Moving Beyond Guidance

A WALKTHROUGH

Family Treatment Court Best Practice Standards (Part 2)

NATIONAL FAMILY DRUG COURT TTA Program

Ohio Specialty Court Conference | November 2019 | Alexis Balkey, MPA and Jennifer Foley

Acknowledgment

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NATIONAL FAMILY DRUG COURT TTA Program

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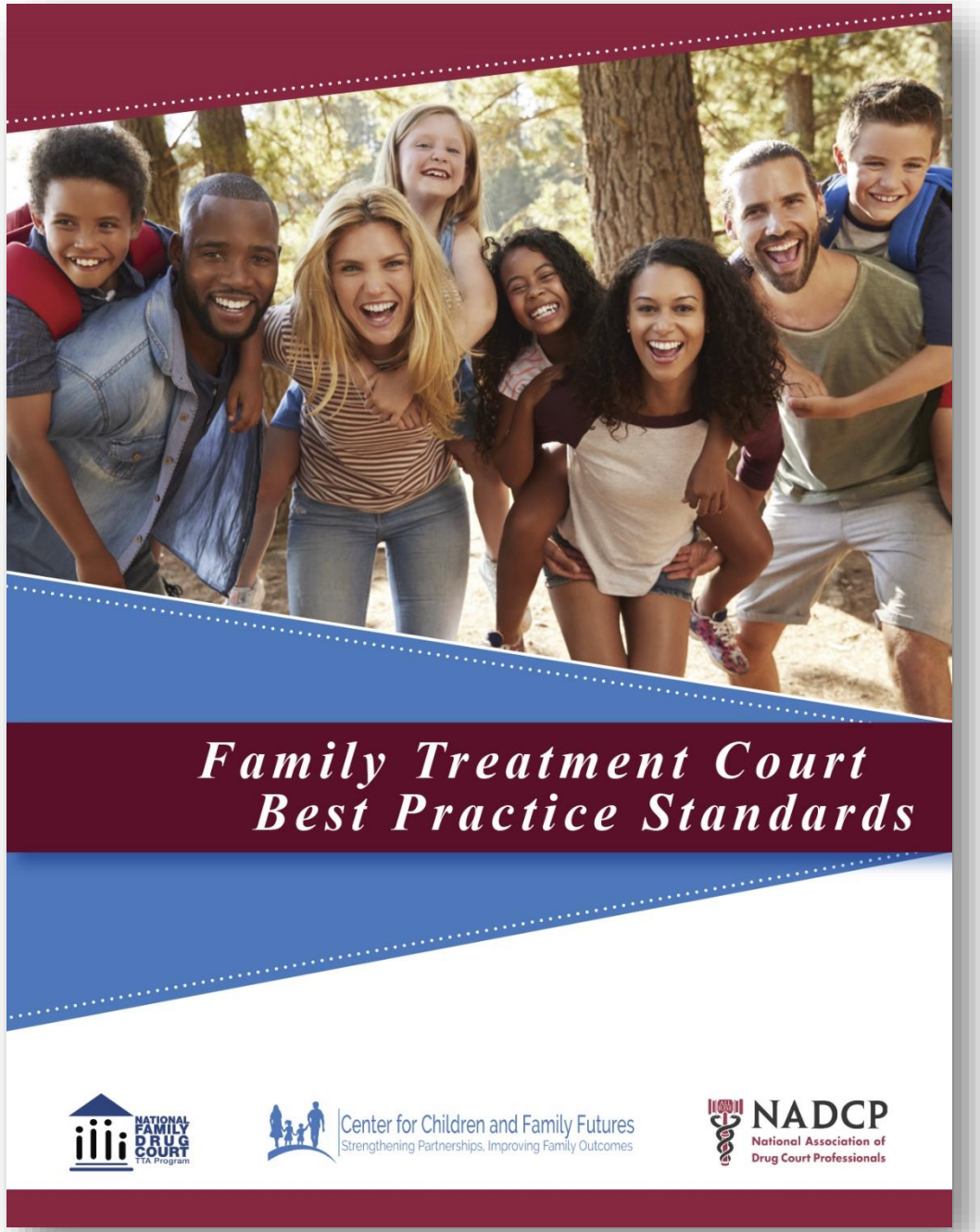


Just Released!

Family Treatment Court Best Practice Standards

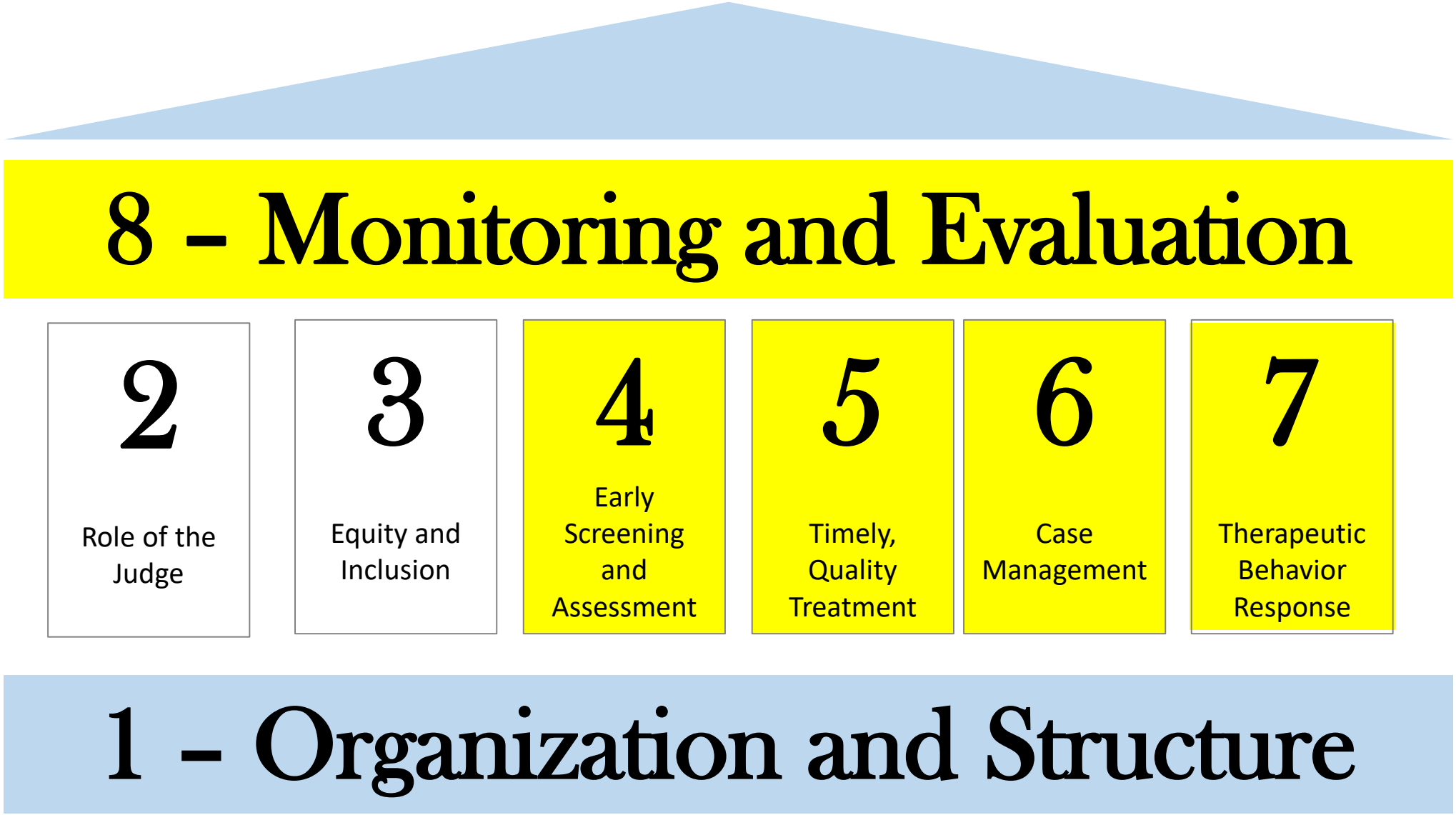
8 *Standards*

and Key Provisions

To obtain a copy or for more information:

Visit: www.cffutures.org

Family Treatment Court Best Practice Standards



Best Practice Standard

Early Identification, Screening, and Assessment

Early Identification, Screening, and Assessment

The process of early identification, screening, and assessment provides the greatest opportunity to fully meet the comprehensive needs of children, parents, and families affected by SUDs that come to the attention of the child welfare system. FTC team members and partner agencies screen and assess all referred families using objective eligibility and exclusion criteria based on the best available evidence indicating which families can be served safely and effectively in the FTC. Team members **use validated assessment tools and procedures** to promptly refer children, parents, and families to the appropriate services and levels of care. They conduct ongoing validated assessments of children, parents, and families while also addressing barriers to recovery and reunification throughout the case. Service referrals match identified needs and connect children, parents, and family members to evidence-based interventions, promising programs, and trauma-informed, culturally responsive, and family-centered practices. FTC team members take on varying roles for this process to occur in a timely and efficient manner.

Early Screening, Identification and Assessment

A. Target population, objective eligibility, and exclusion criteria
B. Standardized and systematic referral, screening, and assessment process
C. Use of valid and reliable screening and assessment for parents and families
D. Use of valid, reliable, and developmentally appropriate screening and assessments for children
E. Identification and resolution of barriers to recovery and reunification

Research

Use of subjective criteria has the potential to exclude families from FTCs for reasons that have not proved valid or meaningful in the course of the court experience. Removing subjective eligibility restrictions and applying evidence-based selection criteria significantly increase the effectiveness and cost-efficiencies of drug courts by allowing them to serve their target population (Bhati and Chalfin, 2008; Sevigny, Pollack, and Reuter, 2013).

What Do We Mean by Systematic Approach?

Objective & Systematic

- Clearly defined protocols and procedures, with timelines and communication pathways (who needs to know what and when)
- Eligibility criteria based on clinical and legal assessments
- Match appropriate services to identified needs
- Broad objective criteria (e.g. all adjudicated families with a SUF diagnosis of moderate to sever

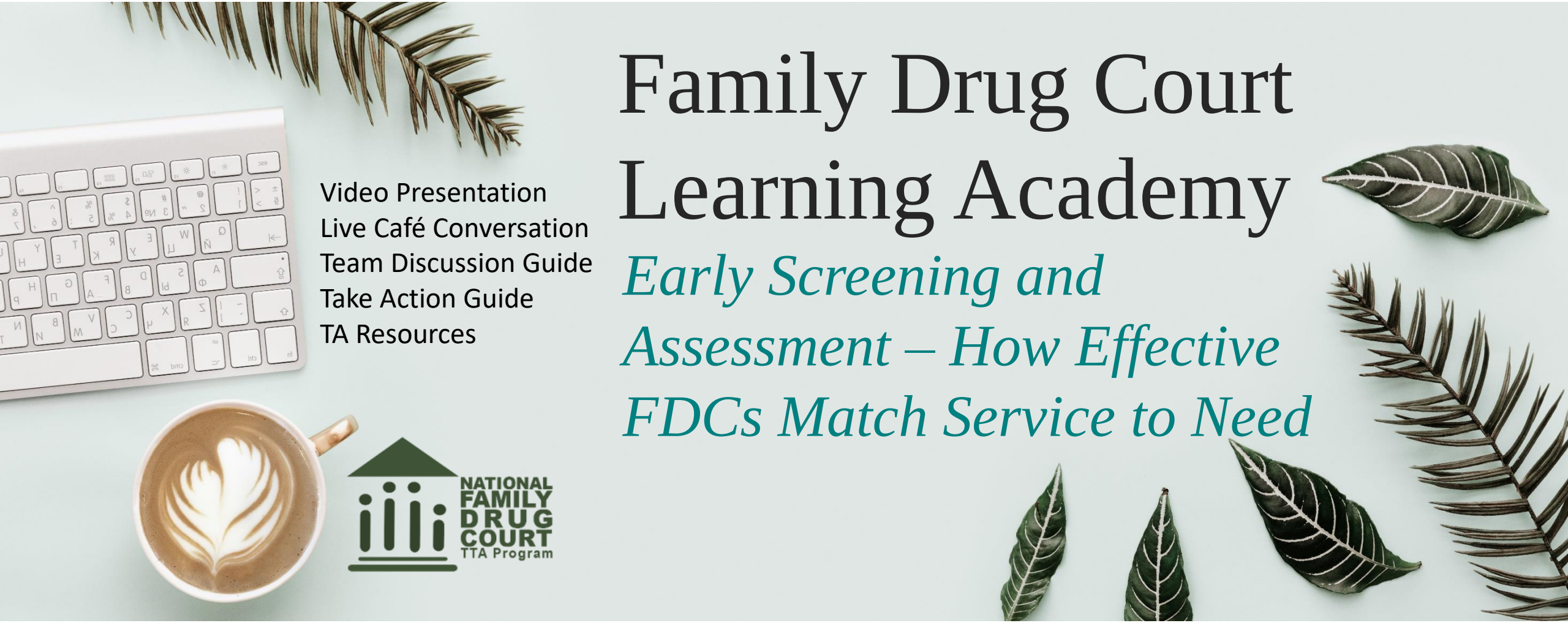
Subjective & Informal

- *I refer all my clients to FDC because I know the people there*
- *I only refer clients who really want to participate*
- *Let me know when you get in the program*
- *I prefer to refer clients who are doing well on their CWS case plan*
- *I refer all my clients with a drug history to the FDC*

Taking a Closer Look – Site Example

Summit County, Ohio

Early Screening Identification and Assessment



Family Drug Court Learning Academy

Early Screening and Assessment – How Effective FDCs Match Service to Need

Visit: www.cffutures.org/fdc-learning-academy

Best Practice Standard

Timely, High Quality, and Appropriate Substance Use Disorder Treatment

Timely, High Quality, and Appropriate Substance Use Disorder Treatment

SUD treatment is provided to meet the individual and unique substance-related clinical and supportive needs of persons with SUDs. For participants in FTC, it is important that the SUD treatment agency or clinician provide services in the context of the participants' **family relationships**, particularly the parent-child dyad, and understand the importance of and responsibility for **ensuring child safety** within the Adoption and Safe Families Act time line for child permanency. A treatment provider's **continuum of services** includes early identification, screening, and brief intervention; comprehensive standardized assessment; stabilization; appropriate, manualized, evidence-based treatment including medications if warranted; **ongoing communication** with the FTC team; and continuing care. The parent, child, and family treatment plan is based on individualized and assessed needs and strengths and is provided in a timely manner including concurrent treatment of mental health and physical health.

Timely, High Quality, and Appropriate Substance Use Disorder Treatment

A. Timely access to appropriate treatment
B. Treatment matches assessed needs
C. Comprehensive continuum of care
D. Integrated treatment of co-occurring substance use and mental health disorders
E. Family-centered treatment
F. Gender-responsive treatment
G. Treatment for pregnant women
H. Culturally-responsive treatment
I. Evidence-based manualized treatment
J. Medication-assisted treatment
K. Alcohol and other drug testing protocols
L. Treatment provider qualifications

Research

Timely access to appropriate treatment

Participants in FTC that provided immediate, intensive SUD treatment had significantly more reunifications, their children had fewer placements in longer-term foster care, and their children spent less time in non-kinship care than families not in the FTC (Burrus, Mackin, Aborn, 2008)

Time To & Time In Treatment Matters

In a longitudinal study of mothers (N=1,911)

Entered substance use disorder treatment faster after their children were placed in substitute care	→ Stayed in treatment longer
Completed at least one course of treatment	→ Significantly more likely to be reunified with their children

Source: Green, Rockhill & Furrer (2007)

Research

Family-centered treatment

Family-centered treatment programs that address the multiple needs of children, parents, and family members are a promising prevention and treatment approach that results in improved outcomes:

- Increased treatment retention rates and reduced substance use rates
- Decrease risk of child abuse
- Increase rates of reunification and positive permanency outcomes
- Reduced rates of infants with prenatal substance exposure
- Improved psychosocial and family functioning
- Improved parental mental health, physical health and employment
- Reduction in depression and parental stress
- Improved parenting attitudes
- Enhanced parental bonding with children
- Improved child developmental and behavioral outcomes

(Source: See pages 86. 104-105 in Best Practice Standards publication for complete listing of citations)

Taking a Closer Look – Site Example

Milwaukee County, WI

Timely, High Quality, and Appropriate Substance Use Disorder Treatment

Best Practice Standard

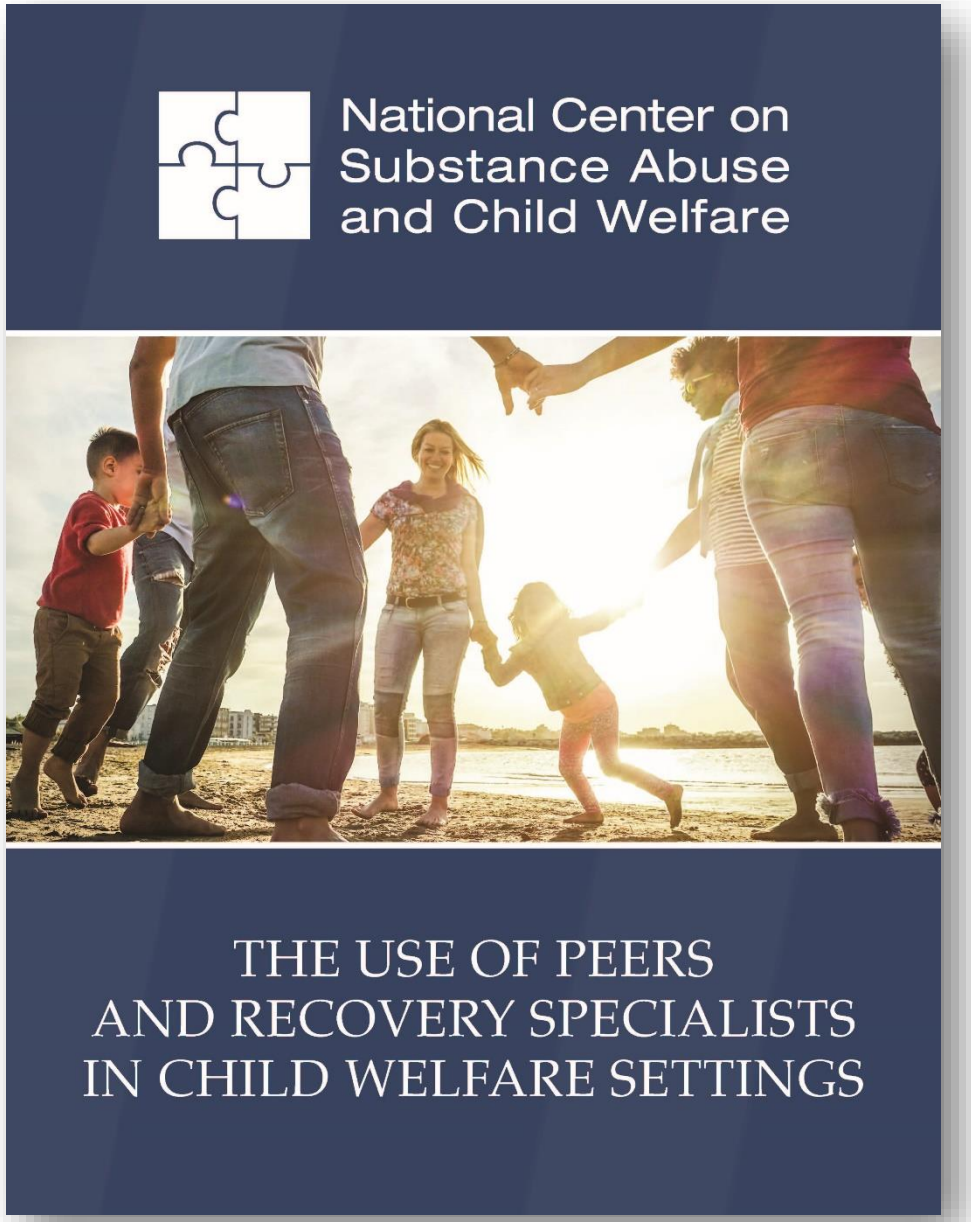
Comprehensive Case Management Services, and Supports for Families

Comprehensive Case Management Services, and Supports for Families

FTC ensures that children, parents, and family members receive comprehensive services that meet their assessed needs and promotes sustained family **safety, permanency, recovery, and well-being.** In addition to **high-quality** substance use and co-occurring mental health disorder treatment, the FTC's **family-centered** service array includes other clinical treatment and related clinical and community support services. These services are **trauma responsive**, include family members as active participants, and are grounded in cross-systems collaboration and **evidence-based or evidence-informed** practices implemented with fidelity.

Comprehensive Case Management Services, and Supports for Families

A. Intensive case management and coordinated case planning
B. Family involvement in case planning
C. Recovery supports
D. High-quality parenting time (visitation)
E. Parenting and family-strengthening programs
F. Reunification and related supports
G. Trauma-specific services for children and parents
H. Services to meet children's individual needs
I. Complementary services to support parents and families
J. Early intervention services for infants and children affected by prenatal substance exposure
K. Substance use prevention and intervention for children and adolescents



National Center on Substance Abuse and Child Welfare

The Use of Peers and Recovery Specialists in Child Welfare Settings

Download @
www.ncsacw.samhsa.gov

Journal of Substance Abuse Treatment 77 (2017) 178–184

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Journal of Substance Abuse Treatment

Timing matters: A randomized control trial of recovery coaches in foster care

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ABSTRACT

Substance use disorders are a major problem for child welfare systems. The abuse of and dependence on alcohol and drugs by parents increases the risk of child maltreatment and interferes with efforts to locate a permanent home for children in foster care. The current study focuses on an intervention designed to increase the probability of reunification for foster children associated with substance using families. We focus specific attention on the timing of the intervention, in particular the timing of comprehensive screening and access to substance abuse services in relation to the temporary custody hearing. A diverse group of children ($n = 3440$) that were placed in foster care and associated with a parent diagnosed with a substance use disorder were randomly assigned to either a control (services as usual) or experimental group (services as usual plus a recovery coach for parents). Binomial logistic regression models indicated that early access to substance use services matters (within two months of the temporary custody hearing) but only when parents were connected with a recovery coach. Additional findings indicated that the recovery coach model eliminated racial disparities in reunification. The implications of these findings are discussed.

1. Introduction

There is a well-documented and long-standing problem of parents struggling with substance use disorders in the child welfare system. The problems associated with parental substance use disorders increase the risk of all forms of child maltreatment and interfere with the system's ability to secure residential and legal permanency and ensure the long term safety of children (Fuller and Wells, 2003; Green et al., 2007; Grella et al., 2009; Rittner and Dozier, 2000; Ryan et al., 2016). The current study focuses on permanency as a primary outcome. Specifically, the current study focuses on family reunification – which occurs when children exit the foster care system and return to their biological parents.

1.1. Child protective service procedures & judicial stages

Following a substantiation of maltreatment, child protective services (CPS) files a petition if court protection is necessary for child safety. The court process then proceeds through several judicial stages including: (a) the temporary custody hearing; (b) the adjudicatory hearing; (c) the dispositional hearing; and (d) permanency hearings (Duquette and Haralambie, 2010; see Fig. 1.) For the purposes of the current paper, it is important to note that children are not removed from the family home solely on the basis of a substance use disorder. Children can only be legally removed from the biological family home when their safety is in jeopardy. The determination of substance use as a primary or contributing factor comes later in the process – at a point in time when assessments are completed and treatment plans developed.

Generally, within 24–72 h after an emergency removal of a child, an expedited hearing is held to review custody. The legal terminology varies across child welfare jurisdictions, but for the purpose of the current study, we will use the term "temporary custody (TC) hearing" to refer to the hearing after the child's emergency removal. The purpose of the TC hearing is to address temporary orders (such as placement, pretrial services, and visitation). Judges at the TC hearing may grant biological relatives limited or full custody of the child under certain circumstances (Duquette and Haralambie, 2010). In the meantime, the child welfare agency is obligated to develop a case plan for the family within 60 days of the child's removal (Duquette and Haralambie, 2010). This is the window of time when caseworkers and judges can order individualized assessments to better inform the treatment planning process. An adjudicatory (fact-finding) hearing is then held to respond to the allegations (i.e., whether the maltreatment charges have been proven true), and a dispositional hearing is scheduled to make a legal determination on the child care and reunification plan (Garland and Besinger, 1997; Sagatun-Edwards et al., 1995).

1.2. Importance of timeliness

Specific laws govern the completion of child protection tasks (e.g., investigation) and establish fairly strict guidelines for the timing of

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0740-5472/

Timing Matters: A Randomized Control Trial of Recovery Coaches in Foster Care

Ryan, Perron, Moore, Victor & Park (2017)
Journal of Substance Abuse Treatment (77): 178-184.

Recovery Support Matters

A Randomized Control Trial – Cook County, IL (n=3440)

Comprehensive Screening & Assessment

+

Early Access to Treatment

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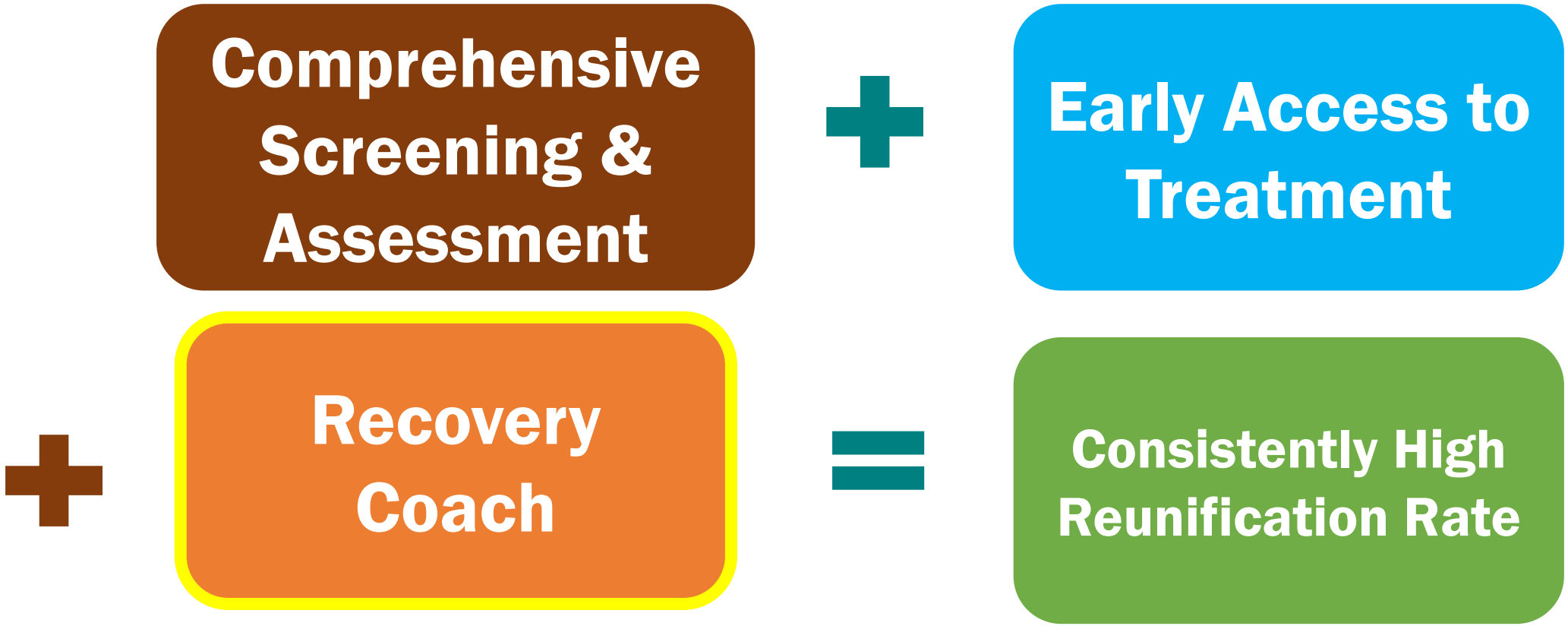
Consistently High Reunification Rate

Ryan, Perron, Moore, Victor & Park (2017) "Timing matters: A randomized control trial of recovery coaches in foster care, Journal of Substance Abuse Treatment (77): 178-184.

Recovery Support Matters

A Randomized Control Trial – Cook County, IL (n=3440)



Ryan, Perron, Moore, Victor & Park (2017) "Timing matters: A randomized control trial of recovery coaches in foster care, Journal of Substance Abuse Treatment (77): 178-184.

The use of Recovery Coaches resulted in

Zero racial disparity

In family reunification

Reunification and permanency planning

Sacramento County, CAM Project, Children in Focus (CIF)

- **Dependency Drug Court (DDC)**
  - **Post-File**
- **Early Intervention Family Drug Court (EIFDC)**
  - **Pre-File**

+

Parent-child parenting intervention

+

Connections to community supports

=

Improved outcomes

DDC has served over 4,200 parents & 6,300 children
EIFDC has served over 1,140 parents & 2,042 children
CIF has served over 540 parents and 860 children

Taking a Closer Look – Site Example

Alameda County, CA

Comprehensive Case Management Services, and Supports for Families

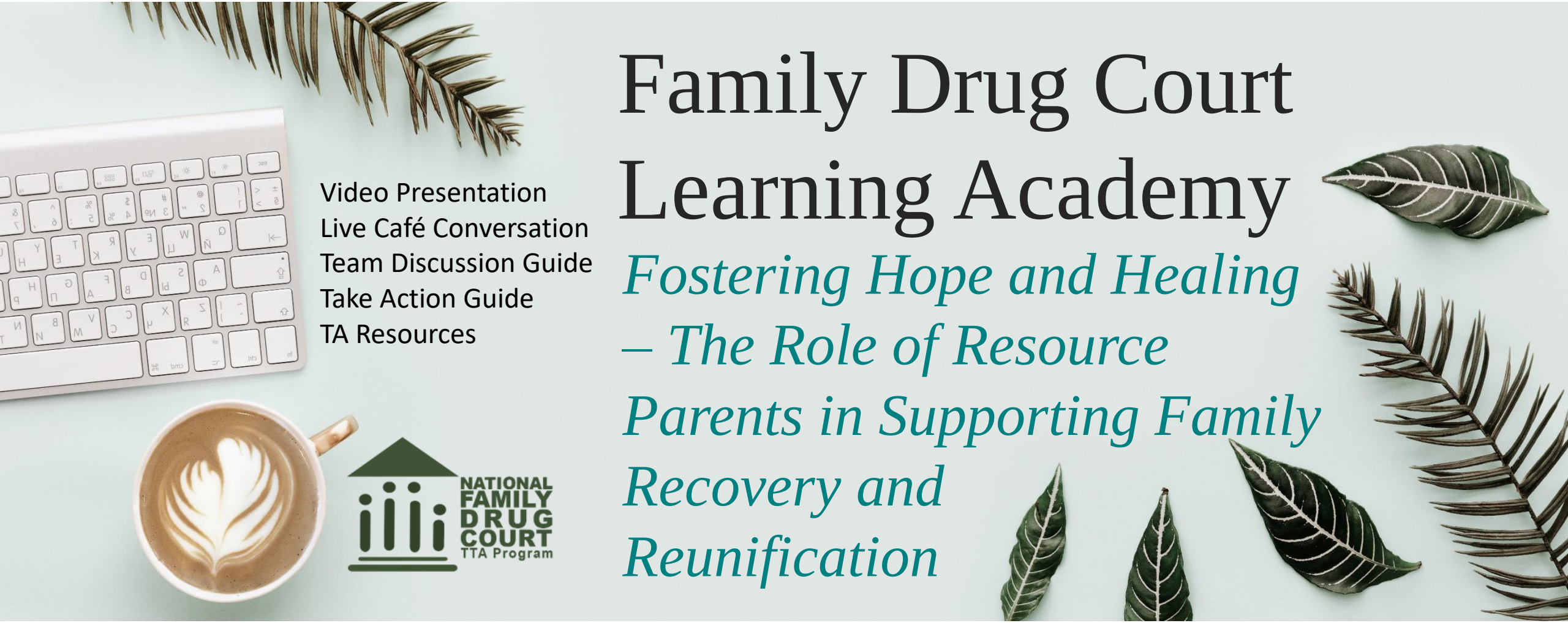
Research

High-Quality Parenting Time

To enhance parenting time, improve positive parenting, and facilitate reunification, the FTC can leverage foster parents (Children's Bureau, 2011; Smariga, 2007; Foster Care Review, 2010; Linares,et al, 2006). Co-parenting (also known as shared parenting) by birth parents and foster parents or other substitute caregivers is a child welfare best practice, particularly given the Adoption and Safe Families Act's requirement to simultaneously explore a secondary permanency goal of adoption if the primary goal of reunification cannot be achieved (Milwaukee Child Welfare Partnership, 2014).

Age Range	Frequency with Parents	Frequency with Siblings	Duration
0-12 months	Daily if possible; 3-5x per week	One or more times per week	At least 60 minutes
12-24 months	Daily if possible; 2-4x per week		60-90 minutes
2-5 years	Daily if possible; 2-4x per week		1-2 hours
6-12 years	At least 1-3x per week		1-3 hours
13-18 years	At least 1-2x per week		1-3 hours

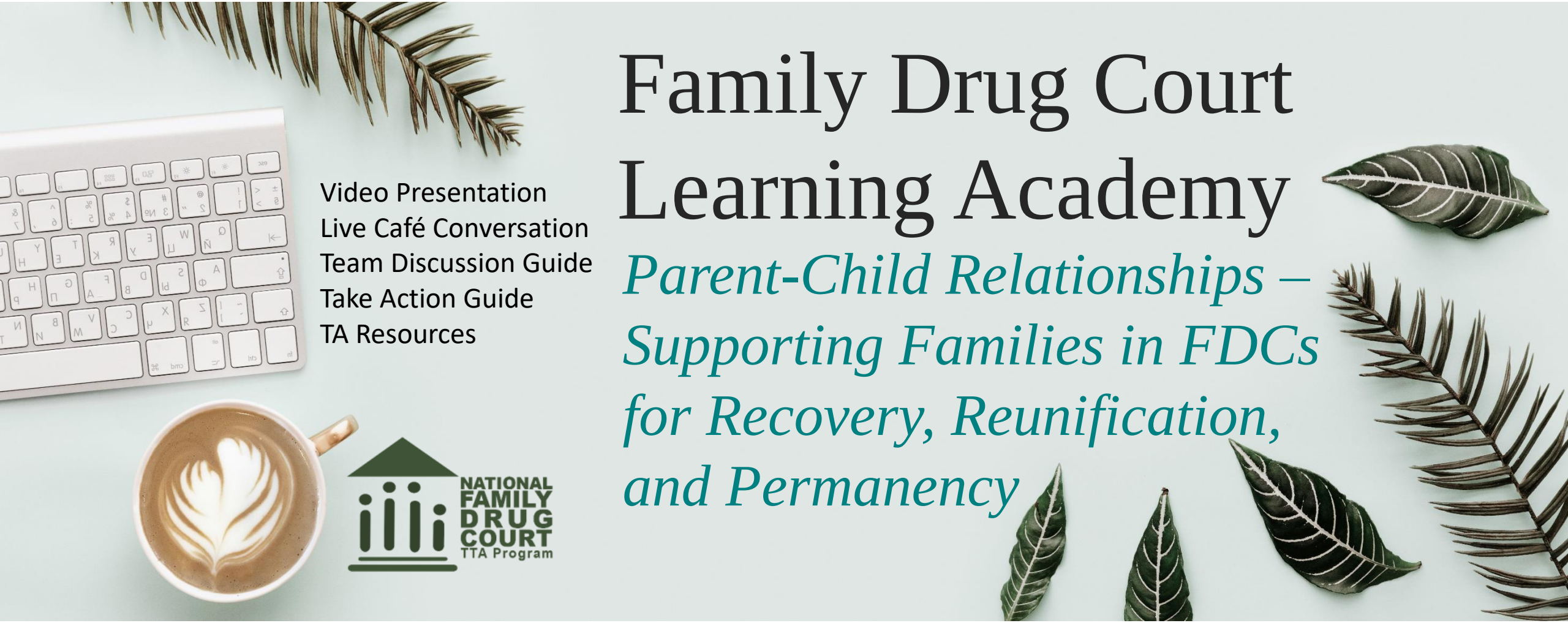
Sources: Weintrub (2008); Child Welfare Capacity Building Collaborative; Child Welfare Information Gateway, 2015)



Family Drug Court Learning Academy

Fostering Hope and Healing – The Role of Resource Parents in Supporting Family Recovery and Reunification

Visit: www.cffutures.org/fdc-learning-academy



Family Drug Court Learning Academy

Parent-Child Relationships – Supporting Families in FDCs for Recovery, Reunification, and Permanency

Visit: www.cffutures.org/fdc-learning-academy

Best Practice Standard

Therapeutic Responses to Behavior

Therapeutic Responses to Behavior

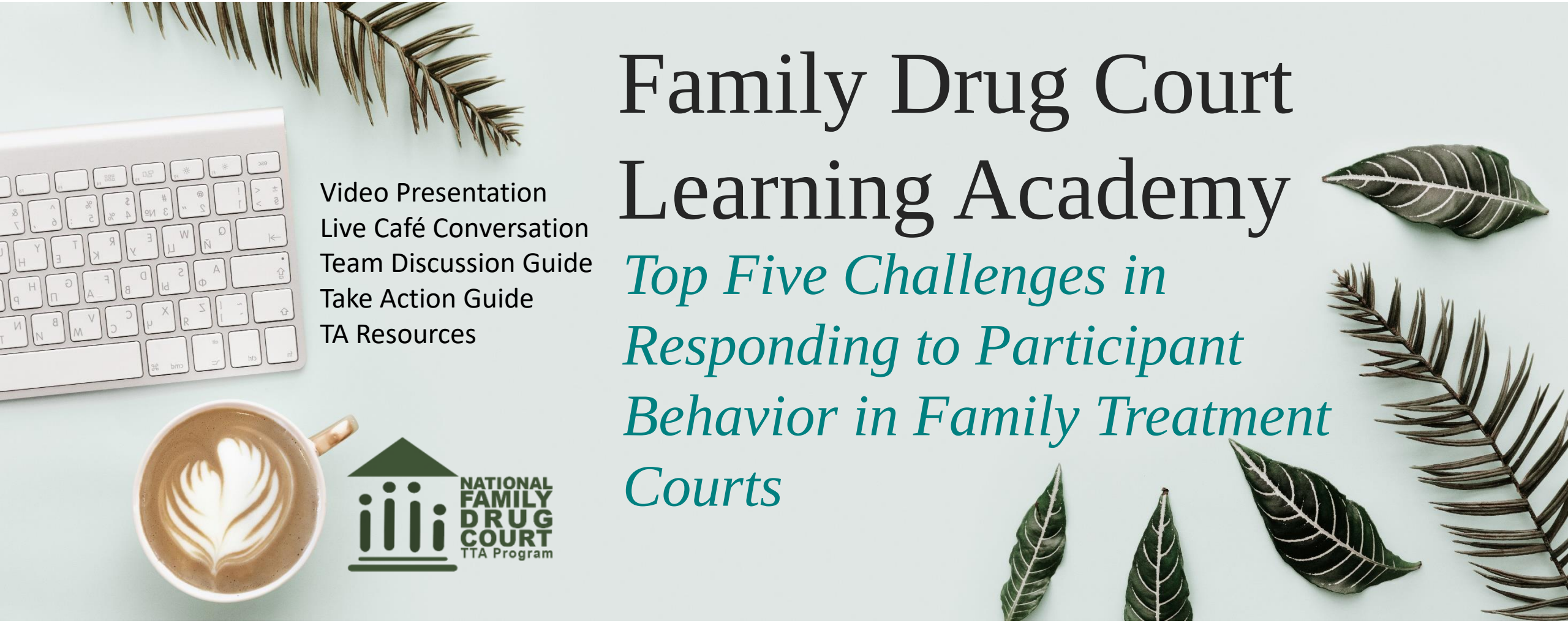
The FTC operational team applies therapeutic responses (e.g., child safety interventions, treatment adjustments, complementary service modifications, incentives, sanctions) to improve parent, child, and family functioning; ensure children's safety, permanency, and well-being; support participant behavior change; and promote participant accountability. The FTC recognizes the biopsychosocial and behavioral complexities of supporting participants through behavior change **to achieve sustainable recovery, stable reunification,** and resolution of the child welfare case. When responding to participant behavior, the FTC team **considers the cause** of the behavior as well as the **effect of the therapeutic response** on the participant, the participant's children and family, and the participant's **engagement in treatment** and supportive services..

Therapuetic Responses to Behavior

A. Child and family focus
B. Treatment adjustments
C. Complementary service modifications
D. FTC phases
E. Incentives and sanctions to promote engagement
F. Equitable responses
G. Certainty
H. Advance notice
I. Timely response delivery
J. Opportunity for participants to be heard
K. Professional demeanor
L. Child safety interventions
M. Use of addictive or intoxicating substances
N. FTC discharge decisions

Research

Child welfare workers are responsible for ensuring child safety and may not delegate that responsibility (Curtis and Alexander, 2012). Child welfare workers and judges must base their decisions regarding visitation and custody on safety criteria. Restrictions on visitation are justified by considerations such as volatility of safety threats, how difficult a threat may be to manage, or whether a child's functioning deteriorates after a visit. Custody and placement are also safety decisions that require knowledge, understanding, and evidence of threats present in the home, and parental protective capacity to manage those threats (Lund and Renne, 2009, Russell, Miller, and Nash, 2014).



Family Drug Court Learning Academy

Top Five Challenges in Responding to Participant Behavior in Family Treatment Courts

Visit: www.cffutures.org/fdc-learning-academy

Taking a Closer Look – Site Example

Grant County, IN

Therapeutic Responses to Behavior

Best Practice Standard

Monitoring and Evaluation

Monitoring and Evaluation

The FTC collects and reviews data to monitor participant progress, engage in a process of **continuous quality improvement, monitor adherence to best practice standards, and evaluate outcomes** using scientifically reliable and valid procedures. The FTC establishes performance measures for shared accountability across systems, encourages data quality, and fosters the exchange of data and evaluation results with multiple stakeholders. The FTC uses this information to improve policies and practices in addition to monitoring the strengths and limitations of various service components. Evaluation results and data are also critical components of effective stakeholder outreach and sustainability, helping the FTC "tell its story" of success and needs.

Monitoring and Evaluation

A. Maintain data electronically
B. Engage in a process of continuous quality improvement
C. Evaluate adherence to best practices
D. Use of rigorous evaluation methods

Research

Continuous quality improvement (CQI), sometimes called performance and quality improvement (PQI), refers to an intentional process of using data to improve outcomes (Barbee, et. al, 2011; Louisiana Department of Children and Family Services). These efforts involve active use of a theory-based management system that examines processes and outcomes toward long-term, shared success (Louisiana Department of Children and Family Services). This work uses a client-centered philosophy and a systematic approach to collect staff and client feedback in addition to data on standard services and processes (Senge, 2006).

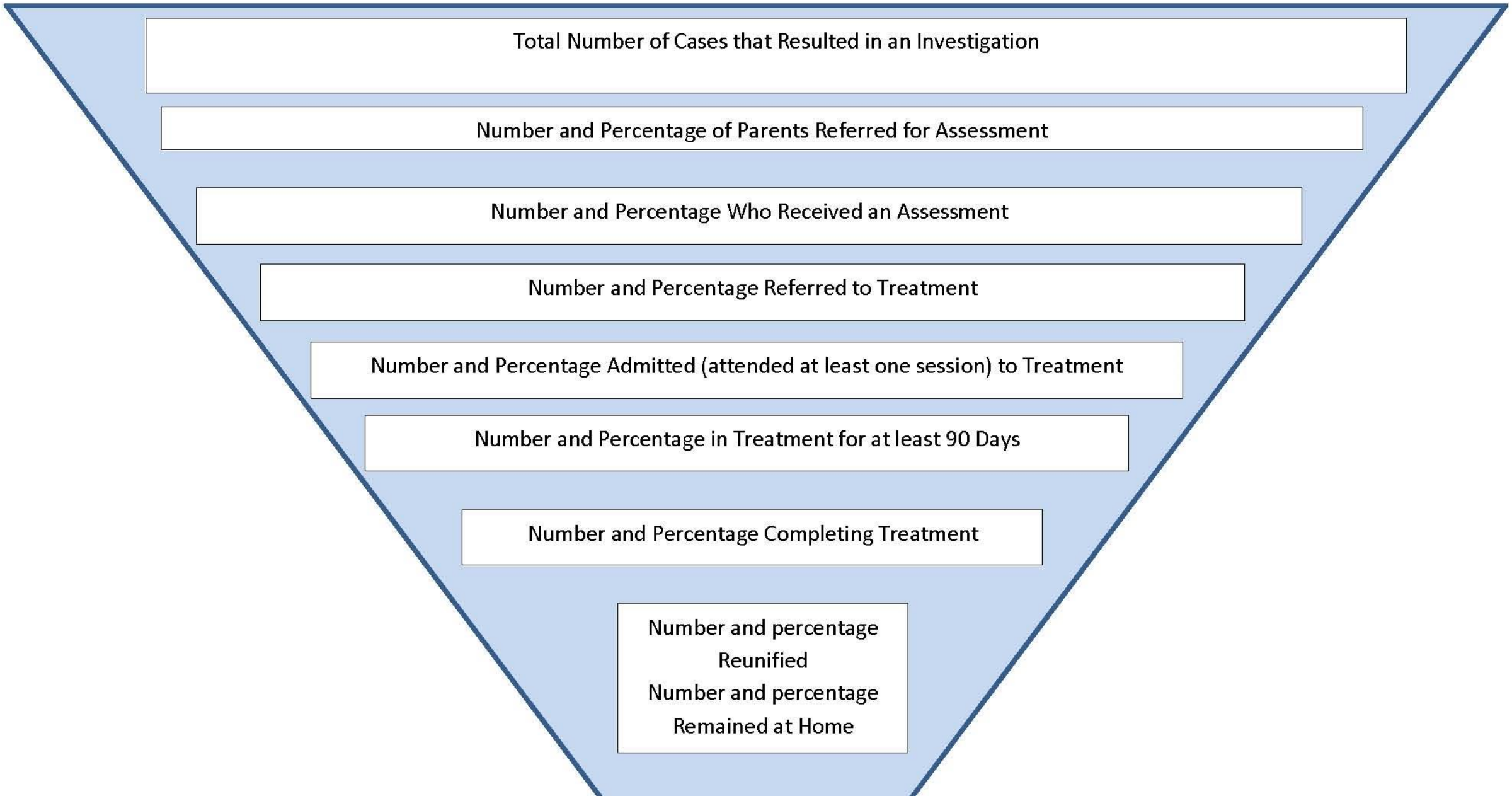
Research

Adherence to research-based best practices is often poor in social services, criminal justice, and SUD treatment programs (Friedmann, Taxman, and Henderson, 2007; McLellan, Carise, and Kleber, 2003; Taxman, Perdoni, and Harrison, 2007). Even when agencies and programs adopt evidence-based practices, ensuring continuing fidelity to the model(s) is a significant and ongoing challenge (Fixsen, et. al, 2005; Wensing and Grol, 2004). Like many complex service organizations, drug courts are highly susceptible to "drift," meaning that the program drifts away from fidelity to the model and outcomes for children, parents, and family members deteriorate over time (van Wormer, 2010; Fay-Ramirez, 2015).

Data Dashboard

Drop-off analysis examines if or when FTC participants drop out of the admissions process and active participation in the FTC and can be used to identify opportunities to create new or modify existing processes to better engage parents and family members *(Children and Family Futures, 2015)*.

Drop-off Points



Data Dashboard

The FTC selects a set of critical data indicators that help the operational team and steering committee members monitor critical FTC operations such as referrals, admissions, completions, and terminations *(Children and Family Futures, 2015; National Drug Court Institute and Center for Children and Family Futures, 2018)*.

Pima County Family Drug Court – Tracking Families' Progress

Observing FDC

~70% of dependency petitions contain allegations of substance abuse

Intake Process

Intake: Reasons eligible observers give for not signing up

- Do not have a substance abuse problem, do not need treatment
- Already have too much to do on DCS case plan
- Have enough recovery support already
- Cannot get to court on Wednesdays
- Still thinking about it

Recruitment Outcomes for Jan. 2017

- # parents who observed FDC = **46**
- # observers eligible for FDC = **35**
- # eligible observers who signed up for FDC Intake = **16**

Intake Sign-Up Rate: 46%
(# eligible observers signed up for Intake / # eligible observers)

Services Received

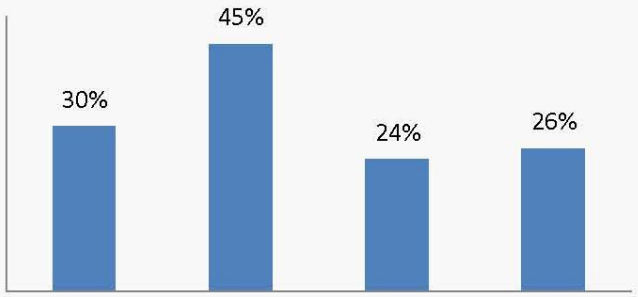
Services Offered During FDC	Parent	Child
Trauma-Focused Therapy	✓	
Individual Therapy	✓	
Evidence-based Parenting Class[1]	✓	✓*
Parent Child Relationship Assessment	✓	✓
Parent Child Relationship Therapy	✓	✓
Child Parent Psychotherapy[2]	✓	✓
Family Therapy	✓	✓
In-Home Services	✓	✓
Dinosaur School		✓
Developmental Services		✓
Other Therapeutic Services		✓

[1] If the class is Strengthening Families, children 6 to 16 can attend.
[2] To date, all children who received CPP have been reunified with their parents.

Types of FDC Discharge

- Successful, graduated
- Successful, voluntary discharge
  - initiated by client
  - initiated by court , either not the right fit or dependency case closed
- Unsuccessful

Services Received Per Discharge Status*



Average # days in FDC	All Parents Discharged	Successful, Graduated	Successful Voluntary	Unsuccessful
	273	385	193	198

Reunification

Reunification & Case Reactivation*

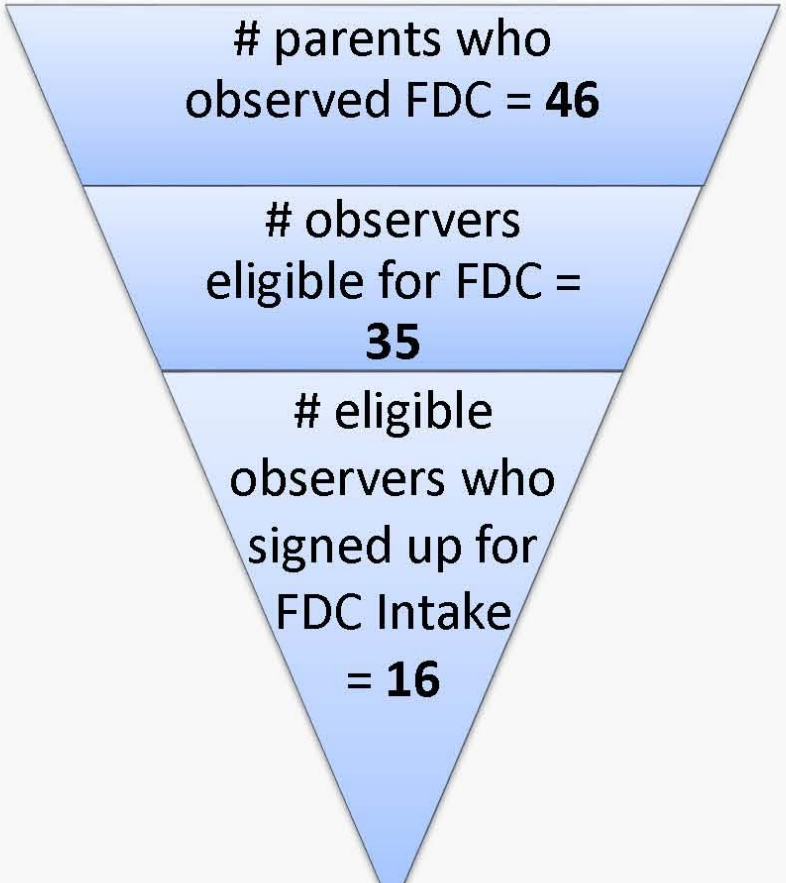
Reunification Rate (# children reunified / # children who achieved their permanent plan)	82%
Reactivation Rate (# children with reactivated cases / # children reunified)	4%

- 93% of parents who graduated and 75% of parents who were voluntarily discharged from FDC, and whose children achieved their permanent plan, were reunified with their children.
- 58% of parents who were unsuccessfully discharged from FDC, and whose children achieved their permanent plan, were reunified with their children.

*Data as of Jan. 2017. Average over past 12 months.

~70% of dependency petitions contain allegations of substance abuse

Recruitment Outcomes for Jan. 2017



Intake: Reasons eligible observers give for not signing up

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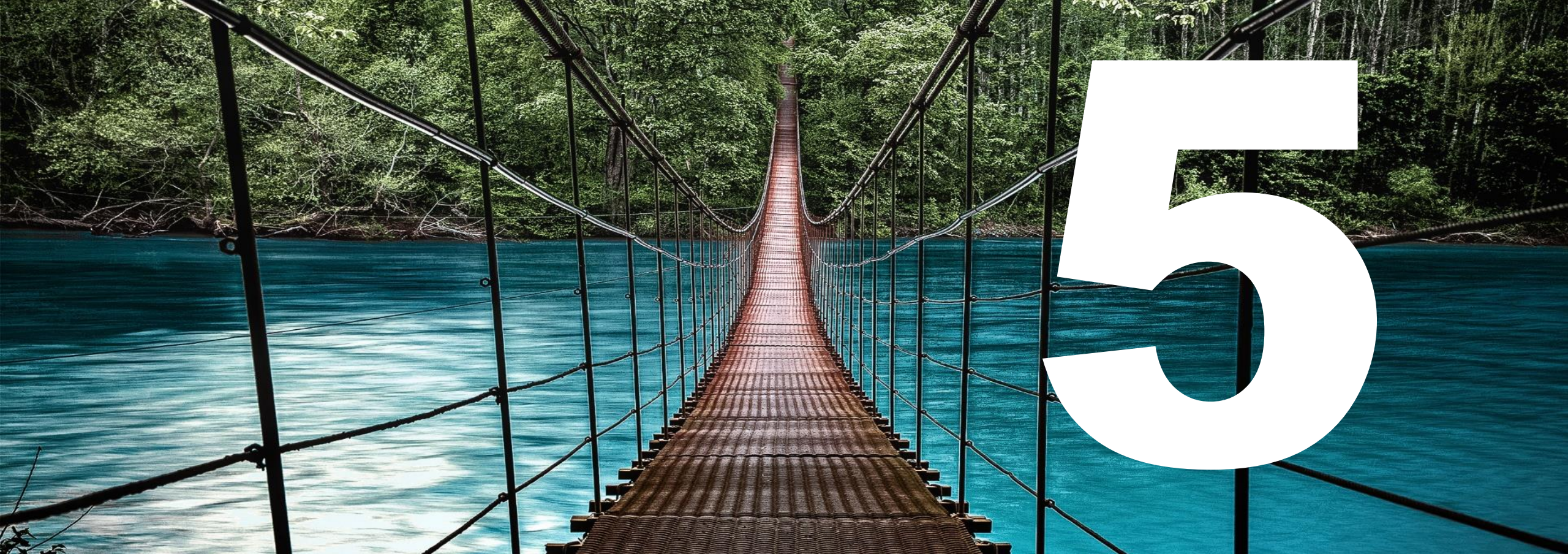
Intake Sign-Up Rate: 46%
(# eligible observers signed up for Intake / # eligible observers)

Taking a Closer Look – Site Example

Jefferson County, CO

Monitoring and Evaluation



Moving Beyond Guidance

NEXT STEPS

National Family Treatment Court Best Practice Standards


#1
Sit & read them

National FTC Best Practice Standards

1. Organization and Structure
2. Role of the Judge
3. Ensuring Equity and Inclusion
4. Early Identification and Assessment
5. Timely, Quality, and Appropriate Substance Use Disorder Treatment
6. Comprehensive Case Management, Services, and Supports for Families
7. Therapeutic Responses to Behavior
8. Monitoring and Evaluation

Structure of FTC Best Practice Standards

Description – Each Standard begins with a descriptive summary paragraph

Provisions – Expand on description and are mandates stating what FTCs should do; they are designed to be as directive and measurable as possible

Rationale – Describes the reasoning and applicable research base for each provision, drawing upon both practice-based evidence and empirical studies from a wide range of related fields of study

Key Considerations – Provide additional explanation of provision and practical implementation advice

References – Included at end of each section


#2
Share them with stakeholders

Adopting the FTC Best Practice Standards

Direct Service Practitioners can use the Standards to reflect on and enhance their work with children, families, individuals, and communities.

Community Leaders can use the Standards as a tool for capacity building within their community.

Policymakers can adopt the Standards as a means of establishing expectations for quality practice for children, families, and individuals involved in child welfare and affected by substance use and mental health disorders.

Funders can adopt the Standards for use in requests for proposals, program monitoring, and quality assurance.


#3
Develop process for self-assessment

Adopting the FTC Best Practice Standards

Developmental – Adoption of all Standards will take patience, persistence, and time

State Standards – States can modify existing State Standards to encompass National FTC Standards or use to develop State Standards

Measure Progress– FTC Standards “set the bar” for practice, use these to measure growth and progress toward full adoption

Adopting the FTC Best Practice Standards

State Standards

- Even states that have State Standards may not have Standards for FTCs (often criminal focused)
- Which stakeholders need to be involved to modify and adopt State Standards that encompass the different stakeholders, legal procedures, and outcomes of families involved in child welfare?
- How can state systems – Court Improvement Program, Family Courts, Treatment, Child Welfare, Medicaid, etc. – work to support adoption of these Standards?

Adopting the FTC Best Practice Standards

Measure Progress

- Begin by establishing your jurisdiction's strengths and needs in regard to the FTC BPS
- Determine which Provisions you can quickly adopt and which will take more time or resources
- Develop a plan to move toward adoption of all Provisions

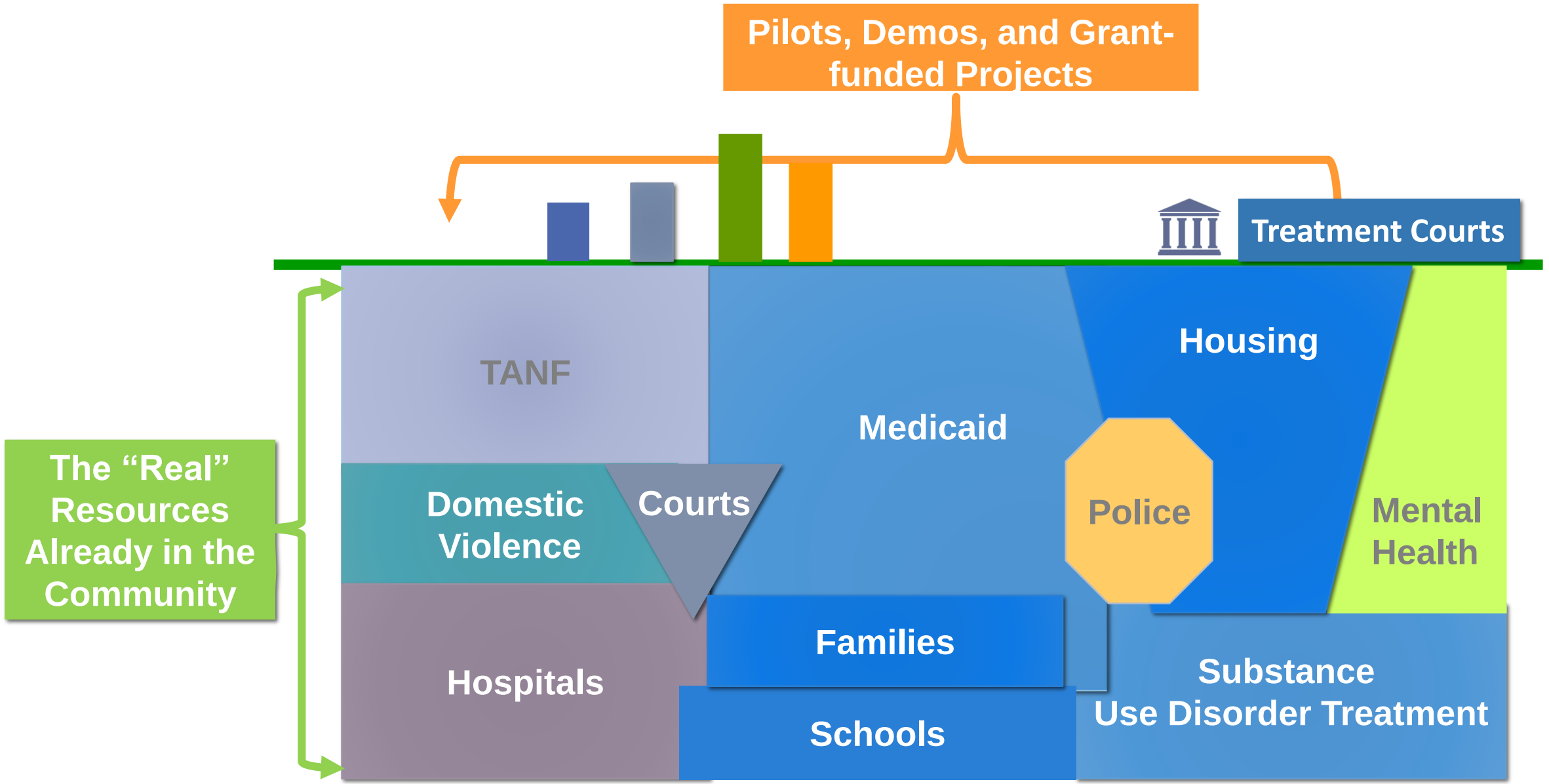

#4
Use to garner resources

Resources for Adopting FTC Best Practice Standards

Developmental process – resources may not be available to meet all provisions

What resources already exist and what partnerships need to be developed to meet the needs of children and families?

Using the Resources Already in Your Community



#5

Align with parallel initiatives

Family First Prevention Services Act (2018)

Makes changes to federal child welfare financing, including allowing for federal Title IV-E dollars to reimburse states for substance use, mental health prevention and treatment services and parenting programs for children at imminent risk of being placed in foster care and their families

- Provisions Related to Substance Use and Mental Health Treatment for Families
  - Reimbursement for Family Residential Substance Use Disorder Treatment – **October 1, 2018**
  - Use of Title IV-E Funds to Prevent Child Placement in Out-of-Home Care – **October 1, 2019**
  - Reauthorization of Regional Partnership Grants

Primary Changes in **CAPTA** Related to Infants with Prenatal Substance Exposure

1974

Child Abuse Prevention and Treatment Act (CAPTA)

2003

The Keeping Children and Families Safe Act

2010

The CAPTA Reauthorization Act

2016

Comprehensive Addiction and Recovery Act (CARA)

CARA's Primary Changes to CAPTA

1. Further clarified population to infants "born with and affected by substance use disorder or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder," **specifically removing "illegal"**
2. Specified **data to be reported** by States
3. Required **Plan of Safe Care** to include needs of **both infant and family/caregiver**
4. Specified increased monitoring and oversight by States to ensure that **Plans of Safe Care** are implemented and **that families have access to appropriate services**

NATIONAL FAMILY DRUG COURT TTA Program

Center for Children and Family Futures
Strengthening Partnerships, Improving Family Outcomes

Family Drug Court Training and Technical Assistance Team
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