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Strengthening Partnerships, Improving Family Outcomes

Family Treatment Court

PLANNING GUIDE

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Family Treatment Court Planning Guide

Prepared by the National Drug Court Institute, the education, research, and scholarship affiliate of the National Association of Drug Court Professionals.

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In the short span of approximately seven years, family treatment court has emerged as one of the most promising models for improving treatment retention and family reunification rates in the child welfare system… The most rational and humane course of action to protect children is to build upon the firm foundation of success that is emerging from family treatment court.[1]

– D. B. Marlowe and S. M. Carey, May 2012

Introduction

Family Treatment Court: Reinventing, Reconnecting, Redefining

In 1995, family treatment courts began concurrently in Reno, Nevada, and Pensacola, Florida.[2] Today, more than 300 family treatment courts nationwide are successfully applying the treatment court model to child welfare cases that involve allegations of child abuse or neglect related to parental use of alcohol or other drugs.[3] But helping individual families from different backgrounds is a complex task. Determining which methods will motivate which families can be difficult. Strong cultural beliefs about what is normal can affect success. Thus, the family treatment court model provides the support system necessary for families with complex needs that require intensive treatment, accountability, monitoring, services, and supports for successful reunification.[4] Family treatment courts are accomplishing this by

- **Reinventing** how communities respond to families affected by substance use disorders
- **Reconnecting** families with the values that are relevant to their system of success
- **Redefining** how child welfare, substance use disorder treatment, and dependency court strategies and practices affect the future of every community

This comprehensive family-centered approach provides a solid foundation for families to grow beyond child welfare, social services, and criminal justice issues.

The Need for Family Treatment Courts

The 2014 National Survey on Drug Use and Health reported 8.7 million children under the age of 18 living with at least one parent who was dependent on or abused alcohol or an illicit drug.[5] Although not all of these children will experience abuse or neglect, they are at higher risk of experiencing maltreatment. The exact number of children and families in the child welfare system who are affected by parental substance use is unknown, but a 2015 article estimates a range of 5% to 90%.[6] The challenges parents face due to substance use disorders potentially hinders their ability to appropriately care for children, delays reunification, and may lead to the termination of parental rights.[7]

Families affected by parental substance use disorders often face co-occurring issues such as mental illness; posttraumatic stress disorder; social isolation; poverty; unstable housing; domestic violence; lack of access to health care services, children's developmental services, and appropriate child care; transportation issues; educational challenges; and lack of stable employment.[8] Under the more traditional family court system, a disconnect between family court, child protective services, and substance use disorder treatment services often leads to uncoordinated and limited services. Without the support of integrated services to aid parents affected by substance use disorders, children will likely spend more time separated from their families.[9]

The Adoption and Safe Families Act

Congress passed the Adoption and Safe Families Act (ASFA) in 1997 to strengthen the performance of child welfare systems. ASFA's primary goal is to provide for the safety, permanent placement, and well-being of children in a timely manner.[10] ASFA mandates that courts finalize permanent placement no later than 12 months after a child enters foster care. It also requires (in most cases) that courts begin termination of parental rights after the child has been removed from the home for 15 of the last 22 months.[11]

Child welfare and clinical experts have expressed concern that the time frames imposed by ASFA are unrealistic, given the time necessary for effective substance use disorder treatment and sustained recovery of parents with a substance use disorder.[12] Without access to appropriate treatment, comprehensive case planning, and structured and frequent visitation/parenting time, parents often struggle to comply with complex court orders. Furthermore, although ASFA mandates more frequent case reviews by the court, the first review hearing commonly occurs six months after the disposition of a case, leaving the parent very little time to complete the case plan and comply with court requirements.

What Is a Family Treatment Court?

The planning, implementation, and operation of a family treatment court is not as simple as taking the adult criminal or juvenile delinquency treatment court model and inserting it into the family court setting. The focus, structure, purpose, and scope of family treatment court differ significantly from those of adult criminal and juvenile delinquency treatment court models and even differ from those of family court. In the traditional family court system, professionals from child protective services, treatment providers, and public health systems often report *separately* to the court. This can result in the different disciplines making requests that are inconsistent with each other and can ultimately lead to outcomes that may not be in the best interests of the children or support the parents' efforts to regain custody and keep their families together.[13]

Family treatment court builds on the treatment court model in family court to include cases entering the child welfare system that allege child abuse or neglect involving parental use of alcohol or other drugs.[14] The family treatment court's mission is to ensure the safety and well-being of children and to offer parents a viable option to reunify with their children. A family treatment court does this by providing children and parents with the skills and services necessary to live productively and establish a safe environment for their families.[15] The court partners with child protective services and an array of service providers for parents, children, and families.[16] The court fosters collaborative relationships among systems to effectively manage cases of abuse and neglect, and to link families to service providers.[17] It also brings professionals together on an interdisciplinary team to work *together* to address the complex issues facing families affected by substance use disorders. Family treatment court draws on best practices from the treatment court model, dependency court, and child welfare services to effectively manage cases within ASFA mandates.[18] In this way, family treatment court ensures the best interests of children while providing necessary services to parents. Without these intensive services, the parents would risk losing custody of their children and put future children at risk.

Family Treatment Court: A Collaborative Team Approach

Improved collaboration between team members from the court, child welfare, and substance use disorder treatment and social services agencies is a key component of the family treat-

ment court approach.[19] To ensure the safety and well-being of children, and to offer parents the tools and support they need to address the challenges they face due to their addiction and to become sober, responsible caregivers, these separate disciplines must work together effectively.[20] To promote the collaborative approach, the court assembles a multidisciplinary team that assesses the family's capacity and strengths and devises a comprehensive case plan that addresses the needs of both the children and the parents.[21] The team systematically addresses the effects of pre- and postnatal exposure to alcohol or other drugs on the children. They determine the pace and order of each requirement in the case and treatment plans, and they meet regularly to review and modify these plans.[22] The team meets at least twice per month with the parent, which allows for timely coordination of services within the community for children and parents and for responses to behaviors. In addition to overseeing parental compliance with substance use disorder treatment and other family court orders, the team also makes recommendations to the judge for responses to behaviors to discourage noncompliance and encourage positive behavior. Finally, the team meets with the judge and provides accurate, timely information on each case brought before the court that day.[23]

Although the leadership role during the development and operation of a family treatment court team may be shared, the judge is the team's convener and leader in the family treatment court process because of the court's legal responsibility to make judgments about the best interests and safety of children. Court appearances are a valuable opportunity for the judge to interact with each parent regularly, providing immediate responses to compliance and noncompliance with both support and redirection. The courtroom, traditionally adversarial, is transformed into an opportunity for judges to acknowledge the success of parents, children, and families, and to constructively address problems. In a family treatment court, parents are empowered to be involved in decision making, encouraged to engage in prosocial activities, required to become involved in services and activities with their children, and acknowledged for their accomplishments. Parents also must face their problems and be held accountable for noncompliance. Although the participants in family treatment court hearings are the parents, the focus of the staffing and court hearing is on the progress and obstacles facing the family.

The family treatment court approach increases communication and information sharing between the constituencies that compose the treatment court team and also increases communication between these constituencies and families, thus providing the necessary support and guidance to protect children and reunite families.[24]

How to Use the Family Treatment Court Planning Guide

The amount of work to launch a family treatment court in your jurisdiction might seem overwhelming. So many questions arise.

- How do you lay a solid foundation to effectively plan your program?
- How do you identify the right partners for collaboration?
- How do you assemble teams to create and maintain your program?
- How do you develop protocols and practices to ensure efficient implementation?
- How do you pay for all of the services for parents and children? How do you maintain your court into the future?
- How do you garner sustained support and buy-in?
- How do you improve your operational components and process as you go forward to generate better outcomes?
- How do you evaluate the program?

This guide will walk you through the critical topics and decisions you and your planning team will have to make when planning a family treatment court.

Who Is the Family Treatment Court Planning Guide For?

No matter what your role in the system is, and no matter where you are in the process of pursuing the institution of a family treatment court, this guide will be a valuable resource in accomplishing your goals. Key decision makers (e.g., family or juvenile court judges, court administrators, directors of child protective services) can use the information within this guide to recruit and motivate the multidisciplinary, collaborative planning team necessary to begin the planning process. Any professional involved with a court (e.g., child protective services worker, public defender, provider of substance-use treatment) can use this guide to gather the information needed to present the family treatment court concept to decision makers and educate them about the tasks involved in starting a program.

However, the primary purpose of the *Family Treatment Court Planning Guide* is to provide step-by-step instructions for a *planning team*. Planning team members will work through the *Family Treatment Court Planning Guide* to complete the entire planning process, either in a series of meetings or in two or three multiday retreats that will lead to the creation of a family treatment court in your jurisdiction.

Organization of the Family Treatment Court Planning Guide

The *Family Treatment Court Planning Guide* is designed to walk a team through the assessment, development, and implementation or enhancement of a program. It has three components: chapters, appendices, and worksheets.

Chapters: The main text describes the critical topics you and your team will address when planning your family treatment court, including laying a solid foundation to plan the program effectively, developing protocols and practices to ensure the efficient implementation of the program, and sustaining and fine-tuning the operational components of the program into the future. This text can also be used as a resource to orient new team members.

Chapter 1. The Planning Process

Chapter 2. Understanding Addiction and Treatment

Chapter 3. Setting a Direction

Chapter 4. Structuring Your Family Treatment Court Program

Chapter 5. Sustaining Your Program into the Future

Appendices: These sections list supporting information and focus on field experts' presentations, sample documents, reference material, and other helpful links to support local efforts and provide national resources to further support the planning, development, implementation, and operation of your program.

Appendix A. Instruments, Tools, and References

Appendix B. Sample Consent and Progress Report Forms

Worksheets: Each worksheet will take you step-by-step through the planning process for each topic, detailing what information to gather, whose help to enlist, and what decisions need to be made. Additionally, the worksheets will become a resource to help you resolve many of the questions your team will face when assessing need, developing a local program, implementing programs, and enhancing existing programs.

Worksheet 1: Making the Case for Change: The Family Treatment Court Model

Worksheet 2: Gathering Relevant Data to Support the Family Treatment Court Concept

Worksheet 3: Community Resources Mapping

Worksheet 4: Planning, Steering, and Operational Teams

Worksheet 5: Visiting a Family Treatment Court

Worksheet 6: Cultural Competence

Worksheet 7: Ensuring System Accountability: Legal Mandates, Ethics, and Confidentiality

Worksheet 8: Vision, Mission, Goals, and Objectives

Worksheet 9: Long-Term Strategic Planning

Worksheet 10: Structural Program Design, Target Population, and Eligibility Criteria

Worksheet 11: Screening and Assessment

Worksheet 12: Family Treatment Court Entry Process

Worksheet 13: Developing Your Family Treatment Court Phase Structure

Worksheet 14: Comprehensive Service Delivery for Parents, Children, and Families

Worksheet 15: Case Management, Community Supervision, and Drug Testing

Worksheet 16: Responding to Behavior

Worksheet 17: Graduation from the Program/ Termination from the Program

Worksheet 18: Monetary and Nonmonetary Funding

Worksheet 19: Community Partnerships and Cross-Training

The success of treatment courts has spawned a new generation of alternative problem-solving court programs that are confronting emerging issues in our nation. The treatment court model has been adapted to other specialized court models including DWI and DUI courts, veterans treatment courts, mental health courts, juvenile treatment courts, and family treatment courts. The adult model paved the way for juvenile and family treatment courts.[25]

1. The Planning Process

Making the Case for Change—The History of Treatment Courts

The first treatment court began operations in Miami-Dade County, Florida, in 1989. Tired of the same faces and the same cases appearing repeatedly before the court, a visionary group of justice professionals decided that the existing system was broken and there had to be a better way.[26] They found a solution by combining substance use disorder treatment with the structure and authority of the court. Working as a team, they were able to effect lasting change in the lifestyle and behavior of treatment court participants.[27]

The Miami-Dade Adult Drug Court sparked a national revolution that has forever changed our justice system. Ten years after the first treatment court was founded, 472 adult treatment courts existed.[28] By 2017, more than 3,100 treatment courts had expanded into every U.S. state and territory.[29] Treatment courts have transformed millions of lives. Today, the treatment court movement continues to spread throughout the world. In the years since the first treatment court was founded, more research has been published on the effects of treatment courts than on virtually all other justice programs combined. The scientific community has put treatment courts under a microscope and concluded that they work better than jail or prison, and better than probation and treatment alone. Treatment courts significantly reduce drug use and crime, and are more cost-effective than any other proven criminal justice strategy.[30]

Nationwide, 75% of treatment court graduates remain arrest free at least two years after leaving the program. Rigorous studies examining long-term outcomes of individual treatment courts have found that reductions in crime last at least three years and can endure for more than 14 years. Treatment courts provide more comprehensive and closer supervision than other community-based supervision programs. They are six times more likely to keep offenders in treatment long enough for them to become clean and sober.[31]

The Family Treatment Court Model

Family treatment court is a juvenile or family court docket for cases of child abuse or neglect in which parental substance use is a contributing factor. Judges, court personnel, attorneys, child protective services, treatment professionals, and other community partners unite with the goal of providing safe, nurturing, and permanent homes and developmental services for children while providing parents with the necessary support and services they need to achieve stable recovery. Family treatment courts aid parents or guardians in regaining control of their lives. They foster long-term stabilized recovery to promote family reunification within mandatory legal time frames.[32] They take a family-centered approach, protecting the best interests of the child by intensive use of resources and commitment on the part of the judge, treatment team, and parent to help the parent address a

substance use disorder, to provide a safe and nurturing environment for the child, and to ensure that timely and developmentally appropriate services reach the child.

Applying the 10 key components of a drug court[33] is necessary to maintain fidelity to the treatment court model. However, family treatment court programs differ from both adult and juvenile treatment courts. Because the focus of a family treatment court is the family unit, the emphasis is on responding to family needs and strengths and attending to both parent and child. Developing a family treatment court is not as simple as applying the adult criminal or juvenile treatment court model to the dependency court setting. Although the parent is the participant, the child's safety and permanency are always the primary concern. The family treatment court model applies a holistic approach to aiding parents and protecting children by focusing on a family's justice and child welfare involvement, identifying collaborative and effective service responses, and ensuring frequent interaction with the family to monitor progress.[34]

The significant differences between family and adult treatment court programs are discussed in two key documents:

- Family Dependency Treatment Court: Addressing Child Abuse and Neglect Cases Using the Drug Court Model [35]
- Guidance to States: Recommendations for Developing Family Drug Court Guidelines[36]

The family treatment court approach has resulted in better collaboration between agencies and better compliance with treatment and other family court orders necessary to improve child welfare case outcomes.[37,38] Creating a family treatment court does not require statutory or constitutional change. The program operates within the family court and child welfare systems as they exist within your jurisdiction.[39,40,41,42]

First Steps

The integration of the family treatment court model into the existing systems is an opportunity for communities to address the issues of parental substance use disorders and child maltreatment. With the focus on the best interests of the child and family, the treatment court planning team will concentrate on critical concepts (e.g., therapeutic jurisprudence, evidence-based services, effective substance use disorder treatment, strengths-based and trauma-informed care, collaborative case planning, information sharing) during the planning process.

You and your planning team should take time to peruse the following lists of components, characteristics, and recommendations to help build the foundation for a family treatment court. These lists summarize three pivotal documents. For your convenience, ***Worksheet 1 sets these lists side by side.***

Key Components of Drug Court

From *Defining Drug Courts: The Key Components* [43]

1. Drug courts integrate alcohol or other drug treatment services with justice system case processing.

2. Using a nonadversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.

3. Eligible participants are identified early and promptly placed in the drug court program.

4. Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.

5. Abstinence is monitored by frequent alcohol and other drug testing.

6. A coordinated strategy governs drug court responses to participants' compliance.

7. Ongoing judicial interaction with each drug court participant is essential.

8. Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.

9. Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.

10. Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court effectiveness.

Family Treatment Court Common Characteristics

From *Family Dependency Treatment Court: Addressing Child Abuse and Neglect Cases Using the Drug Court Model* [44]

1. Focus on the permanency, safety, and welfare of abused and neglected children as well as the needs of the parents.

2. Provide early intervention, assessment, and facilitated access to services for parents and children in a holistic approach to strengthen family function.

3. Develop comprehensive service plans that address the needs of the entire family system.

4. Provide enhanced case management services to monitor progress and facilitate access to services.

5. Schedule regular staff meetings to facilitate the exchange of information and coordinate services for the family.

6. Increase judicial supervision of children and families.

7. Promote individual and systems accountability.

8. Ensure legal rights, advocacy, and confidentiality for parents and children.

9. Operate within the federal mandates of the ASFA and Indian Child Welfare Act.

10. Secure judicial leadership for both the planning and implementation of the court.

11. Commit to measuring outcomes of the family treatment court program and plan for program sustainability.

12. Work as a collaborative, nonadversarial team supported by cross-training.

Guidance to States

From *Guidance to States: Recommendations for Developing Family Drug Court Guidelines* [45]

1. Create a shared mission and vision.

2. Develop interagency partnerships.

3. Create effective communication protocols for sharing information.

4. Ensure cross-system knowledge.

5. Develop a process 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 shared outcomes and accountability.

Language and Principles of Stakeholders

A family treatment court requires the collaboration of multiple systems: child protective services, family court, substance use disorder treatment and other service providers, and—in some jurisdictions—adult criminal court.[46,47] However, collaboration can be a challenge because each of these systems has its own procedures, mandates, and vocabulary, which need to be commonly understood among your planning team members to avoid misunderstanding and confusion as the process unfolds.

Each system has its own definition of who the client is, what outcomes are expected within certain time frames, and how to respond appropriately to setbacks. Beyond these, the legal and policy environments within which the agencies operate also

affect their ability and willingness to work together. Although these environments are shaped by state and federal laws on child abuse and neglect, your planning team can and should adapt policies and procedures further to serve your jurisdiction and address such issues as:

- The sense of crisis under which many child welfare agencies work
- The chronic shortages of substance use disorder treatment services
- The challenges of confidentiality requirements on sharing of information
- Delays in traditional legal practices

Each planning team member must have a fundamental understanding of how various systems work and the value that each discipline brings to a family treatment court program and to the children and families served.

This begins through the development of an understanding of the philosophy, procedures, and language that other disciplines use. For example, the term *assessment* likely means different things to professionals from different disciplines. To the child welfare worker, it might refer to a safety assessment. To a treatment provider, it might be an evaluation of a parent's substance use disorder treatment needs. A trained social worker might assume an assessment addresses social circumstances such as housing, employment, and family makeup, whereas a judge who asks for an assessment likely expects a comprehensive evaluation of the entire family on issues such as health, mental health, and the child's developmental status. Bridging such gaps in vocabulary opens the lines of communication to build relationships across disciplines. With this broader perspective, your team members can tailor the family treatment court to complement existing practices and avoid misunderstandings or duplication of effort.

In the initial stages of planning, your family treatment court planning team should conduct a cross-training session. Team members from each discipline (including court administrative staff) should present a general overview of their discipline's organization and its role with the families it serves. The presentation should also include policy-specific issues that may affect the presenter's ability to support an operational program. Other partners, such as court-appointed special advocates (CASAs), early childhood developmental services, housing services, and parenting skills program providers, should provide additional cross-training sessions when they join the family treatment court effort and before the family treatment court becomes operational. By the end of each presentation, your team members should understand these points:

- What is required of each member in his or her job (roles and responsibilities)?
- What are the statutory or regulatory requirements associated with each member's job?
- How will the team identify overlapping services?
- How should the family treatment court accommodate the requirements of each member's job?
- In what areas can the family treatment court assist each member in doing his or her job?
- How will team members be accountable to each other?

Demonstrating mutual respect for the other disciplines with this collaborative approach will establish the foundation to take your program to scale.

Fundamental Tasks for Implementation

In the initial planning stages, two fundamental tasks are critical to effectively implement a family treatment court.

- Garner support and commitment from agencies that will compose your team, and ask them to help identify additional key stakeholders (e.g., housing providers, early education experts, local business community, faith leaders) who should be on the team.

- Determine and codify the need for a family treatment court in your jurisdiction.

To accomplish these tasks, you and your team, once it is established, will require a thorough understanding of the principles of family treatment court. You will also need local child welfare and substance use disorder treatment data to demonstrate how the family treatment court will help families in your community.

Multidisciplinary Support

The operation of a family treatment court program requires the full commitment of the partners that will make up your planning team. Only with this commitment from agencies and organizations working together will you be able to effectively plan and implement best practices. Team members should be decision makers from each partnering organization with the ability to make policy decisions for their agency. Your planning team will assess current policies and practices across the different disciplines they represent and identify ways to improve services for families through the design of a family treatment court. Although these different partners may work cooperatively with one another, they may not have experience working collaboratively. The family treatment court model is more than just partners cooperating as different disciplines; this approach brings together the justice, child welfare, and substance use disorder treatment systems, as well as other providers, into a seamless program supported by interagency protocols and practices.

Establishing Need

Although the need to implement a family treatment court may be apparent to you, you must make the need crystal clear to all team members and community stakeholders. You must collect relevant data to demonstrate the necessity for a family treatment court in your community to address the pervasiveness and destructiveness of alcohol and drug use on children and families. Some of the data should include the number of annual child welfare cases, the number of children in out-of-home care, and reunification and timely permanency rates. Starting a family treatment court may appeal to some members of the community, but planning and operating a family treatment court involves a significant investment of time, resources, and money. To strategically plan a family treatment court, you will need to gather baseline information to understand the way in which community agencies independently and collaboratively address child protection cases involving parental substance use.

Assessing the Effect of Implementing a Family Treatment Court

First, gather information about the scope and nature of the cases that encompass child abuse and neglect and substance use or co-occurring disorders within families. Strong data establish a clear picture of who, what, when, where, and how substance use is affecting children and families in the child welfare and family court systems. This information is the rationale for the creation of the family treatment court. Later, it will also give you a foundation for making decisions about appropriate participants, program development, and resource allocation. By engaging your team in an analysis of the data and answering critical questions, you will be prepared to make decisions about how to structure your family treatment court.[48]

Second, identify the current processes in place that move cases through the child protection, family court, and treatment service systems for adults, adolescents, children, and families. What are the legal time frames that govern the processes and cases? What services are available to families? How are they provided? Examine the coordination of these procedures. Do they ensure the ultimate safety, timely permanency, and basic well-being of children? Do they also

support parents in their efforts to achieve recovery and provide a nurturing and safe home environment? A clear picture of current practices within jurisdictions across the country has led courts to reconsider business as usual and more effectively address child maltreatment. Your assessment of current practices against federal and state mandates will help you identify the needs in your community and ultimately lead to a blueprint for planning, implementing, and operating your family treatment court.

Although gathering this data will require an extensive effort on the part of your team, doing so is imperative. Gathering this data will aid you in your efforts to bring together stakeholders and to create a proposal for and establish a more effective treatment court. In addition, it will be useful in convincing funders and for writing grants applications and thereby establishing funding, because funders usually ask for problem statements and supporting data.

The information necessary for answering these questions may not be readily available in one location or even in your community. You may need to seek out information kept by child protective services, law enforcement, treatment providers, and the court. Ask around; you may find an agency that is tabulating this information, a group that has recently developed a data set for a grant, or a collaborative effort that conducts ongoing strategic planning activities. Your partners may have contacts in their state offices who can assist in identifying data sources.

Use Worksheet 2 to help you gather the data you need.

Finally, assess the strengths and challenges that community agencies possess. Analyze community assets to discover their limitations and how they might be reallocated or used more effectively. This assessment, or community resources mapping, will prove invaluable for connecting key stakeholders, managing case plans, and providing effective services and support to families. Knowing the existing programs and services available within the community will help you understand how your family treatment court will fit within existing structures and fully meet the needs of children, parents, and families. This is an opportunity for the team to work together to discover what exists in the community and to deliberate on how best to utilize these partnerships to improve outcomes.

The community resources mapping exercise in ***Worksheet 3 will walk your team through identifying those systems, partnerships, and collaborative opportunities***.

Identify a Governance Structure

Family treatment courts depend on the involvement of many organizations that traditionally have not worked together in justice, child welfare, and substance use disorder treatment processes. By finding these organizations and working with them to plan the program, you will build partnerships, involve the broader community, leverage resources, and generate innovative approaches.

Typically, you will assemble the following groups to support the development and guide the operation of your family treatment court:

- The planning team: This team gathers information, develops an operational plan, and evolves to resolve policy and procedure issues that arise once the family treatment court is up and running. Because this team is established to set up a family treatment court, it will eventually disband.
- The steering committee: Made up of high-level administrators across agencies with the authority to shape policies and practices for their organizations, this committee oversees the planning process. It sets major policy directions, identifies and finds solutions to barriers, and secures resources for the family treatment court to ensure its sustainability.

- The operational team: This team works day to day in the family treatment court with the participants.
- Executive oversight committee: Optional but recommended, this committee is made up of high-level administrators across agencies who have the authority in their organization to shape practice and policy and ensure program sustainability.

Membership among these groups may overlap, depending on the size of your jurisdiction and local practices, and in some jurisdictions the planning team becomes the steering committee once the family treatment court is operational.[49]

Worksheet 4 and the sections that follow will guide you in the process of creating a structure for your family treatment court.

The Planning and Operational Teams

During the initial stages of the planning process, you will focus on assembling your planning team. It should be made up of individuals who represent their organizations' goals and interests, are committed to the concept underlying family treatment court, are flexible in how they discharge their agency responsibilities, and have the authority to make policy decisions on behalf of their agencies. This last point cannot be stressed enough. The planning team must be made up of individuals who can make policy decisions for their agencies. During your first few meetings, share your collected information and your decisions about policy and program design. For example, the planning team will undoubtedly be helpful in obtaining dependency court and parental substance use disorder treatment data.

Ultimately, the planning team will dissolve and its members will transfer to either the steering committee or the operational team. The operational team and the planning team share many of the same requirements for their members; however, the operational team is more likely to consist of line staff who are delivering direct services.

Participation on either team requires attention to both traditional and nontraditional roles and responsibilities. Your planning and operational teams need to understand the roles and responsibilities of all team members in both the planning and operational stages of your family treatment court. This understanding will help team members build mutual trust, promote equitable and effective distribution of work, and avoid confusion, gaps in duties, and duplication of effort.[50]

The members of both teams must know the ethical, legal, policy, and procedural restrictions of each discipline. Review the following list of suggested team members and their responsibilities with the members of your teams to identify challenges and determine if adjustments need to be made.

Judicial Officer

- Ensure the child's safety, permanency, and well-being
- Oversee the progress of the family members and serve as the team leader
- Serve as role model and authority figure for participants
- Keep colleagues and the community informed about the family treatment court
- Educate team members and participants about courtroom policies and procedures
- Hold parent participants accountable

Planning Coordinator or Court Administrator

- Prepare monthly budget reports
- Organize planning meetings
- Oversee policies and procedures
- Maintain files
- Oversee record keeping and statistical reporting
- Assist in the budget process and grant writing
- Identify and allocate resources
- Oversee budgeting and evaluation efforts
- Help establish common goals among the systems (e.g., justice, treatment, child welfare)

Child Welfare Professional

- Ensure child safety
- Ensure that children receive appropriate developmental and mental health services
- Ensure frequent and appropriate visitation/ parenting time
- Coordinate foster care placements
- Identify and refer eligible families to the family treatment court
- Develop ways to motivate and encourage parents to enter and complete treatment
- Connect families to supports and services, aftercare, and recovery maintenance services
- Monitor cases during and after treatment

Agency or Prosecuting Attorney

- Ensure that ASFA timelines are planned and met
- Ensure the safety and best interests of the child
- Monitor dependency court cases
- Assist in identifying eligible families
- Formally screen individual candidates to ensure that they meet eligibility criteria for family treatment court
- File all motions and petitions required for parents' involvement in the family treatment court

Parent Attorney or Defense Counsel

- Represent and safeguard parents' interests throughout the planning process while guarding the welfare and safety of the child
- Make parents aware of the benefits of the family treatment court
- Keep parents informed about court procedures
- Encourage parents to participate and engage parents to complete the family treatment court program
- Handle any related criminal charges against parents

Child Attorney or Representative

Representatives include CASAs and guardians ad litem.

- Provide a voice for the children
- Bring attention and focus to the needs of the children
- Protect the children's health and safety
- Advocate for the best interests of the children
- Ensure that the children and their parents receive necessary services in addition to substance use disorder treatment

Substance Use Disorder Treatment Provider

- Develop an assessment-driven treatment plan, understanding the parameters of ASFA
- Provide mechanisms for communicating parents' progress in treatment, the results of drug testing, and other relevant information
- Determine the appropriate substance use disorder treatment and continuum of care for parents
- Educate the teams on relevant issues regarding treatment modalities, relapse, and substance use specific to their jurisdictions

Mental Health Representative

- Assess and treat parent and child mental health conditions, and develop an integrated treatment plan with the substance use disorder treatment provider to address parents' co-occurring disorders.
- Suggest strategies for parents whose mental health issues create a danger to their children
- Provide valuable knowledge and resources to the team regarding children with mental health diagnoses

Child Development Specialist or Therapist

- Provide treatment services to children addressing their physical, developmental, social, emotional, and cognitive needs
- Assist in the development of case plans, which incorporate risk and protective factors

Public Health Representative

- Provide guidance on developing methods to improve the health and ensure the safety of participant families
- Link participant families to needed health services (e.g., dental, medical)
- Assess the recovery environment of the parent's home

Evaluator

- Ensure that the team's goals and objectives are measurable and quantifiable
- Assist the operational team and steering committee in using data to make program modifications
- Gather data relevant to the population affected by family treatment court
- Create and maintain a system for data collection

The Family Drug Court Core Competency Guidelines provide an in-depth description of the roles and responsibilities of each team member and should be referenced as you develop roles or add new team members.

The Steering Committee

The steering committee acts much as a board of directors does. The committee oversees the planning process and resolves policy issues regarding the planned family treatment court. An effective steering committee comprises executive-level personnel from each agency associated with the proposed family treatment court program. Remember to consider members from community organizations outside of the court when assembling your steering committee. Ask yourself what potential members offer in terms of political support or resources. Potential members should reflect a broad cross-section of the community, for example, representatives from civic clubs (e.g., Rotary, Lions), health agencies, local media, vocational or educational services, the faith community, and private foundations.[51,52]

Having elected prosecutors, presiding judges, chief public defender, or other high-level policy makers and stakeholders can promote new collaborations and buy-in for your family treatment court. The committee should have the clearly stated purpose of supporting the treatment court planning effort, and individual members need to fully understand their purpose, specific tasks, and responsibilities. The committee should meet on a monthly or twice-monthly basis and have a procedure for communicating with the planning team, and later with the operational team. The steering committee's purpose once the family treatment court is operational is to assist with barriers identified by the operational team and to develop solutions. With the support of the steering committee, the planning team (often midlevel management) will have the authority to make decisions necessary to implement the family treatment court.[53]

Your steering committee's commitment and support are critical to the success of the family treatment court. The committee provides leadership, influences policy, and garners resources necessary for implementation. You will need to identify the key leaders in your community—those people who are in a position to make decisions about resource allocation, agency cooperation, and policy development. Having the commitment and ownership of the members of the steering committee from the beginning and throughout the process ensures their support of the final program design.[54]

Because these leaders are likely to be on numerous boards and committees, consider looking for an existing body with a focus related to the mission of your family treatment court. Often, existing work groups are best suited to serve the functions that are outlined in this section—and they are likely to appreciate your thoughtful use of resources, including their time. Once your treatment court is operating, the steering committee can advocate for program enhancement, increased interagency collaboration, and sustainability.

Examples of Steering Committee Members

- Judge
- Family treatment court administrator
- Family treatment court coordinator
- Court clerk
- Child protective services administrator
- Prosecutor
- Agency directors (e.g., recreation, mental health)
- CASA director
- Child attorney or representative
- Public defender or parent attorney or representative
- Treatment provider
- Children's development service provider
- County or city council member
- Director of nonprofit organization
- Medical director or hospital administrator
- Community college or university representative

Visit a Family Treatment Court

Nothing is more instructive for a new planning team than seeing a family treatment court in operation, even if the host court does not resemble your jurisdiction in population, demographics, or other characteristics. The concepts underlying family treatment courts are similar: a coordinated, nonadversarial, and timely process by which a dependency case involving substance use by a parent is addressed while being judicially monitored and subject to increased accountability and drug testing with coordinated substance use disorder and other treatment and case planning for both the children and parents.

A site visit to a family treatment court will give your team the opportunity to observe the court environment, the judge's interaction with parents and children, the composition of the operational team, the staffing process, and the structure of the court. If you have not already participated in a site visit, now is a great time to check this off your to-do list. Make sure to have as many team members attend as possible. Take notes about the court environment, the types of services available for children and families, the interaction between participants and staff, judicial style, and staffing.

Visit more than one court if you can. Because individual jurisdictional practices are unique, viewing more than one style of court structure and hearing format will give you added information on which to base your program decisions. Be sure to arrange time to view staffing and hearings and to meet the judge and other team members to ask questions and share ideas. If you can arrange to meet graduates of the family treatment court, that will further enrich your experience.

The Center for Children and Family Futures operates the peer learning court program to highlight national best practice models for family treatment courts and to further the exchange of learning through peer-to-peer technical assistance from nine mentor sites across the nation.[55] The National Drug Court Institute (NDCI) can help you take advantage of this program or help in selecting another family treatment court that will be willing to have you visit. NDCI will help you find the contact person for that court. Try to pick a date and time that allows all of your team to participate. Before you visit, discuss with your team what you hope to learn or accomplish. Use these expectations to guide your note-taking and debriefing session.

Worksheet 5 provides questions to help you assess your visit.

This chapter addresses in broad strokes the issues that your planning team will face when creating the treatment program for your family treatment court. This discussion will serve as a background for the work your team will do to establish your family treatment court program.

2. Understanding Addiction and Treatment

Substance Use Disorders

Family treatment court team members must have a comprehensive understanding of substance use disorders. Even though a substance use disorder treatment professional is on the team, all team members will need to learn the terminology, best practices to support recovery, and behaviors associated with drug use. A basic understanding of the severity of substance use disorders could affect the design and operation of your program. Once the team comprehends the mechanisms driving substance use disorders, it can effectively address underlying factors and improve outcomes.

Understanding substance use disorders will also facilitate effective communication within the team and promote improved case management plans with better targeted and more comprehensive services. Beyond that, your team members will rely on this background to communicate with parent participants, the participants' children and families, service providers, and the community, and to help all of them understand substance use disorders and the role of your family treatment court.

Since this is an important subject, your team may wish to invite a speaker, such as your team's treatment provider or a colleague, a university professor, or someone from your state alcohol or other drug division, to give a presentation to the team.

What Is Recovery?

To understand recovery, it helps to be familiar with the working definition developed by the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA defines recovery from mental and substance use disorders as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."[56]

SAMHSA goes on to identify four dimensions that support a life in recovery:

- **Health:** Overcoming or managing one's disease or symptoms—for example, abstaining from the use of alcohol, illicit drugs, and nonprescribed medications if one has an addiction problem—and, for everyone in recovery, making informed, healthy choices that support physical and emotional well-being
- **Home:** Having a stable and safe place to live
- **Purpose:** Conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society
- **Community:** Having relationships and social networks that provide support, friendship, love, and hope[57]

A Holistic Approach

A family treatment court in its planning stage should address family recovery holistically. A holistic approach encourages a better understanding of the complex relational dynamics, promotes effective ways to address them, and encourages better collaboration among all the disciplines that make up your team.[58]

Often the various disciplines that compose the family treatment court team come to it with different philosophies, goals, and practices that can interfere with successful collaboration. For example, when child protective services and substance use disorder treatment services do not have a shared mission, their individual efforts tend to polarize the child's and parent's best interests, often with little understanding of the complex relational dynamics. A holistic approach promotes the family as a whole and addresses parent and child issues *in tandem*. Your team should look at recovery, relapse, and reunification from a family-centric perspective as well as an individual one, continuing to keep in mind that the welfare and safety of children is paramount.

Recovery Planning and Reunification

Recovery is a process, not an event. It is more than negative or positive urine samples. Long-term recovery is a bumpy road with setbacks and a lot of hard work. For the parent it involves the redefinition of self as an adult, as a parent, as a partner, and as a family member. In the family treatment court, the focus on parenting and parent-child interactive interventions is central to the recovery process. Relapse prevention relies on the supports that are established during the treatment process and a solid community-based aftercare plan to ensure that a network of resources remains accessible and available to parents.

Recovery is also a family process. The entire family has to establish a new set of relationships and expectations. Parents and children must learn to relate without substance use as a factor. Family roles, boundaries, and authority will be reshuffled. For the program to work, the family must relinquish denial—everyone must enter into recovery.[59]

Reunification with inadequate preparation and support can set families up for failure; therefore, your team should institute a well-prepared reunification process with necessary in-home supports and services for both parents and children.

Educating the team about family recovery and reunification dynamics from a clinical perspective will help the team develop principle-based family treatment court practices. Bring in presenters on recovery and reunification issues to educate your team on the dynamics of reunification while a parent is in the recovery process. Invite a child welfare expert to meet with your team to discuss how state regulations affect reunification.

Parenting/Family Time

Part of the gradual process of recovery and reunification is an incremental approach to parenting time. The term *visitation* is commonly used to describe the time a parent and child spend together when the child is in out-of-home placement. However, there is a new way of thinking of this conceptually as more than simply "visiting" with each other.[60]

Supervised and unsupervised visits between parents and children should be coordinated with progress in treatment and planned into the participant's relapse prevention plan. It is important to note that parenting time is a right of both the child and the parent and is an important need for families. It should not be used as a reward or sanction for participant behavior.

Children and youth who have regular, frequent contact with their families are more likely to reunify, spend less time in out-of-home care, and are less likely to reenter foster care after reunification.[61] Research shows that frequent visitation also promotes healthy attachment and reduces negative effects of separation.[62]

Parenting time provides an important opportunity for parents to apply what they are learning in parenting education and demonstrate newly acquired skills with their child.

Additionally, partner agencies are able to gather information about a parent's capacity to appropriately address and provide for their child's needs, as well as the family's overall readiness for reunification.

Because the risk of relapse rises upon reunification, many family treatment courts structure their programs to include reunifying families prior to graduation. Planning reunification as early as possible ensures that the support and monitoring provided by the program are still available after the child returns home. Some family treatment courts offer family reunification groups to provide enhanced support as parents move through the reunification process. Parent participation typically begins during unsupervised or overnight visitations and continues through three months after reunification. Reunification groups are typically staffed by an outside treatment provider, recovery support specialist, or other mentor role. This group process provides guidance and encouragement and an opportunity to express concerns about parenting in a safe and supportive environment without repercussion. Parent feedback regarding reunification groups has been overwhelmingly positive, and many appreciate the opportunity to discuss their parenting concerns with their peers.

Approaches to Substance Use Disorder Treatment

Three decades of research and clinical practice have yielded a variety of effective approaches to substance use disorder treatment. Extensive data document that substance use disorder treatment is as effective as treatment for most other similarly chronic medical conditions.[63] Research has provided a great deal of evidence about what works in substance use disorder treatment. In spite of scientific evidence that establishes the effectiveness of substance use disorder treatment, many people believe that treatment is ineffective. In part, this is because of unrealistic expectations. Many people equate addiction with simply using drugs and therefore expect that addiction should be cured quickly. If it is not, they consider treatment a failure. In reality, because addiction is a chronic disorder, the ultimate goal of long-term recovery often requires sustained and repeated treatment episodes.

Referral to treatment is a core function of a family treatment court. For your family treatment court to function at its best, your planning and operational teams must understand different models of treatment and their applicability to different populations. Your teams should be aware of the quality and scope of resources available in the community. Team members also must be able to articulate the treatment philosophy of the family treatment court, its rationale, and its effectiveness.[64]

Invite several treatment specialists to talk with your team about effective substance use disorder treatment for your target population. These specialists should include professionals who are knowledgeable about evidence-based substance use disorder treatment (e.g., medication-assisted, counseling, inpatient); treatment for mental health and co-occurring disorders; gender and culturally appropriate treatment approaches; trauma-informed services; recovery and continuing care support; and access to primary health care services (e.g., dental, HIV prevention). Bring in local and state-level professionals who can educate your teams about payment for treatment—for example, resources available for participants who are insured and for those who are uninsured.

Substance Use Disorder Diagnoses

Your program will mostly be working with parents with a moderate or severe substance use disorder,

as defined in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) published by the American Psychiatric Association (APA).[65] It is useful to understand the factors that contribute to a diagnosis.

The individual diagnosis is based on two main characteristics: the drug of choice and the severity. DSM-5 identifies 10 separate classes of drugs: alcohol, caffeine, cannabis, hallucinogens, inhalants, stimulants, opioids, sedatives/hypnotics/anxiolytics, tobacco, and other (unknown) substances. The manual recommends that when rendering the diagnosis, the specific substance used should be listed. For example, cocaine use disorder should be listed instead of stimulant use disorder.

The second characteristic relates to the severity of the condition. DSM-5 identifies the severity as mild, moderate, or severe based on the number of critical symptoms demonstrated by the individual. There are 11 critical symptoms:

1. Taking the drug in larger amounts or over a longer period than intended.

2. A persistent desire or unsuccessful efforts to cut down or control drug use.

3. Spending a great deal of time in activities necessary to obtain the drug, use the drug, or recover from its effects.

4. Having a craving or a strong desire or urge to use the drug.

5. Recurrent drug use resulting in a failure to fulfill major role obligations at work, school, or home.

6. Continued drug use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the drug.

7. Giving up or reducing important social, occupational, or recreational activities because of drug use.

8. Recurrent drug use in situations where it is physically hazardous.

9. Continued drug use despite knowledge of a persistent or recurrent physical or psychological problem that is likely caused or exacerbated by the drug.

10. Tolerance, as defined by either of the following:

- **a.** A need for markedly increased amounts of the drug to achieve intoxication or the desired effect.
- **b.** A markedly diminished effect with continued use of the same amount of the drug.

11. Withdrawal, as manifested by either of the following (note: this symptom does not apply to certain substances that lack an identified withdrawal syndrome):

- **a.** The characteristic withdrawal syndrome for the drug.
- **b.** Another drug is taken to relieve or avoid the withdrawal symptoms.

Severity is determined as follows:

- **Mild:** Presence of two or three symptoms
- **Moderate:** Presence of four or five symptoms
- **Severe:** Presence of six or more symptoms

What Is Treatment?

Because addictive drugs come in many types, treatment differs based on the specific drug or drugs used. A patient's characteristics and history can also affect treatment choices. Effective treatment includes multiple components, such as individual/group counseling, case management, inpatient and residential treatment, intensive outpatient treatment, medication-assisted treatment, recovery support services, and community and peer support. Behavioral therapies offer people strategies for coping with their drug cravings, teach them ways to avoid drugs and prevent relapse, and help them deal with relapse if it occurs. The best approaches provide a combination of therapies and other services to meet the needs of the individual patient, which are shaped by such issues as age, race, culture, sexual orientation, gender, pregnancy, parenting, housing, employment, past trauma, and physical and sexual abuse.[66]

How Are Children and Families Involved in the Treatment Approach?

In most substance use disorder programs, the adult is considered the primary client. Treatment providers focus on the adult in their therapeutic activities, and although they may engage the family in the treatment process, historically many treatment providers have not considered the interests of the children as a primary concern. For the population that comes before the family treatment court, however, treatment must be in the context of family recovery. A parent's substance use disorder can disrupt relationships within the family unit. Consequently, addressing the developmental needs of the children in the family must be an equal priority in a family treatment court. Treatment must be family-centered, addressing the impact of substance use disorders on every family member. Family-centered interventions focus on parent-child dyads and parent-child interventions rather than assuming parent-only treatment will be effective for the entire family.[67]

In a cross-site evaluation of residential treatment programs for pregnant and parenting women, it was found that postpartum women whose infants lived with them in treatment had the highest treatment completion rates and overall longer stays in treatment compared with women whose children did not live with them.[68] When a range of services in addition to substance use disorder treatment is available, research has shown an increase in both the number of months clients are in treatment and the number of counseling sessions clients receive.[69,70]

In the absence of family-centered treatment resources in communities, family treatment court team members can facilitate an approach that prioritizes family-centered assessment and case planning. They can promote case management and the provision of interventions that involve parents and (where appropriate) children as active participants. Communication and joint case planning with substance use disorder treatment providers can also facilitate this coordinated and comprehensive approach.[71]

Treatment is…

- **A contractual relationship with a clear set of agreements between participants, their family, and the treatment provider**
- **Focused on the addiction or abuse itself**
- **Based on scientific theory, research, and protocols that have been proven and accepted in the field of addiction**
- **A relationship governed by legal and ethical standards that concerns confidentiality and reporting**
- **Subject to peer, supervisory, and administrative review**

What Are the Principles of Effective Treatment?

Much research has been done on the efficacy of substance use disorder treatment. From these studies, the National Institute on Drug Abuse (NIDA) has established evidence-based principles that are widely accepted as a guide for the development and evaluation of effective treatment.[72] Learning more about these principles can help the planning team create a family treatment court structure that supports successful treatment engagement, retention, and outcomes. The principles can also aid your decisions in such areas as choosing providers, identifying and providing services, and creating the phase structure. The principles are as follows:

- Addiction is a complex but treatable disease that affects brain function and behavior.
- No single treatment is appropriate for everyone.
- Treatment needs to be readily available.

- Effective treatment attends to multiple needs of the individual, not just his or her drug use.
- Remaining in treatment for an adequate period of time is critical.
- Behavioral therapies—including individual, family, or group counseling—are the most commonly used forms of drug use treatment.
- Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
- An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs.
- Many individuals with substance use disorders also have other mental disorders.
- Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.
- Treatment does not need to be voluntary to be effective.
- Drug use during treatment must be monitored continuously, as lapses during treatment do occur.
- Treatment programs should test patients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases as well as provide targeted risk-reduction counseling, linking patients to treatment if necessary.

A fuller discussion of these principles is given in NIDA's *Principles of Drug Addiction Treatment: A Research-Based Guide*.[73]

What Are Levels of Care and the Treatment Continuum?

Alcohol or other drug treatment comprises a spectrum of treatment options differing in setting, types and range of services, and intensity of service use and delivery. The goal of treatment is to provide the participant with the proper care. This means getting each participant the services needed at an appropriate intensity within the appropriate setting and maintaining the least restrictive environment necessary to meet the individual's needs. Because the severity of the individual's disorder is likely to fluctuate over time, the level of care should change accordingly.

Many organizations, such as the American Society of Addiction Medicine (ASAM), have developed guidelines regarding levels of care for treating substance use disorders.[74] ASAM's five levels of care for alcohol and other substance use disorder treatment are widely used:

Level 0.5: Early intervention

Level 1: Outpatient services

Level 2: Intensive outpatient/partial hospitalization services

Level 3: Residential/inpatient services

Level 4: Medically managed intensive inpatient services

Levels of care are often broken down into sublevels with greater specificity, such as clinically managed low-, medium-, and high-intensity inpatient treatment. Some models do not fit precisely within these levels of care and may include halfway houses and extended residential programs such as therapeutic communities. Such programs are often used in conjunction with intensive outpatient treatment or inpatient treatment. A continuum of treatment and support would also include detoxification, aftercare, and self-help groups (e.g., Alcoholics Anonymous, Narcotics Anonymous).[75]

In addition to describing the levels of care, the ASAM patient placement criteria also provide specific guidelines for patient placement decisions. As the treatment needs of patients change, clinicians should make recommendations for their transition from one level of care to another. Your team, too, will conduct ongoing comprehensive assessment and reassessment to ensure that participants are getting the services they need to successfully complete your program. We recommend that a

treatment professional on your team review the ASAM criteria and report back to the team.

What Specific Models of Substance Use Disorder Treatment Are Effective?

The team needs to be able to distinguish between popular treatment and evidence-based treatment. A variety of evidence-based treatment approaches have proven effective with populations similar to those who come in contact with the family treatment court. Because no one cure-all approach exists, your participants must be matched with the appropriate evidence-based treatment. NIDA's *Principles of Drug Addiction Treatment: A Research-Based Guide* provides information about scientifically based approaches to drug addiction treatment that includes individual, group, and family models of treatment shown to be effective in treating substance use.[76] Some of the models described in NIDA's guide are multisystemic therapy (MST), community reinforcement approach plus vouchers, voucher-based reinforcement therapy in methadone maintenance treatment, relapse prevention (a cognitive-behavioral approach), and the Matrix Model.[77]

Medication-assisted treatment is another approach for treating certain substance use disorders (e.g., opioid use disorder). This approach uses medications, in combination with behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Medication (e.g., naltrexone, buprenorphine, methadone) can also be used to manage detoxification and maintenance.[78]

Most importantly, you need to gain knowledge about a broad range of approaches and find providers who use evidence-informed models that are the best match for your target population's needs. In addition to level of care, services must be matched and tailored to choice of drugs; co-occurring disorders; history (e.g., physical abuse, trauma); characteristics (e.g., ethnicity, race, gender); and treatment readiness.

What Is Treatment Readiness?

Each participant enters the family treatment court program at a different level of readiness to begin and engage in treatment. Part of your treatment approach should include building motivation. However, as stated previously, treatment does not have to be voluntary to be effective—getting ready is part of the process. In their book *Changing for Good*, Prochaska, Norcross, and DiClemente offer a helpful model for understanding this process.[79] A number of approaches use their framework to create strategies to engage participants, retain them, and move them into community-based support systems. Everyone on the team should familiarize themselves with the Stages of Change concept.

Effective strategies to engage and retain parents include the use of recovery supports. These may incorporate recovery mentors, substance use disorder counselors placed in child welfare offices, and recovery coaches. These engagement specialists address barriers and lack of motivation to help facilitate parent entrance into recovery. The functions of recovery support include encouraging and empowering participants, linking parents to ancillary supports, identifying service gaps, facilitating access to substance use disorder treatment by addressing barriers and identifying local resources, and monitoring participant progress and compliance. Recovery support should continue beyond engagement and early phases of treatment, extend throughout the reunification process and beyond family treatment court participation, and build the foundation into long-term recovery.[80,81]

Research has demonstrated the efficacy of recovery coaches in improving outcomes for families with substance use disorder problems and involvement in the child welfare system. Recovery coaches provide clinical assessments, advocacy, service planning, outreach, and case management to parents throughout the case.[82] Parents assigned a recovery coach were more likely to

engage in treatment, and they engaged in treatment significantly sooner than parents assigned treatment as usual. Women with recovery coaches also had significantly fewer subsequent births of infants prenatally exposed to substances.[83] Additionally, the use of recovery coaches significantly increased the parents' access to substance use disorder treatment and improved family outcomes. Parents assigned recovery coaches/peer mentors or other substance use disorder specialists were more likely to be reunited with their children than parents who were not assigned these types of supports.[84]

A paraprofessional is a person trained to aid a licensed professional. Child welfare agencies have begun to capitalize on the skills of paraprofessionals who are themselves in recovery from addiction to motivate parents with substance use disorders to seek treatment, to engage in other social service programs, and to develop a healthy environment for their children. Working in tandem with social workers and serving as role models, paraprofessionals conduct home visits, monitor the parent's progress, and help him or her overcome obstacles to success.[85] This strategy is also used as a treatment support.

How Should the Treatment Approach Relate to the Program Phases and Participant Behavior?

With ASFA guidelines in mind, structure your family treatment court program's phases to embody realistic expectations of participants as they move through treatment phases—stabilization and engagement (10 to 90 days), early recovery (90 days to 1 year), and maintenance (a lifelong process). See Chapter 4, Construct a Phase System, for information on building the program's phases.

Treatment should never be used as a sanction, and increasing or decreasing a participant's level of care should be based solely on his or her treatment needs. Relapse can be an expected part of the addiction and recovery process and should be accounted for as part of the phase structure and in participants' case plans. Treatment progress alone should not affect decisions about visitation and reunification. Your team should spend some time learning about resistance and relapse in working with individuals with substance use disorders.[86]

What Kinds of Treatment Supports Are Necessary to Promote Recovery for Participants?

One form of treatment support, which is sometimes mistakenly thought of as treatment, is community-based self-help groups. The most commonly known of the self-help groups for addiction is Alcoholics Anonymous (AA). AA is a self-supporting group that relies on the principle that alcoholics can recover by helping other alcoholics through their own stories. Often used as a lifetime support to prevent relapse, AA creates a support network and encourages changes in personality and lifestyle to eliminate or greatly reduce the sense of "needing" a drink or drug to get through the day.

AA's 12-step program model uses anonymous membership, regularly held meetings, and assignment of sponsors. Narcotics Anonymous and other groups are alternative self-help models. Group structure varies to best serve a specific population. These organizations often have subgroups that cater to different genders, cultures, or faiths (or nonfaith). They can address a specific type of drug use. Meetings may occur in person or on the Internet. Be cautious about requiring attendance at self-help meetings. Often self-help groups don't have the structure needed by new family treatment court participants. Some family treatment courts have implemented readiness groups that provide information about what to expect from a community-based support group.

Some treatment programs provide alternative supports for their primary modality, such as acupuncture, hypnosis, and biofeedback, to help participants deal with cravings and avoid relapse. The effectiveness of these supports has not been scientifically determined.

Consult with treatment providers in your area about what self-help resources and alternative supports are available in your community. Have a member of your planning team attend a meeting, then report back to the team. Bring in a person to talk to the team about self-help models (such as AA) or other alternative supports, and discuss how these might fit into your program, especially as a means of recovery support and continued aftercare.

What Are the Special Treatment Concerns for Women?

Women have unique needs that affect engagement in substance use disorder treatment and other services.[87] Gender-specific approaches and services are important when designing and delivering treatment for women. As pointed out in a report by CASAColumbia:

> *When substance abuse treatment is available, it is unlikely to be appropriate for pregnant or parenting women because most programs have been tailored for men. Few treatment programs address the multiple problems that are frequently interwoven with a woman's drug or alcohol use: depression, past and current histories of being battered, troubled relationships, employment problems and unplanned pregnancies. Women need treatment that:*

- *addresses the nexus of substance abuse, poverty, and violence in their lives;*
- *provides all-female support groups to encourage candid discussions about incest, other sexual abuse, and relationships with men that may contribute to their substance abuse;*
- *addresses their particular concerns regarding child-rearing; and*
- *allows mothers to bring their children with them to treatment or offers child care so that a woman need not choose between treatment for herself and custody of her child.*[88]

See Chapter 4, The Special Needs of Women, for information on structuring your family treatment court program to meet the unique needs of women.

3. Setting a Direction

Building an Educational Foundation Across Systems

Before you embark on establishing your family treatment court, you need to ensure that all of your team members 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 various systems (e.g., child protective services, substance use disorder treatment, family court)
- The legal requirements and ethical mandates of each system
- The goals, objectives, and operational components of the family treatment court

Training and staff development are critical to acquiring the skills for effective collaboration and to the delivery of a consistent, supportive, and nonadversarial message to the parent and family in recovery. Cross-system training and shared learning create mutual respect and improve understanding of team members' roles and responsibilities. Team members will have different skills and knowledge they can share with the planning team. Mine this knowledge by having them make presentations specific to their subject matter expertise (i.e., psychopharmacology of drugs; drug testing; healthy child development; federal, state, and local child welfare laws; policies and procedures; and evidence-based practices for children, parents, and families). Look for additional resources outside your team, such as team members' colleagues or outside speakers and videos, books, and other print or electronic material. The goal of these presentations should be cross-discipline training to give all team members a clear, concise understanding of how the material applies to the principles of child protection, treatment, and the court, and of the presenter's role and function on or with the treatment court team.

As your planning team continues to identify and develop the components of the program to meet the needs of your community, it may determine specific training needs for your jurisdiction and your program. For example, will your court serve a rural or an urban jurisdiction? Will you have a greater number of single-parent families or two-parent families engaged in the process? Will your court have a significant population of socioeconomically lower-class participants or more socioeconomically middle-class participants? What is the percentage of children ages 0 to 5?

Strengths-Based Practices

Each case is unique, and each family and the individuals within it have specific strengths that can motivate them toward success. No matter how serious their problems or how difficult their life circumstances, everyone has positive qualities, skills, and resources they can draw on to help them change. However, the professions that aid individuals affected by substance use disorders traditionally have taken a somewhat negative, "deficit-based" approach—focusing on eliminating the substance use disorder. This has a major drawback. Even if the substance use disorder is addressed

successfully, the person you are trying to help likely still has related problems but no additional skills for solving or coping with them.

A strengths-based approach is more holistic. Its focus extends beyond the substance use disorder to identifying and mobilizing the strengths that all people have—whether in themselves, in their family (both immediate and extended), or in their community. By setting a positive tone, a strengths-based approach fosters hope and motivation to change. It also builds a participant's confidence in his or her ability to surmount future life challenges, including parenting, the criminal justice system, and recovery.[89]

To integrate a strengths-based approach into the operation of your family treatment court, your team will need techniques for identifying and harnessing the strengths of participants, their families, and the community. At each contact—during intake, assessment, and in court sessions—allow time to explore and acknowledge the positive aspects of the participant's life, including interests, skills, activities, and accomplishments. Then, during staffing, discuss how these strengths might be harnessed to support the participant's efforts toward change.

Motivational Interviewing

One technique for discovering and harnessing strengths is motivational interviewing. This is defined as a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.[90] Motivational interviewing can engage your family treatment court participants' innate motivations and strengths to elicit change talk and alter their behaviors. In using this method, you would ask questions such as, "How does drug use interfere with the things you would like to do?" or "What would you like to change in your life?" The key points of this method are as follows:

- Motivation to change is elicited from the participant and is not imposed from outside forces.
- It is the participant's task, not the counselor's, to articulate and resolve ambivalence.
- Direct persuasion is not an effective method for resolving ambivalence.
- The counseling style is generally quiet and elicits information from the participant.
- The counselor is directive; he or she helps the participant to examine and resolve ambivalence.
- Readiness to change is not a trait of the participant but a fluctuating result of interpersonal interaction.

Learning and practicing motivational interviewing requires a new way of thinking and acting, which can be difficult for many practitioners, but it is a valuable tool in strengths-based practices. For this reason, we strongly recommend that team members attend a workshop to learn to use the principles and skills of motivational interviewing.[91]

Intergenerational Issues and Opportunities

When working with parents affected by substance use disorders, your team must recognize the myriad factors that affect a parent's progression to abuse and addiction, because those factors will continue to affect the recovery process. These factors, whether genetic or environmental, are present in all of the families served in family treatment courts.

Your team must understand the various ways parental substance use affects the children. All families operate with expected standards of behavior, or rules, that let family members know how to behave, what to think, what to believe, and how problems will be solved. By learning and practicing what the family holds to be true, children remain connected to the family. Often the family affected by alcohol or other drug use operates with two sets of rules, one for when the parent is using alcohol or other drugs and one for

when he or she is not. Intergenerational effects of substance use can have a negative impact on role modeling, trust, and concepts of normative behavior, which can damage the relationships between generations.[92]

To break the cycle of abuse and addiction, the family treatment court must address the needs of *both* the parents and the children. Parents and their children can break free of intergenerational substance use patterns when they experience alternative ways of living in a stable setting with concrete and emotional supports. Providing opportunities in which parents and children can feel secure and are afforded chances to experience success can help empower them to recover from the scars of substance use. This can occur when two generational parenting interventions are provided.

Engaging the Family

Family members are in a unique position to support a participant in making major life changes. They are likely to know the participant and the children best. They may know of neighborhood or family resources the participant has not thought of. Furthermore, a relative living in the home can monitor a child's well-being every day.

However, involving family can also be challenging. Since abuse and neglect can be intergenerational, the court must ensure that safety of the children is primary and that all family members are aware of the goals of the case plan, especially for relatives who offer to provide foster care. Your team needs to address whether other members of the family are using alcohol or other drugs. Family members may harbor negative feelings toward the participant. Both of these issues have the potential to affect the participant's goals for reunification. In addition, participants are sometimes reluctant to ask family members for help, fearing they will be rebuffed. Professionals, too, may be hesitant to involve family members, viewing them as just more problems to solve. So you and your team members may need to challenge both yourselves and the participant to step beyond this hopelessness to enlist family support.

Recruit as many willing family members as possible for family group conferences. Enlist their help in developing a plan for case management and identifying resources to make the plan work. Assist them in identifying how they can help; even small-scale contributions can make a big difference. For example, if the participant has difficulty waking up to be on time for early-morning court hearings, a grandmother who rises early might be willing to wake her or him. Ask family members to identify community resources the participant might call on through churches, neighborhood centers, clubs, or local businesses.

Because substance use can make for a complicated family history, some family members may require motivation to help. Your team should emphasize how everyone's life with the family improves when one family member's life improves. You might also offer services to family members, through either direct support or referrals and follow-up.

Above all, when you interact with the participant and family members, always focus on strengths and resources. By maintaining a stance that is positive, curious, and respectful, you will discover important aspects of the family that may have been previously unknown or undervalued that you can use to improve outcomes for the family.

Cultural Competence

Culture is a system of shared beliefs, values, norms, symbols, traditions, language, and ways of living that are transmitted from one generation to another. Culture is a lens through which we view the world; it provides us with a design for living and conducting ourselves and for interpreting our environment. Culture is so fundamental to human identity that we are often unaware of

its profound effect on our interactions with other people. When we encounter people from a culture other than our own, we may interpret their behavior through the lens of our own cultural values and expectations, attributing to that behavior the meaning it would have if we ourselves had said or done the same thing. As a result, we may misinterpret what other people intend. What makes total sense within their cultural framework may appear baffling or even offensive to us, while we, simply by acting in a way that makes sense to us, may inadvertently baffle or offend them.

Further complicating cultural issues is that people who belong to a society's majority culture are especially likely to be unaware of how cultural values shape their perceptions. This is because the society's values and their own are the same. These values are embodied in the society's institutions and ways of doing business and are constantly reflected back at members of the majority culture in their day-to-day lives. In contrast, people from outside the majority culture are likely every day to encounter cultural values that are different from their own—at work and at school, in the mass media, and in their dealings with government agencies.

As the population of the United States grows ever more diverse, public agencies and other providers are challenged to serve people from many cultures and language groups. The effectiveness of these programs depends in large part on the *cultural competence* of the professionals who staff them—their awareness of how their own cultural values and biases affect communication, their understanding of other cultural perspectives, their ability to bridge the differences between themselves and those they serve, and their commitment to embracing cultural diversity. Program effectiveness also depends on the cultural competence or proficiency of the system as a whole and whether its policies, procedures, and decision-making processes are respectful of cultural differences.

The cultural composition of the community, parent, and child population in your jurisdiction and of your planning team will influence the decision-making process during the family treatment court planning stage. Not only will it affect interactions between the treatment court team and participants, children, and families, but it will also influence the interactions among treatment court team members. This can add strength to your team. The individual cultural composition of your team provides it with a unique set of values, ideals, and tools. In working together as a team and mining their own experiences and expertise, team members have the opportunity to develop a family treatment court program that respects other belief systems and is effective across cultures. Your team will define a culture for your family treatment court of shared values, norms, and customs that shape decisions, ensure the safety and well-being of children, and address the substance use of the parents.

Many aspects of culture affect the work of the family treatment court: approaches to child rearing, gender roles, and family decision making; ideas about nutrition and food; and concepts of health and illness, including attitudes toward the use of alcohol or other drugs—to name a few. All of these are areas in which the values and expectations of the family treatment court may differ from those of parents, children, and families. All are fertile ground for family treatment court team members to misunderstand, make judgments, draw unwarranted conclusions, and inadvertently alienate the families they serve.

To structure a court that will function effectively with diverse groups, your team will need to take cultural differences into account throughout the planning process. ***Worksheet 6 will introduce you and your team to the concept of cultural competence, help you learn more about the cultures represented among your court's target population, and encourage***

you to think about how best to accommodate these cultural differences or even look to them as a potential source of additional support and empowerment for participants and their families. Your ultimate goal is to create a family treatment court that explicitly endorses and respects the cultural diversity of all program participants, staff, and the community.

As you learn about the cultures represented in your community, pay attention not just to the differences between cultures, but also to the differences within each cultural group. Although members of the same culture will have many characteristics in common, each person will express his or her culture in a unique way. To avoid stereotyping—that is, making assumptions about individuals based solely on their affiliation with a group—use your knowledge of a person's culture as a *starting* point that you can confirm or modify as you learn more about that person.[93]

Legal Mandates

One of the major challenges you will face as you plan your family treatment court is designing a program and implementing practices that meet legal mandates, confidentiality requirements, and ethical mandates. Because these regulations affect the work of every discipline on the team, the team as a whole, and every part of the program you design, each person on the team must have a clear idea of the specific requirements outlined in the regulations, exceptions to and nuances of the law, the principles outlined in guidelines, and the implications for practice. Your team will need a thorough understanding of the following regulations:

- Adoption and Safe Families Act (ASFA)
- 42 Code of Federal Regulations (CFR) Part 2
- Health Insurance Portability and Accountability Act (HIPAA)
- Additional federal and state regulations governing your jurisdiction

Those team members who have never attended a neglect hearing will likely find it extremely helpful to observe several (while complying with state confidentiality regulations). Observing such a hearing will better equip your team to make informed decisions such as how your program addresses the ethics of the diverse disciplines at the table and confidentiality issues. Family treatment court peer learning courts are one option for observing effective family treatment courts in action.[94]

Adoption and Safe Families Act (ASFA)

The federal enactment of ASFA in 1997 required changes in most states' practices and procedures in family dependency cases. This law requires that states move to terminate parental rights for children who have been in foster care for 15 out of the last 22 months. Exceptions to this 15-in-22 rule include instances when the agency documents a compelling reason why parental termination is not in the best interests of the child, for example, when a parent is seeking and participating in treatment for a substance use disorder.[95]

An analogy has been offered to describe the often competing timelines operating in the lives of a family in family treatment court: three clocks ticking at different speeds. These ticking clocks can contribute to the frustration and challenges faced by the multidisciplinary family treatment court team.

Child welfare clock: Child welfare cases move quickly. The child welfare timetable is a 12-month period for parents whose children have been placed in the foster care system to develop a safe and nurturing family environment to which the children can be returned. This 12-month timetable may move too quickly to give parents sufficient time to complete treatment or to demonstrate sufficient stability to care for their children. It is therefore essential that parents with substance use disorders get screened and identified, and that they access and engage in treatment as soon as possible.

Treatment clock: Time is of the essence. There has to be a systematic way to identify parents with substance use disorders early to ensure they can get into treatment as promptly as possible. Treatment providers feel that recovery is a lifelong process. Although 12 or 15 months is a long time in the life of a child, it is a relatively short time in the recovery process of a parent with years or even decades of substance use.

Child development clock: The child's developmental timetable relates to the developmental stages of childhood. For example, the critical period of brain development occurs prenatally and in infancy, and young children achieve much of their bonding or attachment during the first 18 months of their lives. By the time children are 3 years of age, they have formed much of their sense of trust and security. It is a challenge to quickly secure safe and nurturing homes for children while allowing adequate time for the parents' treatment and recovery. Thus, timely treatment and services can critically affect outcomes for families and children.

The court's involvement with the parent participants can lead to identifying with the parents and focusing on their many needs and often traumatic childhoods—sometimes to the exclusion of their children. This is one reason why the importance of ensuring the best interests of children in family treatment court cannot be overemphasized. ASFA ensures that all cases coming into the family treatment court arise in the context of child protection. ASFA mandates and permanency guidelines aid courts and practitioners in keeping deadlines and in placing the specific needs and safety issues of the children in the forefront of all interventions.

Confidentiality and Communication Across Systems

As you review the scope of confidentiality and ethics issues in developing and implementing your program, you should understand how federal confidentiality regulations are applied to the family treatment court setting and consider how to address some of the common confidentiality and ethical issues your program will face. Becoming familiar with state and federal regulations ensures that you are protecting the rights of children and families within the context of the court and child welfare. A brief review of the provisions of these regulations is given below.

Two of the primary federal confidentiality regulations affecting treatment-based programs are the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 42 Code of Federal Regulations Part 2 (42 CFR Part 2).

Family Treatment Court Structure and Confidentiality Mandates

The questions to ask to determine the applicability of federal confidentiality mandates to family treatment court programs are:

- Does the program qualify as a covered entity under HIPAA?
- Does the family treatment court qualify as a program within the meaning of 42 CFR Part 2?
- Will the family treatment court receive or redisclose information about a patient from a program within the meaning of 42 CFR Part 2?
- Will the family treatment court have an embedded program or be considered a health care provider covered by the regulations?

Typically, family treatment courts, judges, prosecutors, defense attorneys, probation/parole officers, and child welfare workers are not considered *covered entities* or *programs* within the meaning of the federal regulations discussed below. However, central components of a family treatment court program include assessing whether an individual has a substance use disorder; assessing whether participation in the family treatment court would be beneficial; referring, arranging, and monitoring appropriate treatment for those diagnosed with substance use disorders; and evaluating client progress or failure in treatment to determine case disposition. Most likely, the family treatment court will be interacting with providers who qualify as *programs* and *covered entities*, and, as a result, those involved in family treatment court will be prohibited from redisclosure of such confidential information without appropriate written consent.

It is important to note that if a court requires drug tests of participants and orders the tests, the test results alone would not be protected by 42 CFR Part 2 unless the test was used to diagnose the substance use disorder for purposes of referring individuals to treatment.

HIPAA

HIPAA was enacted to provide better access to health insurance and to toughen the law concerning health care fraud. Additionally, it created national standards to facilitate the electronic exchange of health information and protect the privacy of any patient-identifying health information. A substance use disorder *program* required to comply with 42 CFR Part 2 is not automatically a covered entity under the HIPAA Privacy Rule. Under the Privacy Rule, a *covered entity* is a:

- **Health plan:** An individual or group plan that provides or pays the cost of medical care, including a group health plan, health insurance issuer, HMO, Medicare, Medicaid, CHAMPUS, or Medicare + Choice
- **Health care clearinghouse:** A public or private entity that processes or facilitates processing of health information from one format to another
- **Health care provider:** A provider of medical or health services and any other person or organization that furnishes, bills, or is paid for health care in the normal course of business if the provider transmits health information in electronic form to carry out financial or administrative activities related to health care. If the provider does not transmit any health information electronically, the provider is not a covered entity under the Privacy Rule.

The family treatment court would not be considered a *covered entity*; however, the treatment provider rendering services to family treatment court participants would likely need to comply with HIPAA.

There are a number of ways to legally share information under HIPAA. Disclosures are permissible when required by law for public health activities (e.g., mandated child abuse reporting); to government authorities regarding reports of child maltreatment or domestic violence or health oversight activities; for inquiries by law enforcement for limited situations; to coroners or medical examiners (if a child died of abuse or neglect); and to avert a serious threat to health or safety. Additionally, disclosures are permitted with written authorization, which is the course of action recommended to comply with ethical guidelines for sharing confidential information.

42 CFR Part 2

Drug and alcohol confidentiality regulations restrict both the disclosure and the use of information about individuals in federally assisted drug or alcohol abuse treatment programs.[96] Specifically, these regulations require that records of the identity, diagnosis, prognosis, or treatment of any patient maintained in connection with the performance of any program or activity relating to alcoholism or alcohol abuse or in connection with the performance of any drug abuse prevention

function that is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States must be kept confidential.[97]

Program Analysis

42 CFR Part 2 governs any alcohol or drug abuse program or activity conducted, regulated, or directly or indirectly assisted by any department or agency of the United States. A program means:

- An individual or entity (other than a general medical care facility) that holds itself out as providing, and provides, alcohol or drug use diagnosis, treatment, or referral for treatment
- An identified unit within a general medical facility that holds itself out as providing, and provides, alcohol or drug use diagnosis, treatment, or referral for treatment
- Medical personnel or other staff in a general medical care facility whose primary function is the provision of alcohol or drug abuse diagnosis, treatment, or referral for treatment and who are identified as such providers

The family treatment court would not be considered a *program*; however, the treatment provider rendering services to family treatment court participants would likely need to comply with 42 CFR Part 2. Additionally, Part 2 contains a prohibition on redisclosure.[98] Thus, the family treatment court team members would be able to share information among themselves only with a written consent that expressly authorizes redisclosure. The elements of a written consent are described further below, and a sample consent form that complies with 42 CFR Part 2 and HIPAA as well as Illinois state law requirements is contained in Appendix B.

Patient-Identifying Information

Patient-identifying information is defined broadly to include any information whereby the identity of a patient can be determined with reasonable accuracy and speed, either directly or by reference to other publicly available information. This type of information includes:

- Name
- Address
- Telephone number
- Social security number
- Driver's license number
- Fingerprints or voiceprint
- Photograph

It does not include a number assigned to a patient by a program if that number does not consist of, or contain, numbers (e.g., social security number, driver's license number) that could be used to identify a patient with reasonable accuracy and speed from sources external to the program.

The HIPAA Privacy Rule also protects information that identifies or could reasonably identify an individual. The Privacy Rule contains many of the same identifiers as 42 CFR Part 2; however, the Privacy Rule has numerous additional *identifiers* that will be afforded protection.

It is worth noting that 42 CFR Part 2 covers any information (written or oral) relating to a patient that is received or acquired by a federally assisted alcohol or drug abuse program. The Privacy Rule covers protected health information about an individual (oral or written) only when maintained, collected, used, or disseminated by or for a covered entity.

Disclosing Patient Records

Records are broadly defined to include verbal communications as well as what is typically thought of as written medical records. Therefore, patient records include any information relating to the patient, written or oral. In addition to disclosure of any of the patient-identifying information listed above, the following examples are other implicit ways of disclosing patient information:

- Giving written records with a patient's name on it
- Testifying in court about a patient's treatment
- Reporting to a government agency that the person has sought treatment or referral for treatment

- Reporting a patient's name to a government agency that knows the information is being delivered from a drug or alcohol program

Programs that are governed by 42 CFR Part 2 must abide by the strict limitations on disclosure of any information, whether recorded or not, that would identify a client with a substance use disorder, either directly or indirectly. Protection is afforded to those persons who are *patients* in a program, meaning any individual who has applied for or been given diagnosis of or treatment for substance use or an individual who has been identified as having a substance use disorder after the individual has been arrested on a criminal charge. The restrictions on disclosure apply even if you believe that the person seeking the information already has the information, has other means of obtaining it, is a law enforcement or other official, has obtained a subpoena, or asserts any other justification that is not permitted by the regulations.[99]

Patient Written Consent

The basic premise of both 42 CFR Part 2 and the HIPAA Privacy Rule is that disclosure of confidential information is impermissible unless authorized in writing by the client. The Privacy Rule calls this written client document an *authorization*, whereas 42 CFR Part 2 refers to it as *consent*.

42 CFR 2.31 specifies the following required elements for a valid written consent:

1. The specific name or general designation of the program or person permitted to make the disclosure

2. The name or title of the individual or the name of the organization to which disclosure is to be made

3. The name of the client

4. The purpose of the disclosure

5. How much and what kind of information is to be disclosed

6. The signature of the client or personal representative

7. The date on which the consent is signed

8. A statement that the consent is subject to revocation at any time except to the extent that the program has already acted in reliance on it

9. The date, event, or condition upon which the consent will expire if not revoked before

The required elements under the Privacy Rule are essentially the same as those listed above, except that the Privacy Rule requires a few additional elements as follows:[100]

10. If a personal representative, rather than the client, signs the authorization, the authorization must specify why the representative is authorized to act for the client.

11. The authorization must describe how a person may revoke the authorization. Under the Privacy Rule, an individual is allowed to revoke an authorization at any time, except to the extent that an entity has taken action in reliance on the authorization. This statement, as well as instructions for revoking the authorization, should be included on the form.

12. The authorization must address the question of redisclosure. For substance use disorder treatment providers, disclosure is prohibited unless expressly permitted by 42 CFR Part 2.[101] This statement should be included on the authorization.

13. The authorization must also address the ability or inability to condition treatment, payment, enrollment, or eligibility for benefits on the authorization. With the exception of treatment for research purposes or for fitness-for-duty examinations, the Privacy Rule does not permit a provider to condition the provision of treatment on the receipt of an authorization. Therefore, the authorization should state that the provider will not condition treatment, payment, or eligibility for benefits on the authorization.

An authorization must include all 13 elements described above in order to be valid under both 42 CFR Part 2 and the Privacy Rule. The authorization must be written in plain language and may contain additional elements as long as they do not contra-

dict the required elements. An authorization may be combined with another authorization to create a compound authorization, except authorizations for use or disclosure of psychotherapy notes may be combined only with another authorization for psychotherapy notes. In addition, an authorization cannot be combined with any other type of document, such as a notice of privacy practices, except that a research authorization may be combined with any other type of written permission for the same research study. A multiparty authorization is permissible if the information to be disclosed and the purpose for the disclosure are the same for all parties. However, if the client revokes the authorization for one party, the entire multiparty authorization is revoked.

If the authorization expires or is revoked, you cannot release information. Similarly, if the person or agency on the authorization wants information that the client has not included on the form, you cannot release it. That is why it is critical to discuss with the client how much information and the types of information he or she wants to share.

42 CFR 2.32 requires each disclosure made with the patient's written consent to be accompanied by a notice informing the recipient of the following:

- The information has been disclosed to the person from records protected by federal confidentiality regulations.
- The federal confidentiality regulations prohibit the person receiving the information from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by the federal confidentiality regulations.
- A general authorization for the release of medical or other information is not sufficient for disclosure of the information.
- The federal confidentiality regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug use patient.

Information may be redisclosed with patient authorization, pursuant to an appropriate court order or pursuant to another exception contained within the federal confidentiality regulations. The regulations, however, provide many ways for programs to communicate information lawfully to family treatment courts; for example, for a child abuse report, written consent or an appropriate court order that meets the requirements of 42 CFR 2.61–2.67.

Because a violation of 42 CFR Part 2 is a federal criminal offense, the consequences are serious. A drug or alcohol program that violates Part 2 may have funding contract penalties or could be exposed to state licensure/certification sanctions.

Additional Federal and State Regulations

As explained above, if applicable, the team must honor state and federal mandates regarding confidentiality laws as they apply to juveniles, families, and treatment services. The confidentiality laws help establish the framework for confidentiality policies and procedures to protect participants and deliver adequate services to them.

Therefore, before you work on your confidentiality procedures, you should consult with a county or state agency attorney who is familiar with this area of the law and can advise you about any additional regulations you will need to follow. Once you have drafted your confidentiality procedures, the same attorney should review them.

Sharing Information

Proper consents can authorize all parties involved in a family treatment court program to share information necessary across disciplines and systems. The key questions to answer in the process include the following:

- Who needs to know what, when?
- What information is necessary to share among family treatment court parties?

- Will information need to be redisclosed among the parties?
- When does the information need to be disseminated?
- Are there standardized report forms that should be referenced?
- What are the conditions under which the consent will be terminated or expire?
- How will the information be disseminated (e.g., email, secure web portal, fax, testimony, paper)?

Remember, some circumstances require mandatory disclosure of the information, even without written consent. These may include state-mandated child abuse reporting laws, a valid court order meeting the requirements of 42 CFR Part 2.61–2.67, and state laws relating to cause of death/coroner inquiries.

Worksheet 7 will guide your discussion.

Develop a Family Treatment Court Planning Timeline

One of the biggest challenges that the team will face in implementing a family treatment court is deciding who will do what by when. First, you will have to establish the *who*. Identify the members of your steering committee who will provide direction and oversight, and the members of the planning team who will conduct the planning, development, and implementation. Second, you must establish the *what*. Set the roles of everyone involved, remembering that some roles can be shared to enhance team functioning. Have your team identify the key tasks that will serve as milestones. Finally, you need to establish the *when* by setting deadlines for those milestones. To maintain momentum during the planning process, your team members must also agree on how often the planning team will meet and how much time they can commit. Completing these tasks will give you a timeline for the implementation process.[102]

Determine Vision, Mission, Goals, and Objectives

The next critical step in the planning process is to build a strong foundation for your family treatment court through the development of a vision statement, mission statement, goals, and objectives. Every discipline represented on your family treatment court team brings a different perspective regarding core values, beliefs, and operating principles. Although all these fields share the vision of permanency, safety for children, and healthy, functioning families, their key differences have the potential to create misunderstandings, engender mistrust, and undermine cooperation.

Every team member needs to participate actively in defining your treatment court's core values and in drafting your vision and mission statements and goals and objectives. Do not try to delegate them to one or a few people. Meet in a comfortable setting and allow plenty of time to hear and consider every member's perspectives. Draw on what you have learned about the characteristics of a family treatment court and your observations of family treatment courts in operation.[103,104]

Worksheet 8 will guide you in this process. You'll begin by defining your family treatment court's core values, and then you'll draft vision and mission statements. Finally, you'll develop goals and objectives for implementing your values, vision, and mission. The following sections give brief descriptions of these items and samples of these statements from other treatment courts.

Core Values

The core values are the values most important to your family treatment court. You can also think of them as core beliefs and operating principles.[105] For example, the core values of the Prairie Center, Vermilion County, Illinois, Drug Court, are:

Family-centered approach

Respect for each person we encounter

Service with excellence and accountability

Innovative solutions

Integrity

Providing hope to those we serve

Vision Statement

A vision statement defines the purpose of an organization. It communicates an image of the future that draws others in and speaks to what they see and feel. A good vision statement paints a mental picture by defining the desired future that an organization wants to achieve in 5 or 10 years, or even longer. It is an organization's north star, providing direction, guidance, and motivation in a concise, inspiring statement that is easy for all to remember and repeat.[106,107]

For example, this is the vision statement of the National Association of Drug Court Professionals (NADCP):

We will not rest until there are Drug Courts within reach of every American in need.

The process of drafting your family treatment court vision statement will challenge your team to clarify a common understanding of where you are headed and what you want to accomplish. Once drafted, the statement will serve as a touchstone for your team's activities. It will be a tool to give direction to your decisions and for guidance in overcoming conflicts. Determining whether potential remedies or courses of action align with your vision will help your team agree on appropriate resolutions. An example of a family treatment court vision statement is this one from Pima County, Arizona:

All children will be raised in a nurturing and healthy environment with parents who are drug free.

Once you have your vision statement, you will find it useful in other ways. It will guide the development of your mission statement, your goals, and your objectives. You will use your vision statement in presentations, press releases, brochures, funding proposals, and other written materials to explain your program, build community support, and inspire people to share your vision of the future.

Mission Statement

A mission statement is a concise summary of *what* you plan to do, *how* you will do it, and *who* you will do it for. It is an organization's reason for existing. An organization's mission statement is the path that leads from the present to the future that the organization has described in its vision statement. Like the vision statement, the mission statement is a touchstone to guide the decisions and activities of your planning team and later of your operational team in its daily operation. Note how this sample mission statement answers *what*, *how*, and *who*:

To ensure to every family that enters our court the well-being of the children and to transform the parents into responsible caregivers with the resources to provide safe, stable homes through the collaborative services of the court, treatment, and community.

Like your vision statement, your mission statement can guide development of goals and objectives and be used in the same types of documentation and presentations to promote your program.[108,109]

Goals and Objectives

Goals are broad statements of desired outcomes that support the mission. They are usually a collection of related projects that shape your family treatment court programmatically and organizationally and clarify how you will achieve your mission. Establish your family treatment court goals to remedy the problems you face and to promote the outcomes you want for the families and children your court will serve.

Objectives identify the specific, measurable achievements that support attainment of each

aspect of a goal and help you determine the programming and processes needed. Each objective can be monitored as part of quality assurance and measured as part of the process evaluation.

For example, a goal and related objectives might be the following:

Goal: Restore healthy families
- Objective 1: Increase reunification rates
- Objective 2: Reduce reentry into foster care
- Objective 3: Reduce repeat maltreatment

Begin working on the short- and long-term goals and objectives for your family treatment court; ***use Worksheet 9 to assist you***. For additional assistance in your strategic planning exercise, see examples of goals and objectives assembled by other treatment courts around the country.[110]

4. Structuring Your Family Treatment Court Program

Family Treatment Court Structural Program Design

Now that many or most of your team members have visited an operating family treatment court and had a chance to observe operations first hand, you will have to decide which of two structural designs will work the best in your jurisdiction: the integrated model with one judge or the parallel model with two judges.[111] This decision is not one you and your team should make lightly. The structural program design must fit with the child welfare and court processes in your jurisdiction. Remember, whichever one you choose will define what decisions can be made during treatment court hearings related to child welfare cases.

Key considerations when selecting a model include the following:

- Does the structure meet the needs of your jurisdiction and help the team ensure effective treatment, services to children, sharing of information, and shared accountability?
- Have all team members discussed shared principles or goal statements that reflect a consensus on key issues?
- Has the family treatment court team considered all the benefits and challenges of each model in the selection process?
- Does the family treatment court team understand the importance of information sharing, regardless of the model selected?

Integrated Model: One Judge

In this type of program, one judge oversees progress in substance use disorder treatment for the parent and the juvenile dependency case for the child. Potentially, the judge could also handle criminal cases pending for child endangerment.[112] In this structure, courts are less likely to impose conflicting demands on families. Gathering information to coordinate the different disciplines, services, and treatment options is simpler with only one judge making decisions. As a result, services to the families are more likely to be comprehensive and well coordinated, addressing addiction and other needs and issues that brought the family before the court. For this reason, we recommend the integrated program design.

However, not all jurisdictions will be able to adopt this structure, and it does have disadvantages. Challenges of this model include perceived problems with ex parte communication and judicial ethics. The scale of an integrated family treatment court may be limited because of the need for time-intensive staffings, which include decisions about dependency matters as well as reviews of treatment compliance.

This structure creates more work for a single judge, and dependency judges will need additional training to achieve expertise in substance use disorder issues. If you choose the integrated program

design, you may need to decide whether a single dependency judge will handle all the cases involving parental substance use or whether you will train some or all of your dependency judges to handle them. If you will train more than one dependency judge, your team will need to address how team members can best be deployed to support all of the family treatment court judges.

Parallel Model: Two Judges

In this type of program, two judges split the work done by one judge in the integrated program design. The dependency court judge addresses the juvenile dependency cases but refers the parental substance use disorder cases to the family treatment court presided over by another judge. This allows judges to share workload. Each judge can specialize in his or her area (dependency issues versus substance use disorder issues). However, this design can be complicated by legal and communication issues. Issues of potential ex parte communication between the two judges must be considered at all times. In the parallel program design, the treatment court judge works with the family treatment court team to identify the comprehensive needs of parents, children, and families, and to coordinate services for them. However, the family treatment court judge makes court orders related only to the parent, whereas orders regarding the status of the child and child welfare case must be referred back to the dependency court judge. This dichotomy increases the risk of imposing conflicting demands on the family.[113]

The parallel model has the ability to serve a larger number of families because staffings do not include a comprehensive review of dependency matters. However, for the parallel model to be effective, it is imperative that information is integrated between systems and that the needs of the entire family are met. If your planning team chooses the parallel program design, you must be prepared to address the legal and child welfare requirements affected by the protocols you put in place. Your team must establish reporting mechanisms and communication procedures between the two courts that ensure all parties and attorneys remain apprised of parent-child issues. For example, if your team determines that changes in parenting time may take place during the treatment court session, all parties to the case must be given proper notice and provided the opportunity to address the court. In ensuring that information reaches all parties across courts, your team will need to consider the following:

- How will the treatment court hearing incorporate information and issues about the child and progress toward timely permanency?
- How will the dependency court hearing incorporate information and issues about the parent's progress in substance use disorder treatment?

Worksheet 10 will help you document your family treatment court's structural design.

	Integrated: One Judge	Parallel: Two Judges
Advantages	• All information held by one court, making communication across all partners easier • Court less likely to impose conflicting demands on family	• Treatment court judge able to specialize in substance use disorder issues • Workload shared • Potential to serve larger number of families in program
Disadvantages	• Juvenile dependency judges must have expertise in substance use disorder issues • More work for a single judge • Expanding program capacity limited to single docket/available resources	• Need to maintain close, ongoing communication between two judges • Progress in dependency court and treatment court have to be aligned through effective information sharing • Greater risk of imposing conflicting demands on family

Target Population

A clearly defined target population allows your family treatment court to focus on the community problems that the planning team, steering committee, and other stakeholders identified during planning. This increases your family treatment court's chances of achieving its goals and objectives and having the greatest effect in your community. The more you and your team understand who your target participant families are, the better you will define who your family treatment court can best serve.

Your target population will typically come from families entering the child welfare system. In jurisdictions with a pre-file model, parents can participate in a family treatment court prior to the filing of an abuse and neglect petition with the dependency court. The pre-file model is designed to enhance a parent's recovery by providing timely access to substance use disorder treatment while allowing children to be safely maintained with their parents. The vast majority of family treatment courts are post-file, where the abuse and neglect petition has already been filed with the dependency court.

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, if the parent meets the legal and clinical eligibility criteria for family treatment court, and if the parent will enroll in the family treatment court. Parents who are identified as participants in family treatment court 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. Additionally, it is critical to determine the degree of treatment intensity and what modality is clinically appropriate.

Given the large population of parents and children who can potentially benefit from the intensive services of a family treatment court, one of your planning team's major planning tasks will be to determine the characteristics and backgrounds of the parents and children who will be best served by your program.

Studies show equivalent or better outcomes in family treatment courts that serve individuals who fit into any or all of the following categories:[114,115,116]

- Previous child welfare contact
- Co-occurring mental health problems
- Unemployed
- Less than a high school education
- Criminal history
- Inadequate housing
- Risk for domestic violence
- Methamphetamine, crack cocaine, or alcohol as primary drug of choice

You may have to start with a small priority population and grow capacity over time to serve all families who could benefit from family treatment court. Developing a plan in which family treatment court becomes business as usual is a commitment to systemic change that should be one of your program's long-term goals. Because this task is fundamental in setting the direction of the program, all stakeholders must be involved.

The flow of determining the initial target population may look something like the following:

Target Population Flowchart		
1.	Community population	
2.	Dependency court population	
3.	Cases involving parental substance use	
4.	Cases after eligibility criteria review	
5.	Cases identified for family treatment court	
6.	Number of cases in your jurisdiction	
7.	Number of cases your family treatment court can handle	

This process begins with an accurate assessment of the total need in the community. The analysis by the planning team should include the prevalence rate of substance use disorders in the child welfare population, the potential scale of the family treatment court, and an understanding of the local policy, parallel initiatives, and partnerships in the community.

Once your target population is established, you must periodically reexamine your processes and participant characteristics to determine whether or not your family treatment court is serving the defined target population, whether your target population needs to be redefined, and whether it is time to grow your program. This cycle of monitoring outcomes and reevaluating your target population plays a critical role in the long-term effectiveness of your program.[117]

Worksheet 10 will help you work through the process.

Eligibility Criteria

Once the planning team has determined the group of families the court will serve, you will need to establish eligibility criteria for participation in your family treatment court. Eligibility criteria are those factors that allow or prohibit a family's admittance to your program. Eligibility and exclusion criteria are defined objectively and specified in writing. Determining who may become a participant in your program requires discussion and agreement among team members. You should keep the selection of eligibility criteria objective so that personal impressions of potential participants do not play a role in determining their suitability for the program.

The eligibility criteria should promote reaching your target population. Funding restrictions might place limits on your participant group. ASFA can exclude parents who are at a point in the process that leaves them too little time to complete your program, so your team may need to include minimum time frames in the eligibility criteria, but use caution not to exclude families unnecessarily for any reason. Exclusion criteria should be minimal. Consider criteria for giving priority to particular cases, especially if your jurisdiction has more eligible families than you have capacity. For example, some courts give priority to parents with more than one child and parents with children under 10 years old. When determining eligibility criteria, your team will consider many critical factors:

Jurisdictional Factors

- Geographic area in greater need
- Gender or age group in greater need
- Nature of alcohol or other drug problems in your population

Case Factors

- Child's current status
- Parenting history
- Legal status and history of the case
- Parental criminal history
- Parental substance use and treatment history
- Parental medical status and history
- Parental mental health status and history
- ASFA timelines
- Availability of support services

Studies have found that the admissions process in many treatment courts included informal or subjective selection criteria, multiple gatekeepers, and numerous opportunities for candidates to be rejected by the program.[118] In establishing your program's eligibility requirements objectively and in writing, your team is removing subjective eligibility restrictions and potentially increasing the effectiveness of your family treatment court.

Use Worksheet 10 to guide your discussion.

Referral, Screening, and Assessment

Once you have identified the target population, the next logical step is to discuss how to refer, screen, and assess cases for inclusion in your family treatment court program. Your team's objective when addressing these issues is to streamline the process to ensure that the program reaches your target population in a timely and effective manner.

Referral to the Family Treatment Court

Your planning team will need to answer the question of who will be responsible for referring cases to your family treatment court. Identification of referral sources will depend on your choice of a target population and where they are in the juvenile dependency court process. Referral sources might include judges, child welfare services, parent attorneys, and treatment providers. Making sure your eligibility criteria are straightforward and in writing will allow you to communicate them clearly and consistently to your referral sources. Educating all of your referral sources and having a formal process in place will ensure that eligible cases come to the attention of the appropriate people as quickly as possible.

Your team will also need to address at which point or points in a child protection case your court will intervene. Although the information your court will need to make a decision on admittance of a parent to your program will be the same, you may need different processes to address referral and screening at different points of entry. The following are examples of points where parents are offered admittance to family treatment court:

- At the parent's preliminary hearing in an uncontested adjudication
- At the disposition proceeding when the order reflecting the case plan is issued
- At the shelter care hearing, which occurs after a child is removed on an emergency basis from his or her home, if the complaint alleges substance use
- At the mediation hearing
- At the adjudication and disposition hearing where, once the child has been found to be abused, neglected, or dependent in the adjudication portion of the hearing, the court offers the parent a chance to enroll in family treatment court
- After a motion to show cause or contempt hearing when the parent has been noncompliant (e.g., with treatment services or abstinence)

Your target population and eligibility criteria will also affect the point of admittance to your program. For instance, you would target parents in the following situations differently:

- **Parents with newborns:** For example, in one family treatment court, most cases are referred at the initiation of the court process through the newborn crisis program. Babies born with positive drug screens and their parent are referred for acceptance in the family treatment court immediately so the mothers can be promptly enrolled in treatment and separation of mother and child can be avoided.
- **Parents with repeated treatment failures:** In some family treatment courts, parents have the option of being admitted early in the court process if they acknowledge substance use issues. They may elect to enroll later after a petition has been filed and the court has made a formal finding of willful contempt of a court order.

Screening and Assessment

Family treatment court screening is a multi-step process that may involve a variety of team members and the use of several instruments (see Screening Instruments and Tools in Appendix A). The procedural guidelines developed by your family treatment court must allow for both the child welfare and legal system screening processes. In addition, clinical screening and safety and risk assessment must also occur but may happen simultaneously.

A clinical screening of parents consisting of a complete biopsychosocial interview should be conducted by a qualified professional. In some cases, nonclinical staff can be trained to administer certain screening tools; in other cases, a clinician must administer the screening tools. It is important to know the difference when considering what tools to use. Use screening results to identify potential substance use and mental health disorders, history of trauma, and cognitive impairments that may require further assessment. A safety and risk assessment should also be conducted to help determine parent eligibility for your program and to gauge the level of environmental safety for the children.

Multiple screening tools are available for use in both the public and private domains, and your family treatment court planning team should be diligent in selecting tools that best match your program design and the skill level of those working in the program. Factors to consider include the precipitating incident, child assessment, caretaker assessment, family assessment, and family/agency interaction. Risk should be examined in the context of family strengths and of interactions with critical risk factors.[119]

There are many examples of evidence-based tools and instruments that can help your team with eligibility screening, substance use disorder assessment, and child safety and risk assessment. Instruments are available for other factors as well, such as mental disorders; trauma and post-traumatic stress syndrome (PTSD); and cognitive, intellectual, and other functional impairments.

Types of Screenings

The following are examples of screenings and assessments as they might be described in policy and procedure manuals:

Eligibility Screening

Child neglect cases in which substance abuse has been alleged in the petition by Children's Protective Services (CPS) may be eligible for consideration for the family treatment court. On the day that CPS files a neglect case with the family court, a special screening clerk determines if substance abuse has been alleged and if the case meets the other specific screening criteria. Eligible cases are sent to the treatment court immediately for intake, arraignment, and orientation.

Alcohol and Drug Assessment

This diagnostic or clinical assessment uses tools or procedures to determine the probability that an individual has a given condition, or disorder. Ideally, the assessment should be quick, easy to administer, inexpensive, and capable of detecting a problem, or condition, when it exists. Screening for substance use disorders should include a combination of observations and a brief oral screen.

Child Safety/Risk Screening

This evaluation of child, caretaker, and family factors is designed to identify the level of safety and risk for children in a family. Safety is defined by immediate danger or harm and when it has or might occur. Risk is the likelihood of future maltreatment or abuse and can vary from high to low at different points in the child's life. This is not a one-time assessment but is done throughout the life of the dependency case.

The team must determine the parameters for the development of screening criteria. Policy and procedure should include the roles and responsibilities of the people who will screen cases. Make provisions for how to address exceptions and what to do regarding conflicts about the admission of specific participants.

Worksheet 11 will guide your discussion.

Entry Process

The entry process is how your family treatment court program will move the cases from judicial involvement to program entry. Referrals to the program may come from any party involved in the process (e.g., judge, child welfare services, parent attorney, treatment provider). Depending on statutory regulations and program design, cases may come into the program from multiple sources. During the development of the entry process, the team should consider the following:

- How to enhance internal systems to develop realistic time frames from early identification to beginning treatment
- Identifying the agencies and tasks involved in the entry process
- Identifying potential conflicts or process challenges and ways to address them
- How to handle cases that are determined ineligible

Use Worksheet 12 to plan the entry process.

Plan an Orientation for Participants

Shortly after being accepted in your program, a participant should be given a complete orientation to your family treatment court. Orientation is the process of situating eligible individuals in the family treatment court and explaining the parameters, expectations, and consequences of their participation. This can include observation of a treatment court hearing to help parents understand what family treatment court is really like. The orientation serves a number of important purposes:

- It begins your relationship with a strengths-based approach and furthers the engagement process.
- It familiarizes parents with the services and supports available to them and their children.
- It clarifies everyone's expectations. The overview should include a review of potential incentives, sanctions, and consequences of compliance and noncompliance with the program.
- It defines everyone's roles and responsibilities. This lets a participant know who to go to with questions and what each team member will be doing.
- It helps the family feel comfortable with the program. Orientation should involve the participant's support system so that all may understand the family treatment court program.

How your program orients participants depends on how many you have entering the program at any given time. You may choose individual or group orientations. You should account for language barriers and work to avoid information overload in the development of your written materials and verbal presentations. Consider doing more than one orientation to be sure that participants understand the commitments they are making.

Staffing and Court Structure (Hearings)

The staffing and court sessions are opportunities for the team to discuss case status and parent progress, further identify parents' and children's needs, develop team-based responses to participant behaviors, and apply the benchmarks for case processing in a family treatment court model. These benchmarks include the following:

- Key components, from *Defining Drug Courts: The Key Components*[120]
- Family treatment court common characteristics, from *Family Dependency Treatment Court: Addressing Child Abuse and Neglect Cases Using the Drug Court Model*[121]

Example of an Orientation Policy

On the first day the respondent appears, she or he is assigned a lawyer who, together with a treatment court staff member, conducts an orientation about the treatment court program. Once before the judge, the allegations as well as the program are again explained and the respondent is offered the opportunity to be assessed by the treatment court clinical staff.

- Guidance to states, from *Guidance to States: Recommendations for Developing Family Drug Court Guidelines*[122]

During staffing meetings, the operational team shares information and updates on the family's performance in the program. 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.[123] Information shared during staffing should be used to make informed recommendations to the judge. The judge can also use this information to apply strengths-based practices when interacting with the participant at his or her next status review.

The scheduling of your family treatment court hearings depends on whether your court structure is based on the integrated program design with one judge or the parallel program design with two. Local determinations, such as required frequency of status reviews and available calendar time, are based on what works within the boundaries of best practices and can also affect scheduling.

Research on best practices in adult treatment courts reveals the most effective treatment courts offer both treatment and social services to address participants' needs, conduct urine drug testing at least twice weekly, 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.[124,125]

Typically, court hearings are held immediately after staffing. Judge, courtroom staff, and family treatment court team members are present to observe the judge's interactions with participants based on the decisions made at staffing. This is an opportunity for the judge to interact one-on-one with the participants and provide feedback based on accomplishments and challenges since the last court appearance. This is also an opportunity for the judge to monitor service delivery and help to break down any barriers to service access for parents and children.

Construct a Phase System

Family treatment courts are usually structured into phases. Each phase has a set of milestones to gauge participant progress in the program. The length and number of phases depend on the overall length of your program. Your program length is defined by the ASFA mandate and the treatment needs of your target population.[126]

Having the framework of a phased program gives the participants and the team visible steps for measuring success. Treatment courts tend to be long, rigorous programs, lasting one year or more. Breaking down the program into phases gives participants smaller steps to climb one at a time to reach their ultimate goals. Following are some of the components that can be distributed into the phases to make manageable steps for participants:

- Treatment
- Support services
- Parenting interventions
- Community-based support meetings
- Court progress hearings
- Monitoring and support
- Random drug testing
- Employment and education
- Prosocial activities
- Period of negative drug tests
- Phase advancement criteria

Decide on a Direction

Rather than number the phases, you may want to name them based on the key issues in each phase as a way of helping participants understand phases. For example, one program calls its three phases *Choices*, *Challenges*, and *Change*. Coordinating phases with the steps necessary for permanency planning and reunification is an important consideration. The clearer you are about what you are hoping to accomplish in each phase of the program, the more easily you will establish program expectations, service options, and decision-making processes. As you consider your goals, remember to make them realistic for your target population. For example, if your population consists of individuals with long-term opioid use disorder, you would not expect them to obtain employment in the early phases of the program but would have that expectation later in their progress.

Each phase will have a different set of requirements based on participant progress in treatment and in reunification and permanency issues. Therefore, the frequency and intensity of services and requirements will vary by phase. As some interventions decrease intensity over time and with progress (e.g., family treatment court hearings), other services and intervention will begin or intensify (e.g., parenting time, parental obligations, vocational training).

When determining the phase structure and requirements the team should consider:

- Child's best interests, safety, and welfare
- Target population (e.g., type of substance use disorder, physical and mental challenges)
- Accountability
- Community resources
- Cultural proficiency and responsiveness
- Realistic time frames and expectations designed to promote recovery
- ASFA mandates

Excerpt from a Family Treatment Court Participant Handbook

The [program] consists of three phases, with a minimum of one year and a maximum of two years of participation. Staying in the program depends on you and how well you deal with the structure that will be added to your life.

- **PHASE I** is primarily concerned with orientation into the program and getting you introduced to the beginning phases of treatment, case management, and the court process.
- **PHASE II** is primarily concerned with teaching you how to achieve and maintain recovery and to strengthen your parenting skills and abilities.
- **PHASE III** will be teaching you coping and relapse prevention techniques and skills to help you deal with things in your life on a day-to-day basis.

Each phase requires you to be in good standing with treatment, to meet with your case manager, to submit to drug tests, to have contact with the your probation officer (if you are on supervised probation), to attend community-based support groups, and to attend the biweekly court sessions. You will need to comply with requirements to receive a good report. Recognition is made for your performance and incentives or sanctions are given when earned based on the requirements of the program.

- Support mechanisms (e.g., childcare needs)
- Team member responsibilities

Your team must determine the number of phases your program will have and the objectives for each phase using the information above and that you assembled in establishing your program and intervention requirements. Establish these objectives clearly and in writing; you can use them as requirements for advancement through your program's phases.

Worksheet 13 will guide your discussion

Comprehensive Service Delivery and Quality of Services

Effective, high-quality substance use disorder and other treatment is central to the success of a family treatment court. You and your team will establish a network of providers that covers the spectrum of treatment needed by family treatment court participants and their children.

Your planning team members need to make educated decisions when selecting providers. At this point in the planning process, it is expected that any treatment providers on your planning team have oriented the team on treatment values, procedures, and terminology. There is value in obtaining targeted cross-training geared toward services for parents, children, and families. Create selection criteria (e.g., evidence-based curriculum, treatment outcomes) by developing a set of questions to ask of prospective providers that you have identified in your jurisdiction, to evaluate each provider's suitability for working with your family treatment court. Look for a willingness to collaborate across systems and move beyond traditional roles to focus on the needs of children and families in holistic ways. Contact the potential providers, visit the programs, and develop memoranda of understanding (MOU) with those you select.

The scope and complexity of this task will differ according to the size of your jurisdiction and the number of available providers. Large jurisdictions may have more choices, which will require more time to screen, whereas smaller jurisdictions may devote less time to screening existing providers and more time to figuring out how to fill in the gaps in treatment services.

Worksheet 14 will guide your discussion.

Co-Occurring Issues

The term *co-occurring disorders* is used to describe individuals who have at least one mental disorder and at least one substance use disorder, as defined by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), although individuals with co-occurring disorders in the justice system usually have more than one mental disorder and more than one substance use disorder. DSM-5 identifies mental disorders but no longer classifies them by *axes* (Axis I, Axis II, and Axis III) as previous editions did. The most significant change in defining substance use disorders is that *dependence* and *abuse* are no longer differentiated. Substance use disorders are now classified by type of substance and exist along a continuum of *mild*, *moderate*, and *severe*. Co-occurring disorders can be difficult to diagnose, and often one type of disorder is treated while the other goes untreated.[127,128] Family treatment courts, however, provide an environment to screen, assess, and treat co-occurring disorders simultaneously.

For information about serious mental disorders, we recommend that you consult the National GAINS Center website, which serves as a national locus for the collection and dissemination of information about effective mental health and substance use disorder services for people with co-occurring disorders in contact with the justice system.[129]

In establishing eligibility criteria, your team decided how a parent's mental health status would affect admission to your program. Co-occurring disorders

are significantly intertwined with alcohol and other drug problems. These disorders are difficult to identify at intake because they can be masked by an alcohol or other drug problem. This is frequently the case for women with histories of trauma who use alcohol or drugs to self-medicate for depression or anxiety.[130,131] The underlying mental disorder may not be revealed until substance use disorder treatment has progressed.

We recommend that you think of co-occurring issues as the expectation rather than the exception and plan to address them in your program. Despite the potential difficulty of diagnosing co-occurring mental and addictive disorders, such a diagnosis where applicable is extremely important for effective treatment and recovery. Below we map out the co-occurring issues your teams need to learn about and suggest resources your operational team can draw upon, and your planning team can use in designing your program.

Some parents with mental health diagnoses are likely to require extra time and resources because of the special challenges they present to substance use disorder treatment providers:

- Greater vulnerability for rehospitalization
- More psychotic symptoms
- More severe depression and suicidality
- Higher rates of violence and incarceration
- More difficulty with daily living skills
- Greater difficulty complying with treatment regimens
- Increased vulnerability to HIV infection
- High service utilization

SAMHSA recommends an integrated approach to treating co-occurring mental and substance use disorders. Although integrated treatment requires collaboration across disciplines and careful planning to address both types of disorders in a unified way, it tends to be less costly than treatment that addresses the disorders separately. Additionally, integrated treatment offers better outcomes such as:[132]

- Reduced substance use
- Improved psychiatric symptoms and functioning
- Decreased hospitalization
- Increased housing stability
- Fewer arrests
- Improved quality of life

The Special Needs of Women

Research on gender differences has revealed that the distinctions between men and women extend to mental health and substance use disorders. In its 2008 publication Action Steps for Improving Women's Mental Health, SAMHSA noted that research consistently found "the influence of gender differences in the prevalence, course and burden of mental illnesses."[133] Women often differ from men in the paths they take to substance use as well as in the risk factors they have, the consequences they bear, the treatment barriers they face, and the recovery-support structure they need. Other differences include drug of choice, frequency and mode of drug use, and relapse predictors.[134,135,136,137,138,139]

A high percentage of women in substance use disorder treatment experienced physical or sexual abuse in childhood.[140] Some women use alcohol or drugs to self-medicate to cope with co-occurring disorders, emotions, or memories of trauma. As a result of their childhood or adult experiences, they may suffer from posttraumatic stress disorder. In addition, women with substance use disorders may have experienced physical or sexual victimization as adults (e.g., domestic violence).[141] Victims of violence are at increased risk of chronic health conditions, including obesity, chronic pain, and depression, as well as substance use.[142]

For all of these reasons, treatment of women is more successful when tailored to their specific needs. Substantial evidence shows that women, particularly those with histories of trauma, perform significantly better in gender-specific substance use disorder treatment groups and when they receive trauma-informed care. Female participants tend to have a variety of needs that include prenatal care, childcare, socioeconomic limitations, family or partner concerns, and social stigma. SAMHSA's Center for Substance Abuse Treatment has developed a model for women's substance use disorder treatment services. The model recommends that all services be age appropriate, culturally relevant, and gender-specific for the different populations of women and their children. The model addresses substance use counseling, obstetrical and gynecological services, parental counseling, and housing and legal services.[143]

To best support female participants in your family treatment court, your planning team will need to give special attention to the unique needs of women. Bring in a speaker or presenter who specializes in women's services to talk with the team about gender specific treatment and support services.

Domestic Violence

Research has found that women in substance use disorder treatment experience higher rates of partner violence than women in comparative community samples—often two to four times higher. In studying this issue, SAMHSA concluded that "failure to address domestic violence issues interferes with treatment effectiveness and contributes to relapse."[144]

In the worst case, treatment of substance use disorders may actually put women at greater risk of abuse:

Women with substance abuse problems are frequently involved with men who are also substance abusers. In fact, women are often introduced to substance abuse by male partners. [A male partner] may feel threatened by [his] partner's efforts to get clean and may actively or tacitly undermine the goals of her treatment. A woman's efforts to separate from an abusive partner during recovery may also place her at risk for further violence. Treatment programs [that] fail to recognize this dynamic may inadvertently contribute to escalating violence.[145]

A parent who is in physical danger will not be able to focus on substance use disorder recovery; therefore, your family treatment court needs to partner with local domestic violence programs. Your team will need to identify and refer women in need of shelter and counseling immediately. To

increase effectiveness, your substance use and co-occurring disorder treatment providers must be well informed about domestic violence and the potential for increased risk to women in recovery. Some family treatment courts include on their operational team a domestic violence services provider who attends all staffings and court hearings, which makes him or her immediately available for referrals and counseling. You should schedule an additional speaker or presenter by someone knowledgeable about domestic violence and its relationship to substance use for your planning team and later your operational team.

Engaging Fathers

Family treatment courts that seek to be family centered and gender responsive must also thoughtfully plan how they will effectively serve fathers. Fathers play an invaluable role in a child's successful development, a role that has been correlated with benefits such as better cognitive outcomes, higher self-esteem, and better educational performance.[146] Unfortunately, fathers often face numerous barriers when they enter the child welfare, treatment, and court systems, including biases and misperceptions. Men are less likely than women to seek behavioral health counseling.[147] Traditionally, child welfare agencies have been challenged with engaging fathers in service case plan and family activities. Fathers are often seen as a threat and as being potentially violent and abusive toward women and children. They are presumed to be a liability, uncooperative, unable to take responsibility, and not committed to family life. Like women, men have unique treatment needs. Unfortunately, in comparison to women, there is a scarcity of treatment approaches for men. The therapeutic process itself may be incompatible in some ways with how men are raised and socialized.[148] Some of the messages that men receive may be contrary to what is expected of them in the treatment setting. Messages such as "don't lose control" and "don't ask for help" are indeed at odds with the expectations in the treatment setting that men should "show vulnerability" and "admit powerlessness."[149]

Substance use disorders affect the entire family. By taking a gender-responsive approach, your planning team has the opportunity to create a process to better engage fathers in treatment by placing substance use disorders and recovery within the context of their socialization as men. Family treatment courts have a unique opportunity to promote father involvement through enhanced service coordination and service delivery. Outcomes for children who have been substance exposed prenatally can be improved when the multiple needs of mother, father, and child are addressed.[150] Several family treatment courts have implemented an array of innovative strategies to better engage fathers in treatment by recognizing the unique needs, roles, and responsibilities of fathers. These strategies include the following:

Recognizing and addressing the unique trauma responses of men: As they do with women, family treatment courts should take trauma into account when working with men. Practitioners should learn the skills and strategies to effectively engage with fathers to avoid triggering trauma reactions and/or traumatizing the individual.[151] Counselors and other staff should seek to adjust their own practice and perceptions to support men's coping capacity. This would include assuming that fathers have a desire to be involved in their children's lives and suspending judgments to increase compassion and empathy. Social workers, clinicians, attorneys, and judicial officers should also recognize interpersonal barriers related to trust and power, and that their positions automatically put them in a power position that can foster mistrust and anger. Making allowances for expressing anger can also help family treatment court professionals become more trauma-sensitive by changing the question from *"What's wrong with you?" to "What happened to you?"*

Offering specific men's programming: Family treatment courts can ensure that treatment is gender responsive by creating a delivery system attuned to the needs of fathers through program development, content material, and staffing. Recovery groups for men enable fathers to explore sensitive issues such as family violence, paternity, custody, co-parenting, visitation, child support, and men's health, and men are responding. One family treatment court was able to demonstrate, through increased attention to male-specific programming, an overall increase in successful outcomes for fathers, from 57% in 2009 to 78% in 2015.[152] Offering recovery groups for fathers can also yield additional benefits, including increased morale and camaraderie among the men in the program, often leading to positive, long-standing support networks and job connections, and new opportunities for kinship care and permanency by engaging the paternal side of the family.

Supporting logistical concerns: A gender-responsive approach can include strategic staffing decisions, including employing male facilitators, clinicians, and recovery support specialists. Another strategy employed by family treatment courts is to offer programming in the afternoon and evening to accommodate fathers who are employed, in school, or actively looking for employment and educational opportunities. One family treatment court holds two separate dockets, one for mothers and one for fathers, to provide better engagement in services. Providing choice even in small ways can be an important engagement strategy, such as allowing participants to choose the day of the week for their treatment sessions.[153]

Meeting basic needs: Through partnerships in the local community, family treatment courts can link fathers with important services to meet basic needs. These include employment, vocational training, economic self-sufficiency, housing, and transportation. These services not only support successful participation in and completion of treatment and the child welfare case plan, but also affirm men's unique role of wanting to provide for themselves and their children. Providing comprehensive, family-centered services is critical.

Facilitating quality family or parenting time for fathers: Many family treatment courts now refer to "visitation" as family or parenting time to emphasize the importance of supporting and healing the parent-child relationship through frequent and quality interaction. Fathers who are involved in the child welfare system due to substance use disorders can carry a heavy load of shame and guilt as well as anger toward themselves and other family members. In addition to establishing safe and nurturing settings for children, case workers and staff should take a trauma-sensitive and family-healing approach toward family and parenting time for fathers.

There are many ways in which family treatment courts can identify and meet the specific needs of fathers. During the planning process, teams can develop engagement strategies to ensure that fathers enter the program and stay involved. Planning teams can also prepare to use data once they become operational to determine how fathers' outcomes differ from those of mothers. If fathers are not faring as well in the program, the family treatment court team has an opportunity to further explore the reasons why and to develop strategies to increase their success.

Trauma-Informed Approach and Trauma-Specific Interventions

Although both men and women can suffer from trauma, women are more than twice as likely as men to develop posttraumatic stress disorder (PTSD).[154] The National Institute on Drug Abuse estimates that as many as 80% of women seeking substance use disorder treatment have reported lifetime histories of trauma in the form of physical and/or sexual assault.[155] In its *Adult Drug Court Best Practices Standards*, the National Association of Drug Court Professionals noted that "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."[156] It is also important to note that treatment court participants with co-occurring disorders are very likely to have experienced trauma.[157]

Trauma affects how participants will respond to your family treatment court program, and because of how many people suffer from trauma, your program and its outcomes will be affected, especially if your program does not plan properly for it. Throughout the planning process, your team will need to take into account the difficult life histories of participants—particularly women—to make certain that the court's interactions with them and the services you refer them to are sensitive and responsive to trauma. The team should not only develop policies and procedures that avoid retraumatizing parents but also identify appropriate evidence-based interventions that target the specific needs of those who have experienced trauma.

In formulating your policies and procedures, keep in mind SAMHSA's six key principles of a trauma-informed approach:[158]

- **Safety:** Both staff and families feel physically and psychologically safe, and the setting and interactions promote a sense of safety.
- **Trustworthiness and transparency:** The goal is to build and maintain trust with families and among staff and others involved.
- **Peer support:** By sharing their experiences, peers, also called trauma survivors, help promote healing and recovery.
- **Collaboration and mutuality:** Partnering and leveling of power differences between staff and clients and among staff allows everyone to play a role in the recovery process.
- **Empowerment, voice, and choice:** Focus is on empowering trauma survivors and helping them find their own voices and make their own choices.
- **Cultural, historical, and gender issues:** The goal is to move past stereotypes, to recognize and address historical trauma, and to offer gender-responsive services.

Identify Services for Participants and Their Children

People affected by substance use disorders often have complex health and social needs. Research shows that people who use substances are more likely to be homeless, face unemployment, live in poverty, and experience multiple forms of violence.[159]

The presence of so many serious issues also implies that addressing the substance use disorder alone is not likely to produce the changes in a family that are necessary to ensure a healthy environment for a child. Unless the whole of a family's situation is addressed, substance use disorder treatment is unlikely to be successful—and even if a parent achieves abstinence, the other issues present may continue to pose safety problems for the child.[160]

Your planning team needs to learn about problems common among families in a family treatment court and the services (in addition to substance use disorder treatment) proven useful to address these problems. The services fall into several categories: health services, services to meet basic needs, services for children, and life enhancement services. Your team will need to plan for all of these services to be available to the parents, children, and families in your program who need them. In some cases your program will deliver the services directly, and in most cases you will develop a systematic process for referring them to and monitoring these services.

Health Services

Substance use is frequently associated with health problems such as malnutrition, cardiac conditions, vascular disease, dental disease, and

immune system disorders. Alcohol and drug use has long been linked to HIV infection and transmission; research has shown that their use can impair judgment, leading to risky sexual behavior and potentially HIV.[161]

Unless treated, health problems impede progress in alcohol and other drug treatment. Following are some of the services that can help your participants improve their health and thus their chances for successful outcomes.

- HIV treatment and counseling
- Dental
- Reproductive
- Mental
- General medical
- Nutrition counseling
- Smoking cessation

Smoking is on the list because it accounts for more than five times as many deaths as alcohol, and more than 30 times as many deaths as illicit drugs. Moreover, children regularly exposed to a caretaker's second-hand smoke are at far greater risk of developing asthma and other serious respiratory conditions.

Services to Meet Basic Needs

Like untreated medical problems, other unmet basic needs can make it difficult for parents to take advantage of alcohol and other substance use disorder treatment and impede their progress toward recovery. The following are basic needs that must be met (remember, if domestic violence is present, it should be addressed immediately):

- Housing
- Food
- Transportation (to access treatment and other services)
- Legal services
- Clothing
- Domestic violence counseling and shelter

Services for Children

Parental substance use disorders can have a profoundly negative and lasting effect on children's physical, social, and psychological development. There is a growing body of research focused on the dynamics of substance use disorders within the context of family relationships. Compared with children from other families, children of parents with substance use disorders are more likely to be developmentally impaired—physically, intellectually, socially, and emotionally. They are also at greater risk for becoming substance users themselves.[162,163]

Children grow and develop at different rates. Although their paths through childhood differ, most pass a set of predictable milestones along the way. Parents can set reasonable expectations when there is an understanding of the various stages of child development. Parents with substance use disorders often believe that very young children can stop crying on command and should respond naturally to caregivers' needs. Typical experiences of children whose primary caregiver has a substance use disorder include: (a) chaotic and unpredictable home life; (b) inconsistent parenting and lack of appropriate supervision; (c) inconsistent caregiver emotional responses and care; and (d) physical or emotional abandonment.[164] Parents with a substance use disorder often saddle children with responsibilities beyond their capabilities, such as being expected to care for younger siblings, a process called *parentification*.[165]

You will need to find ways to assist families in overcoming these challenges and reaching goals of health, safety, and permanency for their children. To do this, members of your planning and operational teams need to be educated in and understand milestones of child development and the needs of children in each developmental stage. Your teams *must* rely on recognized protocols when creating or enacting your court's protocols regarding child health and safety issues and risk for future abuse or maltreatment. To help

team members avoid confusion that may lead to further endangering children, discuss the issues that families will encounter in your program, the milestones of child development, and the developmental stages children pass through. Be sure to cover the following topics:

- Planning ways to make the courtroom environment child friendly
- Determining the effect of incentives and sanctions on the child
- Assessing a parent's interaction with and expectations for the child
- Addressing needs for daycare for parent appointments and court appearances
- Referring parents to evidence-based, parent-child interactive parenting classes
- Evaluating services provided
- Ensuring children have comprehensive mental health assessments including screening for developmental delays and neurological effects of prenatal exposure to alcohol and other drugs
- Assessing progress of dyadic parent-child relationship
- Guiding parents to realistic expectations for the child
- Balancing recovery time frames with child development time frames
- Planning for and assessing alternate placement options
- Planning and monitoring parenting time
- Making referrals to services for children

Information about developmental issues coupled with evidence-based services will guide the team in setting realistic expectations for parents, and in turn assist parents with engaging in age-appropriate activities and establishing healthy discipline routines.[166]

When the trauma that a child experiences impacts the attachment to and quality of relationship with the parent, interventions should target rebuilding the parent-child attachment and relationship. Some children may also require more intensive therapeutic and developmental services to address the complex social, emotional, developmental, and behavioral consequences of child abuse and neglect and parental substance use.

Direct intervention with the child is essential to remedy developmental deficits and to prevent future problems that could perpetuate the generational cycle of abuse and neglect. Following are services that the children associated with your family treatment court will need:

- **Trauma-focused interventions, education and prevention:** Given the profound impact that trauma has on child development and family relationships, it is important that your family treatment court provide trauma-focused interventions, such as Theraplay and Trauma-Focused Cognitive Behavioral Therapy (TFCBT) to address the effects of trauma. It may be necessary for both the child and the parent to receive services that address their own issues as a part of restoring and strengthening their relationship.
- **Therapeutic-based parent-child interventions:** Effective parenting training and parent-child therapy lead to improved mental health for parents and children, family bonding and relationships, school outcomes, and social skills as well as a decrease in behavioral problems for children.[167,168] Essential interventions to address the parent-child relationship include attachment-based therapy and therapeutic interventions such as parent-child interaction therapy and child-parent psychotherapy.
- **Developmental screening and assessment:** Your family treatment court should ensure that children of participant families have a comprehensive mental health assessment that includes screening for developmental delays and neurological effects of prenatal exposure to alcohol and other drugs. Examples of assessments include the Ages and Stages Questionnaires or the Child Behavior Checklist.

- **Support groups for children of parents with a substance use disorder:** Educational and support groups for children of parents with substance use disorders have proven to significantly reduce risk factors and improve social competencies and effective problem solving skills.[169]
- **Assessment and counseling for exposure to violence:** To learn more about the needs of children exposed to violence, see *Safe From the Start: Taking Action on Children Exposed to Violence*, which provides information about Safe Start Initiative activities.[170]

The primary concern of your family treatment court will be to promote the best interests of the child and to support the development of a functional, safe, and nurturing family for that child to grow up in. To achieve this, you will need to incorporate into your program services focused on the family as a whole.

- Parenting education
- Parent/child interaction programs
- Frequent visitation/parenting time
- Family therapy
- Family group conferencing
- Domestic violence prevention

As you look for programs to serve families and children involved with your family treatment court, keep in mind two fundamental criteria:

- *Services must be developmentally appropriate for children*. The programs you work with must assess children to identify their developmental deficits and then reassess periodically to gauge what progress has been made in addressing them.
- *Services must take into account the effect of a parent's substance use on the child*. Parents with substance use disorders tend to use ineffective or poor parenting practices, including inconsistent, irritable, explosive, or flexible discipline; low levels of supervision and involvement; insufficient affectionate care and attention; and tolerance for youth substance use.[171,172] Children who are exposed to substance use in the home are five times more likely than children who aren't similarly exposed to have experienced a traumatic event and to have a stress response to the event.[173] Also, a child's developmental deficits from prenatal and environmental exposure to a parent's substance use may precipitate behavior, social, and emotional problems, putting the child at greater risk for maltreatment and neglect.[174] Additionally, as noted previously, children of parents with a substance use disorder are more likely to develop a substance use disorder themselves.

Life Enhancement Services

Meeting critical needs is just one step in promoting better outcomes. Services that help your participants build skills put their lives on a more solid footing so that they will be less vulnerable to relapse and will be better able to care for their children. In setting the phases for your program, your team determined milestones as conditions for moving on to the next phase. You will need to identify the organizations in the community that can provide the skills training that will enable participants to achieve their goals. For instance, if you require participants to set educational and vocational goals as a condition for moving into more advanced phases, they will need to enroll in services that promote those goals:

- GED programs
- Adult education or remedial courses
- Literacy programs
- English as a second language classes
- Vocational training
- Employability skills training
- Employment referrals
- Budgeting and finance skills
- Talent and interest development

Employment services provide much broader skills training than just those for a particular type of job. Many parents will need training in how to apply for a job and how to prepare and dress for an interview. Once parents are employed, they may need help in staying employed through further training in time management, communication skills, giving and following directions, and proper attire for the job.

Although, at first glance, developing talents or interests might not seem as essential as literacy or job training, cultivating a neglected talent or interest can be an important component of a strengths-based approach. Talents and interests can build self-confidence and contribute to a sense of accomplishment while encouraging productive leisure and prosocial activities.

Support Services

Over the past 20 years, evaluation research has identified dozens of family intervention programs that are effective in improving behavioral and emotional outcomes for both parents and children.[175] Among the many support services to consider are family group conferences, which uses the resources of team members. Also look for resources within the community to fill in gaps in services or to expand services (see **Worksheets 3** and **14**).

Family Group Conferences

A family group conference brings together parents, children (depending on their ages), extended family members, foster parents, and others involved in the family's day-to-day life. With the guidance of a caseworker or facilitator, the family group participates in the development and implementation of a family reunification plan.

Your team can structure these conferences in different ways. For example, initial conferences might provide families with information regarding the court process, the treatment plan, the terms of visitation, and information about addiction and recovery. Later sessions might identify family strengths, map family histories of substance use and criminal justice involvement, and help families build drug prevention strategies for their children. Throughout the family's participation in the family treatment court, family conferences will provide a forum for exchanging information and solving problems, drawing on the family's own knowledge and resources.

Although a significant body of research on family group conferences has not yet been amassed, the many advantages of such conferences have led some states and counties to adopt this approach as a routine part of their child welfare work. If your family treatment court would like to explore family group conferences as an option, keep in mind that having a facilitator knowledgeable about the dynamics of alcohol and other drug use and the related intergenerational issues is critical. For further background, read *Family Group Conferencing: New Directions in Community-Centered Child and Family Practice* as well as *Responding to Alcohol and Other Drug Problems: Weaving Together Practice and Policy*.[176,177]

Case Management

Case management is a process to ensure that treatment and services for both parents and children are available and delivered, and that participant progress and compliance are monitored and reported in a timely fashion to the family treatment court team. In the family treatment court arena, case management is complex because of the number of disciplines involved—dependency court, child welfare, substance use disorder treatment, and mental health—each of which has its own case management process, philosophy, and values. Well-planned case management can provide appropriate, comprehensive treatment services that engage and motivate, and support services that enable parents to maintain long-term recovery and a safe and nurturing environment for their children.

The *collaborative model* of case management facilitates the strongest coordination and information sharing. Case managers work together as a team. They meet frequently and regularly to share information, consult, review and revise case plans, and ensure that all involved in a case are working toward the same goals.

Case Manager's Role

- **Conduct needs assessments:** The case manager determines a participant's needs for substance use disorder treatment, child development, family functioning, parenting capacity, and support services (primary and mental health, educational, vocational, employment, housing, financial, and transportation to school, work, court, and treatment).
- **Plan the participant's involvement with the family treatment court:** The case manager develops and coordinates the case plan, determining how and when these services will be available to the participant. He or she finds, negotiates for, or creates critical services to fill gaps in the participant's treatment and arranges a process for home visits.
- **Partner and coordinate with agencies and service providers:** The case manager brokers the services that he or she determined were necessary in the assessment: substance use disorder treatment, education, vocational training, primary and mental health care, nutrition education, transportation, parenting classes, domestic violence education, life skills to support sober lifestyle, community service, housing, financial management, and relapse prevention.
- **Advocate for parents and children:** The case manager takes a holistic approach to the needs of the parents, children, and family, and ensures that services fit the participant's needs.
- **Oversee the case:** The case manager monitors progress and compliance, service delivery, exchange of critical information among service providers, and ASFA time frame.
- **Communicate with the participant and his or her family:** The case manager interacts with parents to provide support, promote accountability, and keep them informed.
- **Coordinate information with other team members:** The case manager keeps the operational team updated with current information about the case. He or she identifies and eliminates gaps in service and avoids duplication of services. The case manager also ensures that the various disciplines work together toward the same goals and manages any conflicts and barriers.

Have your team discuss how case management functions will be determined for your family treatment court program.

Worksheet 15 will guide your discussion.

Oversight and Accountability

Keeping track of participants and their children and knowing what is going on in their lives are important in a family treatment court program. Research shows that timely responses to compliance or noncompliance increase the effectiveness of incentives and sanctions.[178] To achieve timely responses, your case management plan must address frequency and intensity of monitoring. Some family treatment court teams include community policing representatives who receive specialized training and provide an added level of accountability and support for families. Although the judiciary, child protective services, and treatment are at the forefront of overseeing parent compliance and the safety of children for a family treatment court, all team members will hold participants accountable in some way and at some point in the process. Oversight and accountability should include the following:

- Monitoring and support protocols
- Assignment of monitoring and support roles and duties (which may include a combination

of child welfare, and case management, and, in some cases, law enforcement and probation)

- A process and defined resources for referring participants to comprehensive services designed to increase their overall success
- Cross-training for all persons brought onto the team to conduct supervision and monitoring so that they are familiar with program operating protocols
- Support systems and advocacy to assist families through change
- Process for applying the principles of recovery outside of treatment and the courtroom to ensure that participants are engaged in the recovery process
- Process for reporting back to the operational team and for keeping the judge apprised of findings in a timely fashion

Worksheet 15 will guide your discussion.

Drug Testing

An essential part of the oversight and accountability process is alcohol and drug testing. Frequent, random drug testing is an effective way to support parents in their efforts to stop alcohol and drug use and to assess and verify that participants are complying with abstinence requirements. Testing provides a timely, objective, and reliable measure of abstinence, which is a component of successful recovery.

Drug testing is one part of the assessment process to determine a parent's progress toward his or her goals. Rather than an impersonal, watchdog process, it can be a way to connect with the participant. At the beginning of program participation, make clear to the participant the purpose of testing and which system your family treatment court uses. Including the participant can be part of the engagement process. For example, if testing is being done because of suspicion of relapse, ask the participant first to admit to the drug use, emphasizing the primacy of honesty, the inevitability of detection, and the acceptance of relapse as a natural part of addiction and recovery. However, remember that accepting a participant's admission of drug use in lieu of administering a test allows for the participant to admit to the use of one drug while failing to report the use of others.

The four common types of drug testing are urinalysis, breath, saliva, and patch. Urinalysis is the preferred method in most situations because of availability, ease, and reliability of analysis, and length of detection window. When choosing a testing method, review the current drugs being used by eligible parents and the feasibility of testing for those drugs. To align the method and frequency of testing with the program's goals, your team must budget for testing as part of the overall cost of the program. Your team will also need to establish a procedural process for retesting to confirm positive test results, which require setting aside additional funds for a certified lab to confirm the drug test results as needed. Retesting is only necessary if the participant disputes the initial test results.

Some treatment courts choose to safeguard the reliability of test results by using more than one type of test. While drug testing a participant for primary drug of use (which may include alcohol), continue testing for other drugs as some participants switch drugs to avoid detection. Remember, to be reliable, drug testing needs to be frequent, random, and observed.

Frequent: The frequency of drug testing depends on the drug you need to detect, the resources available, and the design of your program. Best practice models and current research indicate that testing twice a week throughout the program supports the recovery process.[179,180,181] When you establish frequency, keep in mind that some drugs are detectable for no more than 24 to 48 hours after consumption. Alcohol dissipates even faster, so testing frequency of someone indicating alcohol as their primary drug of use should be more frequent.

Random: Random testing is scheduled so that participants cannot plan ahead to avoid detection. Designing random drug testing may appear straightforward but is actually quite complex. For example, testing that occurs only on a specific day each week is not random. Even if a participant were selected at random for testing that day, he or she could routinely avoid detection simply by abstaining each week for a day or two before the designated day.

Observed: Because the reliability of drug tests depends on the test sample's integrity, your team needs to arrange for observation of sample collection as part of your program's procedures even if the test is designed to detect adulterants. Observation protects against other forms of tampering and is a good way to safeguard against attempts to alter the specimen, such as

- Substituting a specimen taken earlier or from another individual
- Adding other substances to the test specimen
- Ingesting other fluids before testing
- Damaging the collection materials

A word of caution: Quality case management cannot rely solely on drug test results. Drug testing can and should be part of the ongoing assessment process but is only one component of the treatment court's coordinated approach. Frequent testing can act as an external incentive to reduce or stop using while the parent develops internal refusal skills. Treatment decisions should also factor in the participant's behavior and other key indicators of progress or relapse. Remember, detecting the use of alcohol is difficult even with frequent, random, and observed testing. A participant who is continuing to use alcohol and other drugs may find ways to evade detection through testing. Lastly, drug testing should be conducted only to monitor and supervise treatment; test results from your family treatment court should never be used for prosecution.

Worksheet 15 will guide your discussion.

Responding to Participant Behaviors

Managing your participants' behaviors is an important part of your program. Incentives and sanctions are your team's tools to promote desired behaviors and remind participants of the importance of adhering to programmatic goals. Your planning team will design a framework for incentives and sanctions to promote each parent's ability to make healthier and safer decisions and be accountable for his or her actions. As you design your process and compose a list of creative, graduated sanctions and incentives, remember that all responses need to promote the best interests of children. Your goal is timely permanency for children through reunification, when possible, with a parent who is in recovery and within the time frame set by ASFA.

To help you with this task, the National Drug Court Institute has provided a sample list of incentives and sanctions on its website.[182] The following key ideas, based on research in behavioral science and treatment court practice, will help you develop your incentives and sanctions process to encourage the behaviors your participants need to develop for successful outcomes:

- **Be goal oriented:** Determine the specific, observable behaviors that would indicate progress toward the goals you developed with the participants. These are the behaviors you want to reinforce or encourage with incentives. Determine those behaviors that would interfere with goal attainment. These are the behaviors you want to discourage or eliminate through sanctions. Goal-oriented incentives and sanctions will help you not only target specific behaviors to change, but also assess a participant's progress.
- **Be certain:** Clarify behavioral expectations and consequences with participants during orientation, then follow through consistently during

the program. Make certain that the participants understand clearly the reason for the incentives or sanctions. Certainty of response is paramount to participants making the connection between behavior and consequence. Knowing ahead of time what will happen in response to their actions (or inactions) gives them control and fosters a sense of responsibility.

- **Be consistent:** Develop a plan that fosters a consistent approach to and consistent delivery of consequences for targeted behaviors. Decide who on your team will deliver the incentives and sanctions and how the family might be involved. Positive reinforcement brings about more rapid behavior change when given every time the target behavior occurs. Family treatment court participants who receive sanctions for each occurrence of noncompliant behavior have significantly lower rearrest rates than those who are sanctioned intermittently.
- **Be immediate:** The impact of incentives and sanctions is diminished by any delay between the behavior and the purposeful response to that behavior. Design your process to include monitoring behavior and delivering immediate responses. Identify who, in addition to the judge, can be involved in the process and how.
- **Be fair:** Participants who feel fairly treated do better than those who don't. Determine which of your rules are hard and fast and which ones are negotiable. A person's perception of fairness has more to do with the clarity of expectations, the consistency with which the responses are issued, the opportunity the person has to be heard, and his or her overall feelings of trust of those who issue the responses. Incentives and sanctions are more effective when viewed by the participant as an effort by the court to provide an opportunity for success.
- **Use a graduated approach:** Family treatment courts should employ a graduated system of incentives and sanctions to adequately and appropriately address behavior responses. Planning teams should develop a range of incentives and sanctions that will encourage positive participant behaviors and discourage negative ones. Research indicates that lower magnitude incentives should be provided for relatively simple, or proximal, achievements than for difficult, or distal, achievements. Proximal achievements are those the participant is already capable of engaging in, such as attending court hearings, whereas distal achievements occur over the long term, such as improved parenting skills. Your team should continually gauge the effectiveness of imposed responses within your programs to ensure the best possible outcomes.

  Initial sanctions need to be strong enough to be noticed, but not so strong that they are perceived as overly harsh or unfair (triggering defiance) or that they leave no room to increase intensity. Incremental increases in intensity of sanctions need to be significant enough to avoid habituation, in which the participant becomes gradually accustomed to the responses and is inured to the highest level sanction, making it ineffective.
- **Be individual:** When establishing parameters for graduated responses, maintain the flexibility to tailor incentives and sanctions to the individual participant. Something that might motivate or deter one participant may not have the same effect on another. By tailoring responses to the individual, you personalize your reactions and strengthen the relationship between the participant and the team. To do this, assess each participant's strengths and needs to determine whether that individual is capable of understanding how his or her actions led to the resulting response. During the assessment, invite the person to participate in creating a range of potential incentives and sanctions that are culturally appropriate and correspond to his or her individual perception of a reward or punishment.
- **Be therapeutically sound:** Distinguish between court sanctions and treatment responses. Changes in a participant's treatment regimen should come from the treatment provider.

Altering a treatment plan from the bench is not employing best practices, especially if the infraction is not a treatment-related issue.

Worksheet 16 will guide your discussion.

Graduation from the Program

An integral part of designing your program is determining the requirements for successful completion. Many courts begin with the end in mind and create the phase requirements based on the goals established for graduation. Graduation requirements for your family treatment court should consider time in the program, completion of treatment and other program components, dependency case decision making, ASFA timelines, participant connections to ongoing support and community involvement, and aftercare planning.

The example below itemizes the requirements for completion of the final phase of one family treatment court program. The treatment court reunifies families prior to graduation, providing it with an important opportunity to monitor the family's progress. The court also requires an established connection between the participant and community through outreach and participation in support groups.

Example of graduation requirements:

- *Consistent court appearances*
- *Compliance with sanctions*
- *Satisfactorily met treatment criteria for discharge and is meeting objectives in an aftercare program or relapse prevention*
- *A minimum of 12 consecutive weeks of negative drug tests in final phase*
- *Consistent compliance with alcohol and drug testing*
- *Consistent verified attendance at community-based support meetings*
- *Children reunified*
- *Income or job verified*
- *Housing secured and approved*
- *Outstanding legal issues satisfactorily addressed*
- *Participation in a family group decision-making meeting (when appropriate)*
- *Participation in the alumni association*
- *Team recommendation*

In the following example, the family treatment court spells out the requirements for successful completion of its program:

Successful completion certificates will be awarded to participants who have remained in the program for one year, have remained substance free for 90 days and have developed a plan for ongoing recovery and relapse prevention.

Your team must determine clearly defined criteria for successfully exiting the program and resolve who will make final decisions on whether a participant has met those criteria and will graduate. Your team also needs to establish mechanisms to gather information from each provider and discipline so that your team and the person or people deciding on graduation have current information for decision making.

Your team will also need to create agreements and communication procedures with all courts with which the participant is involved. For instance, the dependency case may be handled by a separate court or the participant may be involved in a criminal case. You must keep other courts apprised of the participant's successful completion of the family treatment court program so that they can link that information to their decision making. This information is important in dependency cases as it is integral to how and when to reunify parent and child. Because graduation can be a trigger for relapse, in some courts the dependency case is purposely held open for an agreed-upon amount of time to ensure that success is sustained.

Successful completion of the treatment court program is a time for celebration and recognition. A unique feature of the family treatment court is

its focus on strengths and incentives for changing behavior. Commencement is an opportunity to recognize the hard work and achievements of the participant and his or her family. Involve the whole family in a formal commencement event. Consider inviting key stakeholders, the participant's sponsor, and other people the participant feels have been supportive.

Termination from the Program

To give the participants in your family treatment court the best opportunity to succeed in your program, they will need a clear understanding of what triggers termination. Although the goal of your family treatment court is therapeutic jurisprudence, your team must have a termination process for when all possible incentives and sanctions have been applied and have failed to alter participant behavior responses. Your team will need to establish the criteria for termination and a means of communicating those criteria to a participant as clearly as is done for sanctions.

In composing your list of reasons for termination, look back at your eligibility criteria. Any issue that would exclude a parent from participating in your program will result in termination from the program should the situation arise during his or her enrollment in family treatment court. For example, if your program excludes parents found guilty of felony child abuse, then should a participant be convicted of that felony during the program, he or she would be terminated from your family treatment court.

Next revisit sanctioning. At what point do sanctionable behaviors become grounds for termination from the program because of repeated offenses? Your team should discuss sanctionable behaviors and decide at what point repetition of noncompliant behaviors becomes grounds for dismissal. Be sure that you make clear the difference between a noncompliant behavior being sanctionable and the same behavior later becoming grounds for termination.

You might also look at other family treatment courts' established guidelines.

As your team considers what should be grounds for termination, keep in mind treatment factors, length of time in the program, repetition of noncompliance, family factors, and jurisdiction. Develop a policy that clearly outlines and conveys to participants the circumstances that can lead to termination. Above all else, develop a procedure that ensures the best interests of the children.

Worksheet 17 will guide your discussion on establishing criteria for graduation/termination from the program.

Once your family treatment court is up and running, your operational team will revisit how well the established program is achieving its goals and producing positive outcomes for children, parents, and families. Are you reaching your target population? Are you employing current best practices? Are you affecting systems change? Because monitoring and evaluating your family treatment court is an ongoing process to keep the court functioning successfully into the future, your team must establish systems, processes, and relationships that will sustain your program past the planning team's involvement. You must create a sustainability plan, which funders often require, to ensure the future of your family treatment court.

5. Sustaining Your Program into the Future

Ongoing Evaluation of Your Program

No matter how carefully you have implemented your plan, all your work won't matter unless what you have done is successfully fulfilling its mission. And if the program is not working as anticipated, you will want to know why. Is it because you didn't carry out the activities as planned, or is it because your plan was flawed? Unless you keep track of what you have done by monitoring your program, you will have no way to tell. Several types of evaluation—process, impact, and outcome—will help your family treatment court answer those questions.[183] Finally, a SWOT analysis is a much-used technique that you may find helpful:

- **Process evaluation:** This type of evaluation documents what the program is doing and how well you are carrying out the program activities. By monitoring what you are doing as you go along, you will have the ability to pinpoint problems early on and fix them quickly.
- **Impact evaluation:** This type of evaluation reveals what effect you have had on the problem you set out to address. Effects may be short or long term.
- **Outcome evaluation:** This type of evaluation measures the program's effect on graduation rates, child welfare measures (rates of reunification, recurrence of child maltreatment, re-entry into foster care), and treatment outcomes (timeliness to treatment entry, treatment completion).
- **SWOT analysis:** This is used to evaluate *strengths*, *weaknesses*, *opportunities*, and *threats* in relation to a specific task or objective. Customarily, the analysis takes account of internal resources and capabilities (strengths and weakness) and factors external to the organization (opportunities and threats). This tool will help your team in preparing or amending plans, in problem solving and decision making regarding implementation, and in enhancing operation of the family treatment court program.[184]

Collecting Data

The foundation for evaluation is data. The procedures for collecting data must be established at the outset of your program because reconstructing it later will be difficult. To set up the process of collecting data for your evaluations, you will need to do three things. First, you will need to know what data is useful for tracking your program. As a team, consider how you will define success and how you will measure it. Consult your funders and other stakeholders to find out what they will want to know about your program. Then, by working backward, determine what information you will need to keep track of. Once you have that information, you will proceed to your second task: devising the procedures for recording and analyzing your data. Third, you will need an information management system to track and crunch the data. Together, these three elements make up your *evaluation plan*.

Take care when choosing which data you want to track. Too little, and you won't have enough for meaningful feedback, but too much could bog down your service providers and court personnel in paperwork, taking time away from the families you want to help. To avoid the latter, focus on the most essential data, and develop a system that makes it easy to gather and tabulate data. Train staff in how to record the data, and make certain they understand why collecting it is ultimately in their best interest—otherwise they may not be motivated to do the paperwork accurately or even at all.

You can use data and evaluation to do more than track successes, needs, and deficiencies within your program—you can also use them to justify and strengthen requests for new or continued funding. Most funders, both government and private, require an evaluation plan as part of a funding proposal.[185] Data and evaluation outcomes are also critical to ongoing program quality improvement. Teams should review a key set of performance measures on a monthly basis and adjust policy and practice as needed based on this review.

Creating a process to collect data and set up a system to track it are complex tasks, yet this process is important if you are to get a solid start and avoid problems later. If no one on your team has the appropriate expertise, we strongly recommend that you seek a consultant who can head you in the right direction. You might seek help for evaluation and management information systems from one of the agencies represented on your team or contact community partners or a local college or university for help.

Monetary and Nonmonetary Funding

The task of funding your program falls into two stages. The first is short-term funding, which addresses the resources you need right now to get your program off the ground. The second is long-term funding to make your program fiscally viable for years down the road. But where do the funds come from? Teams must look to existing local, state, and federal funding sources that are available in the community to fund treatment and other services for parents and children.

Sometimes planning teams assume that their family treatment court will need to be grant funded and that just one funder (e.g., the federal government) will be the source of all start-up funds. This could happen; however, increasingly family treatment courts begin without grants. Instead, they reconfigure already existing resources, supplementing them with local contributions, both in-kind and cash, as now-retired Judge Pach did in the following example:

Family Drug Court, Suffolk County, New York

After learning about family drug courts in Reno, Nevada, and Pensacola, Florida, Judge Pach decided to apply the model to her own docket in Suffolk County. In December 1997, she began accepting parents into the state's first family drug court on a shoestring budget of in-kind donations from participating agencies and Medicaid funding for treatment. Only after beginning to accept a caseload did she secure a $400,000 grant from the Robert Wood Johnson Foundation and $150,000 from the county legislature. "My advice?" she said, "Don't wait for the money."[186]

For up-to-date information about possible funding sources, consult the National Drug Court Resource Center grant solicitation resources.[187]

Developing a Five-Year Funding Plan

Your team's next challenge is to figure out how to institutionalize your program—to come up with a plan that will take your family treatment court from a pilot program to a business that works in your community. To do this, you will need to develop a long-term funding plan. For the first two or three years, you may be relying on grants designed to support new initiatives, but after that, these sources of funding will no longer be available to you. Even if you managed to start your program by reconfiguring existing resources, you should plan for the future.

We suggest that you look five years ahead to identify potential program needs and deficits. Are you serving all families in need of family treatment court, and do you need to increase the capacity of your program? Will you need additional funding to improve it? Once you have an idea of what you need to fund, you will need to pursue potential sources for that funding. Your start-up funding sources are among the first places to consider when you identify future funding. In addition, here are six strategies to consider. Be creative; you may think of others, and you should pursue more than one funding source.

- **Negotiate with participating agencies:** Early in the implementation of a family treatment court, planning team members will likely be the ones to champion your program with their agencies. Over time, you should broaden the base of support within the participating agencies so that everyone is aware of and supportive of the court's work. With a broader foundation of support, planning team or steering committee members can negotiate with agency directors to get your program integrated into their agencies' annual operating budgets. This is the benefit of an executive committee made up of agency and organization leaders who can focus on sustainability efforts. Using data that demonstrates your program's successes can be an important tool to persuade decision makers to support family treatment court. To formalize the family treatment court partnership, the planning team should develop a memorandum of understanding (MOU) with each partner to outline the agency's role, responsibilities, duties, and tasks. MOUs should be reviewed, approved, and signed by partner agencies' executive-level staff and the family treatment court's presiding judge and administrator or coordinator, and provide outcome data to support your continued funding request.
- **Negotiate directly with the city or county:** Approach city or county representatives about making your program part of the city or county's annual budget plan. Since many communities have state requirements for a one-to-three-year plan, this could provide a funding source for up to three years. Research the budget processes for your local government or invite a person who is familiar with these processes to join your steering committee. Then gradually educate elected officials about your program and its accomplishments, perhaps inviting them to graduations or having judges speak at local community organizations (e.g., Rotary Club) or public events. Once your program is in a local agency's budget, have a member of your steering committee or your planning or operational team attend budget hearings and speak up when your funding is being discussed, and provide outcome data to support your continued funding request.
- **Network with other family treatment courts in your state:** Together, you and other family treatment courts can advocate more strongly for state legislation to fund treatment courts. The National Association of Drug Court Professionals (NADCP) and the different state associations of drug court professionals can offer advice on approaching your state government. You can get started with the NADCP web pages, advocacy tools and resources, and state drug court coordinators.[188,189]
- **Build relationships with managed care organizations:** If you haven't already, reach out to executives of managed care plans. Educate them about the work the court is doing and its potential benefits for their organizations, then ask them to cover costs of treatment.
- **Apply for federal enhancement grants:** Although federal funding is not available to continue to support a new initiative, grants are available for program enhancement, either through the addition of new services or an expansion of current services to a new population. Up-to-date information about these federal funding opportunities is available on the Grants.gov website.[190]

Worksheet 18 will guide your discussion.

Community Support

Communities are often willing to offer support to family treatment court programs and their participants once they have information about the court's positive impact on the lives of families and people in the community at large. Many groups within your community will be receptive to information about your program and can offer support in a variety of ways.

As you make a plan for community outreach and education, identify the purpose of your outreach efforts and who you are reaching out to. What constitutes your family treatment court's community?

- The area over which the court has jurisdiction?
- The area from which you secure services?
- The area where the families you serve reside?
- A combination of these?

Although you may identify many groups in your community you wish to reach out to, three are worth special consideration: government officials, the news media, and community organizations.

Local Government Officials

Because they control access to local government resources and also because they have the ear of the public, government officials have the power to bolster or hinder your program. Because of this, educating them is in the best interests of your program. If they understand and appreciate the role of your family treatment court in the community, they will be in a position to channel resources to your program. Establishing a relationship with your local government officials is well worth the investment of time and effort. Consider approaching members of government staff to begin the process. Having someone from your steering committee or one of your teams who is acquainted with your local government budget process can be beneficial.

However, government officials often have many interests competing to be represented in their budget and lack the time to learn about a new program. You will need to bring your program to their attention and create and maintain open lines of communication. Following are some suggestions for doing that:

- Ask a city council member or his or her designated representative to join the family treatment court steering committee.
- Invite a member of the county board of supervisors to your annual strategic planning session.
- Include local and state elected officials in your communications distribution (e.g., newsletter, email) to keep them informed about program successes and needs, making sure to include data and evaluation outcomes.
- Invite local government officials to participate in program celebrations either as guests or speakers. Many elected officials will welcome the chance to be publicly associated with a successful program.

News Media

News organizations are an integral part of the community. Because they have a responsibility to report about public services, they can be influential partners. Keep them abreast of your program's progress and, when appropriate, invite them to celebrations and events. Try to select ahead of time parents and youth who agree to be interviewed, filmed, or photographed. Stories of family triumphs over adversity are quite compelling. Don't overlook local news media such as hometown newspapers and local radio and television stations.

Additionally, the time you invest in developing positive relationships with the media will prove beneficial should a negative incident involving your program occur. If reporters are aware of your accomplishments, they will be more likely to give balanced coverage of program accomplishments and challenges.

Community Organizations

Many organizations beyond your family treatment court's partnering organizations are represented in your community. Involvement of community organizations can and should be a mutually beneficial

relationship. If team members are not already on local boards or committees, consider having them volunteer to serve. Program staff and participants' families can take part in community events such as Make a Difference Day and neighborhood cleanup projects, or they might take a shift in a soup kitchen. Local service organizations such as Rotary and Lions Clubs often welcome speakers for their programs. Consider having a representative of family treatment court and a graduate of the program speak to these organizations. After hearing what you have to say, they may ask how they can help your program.

Worksheet 19 will guide your discussion on establishing community support.

The Planning Team

Once you have your family treatment court up and running, the work of your planning team is essentially done and the work of the operational team is just beginning. Your planning team is now a resource of informed candidates for the operational team, steering committee, or administration. Consider transferring members of the planning team to these other positions within your governance structure as best serves your family treatment court.

The Operational Team

The family treatment court planning team has worked diligently during the planning process to develop a program structure that provides effective and efficient services for children and parents. The family treatment court operational team must now take over and continually assess how to maintain and sustain your program. The day-to-day operations of the family treatment court require constant analysis and oversight of program compliance with the protocols and policy established by the planning team.

Monitoring and evaluating the effectiveness of the program is an essential element in the design of your family treatment court. To ensure that the program maintains fidelity to the treatment court model, your operational team members must actively engage in quality assurance on a routine basis. With the long-term strategic plan as their guide, the operational team will now make every effort to achieve case plans and to ensure the safety and welfare of children through monitoring. The team will also work to provide a system of support for the parents through services, assist the parents and their families through the change process, and maintain healthy family relationships that endure.

Creating a Legacy: The Promise of Family Treatment Court

By instituting a family treatment court, you and your teams are creating a legacy that will strengthen your community. The *Family Treatment Court Planning Guide* and worksheets will lead you through forming your teams, building community contacts and support, and establishing funding and political support. They will aid you in developing a program in which your family treatment court, child welfare, and treatment systems work together effectively to address child abuse and neglect in homes where parental substance use has eroded the children's safety and well-being and the family as a whole.

Parents and their children can break free of intergenerational substance use patterns when they experience living in a stable setting with concrete and emotional supports. By providing participants, children, and families with access to these supports, your new treatment court will show parents alternative and stable ways of living in which they and their children can feel secure. With the help of your new program, families can experience success—in social interactions, academic pursuits, physical health, and specific tasks of daily functioning. Using a holistic, family-oriented approach, your court can empower whole families to recover from the scars of substance use and break the cycle of abuse.

This appendix provides a list of resources such as screening instruments and tools as well as useful websites, publications, and other reference materials. The resources listed here are by no means exhaustive. They are intended as a starting point for you to find the resources you need as you create your family treatment court program.

Appendix A
Instruments, Tools, and References

Screening Instruments and Tools

As with all of the listed resources, these screening instruments and tools are a starting point for you to investigate. Tools specific to family treatment courts are not necessarily available for all of your family treatment court needs so you may have to rely on existing tools. Note that adapting existing screening or assessment tools will make them nonstandardized and should be avoided. The National Association of Drug Court Professionals does not endorse any particular tools or instruments. You should select resources that are most appropriate for your program and target population.

Mental Health

Brief Jail Mental Health Screen
https://www.prainc.com/wp-content/uploads/2015/10/bjmhsform.pdf

GAIN-SS
https://chestnut.app.box.com/v/GAIN-SS-Materials

MHSF-III
www.bhevolution.org/public/document/mhsf-iii.pdf

Trauma and PTSD

Primary Care PTSD Screen (PC-PTSD)
http://www.integration.samhsa.gov/clinical-practice/PC-PTSD.pdf

PTSD Checklist—Civilian Version (PCL-C)
https://www.mirecc.va.gov/docs/visn6/3_PTSD_CheckList_and_Scoring.pdf

Stressful Life Events Screening Questionnaire—Revised (SLESQ-R)
http://library.niwap.org/wp-content/uploads/2015/StressfulLifeEvents.pdf

SLESQ-R can help identify previous traumatic events, and the PTSD screens (PC-PTSD, PCL-C) can then be used to examine the current level of impairment related to each of these events.

Trauma Symptom Checklist (TSC, TSC for Young Children)
https://www.parinc.com/products/pkey/463

Cognitive, Intellectual, and Other Areas of Functional Impairment

Beta-III or the WAIS-Abbreviated Scale of Intelligence (WASI)
http://www.pearsonclinical.com/psychology/products/100000240/beta-iii.html
http://www.pearsonclinical.com/education/products/100000593/wechsler-abbreviated-scale-of-intelligence-wasi.html

Montreal Cognitive Assessment (MOCA) and the Mini-Mental State Examination, 2nd Edition (MMSE-2)
www.mocatest.org/pdf_files/test/MoCA-Test-English_7_1.pdf
http://www4.parinc.com/WebUploads/samplerpts/Fact%20Sheet%20MMSE-2.pdf

Substance Use Disorders

Addiction Severity Index (ASI)—Alcohol and Drug Abuse sections
http://adai.washington.edu/instruments/pdf/addiction_severity_index_baseline_followup_4.pdf

The AUDIT (Alcohol Use Disorders Identification Test)
http://auditscreen.org/

The CAGE
https://pubs.niaaa.nih.gov/publications/inscage.htm

GAIN-SS
https://chestnut.app.box.com/v/GAIN-SS-Materials

The MAYSI-2 (Massachusetts Youth Screening Instrument-Version 2)
http://www.nysap.us/MAYSI2.html

Simple Screening Instrument (SSI)
http://www.bhicares.org/wp-content/uploads/2016/12/Simple-Screening-Instrument-for-Substance-Abuse.pdf

Texas Christian University Drug Screen—II (TCUDS II)
http://ibr.tcu.edu/wp-content/uploads/2016/10/TCU-Drug-Screen-II-v.Dec07.pdf

The UNCOPE
www.evinceassessment.com/UNCOPE_for_web.pdf

Diagnosis and Assessment of Mental Disorders

Minnesota Multiphasic Personality Inventory—2 (MMPI-2)
http://www.pearsonclinical.com/psychology/products/100000461/minnesota-multiphasic-personality-inventory-2-mmpi-2.html

Personality Assessment Inventory (PAI)
https://www.parinc.com/WebUploads/samplerpts/Fact%20Sheet%20PAI.pdf

Addiction Severity Index—5th Edition (ASI)
http://adai.washington.edu/instruments/pdf/addiction_severity_index_baseline_followup_4.pdf

Global Appraisal of Needs (GAIN-Q and GAIN-I instruments)
https://chestnut.app.box.com/v/GAIN-Q3-Materials
https://chestnut.app.box.com/v/GAIN-I-Materials

Texas Christian University, Institute of Behavioral Research (Brief Intake Interview, Comprehensive Intake)
https://ibr.tcu.edu/forms/criminal-justice-cj-treatment-forms/cj-comprehensive-intake-tcu-cj-ci/

Assessment of Criminal Risk and Recidivism

Historical, Clinical, Risk Management–20 (HCR-20)
http://www.minddisorders.com/Flu-Inv/Historical-Clinical-Risk-Management-20.html

Lifestyle Criminality Screening Form (LCSF)
https://www.ncjrs.gov/App/publications/abstract.aspx?ID=133917

Level of Service Inventory—Revised (LSI-R)
http://dhs.sd.gov/drs/recorded_videos/training/lsi-r/doc/LSI-R%20introductory%20training%20Participant%20Manual.pdf

Psychopathy Checklist—Screening Version (PCL-SV)
http://criminal-justice.iresearchnet.com/forensic-psychology/hare-psychopathy-checklist-screening-version-pclsv/

Risk and Needs Triage (RANT)
http://www.courtinnovation.org/sites/default/files/RANTSummaryVlavianos.pdf

Short-Term Assessment of Risk and Treatability (START)
http://criminal-justice.iresearchnet.com/forensic-psychology/short-term-assessment-of-risk-and-treatability-start/

Child Safety Screening

The CAPI (Child Abuse Potential Inventory)
https://www.parinc.com/Products/Pkey/35

The Risk Inventory for Substance Abuse-Affected Families
http://psycnet.apa.org/record/1996-06094-005

The SDM (Structured Decision Making) model
www.nccdglobal.org/assessment/structured-decision-making-sdm-model

Child, Parent, and Family

The ASQ (Ages and Stages Questionnaires)
http://agesandstages.com/

The ASQ:SE (Ages and Stages Questionnaire: Social Emotional)
http://agesandstages.com/

Child and Adolescent Needs & Strengths
https://praedfoundation.org/tools/the-child-and-adolescent-needs-and-strengths-cans/

Child Behavior Checklist
http://www.aseba.org/preschool.html

North Carolina Family Assessment Scale (NCFAS)
http://www.nfpn.org/assessment-tools

The PSI (Parenting Stress Index)
http://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/parenting-stress.aspx

Resources

Websites

Children and Family Futures. (2017). Home page. Retrieved from https://www.cffutures.org/

Children and Family Futures. (2017). Family drug court peer learning court program. Retrieved from https://www.cffutures.org/plc/

Grants.gov. (n.d.). Apply for a grant online now. Retrieved from http://www.grants.gov/web/grants/home.html

Legal Action Center. (2017). State profiles of health care information for the criminal justice system. Putting health and justice on the map. Retrieved from https://lac.org/resources/state-profiles-healthcare-information-for-criminal-justice-system/

National Association of Drug Court Professionals (NADCP). (n.d.). Home page. Retrieved from http://www.nadcp.org/

NADCP. (n.d.). Advocacy tools and resources. Retrieved from http://www.nadcp.org/node/793

NADCP. (n.d.). Lists of incentives and sanctions. Retrieved from http://ndcrc.org/resource/lists-of-incentives-and-sanctions/

NADCP. (n.d.). State drug court coordinators. http://www.nadcp.org/learn/state-leaders/state-drug-court-coordinators

National Drug Court Resource Center. (2017). FY 2017 adult drug court solicitation resources. Retrieved from http://ndcrc.org/fy-2017-adult-drug-court-solicitation-resources/

National Drug Court Resource Center. (n.d.). Sample documents. Retrieved from http://ndcrc.org/resources/?fwp_resource_types=sample-program-documents

Prochaska and DiClemente's Stages of Change model. (n.d.) Retrieved from http://stepupprogram.org/docs/handouts/STEPUP_Stages_of_Change.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA). (2015). Recovery and recovery support. Retrieved from https://www.samhsa.gov/recovery

SAMHSA. (2017). Substance abuse confidentiality regulations. Retrieved from https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs

SAMHSA. (2017). SAMHSA's GAINS Center for Behavioral Health and Justice Transformation. Retrieved from https://www.samhsa.gov/gains-center

SAMHSA. (n.d.). Data. Retrieved from https://www.samhsa.gov/data/

SAMHSA. (n.d.). TIP series. Treatment improvement protocols (TIPs). Retrieved from https://store.samhsa.gov/list/series?name=TIP-Series-Treatment-Improvement-Protocols-TIPS

Strengthening Families Program. (n.d.) Home page. Retrieved from strengtheningfamiliesprogram.org

U.S. Department of Veterans Affairs. (2017). PTSD screening instruments. Retrieved from https://www.ptsd.va.gov/PTSD/professional/assessment/screens/index.asp

Recommended Reading

Annis, H. M., & Graham, J. M. (1995). Profile types on the Inventory of Drinking Situations: Implications for relapse prevention counseling. *Psychology of Addictive Behaviors, 9*:176–182.

Buford, G., & Hudson, J. (Eds.). (2002) Family group conferencing: New directions in community-centered child and family practice. *Journal of Sociology & Social Welfare, 29*(3). Retrieved from http://scholarworks.wmich.edu/cgi/viewcontent.cgi?article=2834&context=jssw

Bureau of Justice Assistance (BJA). (2004). *Defining drug courts: The key components*. Washington, DC: U.S. Department of Justice. Retrieved from https://www.ncjrs.gov/pdffiles1/bja/205621.pdf

BJA. (2004). *Family dependency treatment courts: Addressing child abuse and neglect cases using the drug court model*. Washington, DC: U.S. Department of Justice, Office of Justice Programs. Retrieved from https://www.ncjrs.gov/pdffiles1/bja/206809.pdf

Children and Families Futures. (2013 rev 2015). *Guidance to states: Recommendations for developing family drug court guidelines*. Prepared for the Office of Juvenile Justice and Delinquency Prevention (OJJDP), Office of Justice Programs. Retrieved from https://www.cffutures.org/files/publications/FDC-Guidelines.pdf

Dennis, K., Young, N. K., & Gardner, S. L. (2008). *Funding family-centered treatment for women with substance use disorders*. Irvine, CA: Children and Family Futures. Retrieved from https://www.samhsa.gov/sites/default/files/final_funding_paper_508v.pdf

Marlowe, D. B., & Meyer, W. G. (Eds.). (2011). *The drug court judicial benchbook*. Alexandria, VA: National Drug Court Institute. Retrieved from https://www.ndci.org/wp-content/uploads/14146_NDCI_Benchbook_v6.pdf

National Institute on Drug Abuse. (2012). *Principles of drug addition treatment: A research-based guide* (3rd ed.). NIH Publication No. 12-4180. Retrieved from https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/podat_1.pdf

O'Gorman, P., & Diaz, P. (2004). *The lowdown on families who get high: Successful parenting for families affected by addition*. Washington, DC: Child and Family Press.

Prochaska, J., & DiClemente, C. C. (1984). *The transtheoretical approach: Crossing the traditional boundaries of therapy*. Melbourne, FL: Krieger Publishing.

Prochaska, J., Norcross, J., & DiClemente, C. (1995). *Changing for good*. New York, NY: Morrow. Retrieved from http://healingunleashed.com/wp-content/uploads/2014/03/CHANGE-BOOK.pdf

National Center on Substance Abuse and Child Welfare (NCSACW). (2017) *Understanding substance use disorder treatment in your community: A draft discussion guide for child welfare and court professionals to identify the best treatment fit for families*. Washington, DC: SAMHSA. Retrieved from https://ncsacw.samhsa.gov/files/Quality_Treatment_Guiding_Questions_March2017_508.pdf

Office of Juvenile Justice and Delinquency Prevention (OJJDP). (2000). *Safe from the start: Taking action on children exposed to violence*. Publication No. NCJ182789. Washington, DC: U.S. Department of Justice, Office of Justice Programs. Retrieved from https://www.ncjrs.gov/pdffiles1/ojjdp/182789.pdf

Steadman, H. J., Peters, R. H., Carpenter, C., Mueser, K. T., Jaeger, N. D., Gordon, R. B., … Hardin, C. (2013). *Six steps to improve your drug court outcomes for adults with co-occurring disorders*. Alexandria, VA: National Drug Court Institute. Retrieved from https://www.ndci.org/wp-content/uploads/C-O-FactSheet.pdf

U.S. Department of Health and Human Services. (1999). *Blending perspectives and building common ground. A report to Congress on substance abuse and child protection*. Washington, DC: U.S. Government Printing Office. Retrieved from https://www.ncsacw.samhsa.gov/files/blendingperspectives.pdf

White, W. L., & Popovits, R. M. (2001). *Critical incidents: Ethical issues in prevention and treatment of addiction*. Bloomington, IL: Lighthouse Institute.

Young, N. K., Gardner, S. L., & Dennis, K. (1998). *Responding to alcohol and other drug problems in child welfare: Weaving together practice and policy*. Washington, DC: CWLA Press. Retrieved from https://ncsacw.samhsa.gov/files/respondingtoaodproblems.pdf

Recommended Viewing

National Drug Court Resource Center. Tune in on Tuesdays [webinar series archives]. https://www.ndci.org/uncategorized/webinar-archives/

SAMHSA. Official YouTube video channel of the Substance Abuse and Mental Health Services Administration (SAMHSA). Retrieved from https://www.youtube.com/results?search_query=SAMHSA+videos

SAMHSA. Roadmap for recovery [video series]. Retrieved from https://www.youtube.com/watch?v=dkAY8m-uJI0&index=2&list=PLYoAXJz_Rd-AEnqOKWC0TV8aUeMkFeiBO

Confidentiality Regulations and Sharing Information

Children and Family Futures. (2107). Confidentiality and information sharing: I can't tell you that!...or can I? [presentation]. Retrieved from https://www.cffutures.org/files/presentations/ConfidentialityAndInformationSharing.pdf

Legal Action Center. (2017). Sample forms—confidentiality. Retrieved from https://lac.org/resources/substance-use-resources/confidentiality-resources/sample-forms-confidentiality/

SAMHSA. (2105). Behavioral Health IT Webinar Series - 42 CFR Part 2: Myths & Scenarios [1-hour webinar], Retrieved from https://www.youtube.com/watch?v=9mdFQPmkbVA

SAMHSA. (2017). Substance abuse confidentiality regulations. Retrieved from https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs

Other Resources

The Administration for Children and Families (ACF) supports 61 University Centers for Excellence in Developmental Disabilities, Education, Research, and Service (UCEDDs), which can be accessed through https://www.aucd.org/template/page.cfm?id=667

ACF's Office of Head Start has information about the program, including grants and services, resources for families and communities, and research. This information can be accessed at https://www.acf.hhs.gov/ohs

The Center on the Social and Emotional Foundations for Early Learning is a national center dedicated to strengthening the capacity of child care and Head Start programs to improve the social and emotional outcomes of young children. The website for the center is http://csefel.vanderbilt.edu

The Substance Abuse and Mental Health Services Administration (SAMHSA) supports a variety of services and technical assistance centers related to children and adolescents. They include the following:

- The National Technical Assistance Center for Children's Mental Health at Georgetown University at https://gucchdtacenter.georgetown.edu/ is an excellent resource for children with special mental health needs.
- The Substance Fetal Alcohol Spectrum Disorders (FASD) Center of Excellence offers technical assistance, information, and training on FASD: http://fascenter.samhsa.gov/.
- The Center for Substance Abuse Prevention has developed the Children's Program Kit: Supportive Education for Children of Addicted Parents. This multimedia education kit is geared toward substance use treatment staff, community groups, and schools. The kit can be obtained from http://adaiclearinghouse.org/downloads/childrens-program-kit-supportive-education-for-children-of-addicted-parents-7.pdf
- SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP) serves as a comprehensive resource for learning about and/or implementing model programs. The programs featured on the website have been tested in communities, schools, social service organizations, and workplaces across the country, and have provided evidence that they have prevented or reduced substance use and other related high-risk behaviors. The NREPP website can be accessed at https://www.nrepp.samhsa.gov/landing.aspx

- The purpose of the National Child Traumatic Stress Network (NCTSN) is to improve the quality, effectiveness, provision, and availability of therapeutic services delivered to all children and adolescents experiencing traumatic events. It can be accessed at http://www.nctsnet.org/nccts/nav.do?pid=abt_main.
- The Center for Substance Abuse Treatment (CSAT) operates a web-based facility locator for substance abuse services. The locator can be accessed at http://www.findtreatment.samhsa.gov/.
- CSAT has published *Screening and Assessing Adolescents for Substance Use Disorders* (https://store.samhsa.gov/product/TIP-31-Screening-and-Assessing-Adolescents-for-Substance-Use-Disorders/SMA12-4079) and *Treatment of Adolescents with Substance Use Disorders* (https://www.ncbi.nlm.nih.gov/books/NBK64350/).
- In partnership with ACF, SAMHSA supports the National Center on Substance Abuse and Child Welfare (NCSACW). The center provides technical assistance to states and communities to improve outcomes for families affected by substance use disorders in the child welfare and dependency court systems: http://ncsacw.samhsa.gov.

Appendix B
Sample Consent and Progress Report Forms

This appendix contains three samples of forms commonly used by treatment courts: a consent for disclosure of information form and two types of treatment progress reports. For more examples of forms, see National Drug Court Resource Center, sample forms (http://ndcrc.org/resources/).

CFS 440-7
Rev 3/2005

State of Illinois
Department of Children and Family **Services**

CONSENT FOR DISCLOSURE OF INFORMATION

SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT

I, _____, whose birth date is _____, and whose
(Name of individual) (Birth date)

address is _____ and

whose Social Security Number is _____, hereby authorize:
(Social Security Number)

The Department of Human Services and/or _____
(AOD service program or agency name)

AND

The Department of Children and Family Services and/or _____
(Agency name)

to provide between each other the following information (*Client and/or guardian must initial the applicable information to be disclosed*):

_____Identifying information, including legal name, address, date of birth and SSN

_____Information about substance abuse history

_____Information about treatment attendance, placement, and progress

_____Information about discharge/continuing care plan or discharge status

_____Information on urinalysis results

_____Copy of client's portion of the Individualized Client Service Plan and Social History

_____Information about attendance at assessment interview

_____Notification of upcoming court hearings, case reviews, etc. to allow preparation of status reports

_____Information about parent-child interactions observed during the treatment process

_____Information on return home of children

_____Re-disclosure of information on substance abuse history and treatment progress to the court and certain parties to juvenile court proceedings as authorized by the Juvenile Court Act and as ordered by the Court.

I understand that this exchange of information is necessary to complete my referral for needed services and for obtaining updates regarding my attendance at and progress in treatment. I understand that I may revoke this consent at any time, except to the extent that the disclosure agreed to has been acted on.

I may revoke this consent, in writing, at any time by sending written notification to my DCFS or POS caseworker and the substance abuse treatment provider at

_____ AND _____

(DCFS/POS Caseworker Name) (AOD Agency Contact Person Name)

_____ _____

(DCFS/POS Caseworker Address) (AOD Agency Address)

I understand that I have the right to inspect and copy the information to be disclosed.

If not previously revoked, this consent will terminate when any of the following conditions have been met: 1 year from the date of this signature or 30 days following discharge from treatment (whichever is later) or other date, event, or condition (as specified): _____. Redisclosure of the personal health information of the client referenced above may not occur without prior written consent, except as expressly provided for in this Consent.

Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether or not the consent is signed by the client or his/her personal representative. I further understand that the substance abuse treatment agency will not condition my treatment on whether I give consent for the requested disclosure. However, it has been explained to me that if I refuse to consent to this disclosure, the Department (or private child welfare agency, where applicable) or court entity cannot receive information regarding my progress that may affect the child welfare decisions made regarding my family's case.

☐ Check here if above-named individual refuses to sign the consent.

_____ _____

Signature of Individual 12 years and Older Date

I,_____, the parent or the legal guardian or custodian appointed pursuant to 705 ILCS 405/2-11 or 705 ILCS 405/2-27, am authorized to act on behalf of the individual minor, _____, I hereby consent to this limited disclosure under the terms stated above. The legal guardian or parent is the legal representative of the unemancipated minor, pursuant to HIPAA, 45 CFR 164.502(g), unless otherwise required by law.

_____ _____

Signature of Parent, Guardian, or Authorized Agent Date

_____ _____

Signature of Witness Date

NOTICE TO RECEIVING AGENCY OR PERSON: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general consent for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

FAMILY TREATMENT COURT

Department: ☒ 1 A ☐ 1 B

Recovery Specialist: Mary Kendall

Today's Drug Court Date: 1/10/17

Next Drug Court Date: 2/10/17

PARENT INFORMATION

Last Name: Doe	**First Name:** Jane	**Primary Drug(s) of Use:** ☒ Alcohol ☐ Marijuana ☒ Methamphetamine ☐ Cocaine ☐ Heroin ☐ Barbiturates/Sedatives ☐ Benzos/Tranquilizers ☐ Other:	**Case Numbers:** 1. 0j3021717
Date of Birth: 05/03/90	**Child Welfare Worker:** Sue Smith		2.
FDC Entry Date: 10/10/13	☐ Dependency Investigator		3.
Phase: 2	☒ Family Re-unification		4.
Phase Entry Date: 5/14/14	☐ Family Maintenance		5.
			6.

UA TESTING

Testing Site: Terra Firma

Schedule: ☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5 per week

Notes: Having trouble getting the results from the testing site this week. I have called for three days in a row and have not gotten a call back.

LEGEND: **GREEN=Negative** **RED (Drug) =Positive** **BLUE(X) =Excused** **BLACK (?)=PENDING**

NS= No Show, **OPI**=Opiates, **COC**=Cocaine, **BZO**=Benzodiazepine, **AMP**= Methamphetamine, **ALC**=Alcohol, **THC+** = Marijuana (New Usage), **THC -** =Marijuana (No New Usage)

UA TESTS: **10/16(THC), 10/28(COC,THC-), 11/5(THC-), 11/7, 11/11(X), 11/14(NS), 11/18(NS), 11/21(NS), 11/25(NS), 11/27(THC), 12/5(THC-), 12/17, 12/24, 12/31, 1/1, 1/4, 1/7, 1/9, 1/14, 1/16, 1/21, 1/23, 1/28, 1/30, 2/4, 2/6, 2/11, 2/13, 2/18, 2/20, 2/25, 2/27, 3/4, 3/6, 3/11, 3/13, 3/18, 3/20**

TREATMENT PROGRAM

Treatment Program: Project Pride **Entry Date:** 11/25/13

Modalities: ☐ Detox ☐ Outpatient ☐ Sober Living ☒ Residential ☒ Women Only ☐ Dual-Diagnosed

Outpatient Treatment Schedule: ☐ M ☐ T ☐ W ☐ TH ☐ F Hours Per Week:

TREATMENT PROGRAM REPORT

The parent is doing well in treatment for the past month. There have not been any behavioral problems. The parent has been attending all of her scheduled groups. We believe the parent to be abstinent and she is somewhat engaged in the groups. She has not fully opened up in groups yet.

RECOVERY SPECIALIST REPORT

Ms. Doe has demonstrated a great deal of commitment in staying at Project Pride and adjusting to the program. She seems to have a strong determination to succeed and get her life on a more positive and productive track by having a positive attitude and outlook on her life and future by working on her recovery and doing the work that is necessary for change.

TREATMENT PLAN

Self-help meetings:	☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5 ☒ per week ☐ per month ☒ Full attendance ☐ Partial attendance ☐ No attendance
Contacts with Recovery Specialist:	☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☒ per week ☐ per month ☒ All contact ☐ Some contact ☐ No contact

Therapy/Counseling:	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ per week ☐ per month ☐ Full attendance ☐ Partial attendance ☐ No attendance ☒ N/A
Other Requirements:	

DRUG COURT ATTENDANCE

LEGEND:	**GREEN=Attended RED(NS)=No Show BLUE(X)=Excused**
PAST COURT DATES:	**10/18, 11/1, 11/15, 12/13**

METHADONE REPORT

Clinic:		**Entry Date:**
☐ Detox ☐ Maintenance	**Estimated completion date:**	**Milligrams per day:**
Program Report:		

MENTAL HEALTH

Dual-Diagnosed: ☐ UNKNOWN ☐ YES ☐ NO ☐ Self-Reported ☐ Verified			**Assessment date:**
List All Diagnoses:	1.	2.	3.
Psych Medications:	1.	2.	3.
Notes:			

OTHER MEDICATIONS

List all medications, corresponding conditions, and if verified by physician:

CHILDREN

Names:	Dates of Birth:	Ages:	Open Dependency Case:	Living with Parent:	Services:
			☐ Yes ☐ No	☐ Yes ☐ No	
			☐ Yes ☐ No	☐ Yes ☐ No	
			☐ Yes ☐ No	☐ Yes ☐ No	
Notes:					

RESPONSES TO BEHAVIOR

Recommendations:
Action items from last court session:

Endnotes

1. Marlowe, D. B., & Carey, S. M. (2012). *Need to know: Research update on family drug courts*. Alexandria, VA: National Association of Drug Court Professionals; p. 10. Retrieved from http://www.nadcp.org/sites/default/files/nadcp/Reseach%20Update%20on%20Family%20Drug%20Courts%20-%20NADCP.pdf

2. National Association of Drug Court Professionals. (2016). Drug court history. Retrieved from http://www.nadcp.org/learn/what-are-drug-courts/drug-court-history

3. National Institute of Justice. (2016). Drug courts. Retrieved from http://www.nij.gov/topics/courts/drug-courts/pages/welcome.aspx

4. Marlowe & Carey, 2012.

5. National Institute on Drug Abuse. National survey on drug use and health, 2014. (2016). Retrieved from http://www.icpsr.umich.edu/icpsrweb/NAHDAP/studies/36361

6. Seay, K. (2015). How many families in child welfare services are affected by parental substance use disorders? A common question that remains unanswered. *Child Welfare, 94*(4e), 53.

7. Hong, J. S., Ryan, J. P., Hernandez, P. M., & Brown, S. (2014). Termination of parental rights for parents with substance use disorder: For whom and then what? *Social Work in Public Health, 29*(6), 503–517. doi: 10.1080/19371918.2014.884960. Retrieved from http://digitalcommons.wayne.edu/soc_work_pubs/31

8. Child Welfare Information Gateway. (2014). *Parental substance use and the child welfare system*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Retrieved from https://www.childwelfare.gov/pubPDFs/parentalsubabuse.pdf

9. 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

10. The Adoption and Safe Families Act of 1997 (ASFA), 42 U.S.C. §§ 670-679. Retrieved from https://www.gpo.gov/fdsys/pkg/PLAW-105publ89/pdf/PLAW-105publ89.pdf

11. ASFA, 1997.

12. Townsend, S., Hignight, A., & Rubovits, D. (2008). Factors affecting permanency outcomes for foster children before and after passage of the Adoption and Safe Families Act of 1997. *Illinois Child Welfare, 4*(1), 59–73.

13. Brook, J., Akin B. A., Lloyd, M. H., & Yan Y. (2015). Family drug court, targeted parent training and family reunification: Did this enhanced service strategy make a difference? *Juvenile and Family Court Journal, 66*(2), 35–52.

14. Brook et al., 2015.

15. Bureau of Justice Assistance (BJA). (2004). *Family dependency treatment courts: Addressing child abuse and neglect cases using the drug court model*. Washington, DC: U.S. Department of Justice, Office of Justice Programs. Retrieved from https://www.ncjrs.gov/pdffiles1/bja/206809.pdf

16. Substance Abuse and Mental Health Services Administration. (2014). *Grants to expand services to children affected by methamphetamine in families participating in family treatment drug court: Children affected by methamphetamine (CAM) brief*. Washington, DC: Author. Retrieved from https://ncsacw.samhsa.gov/files/CAM_Brief_2014-Final.pdf.

17. BJA, Family dependency treatment courts, 2004.

18. BJA, Family dependency treatment courts, 2004.

19. Brook et al., 2015.

20. Pach, N. M. (2008). An overview of operational family dependency treatment courts. *Drug Court Review, 6*(1), 67–108.

21. BJA, Family dependency treatment courts, 2004.

22. Children and Families Futures. (2013 rev 2015). *Guidance to states: Recommendations for developing family drug court guidelines*. Prepared for the Office of Juvenile Justice and Delinquency Prevention (OJJDP), Office of Justice Programs. Retrieved from https://www.cffutures.org/files/publications/FDC-Guidelines.pdf

23. Edwards, L. (2013). Ethical issues in the family drug treatment court. *Juvenile and Family Court Journal, 64*(1 Winter), 1–21.

24. Guidance to states, 2013 rev 2015.

25. Office of Justice Programs Drug Court Clearinghouse and Technical Assistance Project. (1998). *Juvenile and family drug courts: An overview*. Washington, DC: American University, School of Public Affairs, OJP Drug Court Clearinghouse and Technical Assistance Project. Retrieved from https://www.ncjrs.gov/html/bja/jfdcoview/dcpojuv.pdf

26. National Association of Drug Court Professionals (NADCP). (n.d.). History: Justice professionals pursue a vision. Retrieved from http://www.nadcp.org/learn/what-are-drug-courts/drug-court-history

27. NADCP, Justice professionals pursue a vision, n.d..

28. Marlow, D. B., Hardin, C. D., & Fox, C. L. (2016). *Painting the current picture: A national report on drug courts and other problem-solving courts in the United States*. Alexandria, VA: National Drug Court Institute. Retrieved from https://www.ndci.org/wp-content/uploads/2016/05/Painting-the-Current-Picture-2016.pdf

29. National Drug Court Institute. (n.d.). Home page. Retrieved from https://www.ndci.org

30. Marlow, Hardin, & Fox, 2016.

31. Marlow, Hardin, & Fox, 2016.

32. Marlowe & Carey, 2012.

33. Bureau of Justice Assistance (BJA). (2004). *Defining drug courts: The key components*. Washington, DC: U.S. Department of Justice. Retrieved from https://www.ncjrs.gov/pdffiles1/bja/205621.pdf

34. OJP, Juvenile and family drug courts, 1998.

35. BJA, Family dependency treatment courts, 2004

36. Guidance to states, 2013 rev 2015.

37. Huddleston, C. W., Freeman-Wilson, K., Marlowe, D. B. , & Roussell, A. (2005). *Painting the current picture: A national report card on drug courts and other problem solving court programs in the United States*. Alexandria, VA: National Drug Court Institute. Retrieved from http://www.ndci.org/sites/default/files/ndci/PCPI.2.2005.pdf

38. Guidance to states, 2013 rev 2015.

39. Boles, S. M., Young, N. K., Moore, T., & DiPirro-Beard, S. (2007). The Sacramento Dependency Drug Court: Development and outcomes. *Child Maltreatment, 12,* 161–171. doi: 10.1177/1077559507300643

40. Green, B. L., Rockhill, A., & Furrer, C. (2007). Does substance abuse treatment make a difference for child welfare case outcomes? A statewide longitudinal analysis. *Children and Youth Services Review, 29,* 460–473. doi: 10.1016/j.childyouth.2006.08.006

41. Worcel, S. D., Green, B. L., Furrer, C. J., Burrus, S. W. M., & Finigan, M. W. (2007). *Family treatment drug court evaluation: Executive summary*. Portland, OR: NPC Research. Retrieved from http://npcresearch.com/wp-content/uploads/FTDC_Evaluation_Executive_Summary.pdf

42. Worcel, S. D., Furrer, C. J., Green, B., Burrus, S. W. M., & Finigan, M. W. (2008). Effects of family treatment drug courts on substance abuse and child welfare outcomes. *Child Abuse Review, 17,* 427–443. doi: 10.002/car.1045

43. BJA, Defining drug courts: The key components, 2004.

44. BJA, Family dependency treatment courts, 2004.

45. Guidance to states, 2013 rev 2015.

46. Pach, N. M. (2008). An overview of operational family dependency treatment courts. *Drug Court Review, 6*(1), 67–108.

47. Gifford, E. J., Eldred, L. M., Vernerey, A., & Sloan, F. A. (2014). How does family drug treatment court participation affect child welfare outcomes? *Child Abuse & Neglect, 38*, 1659–1670.

48. Young, N. K., Nakashian, M., Yeh, S., & Amatetti, S. (2006). *Screening and assessment for family engagement, retention, and recovery (SAFERR)*. (DHHS Pub. No. 0000.) Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from https://www.ncsacw.samhsa.gov/files/SAFERR.pdf

49. Young et al., 2006.

50. Tauber, J., & Huddleston, C. W. (1999). *Development and implementation of drug court systems*. Alexandria, VA: National Drug Court Institute. Retrieved from https://www.ndci.org/sites/default/files/ndci/Mono2.Systems.pdf

51. Young et al., 2006.

52. Guidance to states, 2013 rev 2015.

53. Guidance to states, 2013 rev 2015.

54. Guidance to states, 2013 rev 2015.

55. Children and Family Futures. (2017). Family drug court peer learning court program. Retrieved from https://www.cffutures.org/plc/

56. Substance Abuse and Mental Health Services Administration (SAMHSA). (2012). SAMHSA's Working definition of recovery. Retrieved from https://store.samhsa.gov/shin/content/PEP12-RECDEF/PEP12-RECDEF.pdf

57. SAMHSA. (2015). Recovery and recovery support. Retrieved from https://www.samhsa.gov/recovery

58. Guidance to states, 2013 rev 2015.

59. Werner, D., Young, N. K., Dennis, K, & Amatetti, S. (2007). *Family-centered treatment for women with substance use disorders: History, key elements and challenges*. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/sites/default/files/family_treatment_paper508v.pdf

60. Gatowski, S., Miller, N., Rubin, S., Escher, P., & Maze, C. (2106). *Enhanced resource guidelines: Improving court practice in child abuse and neglect cases*. Reno, NV: National Council of Juvenile and Family Court Judges. Retrieved from http://www.ncjfcj.org/sites/default/files/%20NCJFCJ%20Enhanced%20Resource%20Guidelines%2005-2016.pdf

61. Silberman School of Social Work at Hunter College, National Resource Center for Permanency and Family Connections. (2012). Family/child visiting. Retrieved from http://www.hunter.cuny.edu/socwork/nrcf-cpp/info_services/family-child-visiting.html

62. Dougherty, S. (2004). *Promising practices in reunification*. New York, NY: National Resource Center for Foster Care and Permanency Planning, Hunter College School of Social Work. Retrieved from http://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/promising-practices-in-reunification.pdf

63. National Institute on Drug Abuse (NIDA). (2014). *Drugs, brains, and behavior: The science of addiction*. Retrieved from https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery

64. BJA, Family dependency treatment courts, 2004.

65. American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders*. 5th ed. Arlington, VA: American Psychiatric Press.

66. NIDA. (2012). Cognitive-behavioral therapy (alcohol, marijuana, cocaine, methamphetamine, nicotine). Retrieved from https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral

67. Guidance to states, 2013 rev 2015.

68. 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.

69. Guidance to states, 2013 rev 2015.

70. 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.

71. Guidance to states, 2013 rev 2015.

72. NIDA. (2012). Principles of effective treatment. Retrieved from https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/principles-effective-treatment

73. NIDA (2012). *Principles of drug addiction treatment: A research-based guide* (3rd ed.). Bethesda, MD: National Institutes of Health, U.S. Department of Health and Human Services. Retrieved from https://www.drugabuse.gov/sites/default/files/podat_1.pdf

74. American Society of Addiction Medicine (ASAM). (2017). The ASAM criteria. Retrieved from http://www.asam.org/quality-practice/guidelines-and-consensus-documents/the-asam-criteria/about

75. The ASAM criteria, 2017.

76. NIDA, Principles of drug addiction treatment, 2012.

77. NIDA, Principles of drug addiction treatment, 2012.

78. Kampman, K., & Jarvis, M. (2015). American Society of Addiction Medicine (ASAM) national practice guideline for the use of medications in the treatment of addiction involving opioid use. *Journal of Addiction Medicine, 9*(5), 358–367.

79. Prochaska, J., Norcross, J., & DiClemente, C. (1994). *Changing for good*. New York, NY: Morrow.

80. Douglas-Siegel, J. A., & Ryan, J. P. (2013). The effect of recovery coaches for substance-involved mothers in child welfare: Impact on juvenile delinquency. *Journal of Substance Abuse Treatment, 45*(1), 381–387.

81. Douglas-Siegel & Ryan, 2013.

82. 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,* 95–107.

83. 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 and Neglect, 11,* 1072–1079.

84. Ryan et al., 2006, p. 95.

85. The National Center on Addiction and Substance Abuse at Columbia University. (1999). *No safe haven: Children of substance-abusing parents.* New York, NY: Columbia University. Retrieved from https://www.centeronaddiction.org/addiction-research/reports/no-safe-haven-children-substance-abusing-parents#.WQPL-2ekKio

86. Burry, C. L., & Wright, L. (2006). Facilitating visitation for infants with prenatal substance exposure. *Child Welfare, 85*(6), 899–918.

87. Green, C.A. (2006). Gender and use of substance abuse treatment services. Retrieved from https://pubs.niaaa.nih.gov/publications/arh291/55-62.htm

88. No Safe Haven, 1999, p. 35.

89. Saleebey, D. (2012). *The strengths perspective in social work practice* (6th ed.). Upper Saddle River, NJ: Pearson Education.

90. Miller, W. R., & Rollnick, S. (2012). *Motivational interviewing: Helping people change*. New York, NY: Guilford Press.

91. Substance Abuse and Mental Health Services Administration (SAMHSA). (1999). *Enhancing motivation for change in substance abuse treatment*. Treatment Improvement Protocol (TIP) Series, No. 35. HHS Publication No. (SMA) 13-4212. Rockville, MD: Author. Retrieved from https://store.samhsa.gov/shin/content/SMA13-4212/SMA13-4212.pdf

92. SAMHSA. (2004). *Substance abuse treatment and family therapy*. Treatment Improvement Protocol (TIP) Series, No. 39. HHS Publication No. (SMA) 15-4219. Rockville, MD: Author; pp. 21–29. Retrieved from https://store.samhsa.gov/shin/content/SMA15-4219/SMA15-4219.pdf

93. SAMHSA. (2014). *Improving cultural competence*. Treatment Improvement Protocol (TIP) Series, No. 59. HHS Publication No. (SMA) 14-4849. Rockville, MD: Author. Retrieved from https://store.samhsa.gov/shin/content/SMA14-4849/SMA14-4849.pdf

94. Children and Family Futures. (2017). Family drug court peer learning court program. Retrieved from https://www.cffutures.org/plc/

95. The Adoption and Safe Families Act of 1997, 42 U.S.C. §§ 670-679.

96. 42 CFR 2.3(a)

97. 42 CFR Part 2.12(a) and (b)

98. 42 CFR 2.32

99. 42 CFR 2.13(b)

100. 42 CFR 2.32; 45 CFR 164.508(c)

101. 42 CFR 2.32

102. Guidance to states, 2013 rev 2015.

103. Guidance to states, 2013 rev 2015.

104. Young et al., 2006.

105. Young et al., 2006.

106. Guidance to states, 2013 rev 2015.

107. Young et al., 2006.

108. Guidance to states, 2013 rev 2015.

109. Young et al., 2006.

110. National Drug Court Resource Center. (2012). Goals and objectives. Retrieved from http://old.ndcrc.org/category/sample-forms-category/goals-and-objectives

111. Green, B. L., Furrer, C. J., Worcel, S. D., Burrus, S. W. M., & Finigan, M. W. (2009). Building the evidence base for family drug treatment courts: Results from recent outcome studies. *Drug Court Review, 6*(2), 53–82.

112. Chuang, E., Moore, K., Barrett, B., & Young, M. S. (2012). Effect of an integrated family dependency treatment court on child welfare reunification, time to permanency and re-entry rates. *Children and Youth Services Review, 34*(9), 1896–1902. doi: 10.1016/j.childyouth.2012.06.001

113. Chuang et al., 2012.

114. Gifford, E. J., Eldred, L. M., Vernerey, A., & Sloan, F. A. (2014). How does family drug treatment court participation affect child welfare outcomes? *Child Abuse & Neglect, 38*, 1659–1670.

115. Dakof, G. A., Cohen, J. B., Henderson, C. E., Durate, E., Boustani, M., Blackburn, A., … Hawes, S. (2010). A randomized pilot of the Engaging Moms Program for family drug court. *Journal of Substance Abuse Treatment, 38,* 263–274.

116. 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*. Portland, OR: NPC Research.

117. Guidance to states, 2013 rev 2015.

118. Boles, S., & Young, N. K. (2010). *Sacramento County Dependency Drug Court year seven outcome and process evaluation findings*. Irvine, CA: Children and Family Futures.

119. Young et al., 2006.

120. BJA, Defining drug courts: The key components, 2004.

121. BJA, Family dependency treatment courts, 2004.

122. Guidance to states, 2013 rev. 2015.

123. 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

124. National Association of Drug Court Professionals (NADCP). (2015). *Adult drug court best practice standards, volume II*. Alexandria, VA: Author. Retrieved from http://www.nadcp.org/Standards

125. NADCP. (2013). *Adult drug court best practice standards, volume I.* Alexandria, VA: Author. Retrieved from http://www.nadcp.org/Standards

126. Guidance to states, 2013 rev. 2015.

127. American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders*. 5th ed. Arlington, VA: American Psychiatric Press.

128. Substance Abuse and Mental Health Services Administration (SAMHSA). (2015). *Screening and assessment of co-occurring disorders in the justice system*. HHS Publication No. (SMA) 15-4930. Rockville, MD: Author. Retrieved from https://store.samhsa.gov/shin/content/SMA15-4930/SMA15-4930.pdf

129. SAMHSA. (2015). About the GAINS Center. Retrieved from https://www.samhsa.gov/gains-center/about

130. Child Welfare Information Gateway. (2014). *Parental substance use and the child welfare system*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Retrieved from https://www.childwelfare.gov/pubPDFs/parentalsubabuse.pdf

131. Najavits, L. M., Weiss, R. D., & Shaw, S. R. (1997). The link between substance abuse and posttraumatic stress disorder in women. *The American Journal on Addictions, 6*(4), 273–283. doi: 10.1111/j.1521-0391.1997.tb00408.x

132. SAMHSA. Behavioral health treatments and services. (2017). Retrieved from https://www.samhsa.gov/treatment#co-occurring

133. U.S. Department of Health and Human Services, Office on Women's Health. (2008). *Action steps for improving women's mental health*. Rockville, MD: Author; p. 2. Retrieved from https://store.samhsa.gov/shin/content/OWH09-PROFESSIONAL/OWH09-PROFESSIONAL.pdf

134. SAMHSA. (2011). *Addressing the needs of women and girls: Developing core competencies for mental health and substance abuse service professionals*. HHS Pub. No. (SMA) 11-4657. Rockville, MD: Author. Retrieved from https://store.samhsa.gov/shin/content/SMA11-4657/SMA11-4657.pdf

135. Action steps for improving women's mental health, 2008, p. 2.

136. Grella, C. E. (2008). From generic to gender-responsive treatment: Changes in social policies, treatment services, and outcomes of women in substance abuse treatment. *Journal of Psychoactive Drugs, 40*(Suppl. 5), 327–343.

137. Covington, S. S. (2008). Women and addiction: A trauma-informed approach. *Journal of Psychoactive Drugs, 40*(Suppl. 5), 377–385.

138. Brown, V. B., Melchior, L. A., & Huba, G. J. (1999). Level of burden among women diagnosed with severe mental illness and substance abuse. *Journal of Psychoactive Drugs, 31*(1), 31–40.

139. Grella, C. E., Scott, C. K., Foss, M., & Dennis, M. L. (2008). Gender similarities and differences in the treatment, relapse, and recovery cycle. *Evaluation Review, 32*(1), 113–137.

140. Greenfield, S. F., Back, S. E., Lawson, K., & Brady, K. T. (2010). Substance abuse in women. *Psychiatric Clinics of North America, 33*(2), 339–355. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3124962/

141. Rees, S., Silove, D., Chey, T., Ivancic, L., Steel, Z., Creamer, M., … Forbes, D. (2011). Lifetime prevalence of gender-based violence in women and the relationship with mental disorders and psychosocial function. *JAMA, 306*, 513–521.

142. U.S. Department of Health and Human Services, Outreach Activities and Resources. 2013 Trans-HHS intimate partner violence screening and counseling: Research symposium. (2015). Retrieved from https://sis.nlm.nih.gov/outreach/2013IPVsymposium.html

143. SAMHSA. (2013). *Substance abuse treatment: Addressing the specific needs of women*. Treatment Improvement Protocol (TIP) Series, No. 51. HHS Publication No. (SMA) 15-4426. Rockville, MD: Author. Retrieved from https://store.samhsa.gov/shin/content/SMA13-4426/SMA13-4426.pdf

144. SAMHSA. (1997). *Substance abuse treatment and domestic violence*. Treatment Improvement Protocol (TIP) Series, No. 25. HHS Publication No. (SMA) 97-3163. Rockville, MD: Author. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK64437/#!po=25.0000

145. U.S. Department of Health and Human Services. (1999). *Blending perspectives and building common ground. A report to Congress on substance abuse and child protection*. Washington, DC: Government Printing Office, pp. 59–60. Retrieved from https://www.ncsacw.samhsa.gov/files/blendingperspectives.pdf

146. National Fatherhood Initiative. (2015). *Father facts 7.* 7th ed. Germantown, MD: Author.

147. SAMHSA. (2013). *Addressing the specific behavioral health needs of men.* Treatment Improvement Protocol (TIP) Series, No. 56. HHS Publication No. (SMA) 13-4736. Rockville, MD: Author.

148. Covington, S. S., Griffin, D., & Dauer, R. (2011). *Helping men recover.* San Francisco: Jossey-Bass.

149. Griffin, D. (2014). *A man's way through relationships: Learning to love and be loved.* Las Vegas: Central Recovery Press.

150. 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.

151. Fallot, R. D., & Harris, M. (2006). *Trauma-informed services: A self-assessment and planning protocol.* Washington, DC: Community Connections. Retrieved from http://www.theannainstitute.org/TISA+PPROTOCOL.pdf

152. Pima County Family Drug Court. (2016). *Pima County Family Drug Court fathers: A brief comparison of outcomes between FY2009 and FY2015.*

153. SAMHSA, Addressing the specific behavioral health needs of men, 2013.

154. U.S. Department of Veterans Affairs. (2015). PTSD: National Center for PTSD. Retrieved from https://www.ptsd.va.gov/public/PTSD-overview/women/women-trauma-and-ptsd.asp

155. National Institute on Drug Abuse. (n.d.). Women's treatment for trauma and substance use disorders. Retrieved from https://www.drugabuse.gov/about-nida/organization/cctn/ctn/research-studies/womens-treatment-trauma-substance-use-disorders

156. NADCP, Adult drug court best practice standards, volume II, 2015; p. 25.

157. Steadman, H. J., Peters, R. H., Carpenter, C., Mueser, K. T., Jaeger, N. D., Gordon, R. B., … Hardin, C. (2013). *Six steps to improve your drug court outcomes for adults with co-occurring disorders*. Alexandria, VA: National Drug Court Institute. Retrieved from https://www.ndci.org/wp-content/uploads/C-O-FactSheet.pdf

158. SAMHSA. (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Author. Retrieved from https://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf

159. Blending perspectives and building common ground, 1999.

160. Blending perspectives and building common ground, 1999, pp. 59–60.

161. The NSDUH report. (2010). HIV/AIDS and substance use. Retrieved from https://archive.samhsa.gov/data/2k10/HIV-AIDS/HIV-AIDS.htm

162. Jaudes, P. K., & Mackey-Bilaver L. (2008). Do chronic conditions increase young children's risk of being maltreated? *Child Abuse & Neglect, 32*, 671–681. doi: 10.1016/j.chiabu.2007.08.007

163. SAMHSA. (2009). *Children living with substance-abusing or substance-dependent parents: 2002 to 2007. The NSDUH report*. Rockville, MD: Author.

164. Breshears, E. M., Yeh, S., & Young, N. K. (2009). *Understanding substance abuse and facilitating recovery: A guide for child welfare workers*. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from https://ncsacw.samhsa.gov/files/Understanding-Substance-Abuse.pdf

165. Burnett, G., Jones, R. A., Bliwise, N. G., & Ross, L. T. (2006). Family unpredictability, parental alcoholism, and the development of parentification. *American Journal of Family Therapy, 34*(3), 181–189.

166. Young et al., 2006.

167. Lieberman, A. F., Ghosh Ippen, C., & Van Horn, P. (2006). Child-parent psychotherapy: 6-month follow-up of a randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry, 45*(8), 913–918.

168. National Scientific Council on the Developing Child. (2007). Science briefs: How early child care affects later development. Retrieved from http://www.developingchild.net

169. Blending perspectives and building common ground, 1999, p. 68.

170. Office of Juvenile Justice and Delinquency Prevention (OJJDP). (2000). *Safe from the start: Taking action on children exposed to violence*. (Publication No. NCJ182789.) Washington, DC: U.S. Department of Justice, Office of Justice Programs. Retrieved from https://www.ncjrs.gov/pdffiles1/ojjdp/182789.pdf

171. Lam, W. K., Cance, J. D., Eke, A. N., Fishbein, D. H., Hawkins, S. R., & Williams, J. C. (2007). Children of African-American mothers who use crack cocaine: Parenting influences on youth substance use. *Journal of Pediatric Psychology, 32*, 877–887.

172. Staiger, P. K., Melville, F., Hides, L., Kambouropoulos, N., & Lubman, D. I. (2009). Can emotion-focused coping help explain the link between posttraumatic stress disorder severity and triggers for substance use in young adults? *Journal of Substance Abuse Treatment, 36,* 220–226. doi:10.1016/j.jsat.2008.05.008.

173. Sprang, G., Staton-Tindall, M., & Clark, J. (2008). Trauma exposure and the drug endangered child. *Journal of Traumatic Stress, 21*(3), 333–339.

174. Jaudes & Mackey-Bilaver, 2008.

175. Cicchetti, D. (Ed.). (2016). *Developmental pathopsychology, risk, resilience, and intervention* (Vol. 4). Hoboken, NJ: John Wiley & Sons.

176. Buford, G., & Hudson, J. (Eds.). (2002) Family group conferencing: New directions in community-centered child and family practice. *Journal of Sociology & Social Welfare, 29*(3). Retrieved from http://scholarworks.wmich.edu/cgi/viewcontent.cgi?article=2834&context=jssw

177. Young, N. K., Gardner, S. L., & Dennis, K. (1998). *Responding to alcohol and other drug problems in child welfare: Weaving together practice and policy.* Washington, DC: CWLA Press. Retrieved from https://ncsacw.samhsa.gov/files/respondingtoaodproblems.pdf

178. Marlowe, D. B., & Kirby, K. C. (1999). Effective use of incentives and sanctions in drug courts: Lessons from behavioral research. *National Drug Court Institute Review, 2,* 1–31.

179. Carey, S. M., Finigan, M. W., & Pukstas, K. (2008). *Exploring the key components of drug courts: A comparative study of 18 adult drug courts on practices, outcomes and costs*. Portland, OR: NPC Research.

180. NADCP, Adult drug court best practice standards, volume II, 2015; p. 26.

181. SAMHSA. (2010). *Drug testing in child welfare: Practice and policy considerations*. HHS Publication No. (SMA) 10-4556. Rockville, MD: Author. Retrieved from https://www.ncsacw.samhsa.gov/files/DrugTestinginChildWelfare.pdf

182. National Drug Court Institute. (n.d.). List of incentives and sanctions. Retrieved from https://www.ndci.org/site-resources/list-of-incentives-and-sanctions/

183. Riggs, K. (2012). *Strategies for sustainability of grant-funded programs*. Utah State University Cooperative Extension. Retrieved from https://digitalcommons.usu.edu/cgi/viewcontent.cgi?article=2001&context=extension_curall

184. National Institute of Justice. (2014). Drug court performance measures, program evaluation and cost efficiency: Logic model for adult drug courts. Retrieved from https://nij.gov/topics/courts/drug-courts/pages/measures-evaluation.aspx

185. Strategic Plan Builder. (n.d.). Strategic planning templates and tools. http://www.strategicplantool.com

186. Riggs, 2012.

187. National Drug Court Resource Center. (n.d.). Resources. Retrieved from https://ndcrc.org/resources/?fwp_search=grant+solicitation

188. National Association of Drug Court Professionals (NADCP). (n.d.). Advocacy tools and resources. Retrieved from http://www.nadcp.org/node/793

189. NADCP. (n.d.). Current state drug court coordinators. Retrieved from http://www.nadcp.org/learn/find-drug-court/state-leaders/state-drug-court-coordinators/current-state-drug-court-coordinat

190. Grants.gov. (n.d.). Apply for a grant online now. Retrieved from https://www.grants.gov/web/grants/home.html

Worksheets

Worksheet 1

Making the Case for Change: The Family Treatment Court Model

Use the following three lists to discuss how to enhance your family treatment court's practices in addressing child maltreatment and parental substance use.

Key Components of Drug Court[1]

1: Drug courts integrate alcohol and other drug treatment services with justice system case processing.

2: Using a nonadversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.

3: Eligible participants are identified early and promptly placed in the drug court program.

4: Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.

5: Abstinence is monitored by frequent alcohol and other drug testing.

6: A coordinated strategy governs drug court responses to participants' compliance.

7: Ongoing judicial interaction with each drug court participant is essential.

8: Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.

9: Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.

10: Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court effectiveness.

Family Treatment Court Common Characteristics[2]

1: Focus on the permanency, safety, and welfare of abused and neglected children as well as the needs of the parents.

2: Provide early intervention, assessment, and facilitated access to services for parents and children in a holistic approach to strengthen family function.

3: Develop comprehensive service plans that address the needs of the entire family system.

4: Provide enhanced case management services to monitor progress and facilitate access to services.

5: Schedule regular staff meetings to facilitate the exchange of information and coordinate services for the family.

6: Increase judicial supervision of children and families.

7: Promote individual and systems accountability.

8: Ensure legal rights, advocacy, and confidentiality for parents and children.

9: Operate within the federal mandates of the Adoption and Safe Families Act and Indian Child Welfare Act.

10: Secure judicial leadership for both the planning and implementation of the court.

11: Commit to measuring outcomes of the family treatment court program and plan for program sustainability.

12: Work as a collaborative, nonadversarial team supported by cross-training.

Guidance to States Recommendations[3]

1: Create a shared mission and vision.

2: Develop interagency partnerships.

3: Create effective communication protocols for sharing information.

4: Ensure cross system knowledge.

5: Develop a process 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 shared outcomes and accountability.

[1] Bureau of Justice Assistance (BJA). (2004). *Defining drug courts: The key components*. Washington, DC: U.S. Department of Justice. Retrieved from https://www.ncjrs.gov/pdffiles1/bja/205621.pdf

[2] BJA. (2004). *Family dependency treatment court: Addressing child abuse and neglect cases using the drug court model*. Washington, DC: U.S. Department of Justice, Bureau of Justice Programs. Retrieved from https://www.ncjrs.gov/pdffiles1/bja/206809.pdf

[3] Children and Families Futures. (2013 rev 2015). *Guidance to states: Recommendations for developing family drug court guidelines*. Prepared for the Office of Juvenile Justice and Delinquency Prevention (OJJDP), Office of Justice Programs. Retrieved from https://www.cffutures.org/files/publications/FDC-Guidelines.pdf

Worksheet 2

Gathering Relevant Data to Support the Family Treatment Court Concept

Gathering critical data specific to your jurisdiction's current dependency court, child protection, and treatment services will help the planning team identify the impact of dependency cases on your community and the services available. Answering the following questions will provide your team with the basis to advocate for the development of a family treatment court in your community and assist in developing a planning process.

1. How many abuse and neglect cases are filed in your jurisdiction annually?

_____

2. How many of your jurisdiction's annual abuse filings include allegations of substance use? What percentage is this of the total child welfare cases filed?

_____

_____

3. What percentage of child welfare cases involve parental/caregiver substance use in which the use is not identified until after the initial hearing?

_____

4. Does child welfare use a tool or set of protocols to screen for parental substance use?

_____

_____

5. What is the current caseload of the judges, child welfare caseworkers, agency attorneys, parent attorneys, and child attorneys in your jurisdiction?

_____

_____

6. How many children, under court jurisdiction, are in out-of-home placement in your community?

_____

7. What is the economic cost to the community, judicial system, and child welfare system of investigating and processing these cases and of the consequent out-of-home placement of these children?

_____

_____

Worksheet 2 *continued*

8. What are the noneconomic cost factors to the community of investigating, prosecuting, and processing these cases and of the consequent out-of-home placement of these children?

9. What percentage of drug- or alcohol-involved parents reenter the dependency court system (due to child abuse and neglect recidivism)?

10. What are the predominant drugs of choice in the community? How did you identify these as the predominant drugs?

11. What is the demographic profile of the parents and children involved in abuse and neglect cases? By ethnicity? By age? By gender?

12. What are the legal time frames governing the processes and cases?

Worksheet 3
Community Resources Mapping

The effectiveness of any family treatment court ultimately depends on the quality of community resources to which it has access. Using the community resources mapping exercise below, begin to identify unique resources and programs available in your jurisdiction and the contact information for each.

Community Resources Mapping Exercise

Within each box provided, list the agency or agencies responsible for providing the services indicated. You will need to find the most useful contact person within each agency.

FAMILY TREATMENT COURT

Developmental Services for Children	Community Foundations
Family Therapy	Foster Families
Faith Community	Child Protective Services
Schools, Colleges, Universities	Service Organizations
Health Services	Law Enforcement/Probation
Residents	Parenting Programs
Mental Health Services	Treatment
Government Agencies / Officials	Other Community-Based Organizations

Worksheet 3 *continued*

After completing the community resources mapping exercise, answer the following questions:

1. What gaps have you identified?

2. Who do you need to add to the family treatment court team?

3. What additional information about resources and contacts do you need to gather?

Worksheet 4

Planning, Steering, and Operational Teams

Planning Team

The planning team is made up of members from various organizations who are committed to the planning and development of your family treatment court. Use the form below to identify the members of your planning team, their agency affiliations, and their roles and responsibilities. Also determine if you have all necessary planning team members or need to add others.

Planning Team Composition

Team Member	Agency	Role/Responsibilities
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Worksheet 4 *continued*

Steering Committee

The steering committee functions as a board of directors with respect to the planning team, which acts like officers of a corporation. Its purpose should include oversight of the planning process by expeditiously resolving policy issues regarding the planned treatment court. A steering committee should provide buy-in for the treatment court concept by the upper echelon of policy makers and stakeholders (e.g., elected prosecutor, presiding judge, chief public defender). In this way, the planning team, which may comprise nonexecutive personnel, will be confident that the head of each participating agency has made treatment court a priority and has delegated to the agency the authority to make decisions necessary to implement the planned treatment court. The committee should have the clear purpose of supporting the treatment court planning effort. It should meet on a regularly scheduled basis and have a procedure for communicating with or exercising supervision over the planning team.

The planning team should discuss the following questions:

1. Who will serve on the steering committee?

2. Do proposed steering committee members reflect a representative cross-section of your community? Do any potential members require additional persuasion?

3. What is the level of commitment among prospective steering committee members?

4. What possible resources could each prospective steering committee member bring to the family treatment court planning effort and, ultimately, the operation of your family treatment court?

Worksheet 4 *continued*

5. Have the goals and tasks of the steering committee been memorialized?

6. How often will the steering committee meet on its own to provide oversight and direction?

7. How often will the steering committee meet with the planning team or its representatives?

8. What will be the relationship between the steering committee and the planning team?

9. How will steering committee members be informed of the results of the implementation of the family treatment court?

Worksheet 4 *continued*

Operational Team

The operational team carries out the daily tasks involved in operating the family treatment court. This group can have members in common with the steering committee and the planning team, but it should, at a minimum, consist of representatives of entities that will be involved in the day-to-day operation of the treatment court (e.g., judge, child welfare representative, parent attorney, prosecutor/agency attorney, child representative, planning coordinator, treatment provider, evaluator, child development representative, public health representative). Each member will attend staffing and court sessions, and provide information to the court and other agency representatives to ensure that the program is operating within the policies and practices established, respond to issues of child well-being and safety, monitor participant compliance, ensure systems' accountability, and ensure that appropriate decisions are made and carried out. Operational team members should be committed to the concept underlying family treatment court and be competent in their respective disciplines within the family treatment court environment.

The planning team should discuss the following questions:

1. Who will serve on your operational team?

2. Have you arranged for the operational team to meet with the planning team for cross-training purposes?

3. What recommendations could operational team members bring to the family treatment court planning effort?

Worksheet 4 *continued*

4. Which members of the operational team are best suited to compile the data necessary to begin identifying a target population for your family treatment court?

5. Among the operational team members, what is the level of commitment to change existing case processing? If someone is not committed, is there information that would convince the person—or is there an alternative contact in the community?

6. Who will act as the contact person for the operational team to ensure that decisions made related to programming, as well as minutes, are communicated before each meeting?

7. How often will the operational team meet with the planning team and/or steering committee or its representatives?

8. What sites has the operational team been able to visit during the planning stage? Would it be beneficial for the operational team to visit a family treatment court?

Worksheet 5
Visiting a Family Treatment Court

Nothing is more instructive than seeing a family treatment court in operation. The jurisdiction of the family treatment court you observe may or may not resemble your jurisdiction in population, demographics, or other characteristics. However, all family treatment courts are based on the same general concept. Information on visiting a family treatment court peer learning court can be found at: https://www.cffutures.org/plc/.

This worksheet will provide your planning team with questions to consider during the staffing and court sessions and to discuss with the team after the visit.

1. How would you describe the family treatment court environment?

2. Does this description coincide with the courtroom environment in your jurisdiction?

3. What was unique about the physical layout of the courtroom?

4. What was unique about the role of the judge, child welfare professional, and other team members?

5. What was unique about the relationship between the judge and the participant? Between the judge and the child?

Worksheet 5 *continued*

6. Did you observe the imposition of consequences? Did they appear to be graduated?

7. Will you consider imposing similar consequences?

8. Did you observe that the ASFA status of the case was addressed in the court review?

9. How did the team monitor the ASFA status in the family treatment court?

10. Did you observe that the needs of the child were addressed in the court review?

11. Did you observe changes in treatment level?

Worksheet 5 *continued*

12. What elements of the staffing would you like to adopt?

13. What did you learn from the team membership or structure of the host court team?

14. What changes or modifications to the observed team membership or structure would you make?

15. How were planning and cooperation evident in host court operations?

16. What techniques can you use from the host court session?

17. What techniques can you use from the staffing session?

Worksheet 6
Cultural Competence

The cultural composition of your community, the parent and child population to be served, and your planning team will affect the decision-making process during the planning stage. As a team, your individual cultural composition provides you with unique values, ideals, and tools. You will need to work together, respecting each other's belief systems, to develop a family treatment court that will be effective across cultures. Answer the following questions and use your responses as a method to assess the cultural needs of your family treatment court program.

1. Will the data collected be compared with comparable data from the population at large?

2. Will the collected data be used for program evaluation?

3. Will the family treatment court require any training to enhance the cultural competence of its team members?

4. Will the family treatment court treatment providers receive training to enhance the cultural competence of their professional and support staff?

5. What percentage of the planning team reflects the composition of the minority population served?

6. What percentage of the treatment court treatment providers are bilingual or multilingual?

7. What percentage of the treatment court team are trained in cultural awareness?

Worksheet 6 *continued*

8. What percentage of minorities are represented on the steering committee and the operational team?

_____

9. What percentage of minorities are represented on any advisory board?

_____

10. What percentage of minorities are represented at the judicial and/or administrative level?

_____

11. Are there linkages with minority organizations, churches, community-based organizations, and other institutions in the community that serve the same target population?

_____

_____

12. Will contract awards be given to ethnic/racial service providers for issues specifically related to the minority special-needs population? If the answer is no, why not?

_____

_____

13. Will the family treatment court mission statement that you develop provide for culturally competent services and/or training?

_____

_____

14. Will the family treatment court adjust holidays to accommodate cultural and religious diversity?

_____

_____

15. Do you plan to have the target population evaluate the family treatment court performance?

_____

_____

16. Will the family treatment court be located in the community it serves, or will it have a satellite facility where the target population reports?

_____

_____

Worksheet 6 *continued*

17. Will service hours reflect client accessibility?

18. Will cultural sensitivity be considered in treatment matching?

19. Will the treatment environment reflect the culture of the target population?

20. Will the family treatment court distribute materials in languages that its target population understands? Will court-approved interpreters be available to the family treatment court team and treatment providers?

21. Will the family treatment court researcher or evaluator include in the research design (in addition to race ethnicity) questions drafted to elicit cultural practices and/or idiosyncrasies?

22. Will the family treatment court researcher analyze treatment outcomes based on race, ethnicity, and gender?

23. Does the family treatment court seek to improve relations between and among culturally based organizations throughout the larger community?

Worksheet 7

Ensuring System Accountability: Legal Mandates, Ethics, and Confidentiality

During your family treatment court site visit (see Worksheet 5), you may have observed that the court's operational team discussed many issues and came to decisions involving the legal, ethical, and confidentiality requirements of their disciplines. As your team moves through the planning process, the following questions and discussion items will assist you in addressing any challenges and concerns or inquiries your team members may have.

Roundtable and Follow-Up Discussion

First, conduct a roundtable discussion, where each team member identifies the legal mandates, confidentiality requirements, and ethical considerations and issues that will affect their work in family treatment court. Further, identify how the team can assist each team member in complying with ethical standards and confidentiality requirements.

After the roundtable, discuss the following questions:

1. Who on the team will develop in-depth expertise on legal mandates and confidentiality laws as they relate to family treatment court?

2. How will this person ensure that all family treatment court team members are trained in legal mandates and confidentiality laws as they relate to family treatment court?

Initial training:

Training as new staff join team:

3. How will the team discuss legal mandates and confidentiality issues on an ongoing basis?

Worksheet 7 *continued*

Case Examples

As a team, review the case examples below. Discuss and identify the confidentiality or ethical issue presented in each scenario. Discuss and identify the process to address ethical and confidential conflicts of the team.

Case Example 1

You are working with a young mother of two children, ages 5 and 3. Her recovery has been slow and unsure, with relapses and missed treatment sessions. The judge has informed the participant that another relapse will result in jail time. Today's urine drug screen is positive. The participant begs you not to tell the rest of the treatment court team, because if she goes to jail she is afraid her ex-husband may abuse or kidnap her children. Her husband has a long history of violence and has threatened the participant and children in the past. What do you do? Do you inform the rest of the team?

Case Example 2

The children are in the temporary custody of child protective services. The mother has been in treatment court for several months, and all reports indicate she is clean and sober. Child protective services is holding an administrative review to determine the progress made on the case plan for which the goal is reunification. The review is to be held in a family case conference format with parent and family participation. The morning of the case review, at 3 a.m. the mother calls the treatment court case manager. She begins by cursing the case manager. Her speech is slurred, and she is making no sense. There is no confirmation of substance use—that is, the mother denies it and urinalysis does not indicate use. The case manager attends the administrative review. Can the case manager disclose the apparent substance use by the parent? Is the case manager obligated to disclose the information?

Case Example 3

The children are in the custody of child protective services. CPS has filed a motion for permanent custody but has continued the hearing due to both parents' compliance with treatment court. Because of the parents' progress in their case plan, unsupervised in-home visitation is occurring. During an individual session with a substance use disorder counselor, another participant of treatment court disclosed that the parents have been drinking all along, saying, "They have been fooling all of you." There is no independent confirmation of alcohol use. Can the counselor disclose this information to the treatment court team? To CPS?

Case Example 4

Child protective services has filed a motion for termination of parental rights (TPR) due to parents' noncompliance with treatment court and in accordance with ASFA. Should the family treatment court judge preside over the TPR case? How should the parent attorney and agency attorney handle this situation? What hearings, if any, should the treatment court judge hear in the dependency case?

Worksheet 8

Vision, Mission, Goals, and Objectives

The purpose of this worksheet is to help you discuss your family treatment court's core values and to develop targeted vision and mission statements as well as statements of goals and objectives. These various statements provide the team with an opportunity to clarify its group philosophy and combine the essential elements of the program design with the directional elements required for action. Perhaps most important, these statements serve to guide the actions of the team by providing a reference point to measure team activities. Once developed, the vision and mission statements can be useful tools to overcome conflicts or make decisions. Determining whether potential decisions or remedies align with the mission and vision statements will help you develop an appropriate resolution or direction for the team.

Work as a team to identify a set of values and principles you'll need for the development of your vision and mission statements.

Clarify Core Values, Beliefs, and Operating Principles

1. Record individually up to **10** values, beliefs, and operating principles on cards or sticky notes.

2. Group the concepts into similar categories.

3. Post the concepts on the wall.

4. As a team, reach agreement on the **five** most important values. Remember that the **team must agree** on the five values that are most important to your family treatment court.

5. Discuss the following:

a. Did you find that you had to negotiate within your team for the values you wanted?
b. Did you have to sacrifice any of your values? If yes, what were they?

6. List the core values, beliefs, and operating principles that the team has agreed on to assist in developing statements that describe *what* (vision) the team is to achieve through the family treatment court, and *how* (mission) you will achieve it.

Develop Vision and Mission Statements

The process of developing vision and mission statements begins with an understanding of the concepts. The concepts and their definitions are:

1. Vision – **What** is the team going to accomplish, and **where** is the team going? What is the output of the family treatment court? As a team, discuss what you agree to accomplish with your family treatment court. Jot down your thoughts and ideas here, then develop a statement that best expresses the team's vision.

2. Mission – **How** will you implement the vision? As a team, discuss your thoughts and ideas, then jot them down here. Develop a motivational but clear, descriptive statement of the work the team hopes to do to accomplish the vision.

Establish Success Indicators

Next, use the values and operating principles to develop concrete and measurable goals and objectives. List at least five goals and three objectives for each of those goals:

Worksheet 8 *continued*

The Newspaper Story

Once you have developed your vision and mission statements and have a clear idea of success indicators, it's time to review and refine the statements through a "newspaper story" exercise. Before beginning the exercise, answer the following questions:

1. Was the entire team involved in the development of the vision and mission statements?

2. Do the statements include documentation of core values, beliefs, and operating principles?

3. In the space below, list the values, beliefs, and operating principles included in the statements. Are those values important to the operation of the court?

Use the following scenario to refine your vision and mission statements to more closely align with the values, operating principles, goals, and objectives of your family treatment court.

Scenario: A local newspaper reporter has contacted your family treatment court to do a story celebrating five years of the successful operation of your court. As a team, discuss the key issues you would like to have included in the story to describe how you obtained the success achieved in your program. In the space below, identify the values and successes of the family treatment court that should be included in the story.

Worksheet 8 *continued*

Now write your refined vision and mission statements in the boxes below.

Your vision statement

The vision of the _____ County Family Treatment Court:

Your mission statement

The mission of the _____ County Family Treatment Court:

Worksheet 9
Long-Term Strategic Planning

The planning team will need to consider both short- and long-term goals for the family treatment court's strategic planning efforts. In the tables below, list your goals for the next 12 months and over the next five years.

Use the goals to develop a family treatment court strategic plan. You are encouraged to identify multiple objectives for each goal.

Family Treatment Court Goal:

	Tasks/Activities	Person Responsible	Timeline
Objective: Short Term/Long Term (circle one)			

	Tasks/Activities	Person Responsible	Timeline
Objective: Short Term/Long Term (circle one)			

	Tasks/Activities	Person Responsible	Timeline
Objective: Short Term/Long Term (circle one)			

	Tasks/Activities	Person Responsible	Timeline
Objective: Short Term/Long Term (circle one)			

Worksheet 9 *continued*

Family Treatment Court Goal:

	Tasks/Activities	Person Responsible	Timeline
Objective: Short Term/Long Term (circle one)			

	Tasks/Activities	Person Responsible	Timeline
Objective: Short Term/Long Term (circle one)			

	Tasks/Activities	Person Responsible	Timeline
Objective: Short Term/Long Term (circle one)			

	Tasks/Activities	Person Responsible	Timeline
Objective: Short Term/Long Term (circle one)			

	Tasks/Activities	Person Responsible	Timeline
Objective: Short Term/Long Term (circle one)			

Worksheet 9 *continued*

Family Treatment Court Goal:

	Tasks/Activities	Person Responsible	Timeline
Objective: Short Term/Long Term (circle one)			

	Tasks/Activities	Person Responsible	Timeline
Objective: Short Term/Long Term (circle one)			

	Tasks/Activities	Person Responsible	Timeline
Objective: Short Term/Long Term (circle one)			

	Tasks/Activities	Person Responsible	Timeline
Objective: Short Term/Long Term (circle one)			

	Tasks/Activities	Person Responsible	Timeline
Objective: Short Term/Long Term (circle one)			

Worksheet 9 *continued*

Family Treatment Court Goal:

	Tasks/Activities	Person Responsible	Timeline
Objective: Short Term/Long Term (circle one)			

	Tasks/Activities	Person Responsible	Timeline
Objective: Short Term/Long Term (circle one)			

	Tasks/Activities	Person Responsible	Timeline
Objective: Short Term/Long Term (circle one)			

	Tasks/Activities	Person Responsible	Timeline
Objective: Short Term/Long Term (circle one)			

	Tasks/Activities	Person Responsible	Timeline
Objective: Short Term/Long Term (circle one)			

Worksheet 10

Structural Program Design, Target Population, and Eligibility Criteria

Family Treatment Court Structural Program Design

The planning team must first determine the structural program design of the family treatment court. There are two types of structures common in family treatment courts: *integrated design* (one judge) and *parallel design* (two judges). Review the information presented in the guide to decide on the structural program design better suited to your family treatment court.

Target Population and Eligibility Criteria

Describe your target population and determine eligibility criteria. Use the target population flow chart in Chapter 4 of the guide to assist in identifying your target population.

Target population: A broad population of individuals are identified by child protective services and appear before the court as a result of the filing of a petition of abuse or neglect. Review the following questions to develop a target population statement.

1. Do we need to pay particular attention to a specific geographic area?

2. Is there a particular gender or age group that we need to focus on?

3. What is the nature of alcohol and other drug problems in this population?

4. Our target population is:

The _____ County Family Treatment Court will target...

Eligibility Criteria are those factors present in potential participants who may be admitted into the family treatment court based on the target population. When determining eligibility criteria the team needs to consider factors in the following areas:

Eligibility criteria: These are the factors that determine which potential participants among the target population may be admitted into your family treatment court. When determining eligibility criteria, your team must consider the following:

1. *Child's current status:* Where is the child placed? Is visitation occurring? Is there evidence of bonding or attachment? Does the child have special needs or medical conditions? What is the educational status of the child? What current services are being utilized?

2. *Parenting history:* Did the potential participant parent this child or others? Has the person parented this child sober? Has the person successfully parented a child? How has the use of drugs interfered with parenting? Has there been prior termination of parental rights?

3. *Legal status and history of the case:* Note any condition of the dependency case that affects participation (e.g., whether reunification is a goal, the nature of the abuse and neglect, any domestic violence). What are the current charges? What is the respondent's legal history? Are there charges pending in other courts? Is he or she currently on probation or parole? For how long?

4. *Parental criminal history:* Are there any past charges and past convictions for criminal behavior? Have drugs been involved in any of the respondent's criminal activities? Does he or she have current or prior arrests for dealing drugs?

5. *Parental substance use and treatment history:* Find out the nature of the parent's substance use and the number of times he or she has been in treatment.

Worksheet 10 *continued*

6. Parental medical status and history: Does the parent have any diseases or illnesses that will affect participation.

7. *Parental mental health status and history:* Does the parent have any condition that will affect participation? What is the parent's past experience with treatment (e.g., success, compliance)? Keep in mind that co-occurring disorders are not uncommon and should not automatically disqualify a participant. Rather, the severity of the problem and your family treatment court's resources are important considerations.

8. *ASFA timelines:* What is the window before the child must be permanently removed from the care, custody, and/or guardianship of the parent?

9. *Availability of ancillary services:* Are there resources available to address the needs of this family.

10. *Other relevant factors:* Does the potential participant have transportation, child care? Does he or she express a desire to enter the program? If not, does it matter? Is the family supportive? Is the potential participant employed or in school? Is his or her schedule flexible enough to allow reliable participation in the family treatment court program?

Worksheet 10 *continued*

In the space below, identify the qualifying factors of the parent, child, and pending case in the court process, and the disqualifying factors of the parent and pending case.

	Qualifying Factors	Disqualifying Factors
Parent		
Child		
Legal case		

Worksheet 10 *continued*

From these categories identify the factors (eligibility criteria) that must be present in the target population for inclusion in your family treatment court. List them in the space below.

Worksheet 11
Screening and Assessment

Determine who will conduct the screening and assessment and what instruments and information will be used to identify families that meet the eligibility criteria. Address the following questions with your team members, then complete the chart below.

- Who will assist the families in navigating through the various systems?
- Where will the assessment be completed?
- Who will conduct the assessment?
- How quickly can the assessment be done?
- How will collateral information be used in the assessment process?
- How will the results of the assessment be shared with the families and professionals?
- What decisions will be made based on the results of the assessment?
- How will the families be involved in the decision-making process?

Task	Person Responsible	Estimated Time Frame	Instrument
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Worksheet 12
Family Treatment Court Entry Process

Use a flowchart to document the entire entry process, from initial contact with child welfare to first appearance in family treatment court. Team members should be prepared to discuss how internal systems can be enhanced to develop a realistic process and timeline, from identification of an eligible family to formal entry into family treatment court. The team should also examine the sequence of the process to identify potential conflicts or challenges. Refer back to previous worksheets to be sure that the flowchart is consistent with previous discussions.

Entry Process Flowchart

Worksheet 13

Developing Your Family Treatment Court Phase Structure

The planning team must work together to develop a phase structure that will guide a participant to successful completion of your family treatment court program. The phase structure should address the comprehensive needs of the parents, children, and family, and identify specific benchmarks for completion of each phase relative to the child welfare, court, and treatment requirements. Your team must further discuss the minimum requirements of each phase to measure program compliance and noncompliance.

Phase Development

Before completing the program design form at the end of this worksheet, have your planning team discuss the following issues:

1. What is the duration of your family treatment court program?

2. How often will a participant be required to attend a court session?

3. Consider the many questions surrounding drug testing: How frequently will participants be tested for drug and alcohol use? How will you ensure that your testing frequency is feasible in relation to your funding resources? Who will be responsible for administering the tests? How will you guarantee random testing? How and by whom will drug tests be observed? Will family members be tested for drug use? Who will pay for the testing? Will participants be asked to pay a portion? What methodology (in-house or lab) will be used? How quickly will you deal with dirty urine screens? How will you deal with adulterated tests and no-shows? What approach will you take to deal with drugs that are difficult to test (e.g., alcohol, inhalants)? How will you monitor and evaluate the effectiveness of your drug-testing program?

4. How will your team coordinate case plans, treatment plans, and additional services for the family? What strategies can your team develop to address potential conflicts in case plans as well as gaps in services required by families? Will information exchange be impacted if multitreatment providers are used?

Worksheet 13 *continued*

5. Who will monitor and supervise the day-to-day expectations of parents? Will someone complete home visits to check on the whereabouts and stability of the home life (even if the child is in out-of-home care)? How often will home visits be required? Will parents be required to meet routinely with the child welfare worker in his or her office?

6. What is the purpose of staffing sessions? Which disciplines will be required to be present? What obstacles do you anticipate as you organize and perform the staffing? How do you intend to overcome those obstacles?

7. How does the planning team intend to physically lay out the courtroom? How close will the participant be to the judge? How will the team exchange information in the courtroom? Will individual or group hearings be conducted? Will the court process be formal or informal? To what extent will the judge interact with the participant and the participant's children?

8. What are the criteria for a participant to graduate from your family treatment court program?

9. What specifically are the proximal and distal behaviors that you will base your phase structure on?

10. As you design your phase structure, keep in mind that there are two types of phases: treatment and court. Remember, your treatment phases do not need to match your court phases.

Worksheet 13 *continued*

Use the design form below to develop a phase structure as well as to identify the elements for inclusion in a policy and procedure manual. Also see the suggested list of components in Chapter 4 of the guide, Construct a Phase System. Add sections as needed to this outline throughout the balance of the planning process. You can choose to number the phases or give them titles.

Family Treatment Court Program Design Form

Components	**Phase 1** (Or_____)	**Phase 2** (Or_____)	**Phase 3** (Or_____)	**Phase 4** (Or_____)
Judicial supervision Court review session				
Protective services supervision				
Substance use disorder treatment				
Supervision/monitoring (probation/TASC)				
Parenting classes				
Random drug testing				
Parental obligations to the child				
Other services required				
Other services required				
Other services required				

Worksheet 14

Comprehensive Service Delivery for Parents, Children, and Families

The planning team should address the following questions before designing the treatment aspect of the family treatment court.

1. What treatment approaches and models are currently available in the community and would best serve the target population? Is the 12-step community supportive of the family treatment court concept?

2. Which treatment providers should you approach?

3. What questions should you ask the treatment providers?

4. How and by whom are treatment services paid (i.e., client, court, treatment, other)?

5. How do you negotiate with the treatment providers (develop linkage agreements) to ensure that the services provided to participants are appropriate, that participants are given access to treatment in a timely manner, and that the treatment provided is effective?

6. What types of information should you expect from treatment providers (e.g., progress reports)? How often will you need that information and who on your operational team will be responsible for getting the information and updates? How will the information and updates be reported?

Review the community resources mapping exercise completed in Worksheet 3. Below, identify specific agencies that have **not** been involved in the family treatment court planning process and how they may be a resource for children, parents, and families.

Substance Use Disorder Treatment Services:

Detoxification _____

Methadone maintenance _____

Inpatient rehabilitation _____

Residential _____

Halfway houses _____

Intensive outpatient _____

Outpatient _____

Aftercare/continuing care services _____

Other Ancillary Services:

Education/prevention _____

Transportation _____

Child care _____

Therapeutic child care _____

Parent and child interactive programs _____

Vocational/educational _____

Domestic violence services _____

Parenting classes _____

Counseling for child _____

Medical/dental services for family _____

Family therapy _____

Dual diagnosis programs _____

Pediatric developmental services _____

Legal services _____

Anger management programs _____

Worksheet 14 *continued*

List the service organizations, faith-based organizations, and other nonprofit agencies that are not included in the activities listed above. Discuss/develop strategies to include these organizations in your family treatment court.

1. _____

2. _____

3. _____

4. _____

5. _____

Reexamine the information in the community resources mapping exercise (Worksheet 3) and the additional community resources your team came up with now. Then use the following questions to discuss your findings.

1. What are the community's assets and strengths?

_____

_____

2. What gaps in services have you identified?

_____

_____

3. Who do you need to add to the treatment court team?

_____

_____

4. What additional information about resources and contacts do you need to gather?

_____

_____

5. What formal supports does the community offer for participants and children?

_____

_____

Worksheet 14 *continued*

6. What informal supports and opportunities does the community offer for participants and children?

7. Which community leaders might be willing to politically support the family treatment court?

8. What nonmonetary resources are available in the community?

9. How does the relationship between families and the community currently stand?

10. Where is the best potential for new and healthy relationships to grow?

Worksheet 15

Case Management, Community Supervision, and Drug Testing

Case Management

A critical part of the planning process is for team members to discuss the case planning and treatment planning expectation, process, mandates, and time frames within each agency to ensure that (a) each agency meets its reporting requirements, and (b) a unified case/treatment planning process is developed to include the services, time frames, and goals of both the children and the parents. The team must discuss the elements of effective case planning and outline the strategies for developing a collaborative case planning process. Use the outline below to guide your discussion. Then develop protocols for collaborative case planning according to the case management functions you discussed.

Discuss these core case management functions:

1. Child protective services
2. Clinical
3. Social service
4. Probation

Define the essential elements and time requirements for

1. Child protective services case planning
2. Clinical treatment planning
3. Social service case planning

Define the potential areas of overlap and competing demands in

1. Child protective services
2. Clinical treatment

Discuss these critical issues to establish the framework for a collaborative plan:

1. Confidentiality/information sharing
2. Consensus regarding priorities and expectations
3. Joint planning
4. Communication with families

Worksheet 15 *continued*

Support, Accountability, and In-Home Services

Parents, children, and families require support in and out of the courtroom. Monitoring parents' efforts and providing in-home services and supports are critical to assure that all family members' needs are met and that positive change is occurring. The family treatment court must develop a plan for team member(s) to visit the participant's home on a regular basis to assure child safety, provide parenting support and skill building, and identify strengths and needs to be shared with the team. Discuss as a team what in-home services, support, and monitoring will look like and who will be responsible.

1. What services are required to effectively and successfully monitor and support parents and children in their home?

2. Which agencies, entities, and individuals will provide services, support, and monitoring in the home for parents and children?

3. What will be the frequency of in-home services, support, and monitoring?

4. How will information about the in-home contacts be communicated to the rest of the team?

5. How will in-home services, support, and monitoring be different if the child is in out-of-home placement?

6. Will the in-home services, support, and monitoring frequency vary by phase or placement of the child? (e.g., more contacts during phase 1, increased contacts after the child has returned home)

7. What will the caseload ratio be for the primary person providing in-home support? (e.g., the case manager).

Worksheet 15 *continued*

Drug Testing

A critical discussion for the team involves strategies for building and maintaining a successful drug testing program. The team should consider the best testing approaches from the perspective of optimizing surveillance. That means determining the most reliable and effective testing methods available in the community, the best time to test, and the most effective screening specimens. The following questions will help the team identify the critical elements for designing an effective testing protocol:

1. Which alcohol and other drug testing services will ensure quick and reliable results?

2. Which agencies or entities will provide the testing?

3. What will be the frequency of testing?

4. Will testing vary according to which phase of the family treatment court program the participant is in?

5. Where will testing take place?

6. What method of testing will be used? (e.g., urinalysis, breath, saliva, patch)

7. How will testing be randomized?

8. How will testing be observed?

9. How will the testing agency communicate test results to the family treatment court?

10. Will a qualified laboratory verify positive test results?

Worksheet 16
Responding to Behavior

Managing participant behavior consists of developing a graduated list of motivational strategies as well as employing actions that remind the participant of the importance of adhering to programmatic goals. In family treatment court, a proposed action must be considered in terms of its short- and long-term impact on the best interests of the child.

This worksheet will help you develop a continuum of incentives and sanctions for implementation in your family treatment court. As a team, define positive behaviors as well as negative behaviors you would like to address. Discuss the following guidelines as you work to develop your incentives and sanctions.

Guidelines for Incentives and Sanctions

1. Best interests of the child
2. Immediate
3. Impact on family
4. Strengths based
5. Consistent and fair
6. Program goals, phase requirements, graduation and termination criteria
7. Goal oriented
8. Competency building
9. Therapeutically appropriate
10. Systems appropriate (court, treatment, child welfare)

Discuss examples of appropriate or desired behavior your team expects to encounter when a family treatment court participant is doing well. In addition, identify goals for the long-term success of the parent-child relationship and for promoting recovery and family stability. Discuss the short- and long-term impacts the incentive will have on the child.

Positive Behavior to Reinforce	Related Goal	Impact on the Child

Discuss the incentives your program could provide to support the continuation of the positive behavior.

Low-Magnitude Incentive	Moderate-Magnitude Incentive	High-Magnitude Incentive

Worksheet 16 *continued*

Discuss examples of inappropriate or problem behavior the team expects to encounter when dealing with a family treatment court participant. In addition, identify goals for the long-term success of the parent-child relationship and for promoting recovery and family stability. Discuss the short- and long-term impacts the sanction will have on the child.

Behavior to Extinguish	Related Goal	Impact on the Child

Worksheet 16 *continued*

Discuss potential sanctions your program could impose to support the discontinuation of the problem behavior.

Low-Magnitude Sanction	Moderate-Magnitude Sanction	High-Magnitude Sanction

Worksheet 17
Graduation from the Program/Termination from the Program

Graduation

An integral part of designing your program is determining the requirements for successful completion. Many treatment courts begin with the end in mind and create the phase requirements based on the goals established for graduation.

Have the planning team complete this sentence:

A participant has successfully completed the family treatment court program when...

Termination

Your team must also determine what behaviors or extent of noncompliance will result in termination from the family treatment court program. It is important to remember the characteristics of the families being served and the realistic goals and expectations that the team has set as well as what the team has learned through the planning process.

Have the planning team complete this sentence:

A participant will be terminated from the family treatment court program when...

Worksheet 18
Monetary and Nonmonetary Funding

The planning team cannot assume that your family treatment court will be grant funded or that just one funder (e.g., federal government) will be the sole source of all start-up funds. The team must determine how the family treatment court program will become operational through existing resources supplemented with local, state, and federal contributions, both in-kind and cash. Follow the four steps to determine start-up funding for your family treatment court:

1. **Create a budget:** Determine exactly what you need funding for by listing all the expenses associated with starting and operating your program. Then estimate the costs for each category.

2. **Survey resources:** Survey the existing resources for each category, considering how they might be reconfigured to meet your budget needs. Look for opportunities to combine or realign resources, especially those that provide services to common or related populations.

3. **Identify gaps in the budget:** By process of elimination, you'll be able to identify the expenses for which you'll need to seek new resources, either in-kind or monetary.

4. **Seek out potential contributors:** Once you've identified the expenses that will require new resources, you'll be in a good position to make presentations and prepare funding requests to community groups, local foundations, and government agencies. You'll be able to document exactly why you need funding and how it will complement existing resources to maximize their impact.

Worksheet 19
Community Partnerships and Cross-Training

Community Partnerships

To formalize the family treatment court partnership, the team should develop a memorandum of understanding (MOU) with each partnering agency. The MOU is a formal document, signed by the authorizing person of each agency, outlining the roles, responsibilities, duties, and tasks of the partnering organizations. It is recommended that the planning team and/or operational team draft the MOU for review, approval, and signature by executive-level staff. For examples of treatment court MOUs, see http://ndcrc.org/resources/?fwp_search=memorandum+of+understanding.

Cross-Training and Education

In the initial stages of planning, the planning team should develop a plan to further educate partnering agencies and community leaders to ensure long-term sustainability of the family treatment court. As a team, discuss your plan to ensure proper ongoing cross-training opportunities. Core training topics include the following:

1. Psychopharmacology of drugs
2. Drug testing
3. Healthy child development
4. Federal, state, and local child welfare laws
5. Policies and procedures
6. Evidence-based practices for children, parents, and families

Additionally, here are examples of topics that may arise after the implementation of your program:

1. Developmentally disabled participants
2. Current drug trends
3. Quality assurance of treatment services and drug testing
4. Developing new and additional funding resources
5. Preparing for team transition
6. Managing transition of participants through the phases
7. Engagement strategies

As a team, generate a comprehensive list of professions, groups, and agencies to target for cross-training, marketing, and education.

Professions:

Agencies:

Service Groups:

Task # 1 Plan for Marketing/Education
Task # 2 Plan for Marketing/Education
Task # 3 Plan for Marketing/Education
Task # 4 Plan for Marketing/Education
Task # 5 Plan for Marketing/Education