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ERIE COMMUNITY COLLEGE

Department of Alcohol and Substance Abuse

Erie County Family Treatment Court Evaluation

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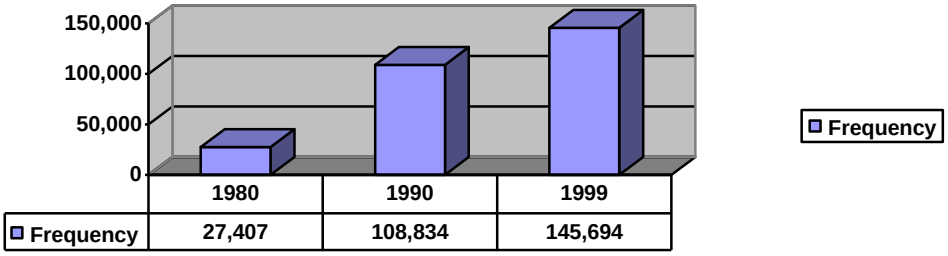
Executive Summary

New York State

New York State's "war on drugs' has been waged since the early 1970's. In 1973 Governor Nelson Rockefeller in response to a burgeoning heroin epidemic announced anti-drug policies that were premised on new law enforcement strategies and strict mandatory sentencing laws. In the last two decades, New York State's criminal justice system has been confronted with a staggering number of drug cases, the volume of which has risen by over 400% in 20 years.

Graph 1.1.New York State Drug Cases

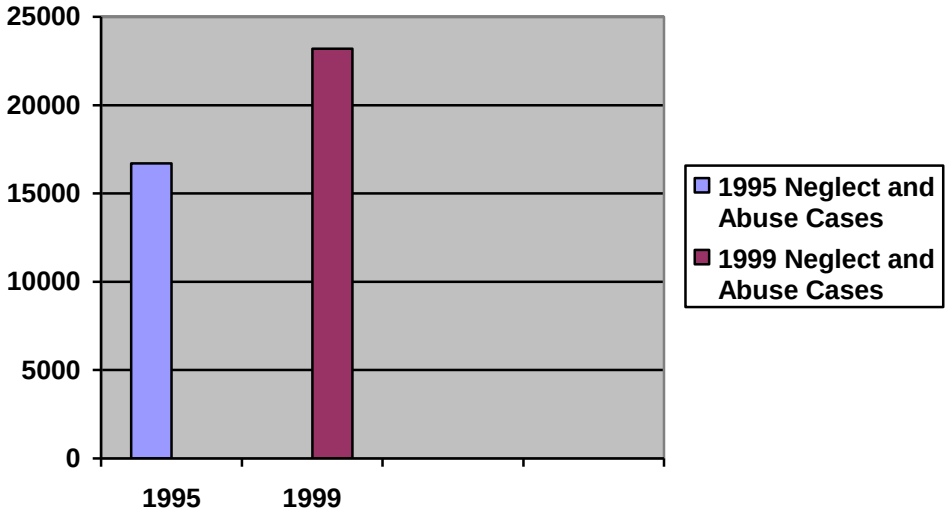


In 1980, for example, data from the Division of Criminal Justice Services (DCJS) indicates that there were 27,407 drug arrests in New York State. By 1990, this number had risen to 108,834 and by 1999 it was 145,694. This vast expansion has come at a great price to the public and has taken a significant toll on the courts.

The impact of substance use and abuse did not limit itself to the criminal courts. Like drug-related criminal offenses, child abuse and neglect cases overwhelmed the dockets at New York's Family Courts, the substance abuse treatment facilities, and child welfare agencies. Many of the parents of these abused and neglected children had histories of abusing alcohol or drugs.

In June 2000, the New York State Commission on Drugs and the Courts issued a report to Chief Judge Judith S. Kaye entitled "Confronting the Cycle of Addiction and Recidivism." This report reflected the problems and challenges confronting Family Court. The number of abuse and neglect cases in New York State increased from 16,170 cases in 1995 to 23,186 in 1999 (a 43% increase). Not only has the incidence increased, but drug abuse is increasingly being recognized as a significant factor in causing delays and preventing the effective resolution of many of these cases (Kaye, 2000).

Graph 1.2 New York State Abuse and Neglect Cases



The "victimless" victims of these delays and of the lack of effective treatment are the children who find themselves in Family Court. Frequently, children involved in drug abuse cases are removed from their parental homes into foster care, waiting for the court "to rule." Often children languish in the foster care system for years. State Child Services Commission reports indicate that the average stay in foster care in New York City is four years, with similar findings in Erie County.

The Commission explained that these delays compromise the basic rights of children and families. In the great majority of neglect cases, federal and state laws require prompt and determined efforts to reunify children with their parents. The Commission reports that what is needed most in the cases of addicted parents is an approach to treatment that is efficient and meaningful, that motivates the parent to succeed, and that circumvents the traditional system delays. Judge Kaye (2000) proposed Family Treatment Court as another approach to create an integrated and monitored intervention approach to family restoration.

"Maternal cocaine use was found to be associated with a more negative care giving environment. Mothers who used cocaine were more likely to experience community violence and have their children remain in foster care for longer periods of time and experience more changes in primary caregivers than non-cocaine using mothers" (Eiden, Peterson & Coleman, 1999).

"Research on fathers' alcoholism and the quality of parent and infant relationships has shown that alcoholic fathers displayed lower sensitivity, lower positive affect and higher negative affect in interactions with their children. These findings suggest these object relational impairments create risks for future problems among children of alcoholic fathers" (Eiden, Cavez & Leonard, 1999).

"When there is dysfunction in adulthood this can often be a causal link to the quality of very early attachment between parents and their children. The most severe attachment disorders are found in abused and neglected children. These children, as adults, experience symptoms of depression, rage, despair and detachment from others" (Ziegler, 1998).

"55% of referrals to the Erie County Family Treatment Court reported being sexually, physically or emotionally abused". (Erie County Family Treatment Court Evaluation, 2003)

Introduction

Adult Drug Treatment Courts and Family Treatment Courts

The reality of incarceration is the primary motivator in adult drug treatment courts, whereas reunification with children is the primary motivator in the family drug court. The family treatment court is a drug court that deals with parental rights. The cases often include parental substance abuse related to custody and visitation disputes, abuse, neglect, dependency matters, petitions to terminate parental rights, guardian ship proceedings, and other loss, restriction, or limitation of parental rights (Bureau of Justice Assistance, 1998b). "The court's goal is to provide intensive treatment and service delivery to reunite the child with the parent in a safe and healthy environment." (Elstein, 1999). Goals of family treatment courts also include helping the parent to become emotionally, financially, and personally self-sufficient and to develop parenting and "coping" skills adequate for becoming an effective parent on a day-to-day basis.

Similar to Adult Drug Courts, Family Treatment Courts cultivate a cooperative approach to justice, promote early intervention and treatment, individualize treatment and service plans, require frequent court appearances, and position the judge in the key leadership role. These roles could be defined as surrogate parenting to troubled addicted parents with at-risk future damaged children. However, Family Treatment Courts do differ from the Adult Drug Courts in a number of ways.

In Adult Drug Court . . .	**In Family Treatment Court . . .**
The focus is on the client.	The welfare of the child is paramount, the approach is family-focused, and no action will be taken before the impact on the child(ren) is considered.
A thorough assessment of each client's substance abuse treatment needs takes place.	A comprehensive assessment of each client's treatment needs, skill-training deficits, development schemas, and mental health needs takes place. The health, safety, and developmental needs of the client's child(ren) are also assessed.
Clients face criminal charges.	Clients have been charged with neglect.
The judge levies client-appropriate and/or policy-dictated sanctions for noncompliance.	The judge may only levy sanctions that have no adverse impact on the child.
More clients are male than female.	More clients are female than male. This necessitates having available gender-sensitive treatment and integrated services for women's health and family planning issues.
The objectives are client sobriety and reduced recidivism. The judge's role is key.	The objectives are client sobriety and the development of the skills and knowledge required to become mature, responsible parents as well as ensuring a safe and permanent placement for the child(ren)
Treatment focuses on the client only.	Treatment focuses on the client but is also extended to the adolescent children of clients, who are at risk for substance abuse, mental illness, developmental disabilities, and so forth. The judge's role remains key, but it also takes on a nurturing quality.

Erie County

The impact that drug cases have had on New York's criminal courts is well documented and known. Less obvious, at least, to the general public is the effect that drug use and abuse has had on the States Family Courts. Erie County, including the City of Buffalo, offers a vivid example of the relationship between poverty, crime, parental substance abuse, and the maltreatment of children. Erie County's total population, according to the 1990 U.S. Census was 953,332, of whom 122,916 were below the poverty level, with the majority living in the City of Buffalo. Available statistics show that while crime in Buffalo has declined in recent years, the number of arrests for drug possession rose by 46% from 1996 to 1997. The Buffalo City Police Department records also showed that the number of arrests for drug sales has continued to increase.

Since 1992, the Erie County Family Court has suffered a serious strain from the vast expansion in the number of drug related filings. Current findings show that over 2,500 abuse and neglect cases per year come before the Erie County Family Court. These numbers show no signs of abating. According to judges within the system, approximately 75% of these cases involve at least one substance-abusing parent. As previously stated, numerous studies have made it clear that children of substance abusing parents are more likely to enter foster care and remain longer than other children involved in the child welfare system (National Center on Addiction and Substance Abuse, Columbia University, 1999). Such children are also more likely to be the victims of severe and chronic neglect.

When an addicted parent is brought into Erie County Family Court, the Court is faced with the difficult task of both assuring the child's safety and addressing the parent's drug problem. Prior to Family Treatment Court start - up, the Court had responded to these issues by placing the child in foster care for a period of one year and by requiring the parent to complete substance abuse treatment. Problems flourished with this arrangement. Parents were referred from the Court to the Department of Social Services, where they were given the names of several treatment providers. There were no means to ensure that the substance-abusing parent enrolled immediately, or even at all. Often it took parents several months to finally begin treatment, which made it difficult to assess their level of stability and sobriety at the end of the 12-month period. Once enrolled in services, there was no mechanism for a Family Court judge to obtain up-to-date, accurate information concerning a parent's progress in treatment. The Court typically had no involvement with the parent until the full year of the court directive had expired and then revisited the case by putting it back on the court docket. At this time, as required by the

Adoption and Safe Families Act, the judge is charged with determining a permanency plan for the child, including whether to return the child to the parents' custody. All too often, at the end of the year, parents showed little progress in recovery. The absence of reinforced treatment plans for each parent and a lack of getting detailed information during the 12-month period about each parent's progress in complying with the plan, resulted in the Court not being in a position to make informed decisions regarding the children's welfare. As a result, many children were returned to foster care, while the parent was directed back to treatment for another year. A system with built - in failures existed, as the emphasis was on separation. The children continued to linger in the foster care limbo, the parents did not maintain the treatment they needed to get off alcohol and drugs, and the courts spent resources handling the same cases over and over again.

Implications for Family Treatment Courts:

For parents battling substance abuse—as well as for the courts and substance abuse treatment providers—the 12-month time frame for the permanency hearing has important implications. Even parents who are committed to a goal of achieving sobriety often require more than 12 months in substance abuse treatment before making significant progress, and one or more relapses during treatment are common. Responding to concerns from the field, the U.S. Department of Health and Human Services entered the following commentary into the Federal regulations: "Parents dealing with substance abuse issues may require more than 12 months to resolve those issues. However, a parent must be complying with the established case plan, making significant measurable progress toward achieving the goals established in the case plan, and diligently working toward reunification in order to maintain the goal of a permanency plan at the permanency hearing. Moreover, the State and court must expect reunification to occur within a time frame that is consistent with the child's developmental needs."

Project Description

This final project report has been prepared by Erie Community College's Department of Community Mental Health in order to satisfy the requirements of the contract with the administrative offices of New York States 8th Judicial District. This report focuses on the process evaluation of the Erie County Family Treatment Court and was made possible by funds provided by the State Justice Institute. These funds were awarded to The New York State Office of Court Administration (OCA) on behalf of the 8th Judicial District and more specifically Erie County Family Court.

The focus of this contract was on process rather than outcomes. The process evaluation occurred for a number of reasons. First, the length of the contract and the available resources did not allow for an outcome study. Second, and more important, it was necessary to define and document the process variables in order to measure outcomes in the future.

There was a need to gather information on programs that showed potential and evaluate why they worked. From information gathered on drug court programs and in responding to grant proposals, programs must include research and evaluation components before implementation begins. Knowing the extent to which a program is effective during operations allows for continuous improvements. When outcomes are evaluated without knowledge of operations, the results seldom provide a direction for action planning. Critical decisions often lack information about what produced the observed outcomes. Unless one knows that a program is operating according to design, there may be little reason to expect it to produce the desired outcomes (Patton, 1986)

"Without Research and Evaluation the Drug Court Field can neither move forward nor achieve ultimate success. Research and Evaluation are the critical elements in the ongoing development of Drug Court programs, and will play a crucial role in their future."

General Barry McCaffrey

This evaluation was designed to help complete and document the Family Treatment Court process and to provide suggestions for designing an outcome study for the future. This project recognized evaluation as a means of keeping track of how each phase of the program and procedures were integrated and linked to expected outcomes. Evaluation is not simply a means of "proving" you have achieved what you set out to achieve; more importantly, evaluation research is a tool that can be used to improve the overall functioning of the program. This process evaluation was a non-experimental case study analysis of how the Family Treatment Court was implemented and how it operates currently. It was concerned with history, operations, procedures, participant enrollment, client progress monitoring, obstacles, and recommended operational improvements. Although primarily qualitative and descriptive, it was necessary to collect demographic, historical, and quantitative measures to summarize the size and nature of the caseload. Knowing that process evaluation sets the stage for future outcomes research, this report also investigated predictive variables to success.

" The most important purpose for a program evaluation is not to prove but to improve"

Dobbin and Gatowski, 2001

Challenges to Evaluation

The Erie County Family Treatment Court represents a collaborative effort between multiple agencies, which are, by definition, considered dynamic with regard to change. However, change is often presented as a series of challenges to everyone when comprehensive evaluation takes place. Individuals become fearful of reporting what they do, as if someone is judging rather than exploring. This appears to be true when viewing the components comprising the Family Treatment Court program. There are diverse interests, with program partners having different stakes in the outcomes. Furthermore, the system necessitates drawing on scarce resources and reallocating them to maintain effective participation. There tends to be a divergence, rather than consensus, when different organizational stakeholders have specific program goals and objectives but fail to identify with the mission and purpose of the Erie County Family Treatment Court.

Scope and Methodology of the Evaluation Plan

The initiation of an independent, intensive evaluation to measure the effectiveness of the Erie County Family Treatment Court established a baseline of measurement for future evaluations. The evaluation determined the extent to which the drug control efforts of multiple agencies have been integrated and coordinated. This evaluation was accomplished using interviews, focus groups, and structured instruments designed to capture both process and impact results in quantitative and qualitative formats. Individual interviews were conducted to promote ownership and investment in the evaluation and to add any other information the respondents deemed important. The primary purpose was to examine the current operation of the Erie County Family Treatment Court and assess the effectiveness of the implementation process, situational factors, and program impact. This was accomplished by implementing a three (3) step evaluation design that consisted of site visits, focus groups, surveys, and data collection as well as:

- Interviews with members of each member of the Drug Court Team and its participants and
- Intensive, systematic review, collection, compilation, and analysis of all available quantified data, including reviews and assessments of status reports, case management, and treatment files.

The evaluation was conducted through on-site visits at the Family Treatment Court. The Drug Court Team and program participants were interviewed using semi-structured interviews. The systematic reviews of process and outcome indicators were determined through this approach. The collection and analysis of all available quantified data for the Drug Court depended on the cooperation from those involved in the Family Treatment Court. This framework provides a basis for specifying the Family Treatment Court's uniqueness. The evaluation formulates a program logic model[1], including descriptions of all program components and the relationships between program components. The model establishes a baseline for the process evaluation to determine (1) if the components are being implemented as designed and expected and (2) if improvements can be made to current operations.

[1] The approach and definitions presented here are fully explained and demonstrated in: Kirchner, Robert A., Roger K. Przybylski and Ruth A. Cardella, Assessing the Effectiveness of Criminal Justice Programs. Assessment and Evaluation Handbook Series Number 1, January 1994. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance. This publication is available on the INTERNET at: **www.bja.evaluationwebsite.org**.

Data Sources

Multiple sources were used to collect data for this evaluation. The primary sources of information included the management information system of the C.O.U.R.T.S[2]. Program, Erie County Division of Social Services hard files, and the database built by the Department of Social Services Family Treatment Court Coordinator. The C.O.U.R.T.S. Program information system was modified for use by the Family Treatment Court. The Buffalo DMIS-2001 is a management information system (MIS) built on Access 97 that was initially designed and customized on site at the C.O.U.R.T.S. Program and later adapted for the Buffalo City Drug Court operations. Although this MIS was primarily designed for Criminal Drug Courts, it provided the Family Court with:

- A structured psychosocial intake screening for all participants including information on demographics, education, employment, physical and mental health, drug use, and treatment history;
- Ongoing monitoring of participant compliance with court appearances, drug testing, and treatment attendance; and
- Areas for comments, case notes, and structured entry of occurrences and court responses to both achievements and infractions.

The C.O.U.R.T.S. Family Treatment Court Coordinator and support staffs were responsible for the collection of the data. The data was easily exported for analysis purposes into spreadsheets and data tables, such as those that can be directly used by the program manager for monitoring purposes, as well as for use by the evaluator. In addition, this system provided the judge with an easy-to-read, printed summary (see Appendix 2) of each participant's progress throughout the program. This timely information increased accountability and improved judicial decision-making. Other key features of this MIS were:

- The ability to quickly store and retrieve information about drug court participants;
- The creation of statistical reports for program improvements;
- The ability to create Power Point visual graphics for snapshot overview presentations;
- The ability to sort data by predictive variables for success (return court date, last name, age, treatment history, educational levels, and other);
- The opportunity for user(s) to print hard copies of participants records; and

[2] The C.O.U.R.T.S. program was launched in 1995 from the City of Buffalo Criminal Court to link individuals who come through the criminal court system with a full range of social services including drug treatment, mental health treatment, medical care, anger management services and one-on-one as well as family counseling.

- The user's ability to document a participant's treatment history, types of service received, start dates, and discharge dates. Additionally, the program allowed automatic calculation of the length of stay (in days).

The Buffalo system was not modified to address many of the more complex issues unique to the Family Court situation, especially for the children (needs, services, and placements). This was not an oversight by the planners. It was consistent with the designated responsibilities of the C.O.U.R.T.S. Program to manage the treatment needs of the adult participants, while the Department of Social Services was responsible for the children.

The Department of Social Services Family Treatment Court Coordinator collected aggregate data on all children served by the Family Treatment Court using a Microsoft Access database. Data collected included the number of active clients, total numbers of children served, placements to foster care, kinship and parental custody, reunifications, number of children prevented from entering foster care, and cost savings. However, this system was not designed to record longitudinal changes and was therefore not a good source of historical information on time in placement for children with multiple moves. Thus, information critical to the evaluation effort, including dates on which court ordered changes in custody or visitation privileges were mandated, was not readily available for analysis.

The Department of Social Services hard files that were made available for review included limited demographic information on each child (gender and date of birth). The files were not centralized, information was entered on several different forms, and the records were not available in a consistent format. It was reported that all children received a physical and an evaluation. However, these findings were not made available.

Family Treatment Court team members, case managers for children and respondents, and CPS case workers all maintained case notes and qualitative reports that permitted them to serve their clients' needs. What was lacking for evaluation purposes was a consistent, integrated input-recording system for assessing longitudinal changes in client functioning. Consequently, it was not possible to measure changes in quality of life or domains of psychosocial functioning (such as living situation, economic status, health status, or parenting skills of families). It was also not possible to measure compliance with service plan goals in a systematic fashion. There was a lack of unified service plan descriptions available on the clients admitted during the time period covered by this report.

The Family Treatment Court process evaluation was designed to answer the following questions:

1. When was the program started? Who was involved? What were their aims and agendas? How and why were initial decisions made governing the policies and procedures of the Court?

2. What are the policies and procedures regarding (a) screening criteria used to determine eligibility, (b) the point in the Family Court System at which referrals to drug treatment court occur, (c) program requirements, and (d) sanctions available in cases of noncompliance?

3. What was the expected capacity and nature of the total population eligible for drug treatment court? How were screening and referral functions carried out? How many people were referred to Drug Court, how many were accepted, and what constituted non-acceptance? How many children were indirectly or directly effected by their parents' involvement in the Family Treatment Court?

4. What are the characteristics of the program participants in terms of their demographics, substance abuse problems, and criminal histories? Additionally, what were the characteristics of the children of participants?

5. What are the characteristics of available treatment interventions? What treatment and other services are participants receiving? What services are available for the children?

6. What are the major case processing steps? What happens to participants in drug treatment court? What are the treatment regimen, procedures and outcomes of urinalysis test results, point accumulations, back sliding, and sanctions?

7. Who is the staff, and what are its responsibilities? Is the staffing pattern adequate? What is the Drug Court's annual budget and source of funds?

8. Is there an advisory board or governing task force? If so, who serves, and what are their responsibilities? What are the roles of the judge, petitioner, and respondents' attorneys?

9. What is the extent of coordination and collaboration with other agencies, such as probation, parole, treatment providers, and social services agencies? What information is routinely made available to and from these agencies?

10. What local conditions inhibit the implementation (court caseloads, community attitudes, local legal culture, and other) of the drug treatment court?

11. How long do participants stay in Drug Court? Who drops out, at what point, and why? How many participants, with what characteristics, graduate from Drug Court?

Literature Review

History of Drug Courts

The birth of treatment courts was initiated in the late 1980's with the start of judicially led interventions, aimed towards alternatives to incarceration for non-violent substance abusing offenders with diagnosable mental health disorders. Enthusiasms about drug courts have spawned an entire Drug Treatment Court Movement. Adult Drug Courts were the forerunners of Family Treatment Courts, Juvenile Drug Courts, Domestic Violence Courts, and others. Knowing this history of the Drug Court movement allowed for a continuous development process, without having to "re-invent the wheel". Elstein (1999) noted that family drug courts evolved from adult and juvenile drug courts. Furthermore, the initiation process for change was started where tradition was being challenged. The supporters welcomed fresh ideas and partnerships with the courts, while the skeptics rolled with the process awaiting failure. Clearly, the international court system embraced a new approach to legal justice.

The War on Drugs

The SAMHSA 1999 National Household Drug Abuse Survey (SAMHSA, 2001) reported that an estimated 14.8 million Americans were illicit drug users (respondents to a survey who indicated that they had used an illicit drug during the month prior to the interview). This represented 6.7 percent of the population 12 years old and older. Marijuana was reported as the most commonly used illicit drug by 75 percent of drug users. Forty-three percent (an estimated 6.4 million Americans) used illicit drugs other than marijuana and hashish. An estimated 1.5 million were current cocaine users, approximately 900,000 were current hallucinogen users; and an estimated 200,000 were heroin users. When illicit drug use was determined by age, SAMHSA reported that 10.9 percent of youth aged 12-17 had used an illicit drug within the 30 days prior to interview. This included 7.7 percent who had used marijuana and 5.3 percent who had used an illicit drug other than marijuana. The cohort of those between 18 to 20 years of age had the highest rate of illicit drug use (21 percent), with use dominated by marijuana. When analyzed by race, drug use was found to differ only slightly among the major racial/ethnic groups. Findings reported were 6.6 percent for whites, 6.8 percent for Hispanics, and 7.7 percent for blacks. Persons who reported being multiracial had the highest rate at 11.2 percent.

The survey reported that the percentage of the population age 12 and older using illicit drugs in the month prior to interview did not change significantly between 1998 and 1999. The number of first-time users of marijuana increased by 63% (from 1,437,000 in 1990 to 2,338,000), the number of cocaine users by 37%, users of inhalant by 154%, and of stimulants by 165%. These increases contrast with the 44% increase in first-time tobacco users from 1990 to 1999.

In conclusion, there appears to be a leveling off in the growth of new users, however, the data certainly suggests that illicit drug use continued to grow at substantial rates during the years when billions of dollars were being spent on drug enforcement and incarceration. It would be fair to say that the War on Drugs failed to realize expected outcomes. Legislating justice without recognizing the nature of addicted behavior was short sighted and not designed to change behavior. Two alternatives to the "get tough" position have emerged over the past decade, with drug courts first implemented in south Florida, then in California, and now in most states. This alternatives incorporate "court monitored treatment" as an integral component of the penal and rehabilitative alternatives within the criminal justice system.

Drug Treatment Courts

While operational since 1989, drug treatment courts are considered to be the most innovative, comprehensive, and successful alternatives to incarceration developed yet. Drug Courts grew from a grass roots, in-the-courthouse realization that the turnstile in the criminal justice system of repeated incarcerations following repeated arrests of habituated drug users was clogging the system and costing million of dollars in non-effective efforts to rehabilitate addicted chronic offenders. The Miami-Dade County Circuit Court was the first court to integrate a mandatory "treatment" component into the supervisory responsibilities of the court. The court relied upon the authority of the judge to develop and supervise a comprehensive, community-based rehabilitation and supervision program intended to use the "coercive powers" of the court to compel "participants" (a.k.a. offenders) to abide by the treatment plan in order to avoid incarceration. The essence of drug courts today continues to be the coercive power of the court to impose sanctions, including incarceration, on participants who deviate from the treatment plan. Drug treatment courts, according to Tauber and K. Snavely, emerged from wide recognition that traditional criminal justice methods of incarceration, probation, and supervised parole have not had much impact on drug use or on drug-related crime (1999). These authors suggested that drug courts unknowingly applied the concept of "therapeutic jurisprudence". Therapeutic jurisprudence is defined as

the study of the extent to which substantive rules, legal procedures, and the roles of lawyers and judges produce therapeutic or anti-therapeutic consequences for individuals involved in the legal process; the use of social science to study the extent to which a legal rule or practice promotes the psychological and physical well-being of the people it affects; and the study of the role of law as a therapeutic agent (Hore, et. al, 1999). Therapeutic jurisprudence and its actualization in drug courts realize that drug use is not solely a criminal justice/law enforcement problem but a public health problem with deep roots in the community.

As of early 2001, more than 1,000 drug treatment courts were in operation or in the planning stage in all 50 states, most United States Territories, many Native American Tribal Courts, and in the federal court system (Huddleston, 2001). Nineteen of these are Family Drug Treatment Courts.

Although each jurisdiction tailors its specific drug court policies and procedures to accommodate local conditions and needs, they all share a commitment to several "key best practices components" and to the proactive need to obtain empirical data to assess the impact of these courts.

In June 1998, Columbia University's National Center on Addiction and Substance Abuse (CASA) released the first major academic review and analysis of drug court research in a study entitled "Research on Drug Courts: A Critical Review," by Steven Belenko. This study found that drug courts provide closer, more comprehensive supervision and much more frequent drug testing and monitoring during the program than other forms of community supervision. More importantly, drug use and criminal behavior are substantially reduced when offenders are participating in drug courts, according to this report (Belenko, 1998). Additionally, the Drug Court Clearinghouse operated by American University reported in June of 1999 that 140,000 individuals have been diverted to drug courts. Only about a quarter of the offenders handled by drug courts ever had any treatment in the past. When facing incarceration as an alternative, many users are able to give up drugs entirely or greatly reduce their consumption as a result of treatment (McCaffrey, 2000).

History of Family Drug Courts

In February 1995, the Second Judicial District Court of Washoe County (Reno), Nevada, convened the first session of Family Drug Court. This court was implemented as a means of addressing the complex needs of the growing number of families in which children are placed in danger as a direct result of

parental substance abuse. This Reno court was the first in a growing movement towards the welfare of families that has taken hold in cities and counties across the United States.

Borrowing from the proven adult drug court model, which has been helping substance-abusing criminal offenders achieve sobriety for more than a decade, Family Treatment Courts (FTC) take a similar collaborative approach to justice. These courts build teams that include the judge, the defense, the child's attorney, treatment providers, child welfare specialists, children's service providers, and other community agencies. Together, these practitioners operate a formal program of early intervention treatment linkage: comprehensive needs assessment, case plan development, frequent court appearance monitoring, and client accountability. Early results indicate that these courts are achieving the expectations of protecting the safety and welfare of children by giving their parents the tools they need to become sober, clean, and responsible adults.

Evolution of Family Courts

Child abuse and neglect cases, coupled with drug-related criminal offenses are overwhelming the caseloads of our nation's justice system, the substance abuse treatment system, and the child welfare system. Every day, courts across the country grapple with troubling cases involving children who have been neglected by substance-abusing parents. The parents' addiction in many cases causes them to put the needs of their own drug dependency ahead of the welfare of their children. Problems are compounded when these adults lack the maturity and the basic skills required to care for their children, hold down a job, or even maintain a stable home environment. According to a survey by the National Committee to Prevent Child Abuse, state child protective service agencies across the United States confirm that over 1 million children each year are victims of addiction related child abuse and neglect. In actuality, the true figures could be far larger. The 1999 study by CASA reported that the number of abused and neglected children has almost doubled over the past 10 years to over 3 million children. The National Committee's survey estimated that 10 million children are being raised by drug or alcohol-addicted parents. The connection between the two problems, child neglect and addiction is clear. CASA (1999) found that substance abuse causes or exacerbates 7 out of 10 cases of child abuse and neglect. More recent research by the Children of Alcoholics Foundation indicates that 40% of confirmed cases of child maltreatment involve the use of alcohol or other drugs. According to state agency records, substance abuse is one of the major problems exhibited by families in 81% of the reported cases.

Sadly, the victimization of children whose parents are addicts does not end with childhood. These familial scars are long lasting and life altering. According to a 1992 study by the National Institute of Justice, maltreatment in childhood increases the likelihood of arrest as a juvenile by 53 percent and as an adult by 38 percent. The problems of child neglect and substance abuse do not simply go away. They are the future offenders who are likely to appear in court over and over again in one form or another. We are seeing the intergenerational nature of addiction, as well as that of criminal offenders.

Over the past 10 years, both child welfare and substance abuse treatment services providers became more aware of the importance of integrating substance abuse treatment with parenting education (Downs, 2000). It was determined that the severity of problems with these families in crisis can be more effectively addressed only through a coordinated approach to breaking the cycle of substance abuse and child maltreatment. Practitioners in the court and substance abuse treatment providers began experimenting with a new, holistic approach to treating the addicted family syndrome. They drew on the best aspects of family and juvenile courts and the experience and proven success of the adult drug court system. Family Drug Treatment Courts (FDTC) emerged to help families with addiction problems. In the monograph "Juvenile and Family Drug Courts: an Overview," the Family Drug Treatment Court is defined as "a drug court that deals with cases involving parental rights, in which an adult is the party litigant, which come before the court through either the criminal or civil process, and which arise out of the substance abuse of a parent." Family Drug Treatment Courts emerged as a key response to the problems faced by the child welfare system, which had been dealing with parental drug addiction with children in the foster care system for many years. Family Drug Treatment Courts responded to the growing awareness that traditional parental drug addiction treatments do not work well, and the children were not participants but victims. The rise of Family Drug Treatment Courts evolved, as the managed care coverage for treating entire families in addictions treatment was no longer an approved service.

In a review of family drug courts, Elstein (1999) states that they have the ability to help break the cycle of drug dependency among families served by the child welfare system. Like traditional family courts, family drug courts can handle dependency, abuse, and neglect proceedings. Unlike traditional family courts, family drug courts can focus on providing intensive substance abuse treatment to parents and children in addition to their usual functions.

The Adoption and Safe Families Act

The Adoption and Safe Families Act of 1997 ("ASFA" – Public Law 105-89. Sec. 103.111 Stat. 2115) influenced major changes in the courts' handling of child abuse and neglect cases. Family Courts now have an expanded judicial oversight role and are expected to ensure a safe, permanent home for each abused and neglected child. AFSA added impetus to the development and implementation of family treatment courts by calling for States to initiate termination of parental rights proceedings for children who had been in foster care for 15 of the previous 20 months. Absent a variety of exceptions that may apply, ASFA requires that a permanency plan for the child be developed within 12 to 15 months. Following this time, the court must decide whether the child will be returned to his or her natural parent or whether proceedings to terminate parental rights will be brought.

Upon ASFA passage, it became immediately apparent that for those cases with addicted respondents, the time-frames were stacked against them. Realizing this, the Erie County Family Court could not continue to do business the way it had always been done. Recognizing that recovery from chemical dependency is a process and that relapse is part of that process, neither the Department of Social Services, the Court, nor the treatment provider communities were equipped to handle these cases with the required urgency. Erie County turned to the development of the family treatment court to assist in the reunification of as many families as possible or the earliest possible transfer of a child to a new, healthy, and permanent environment.

Observation

ASFA may present many challenges, but the intent is to prevent foster care drift, and its passage is forcing courts and related system-wide services to take innovative approaches to helping substance-abusing parents stabilize their lives and maintain their families. The key components of Family Treatment Court (immediately available services, collaboration among all stakeholders, and numerous and frequent court reviews) are essential to the successful implementation of ASFA. The accelerated time-frames, the joint accountability by the parent(s), service provider and the court, and the reduced duplication of services

characteristic of Family Treatment Courts all further the goal of safely returning children to their families or finding permanent placements for those who cannot return home.

Family Treatment Court Program Description

The Family Treatment Court (FTC) is a project initiated by the Erie County Family Court in partnership with the Erie County Department of Social Services (DSS) and the Buffalo City Court C.O.U.R.T.S. program. The implementation of the FTC was made possible through a grant proposal that was developed and submitted by the Special Projects Office of the New York State Unified Court System. Planning began in January of 2000 and culminated in a press conference announcing its establishment in May 2001. The project was designed and implemented by a dedicated multi-disciplinary committee including representatives of the Assigned Counsel Program, Law Guardian office, private counsel, CASA volunteers, treatment providers, the Department of Social Services counsel and other children services staff, and court personnel. Additional acknowledgement must also go to the New York State Center for Court Innovation and the State Justice Institute for securing the initial funding and the Permanent Judicial Commission on Justice for Children and the National Council of Juvenile and Family Court Judges for the technical assistance necessary to embark on this special project.

The FTC, led by Judge Margaret O. Szczur, represents a comprehensive approach designed to act in the best interest of the child by maximizing the opportunity for reunification or preservation of the family. This comprehensive approach was modeled on the Suffolk Family Treatment Court, which was designed to break the cycle of addiction and neglect through monitored service delivery. At the same time, the court limits foster care stays through ongoing case monitoring and expedited, informed permanency planning. By offering parents treatment, parenting skills, ongoing case management, and judicial monitoring, the Court provides parents with a realistic chance to succeed in treatment and subsequently to preserve their families. By ensuring that the judge receives regular updates about parental performance in treatment, the Court reinforces the judge's ability to make informed decisions about custody issues. The FTC is best defined as a weekly case conference where the collaborative effort of providers from the court, treatment, and child welfare come together in a non-adversarial setting. Teams from the Department of Social Services, who focus on the safety and needs of the children and family, and from the Buffalo City Court C.O.U.R.T.S. program, which coordinates the parents addiction recovery services, staff the project. They work together to conduct comprehensive client needs assessments and build

workable case plans that give their clients a viable chance to achieve sobriety, become responsible for themselves, and restore their families well being.

Mission Statement

The mission of the Family Treatment Court is "to provide safe, permanent, healthy homes for children in the shortest possible time." The Erie County Family Treatment Court Model will represent a comprehensive approach designed to act in the best interest of the child, by maximizing the opportunity for reunification or preservation of the family. It seeks to do so by breaking the cycle of addiction as well as the patterns of neglect associated with parents' chemical dependency. The Family Treatment Court will accomplish this through monitored resource delivery, with the goal of limiting foster care stays through ongoing case management and expedited, informed permanency planning.

Goals and Objectives

1) **To create a Family Treatment Court in Erie County that would provide a coherent integrated response to the needs of drug-addicted parents and their children.**

   Objective 1.1: To break the cycle of addiction and neglect through monitored service delivery.

   Objective 1.2: To provide early intervention and speedy enrollment of substance-addicted parents into appropriate treatment programs and other services in one month of filing a petition in Family Court.

   Objective 1.3: To develop a coordinated service and treatment plan within 30 days of cases being transferred to the Family Treatment Court.

2) **To provide safe, permanent, healthy homes for children within a timely manner.**

   Objective 2.1: To limit foster care stays in order to facilitate family reunification through ongoing case monitoring and expedited, informed permanency planning.

   Objective 2.2: To develop a permanency plan for children consistent with the time frames established by the Adoption and Safe Families Act.

   Objective 2.3: To improve service delivery outcomes by exchanging comprehensive, accurate and timely information about parents and their children with social service and

treatment agencies responsible for monitoring parents and investigating the placement of children.

Successful program outcomes are one of the essentials of any evaluation. Family Treatment Court outcomes were addressed through the analysis of each objective, and the definition of success was addressed through question seven of the process evaluation interviews. From the interviews conducted, there was not a clear definition of what the Family Treatment Court team considered a success. The responses were varied, clearly reflective of their discipline and role in the process. For example, some respondents noted a clean/sober lifestyle for the parents, others specified safety of the children, and others indicated reunification of the family. This could be perceived as a lack of congruency, however, it is important to keep in mind that any new program needs time for consensus building and clarity of purpose.

It appeared that both the child welfare and substance abuse treatment practitioners within the Family Treatment Court share the same vision of healthy, functioning families. However, different perspectives and or methods of reaching the common goal do exist. Successful outcomes from the substance abuse treatment perspective are measured, in part, by decreased drug and alcohol use, negative behavior, and need or utilization of health services. Child- and family-related outcomes are often not considered, and safety issues may remain, even when treatment goals are met. However, for the Family Court and child welfare agency, the child's safety and permanency are the primary goals and define success.

Key Principles

The Family Treatment Court incorporated a number of principles developed and adapted by the planners of the Family Treatment Court, which are set forth below.

1. Voluntary Participation: Participation in the Family Treatment Court must be knowing, informed, and voluntary. Consequently, a respondent who chooses not to participate in the Family Treatment Court program shall be treated no differently or more harshly than a respondent in the absence of the program**.** However, all parties have not agreed to the definition of voluntary. It has been argued that if participation is contingent on an early

admission of neglect, the client should not be obligated to make such an admission as a requirement for participation in a program.)

2. Opting Out of Participation: There will be no adverse consequence, either explicit or otherwise, to the client as a result of the client's choice not to participate in the Family Treatment Court program.
3. Admissions Against Interest: It is important to encourage full and open participation in the Family Treatment Court program in order to insure the effectiveness of such treatment and of the program. In order to encourage such openness, any statements against interest and admissions by the client made in the course of treatment and during participation in the Family Treatment Court program, whether made in or out of court, cannot be used against the client in any subsequent Family Court proceeding. This includes a petition for termination of parental rights. Likewise, statements made by the client in the course of treatment and during participation in the Family Treatment Court program should not be used in either ongoing or subsequent criminal proceedings against the client. Otherwise, the respondent's willingness and ability to participate in the program will be impeded and respondent's counsel may not be able to recommend participation in the program to the client.
4. Discovery: The Department of Social Services may not subpoena or otherwise obtain treatment records on the client created through or in the course of participation in the program. To the extent that the Department of Social Services has access to such information as part of the program itself, it should not be able to use such information unless it would have otherwise been discoverable and admissible in the normal course of events outside the context of the Family Treatment Court.
5. Prompt and Appropriate Treatment: Prompt engagement in the prescribed level of care is recognized as being essential to effective treatment of substance abuse and addiction, and the immediacy of client linkage to treatment after entry into the Family Treatment Court is essential. This linkage must be driven by effective treatment planning pursuant to Patient Placement Criteria as developed by the American Society of Addictions Medicine with respect to type of treatment, level of treatment, choice of service provider, and geographic location of the provider.

6. Rewards: Progress and productive effort toward recovery on the part of the client must be rewarded promptly, consistently, and meaningfully.
7. Communication of Expectations: Expectations of the client, and the definition of success in the program, must be clearly communicated by both the Court and all other participants of the Family Treatment Court program.
8. Sanctions: In light of the typical recovery process of an addict, there should be minimal sanctions for dirty urine for 30 days after treatment has initially begun.
9. Re-engagement of Relapsed Clients: Aggressive Family Treatment Court efforts must be undertaken to re-engage clients who may have relapsed.
10. Broad Case Management: Comprehensive case management and direct services must be provided across all areas of the client's life, including housing, medical care, mental health, education, and employment skills. A client's realistic chances of recovery may depend as much on receiving assistance in these areas as on receiving direct addictions treatment.
11. Individualized Treatment Plans: Drug use cannot be viewed independently from other issues facing the respondent and the family. In order to maximize the likelihood of successful intervention, a comprehensive case plan must be developed by a licensed, certified, and accredited treatment agency. The plan needs to be individualized and must address the issues of family restoration. For example, attention should be given to treatment needs of respondents who have personal histories of childhood trauma and adult sexual or physical abuse. Often participants with these scars have the tendency to make poor choices in relationships, have dual diagnoses of substance abuse and mental illness (with depression and borderline behaviors being most common), and undiagnosed fetal alcoholism effects, often with histories of attention deficit and conduct disorders (first noticed in early adolescence).
12. Role of Respondents' Attorneys: The respondents attorneys need to be considered equal participants in the Family Treatment Court program, along with the Department of Social Services Counsel, the Department of Social Services caseworkers and/or advocates, Law Guardians, and court personnel. While the functioning of the Family Treatment Court tends to be somewhat less formal than the traditional parts of the court, there should be no discussions about a case, however informal, without all members of the Family Treatment Court team present.

Family Treatment Court Team Description

There are five primary entities involved in the Family Treatment Court process, in addition to each respondent: the judge, the Department of Social Services, the C.O.U.R.T.S. Program, the respondent's counsel, and the Law Guardian.

The Judge – The Honorable Margaret Sczur oversees what needs to be done to achieve program standards for all family members and social service agencies involved. She plays a unique role in holding public as well as private agencies accountable for the performance of their responsibilities. The primary role of the judge is to ensure the child's health and safety. To accomplish this goal, the Family Treatment Court judge oversees the progress of the family member's treatment. The judge, as the team leader, brings together various components of the program, including those within the family court system, the substance abuse treatment community, child welfare case managers, mental health service providers, and other community supports. The judge is central to the treatment and recovery of the participants, serving as the role model and authority figure to whom participants look for guidance and support. The judge is in a position to influence recovery-related efforts, as well as keep colleagues informed about the Family Treatment Court. The judge has shown a commitment to educate team members and participants about courtroom policies and procedures, while remaining open to learning from other team members about their systems and responsibilities. It appears that training and conference attendance has played a vital role in the Family Treatment Court judge's ability to understand the dynamics of family addiction, the relapse and recovery process, addiction psychopharmacology, and the various treatment options available in the community. The judge is also well versed in the areas of child development, family violence, and other child welfare-related issues, including services for children and families.

The Department of Social Services (DSS) Attorney - analyzes the legal issues in a case and assists the caseworkers in using the law to achieve what is best for the child. The attorney prepares the neglect petition, with input from the caseworker, represents the Department at all court appearances, gives input into the case conferences on each client, and provides the legal advice for any subsequent proceedings (termination of parental rights, orders of protection, and foster care review hearings). When necessary, the Department of Social Services Attorney will

also help prepare the caseworker's testimony for court. The Attorney will go over the caseworker's personal knowledge of the case, review the records, and explain in detail what is being decided at the hearing and how the proceeding will be conducted. The Attorney also has a responsibility and an obligation to go over the strengths and weaknesses of the case being presented.

The Respondent's (Participant's) Counsel –represents the respondent and potential Family Treatment Court participants. These groups of Assigned Counsel attorneys are private practitioners who are reimbursed to represent indigent respondents. A pool of specially trained assigned counsel is designated to represent clients who are participating in the Family Treatment Court.

The Law Guardian – represents the rights of the child.

The C.O.U.R.T.S. Family Treatment Court Coordinator is responsible for referring the Family Treatment Court participants to alcohol and drug treatment programs and services, ensuring that they attend these programs, and obtaining regular reports on their progress and compliance with court mandates. The coordinator, in effect, serves as the hub of treatment information on the participants for the judge and aids the court in promoting accountability among the treatment providers. The C.O.U.R.T.S Family Treatment Court Coordinator position was established by the 8th Judicial District and is assigned to the Family Treatment Court branch of the Buffalo City Court C.O.U.R.T.S. (Courts Outreach Unit: Referral and Treatment Service) Program.

The C.O.U.R.T.S. Family Treatment Court Coordinator activities are to:

- Assists the Project Director in the implementation of the grant activities including formulation of policies, procedures, program manuals, and client handbooks, and evaluation considerations;
- Coordinates working relationships with the judge, various attorneys, the Department of Social Services workers, treatment providers, and family court staff;
- Supervises the C.O.U.R.T.S. Program support staff members in all aspects of their work;
- Participates in case conferences, court appearances, and other client-related meetings;
- Markets the program to the community;

- Coordinates the Quality Assurance and Improvement elements within the Family Treatment Court (collecting data and program monitoring); and
- Recommends improvements or process alterations to policy-makers and/or decision-makers.

The C.OU.R.T.S. case managers are focused on alcohol and drug treatment activity. The role of the C.O.U.R.T.S. Program FTC case manager includes the initial alcohol and drug screening, level of care determination, and initial placement of the participant. Screening is accomplished the same day as referral or the next business day. Referrals and appointments at a licensed treatment site are made immediately upon completion of the initial screen. Placement goals (initial clinical contact) are completed within 72 hours of the initial interview. The C.O.U.R.T.S. Program case managers:

- Gather relevant background information on the case and prepare information for the C.O.U.R.T.S. coordinator on case conferences and court appearances;
- Document all relevant activity in the client record (C.O.U.R.T.S. database);
- Perform the initial alcohol and drug screen;
- Make initial appointment for participant with a treatment provider;
- Establish communication links with provider;
- Exchange information with treatment provider;
- Communicate with treatment providers to monitor the client's progress in treatment;
- Gather status reports from treatment providers on a timely basis;
- Work with the senior caseworkers from the Department of Social Services to form service teams that will be assigned to each case; and
- Meet regularly with the Department of Social Services caseworker.

The DSS Court Coordinator:

- Represents the views of the DSS administration in establishing and executing the program;
- Coordinates working relationships with the judge, various attorneys, the Buffalo City C.O.U.R.T.S. Program, treatment providers, family court staff, and New York State, and Regional Drug Court personnel;
- Supervises the DSS/FTC caseworkers in all aspects of their work, most importantly their documentation;
- Educates and trains other divisions within DSS on the workings of the FTC;

- Participates in case conferences, court appearances, and other client-related meetings;
- Markets the program to the community;
- Coordinates the DSS Quality Assurance and Improvement Program;
- Recommends improvements or process enhancements to DSS Administration, the Judge, and the Family Treatment Court team; and
- Provides direct services to the client, including the child, to augment the services of the DSS caseworkers.

The Department of Social Services FTC caseworker – ensures that the case is being handled properly according to TANF requirements, ASFA time-frames, departmental regulations and policies, and child welfare goals, including:

- Gathering background information on the case, along with the CPS/direct care/indirect care caseworkers;
- Presenting relevant information on the case at conferences and court appearances, and documenting activities in the client record;
- Performing client assessments, such as psycho-socials, when the case requires additional assessments to supplement what is already in the Department of Social Services file;
- After the initial CPS safety/risk assessment, performing additional safety/risk assessments on the child to ensure the ongoing well being of the child during the course of the client's involvement with the FTC;
- Developing the client service plan, along with other clinical members of the team and other Department of Social Services staff working on the case;
- In addition to the Department of Social Services caseworker from Direct Services or the caseworker from a contract agency, providing a variety of direct services to clients, such as home visits and counseling;
- Meeting regularly with the Buffalo City C.O.U.R.T.S. staff to gather information and coordinate service planning; and
- Communicating with service providers to monitor the client's progress in treatment.

CPS Worker/Children's Services caseworkers are ultimately responsible for the creation and implementation of the service plan as has always occurred in similarly situated Family Court cases. Within the FTC, however, the caseworker will report regularly to the Department of Social Services FTC team on plan issues and compliance and will receive the assistance of the C.O.U.R.T.S. Program in assessing substance abuse treatment needs, making treatment referrals, and monitoring treatment outcomes.

All other "service" referrals and monitoring remain the responsibility of the caseworker, including all needs of the children and other family members.

Observation

Historically, team differences have been an integral part of any interdisciplinary system collaboration in which "professionals" from diverse disciplines work on a common goal but continue to be administratively responsible to their own department superiors as well as compartmentalized team leaders. Taking into consideration the relative infancy of the Family Treatment Courts in New York State, the Erie County FTC has done a noteworthy job of overcoming many of these obstacles. The end result in this exercise built on trust is the development of a team mentality that is focused on helping drug addicted parents "break the cycle of drug dependency among families served by the child welfare system."

Family Treatment Court Staff and team interviews

POSITION
Family Treatment Court Judge
Family Treatment Court Coordinator
The Department of Social Services/Family Treatment Court Coordinator
Family Treatment Court Case Manager
The Department of Social Services/Family Treatment Court Senior Case Worker
The Department of Social Services/Family Treatment Court Senior Case Worker
The Department of Social Services Direct Children's Service Worker
CASA/Family Treatment Court Coordinator
Director of Law guardian Program
The Department of Social Services Attorney
The Department of Social Services Attorney
Respondent Counsel/Assigned Counsel Attorney
Deputy Chief Clerk/Family Treatment Court Project Director

The interview process was designed to elicit information, attitudes, opinions, and perspectives of all respondents relative to the FTC Program. In addition to the role of the particular individual in the functioning of the program, each interview focused on the overall perspective of the "quality" of the program relative to perceived goals. Interviews of staff and partners were designed as a series of open-ended interviews with the various players (components) of the FTC and other individuals with historical perspectives on the development of the Drug Court program. In order to extract the most from the interview process, respondent anonymity was insured. In all, 33 individuals were interviewed. Open-ended interviews were selected over a more empirically rigorous interview schedule methodology. The open-ended interview process was selected in the interest of candor and to retain the most flexibility in gathering information. A single interviewer carried out the interview process. Bias was further minimized in that the interviewer had no

prior knowledge of the Drug Court program or familiarity with any of the program components or participants.

Although each individual was aware of the purpose of the interview, every effort was made to create as informal an interview situation as possible. Each interview was conducted during the working day and held to a maximum of one hour. The notes were ultimately condensed into the relevant dimensions of FTC activities.

Results of the Interview Process: Overview

As would be expected, responses from the individual interviews varied substantially. The substance of information gathered depended on one's knowledge of the Family Court program history and dynamics, the subject's role in the Drug Court program, and the inclination of the individual to comment. Without exception, each individual was prepared to share his or her knowledge, insight, opinions, and perspectives without hesitation. In some instances, the interviewers were required to terminate the interview in the interest of time.

The most significant overall finding from the interview process was the extraordinary level of both professional and personal enthusiasm expressed by the interviewees toward the FTC. Without exception, each individual interviewed maintained the firm belief (based on participation and observation) that the FTC is functional and innovative and produces the desired results. There existed a general perception among the interviewees that the structure and function of the FTC not only presents the best opportunity to affect systematic change but does change the lives of individuals entering the program. In the words of one respondent, "This is the first time in my professional experience that community resources have been brought to bear on a significant problem with real results, for both the individual and the community".

A second general finding related to the spirit and level of cooperation that existed among the various components of the FTC that typically are not found in governmental programs. The most frequently given reason for this was that the structure of the program itself has positive benefits for each of the program partners relative to the resources required and overall mission. From the judicial perspective, the program offers the opportunity to re-direct resources to solve problems, tailors those resources to the needs of both the Court and the individual offender; and provides the judiciary with the opportunity to craft, monitor, and evaluate the results of decisions.

The prosecutorial perspective is that the program expedites the case processing while also reallocating scarce resources to the FTC participant. Other benefits include the improved image of the prosecutorial function over the typical public perception that to prosecute is to punish, and the existence of previously unavailable options that have a greater chance of reducing future court involvement while promoting the safety of the child.

Both assigned counsel attorneys and the DSS attorneys noted that resource requirements are minimized and the interests of the participant are better served. From the assigned council perspective, participation in the FTC addresses the individual needs of the respondents and quickens the pace of visitation. Perhaps more importantly, participation in the program provides an opportunity for the respondents to re-establish more meaningful relationships with their children while addressing their substance abuse problems. From the reported point of view of the legal systems involved in Family Treatment Court, perhaps the most profound change has been from an adversarial to a collaborative model. The systems are involved in enabling the parent to admit to neglect rather than advising and defending against a declaration of guilt. All involved systems reported this as the strength of the Family Treatment Court. These respondents voiced their belief that resistance to Family Treatment Court was lower now. The animosity among team members was greater in the beginning, but tensions have diminished as the team gains more knowledge and experiences achievement of program goals and objectives.

It should be noted that one of the most frequently expressed observations was the importance that personalities play in the continued functioning and success of the FTC program. Personal and professional collaboration efforts aside, it is a widely held opinion that without the force of judicial personality and the visionary dedication to program operation, characteristic of the current judicial leadership, the program would be in danger of eventual collapse.

Case Processing at the Family Treatment Court

Typical Case Process

1. At the first appearance in court following filing of a petition (arraignment), the potential FTC participant is referred to the Assigned Counsel Program with a revised referral form specifically indicating that the client is a possible Family Treatment Court candidate. For these cases, a return court date is given and indicated on the referral form. The first return date is scheduled generally two weeks from the arraignment date. At the same time, a participant handbook explaining the program is given to the client and reviewed in detail. Either the FTC coordinator or case manager reviews the handbook with the participant.
2. Prior to the first return date, the attorney, who will have previously been advised that the client may be a candidate for the program, will meet with the client and preliminarily discuss the FTC program. If the client is interested, he or she will be sent to the C.O.U.R.T.S. Program for alcohol and drug screening prior to the next scheduled court appearance. This screening is only for the purpose of determining suitability for participation.
3. At the first appearance, C.O.U.R.T.S. staff will be present, along with the respondent and his or her attorney, to report the findings regarding the alcohol and drug screening. Specifically, this is to inform the judge whether or not the client is appropriate for FTC involvement (i.e., abuse or dependency diagnostic indicators are present).
4. If deemed appropriate and the respondent wishes to proceed further with the process based on preliminary discussions with his or her attorney, the respondent will receive a detailed program explanation and orientation by the C.O.U.R.T.S. Liaison with the FTC. The respondent's attorney must be present at this time.
5. The client will make the decision as to participation after consultation with his or her attorney.
6. The client's decision is articulated in Court. Jointly, the FTC Team develops a coordinated, seamless plan that includes the family service plan (Department of Social Services driven) coupled with the alcohol/drug treatment plan.
7. The coordinated plan is then presented to the client and the attorney. After any modifications are incorporated, the plan is then presented to the Court for its consideration and approval. The client then signs the program contract after a final review of the contract with his or her

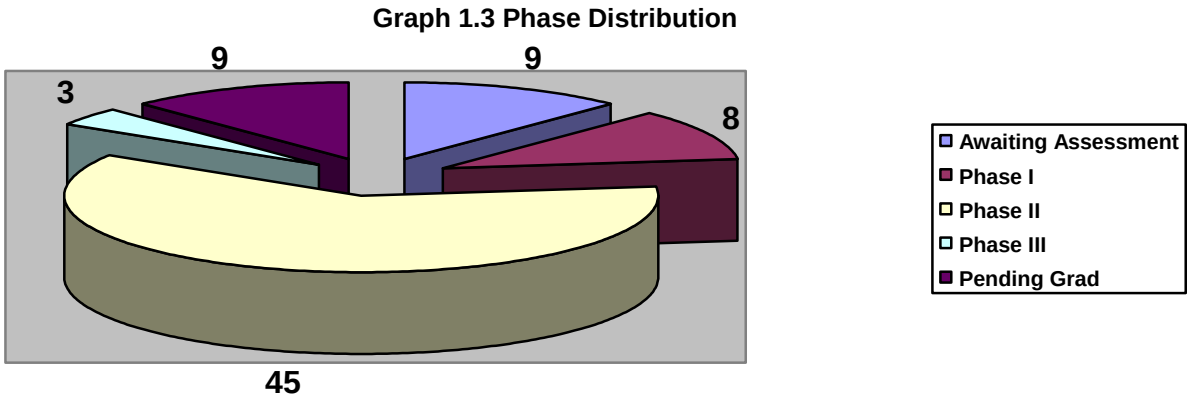
attorney. The client also signs a dispositional menu and the Family Treatment Court Contract.

8. Placement at the treatment agency generally occurs at the screening and the family recovery service plan is initiated the day the contract is signed.. There are times when addictions and clinical stabilization require inpatient detoxification and residential treatment (30 to 60 days) before implementing services pursuant to the family service plan, so that the client is able to benefit from and respond to those services.

Case Conferences: A case conference is held before each court appearance. The respondent's attorney, the child's law guardian, the Department of Social Services lawyer, and the Department of Social Services caseworkers and court liaison meet with clinical staff and review assessment summary information and the initial treatment plan. Should new information be revealed, modifications can be made to the treatment plan.

Dispositional Hearing and Admission into the Program: Respondents who agree to participate in the FTC program make an admission of neglect due to substance abuse and sign the FTC contract, in which they formally agree to the treatment plan and agree to abide by all Treatment Court rules and regulations. Once the participant signs the contract, he or she is admitted to the FTC. In addition, for participants, this appearance constitutes a d*ispositional hearing.*

Client Participation, Treatment and Court Process: Once a client is accepted in the Family Treatment Court, he or she again meets with the C.O.U.R.T.S program case manager to review treatment and services as indicated in the treatment plan. Upon placement in treatment, client progress is governed by a three-phase system driven by the client's accomplishments and performance, rather than by time considerations. Graduated sanctions and rewards are utilized to support participant accountability to the service plan. In addition to participation in a treatment program, clients must meet regularly with court case managers for counseling and urine testing. Parents may also be required to complete parenting programs and other services in addition to drug treatment.



Clients in the first phase of FTC involvement are required to appear in court weekly. Frequency of court appearances in Phases II (generally bi-weekly) and III (monthly) may change, depending on client situation and/or progress. Court case managers reach out to clients who fail to appear for court or other mandated services. Of the 74 active participants, more than half (61%) are in phase II, and 8 (12%) have met all program requirements and are pending graduation.

Chemical Dependency Services

Existing community based treatment facilities licensed by the New York State Office of Alcohol and Substance Abuse Services (OASAS) provide treatment services. A majority of FTC clients (60%) are receiving Medicaid or are Medicaid eligible and are assisted by the case management team in securing entitlements. Respondents who are ineligible for benefits are referred to facilities that accept sliding scale fees or are deficit-funded providers. As a result, no client is refused treatment based on inability to pay. The Family Treatment Court and the Western New York Consortium of Alcohol and Substance Abuse Providers follow national, state, and local guidelines to determine levels of care for participants. These guidelines (adapted from the American Society of Addictions Medicine [ASAM] criteria) include dimensions for intoxication and/or withdrawal, biomedical conditions, emotional/mental heath status, treatment acceptance/resistance, recovery environment, and relapse potential. OASAS has reported that the Western New York treatment system is currently underutilized and that service capacity is expandable, if necessary. Many local providers have assimilated the ASAM Patient Placement Criteria and are using the Comprehensive Assessment and Diagnostic Summary developed through the Erie County Consortium of Alcohol

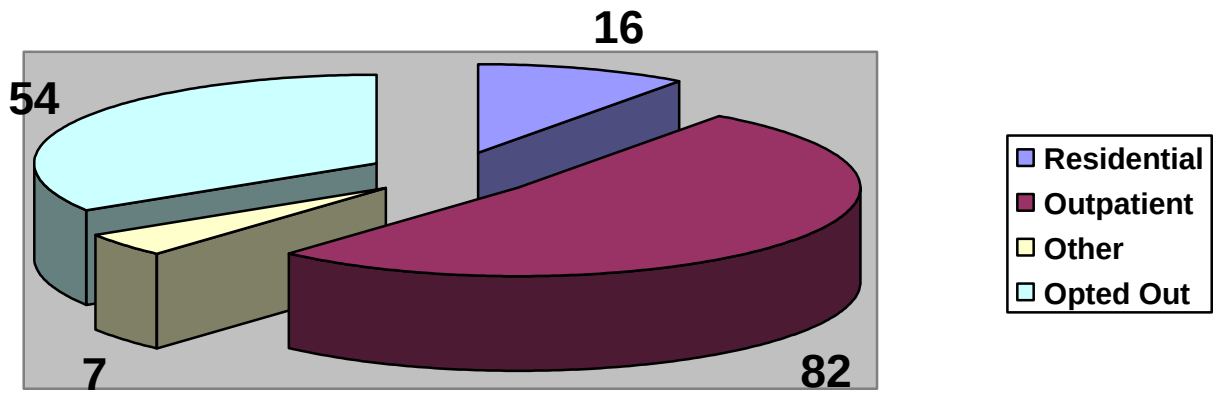
and Substance Abuse Provider's Treatment Subcommittee as the standard intake evaluation. They represent the best practices available for the addicted parent. These clinical instruments are not a substitute for the clinical expertise of skilled clinicians, nor are they specific to the unique issues and problems of FTC participants.

However, between departments and or disciplines the question of "who is the client" is often debated. For many within the substance abuse treatment community, the adult (parent) is considered the primary client, and everything else in the client's life is of secondary importance. Treatment providers may or may not consider the children's interests or include them in therapeutic activities. For the child welfare agency, the child is the primary focus of the intervention, with the entire family being defined as the client. When a choice must be made between balancing children's and parents' needs, the child welfare system must put the children first. The FTC itself could be viewed as an experiment in the balanced integration of system ideologies.

Understanding healthy child development and the ways in which at risk families can be strengthened through interventions is a critical piece in the development of a comprehensive Family Treatment Court. Traditionally, the judicial system has dealt with substance abusing adults and their addiction issues. It has only peripherally seen the courts' role of leadership in creating linkages for the children in the families through prevention, services, intervention, and monitoring to help increase the chances that the children's development will stay on course and to lessen the chances of children becoming substance abusers. While, health and safety issues have been foremost in the courts mind and permanency the goal for each family, most members of the judiciary as well as associated family dependency treatment court team members admit that they have to become more knowledgeable about the building blocks of healthy child development. Once there is a more fully understood model of what children need to grow and develop, family treatment courts can better assist families in reaching these goals. Family Drug Courts can play a critical role in creating a more positive trajectory for the lives of at - risk children, stretching beyond primarily health and safety issues to other key components. Continuing education and team development will improve the likelihood of program success (Kumpher, 1998b).

The fundamental principle of the FTC Participant Placement System is that the participant be placed in a level of care that has the appropriate resources to assess and treat the participant's condition based on severity of the presenting disorders and life functioning skills deficits.

Graph 1.4 Total Referral to FTC



Initial Family Treatment Court Participant Level of Care

Treatment Experience

There were 159 participants screened for involvement in the Family Treatment Court from 5/31/01 through 12/31/02. Of these, 54 did not sign the FTC participation contract and were excluded from further analysis. This may relate to procedural limitations, lack of participant motivation and/or lack of facilitating participant engagement by the FTC team. Simply stated, this should not be considered a significant deficiency, as start up of any new program requires the trials of correcting policies and procedures. (It should be noted that this non-engaged population would be an excellent control group for an outcomes longitudinal research study, if funding became available).

Of the 105 FTC participants who entered treatment during the study period, 82 (78%) initially entered outpatient treatment. This included 13 (12%) who initially entered intensive outpatient treatment (4 - 5 days per week) and 69 (66%) who initially entered outpatient treatment 2-3 days per week. An additional 16 (15%) entered short-term inpatient residential facilities, 6 (6%) entered long-term halfway house/recovery care treatment, and 1 individual entered inpatient detoxification. In approximately 80% of these cases, the specific agency that was initially entered by the participant was the same agency that the drug court team suggested at the treatment recommendation hearing. However, as expected, there were treatment changes based

on participation and compliance with the initial treatment plan recommendations. These changes in levels of care were consistent with the ASAM Patient Placement Criteria in addressing immediate participant disturbances as part of the recovery process.

The treatment episodes of the cohort of 105 FTC participants included the following: 98 participants who experienced outpatient treatment (ASAM Levels I & II), and 54 entered at least one inpatient rehabilitation or residential treatment experience during the study period (ASAM Level III). Of these, 21 were linked to long-term inpatient treatment facilities (ASAM III.I, III.3 or III.5), and the remaining 33 had short-term inpatient rehabilitation admissions (ASAM III.7) Fifteen (15) of these had two inpatient rehabilitation admissions, and 3 individuals had 1 admission for detoxication treatment (ASAM IV). As is evident, many participants had many levels of treatment experiences. In addition to the traditional placements, six females were admitted to long-term recovery care accompanied by their children (there are no similar programs for males). Of the 54 individuals who had at least 1 inpatient/residential treatment experience during the study period, 37 (68%) were still active in this level of care at the 12/31/02 date, and 17 were voluntary or involuntary failures.

Research continues to affirm the importance of the length of time in treatment for addicts, with better results usually occurring with longer participation in treatment programs. Beyond a 90 day threshold, treatment outcomes improved in direct relationship to the length of time spent in treatment, with one year generally found to be the minimum effective time spent in treatment. Simpson et. al., (1997) and Taxman (1998) illustrate how a treatment process can assist in increasing the length of time in treatment by providing a treatment process with different levels of intensity. The goal is to engage the offender in treatment for longer periods of time, by combining intensive and less intensive services. The length of time a patient spent in treatment was a reliable predictor for post treatment performance. Graduates of the FTC averaged 456 days in the program (from initial contact to graduation date), comparatively, participants who were terminated averaged 149 days.

Program Phases/Expectations and Advancement Criteria

Beginning Phase

Goal: **Initiate Treatment Program.**

Minimum length: 8 court appearances

Expectations:

1. Acknowledgement of substance abuse problem.
2. Abstinence from alcohol/mood-altering drugs.
3. Consistent attendance at scheduled court appearances.
4. Cooperation in assessment(s) for substance abuse issues or other service needs.
5. Compliance with Contract and Plan for Services which may include but not be limited to:
   - Several successful visits with children;
   - Consistent participation in treatment;
   - Attendance at all family conferences and scheduled meetings with the Department of Social Services caseworker; and
   - Introduction to 12 Step/Alternative Support groups in the community.
6. Participation in treatment-based and court-ordered random drug testing.
7. Development of relapse prevention plan.
8. Treatment team recommendation of advancement.

If expectations are successfully met, result is:

1. Recognition and praise by those present in the courtroom, including the judge, attorneys, treatment court staff and other participants (i.e., a round of applause).
2. Certificate of completion of Phase 1.
3. Advancement to next stage.

Advanced Phase

Goal: **Achieve sustained sobriety and return of children**

Average length: 20 court appearances

Expectations:

1. Minimum of six consecutive months of clean drug tests and documented sobriety.
2. Identification of recovery goals, including commitment to ongoing recovery.
3. Continued consistent attendance at scheduled court appearances.
4. Continued compliance with Contract and Plan for Services, which may include but not be limited to:
   - Consistently successful visits with children;
   - Consistent participation in all aspects of treatment;
   - Involvement in parenting skills training;
   - Participation in services directed toward obtaining stable housing and educational/vocational training;
   - Attendance at all family conferences and scheduled meetings with the Department of Social Services caseworker; and
   - Introduction to and consistent participation in Twelve Step/Alternative Support groups in the community, including obtaining a sponsor.
5. Participation in treatment-based and court-ordered random drug testing.
6. Demonstration of commitment to relapse prevention plan.
7. Completion of recommended substance abuse treatment.
8. Treatment team recommendation of advancement.

If expectations are successfully met, the result is:

1. Recognition and praise by those present in the courtroom, including the judge, attorneys, treatment court staff, and other participants (i.e., a round of applause).
2. Advanced Stage completion ceremony with family, children, and treatment team.
3. Advancement to Aftercare Program.

Phase - 3

Goal: **Maintain sobriety while addressing all remaining child welfare issues.**

Average length: 6 - 12 court appearances

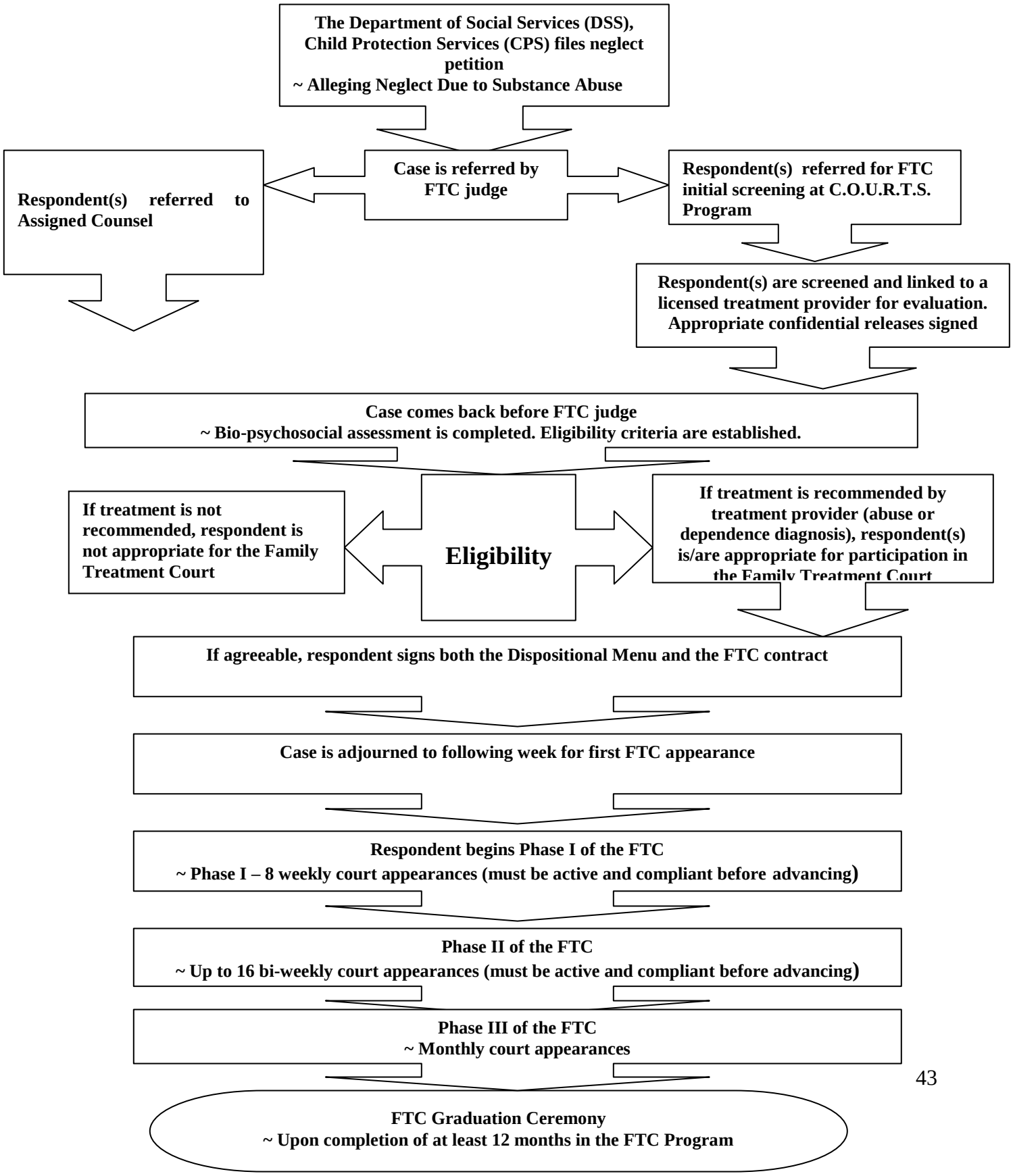
Expectations:

1. Minimum of six consecutive months of clean drug tests and documented sobriety.
2. Continued consistent attendance at scheduled court appearances.
3. Continued participation in treatment-based and court-ordered random drug testing.
4. Completion of all elements of the Contract and Plan for Services.
5. Active involvement on an ongoing basis with Twelve Step/Alternate Support groups.
6. Successful reintegration into the community.
7. Minimum total of six months of successful interactions with children.
8. Development of an Aftercare Plan, incorporating any recommended counseling or services.

If expectations are successfully met, the result is:

1. Recognition and praise by those present in the courtroom, including the judge, attorneys, treatment court staff, and other participants (i.e., a round of applause).
2. Graduation ceremony with family, children, and treatment team, including a certificate and photo with the judge.
3. Invitation to join Court Alumni program.
4. Solicitation to be a mentor for new clients in the Family Treatment Court.

Family Treatment Court Process



Disposition: Dispositional orders for FTC clients are entered 90 - 120 days after the dispositional hearing, which meets the court system's goals for disposition of cases. However, contrary to normal case processing (where the court's relationship with a family may end with the entery of the dispositional order), FTC clients are monitored for the entire dispositional period. Therefore, the FTC maintains the ability to frequently amend the dispositional order as the case progresses. Specifically, clients continue to participate in treatment and other programs as per FTC procedures. For example, participants appear regularly in court no less than once a month, meet with the court case manager for updates and urine testing (both random and scheduled), participate in family group conferences and visitation, and work toward completion of all listed requirements for graduation/reunification.

For cooperative clients, depending on their individualized treatment/service plan as well as the best interests of the children, dispositional orders can vary widely. In all cases, the pre-and or post-dispositional appearances allow the court to continually reassess the status of the children and make changes as necessary. Visitation can thereby be gradually increased, perhaps to the point that a child is discharged on a trial basis to parents while under court and DSS supervision. At the end of the dispositional period, children may be formally discharged to parents if the family exhibits readiness.

In addition to diligent reunification efforts conducted by the DSS, the FTC team will also attempt to re-engage wayward parents in the treatment and reunification plan. Ultimately, however, lack of compliance with treatment may result in the implementation of an alternative permanency plan for children, which may include a petition for termination of parental rights. For noncompliant participants, dispositional orders will likely mandate the placement of children in foster care.

Collaborative Case Management: Throughout the course of participation, the C.O.U.R.T.S. FTC Program staff work jointly with the DSS liaisons and case workers, as well as foster care workers, to ensure that treatment and services for both parents and children are delivered. Dedicated DSS court liaisons working in the FTC facilitate the flow of information and appear on cases on behalf of the DSS field case managers. Treatment compliance information gathered by Family Treatment Court case managers is shared with the DSS and foster care workers.

Information about children, visitation, and placement gathered by the DSS and foster care workers is shared with FTC staff. In this way, all parties have access to all relevant information and case decisions are made through a collaborative effort.

Visitation: Whenever possible, the Family Treatment Court seeks to consistently increase the amount of contact between parents and children. All respondents are entitled to the statutory minimum visitation schedule of biweekly one-hour -supervised visits, unless otherwise indicated by the circumstances of the case. Visitation may be increased based on the participant's progress in treatment and the best interests of the children. In most cases, visitation will not be reduced unless the child is deemed to be at risk.

Involving Extended Family and Community Supports: Through family group conferences beginning after disposition, the Court seeks to engage other family members and community supports regarding the case and the reunification plan. Family group conferences help to build a community and family-based network of supports for the eventual return of a child. This on-going communication assists family members in dealing with the addicted biological parent and helps to support the FTC rules regarding visitation. Family Group Conferences also help parents build drug prevention strategies for children returning home.

Trial Discharge: In some cases, as described above, the parole or trial discharge of a child may occur when it is clear that the respondent is abstinent and in compliance with all aspects of treatment, and that the child's emotional and physical safety can be confidently assured in the parent's care. Given the ability of the Court to monitor families and parents after disposition, trial discharge need not be a part of the original dispositional order, but it can be instituted at any time thereafter. Realistically, trial discharge will most likely occur after a sustained length of sobriety or under the supervision of a residential parent/child program.

Permanency Hearings:

Permanency hearings determine the appropriate goal for the child or children in question while they are in foster care. These goals include re-unification with parents, placement with a kinship resource, or surrender for adoption. Currently, only individuals who maintain the goal of re-unification continue in the Family Treatment Court. The issue of appropriate goals is assessed each time the parent appears, and when necessary, a separate court proceeding is scheduled if there is no agreement on the goals

Treatment Court Failure: Should the court determine at a permanency hearing that, due to noncompliance by the respondent, the permanency-planning goal could be changed to something other than return to the parent, the case is then considered a treatment court failure. In "failure" situations, the case remains in the FTC and proceeds as quickly as possible to alternative permanency plans decided upon at the permanency hearing. Subsequently, termination of parental rights proceedings may be ordered and/or filed, thereby freeing the child for adoption.

Graduation Successful Treatment Court Completion: Respondents who meet all of the FTC requirements and formulate and implement a permanency plan for all involved children that is acceptable to the Court, are eligible for graduation. In those situations where reunification is the goal for children, graduation can occur when the client has completed treatment, established a safe, stable, drug-free home, has successfully completed all FTC requirements, and addressed all other issues so that Court supervision is no longer necessary. In such cases, the finding of neglect made upon the client's initial admission is vacated (however, the report is still in the New York State central registry).

Responding to Problems: Infractions and Sanctions

Context: Just as it is important to recognize progress, it is also important to respond quickly to problems or shortfalls during treatment participation. In some cases, an appropriate response will be clinical in nature, (e.g., changing the level, nature or intensity of the treatment being provided). In other cases, the appropriate response may be a court action or sanction. By imposing a series of graduated sanctions, clients who are not complying with treatment learn that there are swift consequences for lack of progress in treatment. The objectives, however, are not only to admonish them for noncompliance but to re-engage and encourage clients to continue working through the recovery and treatment process.

What are Infractions? An infraction is a negative behavior or action contrary to the treatment process and or court orders. Infractions are listed below:

- Relapse after the first 30 days after entrance into the FTC Program
- Continued usage
- New child neglect charges
- Tampering with drug screens
- Inconsistent participation/attendance at treatment, court appearances, or other mandated services
- Unsuccessful visits with children, including missing them without reason, and/or when the lack of success is a result of the respondent's behavior
- Negative interference with another FTC client's recovery program
- Verbal or physical abuse of court staff

What are Sanctions? A sanction is a response to an infraction. The seriousness of the infraction determines the severity of the sanction imposed. Sanctions are "graduated." Not only are more severe sanctions imposed for more serious infractions, but as infractions accumulate, the sanctions become more severe (graduated). Sanctions, or negative consequences, are progressive and administered in a fair, consistent, and predictable manner.

How Many Infractions and Sanctions Can a Client Get Before the Permanency Planning Goal for a Child is Changed? The Court recognizes that relapses can be a part of the recovery process. It should be noted that every opportunity is given to the participant within the allowed ASFA timeline. However, clients will not get unlimited chances to change their behavior and succeed in treatment. Overall, the Court has an obligation to determine a permanent living arrangement for the children. If parents demonstrate by continually failing to comply with treatment court orders that returning a child to them is not in that child's best interests or cannot occur in the mandated period of time, the Court will proceed with other permanency plans.

What Are the Sanctions and or Rewards? The following is a list of possible sanctions and or rewards that can be imposed. This list is meant to be a framework, not a formula. The FTC team generally makes recommendations to the judge. The judge has the ultimate discretion in deciding which sanctions are appropriate for which infractions and what rewards are appropriate for accomplishments.

Rewards	**Sanctions**
• Verbal praise and encouragement by judge • Peer support and recognition, resulting in praise by those present in the courtroom, including attorneys, staff, and court (e.g., a round of applause) • Decreased frequency of court appearances • Calendar preference/case called early in court • Presentation of a certificate of achievement at various stages of participation, not necessarily tied to stages • Phase advancement • Small gift certificates suggested for use with children during visitation (e.g. Happy Meals, shopping, movie tickets, and zoo passes) • Small cosmetics (e.g. bottle of nail polish) • Graduation ceremony	• Judicial reprimand • Increased frequency of court appearances • Requiring respondent to attend part of an extra day (not respondent's own scheduled day) in court observing appearances • Requiring respondent to attend an entire extra day (not respondent's own scheduled day) in court observing appearances • Writing essay on appropriate topic (e.g. effects of drug use on children, the effects of drug use on respondents relationships with others, results of drug use on the physical health, and quality of life of the respondent • Journal writing • Letter to child(ren) • Extra Twelve Step/Alternative support group meeting • Increased urine testing • Community service • Reduction in phase (stage) • Incarceration • Termination from program

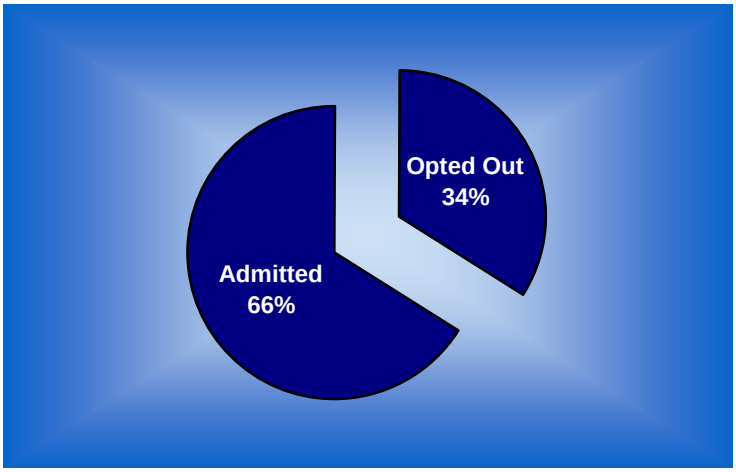
Important Note: Decreases in visitation are not a regular part of the sanction scheme. In general, a single lapse or positive toxicology may not, in and of itself, result in a decrease in visits. However, in cases where there is a prolonged relapse and other noncompliant behavior like missed program attendance, missed visits, etc., the Court may reduce, limit or change the visitation order (if it is determined that such a change is in the best interests of the child).

Table 1:1: Characteristics of Respondents

Variable	Active	Graduated	Terminated/ Failed	Warrants	Total
# of participants	74 (46.6%)	4 (2.5%)	77 (48.4%)	4 (2.5%)	159 (100%)
Gender					
% females	60 – 81%	3 – 75%	53 –68.8%	4 – 100%	120 – 75%
% males	14 – 19%	1 – 25%	24 – 31.2	0 – 0%	39 – 25%
Ethnicity					
% Caucasian	29 - 39%	3 – 75%	35 – 45%	1 – 25%	68 – 43%
% African American	36 - 49%	1 – 25%	37 – 48%	2 – 50%	76 – 48%
% Hispanic	5 - 7%	0 – 0%	2 – 3%	1 – 25%	8 – 5%
% Other	4 - 5%	0%	3 – 4%		7 – 4%
Mean Age	32.8	35.7	34.6	26.5	33.5
Marital Situation					
% Never Married	52 - 70%	1 – 25%	50 – 65%	4 – 100%	107 – 67%
% Currently Married	13 - 18%	3 – 75%	12 – 15%	0 – 0%	28 – 18%
% Other	9 - 12%	0 – 0%	15 – 20%	0 – 0%	24 – 15%
Employed					
% yes	18 – 24%	3 – 75%	62 – 81%	1 – 25%	84 – 53%
% no	56 – 76%	1 – 25%	15 – 19%	3 – 75%	75 – 47%
Education					
% < 12 years	43 – 58%	0 – 0%	30 – 39%	4 – 100%	77 – 48%
% 12 years	14 – 19%	1 – 25%	19 – 25%	0 – 0%	34 – 21%
% >12 years	17 – 23%	3 – 75%	28 – 36%	0 - 0%	48– 30%
% Receiving Government Assistance	35 – 38%	0 – 0%	15 – 23%	2 – 50%	52 – 33%
Pregnancy Status at Intake					
% not pregnant	72 – 77%	2 – 50%	76 – 99%	4 – 100%	154 – 97%
% pregnant	2 –2%	2 – 50%	1 - 1%	0 – 0%	5 – 3%
Mean # children birthed or fathered	3	3.5	3.3		3
% Ever attempted suicide	7 – 9%	0 - 0%	8 – 13%		15 – 9%
%Ever received mental health counseling	14 – 15%	0 – 0%	10 – 13%	1 – 25%	25 – 16%
% Ever emotionally and or physically abused	28 – 38%	2 – 50%	23 – 30%	0 – 0%	53 – 33%

Variable	Active	Graduated	Terminated/ Failed	Warrants	Total
% Ever sexually abused	28 - 38%	2 – 50%	23 - 30%	0 – 0%	53 – 33%
Primary Drug					
% alcohol	25 – 35%	3 – 75%	27 – 35%	0 – 0%	55 – 34%
% cocaine	8 – 11%	0 – 0%	9 – 12%	0 – 0%	17 – 9%
% crack	18 – 24%	0 – 0%	24 – 31%	4 – 100%	46 – 30%
% heroin	6 – 8%	0 – 0%	2 – 3%	0 – 0%	8 - 4%
% marijuana	15 – 20%	1 – 25%	8 – 10%	0 – 0%	24– 16%
% pills	1 – 1%	0 – 0%	1 – 1%	0 – 0%	2 – 1%
% poly-drug	63 - 69%	0 – 0%	43 – 67%	0 – 0%	106 - 67%
% none	1 – 1%	0 – 0%	6 – 8%	0 – 0%	7 –6%

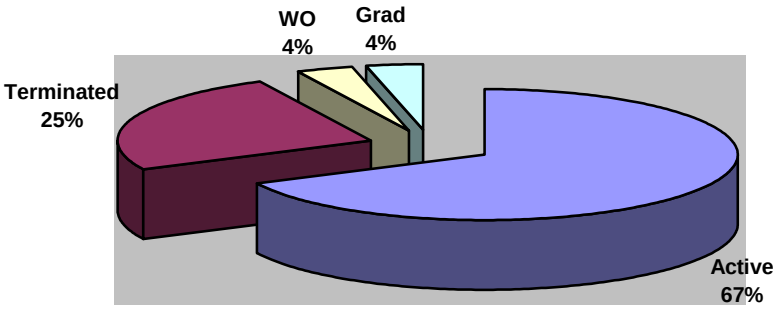
Graph 1.5: Description of Program Participants



During the report period, 159 individuals were referred to the Family Treatment Court, and 54 (34%) opted out prior to program admission and were identified as ineligible (failure to sign a contract and were never formally admitted). It appears that the addiction denies the parent the foresight of associated consequences. Given the compelling nature of addiction and the debilitating influence on the chemically dependent parents ability to appreciate the long-term consequences of their use, termination of parental rights appeared to be a vague process. As one referral suggested, "This could be dealt with later. " Further action, regardless of the severity, did not motivate many of the referrals. The imminent threat of permanent termination of parental rights is not as motivating as one might expect.

In contrast, the greatest incentive the court has to offer for a parent's participation is the re-involvement of that parent with his or her child in a healthy, productive relationship. Of the 105 individuals accepted into the program (accepted being defined as those who signed a contract) during the report period, 74 (71%) were still active in the program on December 31, 2002, 4 (4%) were in warrant status (less than 90 days, still counted as active), 4 (4%) had successfully graduated, and 27 (25%) voluntarily chose to leave the program or were terminated by the court due to noncompliance or treatment failure. For those admitted to the Family Treatment Court, the average number of days, from the date the petition was filed to the contract date, was 73.8. The graduates spent 426.5 days to complete the program (contract date to graduation date). The one year retention rate for this 19 month period, which was calculated by considering only those individuals who entered the program at least one year before the end of the study period and by dividing the number of participants who either graduated or were currently active, detained, or on a warrant for less than 90 days (63) on December 31, 2002, by the total number of participants who entered the program (94) after December 31, 2001, was 67%. This rate is slightly higher than the estimated national average 1 year retention rate for Drug Courts of 60% (Belenko, 1998) and is much higher than the 30-60% 3 month retention rate for voluntary treatment (Condelli & DeLeon, 1993).

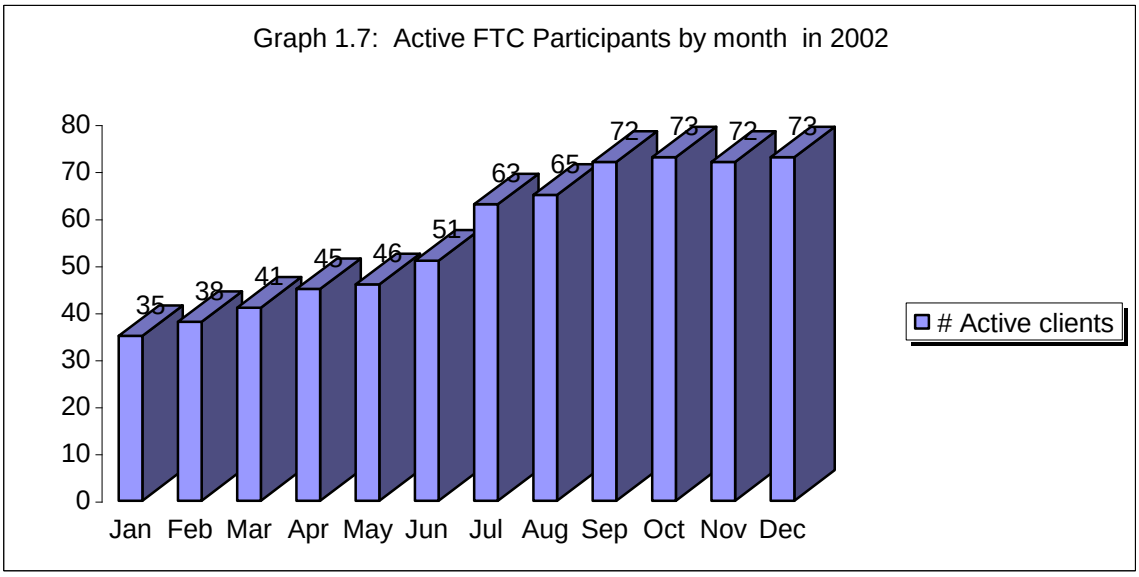
Graph 1.6: Status of Program Evaluation



Is the FTC Conveying an Attitude of Hope and Expectancy?

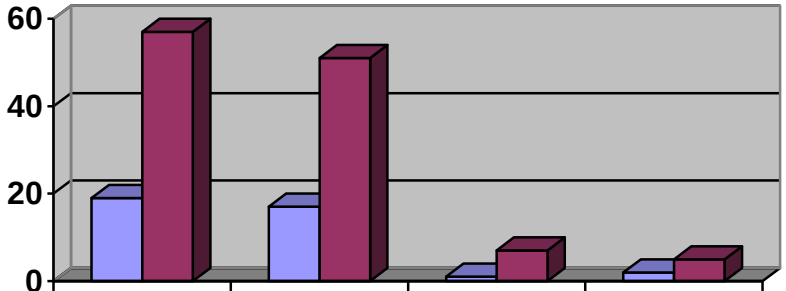
One of four contributors to change (Lambert, 1992) is hope and expectancy. This relates to the referrals' hope and expectancy that changes will occur as a result of entering drug court programming. A number of the FTC practitioners interviewed indicated that they use a strength-based approach. During the report period, as indicated above, 159 individuals were referred to the FTC, with 54 (34%) having opted out prior to program admission.

Michael Clarke (NDCI review 2001), Director of the Center for Strength Based Strategies stated, "In practice, staff may encourage hope and expectancy by (1) conveying an attitude of hope without minimizing the problems and pain that accompany the offender's situation; (2) turning the focus of treatment toward the present and future instead of the past; and (3) instilling a sense of empowerment and possibility to counteract the demoralization and passive resignation often found in drug court participants who have persistent problems." FTC participants and their families often feel "stuck" in their problem states. This feeling can be based partly on negative attitudes that allow no escape from problems ("I can't change," "You don't understand – I have to hang out with my using friends.") One strength-based strategy would be to encourage staff to allow the participants' problems, whether perceived or real, to coexist with the focus on emerging solutions. In many instances within remedial drug court work (and throughout the helping professions), there is a mind-set to conquer, eliminate, or "kill" the problem. Oftentimes it is helpful and much more expedient to allow the problem to coexist with an emerging solution or healthy behavior that is being developed. Strength-based work may instill hope while also acknowledging problems and pain. Instilling hope is more complex than simple encouragement. Participants need to believe that taking part in drug court programming will improve their situations. Therefore, during the orientation phase of the programming, many successful drug court programs provide convincing testimonials of success and program efficacy. Based on research and best practice, it was recommended that participants referred to the FTC have an opportunity to view the court. The FTC judge recognizes the value of this activity and would initiate this practice; however, the size of the courtrooms in the Family Court limits the number of people that have access. This judge indicated that the team would work on a solution to the limitations.



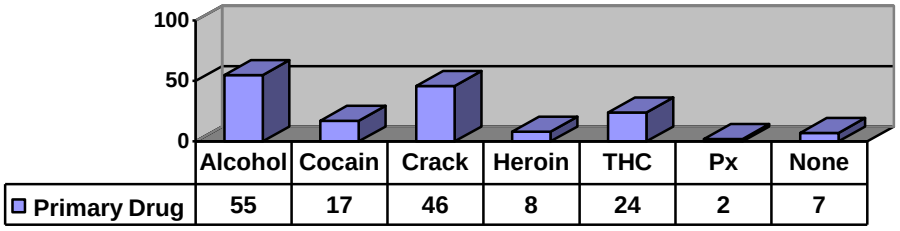
The age of the participants ranged from 19 to 67 years at program entry, with an overall mean of 34.6 years, slightly more than three fourths (77%) reported being employed at the time of program entry. Approximately one half (49%) had less than a high school education, and 50 (31%) were on public assistance. Approximately one fourth (25%) of the participants were male, and slightly less than half (47%) of the participants were African Americans. The specific breakdown of participants by gender and race is summarized below.

Graph 1.8: Race/Ethnicity of all Referrals
5/31/01 - 12/31/02



	AA	Caucasian	Hispanic	Other
Male	19	17	1	2
Female	57	51	7	5

Graph 1.9: Primary Drug Reported by all referrals
5/31/01 - 12/31/02



	Alcohol	Cocain	Crack	Heroin	THC	Px	None
Primary Drug	55	17	46	8	24	2	7

With regard to drug use, the majority of individuals (55%) reported using drugs for more than 10 years at intake, with 84% reporting using drugs for at least 5 years. The drug which was most often reported to be the primary problem substance was alcohol (35%), crack (29%), followed by marijuana (15%), cocaine (11%), and heroin (5%). Poly-drug use was reported to be 67%.

With regard to drug treatment history, 15% of participants reported being in some form of drug treatment program when the petition was filed, and more than half (57%) reported that they had been in a drug treatment program at some time. In fact, over 36% reported at least three treatment program experiences, and 59% reported using drugs prior to age 21. In addition, 75 (47%) reported being arrested within the last 24 months, and 15 (9%) had current cases pending in the criminal court when they were referred to the Family Treatment Court.

In summary, the FTC participants in the Family Drug Treatment Court represented a diverse group of individuals, both males and females, and a wide range of ages and racial groups. Surprisingly, most of the parents were employed. However, close to half were high school dropouts, raising concerns about employment above the federal guidelines for poverty status. Most had failed drug treatment histories. All had in common a history of contact with the Family Court, and all were provided the opportunity to participate in an innovative program to help them face their addiction through this unique collaboration between treatment providers and the Family Court system.

The number of children who were birthed or fathered by these respondents was 536. The mean number of children who were birthed or fathered by these respondents was 3.37. With regard to mental health variables, 11% reported at least one prior suicide attempt, 15% had received prior mental health counseling; and 55% had a history of sexual, physical or mental abuse. The participants reported a mean number of previous treatment episodes of 2.45; the majority of those who were terminated from the Family Treatment Court (57%) were poly substance abusers.

The Erie County DSS reported on the 175 referrals to the Family Treatment Court from 5/01/01-1/30/03. Recidivism data within this group obtained by the DSS from Child Protection Services indicated that prior contact was present in 100% of all cases referred to the FTC. A little more than half (89, or 51%) had one or more previous CPS reports; 30% (53) had a history of one or more positive toxicology babies; 12% (21) had previous termination of parental rights actions (TPR's); and 7% (12) had a previous voluntary surrender of other children.

Comments: Risk and protective factors encompass psychological, behavioral, family, and social characteristics. Over the past 20 years there have been many studies that have tried to determine the origins and pathways of drug abuse, how the problem starts, and how it progresses. Several factors have been identified that differentiate those who use drugs from those who do not. Factors associated with greater potential for drug use are called "risk" factors. NIDA research (NIH Publication 97-4212) revealed that there are many risk factors for drug abuse, each representing a challenge to the physiological and social development of an individual and each having a differential impact depending on the phase of development. NIDA indicated that those factors that affect early development in the family are probably the most crucial, such as:
chaotic home environments, particularly in homes with parents who are substance abusers or who suffer from mental illness; ineffective parenting, especially with children with temperament and conduct disorders; and lack of mutual attachments and nurturing

While not confirmed by research findings, program staff, Family Court practitioners, and other justice professionals indicated that they can frequently predict, at the time of birth, the likely future for the child born to an addicted parent. They voiced the common concern that the majority of these children will likely have behavioral problems resulting in poor school performance and, all too often, criminal conduct and future involvement in their own cases in Family Court. They all recognized that addiction is a chronic relapsing disease, which, if not interrupted, will be passed through generations from family member to family member. These cases are often classified as "career cases" that span generations because of the negative impact on the child caused by the separation from and substance use of the natural parent.

Challenges

To obtain a complete profile of each participant, as well as the children, that included intake characteristics, demographic information, family needs and services, time frames for obtaining program objectives and ultimate outcomes, three sources of data needed to be integrated. This accentuated and promoted the complexity involved in the total understanding of the FTC process. Although the DSS FTC Coordinator keeps extensive case notes, quantitative and qualitative reports that are adequate to enable DSS to serve its clients, what was lacking for evaluation purposes was a structured system for assessing longitudinal changes in client and child functioning. Thus, it was not possible to measure changes in domains of psychosocial functioning, such as living situation and health status, nor was it possible to track the number of moves a child may have made throughout the FTC process. In addition, it was not possible to obtain complete demographic information on the children, as it is not collected in a systematic fashion and all files were not in the same location. The majority of files are on paper, and they were not all organized in a similar manner.

Children of the Family Treatment Court

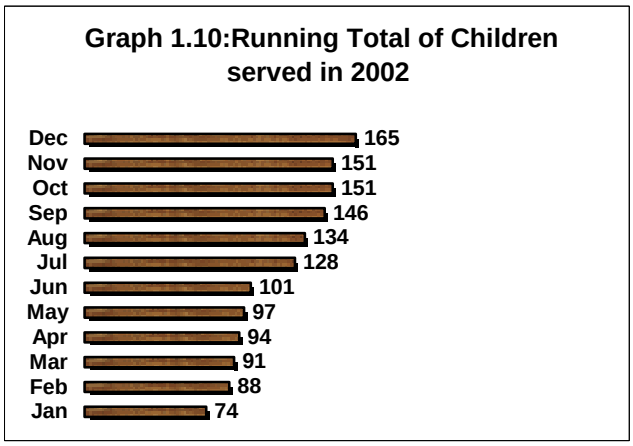
Table 1.2 describes the status of the 229 children who were under the supervision of the Family Treatment Court, who were originally cited on the neglect petitions that brought the participants to the attention of the court, and 1 child who was born to a participant during the study period. This includes 162 children of the 74 active respondents, 8 children of the 4 graduates, and 60 children of the 27 participants who were terminated without completing the program. Their ages ranged from newborn to almost 18 years (mean = 6.8 years, n=168).

Table 1.2: Status of Children under Family Treatment Court Supervision

Variable	Active	Graduated	Terminated/ Failed	Total
# of children	162	8	60	230

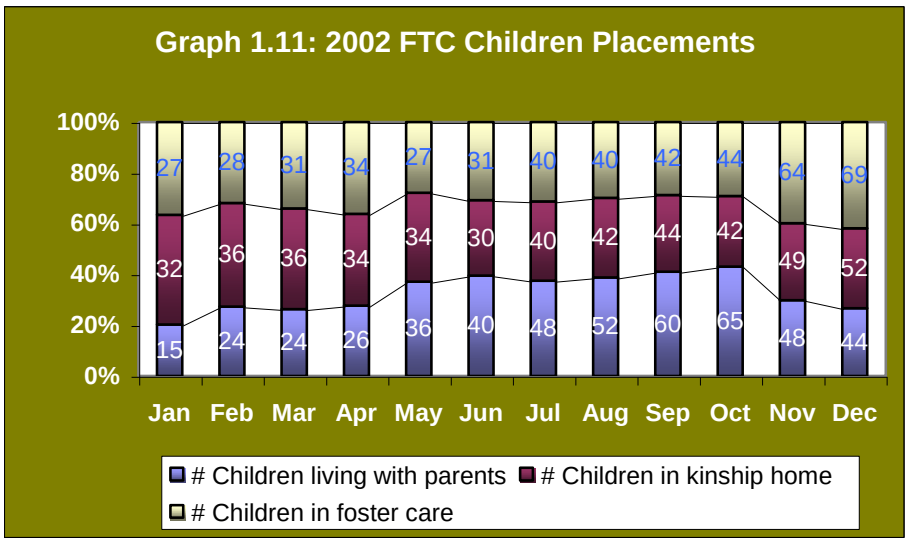
As previously indicated, 67% of the participants were never married, many children were birthed by different partners, and many of these children are in their early developmental stages. These "blended" families often struggle with intimacy issues, security and safety emotions, and

boundary issues. This became more paramount to the treatment providers when 33% of participants reported experiencing trauma histories.



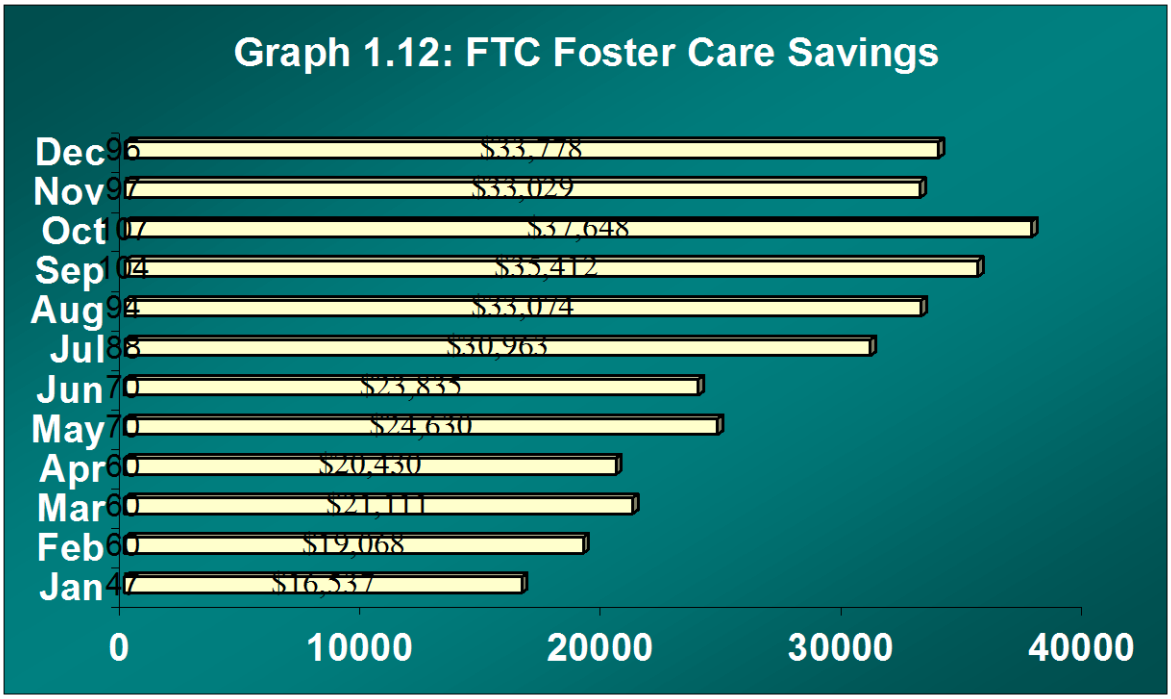
For reference purposes, this evaluation report looked at the cohort of children of participants in 2002. One could speculate that issues of abandonment and emotional deprivation will become key recovery issues for these children. Data about abused and neglected children in out of home placements are disturbing. The populations of children in substitute care in Erie County reached 3,983 in 2002. The child of a substance-abusing parent who has been removed from the home faces many problems during the developmental and adolescent years.

The separation from the parent alone negatively impacts the child even when the child is placed with a caring and nurturing relative. Absent the availability of such a relative, the child is usually placed in foster care. It is not uncommon for these placements to collapse and the child to be moved from one foster home to another. Of the 165 children currently under the supervision of the Family Treatment Court, almost 75% are receiving out of home care, 69 (42%) are in foster care, 52 (32%) are in kinship and 44 (26%) are living with their parents. On the positive side, this means that ninety-six (58%) of these children were still experiencing attachment connections to either their parent(s) and/or other



family members. It should be noted that the Erie County DSS reported that for children in care for less than 12 months, only 9.4% have 3 or more moves within placements.

From a cost analysis, the economic impact on the County is surprising. Foster care services, investigative and protective services, treatment costs, day care, therapeutic services for the child, and other services for both the child and parent can total several hundreds of thousands of dollars. Although costs associated for all services rendered are not readily available, the County does track costs avoided for foster care stays ($329,515 for calendar year 2002). Savings are calculated by multiplying the number of children allowed to stay at home because of parental participation and compliance with Family Treatment Court conditions x $11.35 per day x number of days in the month.



Although this calculation is not "pure", because it is impossible to determine if all these children would have ended up in foster care, it does provide a perspective of cost containment available through Family Treatment Court case management. For example, the 96 children remaining within "family restorative" care, either with parents or kinship, could be viewed as a $329,515 cost savings in social services expenses. Even if we were to take the conservative approach to this calculation using the reported 67% success rate of participants, this would be a cost savings of $220,775. More importantly, the FTC prevented the family separation experiences, which

drive future costs through multiple treatments for the parents and children. A longitudinal prospective research study would be needed to truly calculate the lifetime cost savings for this group.

Evaluation Outcomes Against Stated Goals

The stated goals of the Family Treatment Court and the evaluation of its accomplishments are as follows:

Goal 1: To create a Family Treatment Court in Erie County that would provide a coherent integrated response to the needs of drug-addicted parents and their children.

Objective 1.1: To break the cycle of addiction and neglect through monitored service delivery.

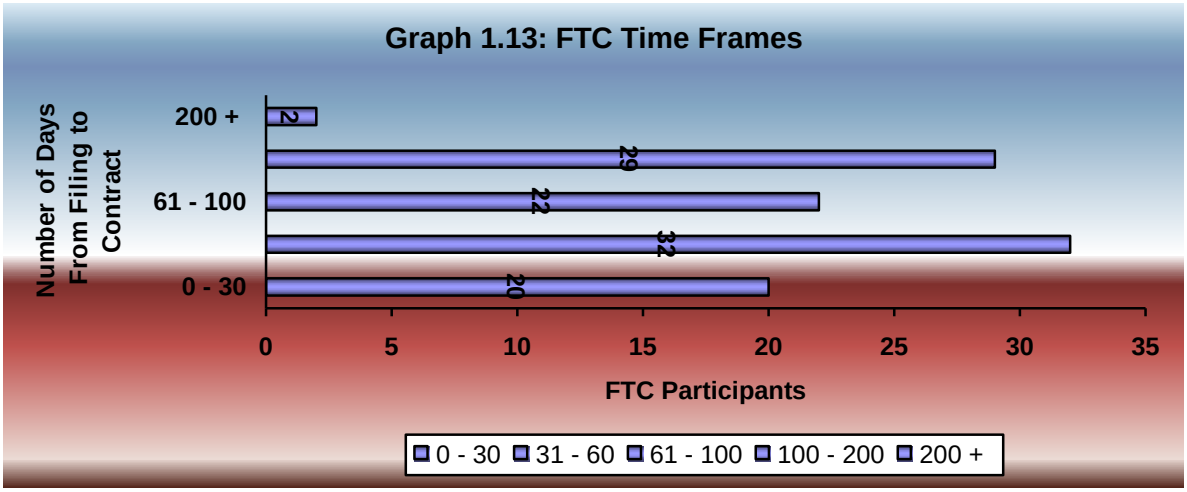
Evaluation: Intensive monitoring of all aspects of the service plan is key to the Family Treatment Court. Through the team approach to case management, the Family Treatment Court did integrate chemical dependency and child welfare services, ensuring coordinated services for the entire family. It appears that court-based case management services through the C.O.U.R.T.S program has enhanced the efforts of the Department of Social Services. Frequent case conferencing between entities ensured the exchange of critical information among service delivery providers. The team also served as a resource for linkages to public assistance, housing, transportation, and other ancillary services. The program successfully established a stable collaboration of treatment providers and Family Court personnel that effectively functioned to develop, implement, and maintain the program.

> **Outcome:** This objective has been fully achieved. Policies, procedures, and case management activities need to be maintained.

Objective 1.2: To provide early intervention and speedy enrollment of substance addicted parents into appropriate treatment programs and other services within one month of filing a petition in Family Court.

Evaluation: For those admitted to the Family Treatment Court, the average number of days from the date the petition was filed to the signing of the contract was 73.8. Time frames ranged from a low of 10 days to a high of 447 days. Slightly less than half (49.5%) of those admitted met the time frame of 60 days or less, and 22 (21%) were admitted within 100 days. Case review of those participants above the 100 day threshold revealed a variety of problems associated with non-compliance, such as warrants, failure to follow through with scheduled assessments, and incarceration. A review of targeting, eligibility, and admission procedures is underway to achieve early intervention and speedy enrollment of substance-addicted parents into appropriate treatment programs and other services within two months of filing a petition in Family Court.

Outcome: The time frames for this objective were not met.



Objective 1.3: To develop a coordinated Buffalo C.O.U.R.T.S. Program and Erie County service and treatment plan with the DSS within 30 days of a case being transferred to the Family Treatment Court.

Evaluation: The development of a comprehensive plan that addresses the needs of the entire family system is one of the foundations of the Family Treatment Court. Strong assessment components leading to the development of a comprehensive service plan are critical to ensure that the needs of the entire family are met. Permanency planning efforts begin early in the process. The enhanced assessment components of the Family Treatment Court are integrated with the service plan developed by DSS, resulting in a more comprehensive and coordinated plan, as well as a more inclusive court order. In addition to placement and visitation issues, service plans frequently include services to address alcohol and drug issues, domestic violence, mental health issues, and services designed to address the developmental and health care needs of the children. One hundred percent of all cases admitted to the Family Treatment Court had initial treatment and service plans developed within the 30-day timeline. The majority of plans (75%) are developed on site before the participants sign the contracts.

Outcome: The Family Treatment Court met this objective.

Goal 2: To provide safe, permanent, and healthy homes for children in a timely manner.

Objective 2.1: To limit foster care stays in order to facilitate family reunification through ongoing case monitoring and expedited, informed permanency planning.

Evaluation: Throughout the course of participation, the C.O.U.R.T.S. Family Treatment Court Program staff worked jointly with the DSS liaisons and caseworkers, along with foster care workers, to ensure that treatment and services for both parents and children were delivered. Dedicated DSS court liaisons working in the Family Treatment Court facilitated the flow of information and appeared on cases on behalf of the DSS field case managers. Treatment compliance information gathered by Family Treatment Court case managers was shared with the DSS case workers. Information about children, visitation, and placement gathered by the DSS and foster care workers was shared with Family Treatment Court staff. This integrated approach allowed all parties to have immediate access to all relevant information for case decision-making. Of the 165 children currently under the supervision of the Family Treatment Court,

almost 75% were found to be receiving out of home care, 69 (42%) were in foster care, 52 (32%) were in kinship care, and 44 (26%) were living with their parents. On the positive side, this means that 58% of these children were still experiencing attachment connections to either their parents and/or other family members.

Outcome: This objective has been fully achieved.

Objective 2.2: To develop a permanency plan for children consistent with the time frames established by the Adoption and Safe Families Act.

Evaluation: The permanency plan (service plan) is reviewed at each scheduled court appearance to ensure ASFA requirements are met.

Table 1.3 Reunification Timetable

Measure	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	*Avg.*	Total
# Reunifications < 12 mos	0	0	0	6	9	9	3	9	3	7	2	0	*5*	48
# Reunifications > 12 mos	0	0	0	0	0	0	0	0	0	0	0	0	*0*	
% Reunifications s < 12 mos	0%	0%	0%	100%	100%	100%	100%	100%	100%	100%	100%	0%	*100%*	

Outcome: This objective has been fully achieved.

Objective 2.3: To improve service delivery outcomes by exchanging comprehensive, accurate, and timely information about parents and their children with social service and treatment agencies responsible for monitoring parents and investigating the placement of children.

Evaluation: Before each court appearance a case conference/staffing is held. The respondent's attorney, the child's law guardian, and the DSS lawyers, caseworkers, and court liaison met with clinical staff and reviewed assessment summary information and the initial treatment plan. When any new information was revealed, modifications were made to the treatment plan.

Outcome: This objective has been fully achieved.

These stated program goals, objectives, and outcomes responded to the nationally identified key program components of:

- Early intervention (speed),
- Team approach to case management (comprehensive case management),
- Close monitoring of client treatment progress (accountability), and
- Frequent judicial reviews to monitor progress toward permanency planning goals (informed judicial decision-making).

Speed: The Erie County Family Treatment Court emphasized early intervention and speedy enrollment through the immediate assessment and referral of substance abusing parents to appropriate treatment and ancillary services. However, assigned counsel mentioned that not all attorneys knew about the Family Treatment Court Program, and this may have negated the enrollment of the 54 individuals who did not sign the contract for participation.

Accountability: This aspect of the program appeared to motivate clients through frequent monitoring of drug use, as well as positive reinforcement of progress achieved. For example, participants making progress were granted earlier visitation privileges with their children. The FTC judge, in conjunction with on-site case managers and agency partners, rigorously monitors parents' performance in treatment, encouraging progress by rewarding achievement and applying graduated sanctions for negative behaviors, such as failed drug tests and missed appointments. The frequent monitoring is viewed as an internal mechanism for following client service provision and ensuring expeditious case handling. The opportunities for uniting families through earlier and more regular, consistent visitation reduced the potential impact of abandonment fears in the children.

Informed Decisions: Based on participants' performance in treatment and the frequent judicial supervision of families, the FTC was consistently apprised of treatment and the permanency

planning process throughout the progression of the case. This increased the FTC ability to render informed decisions regarding the safety and placement of children, without repeated delays.

Enhanced Coordination: The FTC improved service delivery through the establishment of an effective communication network that generated comprehensive, accurate, and timely information. This communication system provided real-time reporting regarding client progress in terms of drug test results, treatment attendance, and other factors impacting participant recovery. By offering parents treatment, parenting skills, ongoing case management, and judicial monitoring, the Erie County Family Treatment Court provided participants with a realistic chance to succeed in treatment and subsequently to preserve their families. By ensuring that the judge received regular updates about parental performance in treatment, the FTC improved the judge's ability to make informed decisions about custody issues. This ability enabled children to move forward and gain stability more rapidly.

Summary and Recommendations

Collectively, the Family Treatment Court appears to have been implemented as originally intended and to have significantly achieved its stated goals. The program has successfully overcome most barriers to program implementation through the development of an effective collaboration and the development of formal written procedures. The successful development of the treatment team, comprised of representatives from all the major licensed providers, was particularly notable. The historical competitive orientation among these providers, a competition that has been recently been exacerbated by the forces of reduced funding and the in-roads of managed insurance, has been successfully minimized to serve the best interests of the respondent, the children and the Court.

The Court has also effectively addressed the need for accurate and timely information regarding participant substance use. This is key for effective supervision and treatment. In addition to the described system for routine and consistent reporting by providers, supervised on-site urine toxicology examinations, both mandated by the judge and/or randomly implemented, have created accountability and participant self-empowerment. These examinations provide immediate feedback to the Court that can be directly addressed prior to the end of that Court session, generally within five minutes of test administration.

The effectiveness of the FTC is in part contingent on participants' perception that the sanctions for failure to comply with the program are credible and significant. Participants must perceive that non-compliance will result in the sure and swift application of sanctions, including incarceration. The instances of long delay in the apprehension of participants for whom a bench warrant has been issued serves to undermine the Court's effectiveness with those specific respondents. When participants and others perceive that Court sanctions are not credible, the overall effectiveness of the Court is threatened. The Erie County Family Treatment Court judge has instilled the concept that her court is a change agent.

Recommendations

1. Operating the Family Treatment Court on a daily basis requires the coordinated efforts of many individuals from many disciplines and agencies, many of whom have been limited by turf issues and have never attempted to work together in a collaborative venture. Developing as well as promoting working relationships and trust will be an ongoing process and will need nurturing and fine tuning as the program continues to grow. Team members should continue to meet frequently and regularly to openly discuss program procedures and problems as soon as they develop. Judge Sczur's continued commitment and leadership is critical to sustaining the process.

2. When substance abuse treatment is provided in the context of a civil justice setting, the issue of aftercare is multifaceted and even more complex when child abuse and neglect enter the picture. As the Family Treatment Court moves from the implementation stage to an established program, graduations will become more frequent. Strategies need to be developed to monitor and/or prevent relapse and a plan for child safety if relapse occurs, particularly during the first three months post treatment, when it is most likely. It is recommended that child welfare officials and or the Family Treatment Court staff continue monitoring cases for at least 12 months after a parent leaves treatment and regains custody of the children. For example, FTC graduates could be randomly urine tested post-graduation. Continuing care programming should be implemented.

3. The effectiveness of the FTC is in part contingent on the perception of defendants that the sanctions for failure to comply with the program are credible and significant. The instances of long delay in the apprehension of participants for whom a bench warrant has been issued undermine the Court's effectiveness with those specific respondents. Traditionally, most warrant returns have been resolved by a person being picked up on another case. The Family Treatment Court judge has opened a dialogue with the Erie County Sheriff's Department in order to expedite this process, by possibly dedicating an

officer to serve in this capacity. Pursuing a resolution to this problem is greatly encouraged.

4. Some attorneys representing parents in these proceedings have observed that the existence of a mental health problem, even one of relative moderate magnitude, tends to render a potential client ineligible for participation in the program. The consensus of those attorneys is that a mental health issue should only disqualify a client if the issue is of such a magnitude as to make it unlikely that he or she will be able to participate in a meaningful and productive manner in treatment. Many clients have coexisting disorders that could be effectively treated. It is suggested that the universe of eligible clients be expanded to include those with moderate mental disorders.

5. Likewise, it is suggested that potential participants who are being medically treated with prescribed narcotic medications not be automatically excluded from participation. Rather, a focused effort should be made to explore alternative medications that would permit adequate supervision and at the same time address, for example, the participants pain management needs. It is suggested that program policies and procedures be reviewed so as to ensure that otherwise eligible and appropriate participants are not excluded unnecessarily.

6. While visitation tends to be granted to the respondent parents at an earlier time than would otherwise be the case when their participation in the program is positive, some counsel for those parents report that even earlier and more substantial visitation would be appropriate in many cases. It is suggested that this issue be reviewed so that visitation is phased in at the earliest possible time, consistent with the best interests of the children and taking into account the positive steps the parents are taking through the program.

7. Significant steps have been taken to address the transportation needs of clients in the program. Further review of these needs should continue, however, to ensure that the lack of transportation does not function as a barrier to success. Gaps in transportation tend to

occur toward the beginning of each month. It is suggested that a bus pass, rather than bus tokens or money to purchase them, be provided directly to the eligible clients at the beginning of each month.

8. It is the well-founded practice of the Family Treatment Court to be sure that the client has a solid foundation in treatment before adding other components such as parenting classes, and or ancillary services in general, to his or her program expectations. In some cases, however, it is the perception of attorneys representing parents that their clients could engage in some of those other programs earlier. It is suggested that efforts be made by the team to be sure that the individual circumstances, strengths, and needs of each client be considered at each point in the continuum of service and that in appropriate cases engagement in additional services be expedited, so long as doing so does not threaten the client's progress in treatment.

9. Recognizing that information drives decision making, it is essential to have a single linked, integrated database monitoring system. The evaluator's experience of working with multiple databases throughout this evaluation project limited the consistency of reports. Moreover, many hours were spent requesting information from source files that were isolated and specific to agency participant. The creation of a Family Treatment Court MIS file server with multiple entry stations, based on collection of nationally agreed upon cross-systems data, is needed.

10. The perspective of restoring family integration necessitates family system assessment. The Family Treatment Court has not yet taken this approach. Evaluating only adult participants for alcoholism and drug abuse disturbances negates the potential for family interventions for recovery and creates family member fragmentation. Experientially, leaving children out of the participation isolates rather than integrates. A simple solution is one or two evaluation sessions with the entire family, upon acceptance into the Family Treatment Court. The application of the Washousky, et al (1995) family evaluation model is easy to use and practical for family treatment planning.

11. The addictions treatment system in Western New York is not designed for treating recovering addicts' families. Often, the available services have restrictions on how many children are allowed and their ages and do not often have family restoration services on site. Most still use an addiction recovery focus, where the family members are visitors, not participants. These programs are not yet fully integrated into the mandatory, judicial requirements of the Family Treatment Court. There are no current inpatient treatment programs for fathers who have custody of their children. Furthermore, parents are united with their children following foster care placement without the transition needed. It is recommended that the Family Treatment Court meet with the Salvation Army Family Treatment Center, Buffalo Area Office, which has experience in working with entire families through its homeless shelter. The staff there is familiar with the "Strengthening the Families" model of therapeutic recovery and believes in the placement of children from foster care with their parents for short periods of time, prior to independent living to provide "family foster care" for children and parents with the family addiction syndrome. The bed capacity is for 77 family members. Potential grant funding for this expansion may be available through HUD.
12. As there were few graduates at the time of this process evaluation, it was difficult to get a clear picture of these participants who are likely to be successful. For this reason and to provide more scientific investigation in to whether family treatment courts make a difference, it is recommended that both a predictive and prospective research study be conducted. This could easily be accomplished with a experimental/control group design with pre-/post-test measures. Those accepted versus those refusing to participate would serve as the investigated cohorts with outcomes assessment at six months, one year, and two years from entry. These types of longitudinal studies allow for identifying variables on treatment utilization, participation, and costs.
13. Children of alcoholics and substance abusers often have a core center of insecurity, restricted affect, impulse control deficits, attention seeking behaviors, conduct disorders, interpersonal relationship struggles, and often-masked symptoms of anxiety and depression. Their needs for affection and bonding are extreme, especially as they

progress into adolescence. We could not determine if the children of the FTC participants were receiving any treatment for these problems. When this question was asked, the implication was that, if needed, linkages were made. However, realizing the genetic and social learning aspects of addictive disorders, it would be unlikely that any of these children went without some residual scars. These children are prone to not verbalizing their feelings out of fears of rejection and further abandonment. What appears to be a sense of normality does not exist. The Family Treatment Court is in a key position to insure and monitor that the children are also receiving treatment. When the adult parents are seen for their mandatory reports to the FTC, the status reports should also address the children. In fact, those children between the ages of 4 and 17 should be viewed as the collaterals for the court reporting. The goal is to let them feel involved in the process, not just serve as the "carrot" dangling at risk with the custodial parents. Parents working through a true recovery program will experience their children involvement as their responsibility. In a sense, this becomes a "win-win" situation for everyone.

14. Develop a strategic action plan. This may be accomplished by having all stakeholders review the report, prioritize objectives, and put in writing both short - and long - term planning strategies. This report provides the suggestions and specific recommendations for the Family Treatment Court team to consider in developing the next steps for the Erie County Family Treatment Court action agenda and status report as a - three to five - year initiative. The evaluation team recognizes that "Defining Drug Courts, The Key Components", was developed for Adult Drug Treatment Courts; however, this is a set of flexible elements that a treatment court can adapt to meet its specific needs and resources. The components identified reflect the usage of the key components of effective drug treatment courts that relate to the development of the action agenda which may include:

    a. Steps taken to facilitate awareness, knowledge, and practices of the Family Treatment Court

        i. Component #1

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

ii. Component #2

Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants due process rights.

b. Steps should be taken to consistently input and analyze data, for quality assurance purposes and service delivery

i. Component # 8

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

c. Steps taken to insure regular professional development training in addictions, family treatment, and disposition practices.

i. Component # 4

Drug court provides access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.

ii. Component # 9

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

d. Steps taken to view the Family Treatment Court as focusing on the family system from intake to family evaluation to family treatment to family restoration and follow-up support services

i. Component #3

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

ii. Component # 4

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

iii. Component # 5

Abstinence is monitored by frequent alcohol and other drug testing.

iv. Component # 6

A coordinated strategy governs drug court responses to participants compliance.

v. Component #7

Ongoing judicial interaction with each drug court participant is essential.

e. Steps taken to continuously show the effectiveness of the new Family Treatment Court structure, process and outcomes.

i. Component #8

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

ii. Component #10

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

APPENDIX I

FAMILY COURT OF THE STATE OF NEW YORK
COUNTY OF ERIE

_____

In the Matter of

_____ FAMILY TREATMENT
COURT CONTRACT

Child(ren) Under the Age of 18 Docket No._____
Alleged to be Neglected by

_____, Respondent.

_____

I, _____, the Respondent in this case, hereby agree to enter into the Family Treatment Court ("FTC") Program and agree to the following conditions:

1. The respondent hereby knowingly, intelligently, and voluntarily, after consultation with her/his attorney, agrees to participate in the FTC Program, abide by all Court Orders, FTC Program Rules, and the rules and regulations of any outside treatment program or service provider to which referred; and

2. That the respondent agrees to enter a legal admission of neglect based on her/his use of drugs and/or alcohol, and that as a result of such admission, the underlying report of suspected child maltreatment upon which the petition is based will remain on file with the State Central Register until ten (10) years after the 18th birthday of her/his youngest child, and that Family Court will be granted the power to enter a dispositional order affecting her/his child(ren) for a period of up to one year, subject to applications for annual review; and

3. That the respondent understands that statements against interest and admissions made by her/him in the course of screening, evaluation and treatment and of participation in the FTC Program, whether made in or out of court, cannot be used against her/him in this or any other subsequent proceeding, including a petition for termination of parental rights, unless otherwise discoverable as pursuant to the laws of New York State; and

4. That the respondent has met with a member of the FTC clinical team and is fully aware of the requirements of the FTC, including the treatment court stages and the range of possible sanctions and rewards, and agrees and accepts that her/his progress will be decided by the FTC Judge in a manner consistent therewith; and

5. That the respondent agrees and understands that s(he) must comply with all orders and directions of the FTC, including but not limited to, the following:
   a) Initial assessment by the FTC clinical team,
   b) Court appearances as directed by the court,
   c) Compliance with treatment recommendations,
   d) Periodic supervised drug testing without notice or as mandated by the treatment provider,

e) Completion of the requirements outlined in the Dispositional Menu, and
f) Contacts with the clinical team as directed; and

6. That the respondent understands that s(he) has the right to have her/his attorney present at all Court appearances unless s(he) knowingly and voluntarily waives her/his appearance; and

7. That the respondent understands that any person living in her/his home or requlary present at her/his home will be subject to investigation prior to any visit or discharge of the child(ren) to her/his home, and that refusal by any such person to cooperate with the investigation will preclude unsupervised visitation and discharge; and

8. The respondent agrees to keep all treatment providers and the Court advised of her/his current address and telephone number at all times during her/his participation in this program; and

9. That the respondent understands that this program consists of a series of rewards and sanctions. S(he) has been provided a list of possible rewards and sanctions and has discussed them with her/his attorney; and

10. That the respondent understands and agrees that s(he) must comply with all orders and directions of the FTC, and that failure to comply with such orders or directions shall constitute a violation of this agreement and may result in the immediate imposition of sanctions.

11. That the respondent understands that the Department of Social Services may continue to provide supervision of the child(ren) both during and after completion of the FTC program; and

12. That the respondent agrees to execute written authorizations for the release of any and all medical, psychological, psychiatric, and treatment records to the FTC, including but not limited to psychosocial assessments, psychological and/or psychiatric evaluations, individual treatment plans and progress reports, and medical examinations and treatments (including prescribed medications) for the purpose of treatment planning and monitoring the respondent's progress in the FTC; and

13. That the respondent may agree to execute written authorizations for the FTC clinical team to communicate with her/his relevant family or significant others, clergy, employer, or other collateral entity for the purpose of eliciting support, gathering information, or offering services, as appropriate; and

14. That the respondent understands that the disclosure of treatment information obtained in accordance with the releases executed pursuant to 42 CFR Part 2, in the courtroom in the presence of other FTC participants is an integral component of the FTC and consents to such disclosure. This means that reports of participation and performance in treatment and other programs will be discussed in open court in front of other clients and their family members; and

15. That the respondent understands and consents to the incorporation of this agreement and the rules of the FTC into a court order upon disposition; and

16. That the respondent understands that the Treatment Court Judge will make the ultimate determination whether s(he) has complied or failed to comply with any terms of this agreement and that remaining drug-free alone may not guarantee successful completion of the program and the return of the child(ren), which will be based on their best interest; and

17. S(he) further understands that upon execution of this contract, the Judge shall grant an adjournment in contemplation of dismissal.

18. The Erie County Department of Social Services agrees to exercise diligent efforts to assist the respondent in complying with the terms of the Contract and Plan for Services, including the achievement of the FTC goals. These efforts may include, but are not limited to, transportation, childcare, and expeditious referrals for treatment and counseling services; and

19. I understand that the staff of the treatment court, which may include the judge presiding over my case, will be meeting at regularly scheduled staffings to discuss my ongoing progress and participation in the treatment court program, and that such meetings may include my substance abuse provider. I understand that my attorney is invited to these staffings and may or may not attend them in his or her discretion. I agree that any non-appearance by my attorney at a staffing shall be deemed a waiver of his or her participation for that particular staffing. I further understand and agree that communications during these staffings may take place in the absence of myself or my attorney and that the judge may consider such communications.

DATED: _____

SIGNATURE OF RESPONDENT: _____

NAME PRINTED: _____

SIGNATURE OF RESPONDENT'S COUNSEL: _____

NAME PRINTED: _____

SIGNATURE OF FTC CASE MANAGER: _____

NAME PRINTED: _____

SIGNATURE OF DSS COUNSEL: _____

NAME PRINTED: _____

SIGNATURE OF LAW GUARDIAN: _____

NAME PRINTED: _____

APPENDIX II

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