DRUG COURT REVIEW

Volume VI, Issue 1

NATIONAL DRUG COURT INSTITUTE
ALEXANDRIA, VIRGINIA

DRUG COURT REVIEW

Volume VI, Issue 1

NATIONAL DRUG COURT INSTITUTE

C. West Huddleston, III, Executive Director
Carolyn D. Hardin, M.P.A., Director
4900 Seminary Road, Suite 320
Alexandria, Virginia 22311
Tel. (703) 575-9400
Fax (703) 575-9402
www.ndci.org

NDCI is supported by the Office of National Drug Control Policy, Executive Office of the President and the Bureau of Justice Assistance, U.S. Department of Justice.

This document was prepared under Cooperative Agreement Number 2007-DC-BX-K001 from the Bureau of Justice Assistance with the support of the Office of National Drug Control Policy, Executive Office of the President. The Bureau of Justice Assistance is a component of the Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, and the Office for Victims of Crime. Points of view or opinions in this document are those of the authors and do not represent the official position or policies of the U.S. Department of Justice or the Executive Office of the President.

Printed in the United States of America.

Drug courts perform their duties without manifestation, by word or conduct, of bias or prejudice, including, but not limited to, bias or prejudice based upon race, gender, national origin, disability, age, sexual orientation, language, or socioeconomic status.

INTRODUCTION

The Editorial Board is pleased to present the first issue of volume six of the *Drug Court Review* (Volume VI, 1). This issue of Volume VI takes a look at three issues of pertinence to the drug court field: *sanctioning practices*, *outcomes for differing court populations and approaches*, and *family dependency treatment courts*. Though they address divergent issues, each article helps deepen the literature available to the drug court field.

In this issue:

- Patricia L. Arabia, M.S., Gloria Fox, M.S., Jill Caughie, B.A., Douglas B. Marlowe, J.D., Ph.D., and David S. Festinger, Ph.D., explore the issue of sanctions in adult drug court. The authors examine the specific sanctioning practices of a court in Philadelphia, Pennsylvania, in terms of established literature on behavior modification.
- Deborah K. Shaffer, Ph.D., Shelley J. Listwan, Ph.D., Edward J. Latessa, Ph.D., and Christopher T. Lowenkamp, Ph.D., examine the results of an evaluation of drug courts in Ohio in terms of differing outcomes for felony, misdemeanor, and juvenile populations.
- Judge Nicolette M. Pach (ret.) establishes an agenda for a national conversation about family dependency treatment court best practices and circumstantial permutations.

THE DRUG COURT REVIEW

Published semi-annually, the *Review*'s goal is to keep the drug court practitioner abreast of important new developments in the drug court field. Drug courts demand a great deal of time and energy of the practitioner. There is little opportunity to read lengthy evaluations or keep up with important research in the field. Yet, the ability to marshal scientific and research information and "argue the facts" can be critical to a program's success and ultimate survival.

The *Review* builds a bridge between law, science, and clinical communities, providing a common tool to all. A headnote and subject indexing system allows access to evaluation outcomes, scientific analysis, and research on drug court related areas. Scientific jargon and legalese are interpreted for the practitioner into common language.

Although the *Review*'s emphasis is on scholarship and scientific research, it also provides commentary from experts in the drug court and related fields on important issues to drug court practitioners.

THE NATIONAL DRUG COURT INSTITUTE

The *Drug Court Review* is a project of the National Drug Court Institute (NDCI). NDCI was established under the auspices of the National Association of Drug Court Professionals with support from the Office of National Drug Control Policy, Executive Office of the President, and the Bureau of Justice Assistance, U.S. Department of Justice.

NDCI's mission is to promote education, research, and scholarship to the drug court field and other court-based intervention programs.

Historically, education and training in the drug court field have only been available at regional workshops and the annual national conference; analysis and scholarship were largely limited to anecdotes and personal accounts.

That situation has changed. Evaluations exist on dozens of drug court programs. Scholars and researchers continue to apply the rigors of scientific review and analysis to the drug court model. The level of experience and expertise necessary to support such an institution now exist.

Since its creation in December 1997, NDCI has launched a comprehensive practitioner training series for judges, prosecutors, public defenders, court coordinators, treatment providers, and community supervision officers; developed a research division responsible for developing a scientific research agenda and publication dissemination strategy for the field, and developed a series of evaluation workshops; and published a monograph series on relevant issues to drug court institutionalization and expansion.

ACKNOWLEDGEMENTS

I wish to thank all those who have contributed to this issue of the *Drug Court Review*: the Office of National Drug Control Policy, Executive Office of the President, and the Bureau of Justice Assistance, U.S. Department of Justice, for the leadership, support, and collaboration that those agencies have offered to the National Drug Court Institute; and Patricia Arabia, Gloria Fox, Jill Caughie, Douglas Marlowe, David Festinger, Deborah Shaffer, Shelley Listwan, Edward Latessa, Christopher Lowenkamp, and Nicolette Pach for their contributions as authors.

C. West Huddleston, III
Executive Director
National Drug Court Institute

CONTENTS

SANCTIONING PRACTICES IN AN ADULT FELONY DRUG COURT

By Patricia L. Arabia, M.S., Gloria Fox, M.S., Jill Caughie, B.A., Douglas B. Marlowe, J.D., Ph.D., and David S. Festinger, Ph.D
Treatment Research Institute, University of Pennsylvania

Administering negative sanctions to clients for program infractions, and therapeutic consequences for insufficient progress in treatment, are among the key components of the drug court model, yet little research has investigated whether drug courts administer sanctions and therapeutic consequences in accordance with effective principles of behavior modification. A descriptive case study of a felony pre-adjudication drug court (N = 105) revealed that sanctions and therapeutic consequences were typically administered on a progressive gradient, in which lower-magnitude consequences tended to be administered for earlier infractions followed by higher-magnitude consequences for repetitive infractions. There were exceptions, however, for participants who had been issued a bench warrant for absconding from the program or failing to show for court hearings. For those individuals, higher magnitude consequences, including jail detention, house arrest, and show-cause hearings, were more likely to be imposed or were imposed more readily after a smaller number of infractions. Consequences also were generally administered in accordance with participants' expectations about the relative severity or burden of those consequences. Because this study was exploratory and involved a single drug court program, the results are preliminary and must be replicated. However, the data suggest that some drug courts may be capable of applying sanctions and therapeutic consequences in a manner consistent with effective principles of behavior modification.

This research was supported by grant #R01-DA-14566 from the National Institute on Drug Abuse (NIDA).

The views expressed are those of the authors and do not necessarily reflect the views of NIDA. The authors gratefully acknowledge the ongoing collaboration of the staff and clients of the Philadelphia Treatment Court as well as the Office of the District Attorney of Philadelphia, Defender Association of Philadelphia, Philadelphia Coordinating Office of Drug and Alcohol Abuse Programs, and Philadelphia Health Management Corporation.

Patricia L. Arabia, M.S., is a Research Coordinator at the Treatment Research Institute at the University of Pennsylvania. She is responsible for the operational management of all criminal justice and related projects, including data collection and analyses, supervision of research assistants, and monitoring of central-office study activities.

Gloria Fox, M.S., was formerly a Project Coordinator at the Treatment Research Institute at the University of Pennsylvania. She was responsible for the coordination and supervision of in-court research activities in the current study and fostering stakeholder relationships. Ms. Fox is a Staff Development Trainer at the law firm of Blank Rome LLP in Philadelphia.

Jill Caughie, B.A., was a Senior Research Assistant at the Treatment Research Institute at the University of Pennsylvania. She was responsible for subject recruitment, data collection, and management for the current study. Ms. Caughie is enrolled in the Temple University School of Law in Philadelphia.

Douglas B. Marlowe, J.D., Ph.D., is the Director of Law & Ethics Research at the Treatment Research Institute, and an Adjunct Associate Professor of Psychiatry at the University of Pennsylvania School of Medicine. His research focuses on examining the role of coercion in drug abuse treatment, the effects of drug courts and other diversion

programs for drug abusing offenders, and behavioral treatments for drug abusers and offenders.

David S. Festinger, Ph.D., is a senior scientist in the Section on Law and Ethics Research at the Treatment Research Institute and an Adjunct Assistant Professor of Psychiatry at the University of Pennsylvania School of Medicine. His research focuses on evaluating the clinical and ethical impacts of coercive interventions for substance-abusing criminal offenders.

Direct all correspondence to Patricia L. Arabia, M.S., Treatment Research Institute at the University of Pennsylvania, 600 Public Ledger Bldg., 150 S. Independence Mall West, Philadelphia, PA 19106-3475. (215) 399-0980. (215) 399-0987 (fax). plee@tresearch.org

ARTICLE SUMMARIES

BEHAVIOR MODIFICATION

[1] While drug courts impose negative sanctions upon clients in the hopes of changing their behavior, there is little research examining whether drug courts actually succeed in applying sanctions in accordance with accepted behavioral principles.

METHODS

[2] The sample of drug court clients was drawn from a felony post-plea, pre-adjudication drug court in Philadelphia, PA. Researchers were present at all court hearings; additionally, client perceptions of sanctions were gathered through interviews.

RESULTS IN SANCTIONING

[3] Drug court clients usually received sanctions in order from lightest to heaviest and in proportion to their infractions. Those who were returned on bench warrants were an exception to this trend. Client perceptions were in line with court intent.

DISCUSSION

[4] Sanctions imposed in the drug court in question appear to conform to the existing literature on behavioral modification.

INTRODUCTION

Imposing sanctions on clients for program infractions is one of the key components of the drug court model (NADCP, 1997; Tauber, 2000). Some behaviors cannot be permitted to recur and must be reduced quickly in the interest of public safety. Drug court personnel and the public at large need to be confident that drug-abusing offenders—who may only be out on the street because of a diversionary or probationary opportunity—are not continuing to engage in risky activities such as crime or substance misuse (e.g., Harrell & Roman, 2001).

[1] It is an open question, however, whether drug courts administer sanctions in accordance with effective principles of behavior modification. When applied incorrectly, sanctions can bring with them a host of negative side effects that fail to improve outcomes and may actually make outcomes worse (Martin & Pear, 1999; Newsom, Favell, & Rincover, 1983; Sidman, 1988). For example, individuals who are exposed to severe sanctions often will do everything in their power to avoid the sanctions, such as absconding from the program, lying, or tainting their urine specimens. As a result, staff members may spend an inordinate amount of time attempting to overcome clients' resistances rather than conducting effective counseling. In addition, individuals who receive excessive sanctions may become depressed or angry, which can interfere with the development of an effective therapeutic relationship (Seligman, 1975; Schottenfeld, 1989).

There is a common misconception among many criminal justice professionals that sanctions tend to be most effective at high magnitudes. In fact, research suggests sanctions tend to be least effective at the lowest and highest magnitudes and most effective within the mid-range (Marlowe, 2007; Marlowe & Wong, 2008). Weak sanctions can precipitate "habituation" in which the individual becomes

accustomed to being punished (Marlowe & Kirby, 1999). Not only will this fail to improve behavior, it can make behavior worse by increasing the client's ability to withstand sanctions and hindering the credibility of the program. At the other extreme, sanctions that are too severe in magnitude can lead to "ceiling effects" in which further escalation of punishment is impracticable (Marlowe & Kirby, 1999). After an offender has been jailed, for example, the authorities may have used up their armamentarium of sanctions. Worse still, the offender may realize that the available options have been exhausted. At this point, future efforts to improve that individual's behavior may be quite challenging.

For this reason, drug courts were designed to administer a wider range of intermediate-magnitude sanctions that can be ratcheted upward or downward in response to clients' behaviors (NADCP, 1997). For example, clients might receive writing assignments, increased supervision requirements, fines, community service, or brief intervals of jail detention for noncompliance in the program. The sanctions are intended to be administered on a graduated or escalating gradient, in which the magnitude of the sanction increases progressively in response to successive infractions. This can enable drug courts to navigate between habituation and ceiling effects by matching the magnitude of sanctions to the severity and repetitiveness of clients' infractions.

Unfortunately, little research has investigated how sanctions are actually applied within drug court programs. Nearly all of the existing studies have focused on how clients and staff members *perceived* the utility of sanctions. For example, several researchers have conducted confidential focus groups with drug court participants to learn whether they considered sanctions to be a motivator to perform well in treatment. The results generally confirmed that participants viewed the threat of sanctions to be a potentially powerful inducement to succeed in the program, but only when they felt the magnitude of the sanctions was reasonable in light of

the seriousness or repetitiveness of infractions (Cooper, 1997; Goldkamp, White, & Robinson, 2002; Satel, 1998). Sanctions generally were viewed as detrimental to treatment goals when they were perceived as excessive in magnitude, or when it was difficult to predict the type or severity of the sanction that was likely to be imposed for specific infractions.

A recent qualitative survey found that staff members in drug courts similarly perceived sanctions to be potentially efficacious, but mostly for properly motivated or "sincere" clients (Lindquist, Krebs, & Lattimore, 2006). In that same study, staff members in drug courts reported that they applied a wider range of sanctions as compared to traditional criminal courts; the sanctions were reportedly more treatment-oriented as opposed to punitive in nature; and a greater emphasis was reportedly placed on tailoring the sanctions to the needs of the individual as opposed to emphasizing issues of standardization and equivalency.

The use of treatment-oriented or therapeutic sanctions has generated particular controversy within drug courts. Increasing treatment requirements in response to misbehavior could give the inadvertent message to clients that treatment is aversive and thus something to be avoided. For this reason, many drug courts distinguish between punitive sanctions for noncompliance with program requirements and therapeutic consequences for insufficient progress in treatment (Marlowe, in press). A client might, for example, receive a verbal reprimand or community service for failing to show up for counseling sessions, but might be required to attend a more intensive modality of treatment or more frequent self-help groups in response to continued drug-positive urine results. Unfortunately, little research exists to indicate whether clients recognize a meaningful distinction between therapeutic as opposed to punitive consequences.

Only two studies have been located that measured the effects of sanctions on drug offenders' outcomes. One correlational

study reported that outcomes in drug courts were significantly better among participants who perceived a direct and immediate connection between their own conduct and the imposition of sanctions and rewards in the program (Marlowe, Festinger, Foltz, Lee, & Patapis, 2005).

Another study randomly assigned drug-involved arrestees in a pre-trial supervision program to (1) the standard regimen of pre-trial services; (2) an intensive day-treatment program; or (3) a graduated sanctions condition, in which urine specimens were collected randomly on a weekly basis and participants received progressively escalating sanctions (including jail stays of up to 3 to 7 days) for positive results (Harrell, Cavanagh, & Roman, 1999). Contrary to expectations, the results revealed that participants preferred the sanctions condition to day treatment. Only 40% of participants assigned to day treatment agreed to participate in day treatment, whereas 66% of participants assigned to the sanctions condition agreed to comply with the sanction requirements (Harrell et al., 1999). Focus-group inquiries provided a possible explanation for this surprising finding. The participants reportedly objected to the substantial time burden and intrusiveness associated with day treatment, which outweighed the minimally intrusive procedures employed in weekly urine collection (Harrell & Smith, 1997). This suggests the participants might not have perceived a clear distinction between therapeutic and punitive consequences. Rather, they tended to view day treatment as a form of a sanction.

Importantly, in that same study, participants in both the treatment condition and the sanctions condition had lower rates of drug use than those receiving standard pre-trial services. However, participants in the sanctions condition had the best outcomes because they also had lower re-arrest rates extending out to 1 year post-entry (Harrell et al., 1999). These results confirmed that graduated sanctions, including

the threat of brief intervals of jail detention, could be acceptable and effective for some drug-abusing offenders.

The current study was undertaken to determine how sanctions are actually imposed within a felony drug court program. The objectives were as follows:

1. Determine whether sanctions are typically administered on a progressive gradient, in which lower-magnitude sanctions tend to be imposed for earlier infractions followed by higher-magnitude sanctions for repeated infractions.
2. Determine whether, and under what circumstances, high-magnitude sanctions are imposed for infractions early in the program.
3. Determine whether sanctions are imposed in accordance with participants' perceptions of the severity of the sanctions. That is, do participants tend to view sanctions imposed earlier in the program to be less severe than sanctions imposed for repeated infractions?
4. Determine how participants rank the perceived burden of treatment-oriented or therapeutic consequences in relationship to punitive sanctions.

The research design was a single-group, descriptive case study. Because the study was exploratory in nature and involved only a single drug court program, the results must be viewed as preliminary and replicated in other drug courts. Moreover, this drug court had been in operation for more than 8 years prior to the initiation of the research and the drug court judge held high offices in national and state professional drug court associations. As such, the operations of this drug court may reflect relatively more experienced practices as compared to typical drug court programs nationally.

METHODS

Participants

[2] The participants (N = 105) were recruited from a felony post-plea, pre-adjudication drug court located in the city of Philadelphia, PA. To be eligible for this drug court program, participants were required to (1) be at least 18 years of age; (2) be charged with a non-violent offense; (3) have no more than two prior non-violent convictions, juvenile adjudications, or diversionary opportunities; 4) be in need of treatment for drug abuse or dependence as assessed by a clinical case manager; and 5) be willing to participate in the program for at least 12 months.

The participants in the study were predominantly male (77%) and most self-identified as African-American (62%), Caucasian (24%) and/or Hispanic (25%). Their mean age was 24.10 years (SD = 7.25 years). Less than one-half (46%) of the participants had a high school education and one-half (50%) were regularly employed either full time or part time. Virtually all of the participants were unmarried (99%) and lived in the homes of other family members (79%) or friends (11%).

Nearly all of the participants (97%) were charged with delivery of a controlled substance or possession with the intent to deliver a controlled substance. In addition, 30% were charged with conspiracy related to a drug offense and 2% were charged with forgery (participants could have multiple charges). Participants also reported involvement in other criminal activities during the 6 months immediately preceding their entry into drug court, which may or may not have been detected by authorities or resulted in a formal charge, including theft offenses (13%), physical assaults (9%), weapons offenses (5%) or prostitution offenses (2%). At entry into the program, participants self-reported abusing cannabis (78%), alcohol (29%), opiates (8%),

cocaine/stimulants (9%), sedatives (5%) or PCP/hallucinogens (4%), and 35% reported regularly abusing multiple substances concurrently. Because the drug-use data were derived from self-report, it is possible that the use patterns were more serious than acknowledged by the participants.

Recruitment and Human Subjects Protections

Participants for the current study on sanctions were recruited from a larger study investigating the effects of contingent rewards on drug court outcomes. The larger study involves providing participants with tangible gift certificates for compliance in the drug court but does not involve any influence on the administration of sanctions.

Both studies were approved and continuously monitored by the Institutional Review Boards (IRBs) of the Treatment Research Institute and the Philadelphia Department of Public Health. Additionally, a Confidentiality Certificate was obtained from the U.S. Department of Health & Human Services, which shields the research data from a court order or subpoena (42 CFR Part 2a; 42 U.S.C. § 2a (6)). All of the research participants provided voluntary, written informed consent to be in the study, including a Health Insurance Portability & Accountability Act (HIPAA) Research Subject Authorization of Confidentiality & Privacy Rights.

Brief Description of the Drug Court Program

In this felony, post-plea, pre-adjudication drug court, defendants are required to plead no contest ("nolo contendere") to the initial charge(s) and the plea is held in abeyance pending graduation or termination from the program. Successful graduates have their no-contest plea withdrawn with prejudice and are eligible to have the record of the current offense(s) expunged if they remain conviction-

free with no evidence of resumed drug use for an additional 12 months. Record-expungement ordinarily enables the individual to respond truthfully on an employment application or similar document that he or she was not convicted of the offense (e.g., Festinger, DeMatteo, Marlowe, & Lee, 2005). The record-expungement petition is granted by the judge following a routine filing by the public defender at or near the 12-month anniversary of each client's graduation.

If a participant fails to complete the program, the no-contest plea is formally entered as a conviction. Given that most participants have been charged with a drug dealing-related offense, the potential sentence can be fairly severe depending upon the nature of the drug involved and the number and type of prior convictions. For example, if the substance was cocaine or heroin and the offender had no prior record, according to state sentencing guidelines the range would generally be 3 to 12 months of incarceration plus or minus 6 months at the court's discretion. If that same offender had two prior felony drug convictions, the range would be 15 to 21 months plus or minus 6 months at the court's discretion.

The drug court program is scheduled to be a minimum of 12 months in length and most participants require approximately 14 to 16 months to satisfy requirements for graduation. Participants generally are required to attend status hearings in court roughly every 4 to 6 weeks although the schedule of hearings may be increased in response to poor performance or serious infractions. Participants can be referred for substance abuse treatment to over 50 licensed programs in the Philadelphia region that are contracted to treat drug court clients. The full range of treatment modalities is available, including detoxification, residential, intensive outpatient, outpatient, and pharmacological services. Referrals are made based upon a clinical assessment of each participant's treatment needs that

includes the American Society of Addiction Medicine (ASAM, 2000) Patient Placement Criteria. Participants are stepped down to less intensive modalities of care based upon their clinical progress and the recommendations of treatment staff. A range of adjunctive services also is available where needed, including housing, educational, vocational, and psychiatric services.

All participants are assigned to a clinical case manager who coordinates treatment referrals, submits regular progress reports to the judge, and appears at status hearings to provide information requested by the court. Finally, participants are required to provide urine specimens on a random basis at least one time per week throughout their enrollment in the program. The frequency of urine testing may be ratcheted upward in response to evidence of relapse or referral to an intensive modality of care.

Imposition of Sanctions

As was noted previously, participants are generally required to attend status hearings approximately every 4 to 6 weeks. During the first 13 months of the program, participants in the current study attended an average of 10.59 (SD = 1.71) status hearings. At each hearing, if the participant was determined by the drug court team to have been non-compliant with program requirements, the judge, in consultation with the team, could elect to impose a sanction(s) and/or therapeutic consequence(s). The team also could administer rewards for good behavior and compliance. Therapeutic consequences are intended to be instructive in nature and to address poor treatment response, whereas punitive sanctions are intended to address more serious or willful infractions. Common infractions that resulted in sanctions or therapeutic consequences are listed below:

- missed treatment sessions
- missed case management sessions

- failure to provide scheduled urine specimens
- drug-positive urine specimens
- missed status hearings
- failure to comply with a previously imposed sanction (e.g., failure to complete an assigned essay)
- unsuccessful discharge or unexcused absence from a treatment program or recovery housing
- new criminal conviction

If a participant incurred a new criminal charge, the sanction was withheld until that charge was formally adjudicated.

Sanctions and therapeutic consequences were typically imposed in open court in the presence of other drug court clients, staff members, and observers. The types of consequences that could be imposed were described in a program manual and included the following. These consequences could be repeated as necessary.

Sanctions

- verbal reprimand
- 200 word essay
- jury box (observe court proceedings all day or all week)
- community service
- house arrest
- placement in a holding cell during the court hearing
- day visit to a local correctional facility for 1 to 2 days to observe in-jail substance abuse treatment sessions
- planned weekend incarceration
- immediate jail sanction of 1 to 7 days
- show-cause hearing (defendant must provide justification to remain in the program)
- termination from treatment court and sentencing on the original plea(s)

Therapeutic Consequences

- increased self-help meetings
- step up from case management only to outpatient (OP) treatment
- step up to intensive outpatient (IOP) treatment
- step up to residential treatment
- referral to a recovery house

Research staff members attended every court hearing and employed standardized procedures for recording all of the sanctions and therapeutic consequences that were ordered during the first 13 months of each participant's enrollment in the program. The consequences were recorded on a dated log in court and immediately transferred to a computer spreadsheet.

Participants' Perceptions of Sanctions

Participants were confidentially interviewed by research staff about their perceptions of the severity of the various sanctions and therapeutic consequences that could be imposed in the program. These interviews were conducted an average of 13.66 months (SD = 2.35 months) after participants' entry into the drug court program. This ensured that each participant had sufficient opportunity to be exposed to, or witness other clients being exposed to, the full range of consequences that were utilized in the program.

Participants were asked to rank order the possible consequences they could receive in the program in terms of "what would most trouble or bother you?" (from 1 = least troublesome to 15 = most troublesome). The consequences were presented in random order to avoid artificially influencing the order of the rankings. The same random order was presented to all participants.

This ranking task was conducted in two ways. Thirty-nine percent (n = 41) of the participants were given a

paper-and-pencil list of the possible consequences that were available in the drug court and asked to rank order them. In the rare instance when a participant was not familiar with a particular consequence, the interviewer provided a standard scripted clarification of that consequence. Sixty-one percent (n = 64) of the participants were presented with laminated cards, each listing a single consequence and including a standard definition of that consequence. Participants were then asked to sort the cards in order of least to most troublesome. The relative rankings from the paper-and-pencil procedure were highly and significantly correlated with the rankings from the card-sorting procedure (r_s = .95, $p < .001$); therefore, the data were combined across the two procedures. Participants required an average of 6.25 minutes (SD = 6.49 minutes) to complete the rankings and there was no difference in the time it took to complete the paper-and-pencil procedure versus the card-sorting procedure.

RESULTS

Imposition of Sanctions

[3] Figure 1 depicts the frequency with which various sanctions and therapeutic consequences were imposed during the first 13 months of the program. Seventy-seven percent of the participants received at least one sanction or therapeutic consequence during their first 13 months, averaging 3.44 (SD = 3.17) sanctions or therapeutic consequences per client.

The most frequently administered sanctions were of generally lesser magnitude and included writing essays, verbal reprimands, and requirements to observe the court proceedings from the jury box (imposed on approximately 45% to 55% of participants). The second most frequently imposed sanctions included mandatory visits to the local correctional facility to attend in-custody substance abuse treatment groups (imposed on approximately 35% of

participants) and brief jail sanctions lasting a few days (29% of participants) or a weekend (7% of participants).

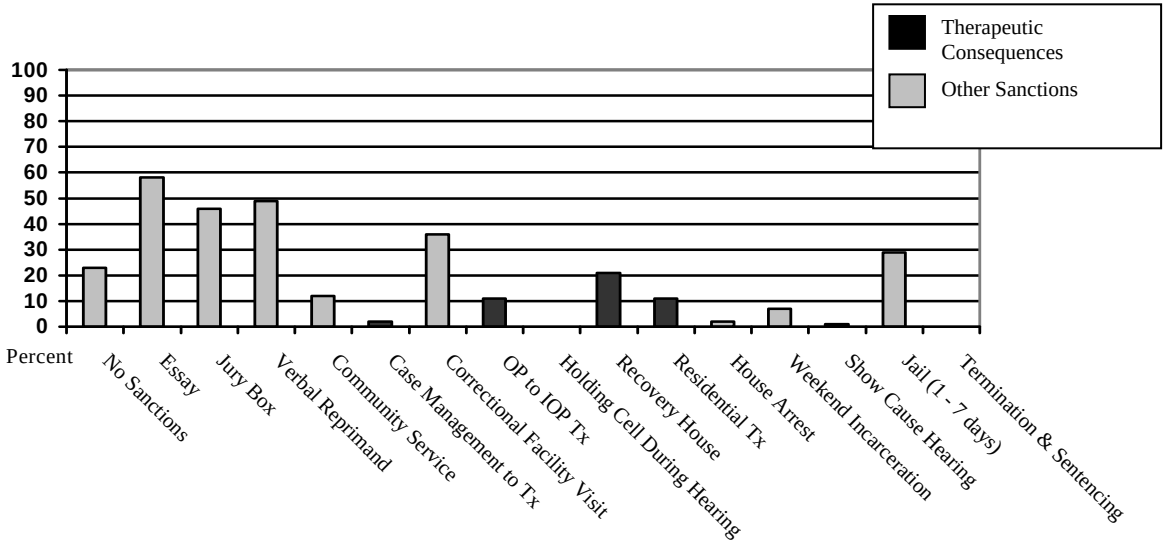


Figure 1. Percentages of participants receiving various sanctions and therapeutic consequences in an adult felony pre-adjudication drug court. Tx = treatment. OP = outpatient. IOP = intensive outpatient.

The most commonly imposed therapeutic consequences included transfer to a recovery house (21% of participants) or residential treatment (11% of participants) or step-up to IOP treatment (11% of participants). Very few participants were scheduled for a show-cause hearing (1%) and none were terminated from the program during their first 13 months. This reflects the court's general philosophy that participants should be given ample opportunity to improve their behavior before expulsion, provided that they do not pose an immediate risk to public safety.

Figure 2 depicts the average order in which the sanctions or therapeutic consequences were imposed. A writing essay was typically ordered as the first sanction for most participants, followed by a verbal reprimand or jury box as the second sanction. Therapeutic consequences such as stepped-up care or transfer to a recovery house were typically imposed subsequently, after an average of roughly three to four infractions. Finally, severe sanctions such as weekend incarceration or jail detention were imposed after an average of roughly three to five infractions.

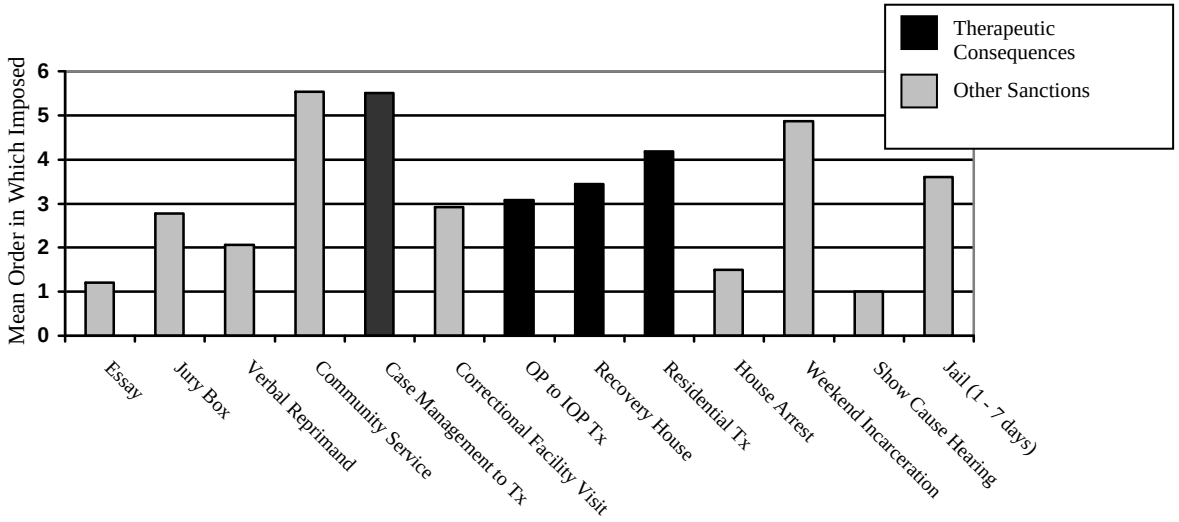


Figure 2. Average order in which sanctions and therapeutic consequences were imposed in an adult felony pre-adjudication drug court. Tx = treatment. OP = outpatient. IOP = intensive outpatient.

Importantly, the average order in which consequences were imposed was unaffected by how often they were imposed. As a result, some of the most serious sanctions, although imposed infrequently, were administered after an average of only one to two infractions. For example, although house arrest was imposed on only about 3% of the participants (see Figure 1) it was imposed on those few individuals after an average of only roughly one infraction (see Figure 2). This suggests that a small proportion of the participants may have committed more serious infractions early in the program resulting in the rapid imposition of more serious consequences.

Community service was meted out later than might be anticipated, most likely because substantial resources are often required to monitor participants' compliance with the conditions of community service. Finally, stepping participants up from case management only to OP treatment also occurred relatively later in the program after multiple infractions. This is not surprising, given that most participants would only have been advanced to case management alone after having completed several earlier phases of the program. An emergence of new infractions would need to have occurred late in the program to necessitate a return to OP care.

Returns from Bench Warrants

Severe sanctions such as weekend incarceration or jail detention are intended to be reserved for more serious types of infractions, such as absconding from the program or committing new offenses. It is possible that jail sanctions were imposed most readily on individuals who had been returned on bench warrants as a means of "getting their attention" and giving them exposure to what is to come if they do not improve their conduct. To test this hypothesis, analyses were conducted contrasting those individuals who were issued at least one bench warrant (20% of the sample) to

those who had never been issued a bench warrant (80% of the sample). Among participants who were issued at least one bench warrant, the mean number of warrants was 1.24 (SD = 0.44).

Analyses confirmed that participants returned on bench warrants received jail sanctions significantly sooner than those who had never been issued a bench warrant. Specifically, participants with at least one bench warrant received jail sanctions after an average of 2.30 infractions, whereas those without a bench warrant received jail sanctions after an average of 4.25 infractions ($p = .011$). Individuals returned on bench warrants were also more likely to be placed on house arrest ($p < .01$) or scheduled for a show-cause hearing ($p < .05$) and were more readily transferred to residential treatment or a recovery house ($p < .05$). This confirms that severe sanctions and restrictive therapeutic consequences were imposed more quickly on individuals who had absconded from the program or failed to show for court hearings.

Participants' Perceptions of Sanctions

Figure 3 depicts participants' mean rankings of the perceived severity of the various sanctions and therapeutic consequences that could be imposed in the program. The relative rankings are consistent with what might be expected. Participants generally ranked as least troublesome those sanctions that are intended to be low in magnitude and remedial in nature (essays, jury box, verbal reprimands, and community service). In contrast, participants ranked as most troublesome those sanctions that are intended to be high in magnitude and punitive in nature (house arrest, jail detention, show-cause hearings, and termination). Participants generally assigned mid-tier rankings to therapeutic consequences involving increased treatment requirements.

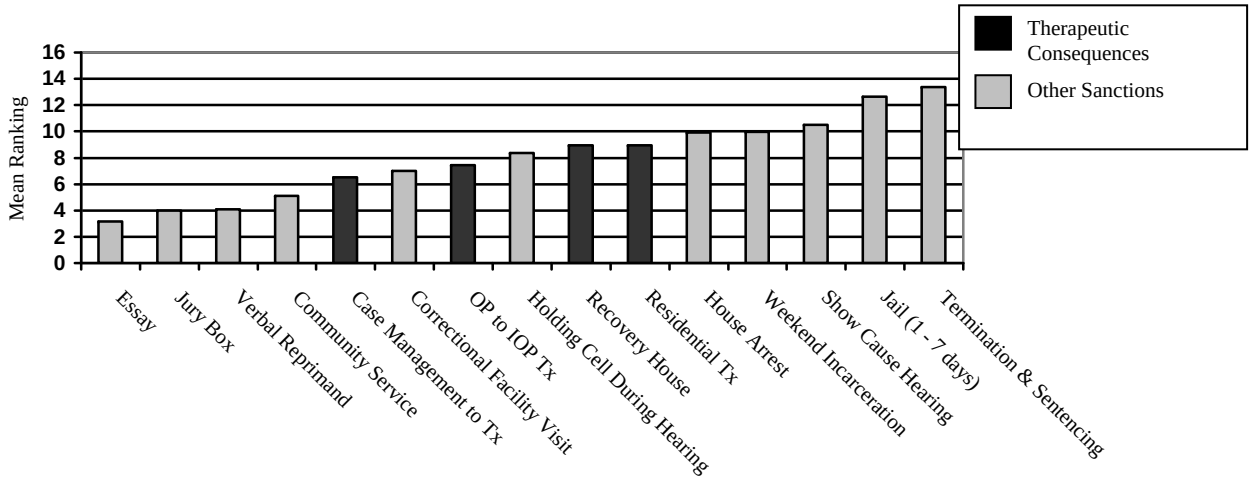


Figure 3. Participants' rankings of the relative severity of sanctions and therapeutic consequences in an adult felony pre-adjudication drug court. Range = 1 (least troublesome or bothersome) to 15 (most troublesome or bothersome). Tx = treatment. OP = outpatient. IOP = intensive outpatient

Importantly, the frequency with which various consequences were imposed in the program was significantly correlated with participants' perceptions about the relative severity of those consequences. Consequences that were ranked as less severe by the participants tended to be imposed more frequently, whereas consequences that were ranked as more severe tended to be imposed less frequently ($r_s = .60$, $p = .017$).

DISCUSSION

[4] This descriptive case study of a felony drug court program was undertaken to determine whether sanctions and therapeutic consequences tend to be imposed on a progressive gradient and whether they are administered in accordance with participants' expectations about the relative severity or burden of those consequences. The results confirmed that the most frequently administered consequences were generally of lesser magnitude, including writing essays, verbal reprimands, and a requirement to observe the court proceedings from the jury box. Sanctions that were intended to give participants a brief exposure to detention were imposed less frequently, although on a substantial plurality (approximately one third) of participants who had committed multiple infractions. Very few participants were scheduled for a show-cause hearing (1%) and none were terminated from the program during their first 13 months.

On average, lower magnitude sanctions tended to be imposed for the first few infractions, followed subsequently by stepped-up treatment requirements and finally by severe sanctions involving brief jail detention. There were exceptions, however, for roughly one-fifth of the participants who had been issued a bench warrant for absconding from the program or failing to show up for court hearings. For those individuals, punitive sanctions involving jail detention, house arrest, or show-cause hearings were more likely to be imposed or were imposed after a smaller number of

infractions. This likely stemmed from the serious nature of their transgressions and an apparent desire on the part of the judge and the drug court team to issue a clear warning of what would happen if these clients did not improve their conduct and obey the rules of the program. Individuals returned on a bench warrant were also more likely to be referred to recovery housing or transferred to a residential treatment setting. This may have reflected greater psychosocial dysfunction or instability on the part of individuals who had absconded from the program.

Importantly, the drug court generally imposed consequences in a manner that was consistent with how participants viewed the relative severity of those consequences. Specifically, consequences that were perceived as less burdensome tended to be imposed more frequently and after the first few infractions, whereas consequences that were perceived as more burdensome tended to be imposed less frequently and after repeated infractions. This suggests that most participants had a reasonably accurate expectation about how consequences were likely to be imposed in the program and were unlikely to be surprised by unexpectedly harsh or unusually lenient responses. It should also be noted that participants tended to rank increased treatment requirements as moderately burdensome, ranging somewhere between mild admonitions or chores at the lower end of perceived burden and brief intervals of jail detention at the upper end of perceived burden.

Limitations

There were several important limitations to this study that must be borne in mind when interpreting the results. First, as was noted earlier, the study was exploratory in nature and involved only a single drug court program. Therefore, the results must be replicated in other settings. Second, this was a relatively experienced drug court with seasoned staff.

As such, the results might not be representative of the practices of typical drug court programs nationally.

Note also that virtually all of the participants in the study had been charged with a felony offense involving the delivery of, or possession with the intent to deliver, a controlled substance. In this pre-adjudication drug court, they could have their guilty plea for this serious charge vacated and avoid incarceration if they were successful in the program. On the other hand, if they were unsuccessful, they often faced substantial jail or prison time. This legal arrangement provided a high degree of coercive leverage over the participants, which could have enabled the drug court staff to be more lenient or prudent in their imposition of other types of consequences. In addition, because many of the participants were involved in a separate study of contingent rewards, the augmented positive reinforcement in that study might have lent additional control over their behavior, thus reducing the need for more severe sanctions.

For these reasons, it is important to replicate the findings in other contexts. In particular, it would be important to examine the administration of sanctions in misdemeanor or post-adjudication drug courts, in which participants face relatively lesser criminal sentences or have already been sentenced on the original drug offense and may only face a potential technical violation of probation charge.

Recall further that the data were only collected during the first 13 months of participants' enrollment in the program. Presumably, more severe sanctions would be imposed for continued transgressions occurring after a longer interval of enrollment, including a greater use of jail sanctions, show-cause hearings, and termination.

Several of the potential consequences in the program could be imposed over a range of time intervals. For example, jail sanctions could be imposed for between 1 and 7

days. These time intervals were combined in the data analyses and in participants' rankings of the relative severity of the consequences. It is unknown what information might have been lost as a result of combining the time intervals in this manner. For example, 3 days of jail time might be perceived by participants as less burdensome than 7 days of residential treatment, although jail time might be perceived as more burdensome than residential treatment over equivalent time intervals. Future research will need to take a more fine-grained look at such gradations in the magnitude and length of sanctions and therapeutic consequences.

Consequences also were frequently imposed based upon the drug court team's global appraisal of participants' performance rather than being tied to specific infractions. For example, a participant who missed a treatment session and also provided a drug-positive urine specimen might have received two separate sanctions for the two infractions or one higher-magnitude sanction for the overall pattern of misconduct. In addition, good performance in some areas of functioning might have cancelled out sanctions for other infractions. For example, a participant who missed a counseling session but still maintained abstinence might not have been sanctioned for the missed appointment because of the continued sobriety. Therefore, it was often difficult to determine which consequences were being imposed for which specific behaviors. It was not possible, for example, to discern whether punitive sanctions tended to be imposed for willful misconduct, as contrasted with therapeutic consequences being imposed for non-responsiveness to treatment. Future research should attempt to disentangle how specific types of sanctions or therapeutic consequences are applied to specific infractions.

Finally, this study could not examine the influence of sanctions on outcomes because no experimental control was exerted over the imposition of the sanctions. By the design of the program, participants in the drug court should have

received more sanctions for the very reason that their performance was determined to be insufficient. Therefore, greater imposition of sanctions would be expected to correlate with poorer performance. This confounded correlation could contribute to the unwarranted conclusion that sanctions made outcomes worse. Further research is needed similar to the study conducted by Harrell and colleagues (1999) that brings the administration of sanctions under experimental manipulation.

REFERENCES

American Society of Addiction Medicine. (2000). *Patient placement criteria for the treatment of substance-related disorders* (2nd ed., revised). Chevy Chase, MD: Author.

Cooper, C.S. (1997). *Drug court survey report: Executive summary*. Washington, DC: Drug Court Clearinghouse and Technical Assistance Project, Office of Justice Programs, U.S. Department of Justice. Retrieved August 24, 2007 from http://spa.american.edu/justice/documents/1931.pdf.

Festinger, D.S., DeMatteo, D.S., Marlowe, D.B., & Lee, P.A. (2005). Expungement of arrest records in drug court: Do clients know what they're missing? *Drug Court Review, 4*(1), 1-21.

Goldkamp, J.S., White, M.D., & Robinson, J.B. (2002). An honest chance: Perspectives on drug courts. *Federal Sentencing Reporter, 6*, 369-372.

Harrell, A., Cavanagh, S., & Roman, J. (1999). *Final report: Findings from the evaluation of the District of Columbia Superior Court drug intervention program*. Washington, DC: The Urban Institute.

Harrell, A., & Roman, J. (2001). Reducing drug use and crime among offenders: The impact of graduated sanctions. *Journal of Drug Issues, 31*, 207-232.

Harrell, A., & Smith, B. (1997). *Evaluation of the District of Columbia Superior Court drug intervention program: Focus group interviews*. Washington, DC: The Urban Institute.

Lindquist, C.H., Krebs, C.P., & Lattimore, P.K. (2006). Sanctions and rewards in drug court programs: Implementation, perceived efficacy, and decision making. *Journal of Drug Issues, 36,* 119-146.

Marlowe, D.B. (2007). Strategies for administering rewards and sanctions. In J. E. Lessenger & G. F. Roper (Eds.), *Drug courts: A new approach to treatment and rehabilitation* (pp. 317-336). New York: Springer.

Marlowe, D. B. (in press). Application of sanctions. In C. Hardin & J. N. Kushner (Eds.), *Quality improvement for drug courts: Evidence-based practices*. Alexandria, VA: National Drug Court Institute.

Marlowe, D.B., Festinger, D.S., Foltz, C., Lee, P.A., & Patapis, N.S. (2005). Perceived deterrence and outcomes in drug court. *Behavioral Sciences & The Law, 23*, 183-198.

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

Marlowe, D. B., & Wong, C.J. (2008). Contingency management in adult criminal drug courts. In S. T. Higgins, K. Silverman, & S. H. Heil (Eds.), *Contingency management in substance abuse treatment* (pp. 334-354). New York: Guilford Press.

Martin, G., & Pear, J. (1999). *Behavior modification: What it is and how to do it* (6th ed.). Upper Saddle River, NJ: Prentice Hall.

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

Newsom, C., Favell, J.E., & Rincover, A. (1983). The side effects of punishment. In S. Axelrod & J. Apsche (Eds.), *The effects of punishment on human behavior* (pp. 285-316). New York: Academic.

Satel, S.L. (1998). Observational study of courtroom dynamics in selected drug courts. *National Drug Court Institute Review, 1*(1), 43-72.

Seligman, M.E.P. (1975). *Helplessness.* San Francisco: W.H. Freeman.

Schottenfeld, R.S. (1989). Involuntary treatment of substance abuse disorders: Impediments to success. *Psychiatry, 52*, 164-176.

Sidman, M. (1988). *Coercion and its fallout.* Boston: Authors Cooperative.

Tauber, J. (2000). *The critical need for jail as a sanction in the drug court model.* Alexandria, VA: National Drug Court Institute.

EXAMINING THE DIFFERENTIAL IMPACT OF DRUG COURT SERVICES BY COURT TYPE: FINDINGS FROM OHIO

By Deborah K. Shaffer, Ph.D., Shelley J. Listwan, Ph.D., Edward J. Latessa, Ph.D., and Christopher T. Lowenkamp, Ph.D.

The drug court model developed out of an organizational need for a community-based alternative to incarceration. These courts attempt to reduce substance abuse and recidivism through techniques such as monitoring, alternative sanctions, and treatment. Evaluations of drug courts around the country are encouraging; however, not all of the research shows a reduction in rearrest rates. The fact remains that despite the rapid expansion of drug courts and their growing prevalence and popularity, little is known about the ability of the drug court model to achieve its objectives in a variety of circumstances. The current study explores the characteristics and outcomes among seven adult and three juvenile drug courts across Ohio. The findings suggest that drug courts reduce recidivism rates, regardless of drug court type.

This research was supported by grant #00DGPEI7375 and #98DGPEI7375 from the Ohio Office of Criminal Justice Services (OCJS). Views expressed are those of the authors and do not necessarily reflect the views of OCJS.

Deborah K. Shaffer, Ph.D., is an assistant professor at the University of Nevada, Las Vegas, Department of Criminal Justice.

Shelley J. Listwan, Ph.D., is an assistant professor in the Department of Justice Studies, and a research fellow with the Institute for the Study and Prevention of Violence at Kent State University.

Edward J. Latessa, Ph.D., is a Professor and Head of the Division of Criminal Justice at the University of Cincinnati. He has served as President of the Academy of Criminal Justice Sciences (1989-90) and has received several awards including the August Vollmer Award from the American Society of Criminology (2004).

Christopher T. Lowenkamp, Ph.D., is an assistant research professor at the University of Cincinnati, Division of Criminal Justice, and the Director of the Center for Criminal Justice Research. Prior to his appointment at the University, Christopher was an adult probation officer and the emergency jail release coordinator in Akron, Ohio.

Direct all correspondence to Deborah K. Shaffer, Assistant Professor, Department of Criminal Justice, University of Nevada, Las Vegas, 4505 Maryland Parkway, Box 455009, Las Vegas, NV 89154-5009.

ARTICLE SUMMARIES

OHIO'S DIFFERING DRUG COURTS

[5] This study examines several different types of drug courts found in Ohio: felony, misdemeanor, and juvenile. It is as yet unclear if the positive effects seen in drug courts are uniform across court type.

METHODS

[6] The three court types were evaluated using a quasi-experimental design.

RESULTS IN REARREST RATE

[7] Drug court clients were rearrested less than their respective comparison groups regardless of court type. Regression analysis specified a number of different predictors of rearrest for clients of each court type.

CONCLUSIONS FROM THE EVALUATION

[8] Drug court appears to be effective across population, albeit at differing rates. The efficacy of the intervention is supported in general, although many avenues of research remain unexplored.

INTRODUCTION

Drug courts have played a significant role in the treatment of drug-abusing offenders over the last 15 years. The recognition that drug abuse is a chronic and relapsing condition that requires intensive treatment has changed how the drug offender is treated in the criminal justice system. The drug court movement emerged in the late 1980s and since then has burgeoned into a popular method for treating the drug-abusing offender. Today, there are over 1,500 adult drug courts (Bureau of Justice Assistance, Drug Court Clearinghouse Project, 2006a) and nearly 500 juvenile drug courts across all 50 states (Bureau of Justice Assistance, Drug Court Clearinghouse Project, 2006b) and it is estimated that over 70,000 offenders are participating in drug court at any given time (Huddleston, Freeman-Wilson, Marlowe, & Roussell, 2005).

The rapid expansion of the drug court concept has occurred for several reasons. Most notably, drug courts are the result of a political and social movement against drugs. The war on drugs severely taxed the criminal justice system and drug courts were offered as a cost effective alternative. In addition, drug courts may be seen as an outgrowth of the interest in developing community-based, team-oriented, criminal justice innovations that have the flexibility to mobilize community support and resources (NADCP, 1997). Research also has revealed that treatment for drug-addicted offenders can work to reduce addiction and drug-related crime (Anglin & Hser, 1990; French, Zarkin, Hubbard, & Valley, 1993; Prendergast, Anglin, & Wellisch, 1995; Van Stelle, Mauser, & Moberg, 1994), even when treatment is involuntary (Anglin, Brecht, & Maddahian, 1989; Hubbard et al, 1989). Taken together, these factors have been instrumental in shaping the drug court movement.

[5] While drug courts generally are implemented at the local level, states often play an integral role in the

development, support, and evaluation of these specialized courts. Ohio's support for the drug court model is evidenced in a number of ways. First, the state routinely provided funding for the development and sustainability of the courts over the last 10 years. Second, resources were dedicated for evaluation and research activities. The Supreme Court of Ohio funded a statewide initiative requiring all of the drug courts to collect specific data elements for future evaluation research. Finally, the Supreme Court provided training and conference opportunities for practitioners through a number of organizations, including the Ohio Drug Court Practitioner Network. This combined support has resulted in the implementation of over 60 drug courts across the state. Given this level of commitment by the state, it is important to ascertain whether drug courts are effective on a statewide level. The current study will examine the combined efforts of several drug courts operating in Ohio.

EXISTING RESEARCH

Drug courts differ substantially from one jurisdiction to the next, which makes comparisons between evaluations that use different designs and data collection tools problematic. Despite these limitations, much of the existing research places the drug court model in a positive light (Brewster, 2001; Goldkamp & Weiland, 1993; Latessa, Listwan, Shaffer, Lowenkamp, & Ratansi, 2001; Peters, Haas, & Murrin, 1999; Spohn, Piper, Martin, & Frenzel, 2001). Research also reports that graduates of drug court programs fare significantly better than non-graduates (Peters et al., 1999; Vito & Tewskbury, 1998) even in a three year follow up period (Dynia & Sung, 2000). In addition to rearrest, drug courts can have other important outcomes. Sechrest and Shicor (2001) report that graduates of a drug court in California are more likely to be self-supporting. An observational study by Wolf and Colyer (2001) revealed that those who successfully completed the program were less

likely to present with problems at treatment review hearings with the judge.

Several national summaries of drug court evaluations also conclude that drug courts are seeing moderate success. Specifically, in 1997 the U.S. Government Accountability Office (GAO) reviewed several evaluations. While the GAO (1997) concluded the research was limited, they were generally optimistic about the effectiveness of drug courts. This review was updated in 2005 when the GAO reviewed 27 evaluations representing 39 drug courts. Twenty-three of these evaluations included recidivism data which the GAO used to conclude that drug court participants tend to recidivate less often, have fewer rearrests or reconvictions, and take longer to recidivate than comparison group members (GAO, 2005). Belenko (1998; 1999; 2001) reached similar conclusions in his reviews of the research. He argued that drug courts appear successful in reducing recidivism and substance abuse, have high retention rates, provide close supervision and monitoring, and have successfully increased partnerships among criminal justice agencies. Similarly, meta-analytic reviews of drug court effectiveness have been supportive with average effect sizes ranging from 9% to 24% (Aos, Phipps, Barnoski, & Lieb, 2001; Lowenkamp, Holsinger, & Latessa, 2005; Shaffer, 2006; Wilson, Mitchell, & MacKenzie, 2002).

Although much of the research is promising, it is important to acknowledge that some courts have failed to show evidence of a reduction in criminal behavior as measured by arrest. Belenko, Fagan, and Dumanovsky (1993) found no difference in arrest rates between drug court and comparison group members in New York City. Similarly, Deschenes and Greenwood (1994) report no difference in arrest rates among drug court participants and controls in Maricopa County, Arizona, although they did find that drug court participants had fewer technical violations. Findings from a study of a Denver drug court failed to find

significant difference in arrests among similar offenders processed in previous courts (Granfield, Eby, & Brewster, 1998). While Listwan, Sundt, Holsinger and Latessa (2003) found arrests for drug related offenses were higher among comparison group members, they failed to find differences in the overall arrest rate. Finally, Meithe, Lu, and Reese (2000) found that drug court participants in Las Vegas had higher recidivism rates (both drug and non-drug offenses) than comparison group subjects.

While many of the reviews focus on adult drug courts, it imperative that evaluations also consider juvenile drug court participants. While juvenile drug courts can be very similar to adult drug courts in many respects, they inevitably must contend with a number of issues unique to an adolescent population. Specifically, the court must consider the impact of system involvement on school access and family dynamics (Cooper, 2002), or the impact of foster care involvement on treatment and program retention. Moreover, it also may be more difficult to ensure that juvenile drug courts are receiving appropriate clients as they may accept juveniles who are simply experimenting with drugs instead of dedicating resources only to those with an assessed drug addiction (Sloan & Smylka, 2003).

Given the unique circumstances facing juvenile drug courts, it is important to consider their effectiveness separate from that of adult drug courts. However, the research on juvenile drug courts is relatively scarce and the evaluations that have been completed are decidedly mixed. There is some research to support the efficacy of juvenile drug courts (Canterbury, 2003; Rodriguez & Webb, 2004; Thompson, 2002), although others have found null (Anspach, Ferguson, & Phillips, 2003; O'Connell, Nestlerode, & Miller, 1999) or negative (Wright & Clymer, 2001) effects.

This study will attempt to add to the existing literature by providing a multi-site impact study of both adult

and juvenile drug courts in Ohio. This study examines the differences between drug court and comparison group members along a variety of measures. Examining rearrest rates between both groups will provide an assessment of the impact of drug courts on future criminal behavior. While most published evaluations report outcomes of only one court, the current study reports outcomes of several adult and juvenile drug courts across the state in an effort to fill this gap in our overall knowledge of drug courts. The current study will assess whether drug courts are effective in reducing recidivism and identify the factors associated with failure.

METHODS

Research Design and Subjects

[6] The evaluation utilized a quasi-experimental matched comparison group design in an effort to estimate the impact of drug courts on future criminal involvement.[1] Three distinct types of drug courts were evaluated: 1) common pleas (felony), 2) municipal (misdemeanor), and 3) juvenile. Random assignment to groups was not feasible; however, in order to develop the comparison group, the groups were matched with regard to selected demographic characteristics as well as the presence of a substance abuse problem. The criteria for inclusion in the comparison group was that each participant must have (1) a reported substance abuse problem; and (2) be eligible for the drug court program. The quasi-experimental design is a common approach with program evaluations since random assignment is difficult to obtain in court-related programs.[2]

---

[1] The Summit County Juvenile Drug Court has used random assignment.

[2] There are several problems with a quasi-experimental design which should be noted. First, there are often important differences between those offenders who participate in a drug court and those who do not. When known, significant differences are controlled

Similar to other states, Ohio has seen a tremendous growth in the number of existing drug courts. Since the first drug court began accepting participants in 1995, over 40 counties have developed and implemented drug courts of their own (Bureau of Justice Assistance, Drug Court Clearinghouse Project, 2006a). This study provides a snapshot of participants processed through ten of these courts between 1997 and 2000. The ten courts were chosen because they provide an adequate sampling of both adult and juvenile drug courts. Moreover, the courts have been in existence for at least 4 years, thus providing sufficient follow up periods.

Ohio's criminal courts are structured along three levels. Common pleas and municipal courts process adult offenders. The common pleas courts typically process those charged with felony offenses while the municipal courts typically target offenders charged with misdemeanor offenses. The juvenile courts process youth (typically under the age of 18) who have been charged with felony, misdemeanor, or status offenses. The current sample includes 788 drug court participants and 429 comparison group members in the common pleas court group; 556 drug court participants and 228 comparison group members in the municipal court group; and 310 participants and 134 comparison group members in the juvenile court group.[3]

---

for, however, offender motivation to change and other important factors cannot be accounted for. Second, one cannot assume that some members of the comparison group did not receive treatment of some type. What we do know is that they did not receive the "drug court" model; however, it is also likely that treatment services similar to those offered through drug courts were available to these offenders.

[3] For a detailed description of the various drug courts included in this study see: Shaffer, Johnson, and Latessa, *Description of Ohio Drug Courts* (2000).

While there are basic differences between the types of drug courts evaluated in this study, the courts are similar to one another and to drug courts across the country. Specifically, community-based treatment services, judicial monitoring, and frequent urinalysis are utilized by each site. Moreover, the eligibility criteria used by each court is based on the current and past behavior of the defendant and a willingness to participate in the services provided. The judge, prosecutor, drug court staff, and treatment agency typically screen the potential participants. The courts generally accept individuals who have been arrested for a drug or drug-related crime and/or exhibit a drug problem. Upon disposition, offenders are often given a suspended sentence of jail or prison time; in the event that they fail to successfully complete the program, the court may invoke the terms. Traffickers, those with a history of violence, sex offenders, severe mental illness, and those with acute health conditions are excluded from participation in the drug courts. Finally, offenders who refuse to participate in the drug court program have their cases adjudicated through traditional courts and typically receive probation or, in some cases, jail or prison.

Variables

There were a number of independent variables examined in this study. Specifically, demographics such as age, race, gender, employment, education, and marital status were examined to determine the comparability of groups. Prior arrest also was used as a measure of criminal history as were factors related to current charges. The primary dependent variables included in this study were arrest and whether an individual had been arrested on multiple occasions. The average follow-up period was 21.4 months for the common pleas courts, 25.6 months for municipal drug courts, and 27.7 months for the juvenile courts.

RESULTS

Intake Data

[7] Table 1 compares the various drug court groups with regard to race, gender, age, marital status, education, and employment at the time of arrest. It also illustrates prior criminal record and information related to current charge. The common pleas drug court and comparison group members were very similar with regard to social demographic characteristics. The typical person in each group was non-white, male, approximately 31 years of age, working part-time, and not married. Drug court participants, however, were significantly more likely to have graduated from high school than members of the comparison group. Common pleas drug court participants were more likely to have a prior record than members of the comparison group.

Similarly, clients of the municipal drug courts and comparison group differed only in terms of education and employment. The typical participant in each group was non-white, male, 30 years of age, and not married. However, drug court participants were not only more likely to have graduated from high school but also were more likely to be employed full-time. Finally, the groups had similar prior records; in fact, the majority of both groups had been previously arrested.

Table 1. Background Characteristics of Drug Court Participants and Comparison Group Members

Characteristics		Common Pleas DC % (n=788)	Common Pleas Comp % (n=429)	Municipal DC % (n=556)	Municipal Comp % (n=288)	Juvenile DC % (n=310)	Juvenile Comp % (n=134)
Race[a]							
	White	48.8	49.8	45.5	32.3	69.7	56.7
	Non - White	51.2	50.2	54.5	67.7	30.3	43.3
Gender							
	Male	76.7	72.5	72.9	78.0	75.5	72.4
	Female	23.3	27.5	27.1	22.0	23.9	27.6
Age (mean)							
	Adult	32.22	30.91	31.58	29.72	---	---
	Juvenile	---	---	---	---	15.77	15.58
Marital Status							
	Married	23.0	23.4	15.8	12.0		
	Not Married	77.0	76.6	84.2	88.0		

Table 1 Con’t.

Highest Grade Completed[b]						
	< High School	58.5	80.4	38.7	53.7	
	High School	41.5	19.6	61.3	46.3	
Highest Grade Completed						
	< 9th					35.8	43.3
	9th-10th grade					55.1	44.1
	11th-12th grade					7.1	12.6

The majority of individuals in the juvenile drug courts and comparison group were male. Despite this similarity, they differed significantly on a number of dimensions. Members of the drug court group were more likely to be white, more educated, and employed. Similar to the other groups, the majority of both participants and comparison group members had a prior record; however, the drug court participants were significantly more likely to have a prior record.

In addition to examining demographics and criminal history, it is also important to consider current charges and legal status. The majority of adult offenders, both in the treatment and comparison groups, had been convicted of drug charges. In contrast, members of the juvenile drug court and comparison group were typically charged with property offenses. While the majority of both juvenile groups had been adjudicated, juvenile drug court clients were significantly more likely to have received treatment in lieu of conviction.

Rearrest Rates

Table 2 illustrates the differences in rearrest rates between drug court participants and comparison group members by court type. For each court type, drug court clients fared significantly better than comparison group members in terms of rearrest. Specifically, approximately 32% of the common pleas drug court clients were rearrested versus 44% of the comparison group. Similarly, 41% of the municipal drug court clients were rearrested compared to 49% of the comparison group, while nearly 56% of the juvenile drug court participants were rearrested compared with 75% of the comparison group.

Table 2. Rearrest of Drug Court Participants and Comparison Group Members

	Common Pleas		Municipal		Juvenile	
	DC %	Comp %	DC %	Comp %	DC %	Comp %
Characteristics	(n=788)	(n=429)	(n=556)	(n=288)	(n=310)	(n=134)
Rearrest[a]						
Yes	31.8	44.2	41.0	49.1	55.7	75.0
No	68.2	55.8	59.0	50.9	44.3	25.0
Arrested Multiple Times[b]						
Yes	66.3	64.3	26.3	39.3	55.1	68.7
No	33.7	35.7	73.7	60.7	44.9	31.3

[a]Common Pleas: χ^2 =18.583, p=.000; Municipal: χ^2 =4.710, p=.030; Juvenile 5.121, p=.024

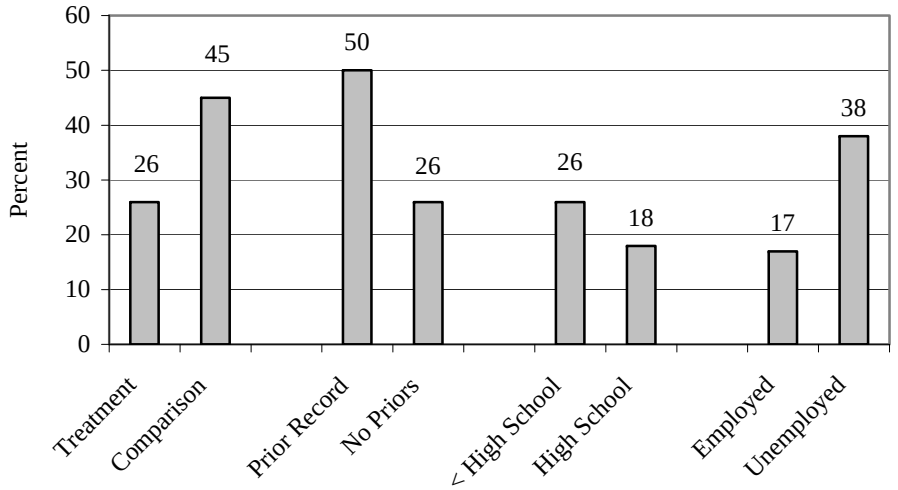
[b]Municipal: χ^2 =8.941, p=.003

In addition to examining whether or not participants had been rearrested, the study examined differences in the frequency of arrests. There were no significant differences in terms of the number of arrests for the common pleas and the juvenile groups. However, municipal drug court participants were arrested significantly fewer times than their comparison group counterparts. Over 26% of the municipal drug court group was arrested on multiple occasions versus 39% of the comparison group.

Determinants of Rearrest

It is also important to explore the factors associated with rearrest to be certain that the services delivered by drug courts have an impact independent of the characteristics of the individuals they serve. Logistic regression was used to identify factors associated with recidivism and to control for differences between the groups. As illustrated in Figure 1, a number of factors predicted rearrest for members of the common pleas group. Specifically, prior record, education, employment status, and group membership (e.g., drug court vs. comparison) were all significant. Those who were members of the comparison group, had a prior record, had less than a high school education, and were unemployed, were significantly more likely to be rearrested.

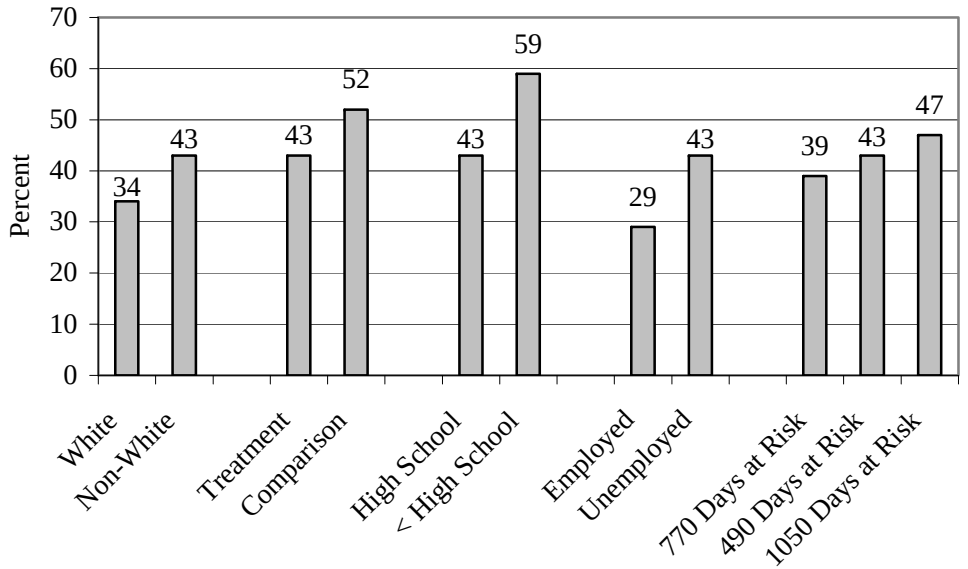
Figure 1. Impact of Significant Predictors on Probability of Rearrest: Adult Common Pleas Court, N = 1217[a]



[a]Only the probabilities for the significant factors from the logistic regression are depicted in this figure.

Figure 2 illustrates the factors predicting rearrest for the municipal group. Similar to the common pleas group, logistic regression analysis indicated that race, education, employment, time at risk, and group status all were related to rearrest. Offenders who were non-white, less than high school educated, unemployed, at risk for rearrest the longest, and comparison group members, were significantly more likely to be rearrested.

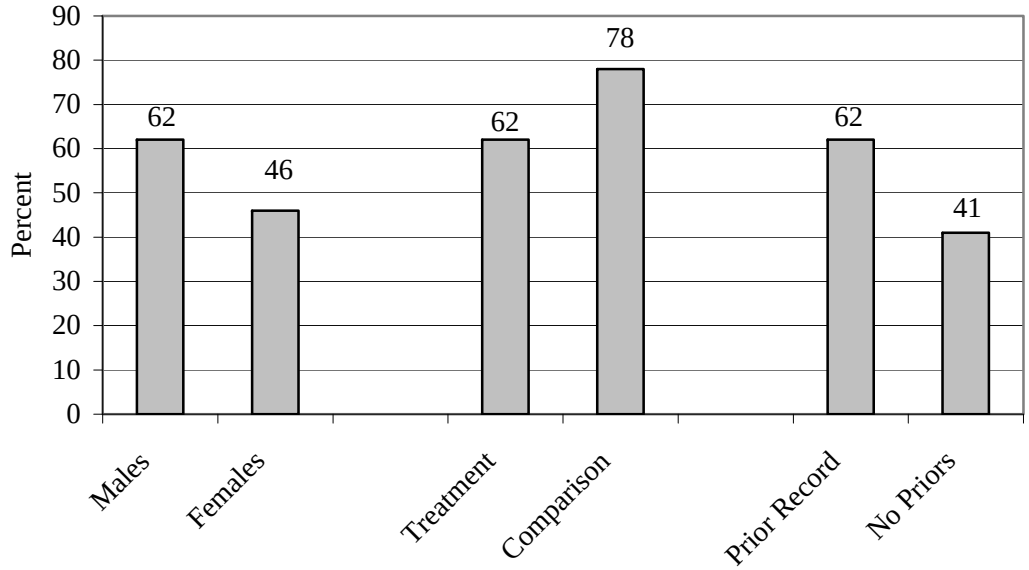
Figure 2. Impact of Significant Predictors on Probability of Rearrest: Adult Municipal Court, N = 884[a]



[a]Only the probabilities for the significant factors from the logistic regression are depicted in this figure.

A third regression equation predicting outcomes for the juvenile groups was also illustrative. Gender, prior record, and group status were found to predict whether juveniles were rearrested as illustrated in Figure 3. Specifically, males, those with prior arrests, and comparison group members, were significantly more likely to be rearrested.

Figure 3. Impact of Significant Predictors on the Probability of Rearrest: Juvenile Court, N = 448[a]



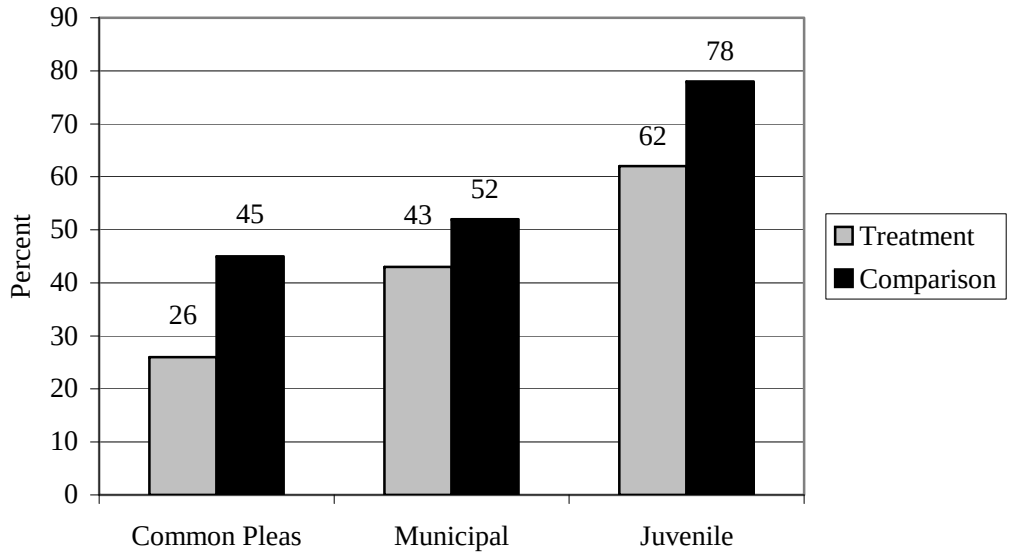
[a]Only the probabilities for the significant factors from the logistic regression are depicted in this figure.

Finally, in addition to determining which factors predict arrest, it is important to determine the probability associated with rearrest[4]. For each group, there was a lower

[4] The log-odds probabilities are the estimates of the anti-logs of the constants. This has the effect of using the parameter estimates that control for the differences to estimate the odds of failure. Using the constant to derive the "base failure expectancy" has the effect of setting all the other values to 0. The estimate thus was derived from the following formula: log odds of failure-constant + $b_{race}(0)$ + $b_{education}(0)$ + $b_{employment}(0)$ +… $b_{group}(0)$. The odds ratios were converted from the log odds by taking the antilog of the estimates described above. The estimated percentages presented throughout the report were derived from the odds rations. For example, an odds ratio of .644 was translated to a percentage by taking its reciprocal (1/.644=1.55) to derive the odds (1:1.55). The odds ratio means that the sample comprised 1 failure and 1.55 successes. The total sample then was the sum of failure and success (1 + 1.55 = 2.55), and the percentage who failed was (1/2.55)*100=39.2. (For a more detailed description of this procedure see: Langworthy and Latessa's "Treatment of Chronic Drunk Drivers: The Turning Point Project [1993].)

likelihood of rearrest for drug court participants (see Figure 4). After controlling for differences between the groups, the probability of rearrest for the common pleas drug court group was 26% compared to 45% for the comparison group. The probability of rearrest for the municipal drug court group was 43% versus 52% for the comparison group. Finally, the probability of rearrest for the juvenile drug court group was 62%versus 78% for the comparison group.

Figure 4: Comparisons in Rearrest Rates between Treatment and Comparison Group Members



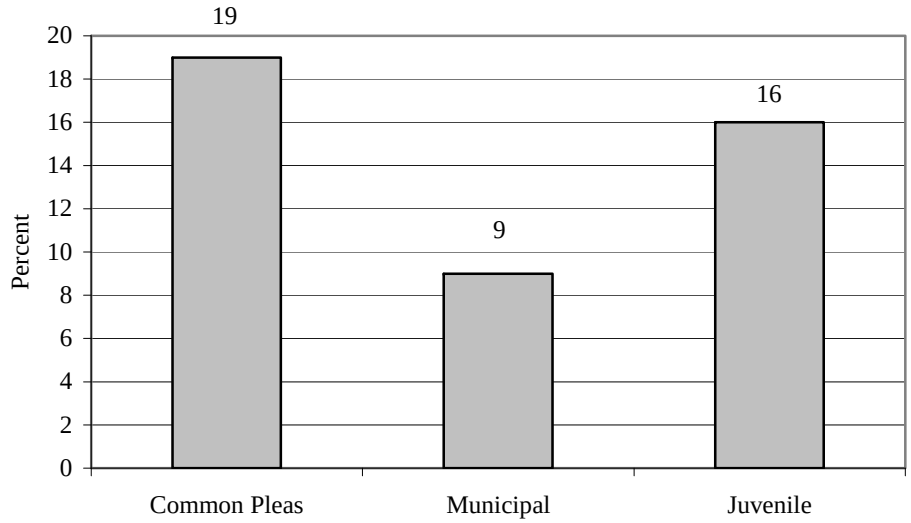
SUMMARY AND CONCLUSIONS

[8] Overall, the evaluation results are very promising. The findings indicate that clients who receive drug court services, regardless of type of court, fare significantly better as a group than individuals who did not receive drug court services. As noted earlier, the basic social demographic characteristics were similar between the two groups and the findings held true when statistically controlling for any differences between the groups. Certain court types (e.g., common pleas) appear to be seeing more significant reductions in recidivism; however, the results support the efficacy of the drug court model in Ohio.

There are several limitations to the study that are worth noting. Assessment results were not available at the time of the study, which limits our ability to examine risk and need levels of the groups. Data were not available on comparison group members on several important dimensions such as level of motivation, participation in treatment activities, and histories of drug and alcohol use. These factors are all important in the effort to learn more about the effectiveness of drug courts in Ohio. Finally, although we have no reason to believe that Ohio's drug courts are substantively different from other drug courts, the findings from this study are limited to Ohio.

Despite the limitations, it is clear that the drug courts under study are having a significant and appreciable effect on recidivism. On two indicators of criminality, initial and repeated arrests, drug court members fared significantly better than those in the comparison group. As illustrated in Figure 4, there was a 19-percentage point difference among the common pleas groups, a 16-percentage point difference for the juvenile groups, followed by the municipal court groups with a 9-percentage point difference. In addition to having lower rearrest rates, we also found that members of the municipal drug court group were arrested significantly fewer times than members of the comparison group.

Figure 5. Reductions in Rearrest Rates between Treatment and Comparison Groups Across all Drug Court Groups



In addition to the significant differences in rearrest among drug court participants and comparison group members, several other important findings emerged. First, gender was a significant predictor among the juvenile group. Specifically, boys were more likely to be arrested than girls. Second, employment and education emerged as significant predictors in both adult courts. Specifically, those with less than a high school education and who were unemployed were more likely to be rearrested. Among all of the various needs of drug offenders, education and employment may be some of the easiest to remedy. Drug courts, however, should pay particular attention to the characteristics of those individuals who are least likely to be successful when developing and modifying services.

It is also important to note that while these results are promising, it is likely that the effects could be stronger. Our previous descriptions of the drug court treatment offered throughout Ohio indicated that the vast majority of treatment providers relied on one primary approach (i.e., 12-Step models). There is some research to indicate that many offenders fail to connect to this model and that other approaches such as cognitive behavioral interventions should be utilized (see Listwan, Hubbard, & Latessa, 2000; Listwan, Shaffer, & Latessa, 2002). Improved offender assessment, treating a wider range of risk and need factors, and utilization of a more skill-based cognitive approach likely will produce stronger results. Thus, improved treatment services, coupled with the supervision and monitoring provided by drug courts likely would result in even greater reductions in recidivism.

The results of this evaluation also are encouraging for the juvenile court group. The juvenile drug court group was significantly less likely to be arrested as compared to those who did not receive services. As mentioned, juvenile drug courts often are confronted with a number of unique

challenges. The community-based drug court model is an important one for an adolescent population that may face risk of incarceration and the further deterioration of important social and protective factors (e.g., schooling, family, peers, etc). The results are supportive of the drug court model; however, it should be noted that the recidivism rate of the juvenile group was higher (62% vs. 26% for the common pleas group and 43% for the municipal group) than the other courts. While it is difficult to pinpoint why this is the case, the findings are in line with the mixed research on juvenile drug courts. We may speculate that system-involved youth often have multiple risk factors that may not be addressed by the traditional drug court model (e.g., parental, abuse/neglect, school failure, mental illness, etc). Further, as noted by Sloan & Smylka (2003), the courts may be inappropriately targeting juveniles where drugs are not a driving force in their criminal behavior. Regardless, the current study points to the need for further research on this topic.

In sum, the findings provide a greater understanding of the impact of this intervention across Ohio. This study is consistent with national studies and other individual studies across the country that find support for the drug court model in reducing criminal behavior. As federal and state legislatures grapple with developing cost effective measures to manage the criminal population, drug courts can provide some answers. However, further research is needed to identify the characteristics that distinguish "successful" and "unsuccessful" drug court models. Future research has the potential to inform the continued development and enhancement of drug courts themselves, as well as other specialty courts (e.g., mental health, domestic violence, young offender, etc).

REFERENCES

Anglin, M.D., Brecht, M.L., & Maddahian, E. (1989). Pretreatment characteristics and treatment performance of legally coerced versus voluntary methadone maintenance admissions. *Criminology, 27*, 537-555.

Anglin, M.D. & Hser, Y. (1990). Treatment of drug abuse. In M. Tonry & J. Q. Wilson (Eds.), *Drugs and crime* (pp. 393-460). Chicago: University of Chicago Press.

Anspach, D.F, Ferguson, A.S., & Phillips, L.L. (2003). *Evaluation of Maine's statewide juvenile drug treatment court program*. Augusta, ME: University of Southern Maine.

Aos, S., Phipps, P., Barnoski, R., & Lieb, R. (2001). *The comparative costs and benefits of programs to reduce crime*. Olympia, WA: Washington State Institute for Public Policy.

Belenko, S. (1998). Research on drug courts: A critical review. *National Drug Court Institute Review, 1*(1), 1-43.

Belenko, S. (1999). Research on drug courts: A critical review, 1999 update. *National Drug Court Institute Review, 2*(2), 1-58.

Belenko, S. (2001). *Research on drug courts: A critical review 2001 update*. New York: The National Center on Addiction and Substance Abuse at Columbia University.

Belenko, S., Fagan, J.A., & Dumanovsky, T. (1994). The effects of legal sanctions on recidivism in special drug courts. *Justice System Journal, 17*, 53-81.

Brewster, M.P. (2001). An evaluation of the Chester County (PA) drug court program. *Journal of Drug Issues, 31*, 177-206.

Bureau of Justice Assistance Drug Court Clearinghouse Project (2006a). *Summary of drug court activity by state and county*. Retrieved September 25, 2006, from http://spa.american.edu/justice/publications/us_drugourts.pdf#search=%22summary%20of%20drug%20ourt%20activity%22

Bureau of Justice Assistance Drug Court Clearinghouse Project (2006b). *Summary of drug court activity by state and county: Juvenile and family drug courts*. Retrieved September 25, 2006, from http://spa.american.edu/justice/resources/Juv.Fam.mb.%20list.August.2006.ADM.pdf

Canterbury, P. (2003). *Juvenile drug court program evaluation final report*. Tuscon, AZ: LeCroy & Milligan Associates.

Cooper, C.S. (2002). Juvenile drug treatment courts in the United States: Initial lessons learned and issues being addressed. *Substance Use & Misuse, 37*, 1689-1722.

Deschenes, E.P. & Greenwood, P.W. (1994). Maricopa County's drug court: An innovative program for first time drug offenders on probation. *Justice System Journal, 17*, 99-115.

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

Dynia, P. & Sung, H. (2000). The safety and effectiveness of diverting felony drug offenders to residential treatment as measured by recidivism. *Criminal Justice Policy Review, 11*, 299-311.

French, M.T., Zarkin, G.A., Hubbard, R.L., & Valley. R.J. (1993). The effects of time in drug abuse treatment and employment on post-treatment drug use and criminal activity. *American Journal of Drug and Alcohol Abuse, 19*, 19-25.

Government Accountability Office. (1997, July). *Drug courts: Overview of growth, characteristics, and results*. Washington, DC: Author.

Government Accountability Office. (2005, February). *Adult drug courts: Evidence indicates recidivism reductions and mixed results for other outcomes*. Washington, DC: Author.

Goldkamp, J.S. & Weiland, D. (1993). *Assessing the impact of Dade County's felony drug court: Final report*. Washington, DC: National Institute of Justice, U.S. Department of Justice.

Granfield, R., Eby, C., & Brewster, T. (1998). An examination of the Denver drug court: The impact of a treatment-oriented drug-offender system. *Law & Policy, 20*, 183-202.

Hubbard, R.L., Marsden, M., Rachal, J., Harwood, H., Cavanaugh, E., & Ginzburg, H. (1989). *Drug abuse treatment: A national study of effectiveness*. Chapel Hill, NC: University of North Carolina Press.

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 courts, 1(2). Alexandria, VA: National Drug Court Institute.

Langworthy, R. & Latessa, E. (1993). Treatment of chronic drunk drivers: The turning point project. *Journal of Criminal Justice, 21*, 265-276.

Latessa, E.J., Listwan, S.J., Shaffer, D.K., Lowenkamp, C.T. & Ratansi, S. (2001). *Preliminary evaluation of Ohio's drug court efforts*. Cincinnati, OH: Center for Criminal Justice Research, University of Cincinnati.

Listwan, S.J., Hubbard, D.J. & Latessa, E.J. (2000). Drug courts and treatment: Lessons to be learned from the "what works" literature. *Corrections Management Quarterly, 4*, 70-77.

Listwan, S.J., Shaffer, D.K., & Latessa, E.J. (2002). The drug court movement: Recommendations for improvement. *Corrections Today, 64*, 120-123.

Listwan, S.J., Sundt, J., Holsinger, A.M., & Latessa, E.J. (2003). The effect of drug court programming on recidivism: The Cincinnati experience. *Crime & Delinquency, 49*, 389-411.

Lowenkamp, C.T., Holsinger, A.M., & Latessa, E.J. (2005). Are drug courts effective: A meta analytic review. *Journal of Community Corrections, 28*, 5-10.

Miethe, T.D., Lu, H., & Reese, E. (2000). Reintegrative shaming and recidivism risks in drug court: Explanations for some unexpected findings. *Crime & Delinquency, 46*, 522-541.

O'Connell, J.P., Nestlerode, E., & Miller, M.L. (1999). *Evaluation of the Delaware juvenile drug court*

diversion program. Dover, DE: Statistical Analysis Center.

Peters, R.H., Haas, A.L., & Murrin, M.R. (1999). Predictors of retention and arrest in drug courts. *National Drug Court Institute Review, 2*(1), 33-60.

Prendergast, M., Anglin, M.D., & Wellisch, J. (1995). Up to speed: Treatment for drug-abusing offenders under community supervision. *Federal Probation, 59*, 66-75.

Rodriguez, N. & Webb, V.J. (2004). Multiple measures of juvenile drug court effectiveness: Results of a quasi experimental design. *Crime & Delinquency, 50*, 292-314.

Sechrest, D.K. & Shicor, D. (2001). Determinants of graduation from a day treatment drug court in California: A preliminary study. *Journal of Drug Issues, 31*, 129-148.

Shaffer, D.K. (2006). *Reconsidering drug court effectiveness: A meta-analytic review*. Doctoral dissertation: University of Cincinnati.

Shaffer, D.K., Johnson, S., & Latessa, E.J. (2000). *Description of Ohio's drug courts*. Cincinnati, OH: Center for Criminal Justice Research, University of Cincinnati.

Sloan, J.J. & Smykla, J.O. (2003). Juvenile drug courts: Understanding the importance of dimensional variability. *Criminal Justice Policy Review, 14*, 339-360.

Spohn, C., Piper, R.K., Martin, T., & Frenzel, E.D. (2001). Drug courts and recidivism: The results of an

evaluation using two comparison groups and multiple indicators of recidivism. *Journal of Drug Issues, 31*, 149-176.

Thompson, K. (2002). *Statistical summary of North Dakota Juvenile Drug Court—May 2000 to June 2002*. Fargo, ND: North Dakota State University.

Van Stelle, K.R., Mauser, E., & Moberg. P.D. (1994). Recidivism to the criminal justice system of substance abusing offenders diverted into treatment. *Crime & Delinquency, 40*, 175-196.

Vito, G. & Tweksbury, R.A. (1998). The impact of treatment: The Jefferson County (Kentucky) drug court program. *Federal Probation, 62*, 46-52.

Wilson, D.B., Mitchell, O., & MacKenzie, D.L. (2002, November). *A systematic review of drug court effects on recidivism*. Paper presented at the annual meeting of the American Society of Criminology, Chicago.

Wolf, E. & Colyer, C. (2001). Everyday hassles: Barriers to recovery in drug court. *Journal of Drug Issues, 31*, 233-258.

Wright, D. & Clymer, B. (2000). *Evaluation of Oklahoma drug courts, 1997-2000*. Oklahoma City, OK: Criminal Justice Resource Center.

AN OVERVIEW OF OPERATIONAL FAMILY DEPENDENCY TREATMENT COURTS

By Judge Nicolette M. Pach (ret.)

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

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

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

Direct all correspondence to Honorable Nicolette M. Pach (ret.), 6165 Jericho Turnpike, Commack, NY 11725. (631) 462-5950; (631) 462-5029 (fax); nicolettep@optonline.net

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

SUBJECT INDEX

The following cumulative Subject Index is designed to provide easy access to subject references. Each reference can be located by:

- *Volume* *by using a roman numeral e.g. I*
- *Issue* *by using a number e.g. 2*
- *Subject reference* *by its page number in parenthesis e.g. (121)*

HEADNOTE INDEX

The Headnote Index provides access to an article's major points or concepts using a cumulative indexing system. Each headnote can be located by:

- *Volume* *by using a roman numeral i.e. I*
- *Issue* *by using a number i.e. 2*
- *Headnote* *by using a number in brackets i.e. [4]*

II2**[6]** Post Program Recidivism
II2**[7]** Cost Savings
II2**[8]** Improving Drug Court Evaluation

Drug Court Participants' Satisfaction
IV1**[11]** Other Studies
IV1**[12]** CDAS/NIDA Drug Court Participant Study
IV1**[13]** CDAS Study Format
IV1**[14]** Basic Client Information
IV1**[15]** Motivation for Drug Court
IV1**[16]** Clients' Thoughts on Treatment
IV1**[17]** Clients' Opinions on the Court
IV1**[18]** Conclusions on Client Perceptions

Drug Court System
I1**[23]** Drug Court System (DCS)
I1**[24]** Drug Court System (DCS)
I1**[25]** Drug Court System (DCS)
I1**[26]** Drug Court System (DCS)
I1**[27]** Drug Court System (DCS)
I1**[28]** Drug Court System (DCS)

Evaluation
I1**[1]** Consistent Findings
I1**[2]** Retention Rates
I1**[3]** Population Demographics
I1**[4]** Supervision
I1**[5]** Cost Saving
I1**[6]** Drug Usage
I1**[7]** Recidivism During Program
I1**[8]** Recidivism
I1**[9]** Design Weakness

Expungement
V1**[1]** Benefits of Expungement
V1**[2]** Methods
V1**[3]** Results
V1**[4]** Discussion

Family Drug Treatment Courts
III1**[17]** Development
III1**[18]** Jackson County
III1**[19]** Criminal/Civil Cases
III1**[20]** Immediate Involvement
III1**[21]** Appropriate Treatment
III1**[22]** Sanctions and Incentives
III1**[23]** Effectiveness
III1**[24]** Challenges
VI1**[9]** Establishing FDTC Best Practices
VI1**[10]** Necessary Partners and Roles
VI1**[11]** Defining the Mission of the FDTC
VI1**[12]** Court Calendaring Practices

IV2**[7]** Study Replication: Felony Population
IV2**[8]** Judge is Key to Drug Court

Juvenile Drug Courts
I1**[19]** Cost Savings-Santa Clara
I1**[20]** Santa Clara- Retention
I1**[21]** Wilmington- Recidivism
I1**[22]** Wilmington- Post Program Recidivism

Multisystemic Therapy (MST): An Evidence-Based Substance Abuse Treatment in Juvenile Drug Courts
III2**[25]** Treating Adolescent Substance Use Effectively
III2**[26]** NIDA's Thirteen Principles
III2**[27]** What is Multisystemic Therapy (MST)?
III2**[28]** Evaluating the Effectiveness of MST
III2**[29]** MST and the Thirteen Principles
III2**[30]** MST and Juvenile Drug Court
III2**[31]** Evaluating MST in Juvenile Drug Court

Perceptions of Drug Court
II1**[15]** Evaluating the FTDO Program in Maricopa
II1**[16]** 12-Month/36-Month Outcomes
II1**[17]** Difficulty of Compliance
II1**[18]** Helpfulness, Strengths/Weakness

Performance Measurement
V2**[5]** What Is Performance Measurement?
V2**[6]** Measuring Drug Court Performance
V2**[7]** Conclusion

Process Evaluation
V2**[8]** What Are Process Evaluations?
V2**[9]** Who Should Conduct These Evaluations?
V2**[10]** What Are the Critical Elements of Process Evaluation?
V2**[11]** What Data Are Needed to Complete These Evaluations?
V2**[12]** What Does It Mean to be "Methodologically Rigorous"?
V2**[13]** What About Experimental Design and Comparison Groups?

Recidivism
V2**[14]** What Do We Know Now?
V2**[15]** What Is "Recidivism"?
V2**[16]** Which Drug Court Participants Should Be Included in the Analysis?
V2**[17]** What Is an Appropriate Comparison Group?
V2**[18]** How Do You Ensure that the Drug Court and Comparison Samples Are Truly Comparable?

Research
II1**[27]** Recidivism and The Utah Juvenile Court
II1**[28]** Delaware Drug Court Evaluation
II1**[29]** Florida's First Judicial Circuit Drug Court Evaluation

VI1**[2]** Methods
VI1**[3]** Results
VI1**[4]** Discussion

Treatment for Offenders
II2**[14]** Successful Treatment Programs
II2**[15]** Therapeutic Setting
II2**[16]** Treatment Completion
II2**[17]** Cognitive Behavioral Tx What Works
II2**[18]** Effective Treatment Components
II2**[19]** Treatment Matching
II2**[20]** Sanctions and Incentives