown to improve functions across child welfare, substance use disorder treatment, and court professionals to the benefit of involved families.[47] As noted in the *Adult Drug Court Best Practices Standards Volume II,* "studies have identified effective communication strategies that can enhance team decision making in Drug Courts. For example, researchers have improved team decision-making skills in several Drug Courts using the NIATx (Network for the Improvement of Addiction Treatment) Organizational Improvement Model (Melnick et al., 2014a, 2014b; Wexler et al., 2012). The NIATx model seeks to create a climate of psychological safety by teaching team members to articulate divergent views in a manner that is likely to be heeded by fellow team members."[48] One study found that adult drug courts that use email to communicate had improved cost savings.[49] A multi-disciplinary team is critical to the success of drug courts. The team, including but not limited to a judge or judicial officer, program coordinator, prosecutor, defense counsel representative, treatment representative, community supervision officer, and law enforcement officer that participates in pre-court staffing to review participant progress has been shown to reduce criminal recidivism in adult drug courts.[50] Also in the adult drug court setting, significantly better criminal justice outcomes resulted when judges attended pre-court staffing regularly.[51,52] As might be expected, when judges do not attend pre-court staff meetings, research shows they are often not adequately prepared for the court hearing.[53]

Effective Strategies for Creating Communication Protocols for Sharing Information:

The list of effective strategies is provided in a self-assessment format to allow readers to determine the degree to which their FDC has implemented the strategies. For each strategy, indicate the number that most closely corresponds to the description of the FDC's status.

1= Not Yet Considered; 2= Exploration; 3= Installation; 4= Initial Implementation; 5= Full Implementation; 6= Sustained Practice

☐ Protocols for Sharing Information

- The FDC has identified the confidentiality provisions that affect child welfare, substance use disorder treatment, and the dependency court and has devised the means of sharing information about parents, children, and families in treatment with the FDC team, while observing these provisions.
- The partners in the FDC have agreed on the level of information about participants' progress in treatment that will be communicated from treatment agencies to the FDC, understanding applicable ethical and legal restrictions. FDC shares data on individual participants in a timely manner to assure effective monitoring of progress and behavior.
- Information provided to the judge and other partners includes positive performance by the parent as well as areas warranting attention.
- Substance use treatment providers routinely ask about the status of children in the families they serve and coordinate their treatment plan with the child welfare case plan.
- Information sharing issues and judicial impartiality have been resolved.

- The FDC has developed formal working agreements/memoranda of understanding that include how child welfare and treatment agencies will share information about clients in treatment with the FDC team and the dependency/juvenile court.
- Information is shared with the parent as part of the case planning process. All FDC team members and the parent are aware of what information will be shared and with whom.[54]
- The FDC has an established practice of staffing cases prior to court for an up-to-date exchange and discussion of information. Participants in the staffing regularly include the judge, coordinator, case manager, parent's counsel, Guardian Ad Litem or children's counsel, prosecuting attorney, treatment staff, child welfare case worker, and other representatives with information critical to the family's overall well-being.
- FDCs use email as a form of communication for exchanging information between scheduled staffing meetings.
- The FDC's intake process identifies prior substance use disorder treatment episodes and prior reports of child abuse/neglect.

☐ Data Management

- The FDC implemented a plan to track, monitor, and use parent/child/family-level information, as well as system-level data.
- The FDC has assessed its data systems to identify gaps in monitoring both child welfare and substance use disorder treatment systems and uses the results of that assessment to make changes.
- The FDC compares project data regularly with system-wide data on outcomes in both systems.
- The FDC has automated data detailing the characteristics and service outcomes of participants and compares outcomes to those achieved in the larger child welfare and substance use disorder treatment systems. The FDC uses the information to make program changes as needed.
- The FDC's child welfare agencies have accurate baseline measures on the percentage of cases in which parental substance use is an identified problem.
- The FDC's substance use disorder treatment agencies have reliable baseline data on the percentage of families involved in child welfare and use the information for program design and service development.

RECOMMENDATION 4: ENSURE INTERDISCIPLINARY KNOWLEDGE

Ongoing cross-training of FDC team members and stakeholders at all levels is essential to ensuring collaboration and consistent, effective practice.

DESCRIPTION:

Many FDCs schedule monthly brown bag sessions where operational team members take turns teaching the fundamentals of their field. These meetings often include an overview of common acronyms and definition of terms as well as ethical and legal mandates.

Cross-training efforts at all levels—among policy makers, program management and line-level clinical staff, as well as administrative support staff and court officers (bailiffs)—are needed to bridge divisions between the systems. Cross-training ensures that all partners have a fundamental understanding of the effects of alcohol and other drug use on child abuse and neglect; the most up-to-date research and science on the relevant topics affecting the systems; the legal requirements of each system; and the goals, objectives, and operational components of the FDC. Training and staff development are critical to acquiring the skills for effective collaboration and to the delivery of a consistent, supportive and non-adversarial message to the parent and family in recovery. This type of cross-system training and shared learning experience results in mutual respect for team members' roles and responsibilities and provides the opportunity to avoid the continuation of conventional practice that often reinforces barriers.

RESEARCH FINDINGS:

Research suggests that promising collaborative models between the child welfare system and the substance use disorder treatment system typically include cross-training.[55] Two studies on documenting parents' substance use disorders suggest the need for cross-training and skills in interdisciplinary work between child welfare and the substance use disorder treatment fields.[56] An area of effective practice that was found to be remarkably consistent across court, treatment, and child welfare systems was knowledge and experience with substance use disorder issues and with the Adoption Safe Families Act (ASFA).[57] Adult drug court research found that drug courts that attend pre-implementation training are more than two and a half times more cost effective and 50 percent more effective at reducing criminal recidivism.[58] Adult drug court programs that "seek out training, acquire the support and insights of experts (including evaluators)…see improvements in outcomes." That same research found that adult drug court teams produced improved outcomes if they had strong working relationships; included a small enough number of treatment providers to promote more individual relationships and communication; and were responsible for a manageable number of program participants that allowed the judge and the team to know each other.[59] Further, better criminal justice outcomes occur when the drug court judge attends annual training conferences on evidence-based practices in substance use disorder and mental health treatment.[60]

Going beyond cultural sensitivity training is a critical practice in addressing service disparities for historically disadvantaged groups. Training on research-based, performance-monitoring procedures can assist in the development of concrete strategies to identify and address service disparities.[61]

EFFECTIVE STRATEGIES FOR ENSURING INTERDISCIPLINARY KNOWLEDGE:

The list of effective strategies is provided in a self-assessment format to allow readers to determine the degree to which their FDC has implemented the strategies. For each strategy indicate the number that most closely corresponds to the description of the FDC's status.

1= Not Yet Considered; 2= Exploration; 3= Installation; 4= Initial Implementation; 5= Full Implementation; 6= Sustained Practice

☐ All FDC team members receive training and education about:

- working with families in the child welfare system that are affected by substance use disorders, including gender-specific and trauma-informed training; the dynamics of addiction and recovery; and evidence-based treatment approaches, including medication assisted treatment
- the effects of pre- and post-natal substance exposure on children and meeting children's needs across the developmental stages
- the responsibilities and mandates of child welfare workers, including ASFA timelines
- the rules pertaining to the Indian Child Welfare Act (ICWA)[j] and on historical trauma
- the responsibilities and mandates of the judge and attorneys, as well as criminal and juvenile justice system practices
- the use of engagement strategies for parents with substance use disorders
- cultural issues to improve the team's cultural competency in working with diverse substance use disorder treatment and child welfare client groups
- the effect of substance use disorders on family relationships

☐ The FDC has developed ongoing, joint-training programs for substance use disorder treatment, child welfare, court staff, and other service providers to learn about each other's mandates, constraints, and goals.

☐ The FDC had developed effective methods of working together among the FDC team and within the larger systems.

☐ The judge pursues training opportunities on evidence-based practices in substance use disorder and mental health treatment.

[j] For example, *see* "A Practical Guide to the Indian Child Welfare Act," Native American Rights Fund (Sep. 2011), *available at* www.narf.org/nill/documents/icwa/.

- ☐ The FDC has a staff development plan that includes periodic updates to the cross-training and orientation received by all the staff.
- ☐ FDC team members receive joint training in methods of increasing participant motivation, such as Stages of Change and Motivational Interviewing.
- ☐ FDC team members receive joint training on therapeutic relationships and understand the effects of one's own response to participants on enabling addictive behavior and supporting recovery.
- ☐ FDC team members receive joint training on self-care and avoiding burnout.

RECOMMENDATION 5: DEVELOP A PROCESS FOR EARLY IDENTIFICATION AND ASSESSMENT

FDCs identify participants early in the child welfare case. FDCs use screening and assessment to determine the needs and strengths of the parent, the child, and the family, and to determine the most appropriate treatment and services.

DESCRIPTION:

Timeliness, accuracy, and ongoing review of the family's progress are three key variables for the successful implementation of the FDC. ASFA timelines mean that prompt screening and assessment is needed. Before or immediately upon the filing of a dependency case in the family court, parents must be screened to identify if a substance use disorder is a factor in the alleged child maltreatment and if the parent meets the legal and clinical eligibility criteria for FDC. Parents who are identified as potential participants in FDC need prompt access to further assessment to determine the nature and extent of the substance use disorder, including screening and assessment for mental health issues, recognizing that co-occurring disorders can be expected. In addition, it is critical to determine the degree of treatment intensity and what modality is clinically appropriate. Screening and assessment for safety risks to the children will have been accomplished by child welfare pre-filing.[k] Once child welfare has filed an abuse and neglect petition with dependency court and after a court hearing, the court will enter orders as necessary to protect the children. Child safety assessments continue throughout the case as will ongoing assessment from the alcohol and drug abuse counselor to promote recovery.

RESEARCH FINDINGS:

In the *Research Update on Family Drug Courts* by Marlowe and Carey, the authors suggest that "FDC is among the most effective programs for improving substance abuse treatment initiation and completion in child welfare populations."[62] Treatment initiation and completion rely on timely screening and assessment. Two studies relevant to early identification and assessment point to the importance of cross-training between child welfare and the substance use disorder treatment professionals. The authors state that child welfare workers need to be familiar with substance use disorder treatment screening, identification, and assessment and substance use disorder treatment workers must be sensitive to the multiple problems and needs experienced by their child welfare clients.[63]

Research has demonstrated that an FDC is effective in improving substance use disorder treatment initiation and completion for parents in child welfare cases.

Marlowe & Carey, 2012

[k] The term "pre-filing" refers to the time period prior to the filing of an abuse and neglect petition with the dependency court.

Another study of families involved in the child welfare system explored factors related to successful treatment completion. The findings suggest that when adequate screening and treatment is available through a streamlined process, many of the ethnic and gender disparities present among other populations of individuals seeking treatment are minimized.[64]

Research conducted among pregnant women indicated that costs to society are reduced and mothers and children are likely to benefit economically from a universal substance use disorder screening. This same study found that similar benefits occur when an intervention policy is implemented during prenatal care and when appropriate and timely child welfare responses are in place.[65] When early identification and assessment lead to appropriate treatment placement, mothers who participate in treatment programs with a "high" level of family/children's services and employment/educational services have been found to be twice as likely to reunify with their children than those with "low" level of these services.[l,66] In the criminal justice setting, outcomes are improved when case managers administer "reliable and valid needs assessment instruments."[67]

Early identification refers to the earliest possible point following contact with the child welfare system. Early access to assessment allows referral and linkage to occur for parents in the timeliest manner.

Parents in FDC were found to enter treatment faster, remain in treatment longer and were more likely to successfully complete treatment than their counterparts in a comparison group. Additionally, their children spent less time out-of-home and had a greater likelihood of being reunified.[68] The impact of the court in the identification and entry process is notable as well: parents who were court-ordered to services were more likely to have been in treatment in the three months prior to and following their FDC start date.[69]

Effective Strategies for Developing a Process for Early Identification and Assessment:

The list of effective strategies is provided in a self-assessment format to allow readers to determine the degree to which their FDC has implemented the strategies. For each strategy, indicate the number that most closely corresponds to the description of the FDC's status.

1= Not Yet Considered; 2= Exploration; 3= Installation; 4= Initial Implementation; 5= Full Implementation; 6= Sustained Practice

- ☐ The FDC has developed a joint policy between substance use disorder treatment, child welfare and the dependency court on its approach to timely, standardized screening and assessment of substance use disorders among families in child welfare.
- ☐ The FDC has developed a formal process in which petitions are reviewed for substance use as a factor and the appropriate treatment engagement specialists are notified.

[l] The authors created three variables ("low=0-3," "medium=4," "high=5-7") based on the number of services such as individual, group, or family counseling regarding family issues; education/training regarding family issues; child care; child development services available.

- ☐ Substance use disorder treatment providers work in tandem with child welfare workers or are out-stationed at child welfare offices and/or the dependency court to facilitate early screening and assessment of FDC participants.
- ☐ The FDC uses assessment results to create coordinated substance use disorder treatment and child welfare case plans that are reinforced through court order.
- ☐ The FDC supplements child abuse/neglect risk assessment with an in-depth assessment of substance use disorder issues and their effect on each of the family members, including the children.
- ☐ A strong strengths and needs assessment tool is used to help identify the substance abuse, mental health and other needs the family must address to provide for the safety and well-being of the children.
- ☐ The FDC's substance use disorder treatment providers have sufficient information about the child welfare case to conduct quality assessments of families referred by child welfare to treatment.
- ☐ The FDC's substance use disorder treatment providers routinely ask questions about children in the family, their living arrangements, and child safety issues and have standard protocols on responding to child safety risks.
- ☐ The FDC team uses screening and assessment information to ensure parents have timely access to appropriate treatment and other services.
- ☐ Legal and clinical eligibility criteria have been developed by the entire team and are implemented in a standardized fashion. Criteria are re-examined annually to assure some groups of families are not being screened out.
- ☐ The FDC routinely monitors the timeliness of its implementation and the quality of its identification, screening, and assessment protocols to ensure they continue to address relevant issues including trends in substances, shifts in demographics and cultural practices.
- ☐ The FDC recognizes the incidence of co-occurring disorders and assesses for trauma, mental health issues, and family history of substance use disorders and mental health, including alcohol/drug use history of parents, siblings, and grandparents.

RECOMMENDATION 6: ADDRESS THE NEEDS OF PARENTS

FDC partner agencies encourage parents in the recovery process and assist them in meeting treatment goals and requirements of child welfare and the court. Judges respond in a way that supports continued engagement in recovery. Working toward permanency and using active client engagement, accountability and behavior change strategies, the entire team makes sure the parent has access to a broad scope of services.

DESCRIPTION:

FDCs are designed to quickly engage and retain parents in treatment within the time frames required by ASFA and the developmental needs of their children. The FDC team understands substance use disorders as chronic diseases, as well as the neurological effects of long-term substance use. FDCs should use specific strategies, including written phase benchmarks and a flexible set of responses to defined and targeted behaviors. Particularly in early recovery, it is critical to provide specific engagement and retention strategies to ensure parents enter and remain in treatment for a sufficient period of time to keep them on track to meet their recovery goals and to learn new coping skills. Each collaborative partner and its staff members need to participate in these behavior change strategies to encourage parents to enter and engage in treatment and other needed services. Child welfare case plans and treatment plans should be coordinated and FDCs should develop partnerships to ensure parents have access to a broad array of culturally relevant, trauma informed services. These services should be tailored to fit individual needs with a continuum of substance use disorder treatment options that include residential placements where children can live with their parent whenever appropriate. Treatment and services should be evidence informed and clinical caseloads should follow best practices. Recovery support is provided and includes culturally and linguistically appropriate services that assist parents working toward recovery. Medication assisted treatment, in combination with counseling and behavioral therapies, should be used when indicated. Additional core services include peer-run support groups, trauma services, mental health services and supportive services such as child care, transportation, housing and employment services.

RESEARCH FINDINGS:

Treatment

Serving the parent begins during the eligibility screening process. Once in the program, it is essential that parents have access to an effective array of services, including treatment options that emphasize a family-centered approach. In a cross-site evaluation of residential treatment programs for pregnant and parenting women, it was found that postpartum women who had their infants living with them in treatment had the highest treatment completion rates and overall longer stays in treatment, when compared with women whose children did not live with them.[70] When a range of services is available, in addition to substance use disorder treatment, research has shown that there is an increase in both the number of months clients are in treatment and the number of counseling sessions clients receive.[71]

These services should include the appropriate use of motivational strategies, including drug testing to monitor and support the parent. Substance use disorder treatment clinicians should carry caseloads of 50:1 if providing clinical case management, 40:1 if providing individual therapy or counseling, and 30:1 if providing both services.[72] Programs should also consider how motivational elements may be addressed during the intake assessment to promote decreasing refusal rates.[73] Significantly better criminal justice outcomes occur in programs when there is some flexibility in responding to participant behavior based on the facts presented in each case,[74] demonstrating the need to avoid a prescribed and strict matrix of consequences.

Programs should consider how motivational elements may be addressed during the intake assessment to aid in decreasing refusal rates.

Cannavo and Nochajski, 2011

The use of addiction medications with counseling services should be considered and supported as a viable treatment strategy for individuals with substance use disorders. Medicines such as methadone, buprenorphine, and extended-release naltrexone have been shown to reduce heroin use and should be made available to parents who could benefit from them.[75]

Individually Tailored Services, Parenting and Recovery Supports

Culturally sensitive attitudes and respect for clients' cultural backgrounds as part of treatment is described as "one of the most significant predictors of positive outcomes for racial and ethnic minority participants in substance abuse treatment" and significantly increases retention.[76] In one article, authors maintain that the conditions and history of genocidal policies aimed at destroying Native family ties as well as experiences of ongoing discrimination, bring added dimensions for consideration when providing services to Native families involved in the child welfare system.[77]

Research has demonstrated that the use of recovery coaches has proven to have a positive effect on outcomes for families with substance use disorders and involvement in the child welfare system. Recovery coaches provide clinical assessments, advocacy, service planning, outreach, and case management to parents throughout the case.[78] Research shows that the parents who were assigned a recovery coach were more likely to engage in treatment and engaged in treatment significantly faster than parents assigned treatment as usual. Parents with recovery coaches also had significantly fewer subsequent births of infants prenatally exposed to substances and fewer new allegations of abuse.[79] In addition, the use of recovery coaches significantly increased the parents' access to substance use disorder treatment and increased family outcomes. Peer mentoring has also been found to have a positive effect on parents. In a study to discern mentoring practices, three emerged; building caring relationships, providing guidance, and putting parents in charge. These practices promoted parents' positive self-beliefs (e.g., worthy of connection, competence), which helped motivate them to participate in services, cope constructively with difficulties, and more effectively manage behaviors and emotions.[80]

The Engaging Moms Program (EMP) in Miami-Dade County has demonstrated that increased length of stay in treatment generates positive outcomes in the areas of substance use, mental health, parenting practices, and family functioning. EMP is based on the theory and method of Multidimensional Family Therapy and was adapted for use in family drug court.[81] A finding from adult drug court research indicates that those programs that provided parenting classes had 65 percent greater reductions in criminal recidivism and 52 percent greater cost savings than programs that did not provide parenting classes.[82]

Mental Health and Trauma Informed Services

Parents in FDCs must receive trauma screening and if indicated, appropriate treatment. Numerous studies have found that the use of alcohol and/or illicit drugs increases risk for a number of different types of trauma. A history of trauma exposure, whether or not the individual has a traumatic stress reaction, is associated with increased risk for substance use disorders. Adverse childhood experiences are associated with a number of negative social, behavioral health and physical health adult outcomes, including alcohol and drug use disorders and depression.[83] One study found that 88.6 percent of clients receiving outpatient substance use disorder treatment services reported at least one traumatic event.[84] As noted in the recently published *Treatment Improvement Protocol,* "By recognizing that traumatic experiences and their sequelae tie closely into behavioral health problems, front-line professionals and community-based programs can begin to build a trauma-informed environment across the continuum of care."[85] The *Adult Drug Court Best Practice Standards Volume II* states, "among female [adult] drug court participants…more than 80% experienced a serious traumatic event in their lifetime, more than half were in need of trauma-related services, and over a third met diagnostic criteria for PTSD."[86]

Research on participation in an FDC has found significant reductions in caregiver reports of substance use, anxiety and depression.[87] Addressing parents' co-occurring mental health concerns, such as depression, is important. One study found that symptoms of depression were related to poorer outcomes for drug court enrollees.[88] Another study of women in adult drug court revealed that current major depression was associated with a participant's increased risk of drug use.[89]

Court Practices and Drug Testing

Parents who have one judge throughout their dependency case were found to be more likely to feel that the court cared about their child and the outcome of their case. Having the same judge throughout the case also increased parents' perception of fairness.[90] When asked their perception of the most important elements of an FDC, parents identify "client/judge relationship" in the top six choices.[91] In addition, entering drug court quickly following the filing of a petition for child protection can lead to faster treatment entry, achieving permanency faster, and a shorter time to case closure.[92]

Parent treatment completion was found to be the strongest predictor of reunification/permanent placement with children in one study.[93] Another evaluation found that using a voluntary method of entry to the FDC resulted in fewer parental rights being terminated, higher percentage of permanency decisions reached within one year, earlier achievement of permanency, and a higher percentage of children's permanent placement to be with their parents.[94]

Research on best practices in adult drug courts reveals the most effective drug courts offer both treatment and social services to address participants' needs,[95] conduct urine drug testing at least twice per week, ensure participants have a minimum of three minutes of the judge's attention at each review session, and have progress review hearings twice monthly in the first phase.[96] In the FDC setting, one study found that when drug testing frequency was increased to a minimum of twice weekly, the rate of positive test results decreased by almost 50 percent.[97]

EFFECTIVE STRATEGIES FOR ADDRESSING THE NEEDS OF PARENTS:

The list of effective strategies is provided in a self-assessment format to allow readers to determine the degree to which their FDC has implemented the strategies. For each strategy, indicate the number that most closely corresponds to the description of the FDC's status.

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- ☐ An array of services are available and the FDC uses treatment and service matching to ensure that substance use disorder treatment and other services are based on evidence. Practices and curricula are gender-specific and designed exclusively for the unique needs and strengths of men or women and culturally relevant and specifically developed and tested with the population(s) being served.
- ☐ Services are geographically accessible and delivered in a location easily reached by participants by public transportation.
- ☐ The FDC has implemented integrated case plans that include the substance use recovery plan and the child welfare case plan as well as other services the family is to receive.
- ☐ Substance use disorder treatment clinicians carry caseloads of 50:1 if providing clinical case management, 40:1 if providing individual therapy or counseling, and 30:1 if providing both services.
- ☐ The FDC staff tracks the status of their participants' progress in the child welfare system and integrates the information into their case plan and service delivery.
- ☐ The FDC is family-focused in its approach and whenever appropriate, allows young children to reside in treatment with parent(s).
- ☐ The FDC is trauma-informed and uses practices and curricula that assume trauma may be part of the parent/child/family's experience and uses trauma-specific services to address these needs.
- ☐ The FDC staff or case worker asks if a parent identifies as Native or tribal member.[m]
- ☐ The FDC has developed or is connected to an evidenced-based parenting program.
- ☐ The FDC participants have access to medication assisted treatment for substance use and mental disorders.

[m] For example, *see* "A Guide to Compliance with the Indian Child Welfare Act," National Indian Child Welfare Association, *available at* http://www.nicwa.org/Indian_Child_Welfare_Act/documents/Guide%20to%20ICWA%20Compliance.pdf.

- ☐ The FDC staff have adequate and timely access to information to determine how participants are progressing through treatment and uses the information in staffing, progress hearings and in case management meetings to encourage full participation.

- ☐ The FDC uses a phase system with benchmarks of accomplishments that define progress and a set of defined targeted behaviors that have been explained and made available to participants in a participant handbook.

- ☐ The FDC tracks participant behavior and the accomplishment of phase milestones of progress toward goals.

- ☐ The FDC staff has realistic expectations for its participants; staff understand the neurological effects of substance use disorders and mental status in early recovery and the challenges faced by parents.

- ☐ The FDC understands what motivates behavior change and applies the principles when working with and responding to participant behavior. Motivational strategies and program practice elements to engage and promote accessibility and accountability are provided in the context of a transtheoretical model of behavior change or Stages of Change.

- ☐ The FDC staff respond promptly to participant behavior through an established system assuring the response is timely and takes into consideration factors such as length of time in the program.

- ☐ The FDC uses drug testing effectively and in conjunction with a treatment program to monitor participants' compliance with treatment plans.

- ☐ The FDC team, and particularly the judge, recognize the effectiveness of positive reinforcement and use it frequently, modeling it for parents.

- ☐ Responses to parent behavior are determined by the judicial officer after a discussion with the team.

- ☐ The judge clearly explains to parents the reasoning behind all responses to behavior to communicate the principle of fairness.

- ☐ The FDC is a multi-disciplinary team that is cross-trained and that uses the relationship between the parent and the judge to reinforce treatment and other service requirements.

- ☐ The FDC has discussed whether jail can and will be used as a sanction and all team members understand the effect on the child and family reunification efforts. The entire team understands the circumstances, the duration and for whom jail may be useful as a method of motivating change.

- ☐ Engagement strategies are used to encourage early entry into FDC.

- ☐ The FDC provides outreach to participants who do not keep their initial substance use disorder treatment appointment or drop out of treatment.

- ☐ The FDC uses a coordinated legal and clinical plan to respond when a parent fails to keep a court date.
- ☐ The FDC has staff who are trained in approaches to improve rates of engagement and retention and uses these strategies with parents.
- ☐ The FDC uses recovery coaches.
- ☐ The FDC responds to participant relapse and other risk indicators by reassessing clinical needs and child safety, and by re-engaging the participant in treatment.

RECOMMENDATION 7: ADDRESS THE NEEDS OF CHILDREN

The physical, developmental, social, emotional, and cognitive needs of children in the FDC setting must be addressed through prevention, intervention, and treatment programs. A holistic and trauma-informed perspective must be in place to ensure children receive effective, coordinated, and appropriate services.

DESCRIPTION:

Children of parents with a substance use disorder may be affected due to prenatal and/or postnatal exposure that can result in deficits, delays, and concerns of a neurological, physical, social-emotional, behavioral, or cognitive nature. Children of parents with substance use disorders are also at an increased risk of exposure to significant trauma experiences, threatening a child's well-being and placing these children at greater risk for their own substance use and mental disorders. FDCs must ensure that specialized services are available to address:

Devoting more funding to direct services for children in the FDC setting has been demonstrated to be more cost effective.

Carey, et al. 2010

- Developmental screening, assessment and services for pre- and post-natal effects of exposure to parental substance use disorders
- The consequences of the child living in a household affected by parental substance use disorder, including trauma associated with removal from the home
- The effects of child maltreatment from abuse or neglect
- The full spectrum of children's developmental stages
- The child's increased risk of developing his or her own substance use disorders, especially focusing on school age, pre-teen and adolescent prevention and treatment

In a cross-site evaluation of residential treatment programs for pregnant and parenting women, it was found that postpartum women who had their infants living with them in treatment had the highest treatment completion rates and overall longer stays in treatment, when compared with women whose children did not live with them.

Clark, 2001

These specialized services are particularly needed to mitigate the risk of intergenerational patterns of substance use and to promote the child's physical, social, and emotional well-being. The FDC, child welfare and dependency court staff must work together to assure the family's needs are met. The services to children should be coordinated with the services for the parent to support the healing of their relationship, while keeping the safety of the child paramount. Ultimately, it is in the best interest of children when services are provided to parents that prepare them to understand and better care for their children, some of whom may exhibit effects of substance exposure or traumatic experiences.

RESEARCH FINDINGS:

FDCs should address the full array of immediate, transitional, and long-term needs of children. A study that examined the perceptions of parents in an FDC revealed that addressing the "distinct needs of parent, child and family" was rated among the most important goals of the court.[98] In another FDC study, family, adult and child psychosocial functioning was measured and results showed there were significant improvements in family functioning associated with improved ratings being on par in areas of child development as well as an increased likelihood of reunification.[99]

Research shows that treating the complex needs of children requires a team of professionals that extends beyond the team members found in a traditional substance use disorder treatment setting.[100] Parents who participate in treatment programs with a "high" level of family/children's services were found to be twice as likely to reunify with their children than those with "low" level of these services.[n,101] Family-centered residential substance use disorder treatment programs that allow women to enter treatment with all of their children have been found to be more effective at retaining women in care to reach stability.[102] Devoting more funding to direct services for children in the FDC setting has also been demonstrated to be more cost effective.[o,103] Another example from an FDC setting showed that a comprehensive, family-centered FDC approach that addressed the specific needs of children and families, in addition to a parent's recovery, contributed to improved child, parent, and family well-being.[104]

Interventions for children with prenatal drug exposure require a comprehensive, culturally relevant, family-oriented approach. One study advocated for the inclusion of prevention strategies for children of parents convicted of driving under the influence.[105] Intervention strategies that address the multiple needs of the mother, father and the child have the greatest promise of improving overall outcomes.[106] For these families, research suggests that an appropriate child welfare response should attend to both children's and parents' needs and include strategies that are well matched to the families' socioeconomic and social support needs.[107] Family-based in-home treatment that integrates substance use disorder treatment and infant mental health interventions has been found to effectively meet the needs of mothers and fathers struggling with the dual challenges of substance use disorder recovery and parenting infants and toddlers.[108] Youth involved in the child welfare system who have had prenatal substance exposure were found to be more likely to have a mental health diagnosis when one of five predictors was present: living in a rural area, a history of neglect, having Fetal Alcohol Syndrome or an alcohol-related neurodevelopmental disorder, and age.[109] These results have implications for adapting existing treatment models. When a brief duration, attachment-based, parenting program was provided in a women-and-

[n] The authors created three variables ("low=0-3", "medium=4", "high=5-7") based on the number of services such as individual, group, or family counseling regarding family issues; education/training regarding family issues; child care; child development services available.

[o] When a greater investment was made in these types of services (21% of the investment budget compared to 5%), there was a significant cost savings.

children's substance use disorder residential treatment setting, the mothers demonstrated significantly improved behaviors with their infants at home post-intervention.[110] FDCs should ensure the frequency, length of time and quality of visitation promote parent-child attachment. Regular parent visits in foster care are linked to child well-being while in care and to reunification.[111] Frequent, meaningful visitations are vital if an attachment bond is to be maintained. Particularly, for infants and toddlers, physical proximity is central to the attachment process.[112]

A comprehensive family-centered FDC approach that addresses the specific needs of children and families in addition to a parent's recovery contributes to improved child, parent, and family well-being.

SAMHSA 2014

In the Children Affected by Methamphetamine (CAM) Grant Program, grantees expanded and/or enhanced services to children in 12 FDCs to improve the well-being, permanency, and safety outcomes children. CAM grantees' performance data showed statistically significant improvements from intake to closure in all ten domains of family functioning, including living environment, parental capabilities, family interactions, family safety, child well-being, social/community life, self-sufficiency, family health, caregiver/child ambivalence and readiness for reunification, as measured by the *North Carolina Family Assessment Scale (NCFAS G+R).*[113] In another study, researchers examined the *Strengthening Families Program,* a family skills training program, and found a reduction in days in out-of-home care than in the comparison group. This program has been demonstrated to be cost effective, saving between $9.15 to $25.35 for every $1 spent.[114]

In the past ten years, there has been an increase in the prevalence of prescription opioid use disorders and an increase in the incidence of neonatal abstinence syndrome (NAS). Specifically, the prevalence of NAS increased from 1.20 incidents per 1,000 U.S. hospital births in 2000 to 3.39 incidents per 1,000 U.S. hospital births in 2009.[115] Individual assessment that focuses on each child's cumulative risk factors, domain of developmental difficulty, and the quality of the caregiving environment must occur. To have the greatest development effect, interventions with caregivers should be implemented early in life and be targeted at caregivers' level of stress, mental health functioning, continued substance use, and parenting interactions.[116]

The potential indirect costs of child abuse and neglect are numerous, among them increased criminal involvement and juvenile delinquency, and poor social functioning.[117] There are also indirect benefits in other systems that are realized when the broad range of children's needs are met. One example is improved outcomes in the education system when fewer school days are missed, resulting in recovered Average Daily Attendance (ADA) funds.[118]

EFFECTIVE STRATEGIES FOR ADDRESSING THE NEEDS OF CHILDREN:

The list of effective strategies is provided in a self-assessment format to allow readers to determine the degree to which their FDC has implemented the strategies. For each strategy, indicate the number that most closely corresponds to the description of the FDC's status.

1= Not Yet Considered; 2= Exploration; 3= Installation; 4= Initial Implementation; 5= Full Implementation; 6= Sustained Practice

- ☐ The FDC uses an established protocol with healthcare professionals and treatment agencies for prioritizing and assisting participants who are pregnant and who are using substances.
- ☐ The FDC follows the rules of the Indian Child Welfare Act (ICWA) and assures that the rights of Indian children are protected.
- ☐ The FDC has implemented substance use disorder prevention and early intervention services for the children of parents in the FDC, using evidence-informed practice.
- ☐ Children under three years of age are provided services that include the parent/caregiver as an active participant (as opposed to individual therapies).
- ☐ Children of parents in the FDC have access to services that include interventions across children's developmental stages, including school readiness, adolescent substance use disorders and other treatment, and at-risk youth prevention and intervention programming.
- ☐ The FDC ensures that children of parents in the FDC have a comprehensive health assessment that includes screening for developmental delays and neurological effects of prenatal exposure to alcohol and other drugs. This assessment also includes the physical, social-emotional, behavioral, and psychological effects of removal from their home, their parents' substance use, and exposure to trauma.
- ☐ The FDC ensures that all children in out-of-home care are protected from further exposure to trauma arising from placement changes.
- ☐ The FDC has the appropriate frequency and quality of visits necessary to establish and maintain attachments and relationships with their parents, while assuring the safety of the child.
- ☐ The FDC has developed linkages to a range of programs, including quality early childhood development programs, that are targeted to meet the special developmental needs of children of parents in the FDC, including programs focused on school readiness and educational support.

Miami, Florida utilizes an evidence-based parenting intervention, Nurturing and Strengthening Families, and uses Multi-Dimensional Family Therapy with older children. Parents with children 0-3 are referred for parent-child psychotherapy (dyadic therapy). In addition, the Engaging Moms program focuses on bonding and attachment with one's children.

- ☐ The FDC uses effective models of prevention and intervention for children of parents with substance use disorders.
- ☐ The FDC identifies gaps in services for children and works to identify or develop services to fill those gaps.
- ☐ The FDC has established linkages to residential substance use disorder treatment that allows children to be placed with parents. Where those services do not exist, the FDC works with providers to develop a plan to create these services.
- ☐ FDCs have access to a full continuum of services for parents and their children. Where there are gaps in the continuum or limited capacity, the FDC works with providers to develop a plan to improve the continuum or capacity of these services.

RECOMMENDATION 8: GARNER COMMUNITY SUPPORT

FDCs connect with community-based organizations to support the multiple needs of parents, children, and families during program participation and to provide ongoing support for continued success after formal FDC services have ended. One of the most important components of an effective FDC is early engagement of stakeholders, which should include advocacy for sustaining the FDC.

DESCRIPTION:

Forging community partnerships increases the availability of necessary services at the client level and promotes broader collaboration at the organizational level. FDCs are part of the continuum of community-based services needed for families' long-term success. To provide a bridge from program participation to on-going supports requires identifying services available in the community and creating and using protocols to link participants to them. Partnerships must be formed with community agencies, businesses, support/self-help groups, and service organizations. These partnerships serve to inform the community and solicit assistance, as well as to provide tangible resources to support families in recovery. Through outreach and education, community support can be developed to strengthen the FDC and to provide for its long-term sustainability, making the FDC part of the fabric of the community it serves.

RESEARCH FINDINGS:

Some Family Drug Courts have a standing Advisory Committee made up of community partners and other stakeholders. These committees often include consumers and provide the FDC with invaluable information, perspective, and resources.

Supportive services ensure that parents with an alcohol or other substance use or mental health disorder fully re-engage with family members, friends, and the community, while preventing relapse and recurrence of child abuse and substance abuse.[119] The aftercare and longer-term supports by family and community providers can ensure a seamless continuum of services. One study conducted in an FDC found that the best predictors of reunification were participation in support group meetings (e.g. 12-step programs, community or church-based programs focused on recovery from substance use disorders) and negative tests for substance use. These findings indicate that initiatives designed to address the needs of families should support engagement in informal, community-based activities as well as formal, clinically focused interventions.[120] FDC families often are exposed to the stress associated with living in poverty and one study in the FDC setting concluded that an important part of providing ongoing community support is to connect families with job training, financial coaching, and financial supports.[121] To ensure the lasting effects of the FDC experience, programs must consider and address the long-term needs of parents and their children.[122]

EFFECTIVE STRATEGIES FOR GARNERING COMMUNITY SUPPORT:

The list of effective strategies is provided in a self-assessment format to allow readers to determine the degree to which their FDC has implemented the strategies. For each strategy, indicate the number that most closely corresponds to the description of the FDC's status.

1= Not Yet Considered; 2= Exploration; 3= Installation; 4= Initial Implementation; 5= Full Implementation; 6= Sustained Practice

- ☐ The FDC has developed and implemented strategies to recruit broad community participation in addressing the needs of the FDC families.
- ☐ The FDC has included community members in a variety of roles. Community members participate in an advisory capacity during planning and program development, as well as offer input throughout the operational process. In some cases, community leaders may have a role on the Steering Committee.
- ☐ The FDC has developed and implemented a formal mechanism to solicit support and input from community members and consumers. Participation in regular advisory and other committee meetings and workgroups, as well as contributing dialogue toward program development, are examples of the role and responsibilities of consumers and community members.
- ☐ The FDC has conducted a needs assessment of program participants, utilizing community mapping to identify existing services and service gaps. This process may build on the needs assessment that has been conducted by team member agencies.
- ☐ The FDC staff identifies and links families with the support services that are frequently needed by participants (e.g., transportation, child care, employment, and housing). It has established relationships and developed memoranda of understanding, linkage agreements, or procedures with service providers.
- ☐ The FDC uses up-to-date community resource directories to locate family support centers and resources.
- ☐ The FDC has access to community-wide accountability systems to monitor substance use disorder and child welfare issues with specific indicators for both systems. In jurisdictions where this ability does not exist, the FDC works with substance use disorder and child welfare leaders to create this resource.
- ☐ The FDC uses sober living communities and housing for parents in recovery.
- ☐ The FDC has connections with services to include job training, financial coaching and supports and faith-based recovery support.
- ☐ The FDC has built upon other community and problem-solving efforts, working with other drug courts when appropriate.
- ☐ Consumers (e.g. parents in recovery, program graduates) have an active advisory role in planning, developing, and providing ongoing feedback in the FDC.

- ☐ The FDC has established alumni groups and uses alumni in an active advisory role in planning, developing, and providing feedback to the FDC.
- ☐ Youth and former foster children/youth have an active advisory role in planning, developing, and providing feedback to the FDC.
- ☐ The FDC has policies and practices to better link parents to continuing care services that include the full array of family income support programs (EITC, Child Support, SCHIP, Supplemental Nutrition Assistance Program (SNAP), Housing Subsidies, etc.).
- ☐ A plan is implemented to conduct regular community outreach and education throughout the year to community groups and other stakeholders to engage and inform, and to support sustainability. All team members participate in the development and implementation of the plan and parents are included as presenters, when appropriate.

RECOMMENDATION 9: IMPLEMENT FUNDING AND SUSTAINING STRATEGIES

The FDC must access the full range of funding, staffing, and community resources to develop long-term stability for its innovative approaches. FDC must continually evaluate its outcomes and effectiveness, modifying the program accordingly to assure its continued success. FDC needs a governance structure that assures ongoing commitment by policy makers, management, community partners, and operational staff.

DESCRIPTION:

There are three aspects to sustaining an FDC: 1) Assuring adequate resources through funding and the optimal use of existing resources; 2) Reviewing and modifying the FDC program and its policies and procedures to optimize program effectiveness; and 3) Community outreach, education and partnerships. To fully realize sustainability in these three areas, data and evaluation that demonstrates resources used and program practices producing improved outcomes are required. Sustainability efforts must address internal and external support, community outreach and education, quality partnerships, and blended funding streams. Adequate resources for multi-year stability requires access to the full range of funding resources across multiple agencies that are available to a State or community. It also requires access to resources already committed to serving the FDC population in the partner agencies. Jurisdictions that have been successful in sustaining their collaborative efforts have leveraged cross-system resources and accessed opportunities for expanded funding, including integrating the FDC into the State and local budget process for the court, child welfare and treatment systems. The effectiveness of an FDC is sustained through ongoing attention to the evaluation, review, and modification of FDC policies, procedures and outcomes, and a governance structure that assures program effectiveness, fidelity to the model, ongoing training, staff development, and education for stakeholders.

RESEARCH FINDINGS:

In one FDC cost evaluation, the program demonstrated an increased use of substance use disorder treatment services, and decreased use of other publicly funded services such as child welfare, community corrections, and the courts.[123] Adult drug courts, where internal review of the data and program statistics led to modifications in program operations, had 131% higher cost savings across all system partners. Programs that had evaluations conducted by independent evaluators and used them to make modifications in operations had 100% greater cost savings.[124] Although there are significant differences between adult and family drug courts, there are no differences that would suggest that these findings would not apply in the FDC setting.

The Child and Family Services Act of 2006 reauthorized the Promoting Safe and Stable Families program, designed to improve the lives of abused and neglected children and their families affected by methamphetamine and other substance use disorders. As part of that federal funding, the Regional Partnership Grant (RPG) Program Round I was initiated in 2007, to improve outcomes for children and families affected by methamphetamine and other parental substance use disorders. Fifty-three grantees received multi-year grants, eight receiving an additional two-year extension. Eighteen of the grantees were new or

existing FDCs. Of the 44 regional partnerships whose grants were not extended, 33.3 percent (15 grantees) sustained their project in its current form or model beyond their grant period and another 53.3 percent (24 grantees) sustained specific components or a scaled down version of their overall program model. The mechanisms of sustainability supporting this effort included: 1) Moving to a more advanced stage of collaboration; 2) Changing the rules for how families are served; 3) Undertaking joint projects or shared grants to sustain services; and 4) Institutionalizing RPG practices and services with system-wide implementation.[125] Grantees used a variety of sustainability tools to assist in the process, including a Sustainability Discussion Guide,[126] Sustainability Matrix,[127] and the Program Sustainability Assessment Tool.[p]

Effective Strategies for Implementing Funding and Sustaining Strategies:

The list of effective strategies is provided in a self-assessment format to allow readers to determine the degree to which their FDC has implemented the strategies. For each strategy, indicate the number that most closely corresponds to the description of the FDC's status.

1= Not Yet Considered; 2= Exploration; 3= Installation; 4= Initial Implementation; 5= Full Implementation; 6= Sustained Practice

☐ The FDC team has a long-range plan focused beyond the expiration of one-time project grant funding to sustain the FDC on an ongoing basis. This plan identifies and has an inventory of:

- Funds already directed to FDC participants and their families, but not necessarily identified as part of the FDC budget
- A full scope of services already available in the community for FDC participants and their families
- A list of service gaps
- Existing civil service positions that can be used or amended to focus on serving the FDC population
- Various Federal, State and local funding streams available to assist the FDC population
- The different funding sources for comprehensive family treatment and what services such funding provides

☐ A plan is implemented to fund substance use disorder treatment, leveraging other funds such as Medicaid, Substance Abuse Prevention, and Treatment Block Grant, child welfare funding streams and other community resources.

☐ The FDC collaborates with TANF to fund substance use disorder treatment and supportive employment-related programming.

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[p] The tool is based on the Program Sustainability Assessment Tool v2, a copyrighted instrument of Washington University, St Louis, MO. Children, and Family Futures modified the instrument to fit the needs of communities, systems, and organizations in the child welfare and substance use disorder arena. The purpose of Program Sustainability Assessment Tool (PSAT) is to assess the current sustainability capacity of collaboratives across a range of specific organizational and contextual factors. The assessment is based on the Program Sustainability Assessment Tool v2, a copyrighted instrument of Washington University, St Louis, MO.

☐ There is a plan in place to fund FDC infrastructure (e.g. coordinator, dedicated case managers) through child welfare funding, the court's budget, and existing community agencies

☐ The FDC has identified items to be included in the FDC overall budget including:

- FDC infrastructure
- Substance use disorder treatment specialized for this population
- Services for children, including resources to assure that each child has developmentally appropriate screenings for the effects of substance use disorders
- Services for families, including services to improve participants' parenting skills
- Training for the FDC team
- Costs of evaluation and outcomes management to enable the FDC to demonstrate accomplishments

Chatham County, Georgia has a food and clothing bank for FDC parents and families. The items in the bank are contributed by community members and organizations. Some items are used as incentives.

☐ Outcomes are used to inform ongoing review and modification of program policy and procedures

☐ FDC partners are aware of, share information about, and use the State and local budget process to support the FDC. The FDC's partners (child welfare system and substance use disorder treatment agencies and dependency courts) are able and willing to share information about each other's budgets and staffing.

☐ FDC partners have implemented joint funding strategies (i.e., braided/blended funding) to support the FDC.

☐ The FDC has created a non-profit 501c (3) corporation or worked with the local community foundation to establish a fund for the FDC so that contributions to the program can be made.

☐ The FDC partners work together to obtain external funding and its application and management is a joint process.

☐ The FDC has sought funding to take the program to the scale of operations needed to meet the demand for these services over a multi-year period.

☐ The FDC is embedded in agency, court and treatment provider budgets rather than relying on one-time project grants.

☐ The FDC has sought commitment to program objectives from a wide range of community based organizations and entities.

☐ The FDC has a community outreach and education plan to further sustainability efforts.

RECOMMENDATION 10: EVALUATE FOR SHARED OUTCOMES AND ACCOUNTABILITY

The FDC team must demonstrate that the FDC has achieved desired results across partner agencies. To do so, FDC partners must agree upon goals and establish performance measures for joint accountability. FDCs must develop and measure outcomes and use evaluation results to guide the work of the collaborative.

DESCRIPTION:

FDC teams can be more invested if they are part of the evaluation design process. When each team member is asked how he or she defines success, measures can be included that can strengthen commitment at the operational team level and at the agency level.

It is the responsibility of the entire team to reach mutually agreed upon performance measures. Although it initially might seem to be only the treatment provider's responsibility to meet treatment outcomes, in fact, each and every FDC team member has a role in treatment engagement and supporting the therapeutic goals of treatment. Similarly, permanency for the child may appear to be a child welfare objective, but when seen in larger context, permanency is an objective in which all team members can participate, modeling a family-centered approach. Team members must make a commitment to evaluation of the outcomes, all of which should be consistent with a logic model based on the mission and vision of the FDC and include agreed-upon criteria for the target population and scale. The FDC should develop methods to evaluate and monitor outcomes with the court, child welfare, and substance use disorder treatment partners. FDCs must not only be aware of their own outcomes (e.g. recurrence rate of maltreatment) but also how it affects the larger system or State in which they live.

Of particular importance are the outcomes for each member and the family as a whole: parents' recovery and well-being, safety and permanency for the children. Jointly developed goals guide the work of the FDC and a careful evaluation can demonstrate whether agreed upon outcomes have been achieved for the FDC program. Without shared outcomes, each of the stakeholders is likely to measure success and the benefits of the FDC as it did prior to the collaboration, based on its own internally defined outcomes. Since a successful FDC requires a collaborative approach, evaluation of the FDC should measure the success of the collaborative efforts.

Research Findings:

To meet the shared goals of child safety, permanency, well-being, and recovery, child welfare agencies and substance use disorder service providers must work collaboratively to provide timely, accessible, and effective substance use disorder treatment and supportive services.[128] Adult drug court research has found that those programs that see improvements in outcomes are those that "collect and use data, seek out training, acquire the support and insights of experts (including evaluators), and use data and expert feedback to make ongoing adjustments to enhance practices."[129] Monitoring adherence to best practices, measuring in-program outcomes and the use of an unbiased comparison group for evaluation purposes are now expected standards for adult drug courts and has been shown to lead to more effective service delivery.[130] It is reasonable to assume that FDCs would realize similar improved outcomes.

There is significant research that demonstrates the need for all drug courts to evaluate the equal access, retention, treatment, and outcomes for historically disadvantaged groups. Research in the adult drug court setting revealed better outcomes when programs seek input from clients about their performance related to cultural competence and cultural sensitivity.[131]

Effective Strategies for Evaluating for Shared Outcomes and Accountability:

The list of effective strategies is provided in a self-assessment format to allow readers to determine the degree to which their FDC has implemented the strategies. For each strategy, indicate the number that most closely corresponds to the description of the FDC's status.

1= Not Yet Considered; 2= Exploration; 3= Installation; 4= Initial Implementation; 5= Full Implementation; 6= Sustained Practice

- ☐ The FDC collects and uses referral and admission data to monitor engagement, and works with child welfare partners to assure all eligible families are referred.
- ☐ The FDC has developed outcomes to be monitored to share accountability and success.
- ☐ The FDC collects and uses data, and seeks the support and insights of experts to make ongoing adjustments to enhance practices.
- ☐ The FDC has identified system level outcomes and has developed methods to monitor them with the court, child welfare, and substance use disorder treatment partners.
- ☐ The FDC has agreed on how to use information to inform policy makers and community leaders and to communicate those outcomes as part of their sustainability plan.
- ☐ The FDC uses outcomes information to determine provider effectiveness and are able to use those providers that are most effective in serving FDC participants.
- ☐ The FDC has identified comparison groups that make the evaluation results credible.

- ☐ The FDC has allocated funds or secured agency resources to collect, analyze, report and monitor data.
- ☐ The FDC team shares accountability for successful treatment and child safety/permanency outcomes and ASFA compliance for their mutual clients.
- ☐ The FDC includes outcome criteria in their contracts with community-based providers and measures the effectiveness of providers in achieving the outcomes. The criteria focuses on measures beyond number of participants served or participants entering treatment to functional improvements after discharge and FDC completion.
- ☐ The FDC participants are referred to child development and parenting education programs that have demonstrated positive results and that use evidence-informed practices with this population.
- ☐ The FDC has developed, identified, and assessed common points where participants drop out of the FDC system prior to completing treatment. This information is used to modify program processes, requirements and services, and informs program benchmarks.

CONCLUSION

These ten recommendations are based on direct interaction with more than 250 FDCs, the research cited throughout this paper, and the reflective practice of hundreds of FDC team members from throughout the nation. These recommendations can assist a state-level policy body in determining the level of resources needed to take advantage of the effectiveness of FDCs in achieving improved participant outcomes and cost savings over time. Similarly, an FDC team that uses these strategies will be able to review how well their partnership is coping with the multiple challenges of operating a successful FDC.

These recommendations can help FDCs respond to the most important decisions facing them as they plan for their future:

- Expanding FDCs' scale and their scope to respond to a wider segment of the population that would benefit
- Linking with parallel reforms in courts, child welfare, treatment, and other agencies, rather than operating as separate, isolated projects
- Responding to fiscal strain at state and local levels with greater emphasis on FDCs because they are cost-effective

Family drug courts have expanded during the past two decades because they have proven that they provide children and families with a stronger system of accountability for results from both families and agencies. These recommendations build on that track record to adopt a systems perspective to move beyond a single FDC project to achieve a lasting impact on the wider systems within which they operate and on the children and families FDCs strive to more effectively serve.

[1] U.S. Department of Justice, Office of Justice Programs. (1997). *Defining drug courts: The key components.* Alexandria, VA: The National Association of Drug Court Professionals (NADCP). Drug Court Standards Committee. Retrieved from http://www.ndci.org/sites/default/files/ndci/KeyComponents.pdf

[2] U.S. Department of Health and Human Services. (2014). *Brief: grants to expand services to children affected by methamphetamine in families participating in family treatment drug court: Children affected by methamphetamine (CAM) brief.* Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse. Retrieved from https://www.ncsacw.samhsa.gov/files/CAM_Brief_2014-Final.pdf

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APPENDIX A – INDIAN CHILD WELFARE ACT (ICWA)

This guide to compliance with the Indian Child Welfare Act (ICWA) is an excerpt from "Screening and Assessment for Family Engagement, Retention and Recovery (SAFERR)." It is included here to assist child welfare partners in their efforts to appropriately serve Native American families, and specifically to meet the legal requirements under ICWA. Additional resources can be found at www.nicwa.org.

A Guide to Compliance With the Indian Child Welfare Act

Following is a guide to Indian Child Welfare Act (ICWA) compliance. This information, including the flow chart on page 12, is from the National Indian Child Welfare Association's curriculum, "Cross Cultural Skills in Indian Child Welfare: Guide for the Non-Indian" (1987), with information derived from Oregon Children's Services Division's "A Guide and Checklist to ICWA Compliance," developed by Maria Tenorio, ICWA Specialist, Salem, Oregon, 1986.
State rules and regulations may vary from this guide; therefore, workers should make sure they know what their agency requires. Also, many States supply sample letters and/or checklists for compliance. Following this guide will ensure compliance with the Act, but not necessarily State rules.

WHEN THE ACT APPLIES

Tribal–State Agreements

The first precaution in applying ICWA is to make sure there is no tribal State agreement that has specific procedures to follow. Several tribes now have agreements with State agencies on child welfare matters.

Not Covered

Juvenile delinquency proceedings (violations of criminal law) are not covered with two exceptions:

- Juvenile delinquency proceedings where parental rights may be terminated; and
- Status offenses (juvenile delinquency proceedings which involve an offense that would not be a crime if committed by an adult, e.g., drinking, being a runaway, and being a truant)

Divorce proceedings when one parent is granted custody

Voluntary placement if the parent may regain custody "upon demand" (placement preferences still apply)

Covered

- Foster care placements
- Termination of parental rights
- Preadoptive placements

Adoptive placements (include conversion from foster care to adoptive placement)

- Both voluntary and involuntary placements if parents can't regain custody of child "upon demand"
- Divorce proceedings in which neither parent will get custody
- Juvenile delinquency proceedings where parental rights may be terminated
- Status offenses (juvenile delinquency proceedings which involve an offense that would not be a crime if committed by an adult, e.g., drinking, being a runaway, and being a truant)

Initial Determination

Oral Inquiry

At intake, and in every change or potential change in custody, the worker orally requests racial/ethnic data by reading aloud the racial/ethnic categories for the client's self-identification and asks: "Which of the following do you consider yourself a member: Asian, Black, Hispanic, Indian, White?"

If the family member responds that he or she is Indian or believes there is Indian ancestry, the worker fills out a family tree chart with the help of client family or other form provided by the agency.

Indian Tribe Verified

If the Indian tribal name and/or address is given, proceed to next section.

Indian Heritage Uncertain

If the parents are unavailable or unable to provide a reliable answer regarding the Indian heritage of their children—

- Make a thorough review of all documentation in the case record;
- Contact the previous caseworker, if any; and
- Make a close observation of the physical characteristics of the child, parents, siblings, and relatives.

Indian Tribe Unknown

If, in following the above steps, you have reason to believe the child is Indian, you will need to identify the Indian tribe by—

- Consulting with other relatives or extended family members; and
- Contacting, as appropriate, the suspected tribe, an Indian social services organization, or the Bureau of Indian Affairs.

Inquiry to Indian Tribe

- The worker checks with the child's tribe to determine whether the child is a member or is eligible for membership. If several tribes are suspected, the worker should send the inquiry letter to all of them.
- The worker can also telephone tribe(s), since this inquiry does not constitute the required official notice to a tribe. Any phone conversation should be documented in the case record with a letter to the effect, "As we discussed by phone today, you believe (stated)... etc."

Tribe Does Not Respond

If the tribe does not respond, call the tribal enrollment officer and follow up with a letter documenting the conversation.

Child Eligible for Membership

- If the tribe responds that the child is eligible for membership, request (or assist the family in filling out) application forms. Proceed to next section.
- If necessary, counsel parents hesitant to enroll a child by emphasizing the positive benefits of tribal membership.

Child Eligible for Membership

Once a tribe has determined that a child is not a member and not eligible for membership, the response must be documented in the case record, including date and source of documentation:

- Document all steps taken to determine the child's Indian or tribal ancestry; and
- File in the case record the tribe's written statement declaring the child ineligible for membership.

Incorporate in any court hearing the tribe's written statement declaring the child ineligible for membership.

Cultural Heritage Protection

For cases in which ICWA does not apply, but the child is biologically an Indian, and considered Indian by the Indian community, follow the Act in your case planning. Respect the child's right to participate in the culture of origin, particularly if such child is identifiably Indian by physical features and/or social relationships declaring the child to be Indian.

THE STATE MAY HAVE NO JURISDICTION

Exclusive Jurisdiction

Some tribes have exclusive jurisdiction over child welfare matters. If the child is a member of such a tribe, the child must be released to his or her parents unless this is an emergency (protective services) removal. You may wish to make a referral to the tribe's social services department to notify them of the family's difficulties.

Nationwide tribes with exclusive jurisdiction as of 1987 are Yakima, Spokane, Colville, and Muckleshoot (Washington); Omaha (Nebraska); Penobscot (Maine); Lac Courte Oreilles and Ho-Chunk Nation (formerly known as the Wisconsin Winnebago) (Wisconsin); Passamaquoddy (Maine); White Earth (Minnesota); and Warm Springs and Burns Paiute (Oregon).

Tribal Court Ward

A tribe has exclusive jurisdiction over tribal court wards, regardless of the child's residence or domicile.

If there is reason to believe that the child has resided or is domiciled on the reservation, phone the tribal court clerk to ask whether the child is a ward of the tribal court.

If yes, the child must be released to parents or custodians unless this is an emergency (protective services) removal. You may wish to make a referral to the tribe's social services department at the same time.

If not, be sure to document this fact in the case record.

NOTICE

Timelines

No requests for a court proceeding (with the exception of emergency removals) can be made until—

- At least 10 days after receipt of notice by parents or custodian, OR after 30 days if 20 days is requested by the parents or custodian to prepare for the proceeding; OR
- At least 10 days after receipt of notice by the tribe, OR after 30 days if the tribe requests an additional 20 days to prepare for the proceeding; OR
- No fewer than 15 days after receipt of notice by the BIA. (See below.)

Who Receives Notice

- Parents, always
- Custodian, if one is involved
- Tribe, always
- If child is affiliated with or eligible for membership in more than one tribe, all tribes should receive notice
- The BIA only if the identity/location of parents or custodians cannot be determined

Service of Notice

Notice should be served in person whenever possible; otherwise, notice should be served by registered mail, return receipt requested. File a copy of this notice with the court, along with any returned receipts or other proof of service.

Tribe Does Not Respond

Even if a tribe does not respond to an official notice sent, or if the tribe replies that it does not wish to intervene in the proceeding, continue to send the tribe notices of every proceeding. It is important to keep the tribe informed because the tribe can intervene at any point in the proceeding to assert its interest and the tribe has the right to notice of all hearings, motions, and other actions related to the case.

Translation of Notice

If there is reason to believe that the parent or Indian custodian will not understand the notice because of possible limited English proficiency, a copy of the notice shall be sent to the BIA Area Office nearest to the residence of that person. BIA staff should be requested to arrange to have the notice explained in the language that the person best understands. The BIA, by Federal regulation, is required to assist in identifying interpreters.

Transfer to Tribal Court

Section 191 L(b) of ICWA allows the parent or custodian or Indian tribe to transfer the proceeding to tribal court. The State court must transfer the proceeding unless the tribal court declines jurisdiction,

either parent objects to such transfer, or if the court determines that good cause exists to deny the transfer.

If the tribe requests orally, or in writing, a transfer of the proceeding to its tribal court—

- Inform the parents or custodians of their right to object to the transfer.

If any party believes that good cause exists not to transfer the proceeding:

- They should state in writing their reasons for such belief; and
- Their written statement must be distributed to all parties so that everybody has the opportunity to provide the court with their views.

Services To Prevent Out of Home Placement

Active efforts must be undertaken to provide remedial services subsequent to an investigation and before a decision is made to place the child out of the home. Proceed by—

- Contacting the tribal social services program for involvement at the earliest possible point; and
- Using other community services specifically designed for Indian families:
  - Extended family;
  - Urban Indian program, when appropriate; and
  - Individual Indian caregivers, such as medicine men.

Definition of Active Efforts

Active effort means not just an identification of the problems or solutions, but efforts showing an active attempt to assist in both arranging for the best-fitting services and helping families to engage in those services. *These can be demonstrated by—*

- Making an evaluation of the family's circumstances that takes into account the prevailing social and cultural conditions and the way of life of the child's tribe and/or Indian community.
- Intervening only when supported by relevant, prevailing Indian social and cultural standards regarding intervention in familial relationships by people who are not members of the family:
  - Develop a case plan with assistance of the parent/custodian that involves use of tribal Indian community resources;
  - Encourage maintenance of the child in his or her own family except where physical or emotional harm may result; and
  - Involve the child, if old enough, in the design and implementation of the case plan.
- Providing time and resources to prevent family breakup in at least equal measure to time and resources provided to other families.
- Assisting parents or custodian and child in maintaining an ongoing familial relationship.

Documentation

All remedial services offered to the family need to be recorded to demonstrate that, prior to petitioning for removal, active efforts were made to alleviate the need to remove the child. The case record cannot simply state that such efforts were unsuccessful, but efforts must *be shown* to be unsuccessful.

Before court proceedings to remove a child are initiated, case records should document that:

- Conduct or condition of the parent will result in serious physical or emotional harm to the child; and
- Efforts were made to counsel and change the parent's behavior, but did not work.

Documentation in the case record should relate indications of the likelihood of serious emotional or physical damage to particular conditions in the home, showing a causal relationship between the conditions and the serious damage that is likely to result to the child. (For example, it is not adequate to show that the parent abuses alcohol. It is necessary to show how, because of alcohol abuse, the parent may cause emotional or physical damage to the child.)

BURDEN OF PROOF

Through ICWA, Congress has declared that an Indian child may not be removed simply because there is someone else willing to raise the child who is likely to do a better job or that it would be "in the best interests of the child" for him or her to live with someone else. Nor can a placement or termination of parental rights be ordered simply based on a determination that the parents or custodians are "unfit parents." It must be shown that it is dangerous for the child to remain in his or her present conditions.

Foster Care Placement: Clear and Convincing Evidence

ICWA states that a court may not issue an order effecting a foster care placement of an Indian child in the absence of a determination, supported by clear and convincing evidence, including the testimony of one or more qualified expert witnesses, that the child's continued custody with the child's parents or Indian custodian is likely to result in serious emotional or physical damage to the child.

Termination of Parental Rights: Evidence Beyond a Reasonable Doubt

In order to ask the court to terminate parental rights, the agency as petitioner must show the court by evidence beyond a reasonable doubt, including the testimony of one or more qualified expert witnesses, that continued custody of the child by the parent or Indian custodian is likely to result in serious emotional or physical damage to the child.

Clear and Convincing

This is a high level of proof, though not as high as proof beyond a reasonable doubt. It means that in order to be successful, the side favoring foster placement must present evidence that is not just slightly more persuasive than the evidence against it, but clearly more persuasive.

Beyond a Reasonable Doubt

This means that the side favoring termination must not only put on a more convincing case than the opposition, but must be so convincing that it eliminates all reasonable doubts in the mind of the person deciding the case. If the court fails to do so, the court is obligated by the Act to deny termination.

Qualified Expert Witnesses

Persons with the following characteristics are considered most likely to qualify as experts:

- A member of the Indian child's tribe who is recognized by the tribal community as knowledgeable in tribal customs as they pertain to family organization and child rearing practices;
- A layperson having substantial education and experience in the area of his or her specialty along with substantial knowledge of prevailing social and cultural standards and child rearing practices within the Indian child's tribe; or
- A professional person having substantial education and experience in the area of his or her specialty along with substantial knowledge of prevailing social and cultural standards and child rearing practices within the Indian community.

This list is not meant to be exhaustive or limited in any manner. Enlist the assistance of the Indian child's tribe in locating persons qualified to serve as expert witnesses. The BIA is also required to provide this assistance.

PLACEMENT OF INDIAN CHILDREN

A diligent search to follow the Act's placement preferences shall include, at a minimum—

- Contact with the tribe's social services program;
- Search of State and county lists of Indian homes; and
- Contact with other tribes and Indian organizations with available placement resources.

Foster Care/Preadoptive

Contact the tribe to ask whether it has a different placement preference from the following:

1. Member of child's extended family;
2. Foster home licensed, approved, or specified by the Indian child's tribe;
3. Indian foster home licensed or approved by an authorized non Indian; or
4. Institution for children approved by an authorized non-Indian licensing authority.

Change of Placement: Notify Parents

If the child is to be moved from one placement to another, or if the foster family plans to move, the child's parents or custodians must be notified in writing. Follow placement preferences outlined above, unless the child is returned to parents or custodians.

Adoptive Placements

Contact the tribe to ask whether it has a different placement preference from the following:

1. Child's extended family;
2. Other members of the child's tribe; or
3. Other Indian families.

Disrupted Adoptive Placements

If an adoption is vacated or set aside, or adoptive parents voluntarily consent to termination of parental rights, the Indian parents or custodians must be notified:

- Notice of their right for a return of their child must include a statement that such petition will be granted unless the court rules it is not in the child's best interest.
- Where parental rights have been terminated, it is up to the agency to decide whether or not to notify parents or custodians of their right to petition for a return of their child.

Documentation

Written records are to be maintained on each child, separate from the court record, of all placements and efforts to comply with required placement records. This record shall contain the following:

- The petition or complaint;
- All substantive orders entered; and
- Complete record of placement determination.

Where required placement preferences have not been followed, efforts to find suitable placements within those priorities shall be documented in detail.

Voluntary Placements

Consent cannot be accepted unless—

- The child is older than 10 days old;
- The consent is in writing and recorded before a judge; and
- The consent is accompanied by the judge's certificate ensuring that terms and consequences of the consent were—
  - ✶ Fully explained in detail and fully understood by the Indian parents or custodians; and
  - ✶ Fully explained in English or interpreted into a language understood by the parents or custodians.

Consent signed by Indian parents or custodians should contain the following:

- Name and birth date of child;
- Name of child's tribe;
- Child's enrollment number or other indication of membership in the tribe;
- Name and address of consenting parents or custodians;
- Name and address of prospective parents, if known, for substitute care placements; and
- Name and address of person or agency through which placement is being arranged, if any, for adoptive placements.

EMERGENCY REMOVALS

Unless circumstances do not permit such inquiry, the racial/ethnic status of the child shall be immediately determined by asking:

Of which of the following do you consider yourself a member?

Asian Black Hispanic Indian White

Indian: Name of tribe and/or band:

Emergency protective custody of any Indian child can be taken only if—

- the child is not located on the reservations of tribes that have jurisdiction over child custody proceedings; and
- the child is in danger of imminent physical damage or harm.

Placement

If the child is believed to be Indian, efforts shall be made to place the child during emergency care in a setting that follows the placement priorities established by either the tribe or ICWA:

1. A member of the child's extended family;
2. A foster home licensed, approved, or specified by the Indian child's tribe;
3. An Indian foster home licensed or approved by an authorized non Indian licensing authority; or
4. An institution for children approved by an Indian tribe or operated by an Indian organization that has a program suitable to meet the child's needs.

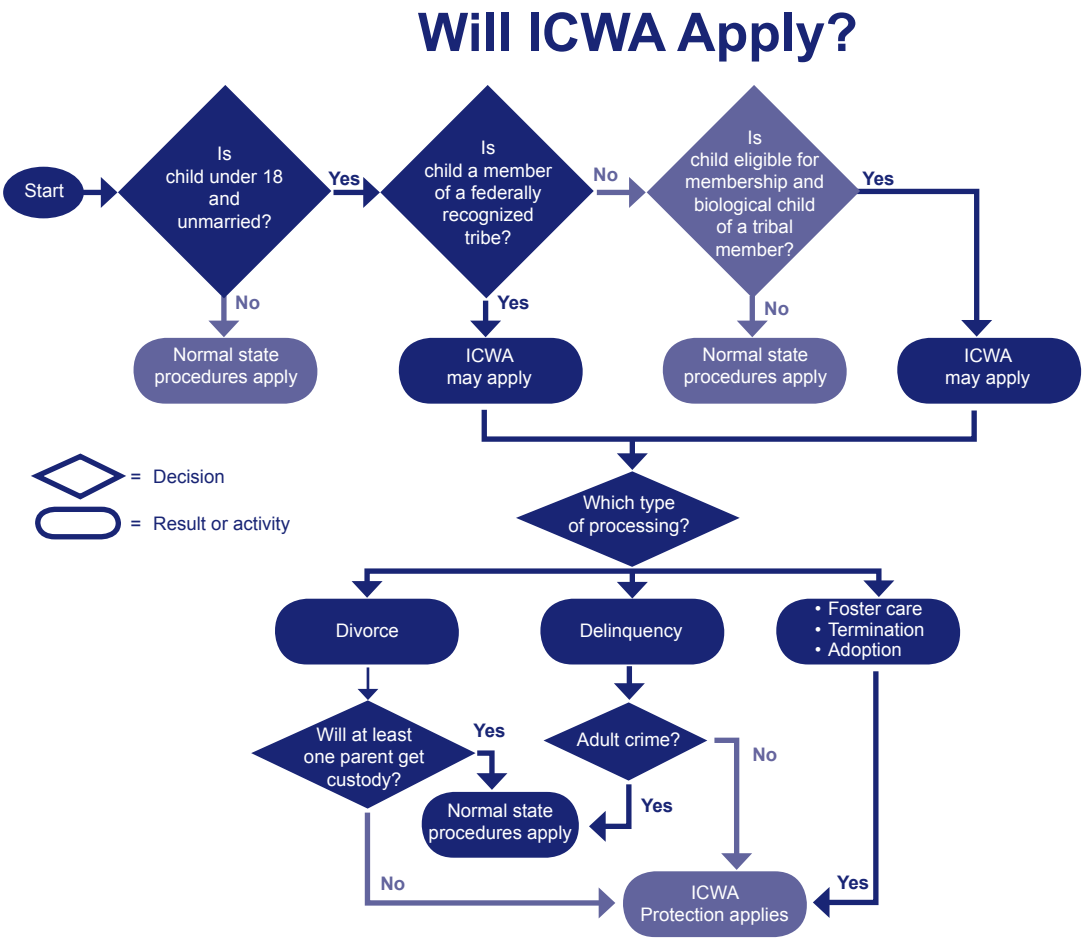
Termination of Placement

Emergency custody must be terminated when removal is no longer necessary to prevent imminent physical damage or harm to the child, or the appropriate tribe exercises jurisdiction over the case.

Continuation of Custody

If termination of an emergency removal is not possible, a court order should be obtained authorizing continued protective custody. The petition filed in such a proceeding should include the following in addition to that information required by State law:

- The name, age, tribal affiliation, and last known address of the Indian child;
- The name and address of the child's tribe and parents and/or Indian custodian, if any. If unknown, the agency shall provide a detailed description of efforts made to locate them;
- If known, whether the residence or domicile of the parent, Indian custodian, or child is on or near a reservation, and which reservation;
- A specific and detailed account of the circumstances that led to the conclusion that the child would suffer imminent physical damage or harm; and
- A specific plan of action to restore the child to his or her parents or Indian custodian, or to transfer the child to the jurisdiction of the appropriate Indian tribe.



Source: National Indian Child Welfare Association. (2002). *Online ICWA course*. Accessed September 18, 2006, at http://www.nicwa.org/services/icwa/index.asp

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APPENDIX B – COLLABORATION AND GOVERNANCE STRUCTURE

Collaboration is the cornerstone of Family Drug Courts, and it starts with the planning process. Whether a statewide effort to develop FDC standards or guidelines, or a local decision to plan and implement an FDC, collaboration is necessary for a successful outcome. Once established, a governance structure is needed to assure the FDC continues to operate effectively. To be most successful, FDC guidelines must be developed in the context of the larger child welfare, substance abuse treatment, and judicial systems. Guidelines should be tied to outcomes and those outcomes should be shared by the collaborating systems. The decision to collaborate on behalf of families involved with substance use disorders, child maltreatment, and the courts has to come from top officials who give priority to this work. If leaders are not committed, little will be sustained. Department heads or high level administrators are the only ones who can free up staff time and invest staff with authority to make decisions on behalf of the agency. The following subsections present a structure for States and counties to use to govern this multidisciplinary initiative.

THE OVERSIGHT COMMITTEE

The top child welfare, substance abuse treatment services, judges and court officials (and, if appropriate, members from the governor's or county commissioner's office) serve as the Oversight Committee for the initiative. Officials on the Oversight Committee must direct senior managers in their systems to give this initiative priority, and they must ask for periodic progress reports. In addition, these officials have to be willing to change their own agencies' policies when those policies impede the ability of staff to serve families.

Because the Oversight Committee includes the most senior officials from each system, all of whom are likely to be facing many demands and pressures for their time, it is anticipated that this committee will meet as a group only three or four times each year. It is also expected that each member will receive regular updates from their representatives on the Steering Committee members between meetings.

THE STEERING COMMITTEE

The Steering Committee should focus on the big picture of State policies, protocols, monitoring and evaluation, including local involvement to assure a broad understanding of how state-level decisions impact communities. After top administrators form the Oversight Committee, they can take a significant first step by establishing a senior-level multidisciplinary Steering Committee. The Steering Committee is charged with creating, directing, and evaluating the activities required to translate shared commitment at the top to shared screening, assessment, engagement, and retention policies, shared outcomes, and the integration of child welfare and treatment practices into the court process.

Committee membership should include representatives of the following, at a minimum:

- Administrators and mid-level managers from State and some county child welfare agencies;
- Administrators from the State substance abuse treatment service agency and directors of some substance abuse treatment provider agencies;
- Judicial officers, Office of Court Administration program administrators and attorneys for parents, children, and the social service agency;

- Representatives from a recognized Native American Tribe that provides child welfare services in the State; and
- Representatives of the families served by these systems, including individuals who received or are receiving services from the child welfare or substance abuse treatment systems.

Running a multidisciplinary Steering Committee requires skills that differ from those required to direct single-agency hierarchical workgroups. The chair/co-chairs must be able to facilitate a variety of perspectives without promoting their agency's over those of others, and should work to assure all members are heard. It is helpful if the Steering Committee is co-chaired by senior managers from the child welfare service, substance abuse treatment service, and court systems who will share responsibility for ensuring that the Committee functions effectively. If this approach is infeasible or unwieldy, consideration should be given to rotating the chair of the Steering Committee among the three systems. Regardless of the arrangement, it must be done in a coordinated fashion so that clear responsibility rests with the chair(s).

This Steering Committee will include members who do not have jurisdiction over each other, who report through separate hierarchies, and who most likely have different, sometimes non-parallel positions within their respective agencies. Decision-making by decree or majority rule will not work in these situations. Instead, consensus should be sought. To achieve this, some jurisdictions hire outside facilitators or the future FDC program coordinator to convene their Steering Committees. These facilitators are generally not considered to be chairs of the Committee and they are not authorized to make decisions that Committee members should make. If funds are available, using facilitators is a good strategy to avoid the perception that the initiative is being "run" by one agency. In addition, facilitators are trained in guiding multidisciplinary groups to make decisions.

There are three minimum requirements for establishing an effective Steering Committee:

Members must have authority to make decisions on behalf of their agencies. The Steering Committee should be able to reach conclusions and take actions without losing time and momentum while members return to their agencies for approval.

Members must have sufficient time to participate in meetings. The committee members must have time to attend meetings and to work on both collaboration building and the substantive issues involved in creating screening, assessment, retention, and engagement strategies. Attending meetings and completing related work between the meetings must be considered part of the members' work assignments. Specific members should be assigned from each entity to assure continuity over time.

An administrative staff person should be assigned to coordinate committee activities. Careful attention must be paid to the way Steering Committee meetings are arranged and conducted or members are likely to either stop attending or send substitutes who lack authority to make decisions.

The staff person should arrange logistics for the meetings, issue agendas, send reminder notices, track Committee milestones and deadlines, take minutes, and reproduce and disseminate meeting materials as necessary. Although freeing up or funding a dedicated staff person represents an investment from one of the agencies, this level of administrative support is a critical component in supporting the work of the Steering Committee and, ultimately, in building a successful collaborative team. Ideally, this investment would be shared among participating agencies if resources permit joint funding of this position.

It is possible that Steering Committee members have had frustrating experiences with multidisciplinary groups who they felt did not yield meaningful results. However, multidisciplinary groups work when members' time is respected, the discussions are engaging and being held at the appropriate policy level, multiple perspectives are sought, and decisions are made. Effective facilitators, whether an agency chairperson or outside facilitator, focus on specific tasks, achieve outcomes that committee members feel are important, guide the group in airing and resolving tensions professionally and create a sense of energy and excitement among members.

As noted earlier, multidisciplinary groups differ from traditional single-agency groups in important ways. Steering Committee members:

- Report to a multidisciplinary Oversight Committee and not solely to supervisors within their own agency;
- Are authorized to make decisions and commitments on behalf of their agency; and
- Cannot make FDC related decisions on their own, independent of the Steering Committee as a whole.

THE FAMILY DRUG COURT TEAM

The Family Drug Court Team is often referred to as the "Operational Team" or "Treatment Team" and is responsible for the day-to-day activities of the FDC. The Team is traditionally led by the drug court coordinator or program manager who organizes the collaborative work of the team. Each partnering organization is represented on the FDC Team as well as other public and community-based service providers. Most FDC Team members provide direct services to children, parents and families in the Family Drug Court, and in some cases a supervisor may have a role on the FDC to represent several director service providers. FDC Team members attend pre-court staffing sessions and court hearings, and share client-level progress information in a timely fashion. Because of its constant interaction with FDC families, the FDC Team is the first to identify challenges and the need for new resources, as well as policy and practice changes. For this reason, the FDC Team should develop a process for alerting the Steering Committee when resources or policy changes are needed and for providing recommendations based on the needs of the families in FDC.

APPENDIX C – FACILITATOR'S GUIDE

This Facilitator's Guide is an excerpt from "Screening and Assessment for Family Engagement, Retention and Recovery (SAFERR)." It was developed for collaboration in the broader Child Welfare and Substance Abuse treatment field, and it is included here to guide collaborative implementation efforts and as noted below to provide "suggestions, tools, and templates to help staff create, govern, and work within a collaborative structure." States and local jurisdictions are encouraged to use the templates as a framework for their own process.

Facilitator's Guide

As noted in the Introduction of this guidebook and of no surprise to anyone working in child welfare, alcohol and drug treatment, and dependency court systems, collaboration is not easy. Even when people sincerely want to collaborate, it is hard to share authority and accountability with people who come from different backgrounds, have different values, and work for different systems from our own. The previous sections of this guidebook recommend activities and approaches that may be quite different from those currently in use. Reading about and even endorsing these strategies will not make them happen. Creating change takes dedication, commitment, support, and perseverance.

This section provides suggestions, tools, and templates to help staff create, govern, and work within a collaborative structure. It is a close companion to Section I of this guidebook, in which a collaborative structure and activities are suggested. This section is specifically aimed at people responsible for chairing or facilitating Steering Committee or Subcommittee meetings. While every collaborative endeavor is unique, collaborative groups tend to go through similar processes and struggles. The material included here draws from insights gained from providing technical assistance to more than 40 States and countless local communities.

The SAFERR tools and materials were developed specifically for use by staff working in the child welfare, alcohol and drug, and court systems, but they are not specific to any particular State. Each jurisdiction should use the information included here in the way that best addresses its own priorities and concerns. Successful collaborative endeavors depend on the leadership, relationships, communication, and specific policy priorities of the group, not on the use of any particular tool. Some communities may adhere closely to the processes suggested in this section, and others may simply use some of the templates to help them in their own processes. In either case, this section is an attempt to provide staff with the benefit of prior efforts made by colleagues across the country.

Screening and assessment are just two components of a larger framework of collaboration. While these materials focus on those two components, communities should approach them in the context of a larger framework of collaboration that goes beyond screening and assessment to include engaging and retaining families in services and evaluating family and systems outcomes (Young & Gardner, 2002). A revised framework, included in the Appendix of Young and Gardner's document, can be found in "Framework and Policy Tools for Improving Linkages between Alcohol and Drug Services, Child Welfare Services and Dependency Courts" at *http://ncsacw.samhsa.gov*.

Step One: Getting Started

Establishing the Project

The Oversight Committee, composed of the top officials in each system, can give the initiative significant weight among their employees and in the larger community if, at the outset, they release a short notice and statement of support. This notice would be signed by all of them on letterhead stationery that includes all agency logos. The notice might include the names of Steering Committee members and a few facts about goals and timetables. The next page is a generic letter, adapted from one developed by staff in Colorado.

Sample Project Announcement Letter

LOGO (Court)	LOGO (Alcohol and Drug)	LOGO (Child Welfare)

Substance abuse and child maltreatment are two of our country's most pressing social problems, and they are elaborately interconnected. Nationally, in cases in which a child has been placed in custody, estimates of parental substance abuse range from 33 percent to 66 percent. Anecdotal evidence suggests that over 90 percent of dependency court cases involve children affected by substance abuse. *(State or county specific data can be added here)*

Despite these connections and the implications involved in removing children from their parents, child protective services workers, substance abuse counselors, and judges and lawyers often lack guidelines, protocols, and knowledge when making decisions about child placement, services to families, and termination of parental rights.

We understand that no employee and no agency can resolve problems of child maltreatment and substance use disorders1 on its own and that unless we work together to better serve families, none of us will succeed. (The term "substance use disorder (SUD)" is used in this paper as the more precise terminology indicating diagnostic criteria of the *Diagnostic and Statistical Manual (DSM)* of substance abuse or dependency. The term "alcohol and drugs" is used when referring to the broad general issue of substance use.) Therefore, we have jointly created a *State-* or *county- (specify)* wide initiative that will result in protocols for screening, assessing, engaging, and retaining families who have substance use disorders and who are involved with our child welfare and dependency court systems.

Overall guidance for this initiative is provided by the Steering Committee listed below. We have asked the Steering Committee to create relevant topic-specific Subcommittees and hope that many of you will participate on these subcommittees. We will serve as the Oversight Committee, and for purposes of this project, the Steering Committee will report to all of us regarding progress, problems, and results.

It is essential that the Steering Committee and Subcommittee processes be inclusive, open, and based on principles shared by all systems. It is equally essential that the results be both grounded in research and practical to implement.

This project represents an important and exciting opportunity for families and staff. We look forward to working together and thank you for your support and interest as we go forward.

_____	_____	_____
Court Administrator	**Alcohol and Drug Director**	**Child Welfare Director**

Steering Committee Members

Name	Affiliation and Contact Information

The Oversight Committee should issue written letters of appointment to each Steering Committee member. These letters give the project prominence within each system, provide support for Steering Committee members to spend the time required to participate in the project, and make it clear that the member has authority to make decisions on behalf of the agency.

Sample Project Announcement Letter

LOGO (Court)	LOGO (Alcohol and Drug)	LOGO (Child Welfare)

Dear

We are pleased to announce that (name of jurisdiction) is launching an initiative to help us better serve families with substance use disorders who are involved with child welfare and dependency courts. With this letter, we are appointing you to serve on the Steering Committee for this important project. The three of us collectively compose the Oversight Committee, and the Steering Committee reports to all of us.

We will meet with the Steering Committee at its first meeting and then quarterly thereafter. At our kickoff meeting, we plan to explore more deeply what each agency would like to achieve from this project, identify areas of common and diverging priorities, and develop one or more overarching goals that cross our three systems. We will also discuss more fully the authority, scope, and mandate of the Steering Committee.

By the end of the kickoff meeting, we plan to have identified areas of greatest interest and priority for action. We also will talk more fully about the Subcommittees that we know will be necessary to achieve the goals, and we will set a schedule of Steering Committee and Oversight Committee meetings for the next 12 months.

You will receive more information about the kickoff meeting in the coming days.

We are very excited about this project and look forward to working with you.
Thank you for agreeing to serve on the Steering Committee.

_____	_____	_____
Court Administrator	**Alcohol and Drug Director**	**Child Welfare Director**

Section I, "Building Cross-System Collaboration," lists the type and level of staff who should serve on the Steering Committee and specifies that they should be at a level to make decisions and commitments on behalf of their agencies. Each jurisdiction should add other perspectives to the Steering Committee as determined by local needs and structures.

Steering Committee Structure and Governance

Initiatives of the scope and importance described in this guidebook that address challenging issues warrant the use of a paid outside facilitator, at least in the beginning. While some members of the

Steering Committee will not know each other before coming together for this project, others will have had prior experiences, both positive and negative, with each other. It is asking a lot of senior managers to participate in
decisionmaking groups in which one of their colleagues is "in charge," even if only as a facilitator. It is also expecting a lot of a senior manager to ask him or her to facilitate a senior-level decisionmaking body while serving as a "voting" member of that body.

The Steering Committee facilitator need not be a full-time job. A skilled consultant who is familiar with the subject matter and State operations can be hired on an hourly or fixed-price basis. Ideally, the three systems should contribute to pay facilitator fees, thus modeling the collaboration they expect of staff. It is also quite possible that a local foundation would fund such a position if requested by the top officials from all three systems.

As noted in Section I, if hiring an outside facilitator is simply not possible, the Oversight and Steering Committees must find other ways to ensure members that they will be treated equally. Communicating to all Steering Committee members that the Steering Committee reports equally to the three Oversight Committee members can help reduce the perception that one agency is running the initiative. Or, the Steering Committee might be co-facilitated by representatives of all three systems. As a last alternative, people from each system could rotate as facilitators. This section uses the term "facilitator" to include internal staff or external consultants.

Using Internal Facilitators

If an internal facilitator is used, it is important for the facilitator and the Steering Committee to be aware of the person's multiple and potentially conflicting roles. The facilitator should tell the group at the outset that he or she is serving as a facilitator and not as a staff member or agency representative, and then must diligently maintain that distinction. The facilitator's job is to manage discussions without getting pulled in. If the facilitator absolutely needs to make a point as a staff or agency representative, he or she should make a statement to that effect, make the point, and then state that he or she is returning to the facilitator role. When the boundaries of these different roles are delineated and respected, others will be more inclined to trust and respect the boundaries as well. (Adapted from Arnie Arnoff, Director of Training and Organizational Development, The University of Chicago, May 2002.)

The Steering Committee will require the services of an administrative person to take minutes during meetings, follow up on decisions and commitments made during meetings, and distribute agendas or other reading material. It is impractical to ask the facilitator or Steering Committee member to perform these tasks.

The Steering Committee should consider using student interns. Graduate public policy or social work students often need field placements in order to complete their course requirements. These students frequently know how to conduct literature reviews and other research, and they are often skilled at preparing presentations or other public information brochures and fact sheets.

One important responsibility of the Steering Committee will be to create and oversee the activities of several Subcommittees that will work on one or a few specific issues related to screening and assessment. Subcommittee members should represent the frontline of practice in each system and come from local offices that are interested in pilot testing and implementing cross-system training strategies, screening or assessment protocols, or multidisciplinary teams that emerge from the project. Ideally, a

Steering Committee member should chair each Subcommittee, to ensure that information flows easily and accurately between the two groups.

Details of Steering Committee members' roles and responsibilities should be thoroughly explored and recorded during its first, kickoff meeting, described below. Initially, it is recommended that the Steering Committee meet monthly, especially if it will meet with the Oversight Committee quarterly. After plans of action have been developed and Subcommittees established, the Steering Committee could possibly meet less often.

Step Two: The Kickoff Meeting

If possible, the Steering Committee should start its work with a 2-day kickoff meeting, with the three members of the Oversight Committee attending for at least part of that time. This meeting should be held in a neutral location, to avoid the appearance that any system is leading the initiative and to reduce the likelihood that members will go back and forth to their offices. If a 2-day meeting is not feasible, the activities planned for that time can be accomplished over a series of meetings.

Outcomes of the Kickoff Meeting

By the end of the kickoff meeting, the following should be in place:

Substantively:

There should be a "wish list" describing the kinds of policies, protocols, training curricula, multidisciplinary teams, and other innovations that members would like to explore through this initiative. This list does not have to reflect consensus of the group, but there should be general agreement on highest priority areas.

Procedurally:

Members should understand their roles and responsibilities, meeting dates should be established for the next 12 months, and members should understand and support ground rules for meetings, discussions, and decisions.

The next two pages offer an annotated generic agenda for the kickoff meeting. This agenda covers all the important items that should be discussed at the first meeting. The page following the agenda provides more information and some exercises to help facilitators guide the discussion on some of the topics included on the agenda.

Sample Kickoff Meeting Agenda

Location and Time

Day One

8:45 – 9:45 Introductions

Participants will introduce themselves to the group, including descriptions of their backgrounds, what they and the organizations they represent hope to gain from this initiative, and what changes they would like to see for the families they serve.

9:45 – 11:00 Overview of the Project

The Oversight Committee, comprising the Court Administrator, and Directors of the Alcohol and Drug and Child Welfare Service2 systems, will describe why they established this initiative, what they expect from it, and what kind of guidance and direction they will provide to the Steering Committee. (The term "child welfare service system" includes public agencies operated by States, counties, and federally recognized Indian tribes as well as nonprofit or for-profit organizations operating under the auspices of those governments.) The Oversight Committee will present its view of roles and responsibilities of the Steering Committee and will hear suggestions and ideas from Steering Committee members.

11:00 – 11:15 Break

11:15 – 12:30 Presentations From Agencies, Tribes, and Consumers

Representatives from the three State systems, a county, a tribe, and consumers will present overviews of their agencies and systems. The presentations will describe agency missions, structures, and principal activities. In addition, the representatives will highlight particular "hot" issues facing their agencies, and will describe relationships their agencies have with each other, the State legislature, and universities.

12:30 – 1:30 Lunch

1:30 – 2:15 Presentations From Agencies, Tribes, and Consumers (cont'd)

2:15 – 3:15 Brainstorming
(including break)

Members will express their ideas and hopes for desired activities, products, and outcomes of the initiative. All ideas will be accepted and recorded. The result of this exercise will form the basis for project goals and tasks.

3:15 – 4:15 Steering Committee Ground Rules and Future Meetings

This session will establish meeting dates for the Steering Committee for the coming year. Meeting times will be established, and ground rules regarding attendance, communication, and decisionmaking processes will be discussed and agreed to. A process for creating and distributing minutes and background materials will be determined.

4:15 – 4:30 **Closing Comments**

Day Two

8:30 – 9:00 **Recap of Day One**

All participants will reflect on the prior day to clarify issues that may seem vague, to ask questions, or to raise additional issues that have occurred to them.

9:00 – 10:30 **Framing the Project**

Members will review the wish list that resulted from the brainstorming and explore key priorities, challenges, and additional tools or resources that might be required to achieve goals. The group will reach consensus on the issues of most importance, the ideal outcomes for those issues, and barriers to achieving the outcomes.

10:30 – 10:45 **Break**

10:45 – 12:00 **Exploration of Subcommittee Topics and Structures**

On the basis of results from the Brainstorming and Framing the Project discussions, the group will identify issues that are most likely to be addressed through the work of Subcommittees. It will determine Subcommittee structures, roles, and responsibilities, including Steering Committee responsibilities in guiding Subcommittees. Preliminary lists of possible Subcommittee members will be established.

12:00 – 1:00 **Lunch**

1:00 – 2:00 **Planning for Next Meeting/Meeting With Oversight Committee**

Members will develop agenda items for the next meeting, assign the lead person for each item, and determine background material required. (Agenda items/exercises are likely to include completing the Collaborative Values Inventory or completing the Understanding Our Systems Worksheet, both of which are described below and included in this *Facilitator's Guide*).

2:00 – 2:30 **Closing and Next Steps**

The Steering Committee will identify unresolved issues and develop strategies for addressing them.

Techniques for Guiding the Kickoff Meeting

Steering and Subcommittee procedures and ground rules are described in Section I. The following paragraphs address the substantive items that will be discussed during the kickoff meeting.

Introductions

Not all Steering Committee members will know one another, especially those Committees that have broad representation including consumers, family members, tribal members, and social service agencies. The facilitator should develop creative and enjoyable ways to have people introduce themselves or each other to the group.

Overview of the Project

The kickoff meeting is the first time the Steering Committee will be coming together, and it will be joined by the directors from all three systems. Some members are likely to be unsure of why they were asked to participate, uncertain of demands that might be placed on their time or resources, and unfamiliar with others on the Committee. The facilitator should work with members of the Oversight Committee before the meeting to help them present their vision and ideas, to concretely describe their goals and expectations, and to specify clearly their charge to the Steering Committee. In addition, the facilitator should ensure that the Oversight Committee is open to hearing ideas and suggestions from the Steering Committee.

Presentations From Agencies, Tribes, and Consumers

Not all Steering Committee members will be knowledgeable about each other's systems. Representatives from the three State systems, counties, tribes, and consumers should be asked in advance to present brief overviews of their agencies, systems, or experiences with agencies and systems. The facilitator should work with presenters before the meeting to be sure they prepare comments in advance and have visual or written information to accompany their comments. Presenters should consider this presentation to be an important and substantive one about their agency mission, structure, and activities.

Brainstorming

Brainstorming is helpful when a group is interested in generating a lot of ideas and when people need encouragement to speak out. The group can use ideas generated in a brainstorming session to choose the specific issues they want to develop into projects and plans of action. Brainstorming discussions are likely to raise questions about which families will be the focus of this initiative. The child welfare and alcohol and drug service systems are involved with a larger group of families than are the courts and will be interested in developing strategies that include both court-involved and non-court-involved families. Court staff will be more interested in focusing on families under court jurisdiction. The box below provides some guidelines regarding brainstorming sessions.

Rules of Brainstorming

1. Postpone and withhold judgment of ideas.
2. Encourage wild and exaggerated ideas.
3. Quantity, not feasibility, counts in brainstorming.
4. Build on the ideas put forward by others.
5. Every person and every idea has equal worth.

(Adapted from Infinite Innovations Ltd., c 1999–2001)

Methods of Brainstorming

Structured Go-Arounds
To be used when interested in hearing from everyone. Each person is given an opportunity to speak, usually within a time limit. Responses are saved until everyone has had a chance to contribute.

Gallery Method
Large sheets of paper, blackboards, or flip charts are used on which general themes or ideas are written. Participants then walk around the "gallery," read the ideas, and add their comments or thoughts. This method is good for people who prefer writing to speaking and for people who are visual learners.

Individual Writing
Group members are given a topic, task, idea, or free reins to write for a defined period of time, typically 15 minutes. This method is good for generating ideas, soliciting opinions, slowing down a heated discussion, or for unlocking a stalled discussion in which no one is participating.

(Adapted from Arnie Arnoff, Director of Training and Organizational Development, The University of Chicago, May 2002)

Framing the Project

The brainstorming session provides the opportunity for everyone to put thoughts on the list without having to explain or defend them. The outcome of the brainstorming session should yield a diverse and rich list of interests, issues, and concerns. The Framing the Project session allows members to think more deeply about these ideas, understand other points of view, and challenge assumptions and be challenged. From this discussion, the group should be able to group topics into general categories and to select a few categories that are the most important to address, even if there is not agreement on every item. This discussion also will help the Steering Committee envision topics for future meetings and for assignment to Subcommittees.

The next steps included in this section provide information about tasks and activities that the Steering Committee should undertake at subsequent meetings.

Step Three: Developing Shared Values, Principles, and a Mission Statement

Experience has repeatedly shown that the most critical first activity in creating an effective collaborative Steering Committee or other workgroup is holding open and honest discussions about values and

principles. These discussions are not focused on securing or forcing agreement on every value, but they should ultimately yield statements of mission, values, and principles that the group endorses and supports.

When people from the alcohol and drug system, child welfare system, dependency courts, tribes, consumers, and other agencies come together, they bring with them both overlapping and divergent values and philosophies. Systems, agencies, and workers have values that reflect their organizations and their professional training. For example, child welfare agencies are charged with ensuring child safety, alcohol and drug treatment agencies have deep concern for the adult's recovery from substance use, and the court is focused on establishing permanent living arrangements for children. These values are intense, deep seated, and long lasting.

Value differences cannot be ignored, and they will not always be reconciled. Unless differences are acknowledged and accepted, however, they will emerge repeatedly and frustrate efforts to make important changes. At the same time, when people acknowledge their differences and then move on to explore and reinforce their shared values, those values become the base on which significant progress can be made.

Developing Trust

At their most fundamental, collaborations are based on trust. Trust is both a prerequisite for and a product of collaborative activities. Trust is most often discussed in terms of relationships between families and workers, but in fact trust includes other important dimensions. For example, staff at all levels in each system must believe that staff in the other systems will respond appropriately to the needs of children and families and will both share their expertise with and seek help from people from other fields. In addition, staff within each system must trust that officials in their own system will give them the skills to do their jobs well and will support them in their work. This *Facilitator's Guide* includes a more detailed discussion regarding how leaders can address all of these dimensions of trust.

The first task of the Steering Committee will often be to create the level of trust required for systems to work together effectively. It is likely that the same trust issues that emerge during Steering Committee discussions also exist in local jurisdictions and at the frontline. To the extent that members of the Steering Committee create and sustain their own trust, they can communicate and model that trust within their own agencies and to their staff. As people develop trust in one area or around one issue, it will be easier for trust to develop in other areas as well. Trust will be an outcome of the work staff does to identify shared values, increase their understanding and knowledge about each other, participate in training together, and develop communication structures.

The table below, **Dimensions of Trust**, summarizes the many dimensions of trust that have to be addressed.

Dimensions of Trust	
Trust Dimension	**Examples**
Workers have to earn the trust of their clients.	Workers have to: • Refrain from passing judgment. • Be comfortable in their knowledge of program rules and services. • Be forthcoming and clear in presenting options and consequences. • Explain why they need to know certain information and what will happen with information provided. • Not turn over to such an extent that recipients feel no one knows them. • Respect recipients. • Believe that recipients have strengths and potential. • Hold confidential information in confidence and explain to families when and how information may be shared.
Agencies have to earn the trust of their clients.	Agencies have to: • Create forms, brochures, and letters that are user friendly. • Ensure that services exist to help recipients. • Develop written and visual material to help recipients learn about services. • Create the most private and pleasant waiting and interviewing areas possible. • Seek feedback from families regarding services and procedures. • Create policies that support recipients in disclosing problems.
Workers have to trust their skills and capacities.	Workers need opportunities to: • Learn about addiction, child maltreatment, and legal processes. • Identify and explore their personal beliefs and values about addiction and child maltreatment. • Visit substance abuse treatment programs. • Work collaboratively with staff from treatment programs in making shared decisions about services and progress. • Achieve and be recognized for their achievements.
Agencies have to earn the trust of their staff.	Workers need to feel confident that: • If recipients seek help, the agency has resources to provide that help. • They will have ample opportunity for training that includes both conceptual and practical elements, and that they can practice and problem-solve what they have learned. • Their judgment, perspective, and autonomy are respected and valued by supervisors and managers. • The agency has employee assistance plans or other mechanisms for staff who have substance abuse problems themselves or within their families. • They have opportunities for growth.

Task 1: Complete the Collaborative Values Inventory and the Collaborative Capacity Instrument

Children and Family Futures staff have been providing technical assistance to collaborative efforts in States and local jurisdictions for the past decade. This work led them to develop the *Collaborative Values Inventory (CVI)*, a self-administered questionnaire that provides jurisdictions with an anonymous way of assessing the extent to which group members share ideas about the values that underlie their collaborative efforts. (The CVI is included at the end of this section and is available at *www.ncsacw.samhsa.gov*.) The CVI is simple and short, but it identifies areas of commonality and difference that are easily overlooked either because people feel uncomfortable discussing values or because they move directly to program and operational issues.

When disagreements arise, it is easy for people to feel that others are merely protecting turf, playing politics, or unaware or unsympathetic to a need. If a group explores values and beliefs, however, and learns that members feel differently about some basic assumptions that affect community needs and responses, it has a better grasp of why disagreements arise. The group also can respond more professionally and appropriately during such disagreements. For example, value discussions frequently lead to the realization that systems have different beliefs on something so basic as "who is the client." The alcohol and drug system has traditionally viewed parents as clients, and the child welfare system has considered the child to be the client. If this difference is aired and discussed, generally staff from both systems conclude that everyone serves the *family*, even though each may focus on specific aspects of family functioning.

The *Collaborative Capacity Instrument* (CCI) is also a self-administered questionnaire that provides people with information on how well members of their group perceive that systems collaborate and on areas in which members believe that collaboration is either strong or weak. The CCI is also included at the end of this section and can be obtained through *www.ncsacw.samhsa.gov*.

Task 2: Create a Mission Statement and a Statement of Values and Principles

By the end of the Steering Committee kickoff meeting, Committee members will have reached general agreement on issues that are the most important or interesting. After completing and discussing the *CVI* and *CCI*, the group will have a good feel for those values members share and are important to everyone.

The next task for the Steering Committee is to translate that agreement and knowledge into a simple, preferably one-page document that includes a mission statement for the initiative and a list of principles and values that will guide the group in its work. The principles should be specific enough to guide decisionmaking.

The box below provides an example of a mission statement and shared values and principles. The values and principles relate to the practice questions posed in Section III of this guidebook, "Collaborative Practice at the Frontline." Section I of this guidebook includes a list of principles that have been developed in some jurisdictions, and the end of this section includes values and principles developed by the Sacramento County Dependency Drug Court and Cuyahoga County, Ohio. It also includes a statement of values and principles developed jointly by the American Academy of Child and Adolescent Psychiatry (AACAP) and the Child Welfare League of America (CWLA).

Mission Statement

To improve screening and assessment for families involved in the child welfare service system and dependency courts who are affected by substance use disorders.

Shared Values and Principles

Determining the existence and immediacy of a child welfare or substance use issue

- In making decisions regarding child safety and family well-being, practitioners from all systems should consider the possibility of substance use disorders and adopt a "screen out" stance with regard to substance use.
- Regardless of which system (alcohol and drug, child welfare, or dependency court) the family enters and what the presenting problem is, practitioners should systematically inquire about potential involvement with the other systems.

Determining the nature and extent of a child welfare or substance use issue

- Team members' effective communication is more critical than the specific tool in determining the relationship between substance use and child safety or risk.
- Sharing information appropriately is desirable, helpful, and feasible.
- To make appropriate referrals for assessment, people from all systems should understand the range of funding streams that are available and should know how to access them.

Developing treatment and family case plans, monitoring change, transitions, and outcomes.

- Case plans can and should be modified as circumstances change.
- Actions should have consequences that are fair, timely, and appropriate to the action.
- Consequences should apply to families and to staff; consequences should not be used solely as punishments.
- Family progress should be recognized, noted, and shared with family members.

Step Four: Review Current Operations

Steering Committee members will by now have at least a passing knowledge of each other's systems, but it is unlikely that they will have enough knowledge on which to make decisions about policy and practice changes. Therefore, it is important for the members to develop a deeper level of understanding about each system and where systems connect.

Task 1: Define Terms and Processes

Section I features the **SAFERR Terms and Processes in the Child Welfare Service, Alcohol and Drug Service, and Dependency Court Systems** table that provides short definitions and descriptions of processes within all three systems at several points in time during the period they are working with families. The Steering Committee should charge a Subcommittee with using this chart to define, review, and describe each process as it exists in the State or jurisdiction. Experience has shown that this task

includes many "eye opening" moments during which people realize that they have been unaware of or misunderstood other agencies' processes.

At the end of this task, members should understand how other systems operate and how different systems define similar processes in different ways. Most important, the Steering Committee should address differences in language or inconsistencies in processes to develop common terms and descriptions. In addition to setting the stage for changes in policies and practice, creating a uniform set of terms and processes provides a good basis for creating or revising training curricula that can be used with staff in all systems.

Task 2: Complete Worksheet 1: Understanding Our Systems

The outcome of the analysis undertaken in Task 1 can be used to complete Worksheet 1: Understanding Our Systems. A sample completed Worksheet 1 follows on the next page. This worksheet provides the Steering Committee with a short summary of the current situation and concerns about current practice that need to be addressed. Information from this worksheet will be useful in creating the plan of action for the project.

	WORKSHEET 1—UNDERSTANDING OUR SYSTEMS *SAMPLE*		
	Where Are We Now?		**Issues with Current Policy/Practice**
PRESENCE AND IMMEDIACY	**How is a substance use disorder identified in the CWS system?**		
	When	Whenever CWS professional identifies it as an issue	CWS professionals often do not have adequate training in identifying and screening for alcohol and drug issues No standard for screening families Over-referral by some CWS professionals and under-referral by other professionals; based on individual knowledge of SUDs Release of information form and history are not always being sent to the provider When CWS professional refers to the ADS treatment provider there may be a lack of follow up; individuals not making it to treatment and no one is going after them to try and engage them
	Where	Wherever the CWS professional is with the family (e.g. CWS office or home visit)	
	By Whom	CWS professional	
	How is this communicated to the other systems?	CWS professional makes referral to ADS treatment provider with signed release of information form and history Inclusion in court report for court-involved families	

How is risk of child abuse or neglect identified in the ADS system?		
When	If an incident arises where a provider needs to report child abuse and neglect	Throughout a State, there is no structured way of identifying child abuse and neglect issues; agencies have their own training programs and ways of identifying (or not) children's issues No structured training on mandated reporting laws; no information given when the law changes
Where	ADS program	
By Whom	ADS professional	
How is this communicated to the other systems?	Through the CWS hotline	
How is a SUD identified in the dependency court?		Case specific; no systemic policy/procedure around CWS informing court of alcohol and drug issue Issue of judges' misunderstanding or having a lack of knowledge around alcohol and drug issues; when and what type of testing is appropriate; same problem with attorneys and other judicial staff
When	At the time of petition filing	
Where	Court	
By Whom	Attorney for CWS presents evidence that includes information from the CWS professional	
How is this communicated to the other systems?	Through the court report	

Task 3: Complete Worksheet 2: Where Do We Want To Go From Here?

Worksheet 2 continues the process started with Worksheet 1. Once people understand and agree on how systems currently operate, how information is or is not communicated, and what concerns exist with current policies and practices, they can begin to identify specific changes they want to make. Worksheet 2 is designed to help the Subcommittees, Steering Committee, and others think generally about the changes to be made in the areas of Determining the Presence and Immediacy of a Child Welfare or Alcohol and Drug Issue, Determining the Nature and Extent of the Issue, and Developing and Monitoring Treatment and Case Plans.

As the Steering Committee gets ready to consider and propose changes, it is helpful for members to review the statements of their mission, principles, and values that they developed, to be sure they continue to be the framework that guides decisions and activities.

Using Worksheet 2, Subcommittee or Steering Committee members should—

- Revisit the list of concerns with current problems included in Worksheet 1;
- Identify the desired goals and outcomes for each issue or concern;
- Consider implications of the desired changes; and
- Start to develop action steps.

At this stage, the analysis should address general implications and action steps and not become distracted by the many details that will arise when implementation starts. The plan of action, described below, will address all facets of implementation.

A sample of a completed Worksheet 2 follows this page.

	WORKSHEET 2—WHERE DO WE WANT TO GO FROM HERE? *SAMPLE*											
	Identified Issues with Current Policies and Practice		**Desired Changes**	**Implications of Changes**							**Action Steps**
	What issues did we raise in the working session using Worksheet 1 regarding current policies and practice?		**As a collaborative, where do we want to be? What do we want our SAFERR policies/practices to be?**	**Family Involvement**	**Community Partners**	**Training/ Staff Development**	**Information Systems**	**Budget/Funding**	**Agency Policies**	**Legislation**	**How does the collaborative get to where it wants to be? What tasks do collaborative members need to complete to get us there?**
Presence And Immediacy	**Alcohol and Drug Services System**	Statewide there is no structured way of identifying children's issues; agencies have their own training programs and ways of identifying (or not) children's issues No structured training on mandated reporting laws; no information given when the law changes	Statewide guidelines for ADS providers to ask questions about participants' children; training for ADS providers on guidelines Online resource guide on services for children from families with SUDs Protocols for information sharing with CWS and the court		X	X	X	X	X		• Develop guidelines and training curriculum • Develop online resource guide • Develop protocols for information sharing among ADS, CWS and the court

	WORKSHEET 2—WHERE DO WE WANT TO GO FROM HERE? *SAMPLE*										
	Identified Issues with Current Policies and Practice		**Desired Changes**	**Implications of Changes**							**Action Steps**
	What issues did we raise in the working session using Worksheet 1 regarding current policies and practice?		**As a collaborative, where do we want to be? What do we want our SAFERR policies/practices to be?**	**Family Involvement**	**Community Partners**	**Training/ Staff Development**	**Information Systems**	**Budget/Funding**	**Agency Policies**	**Legislation**	**How does the collaborative get to where it wants to be? What tasks do collaborative members need to complete to get us there?**
	Child Welfare Services System	CWS workers do not have adequate training in identifying and screening for alcohol and drug issues No standard for screening families Over referral by some CWS workers and under referral by other workers; based on individual knowledge of SUDs Release of information form and history are not always being sent to the provider When CWS worker refers to the ADS treatment provider, there is no follow up; individuals are not making it to treatment and no one is going after them to	Trained CWS staff in identifying and screening for alcohol and drug issues; pilot colocation of ADS worker in CWS office Screen Out policy; all families to be screened for alcohol and drug issues using a standard screening tool Standard screening tool used by all publicly funded treatment providers in the State Protocols for information sharing with ADS and the court Policy and procedure guidelines about follow up on referrals		X	X	X	X	X		• Develop guidelines and training curriculum • Conduct meeting with CWS and ADS administrators to determine where colocation pilot should take place; set up colocation pilot • Develop a Screen Out policy • Conduct research and select the screening tool to be used statewide • Develop referral followup guidelines • Develop protocols for information sharing among ADS, CWS and the court

	WORKSHEET 2—WHERE DO WE WANT TO GO FROM HERE? *SAMPLE*											
	Identified Issues with Current Policies and Practice		**Desired Changes**	**Implications of Changes**							**Action Steps**
	What issues did we raise in the working session using Worksheet 1 regarding current policies and practice?		**As a collaborative, where do we want to be? What do we want our SAFERR policies/practices to be?**	**Family Involvement**	**Community Partners**	**Training/ Staff Development**	**Information Systems**	**Budget/Funding**	**Agency Policies**	**Legislation**	**How does the collaborative get to where it wants to be? What tasks do collaborative members need to complete to get us there?**
	Dependency Court	Case specific; no systemic policy/procedure around CWS informing court of alcohol and drug issue Issue of judges misunderstanding or having a lack of knowledge around alcohol and drug issues; when and what type of testing is appropriate; same problem with attorneys and other judicial staff	Trained judges, attorneys and other judicial staff on alcohol and drug issues and issues of children from families with SUDs Standards for inquiry by judges into whether or not families have been screened for SUDs and issues specific to children from families with SUDs; require screens when they have not been conducted		X	X	X	X	X		• Develop training for judges, attorneys, and other judicial staff • Develop standards of inquiry and court ordering of screens for families

Step Five: Develop and Implement a Plan of Action

By now, the Steering Committee has worked through a brainstorm list of all possible ideas and strategies, developed a set of values and principles to guide its work, identified current systems and operations and the problems with the current situation, and developed a list of desired changes. These changes should now be incorporated into a plan of action that focuses on implementation details, specific action steps, tasks, and timelines.

Task 1: Develop a "Visual" of Team Progress to Date

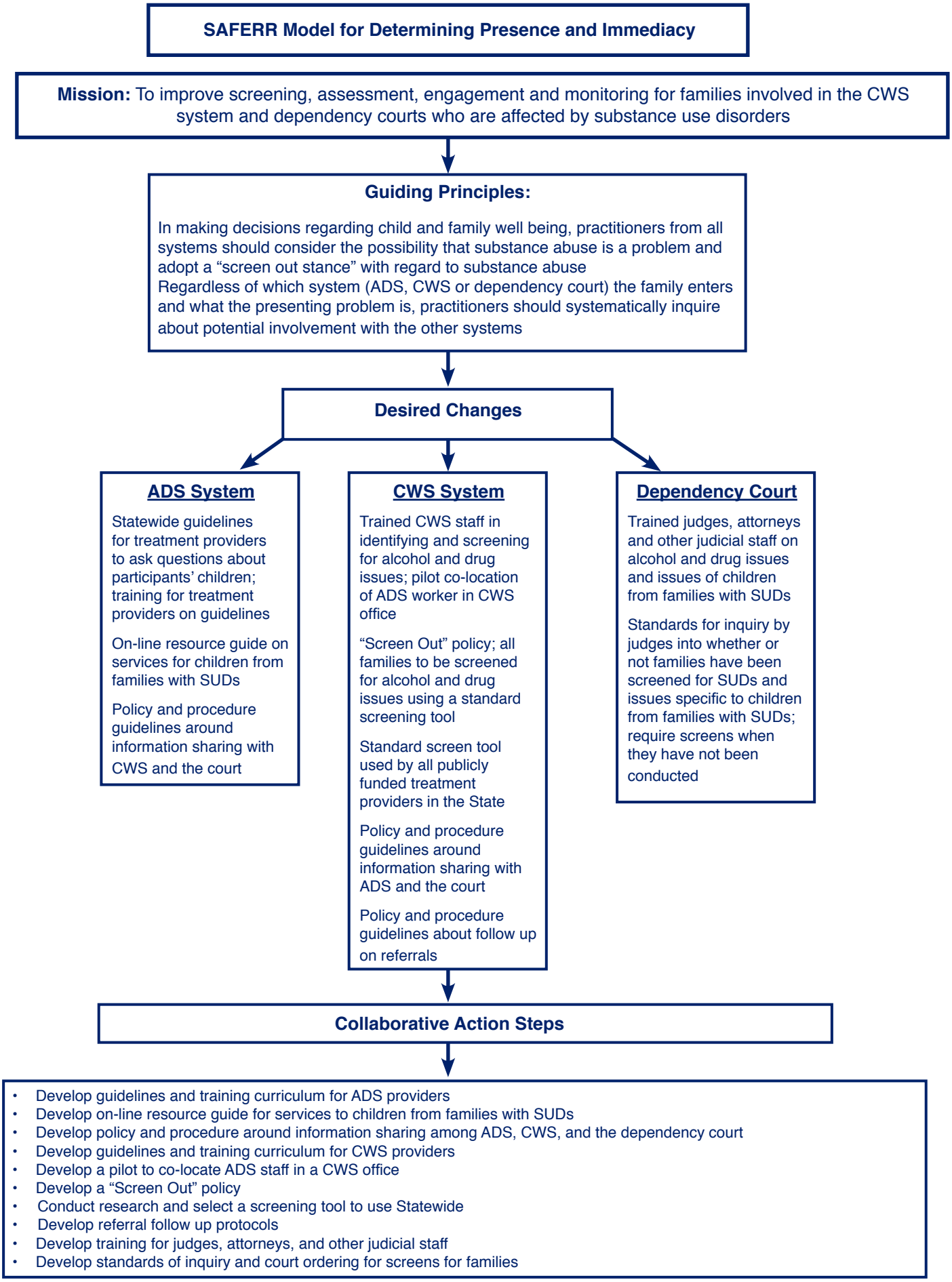
The visual representation of work done in preparation for the plan of action can be used as the first page in the plan and will remind everyone involved of the project's mission, principles, and priorities. It is also a simple, clear record of work accomplished. A sample visual representation follows this page.

Task 2: Develop the Products and Action Steps for the Plan of Action

The plan of action is an extremely important written product of the initiative. It becomes the roadmap or blueprint for the Oversight and Steering Committees and Subcommittees. It serves as the standard against which work of all three groups will be monitored and evaluated. The plan of action should clearly specify the following:

- Major activities to be undertaken;
- Products to be developed;
- Tasks required to complete activities and produce products;
- System and individuals responsible for completing each task; and
- Timelines for completion.

A hypothetical plan of action, **ADS, CWS, and Dependency Court SAFERR Collaborative Plan of Action: Determining Presence and Immediacy**, based on the information included in sample Worksheets 1 and 2, follows the visual representation. Please note that this example is not necessarily a complete or accurate plan for the activities noted. Each Steering Committee or Subcommittee should define its own action steps, tasks, and timelines. The sample is simply an illustration of the concept of a detailed plan of action.


SAFERR Model for Determining Presence and Immediacy
Mission: To improve screening, assessment, engagement and monitoring for families involved in the CWS system and dependency courts who are affected by substance use disorders
Guiding Principles:
In making decisions regarding child and family well being, practitioners from all systems should consider the possibility that substance abuse is a problem and adopt a "screen out stance" with regard to substance abuse
Regardless of which system (ADS, CWS or dependency court) the family enters and what the presenting problem is, practitioners should systematically inquire about potential involvement with the other systems
Desired Changes
ADS System
Statewide guidelines for treatment providers to ask questions about participants' children; training for treatment providers on guidelines
On-line resource guide on services for children from families with SUDs
Policy and procedure guidelines around information sharing with CWS and the court
CWS System
Trained CWS staff in identifying and screening for alcohol and drug issues; pilot co-location of ADS worker in CWS office
"Screen Out" policy; all families to be screened for alcohol and drug issues using a standard screening tool
Standard screen tool used by all publicly funded treatment providers in the State
Policy and procedure guidelines around information sharing with ADS and the court
Policy and procedure guidelines about follow up on referrals
Dependency Court
Trained judges, attorneys and other judicial staff on alcohol and drug issues and issues of children from families with SUDs
Standards for inquiry by judges into whether or not families have been screened for SUDs and issues specific to children from families with SUDs; require screens when they have not been conducted
Collaborative Action Steps
• Develop guidelines and training curriculum for ADS providers
• Develop on-line resource guide for services to children from families with SUDs
• Develop policy and procedure around information sharing among ADS, CWS, and the dependency court
• Develop guidelines and training curriculum for CWS providers
• Develop a pilot to co-locate ADS staff in a CWS office
• Develop a "Screen Out" policy
• Conduct research and select a screening tool to use Statewide
• Develop referral follow up protocols
• Develop training for judges, attorneys, and other judicial staff
• Develop standards of inquiry and court ordering for screens for families

ADS, CWS and Dependency Court SAFERR Collaborative Plan of Action Determining Presence and Immediacy *SAMPLE*			
Goals	**Action Steps/Tasks**	**System/Individuals Responsible**	**Timeline for Completion**
Goal 1—Develop statewide guidelines for ADS providers to ask questions about children	1.1 Convene workgroup on statewide guidelines and training for ADS providers	Representatives of ADS, CWS, dependency court, and any other agencies as deemed appropriate	10/10/06
	Research guidelines from other jurisdictions		12/16/05
	Draft guidelines		1/16/07
	1.2 Steering Committee to review guidelines	Steering Committee	1/30/07
	1.3 Workgroup to edit guidelines based on Steering Committee feedback	Workgroup	2/13/07
	1.4 Elicit input from CWS and ADS providers	Workgroup	3/10/07
	1.5 Workgroup to edit guidelines based on provider input	Workgroup	3/24/07
	1.6 Steering Committee to approve guidelines	Steering Committee	3/31/07
	1.7 Implement guidelines	Administrators and staff of ADS providers	On-going
Goal 2—Implement Training for ADS providers on statewide guidelines	2.1 Convene workgroup on guidelines and training for ADS providers	Representatives of ADS, CWS, dependency court and any other agencies as deemed appropriate	10/10/06
	Research training curriculum		12/16/06
	Select or draft curriculum		1/16/06
	Draft training plan		1/16/07
	2.2 Steering Committee to review training curriculum and plan	Steering Committee	1/30/07
	2.3 Workgroup to edit curriculum and plan based on Steering Committee feedback	Workgroup	2/13/07
	2.4 Elicit input from CWS and ADS providers	Workgroup	3/10/07
	2.5 Workgroup to edit training curriculum and plan based on provider input	Workgroup	3/24/07
	2.6 Steering Committee to approve training curriculum and plan	Steering Committee	3/31/06
	2.7 Train ADS providers	Identified Trainers	On-going

Goal 3—Develop online resource guide on services for children from families with SUDs	3.1 Convene workgroup to develop online resource guide	Representatives of ADS, CWS, dependency court, and any other agencies as deemed appropriate	10/10/06
	Conduct research on local, State and national resources		12/16/06
	Identify Web location for resource guide		12/16/06
	Identify Webmaster		12/16/06
	Draft resource guide		1/16/07
	3.2 Steering Committee to review resource guide	Steering Committee	1/30/07
	3.3 Workgroup to make edits/additions based on Steering Committee feedback	Workgroup	2/13/07
	3.4 Create online format	Webmaster	2/28/07
	3.5 Post online resource guide	Webmaster	2/28/07
Goal 4—Establish protocols for information sharing among ADS, CWS, and the dependency court	4.1 Convene workgroup to develop guidelines for information sharing	Representatives of ADS, CWS, dependency court, and any other agencies deemed appropriate	10/10/06
	Review current practice of information sharing		12/16/06
	Review current information management systems		12/16/06
	Draft protocols for information sharing		2/21/07
	4.2 Steering Committee to review and approve protocol	Steering Committee	2/28/07
	4.3 Implement protocol	Administrators and staff of ADS, CWS, and dependency court	On-going
Goal 5—Implement training for CWS Workers in identifying and screening for SUDs	5.1 Convene workgroup on training for CWS workers and development of colocation pilot	Representatives of ADS, CWS, dependency court, and any other agencies as deemed appropriate	10/10/06
	Research training curriculum		12/16/06
	Select or draft curriculum		1/16/07
	Draft training plan		1/16/07
	5.2 Steering Committee to review training curriculum and plan	Steering Committee	1/30/07
	5.3 Workgroup to edit curriculum and plan based on Steering Committee feedback	Workgroup	2/13/07
	5.4 Elicit input from CWS and ADS providers	Workgroup	3/10/07
	5.5 Workgroup to edit training curriculum and plan based on provider input	Workgroup	3/24/07
	5.6 Steering Committee to approve training curriculum and plan	Steering Committee	3/31/07
	5.7 Train CWS workers	Identified Trainers	On-going

Goal 6—Pilot colocation of ADS Workers in a CWS Office	6.1 Convene workgroup on Training for CWS workers and development of colocation pilot	Representatives of ADS, CWS, dependency court, and any other agencies deemed appropriate	10/10/06
	Research colocation models in other jurisdictions		1/20/07
	Explore interest among CWS offices		4/28/07
	Develop policies and procedures for pilot		4/28/07
	6.2 Steering Committee to review plan for pilot	Steering Committee	5/19/07
	6.3 Steering Committee to select CWS office for pilot	Steering Committee	5/19/07
	6.4 Final touches to plan for pilot	Workgroup	5/26/07
	6.5 Implement pilot	CWS and ADS administrators and staff	6/1/07
	6.6 Review success of pilot to date	Steering Committee	12/15/07
	6.7 Review success of pilot and determine whether going to scale with colocation	Steering Committee	5/31/08
Goal 7—Create a Screen Out Policy Statement	7.1 Convene workgroup to develop Screen Out Policy and develop/select standard screening tool	Representatives of ADS, CWS, dependency court, and any other agencies deemed appropriate	10/10/06
	Research policies in other jurisdictions		1/30/07
	Draft Screen Out policy statement		2/21/07
	7.2 Steering Committee to review Screen Out policy	Steering Committee	2/28/07
	7.3 Workgroup to edit policy based on Steering Committee feedback	Workgroup	3/24/07
	7.4 Steering Committee to approve policy	Steering Committee	3/31/07
	7.5 Implement policy	CWS administrators and staff	On-going

Goal 8—Implement Use of a Standard SUD screening tool by CWS Workers	8.1 Convene workgroup to develop Screen Out Policy and develop/select standard screening tool	Representatives of ADS, CWS, dependency court, and any other agencies deemed appropriate	10/10/06
	Research screening tools		1/30/07
	Select existing tool to use or draft new tool		2/21/07
	8.2 Steering Committee to review screening tool	Steering Committee	2/28/07
	8.3 Workgroup to edit screening tool based on Steering Committee feedback	Workgroup	3/24/07
	8.4 Elicit input from CWS and ADS providers	Workgroup	4/21/07
	8.5 Workgroup to edit screening tool based on provider input	Workgroup	5/5/07
	8.6 Steering Committee to approve screening tool	Steering Committee	5/19/07
	8.7 Implement use of tool	CWS administrators and staff	On-going
Goal 9—Establish guidelines for referral followup	9.1 Convene workgroup to develop guidelines for referral followup	Representatives of ADS, CWS, dependency court, and any other agencies deemed appropriate	10/10/06
	Develop plan for referral followup		2/21/07
	9.2 Steering Committee to review and approve guidelines for referral followup	Steering Committee	2/28/07
	9.3 Implement guidelines for referral followup	Administrators and staff	On-going
Goal 10—Implement training for judges, attorneys and Other judicial staff on SUDs and children's issues	10.1 Convene workgroup to develop training and standards for judges, attorneys, and other judicial staff	Representatives of ADS, CWS, dependency court, and any other agencies deemed appropriate	10/10/06
	Research judicial training in other jurisdictions		1/20/07
	Conduct meeting with the Office of the Court Administrator and the State Bar Association to establish their buy in		1/27/2006
	Select or draft curriculum		4/28/07
	Draft training plan		4/28/07
	10.2 Steering Committee to review training curriculum and plan	Steering Committee	5/19/07
	10.3 Workgroup to edit curriculum and plan based on Steering Committee feedback	Workgroup	6/2/07
	10.4 Elicit input from the Office of the Court Administrator and the State Bar Association	Workgroup	6/30/07
	10.5 Workgroup to edit standards based on input from the Office of the Court Administrator and the State Bar Association	Workgroup	7/14/07
	10.6 Steering Committee to approve training curriculum	Steering Committee	7/21/07
	10.7 Train judges, attorneys, and other judicial staff	Identified Trainers	On-going

Goal 11—Implement Standards for inquiry by judges into screening for families	11.1 Convene workgroup to develop training and standards for judges, attorneys, and other judicial staff	Representatives of ADS, CWS, dependency court, and any other agencies deemed appropriate	10/10/06
	Research standards in other jurisdictions		1/20/07
	Conduct meeting with the Office of the Court Administrator and the State Bar Association to establish their buy in		1/27/07
	Select or draft standards		4/28/07
	11.2 Steering Committee to review standards	Steering Committee	5/19/07
	11.3 Workgroup to edit standards based on Steering Committee feedback	Workgroup	6/2/07
	11.4 Elicit input from the Office of the Court Administrator and the State Bar Association	Workgroup	6/30/07
	11.5 Workgroup to edit standards based on input from the Office of the Court Administrator and the State Bar Association	Workgroup	7/14/07
	11.6 Steering Committee to approve training curriculum	Steering Committee	7/21/07
	11.7 Train judges, attorneys, and other judicial staff	Identified Trainers	On-going
Goal 12—Implement standards for judges to order screenings when they have not taken place	12.1 Convene workgroup to develop training and standards for judges, attorneys, and other judicial staff	Representatives of ADS, CWS, dependency court, and any other agencies deemed appropriate	10/15/06
	Research standards in other jurisdictions		1/20/07
	Conduct meeting with the Office of the Court Administrator and the State Bar Association to establish their buy in		1/27/07
	Select or draft standards		4/28/07
	12.2 Steering Committee to review standards	Steering Committee	5/19/07
	12.3 Workgroup to edit standards based on Steering Committee feedback	Workgroup	6/2/07
	12.4 Elicit input from the Office of the Court Administrator and the State Bar Association	Workgroup	6/30/07
	12.5 Workgroup to edit standards based on input from the Office of the Court Administrator and the State Bar Association	Workgroup	7/14/07
	12.6 Steering Committee to approve training curriculum	Steering Committee	7/21/07
	12.7 Train judges, attorneys, and other judicial staff	Identified Trainers	On-going

Task 3: Develop a Communication Protocol

Systems interact with each other constantly and through a variety of mechanisms. Nonetheless, communication breakdowns, misunderstandings, and gaps are common experiences for agency staff and families alike. Effective communication is the ingredient common to values, principles, trust, and action. As noted throughout this guidebook, the key to quality services is not the tools that are used, but how information from tools and other sources is shared. The clearest test of interagency consensus is whether it works to communicate the status of both parents and their children because both are affected by abuse, neglect, and substance use disorders. Steering Committee and Subcommittee members need to identify key points in all systems where effective communication can and must take place, and they need to develop clear administrative policies and protocols for the proper exchange of confidential information.

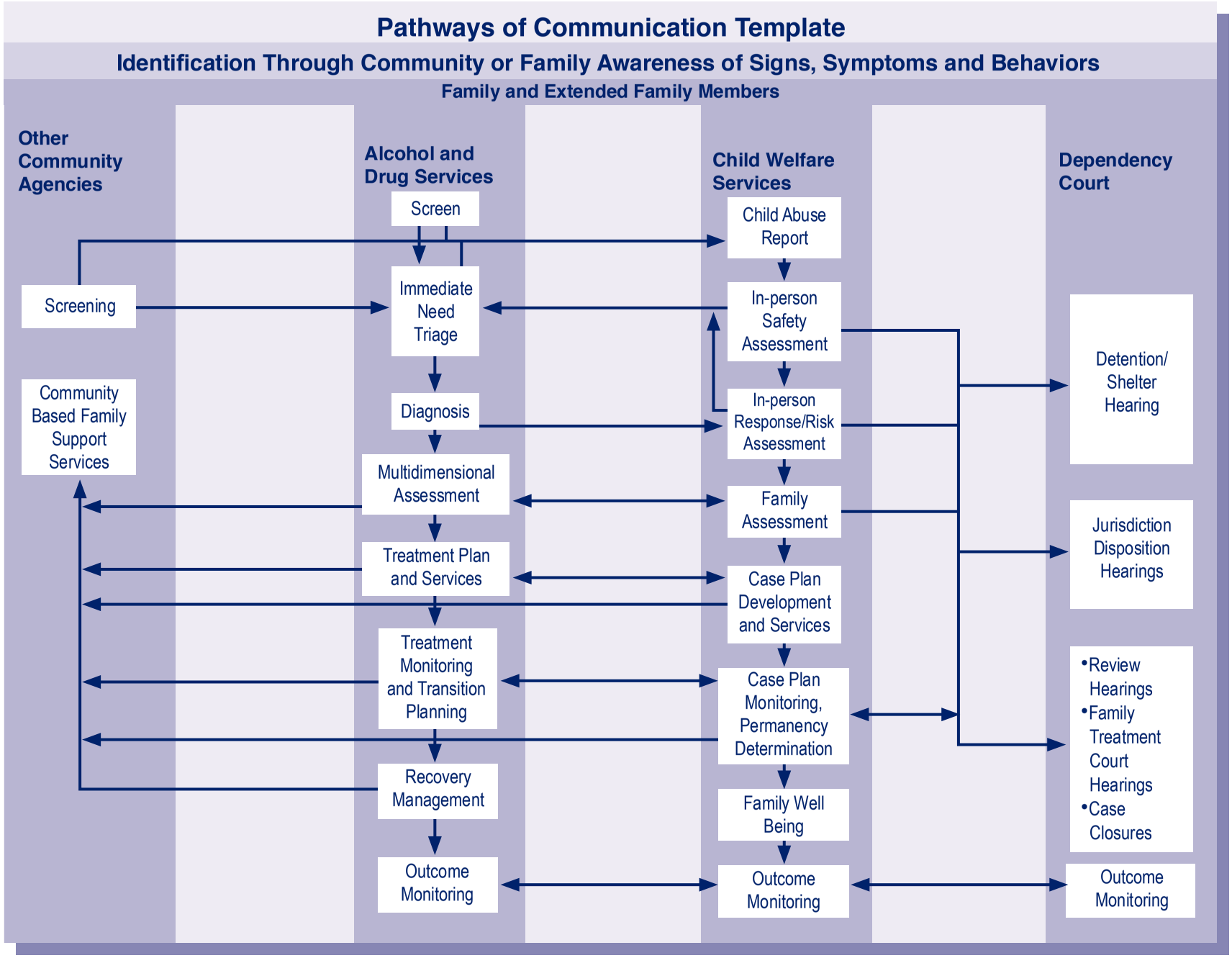
The **Pathways of Communication Templates** on the following pages are designed to help staff move beyond preliminary discussions about communication and toward developing a communication protocol. They are intended to be suggestions, and each community will need to adapt the specific information to its own systems and procedures.

The page immediately following this page is the Overview template. It proposes a model for communication across the systems as a whole. The subsequent three pages provide breakout versions of the Overview template, depicting critical junctures of decisionmaking and detailed information that are examples of information that may be needed to be communicated across systems. They are **Pathways of Communication Templates for Determining Presence and Immediacy of an Issue, for Determining the Nature and Extent of the Issue, and for Treatment and Case Plans, Monitoring Change, Transitions, and Outcomes**.

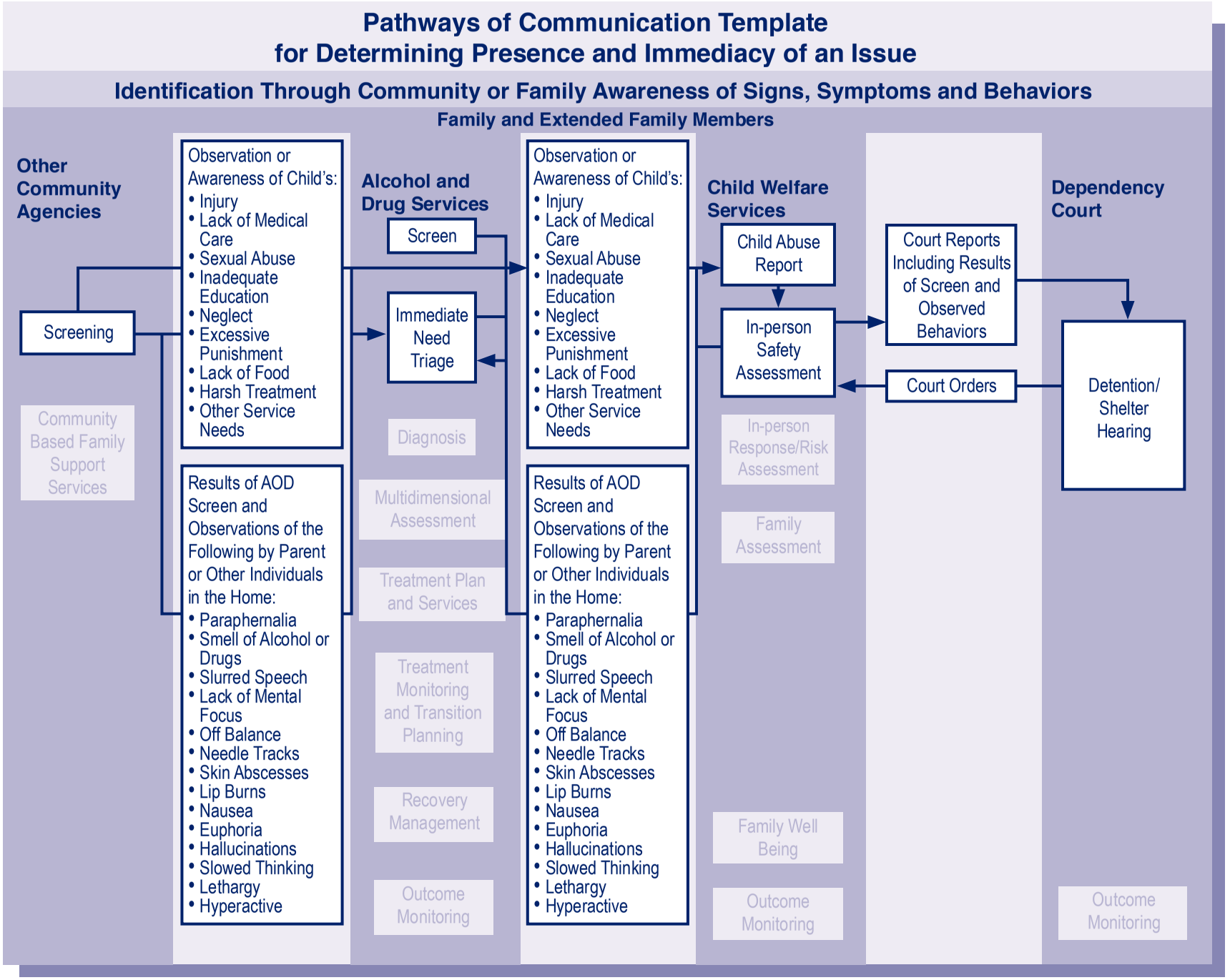
The activities that occur within system are listed in the darker colored columns. The bridges between the systems are represented by the three lighter colored columns.

The Subcommittee or Steering Committee should consider each of these communication points and should adapt them to meet State or local needs. The templates provide a mechanism for staff to understand what activities each system is responsible for undertaking. Once these activities are understood, staff can determine who needs to know what, and when. Staff can then create policies and protocols to share information with family members and among staff.

The goal of communication should derive from serving the whole family and should reduce administrative burden on workers. Each of the communication bridges should be clearly defined, and the content of the information to be exchanged across bridges must be specified.


Pathways of Communication Template
Identification Through Community or Family Awareness of Signs, Symptoms and Behaviors
Family and Extended Family Members
Other Community Agencies
Alcohol and Drug Services
Child Welfare Services
Dependency Court
Screen
Child Abuse Report
Screening
Immediate Need Triage
In-person Safety Assessment
Detention/ Shelter Hearing
Community Based Family Support Services
Diagnosis
In-person Response/Risk Assessment
Multidimensional Assessment
Family Assessment
Jurisdiction Disposition Hearings
Treatment Plan and Services
Case Plan Development and Services
Treatment Monitoring and Transition Planning
Case Plan Monitoring, Permanency Determination
•Review Hearings
•Family Treatment Court Hearings
•Case Closures
Recovery Management
Family Well Being
Outcome Monitoring
Outcome Monitoring
Outcome Monitoring

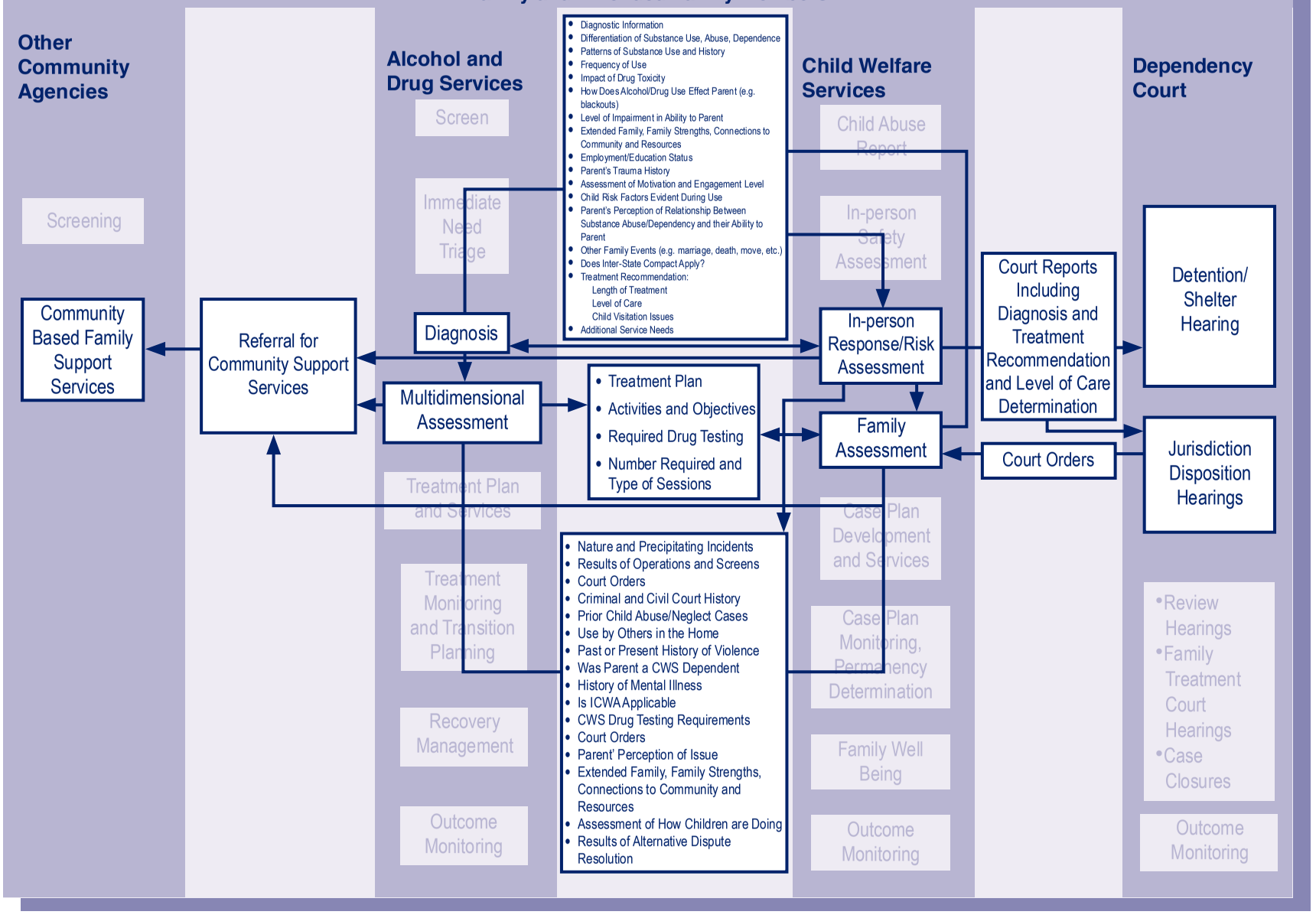
Pathways of Communication Template for Determining Presence and Immediacy of an Issue



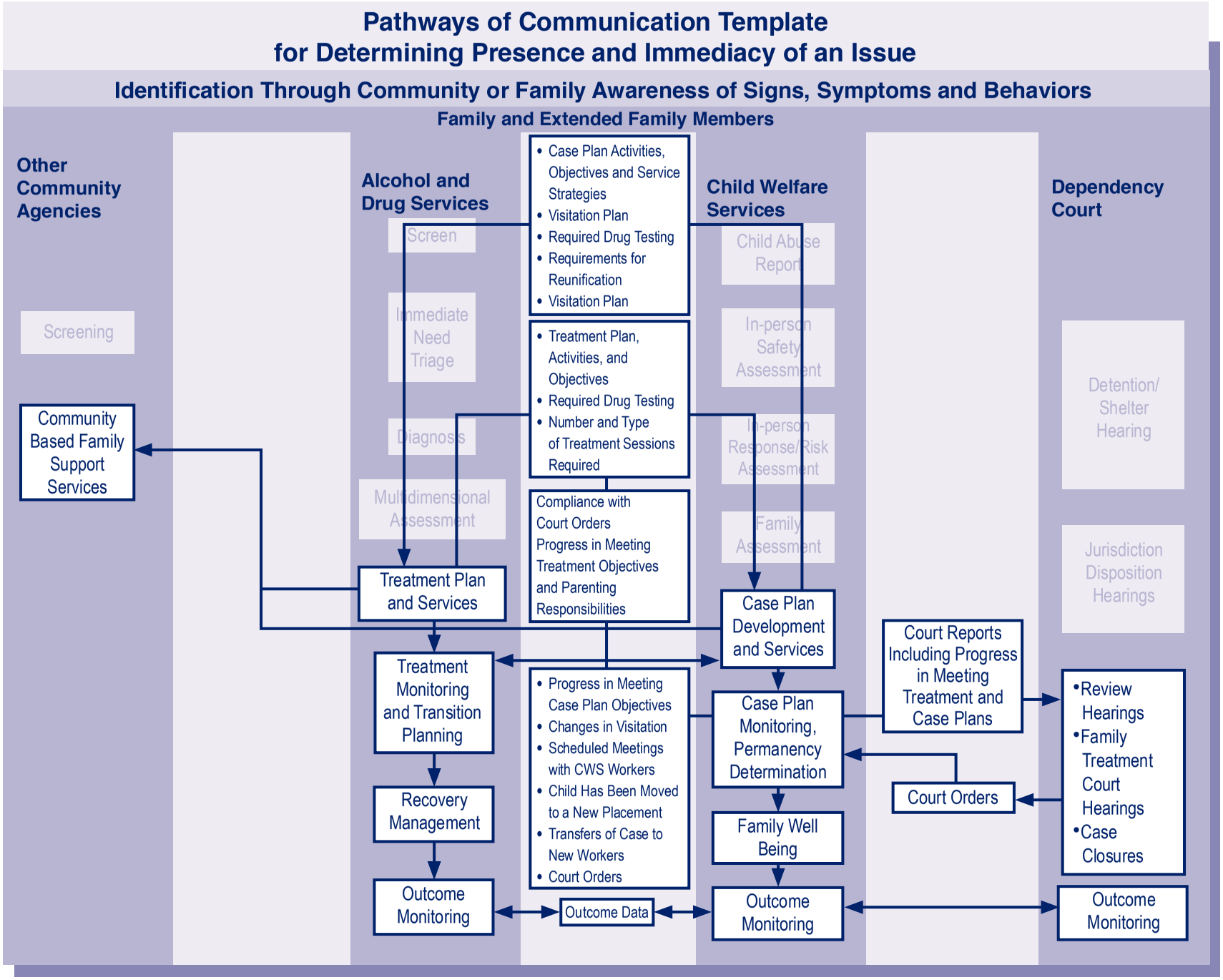
Pathways of Communication Template for Determining Presence and Immediacy of an Issue

Identification Through Community or Family Awareness of Signs, Symptoms and Behaviors

Family and Extended Family Members



Pathways of Communication Template for Determining Presence and Immediacy of an Issue



Step Six: Monitoring and Evaluating Success

The Oversight Committee should charge the Steering Committee with monitoring collaborative efforts. Monitoring is about accountability, and accountability is the difference between an effective collaborative and just another meeting. While Monitoring Success is noted here as Step Six, it really needs to be planned from the beginning of the collaborative effort and included as an ongoing component of the work.

The monitoring process has two focal points:

- Evaluating the collaborative process; and
- Evaluating the benefit to families.

Information collected on both points should continually feed back into the work of the Oversight and Steering Committees and Subcommittees, so that both process and products can be modified based on this information.

Evaluating the Collaborative Effort

The Steering Committee should continually examine itself and the Subcommittees and should closely monitor progress in implementing activities specified in the plan of action. In order to have a foundation for evaluating how far the collaborative has come, it is useful to gather some baseline information. If the various Committees complete the *Collaborative Values Index* and the *Collaborative Capacity Inventory* early on in their work, as described earlier in this section, they can repeat those self-assessments periodically to ascertain whether there have been changes in perceptions about ability to collaborate.

Although it is important to monitor process, it is also important to monitor completion of work. Regular review of progress toward completed activities is essential to keeping the Committees on task, adjusting deliverables as needed, and reporting to the Oversight or Steering Committee and other stakeholders. An example of a Progress Report template, **Determining Presence and Immediacy**, based on the sample plan of action presented earlier, follows on the next page.

Conducting evaluations on an annual or semiannual basis is also beneficial because it allows for a more detailed review of the collaborative process. An example of an evaluation report format based on the sample plan of action follows the Progress Report template.

ADS, CWS, and Dependency Court SAFERR Collaborative
Progress Report
Determining Presence and Immediacy

SAMPLE

Activity/Tasks	Progress Report	Problem/Barriers	Product Modification	Next Steps
Statewide guidelines for ADS providers to ask questions about children				
Training for ADS providers on guidelines				
Online resource guide on services for children from families with SUDs				
Protocols for information sharing among ADS, CWS and the dependency court				
Training for CWS workers in identifying and screening for SUDs				
Pilot colocation of ADS workers in a CWS office				

Activity/Tasks	Progress Report	Problem/Barriers	Product Modification	Next Steps
Screen Out policy statement				
Standard SUD screening tool to be used by CWS workers				
Guidelines for referral followup				
Training for judges, attorneys, and other judicial staff on SUDs and children's issues				
Standards for inquiry by judges into screening for families				
Standards for judges to order screenings when they have not taken place				

ADS, CWS, and Dependency Court SAFERR Collaborative
Midyear Evaluation
Determining Presence and Immediacy

SAMPLE

Deliverable	Due Date	Percent Complete	Revised Due Date
Statewide Guidelines for ADS Providers to Ask Questions About Children	**3/31/07**		
Convene workgroup on guidelines and training for ADS providers	10/10/06		
Research guidelines from other jurisdictions	12/16/06		
Draft guidelines	1/16/07		
Steering Committee to review guidelines	1/30/07		
Workgroup to edit guidelines based on Steering Committee feedback	2/13/07		
Elicit input from CWS and ADS providers	3/10/07		
Workgroup to edit guidelines based on provider input	3/24/07		
Steering Committee to approve guidelines	3/31/07		
Implement guidelines	Ongoing		
Training for ADS providers on Guidelines	**3/31/07**		
Convene workgroup on guidelines and training for ADS providers	10/10/06		
Research training curriculum	12/16/06		
Select or draft curriculum	1/16/07		
Draft training plan	1/16/07		
Steering Committee to review training curriculum and plan	1/30/07		
Workgroup to edit curriculum and plan based on Steering Committee feedback	3/10/07		
Elicit input from CWS and ADS providers	2/13/07		
Workgroup to edit training curriculum and plan based on provider input	3/24/07		
Steering Committee to approve training curriculum and plan	3/31/07		
Train ADS providers	Ongoing		

On-line Resource Guide on Services for Children from Families with SUDs	**2/28/07**		
Convene workgroup to develop online resource guide	10/10/06		
Conduct research on local, State, and national resources	12/16/06		
Identify web location for resource guide	12/16/06		
Identify Webmaster	12/16/06		
Draft Resource Guide	1/16/07		
Steering Committee to review resource guide	1/30/07		
Workgroup to make edits/additions based on Steering Committee feedback	2/13/07		
Create on-line format	2/28/07		
Post online resource guide	2/28/07		
Protocols for Information Sharing Among ADS, CWS and the Dependency Court	**2/28/07**		
Convene workgroup to develop guidelines for information sharing	10/10/06		
Review current practice of information sharing	12/16/06		
Review current information management systems	12/16/06		
Draft protocols for information sharing	2/21/07		
Steering Committee to review and approve protocol	2/28/07		
Implement protocol	Ongoing		
Training for CWS Workers in Identifying and Screening for SUDs	**3/31/07**		
Convene workgroup on Training for CWS workers	10/10/06		
Research training curriculum	12/16/06		
Select or draft curriculum	1/16/07		
Draft training plan	1/16/07		
Steering Committee to review training curriculum and plan	1/30/07		
Workgroup to edit curriculum and plan based on Steering Committee feedback	2/13/07		
Elicit input from CWS and ADS providers	3/10/07		
Workgroup to edit training curriculum and plan based on provider input	3/24/07		
Steering Committee to approve training curriculum and plan	3/31/07		
Convene workgroup on Training for CWS workers	Ongoing		

Pilot Colocation of ADS Workers in a CWS Office	**6/1/07**		
Convene workgroup on training for CWS workers and development of colocation pilot	1/20/07		
Research colocation models in other jurisdictions	4/28/07		
Explore interest among CWS offices	4/28/07		
Develop policies and procedures for pilot	5/19/07		
Steering Committee to review plan for pilot	5/19/07		
Steering Committee to select CWS office for pilot	5/19/07		
Final touches to plan for pilot	5/26/07		
Implement pilot	6/1/07		
Review success of pilot to date	12/15/07		
Review success of pilot and determine if going to scale with colocation	5/31/08		
Screen Out Policy Statement	**3/31/07**		
Convene workgroup to develop Screen Out policy and develop/select standard screening tool	10/10/06		
Research policies in other jurisdictions	1/30/07		
Draft Screen Out policy statement	2/21/07		
Steering Committee to review Screen Out policy	2/28/07		
Workgroup to edit policy based on Steering Committee feedback	3/24/07		
Steering Committee to approve policy	3/31/07		
Implement policy	Ongoing		
Standard SUD Screening Tool to be Used by CWS Workers	**5/19/07**		
Convene workgroup to develop Screen Out Policy and develop/select standard screening tool	10/10/06		
Research screening tools	1/30/07		
Select existing tool to use or draft new tool	2/21/07		
Steering Committee to review screening tool	2/28/07		
Workgroup to edit screening tool based on Steering Committee feedback	3/24/07		
Elicit input from CWS and ADS providers	4/21/07		
Workgroup to edit screening tool based on provider input	5/5/07		
Steering Committee to approve screening tool	5/19/07		
Implement use of tool	Ongoing		

Guidelines for Referral Follow Up	**2/28/07**		
Convene workgroup to develop guidelines for referral followup	10/10/06		
Develop plan for referral follow up	2/21/07		
Steering Committee to review and approve guidelines for referral followup	2/28/2006		
Implement guidelines for referral follow up	Ongoing		
Training for Judges, Attorneys, and Other Judicial Staff on SUDs and Children's Issues	**7/21/07**		
Convene workgroup to develop training and standards for judges, attorneys, and other judicial staff	10/10/06		
Research judicial training in other jurisdictions	1/20/07		
Conduct meeting with Office of the Court Administrator and the State Bar Association to establish their buy in	1/27/07		
Select or draft curriculum	4/28/07		
Draft training plan	4/28/07		
Steering Committee to review training curriculum and plan	5/19/07		
Workgroup to edit curriculum and plan based on Steering Committee feedback	6/2/07		
Elicit input from the Office of the Court Administrator and the State Bar Association	6/30/07		
Workgroup to edit standards based on input from the Office of the Court Administrator and the State Bar Association	7/14/07		
Steering Committee to approve training curriculum	7/21/07		
Train judges, attorneys, and other judicial staff	Ongoing		
Standards for Inquiry by Judges into Screening for Families	**7/21/07**		
Convene workgroup to develop training and standards for judges, attorneys, and other judicial staff	10/10/06		
Research standards in other jurisdictions	1/20/07		
Conduct meeting with the Office of the Court Administrator and the State Bar Association to establish their buy in	1/27/07		
Select or draft standards	4/28/07		
Steering Committee to review standards	5/19/07		
Workgroup to edit standards based on Steering Committee feedback	6/2/07		

Elicit input from the Office of the Court Administrator and State Bar Association	6/30/07		
Workgroup to edit standards based on input from the Office of the Court Administrator and the State Bar Association	7/14/07		
Steering Committee to approve training curriculum	7/21/07		
Train judges, attorneys, and other judicial staff	Ongoing		
Standards for Judges to Order Screenings When They Have Not Taken Place	**7/21/07**		
Convene workgroup to develop training and standards for judges, attorneys, and other judicial staff	10/15/06		
Research standards in other jurisdictions	1/20/07		
Conduct meeting with the Office of the Court Administrator and the State Bar Association to establish their buy in	1/27/07		
Select or draft standards	4/28/07		
Steering Committee to review standards	5/19/07		
Workgroup to edit standards based on Steering Committee feedback	6/2/07		
Elicit input from the Office of the Court Administrator and the State Bar Association	6/30/07		
Workgroup to edit standards based on input from Office of the Court Administrator and State Bar Association	7/14/07		
Steering Committee to approve training curriculum	7/21/07		
Train judges, attorneys, and other judicial staff	Ongoing		

Reasons why a deadline was not been met:

Changes in product deliverables:

Key accomplishments achieved:

Barriers encountered in the collaborative relationships:

Resources developed or discovered for collaborative work:

Fiscal and non-fiscal challenges anticipated in the future:

Evaluating the Benefit to Families

In developing the plan to evaluate the benefit to families, the Oversight and Steering Committees should explore existing data systems and determine what information about critical evaluation criteria or performance measures can be easily obtained. The Steering Committee or a Subcommittee should look at how data from different systems can be used to help all agencies understand the benefits to families they serve in common.

Federal data will likely be a useful resource for evaluating changes in families. In addition to other Federal data sources, the Steering Committee should review how its State scored on the Child and Family Services Review outcomes assessed by the Federal team in its most recent review. The Steering Committee should try to use those outcomes and the State's Program Improvement Plan to inform this collaborative initiative.

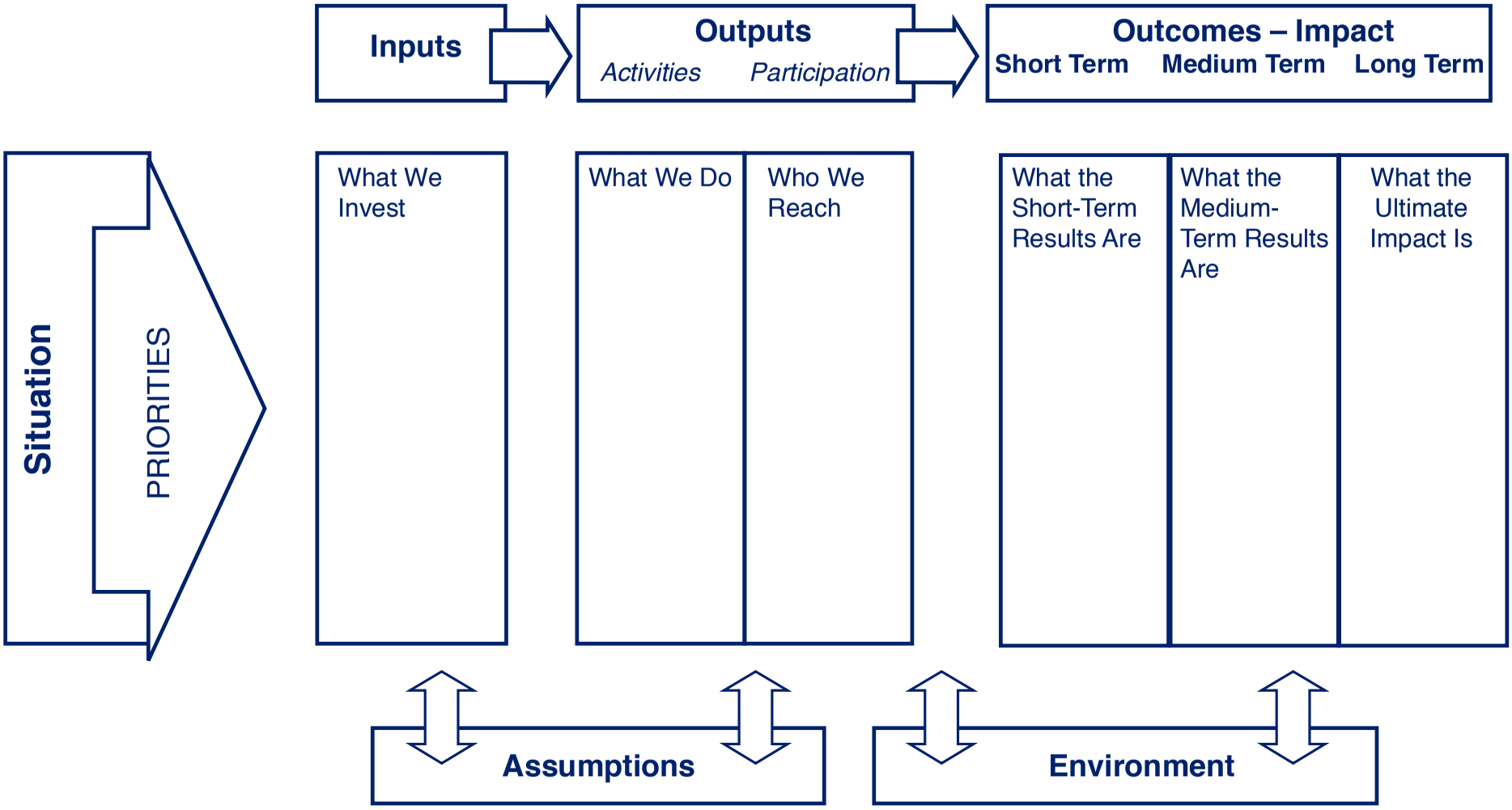
Key to evaluating the benefit to families is the development of collaborative outcome measures. Unless all partners are held jointly accountable to the outcomes, the collaborative will not succeed in creating "best practice" policies and practices. A critical aspect of successful collaboration is that each system feels the same level of accountability to improving family outcomes.

It is recommended that a professional evaluator be hired early in the process of designing the collaborative initiative. The insight a professional evaluator can provide regarding methodology, variables, potential analyses, and other aspects of the process can save program staff time and help ensure meaningful conclusions from data compiled.

Task 1: Develop Collaborative Outcome Measures

The Oversight Committee or Steering Committee may choose to develop collaborative outcome measures by selecting from measures already in use by each system, it may develop new outcome measures specifically for this project, or it may use both existing and new measures. The Federal Government has changed the way it views outcome measures and the paper *Child Welfare and Alcohol and Drug Treatment and Prevention Outcomes* included at the end of this section describes the outcome measures used by the Children's Bureau and the Center for Substance Abuse Treatment. In whatever way outcome measures are selected, the team should be able to use them in conjunction with State data systems to provide qualitative and quantitative information to illustrate the successes and shortcomings of their collaborative work.

The figure below is a logic model format to help Committees determine outcome measures. Completing the logic model as a group may facilitate an understanding of how the group's activities lead to desired outcomes and help to determine what should be evaluated. For more information on logic models and outcomes, see *Nonprofit Leadership Institute 2002 The Power of Evaluation: Achieving Service Excellence Outcomes What are They?* at *www2.uta.edu/sswmindel/Presentations/Handout%20NPLI.pdf*.



- **Situation:** the conditions that give rise to the program
- **Inputs:** the resources and contributions made to the effort
- **Outputs:** activities and products that reach the people who participate
- **Outcomes:** changes or benefits for individuals, families, groups, communities, organizations, and systems.
- **Assumptions:** beliefs we have about the program, the people, the environment, and the way we think the program will work
- **External Factors:** context and external conditions in which the program exists and which influence the success of the program

Supplemental Worksheets and Tools for Facilitators

The following pages provide samples of tools and other resources that may be useful to facilitators, Steering Committee members, and Subcommittee members. These include—

- The *Collaborative Values Inventory*;
- The *Collaborative Capacity Instrument*;
- The *Collaborative Values Inventory/Collaborative Capacity Instrument* Analysis;
- Principle statements developed by Sacramento County, California, Cuyahoga County, Ohio; and the NCSACW Consortium: Americam Public Human Services Association (APHSA), Child Welfare League of America (CWLA), National Association of State Alcohol and Drug Abuse Directors (NASADAD), National Council of Juvenile and Family Court Judges (NCJFCJ), and National Indian Child Welfare Association (NICWA).
- Child Welfare and Alcohol and Drug Treatment and Prevention Outcomes.

APPENDIX D – CHECKLIST

This appendix organizes the effective strategies for each of the 10 recommendations into three categories based on whether these effective strategies are supported by research findings and, if so, whether this research was conducted in a family drug court (FDC) setting.

RESEARCH CATEGORY	DEFINITION
Programs and Activities Supported by Evidence from Research Conducted in an FDC Setting	These programs and activities have been implemented in FDCs with promising results.
Programs and Activities Supported by Evidence from Research Conducted in Non-FDC Settings	The research supporting these effective strategies was conducted in a setting related to FDCs, such as a child welfare, substance use treatment, or adult criminal drug court program. Because the findings come from research in adults with substance use disorders or with families receiving child welfare services in a setting that is related to FDCs, the findings might be applicable to FDCs.
Programs and Activities that are Common in FDCs but are Supported by Little or No Evidence	These practices are frequently part of FDC models, but research and evaluation is necessary to determine their effectiveness.

Research Categories Recommendations and Effective Strategies	Programs and Activities Supported by Evidence from Research Conducted in Family Drug Court Settings	Programs and Activities Supported by Evidence from Research Conducted in Non-Family Drug Court Settings	Programs and Activities That are Common Practice in Family Drug Courts with Little or No Evidence
Recommendation 1: Create Shared Mission and Vision			
Judicial leadership ensures planning, implementation and operations of the FDC.			X
Judicial leadership helps to promote teamwork and to facilitate better working relationships among agencies.			X
The FDC has included the judicial officers, attorneys, child welfare, substance use treatment providers as well as other service providers as partners in understanding core values and the development of the shared mission and vision.[1]		X	
The FDC has used a formal values assessment process such as the Collaborative Values Inventory[2] or the Partnership Self-Assessment Tool[3] to determine how much consensus or disagreement exists about issues related to substance abuse, parenting, and child safety.			X

[1]Green, B. L, Rockhill, A., & Burrus, S. (2002). What helps and what doesn't: Providers talk about meeting the needs of families with substance abuse problems under ASFA: Summary of findings. Portland, OR: NPC Research, Inc. Retrieved from http://npcresearch.com/wp-content/uploads/Executive-Summary-what-works.pdf

[2]Collaborative Values Inventory was developed by Children and Family Futures. The *Collaborative Values Inventory (CVI)*, a self-administered questionnaire that provides jurisdictions with an anonymous way of assessing the extent to which group members share ideas about the values that underlie their collaborative efforts. The CVI is simple and short, but it identifies areas of commonality and difference that are easily overlooked either because people feel uncomfortable discussing values or because they move directly to program and operational issues.

[3]The Partnership Self-Assessment Tool measures a key indicator of a successful collaborative process - the partnership's level of synergy. The Tool also provides information that helps partnerships take action to improve the collaborative process.

Research Categories Recommendations and Effective Strategies	Programs and Activities Supported by Evidence from Research Conducted in Family Drug Court Settings	Programs and Activities Supported by Evidence from Research Conducted in Non-Family Drug Court Settings	Programs and Activities That are Common Practice in Family Drug Courts with Little or No Evidence
Recommendation 1 (continued): Create Shared Mission and Vision			
The FDC revisits mission, vision and values, as well as policies and procedures, on an annual basis and has established meaningful orientation and assimilation of new team members.[4]		X	
The FDC has negotiated shared principles or goal statements that reflect a consensus on issues (e.g. target population, eligibility criteria, parallel or integrated FDC model) related to families affected by substance use disorders in child welfare and the dependency court.			X
The FDC has negotiated priority access to substance use treatment for child welfare clients.			X
Other problem solving courts (e.g. criminal and delinquency, domestic violence, veterans, and mental health) have been included in the planning process to address potential overlap of participants and to assure consistency where appropriate across case types.			X

[4]Carey, S. M., Mackin, J. R., & Finigan, M. W. (2012). What works? The 10 key components of Drug Court: research-based best practices. *Drug Court Review, 8*(1), 6-42. Retrieved from http://www.ndci.org/sites/default/files/nadcp/DCR_best-practices-in-drug-courts.pdf

Research Categories Recommendations and Effective Strategies	Programs and Activities Supported by Evidence from Research Conducted in Family Drug Court Settings	Programs and Activities Supported by Evidence from Research Conducted in Non-Family Drug Court Settings	Programs and Activities That are Common Practice in Family Drug Courts with Little or No Evidence
Recommendation 1 (continued): Create Shared Mission and Vision			
The FDC has discussed and developed responses to the conflicting time frames associated with child welfare/Adoption and Safe Families Act (ASFA), Temporary Assistance to Needy Families (TANF),[5] substance use treatment and child development. The entire FDC team understands the mandates and demands placed on child welfare to close the dependency case and balances this with the parent's recovery needs. The team understands the relationship between the FDC and the underlying legal dependency case and has agreed upon policies and procedures that protect due process and accounts for the ethical obligations of team members.			X
The FDC has selected a model—either parallel or integrated—after considering the benefits and challenges of each. Regardless of the model selected, the FDC demonstrates an understanding that both models underscore the importance of integrated information sharing.			X

[5]Temporary Assistance to Needy Families (TANF) is part of the welfare reform legislation of 1996, (the Personal Responsibility and Work Opportunity Reconciliation Act – PWRORA – Public Law 104-193), TANF replaced the welfare programs known as Aid to Families with Dependent Children (AFDC), the Job Opportunities and Basic Skills Training (JOBS) program and the Emergency Assistance (EA) program. The law ended Federal entitlement to assistance and instead created TANF as a block grant that provides States, territories and tribes Federal funds each year. These funds cover benefits, administrative expenses, and services targeted to needy families.

Research Categories Recommendations and Effective Strategies	Programs and Activities Supported by Evidence from Research Conducted in Family Drug Court Settings	Programs and Activities Supported by Evidence from Research Conducted in Non-Family Drug Court Settings	Programs and Activities That are Common Practice in Family Drug Courts with Little or No Evidence
Recommendation 1 (continued): Create Shared Mission and Vision			
The FDC team has developed detailed policies and procedures, agreed upon by all, covering operations and policy issues such as clients' voluntary or involuntary participation in the program. These policies and procedures are reflective of the team members' values and shared mission and vision.[6]		X	
The FDC has decided whether or not jail will be used as a sanction and through discussion, all team members understand impact of and the rationale behind the decision. If jail is an available sanction, the FDC has agreed upon protocols with respect to due process. FDC team members understand that the ultimate determination to use jail as a sanction rests solely with the judicial officer.			X

[6]Carey, S. M., Mackin, J. R., & Finigan, M. W. (2012). What works? The 10 key components of Drug Court: research-based best practices. *Drug Court Review, 8*(1), 6-42. Retrieved from http://www.ndci.org/sites/default/files/nadcp/DCR_best-practices-in-drug-courts.pdf

Research Categories Recommendations and Effective Strategies	Programs and Activities Supported by Evidence from Research Conducted in Family Drug Court Settings	Programs and Activities Supported by Evidence from Research Conducted in Non-Family Drug Court Settings	Programs and Activities That are Common Practice in Family Drug Courts with Little or No Evidence
Recommendation 2: Develop Interagency Partnerships			
The FDC has established a collaborative structure composed of stakeholders diverse in responsibilities including an Oversight Committee, Steering Committee and a core operational team.[7]			X
Clinical services to address mental health and trauma issues[8] for drug court participants and their children are coordinated. These services are also included in comprehensive assessments and case plans for all families participating in the FDC.[9,10,11]	X		

[7]Young, N. K., Nakashian, M., Yeh, S., & Amatetti, S. (2007). *Screening and assessment for family engagement, retention, and recovery (SAFERR)*. DHHS Pub. No. (SMA) 07-4261. Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA). Retrieved from https://www.ncsacw.samhsa.gov/files/SAFERR.pdf

[8]Powell, C., Stevens, S., Dolce, B. L., Sinclair, K. O., & Swenson-Smith, C. (2012). Outcomes of a trauma-informed Arizona family drug court. *Journal of Social Work Practice in the Addictions, 12*(3), 219-241. DOI: 10.1080/1533256X.2012.702624

[9]Cannavo, J. M., & Nochajski, T. H. (2011). Factors contributing to enrollment in a family treatment court. *The American Journal of Drug and Alcohol Abuse, 37*(1), 54-61. DOI:10.3109/00952990.2010.535579

[10]Osterling, K. L., & Austin, M. J. (2008). Substance abuse interventions for parents involved in the child welfare system: Evidence and implications. *Journal of Evidence Based Social Work, 5*(1-2), 157-189. DOI: 10.1300/J394v05n01_07.

[11]Marsh, J. C., Ryan, J. P., Choi, S., & Testa, M. F. (2006). Integrated services for families with multiple problems: Obstacles to family reunification. *Children and Youth Services Review, 28*(9), 1074-1087. DOI:10.1016/j.childyouth.2005.10.012

Research Categories Recommendations and Effective Strategies	Programs and Activities Supported by Evidence from Research Conducted in Family Drug Court Settings	Programs and Activities Supported by Evidence from Research Conducted in Non-Family Drug Court Settings	Programs and Activities That are Common Practice in Family Drug Courts with Little or No Evidence
Recommendation 2 (continued): Develop Interagency Partnerships			
Domestic violence prevention services are included in comprehensive assessment and case plans for all families participating in the FDC. Where possible, the team includes a representative from a domestic violence service agency.[12]		X	
The FDC ensures that primary healthcare, dental care, child care and transportation are available for families participating in the FDC.[13]		X	
Specialized health services for parents with a substance use disorder regarding HIV/AIDS, Hepatitis C and other diseases frequently transmitted among intravenous drug users are accessible for all families participating in the FDC.[14]		X	

[12]Ibid.

[13]Carey, S. M., Mackin, J. R., & Finigan, M. W. (2012). What works? The 10 key components of Drug Court: research-based best practices. *Drug Court Review, 8*(1), 6-42. Retrieved from http://www.ndci.org/sites/default/files/nadcp/DCR_best-practices-in-drug-courts.pdf

[14]Osterling, K. L., & Austin, M. J. (2008). Substance abuse interventions for parents involved in the child welfare system: Evidence and implications. *Journal of Evidence Based Social Work, 5*(1-2), 157-189. DOI: 10.1300/J394v05n01_07.

Research Categories Recommendations and Effective Strategies	Programs and Activities Supported by Evidence from Research Conducted in Family Drug Court Settings	Programs and Activities Supported by Evidence from Research Conducted in Non-Family Drug Court Settings	Programs and Activities That are Common Practice in Family Drug Courts with Little or No Evidence
Recommendation 2 (continued): Develop Interagency Partnerships			
The FDC uses a family system approach[15,16,17] and a multidisciplinary team monitors the number of referrals made to other programs and services and tracks the number of participants who initiate and complete clinical and supportive services needed by families. The FDC also monitors barriers that prevent access to these services. The process includes a "warm handoff," which is an in-person connection made between the person making the referral and the service provider.[18]	X		
The FDC has substance use disorder support/recovery groups that include a special focus on child welfare and child safety issues.[19]	X		
The FDC has a process for developing and maintaining interagency partnerships, including linkage agreements or memoranda of understanding, and includes these agencies in an advisory group.			X

[15]Rodi, M. S., Killian, C. M., Breitenbucher, P., Young, N, K., Amatetti, S., Bermejo, R., & Hall, E. (2015). New approaches for working with children and families involved in family treatment drug courts: Findings form the Children Affected by Methamphetamine Program. *Child Welfare Journal, 94*(4), 205-232.

[16]Dennis, K., Rodi, M. S., Robinson, G., DeCerchio, K., Young, N. K…, & Corona, M. (2015). Promising results for cross-systems collaboration efforts to meet the needs of families impacted by substance use. *Child Welfare Journal, (94)*5, 21-43.

[17]Pollock, M. D., & Green, S. L. (2015). Effects of a rural family drug treatment court collaborative on child welfare outcomes: Comparison using propensity score analysis. *Child Welfare Journal, (94)*4, 139-159.

[18]Coll, K. M., Stewart, R. A., Morse, R., & Moe, A. (2010). The value of coordinated services with court-referred clients and their families: An outcome study. *Child Welfare, 89*(1), 61-79.

[19]Child, H., & McIntyre, D. (2015). Examining the relationship between family drug court program compliance and child welfare outcomes. *Child Welfare Journal, 94*(5), 67-87.

Research Categories Recommendations and Effective Strategies	Programs and Activities Supported by Evidence from Research Conducted in Family Drug Court Settings	Programs and Activities Supported by Evidence from Research Conducted in Non-Family Drug Court Settings	Programs and Activities That are Common Practice in Family Drug Courts with Little or No Evidence
Recommendation 2 (continued): Develop Interagency Partnerships			
The FDC has established a communication protocol sharing clinical and case information (e.g. treatment success or relapse) among collaborative partners. The protocol addresses confidentiality issues.[20]		X	
The FDC has coordination agreements and information sharing policies with the child welfare system, criminal and juvenile justice systems, law enforcement, and community supervision professionals to meet the needs of participants and their children who are in the criminal or juvenile justice system (e.g., visitation for children with incarcerated parents, treatment while parents are incarcerated).			X

[20]Marsh, J. C., Ryan, J. P., Choi, S., & Testa, M. F. (2006). Integrated services for families with multiple problems: Obstacles to family reunification. *Children and Youth Services Review, 28*(9), 1074-1087. DOI:10.1016/j.childyouth.2005.10.012

Research Categories Recommendations and Effective Strategies	Programs and Activities Supported by Evidence from Research Conducted in Family Drug Court Settings	Programs and Activities Supported by Evidence from Research Conducted in Non-Family Drug Court Settings	Programs and Activities That are Common Practice in Family Drug Courts with Little or No Evidence
Recommendation 3: Create Effective Communication Protocols for Sharing Information			
Data Management			
• The FDC has implemented a plan to track, monitor, and use parent/child/family-level information, as well as system-level data.			X
• The FDC has assessed its data systems to identify gaps in monitoring both child welfare and substance use disorder treatment systems and uses the results of that assessment to make changes.			X
• The FDC compares project data regularly with system-wide data on outcomes in both systems.			X
• The FDC has automated data detailing the characteristics and service outcomes of participants and compares outcomes to those achieved in the larger child welfare and substance use disorder treatment systems. The FDC uses the information to make program changes as needed.[21]		X	

[21]Carey, S. M., Mackin, J. R., & Finigan, M. W. (2012). What works? The 10 key components of Drug Court: research-based best practices. *Drug Court Review, 8*(1), 6-42. Retrieved from http://www.ndci.org/sites/default/files/nadcp/DCR_best-practices-in-drug-courts.pdf

Research Categories Recommendations and Effective Strategies	Programs and Activities Supported by Evidence from Research Conducted in Family Drug Court Settings	Programs and Activities Supported by Evidence from Research Conducted in Non-Family Drug Court Settings	Programs and Activities That are Common Practice in Family Drug Courts with Little or No Evidence
Recommendation 3 (continued): Create Effective Communication Protocols for Sharing Information			
Data Management (continued)			
• The FDC's child welfare agencies have accurate baseline measures on the percentage of cases in which parental substance use is an identified problem.			X
• The FDC's substance use disorder treatment agencies have reliable baseline data on the percentage of families involved in child welfare and use the information for program design and service development.			X
Protocols for Sharing Information			
• The FDC has identified the confidentiality provisions that affect child welfare, substance use disorder treatment, and the dependency court and has devised the means of sharing information[22] about parents, children, and families in treatment with the FDC team, while observing these provisions.		X	

[22]Osterling, K. L., & Austin, M. J. (2006). Substance abuse interventions for parents involved in the child welfare system: Evidence and implications. *Journal of Evidence Based Social Work, 5*(1-2), 157-189. DOI: 10.1300/J394v05n01_07

Research Categories Recommendations and Effective Strategies	Programs and Activities Supported by Evidence from Research Conducted in Family Drug Court Settings	Programs and Activities Supported by Evidence from Research Conducted in Non-Family Drug Court Settings	Programs and Activities That are Common Practice in Family Drug Courts with Little or No Evidence
Recommendation 3 (continued): Create Effective Communication Protocols for Sharing Information			
Protocols for Sharing Information (continued)			
• The partners in the FDC have agreed on the level of information about clients' progress in treatment that will be communicated from treatment agencies to the FDC, understanding applicable ethical and legal restrictions. The FDC shares data on individual participants in a timely manner to assure effective monitoring of progress and behavior.[23]	X		
• Information provided to the Judge and other partners[24] includes positive performance by the parent as well as areas warranting attention.		X	
• Substance use treatment providers routinely ask about the status of children in the families they serve and coordinate their treatment plan with the child welfare case plan.			X
• Information sharing issues and judicial impartiality have been resolved.			X

[23]Green, B. L., Furrer, C., Worcel, S., Burrus, S., & Finigan, M. W. (2007). How effective are family treatment drug courts? Outcomes from a four-site national study. *Child Maltreatment, 12*(1), 43-59. DOI: 10.1177/1077559506296317

[24]National Association of Drug Court Professionals. (2015). *Adult drug court best practice standards Volume II.* Alexandria, VA: Retrieved from http://www.ndcrc.org/sites/default/files/adult_drug_court_best_practice_standards_volume_ii.pdf

Research Categories Recommendations and Effective Strategies	Programs and Activities Supported by Evidence from Research Conducted in Family Drug Court Settings	Programs and Activities Supported by Evidence from Research Conducted in Non-Family Drug Court Settings	Programs and Activities That are Common Practice in Family Drug Courts with Little or No Evidence
Recommendation 3 (continued): Create Effective Communication Protocols for Sharing Information			
Protocols for Sharing Information (continued)			
• The FDC has developed formal working agreements/memoranda of understanding that include how child welfare and treatment agencies will share information about clients in treatment with the FDC team and the dependency/juvenile court.[25]		X	
• Information is shared with the parent as part of the case planning process. All FDC team members and the parent are aware of what information will be shared and with whom.[26]			X

[25]Osterling, K. L., & Austin, M. J. (2006). Substance abuse interventions for parents involved in the child welfare system: Evidence and implications. *Journal of Evidence Based Social Work, 5*(1-2), 157-189. DOI: 10.1300/J394v05n01_07.

[26]Legal Action Center. (2012). Confidentiality and communication: A Guide to the federal drug & alcohol confidentiality law and HIPAA. 7th ed. New York: Legal Action Center of the City of New York, Inc.

Research Categories Recommendations and Effective Strategies	Programs and Activities Supported by Evidence from Research Conducted in Family Drug Court Settings	Programs and Activities Supported by Evidence from Research Conducted in Non-Family Drug Court Settings	Programs and Activities That are Common Practice in Family Drug Courts with Little or No Evidence
Recommendation 3 (continued): Create Effective Communication Protocols for Sharing Information			
Protocols for Sharing Information (continued)			
• The FDC has an established practice of staffing cases prior to court for an up-to-date exchange and discussion of information. Participants in the staffing regularly include the judge, coordinator, case manager, parent's counsel, Guardian Ad Litem or children's counsel, prosecuting attorney, treatment staff, child welfare case worker, and other representatives with information critical to the family's overall well-being.[27]	X		
• FDCs use email as a form of communication for exchanging information between scheduled staffing meetings.[28]		X	
• The FDC's intake process identifies prior substance use disorder treatment episodes and prior reports of child abuse/neglect.			X

[27]Green, B. L., Furrer, C., Worcel, S., Burrus, S., & Finigan, M. W. (2007). How effective are family treatment drug courts? Outcomes from a four-site national study. *Child Maltreatment, 12*(1), 43-59. DOI: 10.1177/1077559506296317

[28]Carey, S. M., & Waller, M. S. (2011). *Oregon drug court cost study: Statewide cost savings and promising practices*. Portland, OR: NPC Research, Inc.

Research Categories Recommendations and Effective Strategies	Programs and Activities Supported by Evidence from Research Conducted in Family Drug Court Settings	Programs and Activities Supported by Evidence from Research Conducted in Non-Family Drug Court Settings	Programs and Activities That are Common Practice in Family Drug Courts with Little or No Evidence
Recommendation 4: Ensure Interdisciplinary Knowledge			
All FDC team members receive training and education about:			
• working with families in the child welfare system that are affected by substance use disorders, including gender-specific and trauma-informed training; the dynamics of addiction and recovery; and evidence-based treatment approaches, including medication assisted treatment			X
• the effects of pre- and post-natal substance exposure on children and meeting children's needs across the developmental stages			X
• the responsibilities and mandates of child welfare workers, including ASFA timelines[29]		X	
• the rules pertaining to the Indian Child Welfare Act (ICWA)[30] and on historical trauma			X
• the responsibilities and mandates of the judge and attorneys, as well as criminal and juvenile justice system practices			X
• the use of engagement strategies for parents affected by substance use disorders			X

[29]Green, B. L, Rockhill, A., & Burrus, S. (2002). What helps and what doesn't: providers talk about meeting the needs of families with substance abuse problems under ASFA: Summary of findings. Portland, OR: NPC Research, Inc. Retrieved from http://npcresearch.com/wp-content/uploads/Executive-Summary-what-works.pdf

[30]For example, *see* "A Practical Guide to the Indian Child Welfare Act," Native American Rights Fund (Sep. 2011), *available at* www.narf.org/nill/documents/icwa/.

Research Categories Recommendations and Effective Strategies	Programs and Activities Supported by Evidence from Research Conducted in Family Drug Court Settings	Programs and Activities Supported by Evidence from Research Conducted in Non-Family Drug Court Settings	Programs and Activities That are Common Practice in Family Drug Courts with Little or No Evidence
Recommendation 4 (continued): Ensure Interdisciplinary Knowledge			
All FDC team members receive training and education about (continued):			
• cultural issues to improve the team's cultural competency[31] in working with diverse substance use disorder treatment and child welfare client groups		X	
• the effect of substance use disorders on family relationships			X
The FDC has developed ongoing, joint-training programs for substance use disorder treatment, child welfare, court staff and other service providers to learn about each others' mandates, constraints and goals.[32,33]		X	
The FDC had developed effective methods of working together among the FDC team and within the larger systems.			X
The judge pursues training opportunities on evidence-based practices in substance use disorder and mental health treatment.[34]		X	

[31]National Association of Drug Court Professionals. (2013). Adult *drug court best practice standards Volume I.* Alexandria, VA: Retrieved from http://www.nadcp.org/sites/default/files/nadcp/AdultDrugCourtBestPracticeStandards.pdf

[32]Osterling, K. L., & Austin, M. J. (2006). Substance abuse interventions for parents involved in the child welfare system: Evidence and implications. *Journal of Evidence Based Social Work, 5*(1-2), 157-189. DOI: 10.1300/J394v05n01_07.

[33]Sun, A. P., Shillington, A. M., Hohman, M., & Jones, L. (2001). Caregiver AOD use, case substantiation, and AOD treatment: Studies based on two southwestern counties. *Child Welfare, 80*(2), 151-178.

[34]National Association of Drug Court Professionals. (2013). *Adult drug court best practice standards Volume I.* Alexandria, VA: Retrieved from http://www.nadcp.org/sites/default/files/nadcp/AdultDrugCourtBestPracticeStandards.pdf

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Recommendation 4 (continued): Ensure Interdisciplinary Knowledge			
The FDC has a staff development plan that includes periodic updates to the cross-training and orientation received by all the staff.			X
FDC team members receive joint training in methods of increasing participant motivation, such as stages of change and motivational interviewing.[35]		X	
FDC team members receive joint training on therapeutic relationships and understand the effects of one's own response to participants on enabling addictive behavior and supporting recovery.			X
FDC team members receive joint training on self-care and avoiding burnout.			X
Recommendation 5: Develop a Process for Early Identification and Assessment			
The FDC has developed a joint policy between substance use disorder treatment, child welfare and the dependency court on its approach to timely, standardized screening and assessment of substance use disorders among families in child welfare.			X

[35]Carey, S. M., Mackin, J. R., & Finigan, M. W. (2012). What works? The 10 key components of Drug Court: research-based best practices. *Drug Court Review, 8*(1), 6-42. Retrieved from http://www.ndci.org/sites/default/files/nadcp/DCR_best-practices-in-drug-courts.pdf

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Recommendation 5 (continued): Develop a Process for Early Identification and Assessment			
The FDC has developed a formal process in which petitions are reviewed for substance use as a factor and the appropriate treatment engagement specialists are notified.			X
Substance use disorder treatment providers work in tandem with child welfare workers or are out-stationed at child welfare offices and/or the dependency court to facilitate early screening and assessment of FDC participants.			X
The FDC uses assessment results to create coordinated substance use disorder treatment and child welfare case plans that are reinforced through court order.[36]	X		
The FDC supplements child abuse/neglect risk assessment with an in-depth assessment of substance use disorder issues and their effect on each of the family members, including the children.			X
A strong strengths and needs assessment[37] tool is used to help identify the substance abuse, mental health and other needs the family must address to provide for the safety and well-being of the children.		X	

[36]Boles, S., & Young, N. K. (2010). *Sacramento County Dependency Drug Court year seven outcome and process evaluation findings.* Irvine, CA: Children and Family Futures. Retrieved from http://www.cffutures.org/files/publications/Year%207%20Summary%20Report%20Final.pdf

[37]National Association of Drug Court Professionals. (2015). *Adult drug court best practice standards Volume II.* Alexandria, VA: Retrieved from http://www.ndcrc.org/sites/default/files/adult_drug_court_best_practice_standards_volume_ii.pdf

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Recommendation 5 (continued): Develop a Process for Early Identification and Assessment			
The FDC's substance use disorder treatment providers have sufficient information about the child welfare case to conduct quality assessments of families referred by child welfare to treatment.			X
The FDC's substance use disorder treatment providers routinely ask questions about children in the family, their living arrangements, and child safety issues and have standard protocols on responding to child safety risks.			X
The FDC team uses screening and assessment information to ensure parents have timely access to appropriate treatment and other services.[38]	X		
Legal and clinical eligibility criteria have been developed by the entire team and are implemented in a standardized fashion. Criteria are re-examined annually to assure some groups of families are not being screened out.			X

[38]Bruns, E. J., Pullmann, M., Wiggins, E., & Watterson, K. (2011). *King County family treatment court outcome evaluation: Final report.* Seattle, WA: Division of Public Behavioral Health and Justice Policy. Retrieved from http://www.kingcounty.gov/~/media/health/MHSA/MIDD_ActionPlan/Appendix_F_Outcome_evaluation_final_report_2_22_2011.ashx?la=en

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Recommendation 5 (continued): Develop a Process for Early Identification and Assessment			
The FDC routinely monitors the timeliness of its implementation and the quality of its identification, screening and assessment protocols to ensure they continue to address relevant issues including trends in substances, shifts in demographics and cultural practices.			X
The FDC recognizes the incidence of co-occurring disorders and assesses for trauma,[39] mental health issues, and family history of substance use disorders and mental health, including alcohol/drug use history of parents, siblings and grandparents.	X		
Recommendation 6: Address the Needs of Parents			
An array of services are available and the FDC uses treatment and service matching to ensure that substance use disorder treatment and other services are based on evidence. Practices and curricula are gender-specific and designed exclusively for the unique needs and strengths of men or women and culturally relevant and specifically developed and tested with the population(s) being served.[40]		X	

[39]Powell, C., Stevens, S., Dolce, B. L., Sinclair, K. O., & Swenson-Smith, C. (2012). Outcomes of a trauma-informed Arizona family drug court. *Journal of Social Work Practice in the Addictions, 12*(3), 219-241. DOI: 10.1080/1533256X.2012.702624

[40]Walker, M. A. (2009). Program characteristics and the length of time clients are in substance abuse treatment. *Journal of Behavioral Health Services & Research, 36*(3), 330-343.

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Recommendation 6 (continued): Address the Needs of Parents			
Services are geographically accessible and delivered in a location easily reached by participants by public transportation.			X
The FDC has implemented integrated case plans that include the substance use recovery plan and the child welfare case plan as well as other services the family is to receive.[41]		X	
Substance use disorder treatment clinicians carry caseloads of 50:1 if providing clinical case management, 40:1 if providing individual therapy or counseling, and 30:1 if providing both services.[42]		X	
The FDC staff tracks the status of their clients' progress in the child welfare system and integrates the information into their case plan and service delivery.			X
The FDC is family-focused in its approach and whenever possible, allows young children to reside in treatment with parent(s).[43]		X	

[41]Marsh, J. C., Smith, B. D., & Bruni, M. (2011). Integrated substance abuse and child welfare services for women: A progress review. *Child and Youth Services Review, 33*(3), 466-472. DOI: 10.1016/j.childyouth.2010.06.017

[42]National Association of Drug Court Professionals. (2015). *Adult drug court best practice standards Volume II.* Alexandria, VA: Retrieved from http://www.ndcrc.org/sites/default/files/adult_drug_court_best_practice_standards_volume_ii.pdf

[43]Clark, H. W. (2001). Residential substance abuse treatment for pregnant and postpartum women and their children: Treatment and policy implications. *Child Welfare, 80*(2), 179-198.

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Recommendation 6 (continued): Address the Needs of Parents			
The FDC is trauma-informed and uses practices and curricula that assume trauma may be part of the parent/child/family's experience and uses trauma-specific services to address these needs.			X
The FDC staff or case worker asks if a parent identifies as a Native or tribal member.[44]			X
The FDC has developed or is connected to an evidenced-based parenting program.[45]		X	
The FDC participants have access to medication-assisted treatment for substance use and mental disorders.[46]		X	
The FDC staff have adequate and timely access to information to determine how participants are progressing through treatment and uses the information in staffing, progress hearings and in case management meetings to encourage full participation.			X

[44]For example, *see* "A Guide to Compliance with the Indian Child Welfare Act," National Indian Child Welfare Association, *available at* http://www.nicwa.org/Indian_Child_Welfare_Act/documents/Guide%20to%20ICWA%20Compliance.pdf.

[45]Carey, S. M., Mackin, J. R., & Finigan, M. W. (2012). What works? The 10 key components of Drug Court: research-based best practices. *Drug Court Review, 8*(1), 6-42. Retrieved from http://www.ndci.org/sites/default/files/nadcp/DCR_best-practices-in-drug-courts.pdf

[46]National Institute on Drug Abuse. (2012). *Principles of drug abuse treatment for criminal justice populations: A research-based guide*. NIH Publication No. 11-5316. Bethesda, MD: Author. Retrieved from https://www.drugabuse.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations/principles

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Recommendation 6 (continued): Address the Needs of Parents			
The FDC uses a phase system with benchmarks of accomplishments that define progress and a set of defined targeted behaviors that have been explained and made available to participants in a participant handbook.			X
The FDC tracks behavior and the accomplishment of phase milestones of progress toward goals.			X
The FDC staff has realistic expectations for its participants; staff understand the neurological effects of substance use disorders and mental status in early recovery and the challenges faced by parents.			X
The FDC understands what motivates behavior change and applies the principles when working with and responding to participant behavior. Motivational strategies and program practice elements to engage and promote accessibility and accountability are provided in the context of a transtheoretical model of behavior change or stages of change.[47]		X	
The FDC staff respond promptly to participant behavior through an established system assuring the response is timely and takes into consideration factors such as length of time in the program.			X

[47]National Association of Drug Court Professionals. (2013). *Adult drug court best practice standards Volume I.* Alexandria, VA: Retrieved from http://www.nadcp.org/sites/default/files/nadcp/AdultDrugCourtBestPracticeStandards.pdf

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Recommendation 6 (continued): Address the Needs of Parents			
The FDC uses drug testing effectively and in conjunction with a treatment program to monitor clients' compliance with treatment plans.[48]	X		
The FDC team, and particularly the judge, recognize the effectiveness of positive reinforcement and use it frequently, modeling it for parents.			X
Responses to parent behavior are determined by the judicial officer after a discussion with the team.			X
The judge clearly explains to parents the reasoning behind all responses to behavior to communicate the principle of fairness.			X
The FDC is a multi-disciplinary team that is cross-trained and that uses the relationship between the parent and the judge to reinforce treatment and other service requirements.[49]		X	
The FDC has discussed whether jail can and will be used as a sanction and all team members understand the effect on the child and family reunification efforts. The entire team understands the circumstances, the duration and for whom jail may be useful as a method of motivating change.			X

[48]Cannavo, J. M., & Nochajski, T. H. (2011). Factors contributing to enrollment in a family treatment court. *The American Journal of Drug and Alcohol Abuse, 37*(1), 54-61. DOI:10.3109/00952990.2010.535579

[49]Carey, S. M., Mackin, J. R., & Finigan, M. W. (2012). What works? The 10 key components of Drug Court: research-based best practices. *Drug Court Review, 8*(1), 6-42. Retrieved from http://www.ndci.org/sites/default/files/nadcp/DCR_best-practices-in-drug-courts.pdf

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Recommendation 6 (continued): Address the Needs of Parents			
Engagement strategies are utilized to encourage early entry into FDC.[50]		X	
The FDC provides outreach to clients who do not keep their initial substance use disorder treatment appointment or drop out of treatment.			X
The FDC uses a coordinated legal and clinical plan to respond when a parent fails to keep a court date.			X
The FDC has staff who are trained in approaches to improve rates of engagement and retention and uses these strategies with parents.			X
• The FDC utilizes recovery coaches.[51,52,53]	X		
The FDC responds to client relapse and other risk indicators by reassessing clinical needs and child safety, and by re-engaging the client in treatment.			X

[50]Ibid.

[51]Dakof, G. A., Cohen, J. B., Henderson, C. E., Duarte, E., Boustani, M…, & Hawes, S. (2010). A Randomized pilot study of the engaging moms program for family drug court. *Journal of Substance Abuse Treatment, 38*(3), 263-274. DOI:10.1016/j.jsat.2010.01.002.

[52]Ryan, J. P., Choi, S., Hong, J. S., Hernandez, P., & Larrison, C. R. (2008). Recovery coaches and substance exposed births: An experiment in child welfare. Child Abuse & Neglect, *32*(11), 1072-1079.

[53]Ryan, J. P., Marsh, J. C., Testa, M. F., & Louderman, R. (2006). Integrating substance abuse treatment and child welfare services: Findings from the Illinois alcohol and other drug abuse waiver demonstration. *Social Work Research, 30*(2), 95-107. DOI: 10.1093/swr/30.2.95

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Recommendation 7: Address the Needs of Children			
The FDC uses an established protocol with healthcare professionals and treatment agencies for prioritizing and assisting participants who are pregnant and who are using substances.[54,55]	X		
The FDC follows the rules of the Indian Child Welfare Act (ICWA) and assures that the rights of Indian children are protected.			X
The FDC has implemented substance use disorder prevention and early intervention services for the children of parents in the FDC, using evidence-informed practice.[56]		X	
Children under three years of age are provided services that include the parent/caregiver as an active participant (as opposed to individual therapies).			X

[54]Dakof, G. A., Cohen, J. B., Henderson, C. E., Duarte, E., Boustani, M…, & Hawes, S. (2010). A Randomized pilot study of the engaging moms program for family drug court. *Journal of Substance Abuse Treatment, 38*(3), 263-274. DOI:10.1016/j.jsat.2010.01.002.

[55]Metsch, L. R., Wolfe, H. P., Fewell, R., McCoy, C. B., Elwood, W. N…, & Haskins, H. V. (2001). Treating substance abusing-women and their children in public housing: Preliminary findings. *Child Welfare, 80*(2), 199-220.

[56]Clark, H. W. (2001). Residential substance abuse treatment for pregnant and postpartum women and their children: Treatment and policy implications. *Child Welfare, 80*(2), 179-198.

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Recommendation 7 (continued): Address the Needs of Children			
Children of parents in the FDC have access to services that include interventions across children's developmental stages, including school readiness, adolescent substance use disorders and other treatment, and at-risk youth prevention and intervention programming.			X
The FDC ensures that children of parents in the FDC have a comprehensive health assessment that includes screening for developmental delays and neurological effects of prenatal exposure to alcohol and other drugs. This assessment also includes the physical, social-emotional, behavioral, and psychological effects of removal from their home, their parents' substance use, and exposure to trauma.[57]		X	
The FDC ensures that all children in out-of-home care are protected from further exposure to trauma arising from placement changes.			X
The FDC has the appropriate frequency and quality of visits necessary to establish and maintain attachments and relationships with their parents.[58,59]		X	

[57]Belcher, H. M. E., Butz, A. M., Wallace, P., Hoon, A. H., Reinhardt, E…, & Pulsifer, M. B. (2005). Spectrum of early intervention services for children with intrauterine drug exposure. *Infants and Young Children, 18*(1), 2-15.

[58]Hess, P. (2003). *Visiting Between Children in Care and Their Families: A Look At Current Policy*. New York: The National Resource Center for Foster Care and Permanency Planning.

[59]Nesmith, A. (2013). Parent-child visits in foster care: Reaching shared goals and expectations to better prepare children and parents for visits. *Child and Adolescent Social Work Journal*, *30*, 237–255.

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Recommendation 7 (continued): Address the Needs of Children			
The FDC has developed linkages to a range of programs, including quality early childhood development programs, that are targeted to meet the special developmental needs of children of parents in the FDC, including programs focused on school readiness and educational support.[60]		X	
The FDC uses effective models of prevention and intervention for children of parents with substance use disorders.[61]		X	
The FDC identifies gaps in services for children and works to identify or develop services to fill those gaps.			X
The FDC has established linkages to residential substance use disorder treatment that allows children to be placed with parents. Where those services do not exist, the FDC works with providers to develop a plan to create these services.[62]		X	

[60]Belcher, H. M. E., Butz, A. M., Wallace, P., Hoon, A. H., Reinhardt, E…, & Pulsifer, M. B. (2005). Spectrum of early intervention services for children with intrauterine drug exposure. *Infants and Young Children, 18*(1), 2-15.

[61]Spartaro, R.M. (2011). Nipping it in the bud: Adopting a family drug court approach to fighting the cycle of alcohol addiction for children when parents are convicted of DUI. Family Court Review, 49(1), 190-206.

[62]Metsch, L. R., Wolfe, H. P., Fewell, R., McCoy, C. B., Elwood, W. N…, & Haskins, H. V. (2001). Treating substance abusing-women and their children in public housing: Preliminary findings. *Child Welfare, 80*(2), 199-220.

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Recommendation 7 (continued): Address the Needs of Children			
FDCs have access to a full continuum of services for parents and their children.[63] Where there are gaps in the continuum or limited capacity, the FDC works with providers to develop a plan to improve the continuum or capacity of these services.	X		
Recommendation 8: Garner Community Support			
The FDC has developed and implemented strategies to recruit broad community participation in addressing the needs of the FDC families.			X
The FDC has included community members in a variety of roles. Community members participate in an advisory capacity during planning and program development, as well as offer input throughout the operational process. In some cases, community leaders may have a role on the Steering Committee.			X

[63]Lloyd, M. H., Johnson, T., & Brook, J. (2014). Illuminating the black box from within: Stakeholder perspectives on family drug court best practices. *Journal of Social Work Practice in the Addictions, (14)*4, 378-401.

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Recommendation 8 (continued): Garner Community Support			
The FDC has developed and implemented a formal mechanism to solicit support and input from community members and consumers. Participation in regular advisory and other committee meetings and workgroups, as well as contributing dialogue toward program development, are examples of the role and responsibilities of consumers and community members.			X
The FDC has conducted a needs-assessment of program participants, utilizing community mapping to identify existing services and service gaps. This process may build on the needs assessment that has been conducted by team member agencies.			X
The FDC staff identifies and links families with the support services that are frequently needed by clients (e.g., transportation, child care, employment, and housing). It has established relationships and developed memoranda of understanding, linkage agreements, or procedures with service providers.[64]		X	
The FDC uses up-to-date community resource directories to locate family support centers and resources.			X

[64]Grella, C. E., Needell, B., Shi, Y., & Hser, Y. (2009). Do drug treatment services predict reunification outcomes of mothers and their children in child welfare? *Journal of Substance Abuse Treatment, 36*(3), 278-293. DOI: 10.1016/j.jsat.2008.06.010

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Recommendation 8 (continued): Garner Community Support			
The FDC has access to community-wide accountability systems to monitor substance use disorder and child welfare issues with specific indicators for both systems. In jurisdictions where this ability does not exist, the FDC works with substance use disorder and child welfare leaders to create this resource.			X
The FDC uses sober living communities and housing for parents in recovery.			X
The FDC has connections with services to include job training, financial coaching and supports[65] and faith-based recovery support.[66]	X		
• The FDC has built upon other community and problem-solving efforts, working with other drug courts when appropriate.			X
Consumers (e.g. parents in recovery, program graduates) have an active advisory role in planning, developing, and providing ongoing feedback in the FDC.			X

[65]Powell, C., Stevens, S., Lo Dolce, B., Sinclair, K. O., & Swenson-Smith, C. (2012). Outcomes of a trauma-informed Arizona family drug court. *Journal of Social Work Practice in the Addictions, 12*(3), 219-241.

[66]Child, H., & McIntyre, D. (2015). Examining the relationship between family drug court program compliance and child welfare outcomes. *Child Welfare Journal, 94*(5), 67-87.

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Recommendation 8 (continued): Garner Community Support			
The FDC has established alumni groups and uses alumni in an active advisory role in planning, developing, and providing feedback to the FDC.			X
Youth and former foster children/youth have an active advisory role in planning, developing, and providing feedback to the FDC.			X
The FDC has policies and practices to better link parents to continuing care services that include the full array of family income support programs (EITC, Child Support, SCHIP, Supplemental Nutrition Assistance Program (SNAP), Housing Subsidies, etc.).[67]		X	
A plan is implemented to conduct regular community outreach and education throughout the year to community groups and other stakeholders to engage and inform, and to support sustainability. All team members participate in the development and implementation of the plan and parents are included as presenters, when appropriate.			X

[67]Children and Family Futures. (2011). The collaborative practice model for family recovery, safety, and stability. Irvine, CA: Retrieved from http://www.cffutures.org/files/PracticeModel.pdf

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Recommendation 9: Implement Funding and Sustainability Strategies			
The FDC team has a long-range plan focused beyond the expiration of one-time project grant funding to sustain the FDC on an ongoing basis. This plan identifies and has an inventory of:			
Funds already directed to FDC participants and their families, but not necessarily identified as part of the FDC budget			X
A full scope of services already available in the community for FDC participants and their families			X
A list of service gaps			X
Existing civil service positions that can be used or amended to focus on serving the FDC population			X
Various Federal, State and local funding streams available to assist the FDC population			X
The different funding sources for comprehensive family treatment and what services such funding provides.			X
A plan is implemented to fund substance use disorder treatment, leveraging other funds such as Medicaid, Substance Abuse Prevention and Treatment Block Grant, child welfare funding streams and other community resources.			X
The FDC collaborates with TANF to fund substance use disorder treatment and supportive employment-related programming.			X

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Recommendation 9 (continued): Implement Funding and Sustainability Strategies			
There is a plan in place to fund FDC infrastructure (e.g. coordinator, dedicated case managers) through child welfare funding, the court's budget, and existing community agencies.			X
The FDC has identified items to be included in the FDC overall budget including:			
• FDC infrastructure			X
• Substance use disorder treatment specialized for this population			X
• Services for children, including resources to assure that each child has developmentally appropriate screenings for the effects of substance use disorders			X
• Services for families, including services to improve participants' parenting skills			X
• Training for the FDC team			X
• Costs of evaluation and outcomes management to enable the FDC to demonstrate accomplishments			X
Outcomes are used to inform ongoing review and modification of program policy and procedures.[68]		X	

[68]Carey, S. M., Sanders, M. B., Waller, M. S., Burrus, S. W. M., & Aborn, J. A. (2010). *Jackson County community family court process, outcome, and cost evaluation: Final Report.* Portland, OR: NPC Research. Retrieved from http://npcresearch.com/wp-content/uploads/Jackson_Byrne_06101.pdf

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Recommendation 9 (continued): Implement Funding and Sustainability Strategies			
FDC partners are aware of, share information about, and use the State and local budget process to support the FDC. The FDC's partners (child welfare system and substance use disorder treatment agencies and dependency courts) are able and willing to share information about each other's budgets and staffing.[69]			X
FDC partners have implemented joint funding strategies (i.e., braided/blended funding) to support the FDC.			X
The FDC has created a non-profit 501c (3) corporation or worked with the local community foundation to establish a fund for the FDC so that contributions to the program can be made.			X
The FDC partners work together to obtain external funding and its application and management is a joint process.			X
The FDC has sought funding to take the program to the scale of operations needed to meet the demand for these services over a multi-year period.			X
The FDC is embedded in agency, court and treatment provider budgets rather than relying on one-time project grants.			X

[69]Children and Family Futures. (2014) Sustainability Matrix. Irvine, CA: Retrieved from http://www.cffutures.org/files/publications/Sustainability%20Matrix.pdf

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Recommendation 9 (continued): Implement Funding and Sustainability Strategies			
The FDC has sought commitment to program objectives from a wide range of community based organizations and entities.			X
The FDC has a community outreach and education plan to further sustainability efforts.			X
Recommendation 10: Evaluate for Shared Outcomes and Accountability			
The FDC collects and uses referral and admission data to monitor engagement, and works with child welfare partners to assure all eligible families are referred.			X
The FDC has developed outcomes to be monitored to share accountability and success.			X
The FDC collects and uses data, and seeks the support and insights of experts to make ongoing adjustments to enhance practices.[70]		X	
0The FDC has identified system level outcomes and has developed methods to monitor them with the court, child welfare, and substance use disorder treatment partners.[71]		X	

[70]Carey, S. M., Mackin, J. R., & Finigan, M. W. (2012). What works? The 10 key components of Drug Court: research-based best practices. *Drug Court Review, 8*(1), 6-42. Retrieved from http://www.ndci.org/sites/default/files/nadcp/DCR_best-practices-in-drug-courts.pdf

[71]National Association of Drug Court Professionals. (2015). Adult *drug court best practice standards Volume II.* Alexandria, VA: Retrieved from http://www.ndcrc.org/sites/default/files/adult_drug_court_best_practice_standards_volume_ii.pdf

Research Categories Recommendations and Effective Strategies	Programs and Activities Supported by Evidence from Research Conducted in Family Drug Court Settings	Programs and Activities Supported by Evidence from Research Conducted in Non-Family Drug Court Settings	Programs and Activities That are Common Practice in Family Drug Courts with Little or No Evidence
Recommendation 10 (continued): Evaluate for Shared Outcomes and Accountability			
The FDC has agreed on how to use information to inform policy makers and community leaders and to communicate those outcomes as part of their sustainability plan.			X
The FDC uses outcomes information to determine provider effectiveness and are able to use those providers that are most effective in serving FDC participants.			X
The FDC has identified comparison groups that make the evaluation results credible.[72]		X	
The FDC has allocated funds or secured agency resources to collect, analyze, report and monitor data.			X
The FDC team shares accountability for successful treatment and child safety/permanency outcomes and ASFA compliance for their mutual clients.			X
The FDC includes outcome criteria in their contracts with community-based providers and measures the effectiveness of providers in achieving the outcomes. The criteria focuses on measures beyond number of clients served or clients entering treatment to functional improvements after discharge and FDC completion.			X

[72] Ibid.

Research Categories Recommendations and Effective Strategies	Programs and Activities Supported by Evidence from Research Conducted in Family Drug Court Settings	Programs and Activities Supported by Evidence from Research Conducted in Non-Family Drug Court Settings	Programs and Activities That are Common Practice in Family Drug Courts with Little or No Evidence
Recommendation 10 (continued): Evaluate for Shared Outcomes and Accountability			
The FDC clients are referred to child development and parenting education programs that have demonstrated positive results and that use evidence-informed practices with this population.			X
The FDC has developed, identified, and assessed common points where clients drop out of the FDC system prior to completing treatment. This information is used to modify program processes, requirements and services, and informs program benchmarks.			X

APPENDIX E – REFERENCES

This appendix provides a list of the publications that Children and Family Futures reviewed to inform the development of the 10 recommendations in this document and to identify the effective strategies for each recommendation.

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