AN OVERVIEW OF OPERATIONAL FAMILY DEPENDENCY TREATMENT COURTS

By Judge Nicolette M. Pach (ret.)

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

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ARTICLE SUMMARIES

ESTABLISHING FDTC BEST PRACTICES

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

NECESSARY PARTNERS AND ROLES

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

DEFINING THE MISSION OF THE FDTC

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

COURT CALENDARING PRACTICES

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

PHASE STRUCTURE AND MANAGEMENT OF CLIENT BEHAVIOR

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

STRUCTURE OF THE FDTC

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

CASE MANAGEMENT

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

QUESTIONS TO BE ANSWERED

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

INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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

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

BACKGROUND

Parental Substance Abuse in Child Abuse and Neglect Cases

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

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

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

Permanency Planning in the Best Interest of Children

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

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

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

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

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

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

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

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

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

NECESSARY PARTNERS AND ROLES

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

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

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

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

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

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

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

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

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

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

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

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

DEFINING THE MISSION OF THE FDTC

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

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

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

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

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

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

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

EXERCISING LEGAL JURISDICTION AND INTAKE

Civil and Criminal Jurisdiction

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

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

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

WHEN TO TAKE JURISDICTION: TIMING OF FDTC INTERVENTION

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

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

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

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

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

COURT CALENDARING PRACTICES

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

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

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

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

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

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

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

PHASE STRUCTURE AND MANAGEMENT OF CLIENT BEHAVIOR

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

STRUCTURE OF FDTC

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

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

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

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

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

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

CASE MANAGEMENT

[15] A significant feature of FDTCs is case management, which includes the following (Siegal, 1998):

- Assessment
- Case planning
- Linkage to services
- Monitoring of participants, families, and case plans
- Advocacy

FDTCs have been creative in finding personnel to provide case management under such structural limitations as funding, court design, and pre-existing agency relationships. In some courts, case management oversight is limited to parental participation in treatment, while in others, it includes service planning for families and children and a broad array of services including housing aid, vocational, educational, and employment planning, and various services to address the children's specific needs. A single team member assigned to work with a single family may perform case management functions, or functions may be shared among various team members.

Credentials for case management also vary. In some FDTCs, case managers are required to have drug and alcohol counseling credentials, but in other courts they are not. In Miami, for example, there are four case managers, called Dependency Drug Court (DDC) Specialists. Their credentials are commensurate with their comprehensive duties. Three of them have master's degrees and the other has a bachelor's degree. They are responsible for:

> Alcohol and drug abuse screening and assessments, referrals to and enrollment in treatment services, alcohol and other drug testing, progress monitoring, crisis and therapeutic intervention, to engage and retain the

> parent in the dependency court process, advocating for the parent, and keeping the parent motivated to treatment and recovery throughout the long DDC process. Specialists report to the court…on treatment progress, health issues, housing issues, employment issues, and dependent children's issues. DDC Specialists collaborate with Division of Children and Families (DCF) counselors to develop the substance abuse screening/evaluation/treatment and aftercare portion of the Children and Families Case plan…review the plan with the parents and their attorney's…staff cases weekly with other team members including DCF counselors, representatives from the Linda Ray Intervention Center, and the nurse practitioner. (Juvenile Court 11th Judicial Circuit, Miami-Dade County, FL, Policy and Procedure Manual, p. 9. See Appendix B)

Given the breadth of their responsibilities, they also are provided with professional weekly clinical supervision and therapeutic training from the University of Miami Department of Psychiatry and Behavioral Sciences.

ASSESSMENT

All FDTCs require a substance abuse assessment of the participating parent to determine the appropriate level of treatment and to establish treatment goals. Courts often make use of existing resources in arranging for substance abuse assessments. Suffolk County was able to outsource a psychiatric social worker from the health department to conduct assessments at the courthouse. The social worker then referred participants to local treatment providers. Other courts depend on treatment providers to conduct assessments. Child welfare, mental health, and other assessments also are conducted by FDTCs, depending on the breadth of their missions.

Comprehensive assessments of the family, parents, and children are important to assure that the problems that brought the family into the FDTC are addressed. Rarely is substance abuse the only problem facing these families:

> Children of substance abusing parents generally, and children in foster care particularly, possess, almost by definition, many of the risk factors and few of the protective factors associated with a host of negative outcomes. For instance, children exposed to severe substance abuse in the home often experience mental, emotional, and developmental problems, as well as severe trauma, which may result from physical or sexual abuse or chronic neglect. (Department of Health and Human Services, 1999)

In addition,

> Usually parents who abuse alcohol and drugs and maltreat their children suffer many problems at once. They tend to be socially isolated, to live chaotic lives, to suffer from depression and other chronic health problems, to be struggling with drained financial resources, and to be unemployed. (National Center on Addiction and Substance Abuse at Columbia University, 1999, p. 14).

The Yellowstone County Family Drug Court utilizes a lengthy neurological/psychosocial evaluation of both parents and children being served by the Family Drug Court to identify the multiplicity of issues facing the family. This 8 to 9 hour evaluation, performed by a doctor, is completed during Phase 1 of FDTC participation and is repeated every 90 days. Staff and parents are afforded a comprehensive view of the issues to be addressed. The completed evaluation informs service planning and intervallic administration allows participants and staff to assess progress on an regular basis.

It also is used to identify needed services, and has been provided to parents who, accompanied by their Child and Family Services (CFS) social worker, are requesting services for their children in the local school district.

Such an extensive assessment is usually not available in other jurisdictions. Most FDTCs use a standard instrument for initial substance abuse screening, such as the Addiction Severity Index, administered by substance abuse counselors either at the courthouse or at the treatment facility to determine appropriate treatment levels. Other assessments are obtained through community resources, such as developmental screens of children conducted by public health nurses.

CASE PLANNING

In dependency cases where parental substance abuse is a factor, multiple case plans may be developed. For instance, treatment providers are required to have a treatment plan for the substance abusing parent, while CPS has statutory responsibility to develop a comprehensive service plan for each case to assure child safety and well being and to promote the reunification of families. Service plans must be developed to assist parents to gain the skills necessary to meet the needs of their children, and these plans must meet the child's needs, such as developmental delays and physical and mental health problems and may be developed by the service provider or an independent diagnostic assessment agency.

Where the FDTC has jurisdiction over the dependency case, all developed plans come under court scrutiny. Dependency courts have the responsibility under ASFA to initially rule on the sufficiency of the original service plan and, subsequently, whether reasonable efforts have been made to carry it out. The court reviews and approves or modifies permanency plans several times over

the life of a case. These multiple service-planning efforts are enhanced by coordination in the FDTC process.

Communities differ to the extent that parents or family members are included in developing the case and service plan. As an example of inclusion, in Yellowstone County, the FDTC coordinator, treatment provider, CFS worker, and client sit down at regular intervals for "roadmapping" sessions to review progress toward long and short-term goals and to make adjustments in the plan and goals as necessary. A roadmap may address substance abuse treatment, physical and medical concerns, mental health treatment, and parenting issues, as well as meeting lifestyle issues such as housing, employment, and outstanding criminal matters. The initial roadmap, which follows the CFS plan, is completed shortly after acceptance into FDTC, and the parents sign off on the plan. The Yellowstone court finds client participation essential as it invests in them by providing treatment, while getting feedback from parents as to their needs, requests, concerns, and priorities.

LINKAGES TO SERVICES

Some of the FDTCs surveyed have sought or developed resources to address the full range of issues which impact families where children have been abused or neglected as a result of parental substance abuse. These families require an array of services such as physical and mental health treatment of the entire family, parenting skills instruction, early childhood intervention to address developmental delays, and services to assist in ameliorating co-occurring issues such as domestic violence and trauma history.

The Miami/Dade County Dependency Drug Court assures that their families have access to comprehensive services by reaching out into the community to preexisting organizations willing to work closely with the court and tailor

their programs to meet the families' needs. Additionally, by developing a strong relationship with the University of Miami, the court has secured additional services. As an example, The Linda Ray Intervention Center associated with the University, provides developmental assessments for children. The Center also provides services for the younger children, at the Center or at home, and moves the children on to Head Start when the children graduate from the Center. The Center offers FDTC parents innovative parenting skills curricula that are scientifically based and use pre- and post-testing to evaluate progress. Additionally, at the Center, under the auspices of the University of Miami School of Nursing, the FDTC operates a health clinic. Parents are referred to the clinic upon entering the court and referrals are made for the full range of health services including family planning. The Center's services are court ordered and their staff participates in the court process by attending hearings and offering written reports.

MONITORING

FDTCs become involved in monitoring parents' participation in planned services to the same extent that they are exercising jurisdiction over the matter. Where the FDTC has taken jurisdiction over only substance abuse treatment and abstinence issues, its efforts are limited to monitoring these issues. Where the court has taken a more holistic approach, monitoring occurs across many more domains.

Frequent judicial monitoring of participants was a central feature of every FDTC reviewed. Parents appeared in court regularly and the judge reviewed their progress with them in open court. The judges develop a rapport with the participants and are an integral part of the participant's support system. Participants must account for their behavior directly to the judge. To keep the judge and child protective services well informed of the participant's progress, there is additional monitoring outside the court session.

There is a great variety among FDTCs as to who monitors service and compliance. Some FDTCs rely directly on treatment and service providers, child protective workers, and probation officers dedicated to the FDTC to amass and report information. In others, independent case managers track client's progress. Some FDTCs have personnel to monitor whether children's need and service requirements are being met. Case monitoring conducted by an entity independent of the service or treatment provider may enhance system accountability and relieves the service provider of the burden of preparing for court appearances, staffings, and reports. While relying directly on providers for information may reduce the number of personnel necessary to run the treatment court, it also reduces the number of personnel able to provide first hand reports.

In Suffolk County, case management functions are distributed among several participating agencies. A local not-for-profit agency employs drug and alcohol case managers and court-appointed special advocate case managers. The drug and alcohol case managers monitor compliance with substance abuse treatment, perform drug testing at the courthouse, and provide some concrete services. When issues are identified or raised by participants, these case managers engage in limited crisis intervention while referring the participant back to their treatment counselor. Special advocate case managers monitor child welfare issues that are addressed by a combination of CPS workers, public health nurses, schools, and other specialized service providers. In Kansas City, Department of Family Services (DFS) workers are assigned specifically to the FDTC to provide case management, although when their caseloads are full, other DFS workers help handle the overflow. In Pensacola, the primary counselor from the treatment agency provides case management in combination with other team members. This primary treatment counselor is responsible for written reports to the judge.

Virtually every FDTC utilizes some form of drug and alcohol testing to monitor sobriety. Where funding is available, FDTCs require frequent testing, initially as often as multiple times per week. Other courts test on a less frequent and random basis, requiring clients to call in daily and submit to random testing immediately upon request. Since dependency proceedings are civil in nature and there is a lower standard of proof required for court hearings, some FDTCs have moved away from the stringent "chain of custody" protocols required for drug testing in criminal proceedings and utilize less expensive forms of testing, saving the more rigorous and expensive procedures for situations in which the results are contested or contempt proceedings are contemplated.

ADVOCACY

Developing Resources to Meet the Complex Needs of Families

"Advocacy is one of case management's hallmarks. While a professional conducting therapy may speak out on behalf of a client, case management is dedicated to making services fit clients, rather than making clients fit services," (Siegal, 1998). FDTCs serve as an example of this kind of advocacy. Miami's Dependency Drug Court has reached out to other community agencies to provide needed services. Aftercare services, ordered at the graduation, are provided by the Project Safe program. They provide peer support, urine testing, and employment assistance. Given the prevalence of traumatic history in their client population, the Miami court also has made arrangements for therapeutic and educational services through another local agency, Victims Services Center.

The Suffolk County court has found that agencies are very willing to adjust their services and service delivery methods to meet the needs of the FDTC participants. Project

Outreach, a substance abuse treatment program, had a specialized women's unit when the court began referring clients there. Soon, Project Outreach altered its transportation zones to accommodate the court participants. As participants stayed in treatment longer and domestic violence issues began to emerge, Project Outreach collaborated with the Victims Information Bureau (VIB). VIB provided domestic violence counseling at the Project Outreach treatment facility, rather than have participants attend at the VIB facility some distance away. This accommodated the client's limited transportation and time constraints, which were already impacted by such responsibilities as parental obligations, 12-step programs, vocational/educational programs, and jobs.

QUESTIONS RAISED

Determining What Model Will Meet the Needs of Families in the Local Community

[16] Family dependency treatment courtswere born out of adult criminal drug courts, a concept so compelling and successful that its application to family court cases was inevitable. After implementing their own versions of these courts, FDTC practitioners' mantra has become "but it's not the same as drug court—it's not just about substance abuse."

In criminal courts and criminal drug courts, the primary objective is fairly straightforward: stop drug-driven criminal behavior by stopping drug use. In family court dependency cases, however, the objectives are: keep the child safe and give the child a safe and stable permanent home in a child-friendly timeframe by reunifying the child with a sober parent if possible or, if not, by finding an alternate safe, permanent placement with relatives or in an adoptive home. The priority of family reunification can only occur if the underlying problems which brought the family to the attention of CPS and the court are addressed and resolved.

These issues often extend beyond substance abuse. It is within this context that FDTCs show their divergence from DUI and drug courts.

Is the scope of the FDTC something that lends itself to a national consensus, or is it a matter that must be resolved in local jurisdictions? In deciding the scope, there needs to be agreement about the objectives of FDTCs. Is the focus to secure parental abstinence, and/or to promote family reunification, and/or to assure safe and stable permanent homes for the children in a timely fashion? Should FDTC teams identify and address children's special needs as part of promoting child well being and family reunification, or should they focus only on parental abstinence?

The first main question to be resolved is: What is the mission of the FDTC? When family courts develop a family dependency treatment court, a pivotal decision is whether its function is to address parental abstinence issues only, or whether the FDTC should address the entire range of issues present in the dependency case. The extent to which they choose to address the range of issues in the dependency case within the FDTC proceedings affects their scope, characteristics, and profile. Jurisdictions choose to be either limited or expansive in their programs for a variety of philosophical, ethical, and practical reasons, and there is wide variation across the country.

Ancillary questions that must be asked include: Is FDTC one feature of a community-wide collaboration of agencies and service providers tasked with meeting the needs of families affected by substance abuse in the child welfare system? Should the FDTC be integrated into the dependency case process or should it stand alone? On one end of the spectrum, there are courts that limit the FDTCs involvement to addressing adult substance abuse with the balance of the dependency case issues being resolved before a different judge in a separate proceeding. On the other end, there are

courts where the entire dependency case comes under FDTC jurisdiction—while adult substance abuse is the precipitating event that makes the case eligible for FDTC, the myriad of other family difficulties, adult and child, are identified, addressed, and monitored by the FDTC as well.

In addition, calendaring practices vary. In FDTCs where the dependency case remains in the home court, the parent's compliance with substance abuse treatment and abstinence is monitored in the drug court. All decisions on the dependency case, such as increased visitation or return of children, are made in the home court, while contempt of court orders regarding attendance at treatment and remaining abstinent are attended to by the drug court judge. In other courts, a single judge in a single proceeding hears dependency and sobriety issues. Routine case reviews include both parental compliance and dependency case plan progress, including children's issues and service needs. In the middle are courts where the dependency case and parental compliance with substance abuse conditions of court orders are monitored by the same judge in the same courtroom, but are heard in separate proceedings. For instance, if at a drug court appearance a parent is in compliance and requests additional visitation, that issue is deferred for determination at a separate proceeding in the dependency case where all parties and attorneys may be present and have an opportunity to respond to, and be heard on, the request.

In deciding the scope of the FDTC, jurisdictions must decide whether to follow a one-family/one-judge calendaring practice, or whether there are legitimate logistical or ethical constraints to this practice. Should the same judge who presides over the intense level of judicial monitoring of the FDTC also preside over TPR or other proceedings that may result in the temporary or permanent loss of custody? Is it possible to have all appropriate parties and attorney's present at every court proceeding or review so that all issues may be resolved as they arise?

The second main question that must be asked is: How should FDTC interface with the Adoption and Safe Families Act? That is, should FDTCs be mindful of ASFA time frames when structuring their programs? Or should they concentrate on the parent's sobriety, admitting parents regardless of their dependency case status? ASFA requires the family court to rule on the adequacy of the CPS case plan for reunification. Accordingly, should the FDTC have that responsibility? Should FDTCs have a role in formulating that plan? Should FDTCs be in the business of assessing parent, child, and family difficulties and service needs? At permanency hearings, family courts have to decide if child welfare agencies have made "reasonable efforts" to reunify families. What is the proper role of FDTCs in informing the permanency hearing?

Under ASFA, all states undergo Children and Family Service Reviews. Upon failure to meet federal standards, the state's department of social services is required to enter into a Program Improvement Plan (PIP) approved by the federal government. FDTCs have a potential impact with respect to whether "[f]amilies have enhanced capacity to provide for their children's needs,"[1]. Does the FDTC have a role in meeting the state's PIP requirements by enhancing that capacity? Does the judicial branch, more particularly, the family court, have a stake or a role in assuring that their state meets the requirements of the PIP? Does FDTC have a role in assuring that needed services are available in their community? Is that role limited to the individual families that come before the FDTC or is that role more expansive in terms of assuring that the community's array of services is adequate to avoid the financial consequences to the taxpayers if the jurisdiction does not meet the mandates of the PIP? Should FDTCs promote collaboration among the many

[1] CFSR Well Being Outcome 1 (Administration for Children and Families, 2007).

service providers who have members of FDTC families as their clients? Moreover, what are the implications of these choices? Can an "abstinence only" drug court be successful in the absence of a broad based community protocol for addressing parental substance abuse? Can an "integrated" drug and dependency court have a positive impact on collaboration across community agencies and services? Finally, what about the many non drug-related dependency cases where outcomes also would be improved if given the level of services and scrutiny afforded FDTC cases? Why should this level of assistance be denied the mentally ill or developmentally disabled parent family? Should FDTCs limit themselves to parental difficulties or should they address the difficulties and obstacles confronting the entire family in their quest for reunification?

This review and posing of questions is intended to promote discussion and debate among FDTC practitioners. The time has come to examine the consequences of choices made in the development of FDTCs to determine which processes and protocols have successfully met the needs of families and children within the context of their individual communities. Furthermore, other more specific operational questions must be addressed in each jurisdiction as they plan. Some of the operational questions raised by each section of this article are contained in Appendix A.

CONCLUSION

Family court has been greatly impacted by parental substance abuse and the rise of caseloads containing parents with co-occurring problems. Simultaneously, the 1997 Adoption and Safe Families Act created additional pressure on the system by requiring the courts and child welfare systems to resolve dependency cases within strict time limits. ASFA also has thrust upon the courts the role of judging the adequacy of efforts made by state departments of social services to assist families and the role of approving or

modifying the case plan. All this is in addition to the court's preexisting duty to hear the evidence, determine if there is enough evidence to establish a case, and assure due process to parents, children, and families.

Jurisdictions have been seeking to develop new ways to meet these demands. To that end, family dependency treatment courts have emerged as one solution. FDTCs were adapted from the practices of adult criminal drug courts. While *Defining Drug Courts: The Key Components* (NADCP, 1997) can provide valuable guidance to FDTCs as well as to adult drug courts, additions and changes must be made to comport with the best dependency court practices and to meet the complex needs of families. The court practices discussed above are some jurisdictions' attempts to adapt the best features of adult criminal drug courts to dependency court use. Several basic issues still need to be resolved, however, and questions still need to be answered by practitioners in the field, including: Of the practices reviewed, what can be determined about the consequences of the different approaches to the participant families and to practice and procedure in the different FDTC models? Do they respect long held, well thought out, philosophical and ethical jurisprudential considerations? Do they take the best advantage of local resources and opportunities? Are vestiges of historical practices hindering their development? Do they help family court professionals in their jobs and enable the system to function more efficiently? Most importantly, (how) do they benefit families?

Spinak (2002) warns that FDTCs must be vigilant in protecting families: "This commitment to ensuring family integrity must permeate the court's oversight role for the court to be distinguished from the child welfare agency's role," (p. 341). Additionally, she notes that up until now Model Courts and FDTCs have served only a small percentage of dependency cases using their own criteria to include or exclude cases. The time has come to try to take

these pilot projects and expand them to meet the overwhelming demands of child protective cases. Can the design be replicated in all family dependency courts? What modifications will be necessary to enable communities to provide these services to all dependency cases?

As FDTCs evolve and are reproduced across the country, it is time for the leaders of child welfare, the courts, and substance abuse treatment to come together to exchange information on FDTC practices and to build a framework for integrating the best of these practices into all family dependency treatment courts. In so doing, we should not disregard Spinak's (2002) admonishment that "the purpose that will justify the court's expanded authority—thus adding value to the family's life—is the rigorous enforcement of the constitutional principles that recognize the importance of children being raised by their families and not by the state." (p. 340)

REFERENCES

Administration for Children and Families. (2007, June 30). Child and Family Services Reviews (CFSRs). *Child welfare monitoring*. Washington, DC: Author, U.S. Department of Health and Human Services. Retrieved August 25, 2007 from http://www.acf.hhs.gov/programs/cb/cwmonitoring/ndex.htm#cfsr.

Child Welfare League of America. (2001). *Alcohol, other drugs & child welfare*. Washington, DC: Author.

Department of Health and Human Services. (1999, April). *Blending perspectives and building common ground: A report to congress on substance abuse and child protection*. Washington, DC: Author.

In re Marino S., 693 N.Y.S.2d 822 (N.Y. Fam. Ct. 1999), *aff'd*, 741 N.Y.S.2d 207 (N.Y. App. Div. 1st Dep't. 2002), *aff'd*, 100 N.Y.2d 361 (N.Y. 2003).

Milliken, J.R. (2001). *The dependency court recovery project: Project summary and current highlights*. San Diego, CA: San Diego County Superior Court.

National Association of Drug Court Professionals. (1997). *Defining drug courts: The key components*. Washington, DC: Bureau of Justice Assistance, U.S. Department of Justice.

National Center on Addiction and Substance Abuse at Columbia University. (1999). *No safe haven: Children of substance-abusing parents*. New York: Author.

New York State Commission on Drugs and the Courts. (2000). *Confronting the cycle of addiction and*

recidivism: A report to the chief judge Judith S. Kaye. New York: Author. Retrieved June 10, 2003 from http://www.courts.state.ny.us/reports/addictionrecidivism.shtml.

Schecter, S.P. (2001). Family court case conferencing and post-dispositional tracking: Tools for achieving justice for parents in the child welfare system. *Fordham Law Review, 70*, 2, 427-439.

Siegal, H.A. (1998). Comprehensive case management for substance abuse treatment (TIP No. 27). Rockville, MD: Center for Substance Abuse Treatment.

Spinak, J. M. (2002). Adding value to families: The potential of model family courts. *Wisconsin Law Review 2002*, 2, 331-376.

Victims of Child Abuse Project. (1995, Spring). *Resource guidelines: Improving court practice in child abuse & neglect cases*. Reno, NV: National Council of Juvenile and Family Court Judges.

Young, N.K. & Gardner, S.L. (2002). Navigating the pathways: Lessons and promising practices in linking alcohol and drug services with child welfare (SAMHSA Publication No. SMA 02-3639). Washington, DC: Substance Abuse and Mental Health Services Administration.

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.

APPENDIX A

There are many practical questions raised in planning and launching a new FDTC in individual jurisdictions. They must be answered in the context of local resources and practices. Some of those considerations are suggested below. They have been structured to track the sections of the foregoing article.

Permanency Planning in the Best Interest of Children

How should FDTCs interface with ASFA? First and foremost, FDTCs will want to assure their practices are focused on the ASFA priority of the safety and best interest of children. Individual courts already may be following calendar practices tailored to individual state ASFA statutes. If these practices have not yet been employed, planning courts should consider what impact the FDTC could have on improving compliance with ASFA time frames and permanency hearing requirements and factor that into the planning process. Courts may build in protocols to assure the work of the FDTC program is recognized when making reasonable efforts determinations. They also may assure that the progress reported in FDTC court reviews is considered when determining the appropriateness of proposed permanency goals and case plans. Finally, planning courts may wish to review their state's federally required CFSR and PIP to determine if the local FDTC can respond to some of the requirements to improve their state's practice.

Necessary Partners

In every jurisdiction, there are partners who must be brought to the table. Since FDTC clearly involves the court, CPS, and treatment, appropriate representatives from those entities must be present. The array of local treatment resources will inform the decision to include the governmental licensing agency and/or the substance abuse

treatment providing agencies. A determination of which other agencies in the community are providing services to the families who will participate in the FDTC and consideration of including them in the planning process will be required.

In this process, the court and stakeholding agencies will examine and question their appropriate role. Judges will consider how their role as a community leader in this effort is shaped by judicial and ethical considerations. Similarly, determinations will be made concerning the nature and extent of judicial and court leadership in developing the FDTC and securing services necessary to assist the families involved. Other partners will examine how to maximize their participation in shaping the treatment court to best benefit families as well as individual agencies and parties they represent, while maintaining appropriate role boundaries once the FDTC becomes operational.

In engaging and maintaining collaboration with partners in the FDTC, cross-systems communication is critical to its success. Localities will have to develop communications protocols that comport with state and federal confidentiality requirements. Once appropriate waivers of confidentiality have been agreed upon, FDTCs must then develop protocols for timely and reliable communication systems. Not only must information be communicated, responses to that information must be coordinated. FDTCs will determine which agencies or individuals will be responsible for managing the information exchange and coordinating the team's response to events. In the course of developing these protocols, teams must take into account the dynamics of addiction and recovery and avoid practices that permit participants to manipulate team members who may then inadvertently enable addictive behaviors.

Defining the Mission of FDTCs

As local jurisdictions define the mission of their FDTC, they will determine the range of case issues that will come under its umbrella. The FDTC may be expansive in scope to include not only parental substance abuse, but also all of the issues that brought the family before the court in the dependency case. Or, the FDTC may be limited to parental substance abuse issues only, with the dependency case issues being addressed elsewhere. The mission and case issues included in the scope of the FDTC will impact case management and identification of necessary partners.

The team will determine the location of the hub of coordination, collaboration, and communication concerning the case plan. It may be court based, centered in CPS, or contracted out to a not-for-profit agency or substance abuse treatment provider. Deciding both which entity has the capacity to perform various functions and the appropriate roles for the court and other agencies will entail practical as well as philosophical considerations.

Exercising Legal Jurisdiction and Intake

State law dictates the type of jurisdiction for FDTCs. In some states, FDTCs will be limited to dependency cases only. In states where the court has broader jurisdiction, a determination must be made as to what other types of cases (i.e., criminal matters) involving the same family will be heard by the FDTC judge and incorporated into the case plan.

The second question regarding jurisdiction is at what point in the life of a case a parent should be considered for FDTC. Some courts will admit the parent as early as the first court appearance, while others may decide it is appropriate to wait until the parent has failed to comply with court orders to engage in AOD treatment and remain abstinent. Jurisdictions

also will need to consider the status of the case relative to ASFA time frames.

Court Calendaring Practices

Some FDTCs utilize the direct one-family/one-judge calendaring practice, keeping all issues in one courtroom and the focus on timely permanency for children. Other jurisdictions maintain the dependency case before one judge and send the parent to another judge or magistrate for the monitoring of compliance with substance abuse treatment and abstinence. This latter practice sometimes develops based on logistical considerations or concerns over whether it is appropriate for one judge to hear the FDTC status hearings as well as modification (such as return or removal of children) and TPR proceedings.

Phase Structure and Managing Client Behavior

FDTCs generally measure parental progress through the program by phases. Movement from one phase to the next is based on the achievement of certain milestones. Accomplishments should be agreed upon across disciplines and, depending on the structure of the court, may include milestones in the permanency/dependency service plan requirements, meeting parental obligations, lifestyle changes to support abstinence along with substance abuse treatment participation and progress. Whether these milestones are divided into three, four, or five phases is a matter of local preference.

Sanctions, incentives, and consequences are integral to motivating parents to comply. Teams will need to discuss a schedule of sanctions and incentives and determine how they can be consistently applied. Jurisdictions will have to explore what rewards are available within their community. With respect to determining appropriate sanctions, courts will first be guided by local law. While incarceration for

contempt may be legally available, local custom or judicial preference may dictate whether or not it will be employed. Teams also will need to educate themselves about relapse to determine when a "response" to address the circumstances of the relapse is more appropriate than a sanction.

Structure of the FDTC

Three levels of support are needed for FDTCs. First is acceptance and support of the FDTC mission and overall policy from the highest level of leadership of each entity involved. Second is agreement by supervisory personnel on protocols and practices that will be used in the FDTC. Third comes from the individuals who will actually be carrying out the work of the FDTC when it becomes operational. These levels of support may be garnered in a steering committee of high ranking officials, a planning and administrative oversight committee of managerial personnel with sufficient authority to agree to protocols and practices on behalf of their agencies/entities, and finally an operational team who is trained to utilize the protocols and practices while working directly with the families. Depending on the size of the community, these may be three distinct groups of individuals or membership may overlap completely or in part. Identifying the right individuals to fulfill these functions will have long lasting impact on the success of the FDTC.

Case Management

FDTCs will have to determine how case management will operate. Initial screening to determine eligibility for participation must occur and clinical and programmatic criteria will need to be developed. For instance, teams will have to assess their ability to work with parents with co-occurring disorders, such as mental illness.

FDTCs require the availability of assessments in order to plan appropriate services. Beyond looking at levels

of AOD use and abuse, FDTCs, depending on their scope, must consider assessments of co-occurring disorders, the presence of domestic violence, mental health concerns, family service needs, and children's health and developmental issues. After deciding what should be assessed, the team will have to agree on the assessment process including what instruments will be used and which team members will be responsible for what parts of the assessment.

The next logistical concern is formulating a case plan to meet the identified needs. The overall case plan must be developed and the multiple service plans of individual entities (CPS, treatment, children's services) must be coordinated.

Families must be linked to services. Not every parent will need the same level of substance abuse treatment, so a continuum of levels will have to be sought. As families will need other services, FDTCs will have to decide how extensive the services under its auspices will be. The court may or may not decide to address housing, vocational training, child development, child health, parent health, day care, and transportation.

A team member will need to be designated to "broker" services or refer cases. Service providers must be selected and their responsibilities to FDTC delineated. Written reports or attendance at staffings may be required, and participants, families, and case plans must be monitored. The team must decide whether CPS, a treatment provider, an independent agency, or a court employee will take responsibility for the monitoring. Depending on the scope of the FDTC and the information to be monitored, this responsibility may include substance abuse issues only or may embrace the entire case plan.

Drug and alcohol testing must be incorporated into FDTC operations. Frequency, payment for testing,

individuals to administer the test, testing protocols including test kits, what substances are tested for and how to assure tests are random and reliable, are all problems to be solved by the team.

FDTCs often engage in some form of advocacy on behalf of their families and programs. FDTCs role in developing resources to meet the complex needs of its families and the roles of the professional staff and the judge in developing resources are other questions to be debated. Other issues for planning FDTC teams to ponder include their ability to bring the program to scale to serve all parents in the community charged with neglect where substance abuse is an issue. Planning jurisdictions should maintain their focus on adding value to the lives of families while serving to reorganize the process for enhanced professional collaboration. In the excitement of developing a program that will increase success in reuniting children with sober parents, FDTCs also must assure they are sufficiently safeguarding parents' and children's due process rights.

APPENDIX B

POLICY AND PROCEDURE MANUALS REVIEWED

Albany County Family Treatment Court
Gerard E. Maney, Judge
David B. Cardona, Chief Clerk
One Van Tromp Street
Albany, NY 11207
(518) 427-3592

Durham County Family Treatment Court
Elaine O'Neal, Judge
Office of Trial Court Administration
Durham County Judicial Building
201 E. Main Street, Suite 278
Durham, NC 27701
(919) 564-7210

El Paso Family Dependency Treatment Court Program
Alfredo Chavez, Judge
Annabell Casa-Mendoza, Coordinator
65th District Court
500 E. San Antonio, Suite 1105
El Paso, TX 79901
acasas@co.el-paso.tx.us
(914) 834-8216

Erie County Family Treatment Court
Margaret O. Szczur, Judge
Erie County Department of Social Services
478 Main Street, Room 604
Buffalo, NY 14202
(716) 858-7954

Or

Erie County Family Court
1 Niagara Square
Buffalo, NY 14202
(716) 858-4764

Escambia County Family Focused Parent Drug Court
John J. Parnham, Judge
2251 N. Palafox Street
Pensacola, FL 32501

Or

Robin Wright, Sr. Deputy Court Administrator
100 W. Maxwell St.
Pensacola, FL 32501
Robin_wright@co.escambia.fl.us
(850) 595-3055

Idaho 7th Judicial District Child Protection and Parent Drug Court
P.O. Box 389
Rexburg, ID 83440
(208) 656-3243

16th Judicial Circuit Jackson County Family Drug Court
Molly Merrigan, Commission
Penny Howell, Administrator
625 E. 26th Street
Kansas City, MO 64108
(816) 435-4757

Manhattan Family Treatment Court/New York County Family Court
Gloria Sosa-Lintner, Judge
60 Lafayette Street
New York, NY 10013
(212) 374-2526

Mecklenburg County Family Treatment Court/ F.I.R.S.T. (Families in Recovery Stay Together)
800 East Fourth Street, Suite 211
Charlotte, NC 28202
(704) 358-6216

Miami-Dade County, Florida Dependency Drug Court
Jeri B. Cohen, Judge
Paul Indelicato, Director
3300 NW 27 Avenue
Miami, FL 33142
(305) 638-6102

Suffolk County Family Treatment Court
Nicolette M. Pach, Judge
Joan Genchi, Judge
Christine Olsen, Director
400 Carleton Avenue
Central Islip, NY 11702

Washoe County, Nevada Family Drug Court
Charles McGee, Judge
P.O. Box 30083
Reno, NV 89520
(775) 325-6769

Westchester County Family Treatment Court
Westchester County, NY

Yellowstone County Family Drug Court
Susan Watters, Judge
Becky Bey, Coordinator
Child and Family Services Building
2525 4th Avenue North
Billings, MT 59101
(406) 657-3156