Travis County Commissioners Court Agenda Request

Meeting Date: November 14, 2013

Prepared By/Phone Number: Juanita Jackson/854-4467

Elected/Appointed Official/Dept. Head: Sherri E. Fleming,
County Executive for Health and Human Services and Veterans Service

Commissioners Court Sponsor: Judge Samuel T. Biscoe

AGENDA LANGUAGE:
RECEIVE UPDATE ON THE TRAVIS COUNTY FAMILY DRUG TREATMENT COURT

BACKGROUND/SUMMARY OF REQUEST AND ATTACHMENTS:
See attached

STAFF RECOMMENDATIONS:
See attached

ISSUES AND OPPORTUNITIES:
See attached

FISCAL IMPACT AND SOURCE OF FUNDING:
See attached

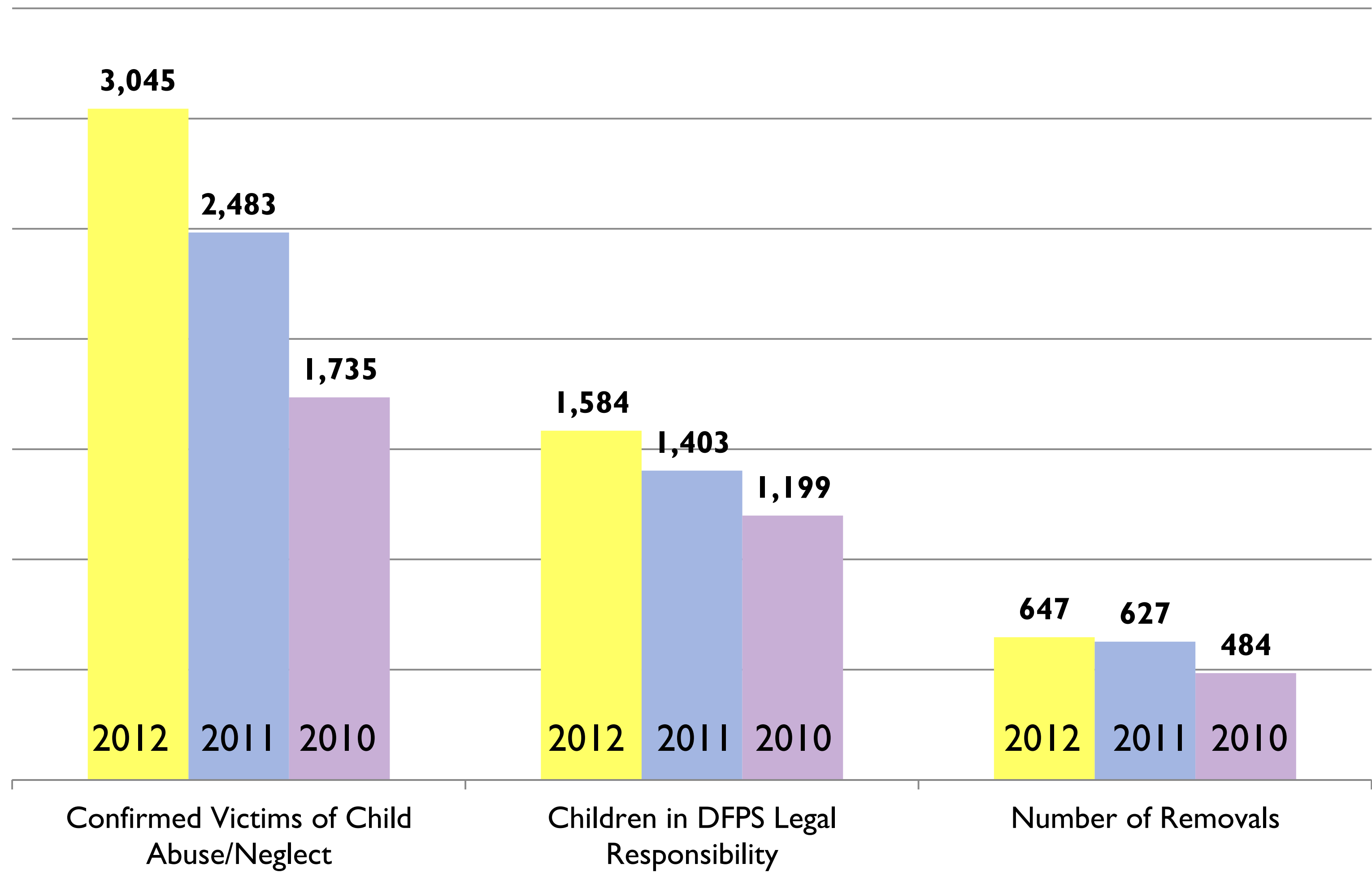
REQUIRED AUTHORIZATIONS:

Presented by Travis County Health and Human Services and Veterans Service in collaboration with the District Court and Justice and Public Safety

- Community Conditions Relating to Child Welfare
  - Travis County District Courts – Civil Statistics
- Current Travis County Investments in Child Welfare
- Travis County Family Drug Treatment Court
  - History & Development
  - Structure
  - Statistics and Outputs/Outcomes
  - Community and Participant Collaboration
  - Sustainability and Funding Need for Fiscal Year 2015
- Justice and Public Safety
  - Office of Child Representation: Maintaining Attorney ad Litem Position in Fiscal Year 2015

- Child Population has increased 11% from 2010 -2012 259,016 children living in Travis County in 2012
- Children account for 30% of the total Travis County population below 200% of the poverty threshold (2011 Data)
- Teen Pregnancy Rate for Travis County is 24.9% (2009 Data)
- High School Drop Out Rate - AISD Class 2012 – 9.5 %
- High School Graduation Rate - AISD Class 2012 – 82.5 %
- Family Violence Incidents in Travis County 8,893 (2012 Data)
- 159,000 households in Travis County Experience a housing cost burden (2012 Data)

Increasing Numbers in Child Welfare



Increasing Numbers in Child Welfare

- The volume of Child Protective Services cases filed per month has increased by **72%** since 2008 (Based on average number of cases filed per month)
- CPS case filings per year have increased by **68%** since 2008 (280 in 2008 to 471 in 2013)
- Number of cases on CPS Docket has increased by **143%** (Based on October Dockets from 2008-13)
- These increases over the last 5 years have resulted in Judges spending an average of less than 9 minutes per CPS case with the national guidelines being 30 to 60 minutes

Travis County Investments in Child Welfare

- Health and Human Services and Veterans Service
  - Child Protective Services Board
  - Children F.I.R.S.T Program
  - CPS Reintegration Project
  - **Family Drug Treatment Court**
    - Parenting in Recovery
    - Children's Continuum
- District Attorney's Office – Family Justice Division
- **District Courts**
- Justice and Public Safety
  - Office of Parent Representation
  - **Office of Child Representation**
- Sheriff's Office – Child Abuse Unit

- Poor outcomes for families involved in the child welfare system due to substance abuse
- Lack of community coordination to serve these families
- National Research and Statistics Showing the Success of Family Drug Courts
- Grants
  - The Office of the Governor- Criminal Justice Division
  - Parenting in Recovery – Administration for Children and Families
  - The Children's Continuum – The Office of Juvenile Justice and Delinquency Prevention

FDTC Structure

- The Charter
- Eligibility and Participant Identification
- Enrollment in FDTC
- Four Phases of FDTC
- Overview of Services to Families
  - Partners Involvement
- Length of Service
- Discharge and Graduation

- Families, children, and parents served
- Demographics of participants
- Participant outcomes & success rate
- Permanency outcomes for children
- Recidivism measures
  - Child Protective Services
  - Criminal Justice

- Participants' Personal Stories from FDTC
  - FDTC Graduates from 2012-13
    - Their Journey
    - Their Challenges
    - Their Success
    - Their Message

- FDTC's Impact on Collaborative Partners
  - Austin Recovery
  - Austin Travis County Integral Care (ATCIC)
  - Aurora Martinez Jones – Attorney at Law
  - Communities for Recovery
  - Court Appointed Special Advocates (CASA)
  - Department of Family and Protective Services/ Child Protective Services
  - District Attorney's Office – Family Justice Division
  - District Judges
  - Foundation Communities
  - Office of Child Representation
  - Safe Place

FDTC Community Collaboration

- Current In-Kind Match for FDTC
  - **Austin Recovery**
    - Positions that support FDTC participants while in treatment at Austin Family House
    - Staff time and expertise to support FDTC
  - **Austin Travis County Integral Care**
    - Reduced MSO fee
    - Supervision of grant positions
    - Staff time and expertise to support FDTC
  - **CPS Board**
    - Funding for drug testing
  - **Communities for Recovery**
    - Staff time and expertise to support FDTC

- Current In-Kind Match for FDTC
  - **Court Appointed Special Advocates**
    - 75% funding of FDTC position
    - Supervision of FDTC position
    - Additional staff time and expertise to support FDTC
  - **Department of Family and Protective Services**
    - Dedicated unit of six people for FDTC
    - Service dollars for evaluation and therapy
    - Staff time and expertise to support FDTC
  - **District Attorney's Office,** Family Justice Division
    - Staff Attorney
    - Staff time and expertise to support the FDTC

- Current In-Kind Match for FDTC
  - **District Court**
    - Dedicated Judge
    - Courtroom and personnel
    - Docket Management
    - Staff time and expertise to support FDTC
  - **Foundations Communities**
    - 75% funding of FDTC position
    - Supervision of FDTC position
    - Staff time and expertise to support FDTC
  - **James Kruger Jewelers**
    - Donations for Participants

- Current In-Kind Match for FDTC
  - **Lone Star Circle of Care**
    - Priority service to FDTC participants
  - **Manos de Cristo**
    - Priority service to FDTC participants
  - **Office of Child Representation**
    - Supervision of grant position
    - Staff time and expertise to support FDTC
  - **SafePlace**
    - Staff time and expertise to support FDTC

FDTC Sustainability and Funding Need for FY 2015

- Current Funding for FDTC
  - Parenting in Recovery
    - Federal Funding :Administration of Children and Families $2,500,000 for initial five year grant
    - Travis County & Partner Match: $456,015 for initial five year grant
    - Federal Funding $981,000 for two year extension grant ending Sept 2014
    - Travis County Grant Match $473,286 in services dollars and staff position for two year extension grant
  - Governor's Grant
    - State Funding – $137,387 annual award since October 2007
  - The Children's Continuum
    - Federal Funding - Department of Justice $550,000 for three years ending September 2014
    - Travis County and Partner Match $183,333

- Grant Funded/Grant Matched Positions
  - Two Child Therapists at Austin Travis County Integral Care (ATCIC)
  - One AAL at Office of Child Representation
  - One Drug Court Coordinator w/ District Court
  - One Project Director/Substance Abuse Manager w/HHS&VS
  - One Case Aide w/ HHS&VS
  - 25% of CASA Supervisor
  - 25% of Foundation Communities Case Manager

- Majority of the FDTC infrastructure will be maintained post grant through in-kind partner commitment.
  - Excluding these positions:
    - Substance Abuse Manager (HHS/VS grant match position)
    - Attorney ad Litem (OCR grant funded position)
    - Child Therapist (ATCIC grant funded position)

- 51% of the service dollars needed to maintain the FDTC design will be maintained post grant through in-kind partner commitment.
  - Additional funding required for:
    - Substance abuse inpatient 90-day Women/Children
    - Recovery Supports

FDTC Sustainability and Funding Need for FY 2015

FDTC Funding Infrastructure Status in FY 2015			
Infrastructure/Partner	**Current Funding Strategy**	**Funding Strategy in 2015**	**Amount Unmet**
DFPS – Dedicated Unit	Match	Continued by Partner	N/A
District Court – Judge	Match	Continued by Partner	N/A
District Attorney's Office – Staff Attorney	Match	Continued by Partner	N/A
CASA - Position	75% Match/25% Grant	Fully Funded by Partner	N/A
Foundation Communities - Position	75% Match/25% Grant	Fully Funded by Partner	N/A
Austin Recovery – Internal Program Support	Match	Continued by Partner	N/A
CPS Board – Drug Screenings	Match	Continued by Partner	N/A

FDTC Sustainability and Funding Need for FY 2015

FDTC Funding Infrastructure Status in FY 2015			
Infrastructure/Partner	**Current Funding Strategy**	**Funding Strategy in FY 2015**	**Amount Unmet**
Substance Abuse Treatment	Grant - $180,000 TC Match - $140,000	Austin Recovery - $150,000	$170,000
Recovery Supports	Grant - $ 75,000 TC Match - $65,000	HHS/VS - $85,000	$55,000
AAL Position	Grant ACF - $90,246	JPS/OCR – Supervision	$90,246
Child Therapist (2)	Grant ACF/DOJ - $124,227	ATCIC – Supervision 15% Medicaid $18,040 DOJ Grant $64,227	$41,960
Drug Court Coordinator	Governor's Grant	Governor's Grant	N/A
SA Clinical Manager	TC Match	HHVS – Supervision	$73,000
FDTC Case Aide	DOJ Grant	DOJ Grant	N/A
		Total Amount Unmet	**$430,206**

FDTC Sustainability and Funding Need for FY 15

- Strategies for funding FDTC in FY 15 / 16
  - Apply for a one year no-cost extension of the DOJ grant for FY 15
  - Transition an existing HHS/VS position to full-time with the FDTC for FY 15
  - Increase the Medicaid billing capacity of the child therapist positions to 20%
  - Utilize existing HHS/VS social service contract funding to support FDTC
  - Redirect existing HHS/VS inter-local contracts to support FDTC

FDTC Sustainability and Funding Need for FY 2015

- Strategies for funding FDTC in FY 15/16
  - Court continue one-time funding that is currently used as match for FDTC into FY 2015 with a slight increase to fund: Substance Abuse Treatment, Recovery Supports, and a Child Therapist ($266,960)
  - Court authorize funding for 2 new FTE’s in FY 15 ($163,246)
    - HHS/VS – Substance Abuse Manager
    - JPS - Office of Child Representation – Attorney ad Litem

- The overall volume increase in the number of Child Protective Services cases filed impacts all aspects of the system – including the representation of the child in court

- Office of Child Representation has specialized attorneys with expertise, experience and knowledge in the child protective services system (child welfare)

- JPS - OCR in FY 15 will submit a budget request to sustain the Attorney ad Litem position currently funded by the grant. This additional AAL will allow OCR to:
  - Increase the number of children represented
  - Maintain a role in representing children in the FDTC
  - Continue to enhance specialized knowledge and experience on addiction to utilize with full CPS docket.

- Shown to be the more successful way to serve families involved in the child welfare system due to parental substance abuse.
- The work of the FDTC improves the overall functioning of the child welfare system through the spread of expertise and knowledge.
- Investing in families now reduces recidivism in both child welfare and criminal justice which improves the overall health of our community.

Work Session Facilitators:
Michelle Kimbrough – Drug Court Coordinator
Chuck Roper – PIR Project Director
Laura Peveto – HHS/VS Program Administrator
County & Community Partners
Contact Website for more information
http://www.traviscountytx.gov/health_human_services/children_services/welfare/family_drug_court.asp

OTHER FAMILY DRUG COURTS IN TEXAS

County	Judge/Address	Phone
Bexar	Judge Peter Sikai 100 Delorosa San Antonio, TX 78205	(210) 335-2300 (210) 335-3026
El Paso	FBSS Court: Judge Oscar Galbaldon Intervention Court: Judge Yahara Lisa Gutierrez 500 E. San Antonio El Paso, TX 79901	(915) 834-8216
Grayson	STAR Family Drug Court 15th Judicial District Court of Grayson County Judge Jim Fallon 200 S. Crockett Sherman, TX 75090	(903) 813-4303
Gregg	Judge Robin Sage 101 East Methvin, Suite 463 Longview, TX 75601	(903) 237-2534
Harris	Harris County Family Intervention Court Judge Bonnie Hellums 1115 Congress, 2nd Floor Houston, TX 77002	(713) 755-3211
Jefferson	Judge Judy Paasch 1149 Pearl Beaumont, TX 77701	(409) 835-8671
Lubbock	Judge Judy Parker 904 Broadway, 3rd Floor Lubbock, TX 79401	(806) 775-1599
Nueces	Judge Terry Shamsie 2310 Gollihar Corpus Christi, TX 78410	(361) 561-6056
Smith	Judge Carol Clark 100 N. Broadway Tyler, TX 75702	(903) 590-1617
Tarrant	Pilot Tarrant County Family Drug Court Judge Jean Boyd 323rd District Court 2700 Kimbo Road Fort Worth, Texas 76111	(817) 838-4620

STATE FAMILY DRUG COURT INFORMATION AND STATISTICS

*2011-2012 Biennial Report to the 83rd Texas Legislature, pp.8-10 (*Available at the The Office of the Governor/ Criminal Justice Division website: http://www.governor.state.tx.us/files/cjd/CJD_2011-2012_Biennial_Report.pdf)

- Report by the Office of the Governor (OOG) regarding Specialty Courts that receive state funding. These include Family Dependency Courts (Family Drug Courts), Traditional Adult Drug Courts, DWI Courts, Juvenile Drug Courts, Re-entry Courts, and other Specialty Court programs ***(Note: the Travis County FDTC is one of these Specialty Courts that the OOG has funded for FY 2014 in the amount of $137,387.88)***
- Of the 136 Specialty Courts in Texas, the OOG funds 67
- Overall the number of participants served by specialty courts receiving OOG funding in Texas was 7,580 in 2011 and 7,399 in 2012. Of these participants 2,138 in 2011 and 2,117 in 2012 successfully completed specialty court programs. These are success rates of 29% both years. ***(Note: the Travis County FDTC had participant graduation/ successful completion rates of 47% in 2011 and 50% in 2012. This rate increased to 65% in FY 2013)***

NATIONAL FAMILY DRUG COURT INFORMATION AND STATISTICS

Marlowe, D.B. & Carey, S.M. (2012, May). *Research Update on Family Drug Courts.* Available at the National Drug Court Resource Center website:
http://www.ndcrc.org/sites/default/files/reseach_update_on_family_drug_courts_-_nadcp.pdf

- Publication of the National Association of Drug Court Professionals with research on the state of Family Drug Courts (FDCs) sited
- Family Drug Courts created to address poor outcomes for children of substance abusing parents in the child welfare system
- Ultimate incentive is family reunification and ultimate sanction is termination of parental rights
- FDCs effective in improving substance abuse treatment initiation and completion by parents
- Children whose parents are participants in FDC spend less time in out of home placements and fewer months in foster care ***(Note: Almost all Travis County FDTC cases begin with children under age 6 in their mother's care while she is in treatment and all cases begin with no children in foster care.)***
- Parents who have participated in a FDC are less likely to be arrested after their participation in FDC
- Cost savings of $6,000-$15,000 per child in foster care payments when parents are in FDCs
- Other cost savings of $5,000-$13,000 per family when parents participate in FDCs
- Treatment completion and longer time spent in treatment is directly related to children spending less time in foster care ***(Note: The overwhelming majority of Travis County FDTC participants successfully complete treatment.)***

- The more days that a parent spends in treatment, the more likely their child is to be reunified with him/her ***(Note: Travis County FDTC provides mothers with 90 days of inpatient substance abuse treatment at Austin Recovery)***
- Drug Courts (even criminal drug courts) who offer parenting classes to participants have lower re-arrest rates after participation in the drug court and more cost savings ***(Note: All Travis County FDTC participants participate in parenting classes while in inpatient treatment, all work with a child therapist to diagnose and improve the parent-child bond, some engage in child-parent psychotherapy or filial therapy with the child therapist, and almost all receive one on one parenting training.)***

Carey, S.M., Sanders, M.B., Waller, M.S., Burrus, S.W.M., & Aborn, J.A. (2010, June). *Jackson County Community Family Court process, outcome, and cost evaluation: Final Report.* Portland, OR: NPC Research. Available at http://www.npcresearch.com/Files/Jackson_Byrne_0610.pdf

- Research on a Family Drug Court (FDC) in Jackson County, Oregon
- Improvements to this Family Drug Court that were suggested as a result of this evaluation include for this Court to include a parent's attorney on the drug court team ***(Note: Travis County FDTC has three parents attorneys on the team)*** and that they shorten the length of time between filing the petition and entry into the program, as no more than 20 days is the optimal time frame ***(Note: Travis County FDTC often has already enrolled participants within 14 days of the petition filing because potential participants are identified and screened by Child Protective Services prior to initiation of the lawsuit.)***
- FDC parents more likely to initiate and successfully complete treatment than a comparison group
- FDC parents spent longer periods of time in treatment
- Children of FDC participants spent less time in foster care
- Parents involved in FDC less likely to have their parental rights terminated to their children
- Children were reunified with parents more often when parent participated in the FDC and the children were returned sooner than those in a comparison group- these rates of reunification are 51% and 45% respectively ***(Note: Travis County FDTC rates are comparable to these – 51% and 41% respectively)***
- FDC participants were less likely to arrested over a period of 4 years than those in a comparison group - arrest percentages at one year after completion were 10% for FDC graduates, 25% for all FDC participants, and 30% for comparison; arrest percentages at four years completion were 20%, 40%, and 60% respectively; FDC graduates were nearly more than half as likely to be arrested after 4 years than a comparison group

Worcel, S.D., Green, B.L., Furrer, C.J., Burrus, S.W.M., & Finigan, M.A. (2007, March). *Family Treatment Drug Court Evaluation: Final report.* Portland, OR: NPC Research. Available at http://www.npcresearch.com/Files/FTDC_Evaluation_Final_Report.pdf

- Research study on four Family Drug Courts (FDCs) in four different counties (San Diego County and Santa Clara County, California; Washoe County, Nevada; Suffolk County, New York)

- Parents in 3 of the 4 sites had greater rates of treatment completion than a comparison group – these were almost double the rates of completion ***(Note: The overwhelming majority of Travis County FDTC participants successfully complete treatment.)***
- Children spent more time in their parents' care and were more likely to be reunified when their parent was a participant in a FDC – for two sites they were twice as likely to reunify ***(Note: Almost all Travis County FDTC cases begin with children under age 6 in their mother's care while she is in treatment and all cases begin with no children in foster care.)***
- Successful treatment completion by a parent closely related to likelihood of reunification
- FDC lawsuits took longer to resolve and for final orders to be entered than comparison lawsuits

Green, B.L., Furrer, C.J., Worcel., S.D., Burrus, S.W.M., & Finigan, M.W. (2009). Building the evidence base for Family Drug Treatment Courts: Results from recent outcome studies. *Drug Court Review*, 6, 53–82. Available at the National Drug Court Institute website: http://www.ndci.org/sites/default/files/ndci/DCRVolume6_Issue2.pdf

- Article summaries outcomes studies for Family Drug Courts (FDCs) over the last few years
- There are 301 estimated Family Drug Courts (FDCs) in the United States
- FDCs increase rates treatment completion and improve treatment outcomes for substance abusing parents involved with child welfare and the civil court systems
- Children of parent participants in FDCs are more likely to be reunified with their parent and spend less time in foster care than comparison groups' children

Family Drug Treatment Court Funding Sources

There are 4 current funding sources for the participants and children of the Family Drug Treatment Court (FDTC):

1. **Parenting In Recovery II (PIR II) - extension of funding for 2 additional years (the first five years were referred to as Parenting in Recovery or PIR). The grant is awarded by the Children's Bureau and runs from 9/30/12- 9/29/14. $500,000 year one and $480,000 (sequestration reduction) in year two. This grant funds these positions and serves for the FDTC:**
    a. A full-time AAL funded through the Office of Child Representation
    b. A full-time Child Therapist funded through Austin Travis County Integral
    c. One quarter of Housing Case manager position with Foundation Communities
    d. Will provide funding for these services: Substance Abuse Treatment (90 days of inpatient treatment), Recovery Supports, Housing/Utility Costs, Medical/Dental Care, Parenting Support, Other Wraparound Supports (continuation)
    e. Will provide funding for an evaluation of PIR/FDTC; Case Study of discharged participants to document their current level of functioning post program; Cost Study analysis. In addition to grant required evaluation component.
2. **The Children's Continuum (TCC) - grant is awarded by the Office of Juvenile Justice and Delinquency Prevention and runs from 10/1/11-9/30/14. $550,000 total for a period of 3 years.**
    a. Child Therapist funded through Austin Travis County Integral Care
    b. Social Services Assistant with Travis County Health and Human Services
    c. One quarter of CASA advocate position for Drug Court
    d. Specialized Services for Children (art therapy, equine therapy, behavioral aides, parent/ child mentors, etc…)
    e. Expanded parent training services utilizing the Nurturing Parenting Program curriculum
3. **Governor's Drug Court Grant - has been awarded annually to the FDTC from the Office of the Governor of Texas since September of 2007 and runs annually from Sept. 1st-Aug. 31st. The award amount for FY 14 is $137,388.**
    a. Drug Court Coordinator Salary and Benefits
    b. Drug Testing
    c. Miscellaneous Supplies – Bus passes, Office, etc….
4. **Travis County Reserve Funds**
    a. Used as match for the PIR and TCC grants
    b. Fund PIR Project Director
    c. Fund Substance Abuse Treatment; Recovery Supports; Parent training; and other wraparound supports

Travis County Family Drug Treatment Court Charter

Purpose

This charter is adopted by the Travis County Family Drug Treatment Court (FDTC) partners as a record of their unified mission and vision. It is intended to support the sustainability of the FDTC, promote accountability, and ensure consistency, as well as clarify roles and responsibilities of FDTC partners.

Introduction

The FDTC is a specialty court created to serve families who are already involved in the Child Protective Services (CPS) Court system due to substance abuse or dependence. It is designed to effectively help parents recover from substance abuse or dependence, guide them along the journey of recovery, and teach them to safely parent their children, thus reducing the incidence of child maltreatment.

History

The idea of a Family Drug Treatment Court program first took root in Travis County in 2005, when several individuals came together to discuss the possibility of forming a drug court to serve families involved in the CPS system. These individuals were moved by the fact that a significant number of child abuse and neglect lawsuits in Travis County involved substance abuse or dependence by at least one parent. Family Drug Court models in other jurisdictions showed that children whose parents were involved with a FDTC program spent less time in out-of-home care than children of parents who were not in a similar program. Data also showed that children of parents involved with FDTC were more likely to be reunified with their parents, and parents had higher rates of treatment completion than their non-FDTC counterparts.[1]

In 2006, the FDTC founding members gathered a multi-disciplinary group of community partners, including judges, lawyers, social workers, child advocates, drug treatment providers, and other community service providers. These agencies researched the efforts of existing drug courts and met to create framework for the formation of a FDTC program in Travis County.

In 2007, grant-funding allowed for the hiring of a Drug Court Coordinator, provided start-up costs for the program, substance abuse treatment services, and housing and wrap-around services. The program began serving clients in February 2008 and as of June 7, 2010; the program has assisted 63 parents and 98 children with achieving safe, healthy, and sober lifestyles.

[1] Family Treatment Drug Court Evaluation / NPC research, March 2007, http://www.npcresearch.com/Files/FTDC_Evaluation_Final_Report.pdf.

Mission, Vision, Values

The **mission** of the FDTC is to provide a spectrum of court and community-based supports for parents involved in the child welfare system that promotes recovery from alcohol and drug addiction and encourages healthy lifestyle choices.

The **vision** of FDTC is for parent participants to become sober, responsible caregivers so they can ensure the safety and well-being of their children.

FDTC **values**:

- The best place for a child is at home, free from abuse and neglect, with clean and sober parents.
- FDTC effectively addresses participants' drug and alcohol abuse.
- FDTC empowers parents to make responsible decisions, lead self-sufficient lifestyles, and engage as family advocates and mentors to other program participants.
- Participating families, partners, and systems are accountable to each other and the FDTC.
- FDTC provides a family-centered, strength-based, culturally competent, evidence-based service delivery system.
- FDTC provides families access to a continuum of professional and community-based supports that encourages them to reach their highest potential.
- FDTC partner entities practice mutual respect, understand their roles and responsibilities, share a goal of improving the lives of children and families, and willingly consider adapting policies and procedures to better serve participants.
- The FDTC provides interdisciplinary training to partners that helps them develop the knowledge and skills required to effectively address participants' needs while remaining sensitive to the cultural diversity of families and communities.
- Partners share appropriate and relevant information/data to ensure an effective system of service delivery.
- A continuous process of data collection, evaluation, and program improvement ensures sustainability of positive outcomes, effective methods of practice, and diversity of funding.
- FDTC contributes to a stronger community by collaborating with community providers to sustain healthy, contributing parents who are productive members of our community.

Membership

This Charter contemplates a variety of opportunities for individuals and organizations to participate in the continued sustainability of the Travis County Family Drug Treatment Court. Each level of participation is crucial to the success of the program.

The membership of FDTC will be comprised of two governing bodies: the Drug Court Team and the Advisory Committee.

Drug Court Team:

Members: The Drug Court Team (DCT) of the Family Drug Treatment Court will be made up of representatives who work directly with FDTC participants. The team will be comprised of representatives from the following entities: Travis County District Attorney's Office, Parent Attorney, Presiding Judge, Child Protective Services, Court Appointed Special Advocates (CASA), Substance Abuse Treatment, Housing, the Drug Court Coordinator, the Parenting In Recovery Project Director, and any other service provider as agreed upon by the DCT.

Purpose: The DCT of the FDTC will oversee the operations and procedures of FDTC through:

- **FDTC Staff Meeting,** held prior to each FDTC docket to review participant compliance with court orders and make recommendations for the hearing on sanctions, dismissals, phase advancement and graduation.
- **Family Drug Treatment Court Docket Review,** held weekly[2] to assess each participant's progress in FDTC.
- **Subcommittee of DCT – Case Management Team Meeting,** held bi-monthly to collaborate on FDTC participant service planning. The Case Management Team (CMT) is comprised of members designated by the DCT.
- **Operations Meeting,** held monthly to review, discuss, and adjust the implementation of FDTC procedures. Additional duties of this meeting are to: 1) create and dissolve subcommittees as deemed necessary; 2) submit policy recommendations to the FDTC Advisory Committee; 3) refer issues to the Advisory Committee for resolution when there is an absence of consensus on the DCT. The Drug Court Coordinator will facilitate Operations meetings.

Length of Participation: Members of the Drug Court Team will serve indefinitely except for the service providers (substance abuse, housing, etc.), whose representatives may be subject to rotation as determined by consensus of the Drug Court Team.

Advisory Committee:

Members[3]: The Advisory Committee of the Family Drug Treatment Court will be made up of a management/supervisory representative from each of the following entities: Travis County District Court, Travis County District Attorney's Office, CASA, Travis County Health and Human Services, Department of Family and Protective Services, Attorney (experienced in representing parents in the CPS system and familiar with FDTC), Substance Abuse treatment provider (rotated on an annual basis between community drug treatment

[2] FDTC is held weekly except on holidays and settlement week

[3] Members of the Advisory Committee cannot directly serve (eg. by providing case management services, court representation, therapeutic services) an active FDTC participant during their membership

providers), two Community Representatives[4] (rotated on an annual basis between community providers), and Drug Court Graduate and/or Family Representative[5]. Additionally, the Drug Court Coordinator will attend the Advisory Committee meetings to represent the Drug Court Team. The committee chair will be selected by committee members and will serve as chair for no more than two consecutive years. The committee meetings will be facilitated by a TCHHS/VS staff member who is not a voting member. The membership of this committee may be expanded by the agreement of a majority of the members.

Purpose: The Advisory Committee of the Family Drug Treatment Court will be responsible for the oversight and sustainability of the program. The Committee will:

- Approve FDTC policies
- Oversee sustainability efforts
- Monitor achievement of long-term goals
- Ensure an evaluation component
- Create and dissolve subcommittees

Length of Participation: Members of the Advisory Committee will serve indefinitely, with the exception of the Substance Abuse treatment provider and the Community Representatives. These positions will be subject to an annual rotation as determined by consensus of the advisory committee. Each member of the Advisory Committee may identify one person who may serve as their designated representative if they are unable to attend a meeting. This representative has the right to participate and vote in the Committee Member's absence. Annually the members of the Advisory Committee shall renew their commitment to the FDTC by reviewing, approving and signing this charter indicating their continued participation.

Meetings: The Advisory Committee will meet quarterly. Additional meetings may be called as needed or at the recommendation of the DCT and may be facilitated by phone, e-mail or other electronic means as is available to the membership. The first meeting of each year the Advisory Committee will select the decision-making process that will govern the committee for that year. The committee will utilize the principals of consensus decision-making[6] as a guide for the process. Additionally, the committee will solicit input from community members that will inform their decision-making on issue areas impacting the FDTC.

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[4] Community Representative refers to individuals/agencies who provide support to FDTC participants, such as housing, mental health, employment/education, child care, and parent education.

[5] Family Representative refers to an individual whose family member has been a participant in FDTC, or a parent or relative (fictive and kin) who has concluded involvement with Child Welfare and exposure to addiction and recovery.

[6] **Consensus decision-making** is a group decision making process that not only seeks the agreement of most participants, but also the resolution or mitigation of minority objections. Consensus is usually defined as meaning both general agreement and the process of getting to such agreement.

GOALS

The primary goals of the FDTC are equivalent to the 10 Key Components[7] of drug courts within the context of a family drug court. Those Components are as follows:

- FDTC integrates alcohol and other drug treatment services with justice system case processing.[8]
- Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.
- FDTC identities participants early and places them in the drug court program promptly.
- FDTC provides access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.
- FDTC monitors abstinence through frequent testing for alcohol and drug use.
- A coordinated strategy governs drug court responses to participants' compliance.
- Drug court participants receive essential ongoing judicial interaction.
- Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.
- Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.
- Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness.

Evaluation

The FDTC is committed to collecting, maintaining, and utilizing data to improve the practice model. The FDTC will promote a sustained evaluation component as part of the program design.

The following criteria will be evaluated, assessed, and shared amongst the partners to be used as a tool to continually improve the FDTC:

- Self-sufficiency of participants
- Abstinence and law-abiding behavior
- Child safety
- Cost-benefit analysis

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[7] The 10 Key Components can be viewed in their entirety at http://www.ojp.usdoj.gov/BJA/grant/DrugCourts/DefiningDC.pdf.

[8] The justice system referenced in this Charter is specific to the civil process through which child welfare suits are litigated.

STATEMENT OF AGREEMENT

This charter is made and entered into as of the 18 day of August, 20 10, by and between the undersigned Partnering Agencies/Organizations ("Partners").

WHEREAS, the Partners desire for the FDTC to be supported and sustained by maintaining a unified mission and vision of the Partners as set forth in this charter, and

WHEREAS, all the below named Partners are in agreement with the mission and vision set forth in this charter,

NOW, THEREFORE, the parties agree that we have read and agree with the terms of this charter.

PARTNERS

The undersigned is authorized to sign this Statement of Agreement as a representative on behalf of their respective partnering agency/organization and have agreed to be committed to this charter.

[signature] 8/18/10
Signature Date

Judge, 126th J.D. Court
Name & Title

Partnering Agency/Organization

[signature] 8/18/10
Signature Date

Laura Wolf, Executive Director
Name & Title

CASA of Travis County
Partnering Agency/Organization

[signature] 8/18/10
Signature Date

Jim Lehrman - Director
Name & Title

Travis Co Health & Human Services
Partnering Agency/Organization

Bill Wigmore 8/18/10
Signature Date

Bill Wigmore, Pres./CEO
Name & Title

Austin Recovery
Partnering Agency/Organization

[signature] 8/18/10

Signature Date

LaRu Woody Asst. Dist Atty

Name & Title

Travis Co. Dst. Atty Off.

Partnering Agency/Organization

Sally E. Melant 8/18/10
for Shelia Brown

Signature Date

Sally E. Melant
CPS Program Administrator

Name & Title

Dept. of Protective and Regulatory Services Region 07

Partnering Agency/Organization

Signature Date

Name & Title

Partnering Agency/Organization

Signature Date

Name & Title

Partnering Agency/Organization

Signature Date

Name & Title

Partnering Agency/Organization

Signature Date

Name & Title

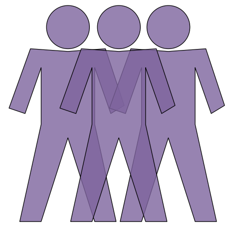
Partnering Agency/Organization

Travis County Family Drug Treatment Court

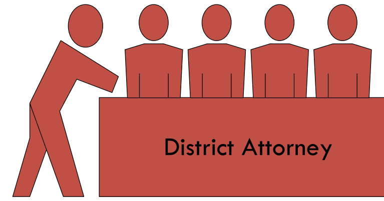
Travis County Family Drug Treatment Court (FDTC) brings together a coalition of community service providers who cooperatively provide a comprehensive continuum of services to women, children, and families of Travis County who have been identified by Texas Department of Family & Protective Services, Child Protective Services (CPS) as exhibiting symptoms of substance use disorders that impact the care and well-being of their young children.

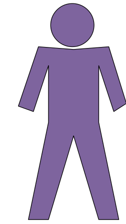
CPS facilitates FDTC participant voluntary enrollment during the investigation stage of the case; while filing a lawsuit for court ordered services. Once enrolled, participants immediately begin engaging in programs, services, and activities that challenge, encourage, and help them recover from substance dependence, maintain or regain custody of their children, and improve quality of life for themselves, their children, and their families. The FDTC participants will move through Four Phases of the drug court, designed to last approximately 12-18 months. Advancement through the phases is based on phase advancement criteria and written requests to move to the next phase. A parent must have successfully completed all four phases prior to commencement.

Services include FDTC participation and support, residential and outpatient substance abuse treatment, collaborative case management, mental health services, parenting skills training, peer recovery coaching, safe housing, individual and family counseling, child-care assistance, medical and dental services, and educational and employment support. Their children receive comprehensive services to meet their social-emotional and developmental needs.



Family Team Meeting





CPS INVESTIGATION

- Assigned to case worker
- Meet with family
- Staff with CPS lead
- Staff with District Attorney
- Initiate petition

INTRODUCTION TO DRUG COURT

- FTM in 1-5 days
- Family decides yes or no to Drug Court
- Participant signs waivers
- Treatment can begin anytime at this point

FILE PETITION

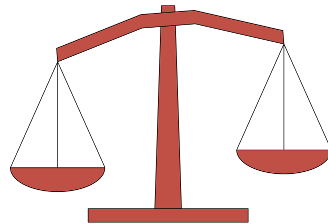
- Family-based safety services
- Court-ordered services

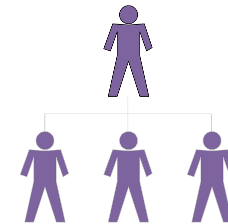
EX PARTE HEARING

- Drug Court parent attorney

AUSTIN RECOVERY

- Women and child(ren) in treatment for 90 days
- Drug Court to begin within first 14 days of treatment
- Parent signs Drug Court document





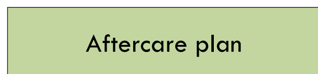
CPS case transfers to:

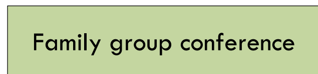
- Family-based safety services
- Court-ordered services
- Kinship placement or with parent in treatment

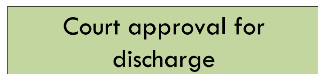
FAMILY GROUP CONFERENCES

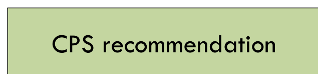
- Collaborative case planning
- Location: Austin Recovery
- First FGC within 45 days
- Future FCG dates determined by CPS caseworker

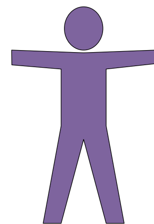
- FC assists participant in securing subsidized housing
- 4-6 weeks outpatient treatment
- 8 weeks aftercare
- Recovery supports as needed











PROGRAM COMPLETION

- Average length of interventions: 12-18 months

Family Drug Treatment Court

Travis County Family Drug Treatment Court

PHASE ADVANCEMENT CHECKLIST

FROM TREATMENT PHASE (1) TO PHASE (2)

(lasts approximately 120 days)

EXPECTATIONS:

- **Follow all court orders and attend all drug court and CPS hearings**
- **Attend all appointments; not showing up for appointments and not calling ahead to make alternate plans can delay phase advancement**
- **Request phase advancement in writing**
- **Complete all pending consequences (for example: community service, essays) before you are eligible to advance**

RECOVERY
☐ Attend **weekly** drug court hearings (**every other week** if in inpatient treatment out of town or if the participant has been in inpatient treatment and Drug Court more than 30 days)
☐ Submit clean drug and alcohol tests as requested **and** as indicated by the drug court call-in system
☐ Submit a clean hair follicle test
☐ Successfully complete primary drug treatment program
☐ Establish a home group for NA/AA/CA meetings and attend meetings as Court ordered (usually this is 3 times a week).
☐ Obtain a sponsor and have weekly contact.
☐ Make a verbal or written report to the court about your plan to work the steps with your sponsor
☐ Submit a written relapse prevention plan and child safety plan (attached)

PLAN FOR TAKING CARE OF MYSELF
☐ Take the following steps to initiate job search: o o
☐ Take the following steps to initiate safe and stable housing: o o
☐ Take the following steps to initiate education/literacy: o o

HEALTHY FAMILY LIFE
☐ Attend and engage in appropriate visitation with your child(ren), as applicable
☐ Complete parenting classes at AR or newborn care class as appropriate
☐ Begin working with parent trainer if one has been assigned, and complete initial AAPI
☐ Participate in individual therapy, as applicable
☐ Actively engage in peer recovery coaching, as applicable
☐ Ensure child(ren) are up to date on well child visit and immunizations
☐ Ensure child has medical insurance or is actively working on obtaining insurance
☐ Ensure child has received dental and eye exam if age appropriate
☐ Complete initial assessment with child therapist

Travis County Family Drug Treatment Court

PHASE ADVANCEMENT CHECKLIST

FROM FAMILY FOCUS PHASE (2) TO PHASE (3)

(lasts approximately 90 days)

EXPECTATIONS:

- **Follow all court orders and attend all drug court and CPS hearings**
- **Attend all appointments; not showing up for appointments and not calling ahead to make alternate plans can delay phase advancement**
- **Request phase advancement in writing**
- **Complete all pending consequences (for example: community service, essays) before you are eligible to advance**

RECOVERY
☐ Attend drug court hearings **every other week**
☐ Submit clean drug and alcohol tests as requested **and** as indicated by the drug court call-in system
☐ Submit a clean hair follicle to advance
☐ Successfully engage in any recommended drug treatment and successfully complete intensive outpatient treatment (if recommended)
☐ Participate in at least 3 NA/AA/CA meetings per week and continue to attend meetings in a home group
☐ Maintain a sponsor and meet with sponsor at least weekly
☐ Review written relapse prevention plan and child safety plan (attached)
SELF SUFFICIENCY
☐ Take the following steps to continue job search: o o
☐ Take the following steps to obtain or maintain safe and stable housing: o o
☐ Take the following steps to continue education/literacy: o
☐ Submit a detailed budget to the team to include monthly expenses and income (attached)
☐ Submit a plan for health care for yourself and your children (attached)
☐ Submit a plan for ongoing transportation (attached)
HEALTHY FAMILY LIFE
☐ Attend and engage in appropriate visitation with your child(ren), as applicable.
☐ Participate in individual therapy, as applicable
☐ Actively engage in parenting classes and/or parenting training, as applicable
☐ Actively engage in peer recovery coaching, as applicable
☐ Submit a completed Healthy Relationships plan (attached)
☐ Participate in a consultation with Planned Parenthood or a primary care physician regarding family planning
☐ Child(ren) will complete all evaluations recommended in their treatment plan
☐ Children will attend scheduled services as applicable
☐ Submit a written schedule of child(ren)'s daily activities including regular food choices (attached)

Travis County Family Drug Treatment Court

PHASE ADVANCEMENT CHECKLIST

FROM BECOMING INDEPENDENT PHASE (3) TO PHASE (4)

(lasts approximately 90 days)

EXPECTATIONS:

- **Follow all court orders and attend all drug court and CPS hearings**
- **Attend all appointments; not showing up for appointments and not calling ahead to make alternate plans can delay phase advancement**
- **Request phase advancement in writing**
- **Complete all pending consequences (for example: community service, essays) before you are eligible to advance**

RECOVERY
☐ Attend drug court hearings **every 3 weeks**
☐ Submit clean drug and alcohol tests as requested **and** as indicated by the drug court call-in system
☐ Submit a clean hair follicle to advance
☐ Successfully engage in any recommended drug treatment
☐ Attend at least three AA/NA/CA meetings per week, including meetings with a home group.
☐ Maintain a sponsor and continue to meet with sponsor regularly
☐ Attend and participate in Family Drug Treatment Court alumni meetings, as applicable
SELF SUFFICIENCY
☐ Obtain stable employment or income source and submit pay check stub unless otherwise approved by the Drug Court team
☐ Submit updated budget, showing current income and long term goals (attached)
☐ Take the following steps to continue job search: o
☐ Take the following steps to obtain or maintain safe and stable housing: o
☐ Take the following steps to continue education/literacy: o
☐ Follow through with transportation plan that you developed and submit long-term transportation plan (attached)
☐ Successfully complete financial education classes with Foundation Communities or another team approved alternative course – you may contact Erika Leos with Foundation Communities by calling her at 512-610-4026 or go to the website to schedule an appointment (http://www.foundcom.org/get-financially-stable/financial-coaching/)
HEALTHY FAMILY LIFE
☐ Attend and engage in appropriate visitation with your child(ren), as applicable
☐ Complete parenting classes and/or parenting training sessions, as applicable; show improvement on the AAPI or maintain scores above the 50% mark
☐ Participate in individual therapy, as applicable
☐ Actively engage in peer recovery coaching, as applicable
☐ Follow previous health care plan and submit long-term health care plan for yourself and your children (attached)
☐ Submit a plan for long-term child care (attached)
☐ Children will attend scheduled services as applicable
☐ Complete follow-up assessment with child therapist
☐ Participate in discharge planning meeting

Travis County Family Drug Treatment Court

PHASE ADVANCEMENT CHECKLIST

FROM HAPPY, JOYOUS, AND FREE PHASE (4) TO COMMENCE FROM FDTC PROGRAM

(lasts approximately 60 days)

EXPECTATIONS:

- **Follow all court orders and attend all drug court and CPS hearings**
- **Attend all appointments; not showing up for appointments and not calling ahead to make alternate plans can delay phase advancement**
- **Request commencement in writing**
- **Complete all pending consequences (for example: community service, essays) before you are eligible to advance**

RECOVERY
☐ Attend **monthly** drug court hearings (Note: Must attend at *least* one hearing while in Phase IV prior to drug court commencement/ graduation.) ☐ Submit clean drug and alcohol tests as requested **and** as indicated by the drug court call-in system ☐ Submit a clean hair follicle to commence ☐ Document attendance to at least three AA/NA/CA meetings per week or as court ordered ☐ Maintain a sponsor and continue to meet with sponsor regularly ☐ Attend and participate in Family Drug Treatment Court alumni meetings
SELF SUFFICIENCY
☐ Maintain stable employment or income ☐ Maintain permanent, stable housing ☐ Submit projected monthly budget showing self-sufficiency (attached) ☐ Actively participate in planning your commencement celebration
HEALTHY FAMILY LIFE
☐ Make a verbal or written report to the court addressing your long-term support network (attached) ☐ Follow previous health care plan and submit long-term health care plan for yourself and your children after drug court commencement(attached) ☐ Follow plan for long-term child care and submit plan for continuing child care after drug court commencement (attached) ☐ Follow through with transportation plan that you developed and submit long-term transportation plan following drug court commencement (attached)

Travis County Family Drug Treatment Court

PHASE ADVANCEMENT CHECKLIST FOR ____________________________

FROM RELAPSE PHASE TO FORMER PHASE IN FDTC PROGRAM

EXPECTATIONS:

- **Follow all court orders and attend all drug court and CPS hearings**
- **Attend all appointments; not showing up for appointments and not calling ahead to make alternate plans can delay phase advancement**
- **Request phase advancement in writing**
- **Complete all pending consequences (for example: community service, essays) before you are eligible to advance**

RECOVERY
☐ Attend **weekly** drug court hearings (**every other week** if in inpatient treatment or if the FDTC team specifies) ☐ Submit clean drug and alcohol tests as requested **and** as indicated by the drug court call-in system (**Reminder**: when in Relapse Phase you have to call **EVERYDAY** like Phases I or II) ☐ Submit a clean hair follicle test (for 0-30 days) to return to prior Phase from Relapse Phase ☐ Participate in a screening with OSAR for further treatment if you have been out of a treatment program for an extended time **or** follow the recommendations of your last treatment provider if currently in treatment or you have recently completed treatment ☐ Successfully complete recommended drug treatment program ☐ Attend 60 NA/AA/CA meetings within 60 days and re-establish a home group ☐ Obtain a sponsor, have weekly contact with sponsor, and demonstrate progress on working the 12 steps. ☐ Submit a relapse prevention plan with phase advancement request.
SELF SUFFICIENCY
☐ Take the following steps to continue job search or maintain employment/ income: ○ ○ ☐ Take the following steps to continue in safe and stable housing or find such housing: ○ ○ ☐ Take the following steps to continue education/literacy: ○ ○
HEALTHY FAMILY LIFE
☐ Attend and engage in appropriate visitation with your child(ren), as applicable ☐ Actively engage in parenting classes and/or parenting training, as applicable ☐ Actively engage in peer recovery coaching, as applicable ☐ Participate in individual therapy, as applicable

Family Drug Treatment Court (FDTC) Statistics as of 10-18-13

Number Served by FDTC Since Implementation (2/18/08)	
Parents	154
Children	230
Families	131

	All FDTC Participants		All Discharged Drug Court Participants	
All	154	100%	124	100%
Currently Enrolled	30	19%	N/A	N/A
Discharged *Successful*	55	36%	55	44%
Discharged *Unsuccessful*	57	37%	57	46%
Discharged Neutral	12	8%	12	10%

FDTC Participant Demographics

FDTC Participant Demographics – as of 10/18/13 (n=154 parents)					
Race	Hispanic: 39%	Caucasian: 34%	African American: 17%	Other: 9%	Native American: 1%
Average Age	28	Range: 18-44			
Gender	Women: 86%	Men: 14%			
Average IQ	92	Range: 57-119			
High School Diploma or GED	56%				
Mental Health Diagnosis: Not Substance Use Related	99%- only 2 participants with no other DSM diagnosis (excluding substance use disorders)				
Criminal History	None: 12%	Drugs: 58%	Violence: 36%	Other: 68%	
Trauma History: Victim of Abuse	74%				
Drug of Choice (all have 1, 2, or Poly)	Cocaine: 31%	Poly: 29%	Meth: 20%	THC: 20%	
	Opiates: 10%	Alcohol: 7%	Benzos: 4%	PCP: 2%	
Prior CPS Involvement	As Adult: 66%		As Child: 24%		
Prior Termination of Parental Rights	18%				

All FDTC Participants Discharged by Office of the Governor's Fiscal Year (Sept 1st – Aug. 31st)

Discharged Participants: Completed	Program Completion Year 1 FY 2008		Program Completion Year 2 FY 2009		Program Completion Year 3 FY 2010		Program Completion Year 4 FY 2011		Program Completion Year 5 FY 2012		Program Completion Year 6 FY 2013	
All: Program Completion	2	100%	14	100%	31	100%	19	100%	28	100%	26	100%
Discharged *Successful*	0	0%	2	14%	10	32%	9	47%	14	50%	17	65%
Discharged *Unsuccessful*	2	100%	10	72%	16	52%	8	42%	12	43%	8	31%
Discharged Neutral	0	0%	2	14%	5	16%	2	11%	2	7%	1	4%

Permanency Outcomes for FDTC and Control Children[i]

Permanency Outcomes for all Children 2/18/08 – 10/18/13				
	FDTC		Control (w/ lawsuit filed)	
All Children with Final Orders	175	100%	161	100%
Permanency with FDTC parent	89	51%	66	41%
Permanency with relatives or other parent (not FDTC or control participant) without termination of parental rights	39	22%	31	19%
Adoption by relatives with termination of parental rights	29	17%	46	29%
Unrelated/ Non-kin adoption with termination of parental rights	18	10%	18	11%

Children Born to Drug Court Participants

	All FDTC Successful Graduates (n = 47 women)	All FDTC (n = 131 women)
Number of Drug Positive Births During FDTC	0	0
Number of Drug Negative Births During Open Lawsuit	4	10
Number of Drug Positive Births After Lawsuit Closed	0	9 (1 participant had two babies)
Number of Drug Negative Births After Lawsuit Closed	4+ (2 expecting)	7+ (2 expecting)

Recidivism Rates

Recidivism – New Lawsuits Filed in Travis County						
	FDTC Graduates	Percentage	FDTC	Percentage	Control	Percentage
All Families (Parents and Children) with Final Orders	48	100%	99	100%	86	100%
No New Child Welfare Lawsuits in Travis County	43	90%	80	81%	71	83%
New Child Welfare Lawsuit within 1 year	3	6%	8	8%	10	12%
New Child Welfare Lawsuit within 2 years	4	8%	15	15%	12	14%
New Child Welfare Lawsuit within 2+ years	5	10%	19	19%	15	17%
Drug Positive Birth with New Lawsuit	0	0%	9	9%	9	10%

[i] (children of parents who have been discharged either successfully or unsuccessfully from the FDTC program or children of parents who participated in the control group and a final order has been entered)

Family Drug Treatment Court (FDTC) Children and Family Services
Fiscal Years 2011-2014

The FDTC Children's Continuum provides comprehensive assessment, treatment, and referral services to families enrolled in FDTC. The primary focus is the children—assessing and meeting their developmental and social-emotional needs. This part of the FDTC is funded by two grants, one from the Office of Juvenile Justice and Delinquency Prevention and the other from the Administration for Children & Families: Children's Bureau. These grants provide funding for two licensed child and family therapists who provide assessment, individual and family therapy, and referrals to community services, a court appointed special advocate and an attorney ad litem who represent the children's interests in court, and a social services assistant who helps with case management activities.

Children's Services

- Assessment and Screenings: Ages and Stages Questionaire, Child and Adolescent Needs and Strengths, Adult-Adolescent Parenting Inventory, and others as needed
- Psychotherapeutic Services: Child-Parent Psychotherapy, Play Therapy, Trauma-Informed CBT, Family Therapy, EMDR Therapy, and Equine Therapy
- Group Therapy: Pro-Social Skills Group, Safezone Group, and Therapeutic Summer Camp
- Developmental Therapy: Speech, Occupational and Physical Therapy
- Non-Traditional Support Services: Family and Individual Mentoring, Tutoring, Behavioral Aide, Infant Massage and supervised family visitation
- Parent Training: Nurturing Parenting Program curriculum
- Case Management services: Transportation and concrete services

Children's Outputs

Age Group	Number of children in FTDC FY 2008-2014	Number of children receving grant funded services FY 2012-2014
Newborn	71	19
3 mos.-4 yrs	101	44
5-12 yrs.	42	27
13-17 yrs.	9	2
Total number	223	92

Assessment Outcomes

Assessments have been administered to both parents and children since FY 2012. They are administered at the beginning of the case in order to identify the domains that require intervention and again at the end of the case in order to determine the impact of services delivered, as indicated by percentage improvement in scores.

- Ages and Stages Questionaire (ASQ: Developmental screening administered to children age 0-5).
  - All children who completed the ASQ pre and post showed either improvement or demonstrated no regression in their development.
- Adult and Adolescent Parent Inventory (AAPI: Parenting and child rearing attitudes administered to parents).
  - Changes in raw scores:
    - Parent completed Pretest and Posttest #1 (41) = 19.46% increase (pre- to post-1)
    - Parent completed Pretest, Posttest #1, and Posttest #2 (19) = 35.56% increase (pre- to post-2)
    - Parent completed Pretest and Posttest #1 and failed to increase score (7) = -.06% decrease

CONSIDERATIONS FOR REPRESENTING PARENTS IN FAMILY DRUG COURTS

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National Association of Counsel for Children
36TH NATIONAL CHILD WELFARE, JUVENILE, AND FAMILY LAW CONFERENCE
August 28, 2013

Introduction to Family Treatment Drug Courts

Family Treatment Drug Courts (FTDCs), which are also known as Dependency Drug Courts, have become increasingly popular nation-wide. The primary focus of FTDCs are to enhance functional status and reunification success among families involved in child welfare legal systems and affected by substance use disorders.

Recently, in May 2013, Children and Family Futures, through the Office of Juvenile Justice and Delinquency Prevention (OJJDP), Office of Justice Programs, released *"Guidance to States: Recommendation for Developing Family Drug Court Guidelines."* This document seems to function much like the traditional *"Defining Drug Courts: The Key Components"* created by the U.S. Department of Justice, Office of Justice Programs in collaboration with National Association of Drug Court Professionals.

Both documents give reference to the main focus of drug courts and provide a structure in which drug courts should function. The original 10 Key Components are as follows:

1. Drug courts integrate alcohol and other drug treatment services with justice system case processing.
2. Using a nonadversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights
3. Eligible participants are identified early and promptly placed in the drug court program.
4. Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.
5. Abstinence is monitored by frequent alcohol and other drug testing.
6. A coordinated strategy governs drug court responses to participants' compliance.
7. Ongoing judicial interaction with each drug court participant is essential.
8. Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.
9. Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.
10. Forging partnerships among drug courts, public agencies and community-based organizations generates local support and enhances drug court program effectiveness.

As evidenced by these Key Components, drug courts function as more of a collaborative process which requires multidisciplinary education by the collaborators. Drug courts and especially FDTCs differ extraordinarily from the traditional adversarial litigation process most are used to. Thus, working in drug courts require the professionals to come to the table with an open mind and "buy-in" of the process in order for it to be successful.

Overview of the Travis County, Texas Family Drug Treatment Court (TCFDTC)

The TCFDTC is geared towards maintaining children in the care of their parents while they attempt a life in recovery from addiction and develop the skills and ability to safely parent their children. The focus is on support and accountability for the parents while attempting to stop the cycle of abuse, neglect, and addiction for the next generation. The TCFDTC accepted its first participants in February of 2008.

For the TCFDTC, participants are identified by the Texas Department of Family and Protective Services (DFPS) during the investigation of referrals for abuse and neglect when substance abuse is involved. DFPS, as a collaborative partner to the TCFDTC, has committed an investigative unit that has all substance abuse involved referrals funneled to them so that prospective participants can be identified.

The DFPS investigators offer the TCFDTC program to eligible parents at their Family Team Meeting which takes place prior to an Original Petition for Termination of Parental Rights

being filed by the State. Eligible parents interested in the program observe the TCFDTC twice and are advised by defense attorneys about the program prior to joining. Upon joining, parents sign a contract for voluntary participation in the program. This contract is less used as an enforceable agreement but more memorializes the parents understanding and "buy-in" for the program.

One of the benefits for parents to join the TCFDTC is that this program has several sources of funding that provides the participants with more services and more opportunities than they would in a traditional child welfare legal case. The additional services are funded through grants, primarily the Parenting In Recovery (PIR) grant. It was initially granted for 5 years and was recently renewed for an additional 2 years. The grant awards $500,000 per year and provides for a full-time attorney ad litem for the children of the participants in the TCFDTC, a full-time child therapist, a part-time housing case manager, and part-time research assistant to assist with evaluations. Additionally, the grant provides funding for services such as housing and utility costs, medical and dental care, parenting support, and training for the professionals of the TCFDTC.

The second major grant funding the TCFDTC is The Children's Continuum grant which provides for services involving the children of the participants in the TCFDTC, including a social services assistant to help with transportation involving the children and specialized services such as various forms of therapy. Other funding resources include The Office of the Governor Drug Court Grant which funds drug testing and supplies such as bus passes for the participants, and County funds are also utilized as needed.

The TCFDTC holds staffings of participant cases with the professionals each Thursday morning at 8:30 a.m. Professionals on the team include the Judge, the prosecutor, the defense attorney, the attorney ad litem, the guardian ad litem, the child welfare agency's social worker and supervisor, and various service providers. Participants are ordered to appear at the court for a Cross-Talk meeting at 9:00 a.m. while the professionals continue to staff cases. At 10:00 a.m. hearings begin. The TCFDTC hearings are separate and apart from the traditional child welfare hearings.

Since inception, the TCFDTC has served 108 mothers with 207 children. 44 of those mothers discharged successfully, 34 discharged unsuccessfully, and 16 discharged neutrally. The TCFDTC maintains between 25-35 participants, at a time, on its docket.

Obstacles for the TCFDTC

As a FDTC that has been operating for several years, many obstacles have presented themselves and the TCFDTC continues to struggle with finding ways to improve. One of the more apparent obstacles is that services for mothers and fathers are not always equal, particularly because of grant structure, but more so when a father is not involved in the FDTC. The TCFDTC PIR grant focuses on mothers and thus, funding for additional services for fathers typically must come from state or county funds which are not as readily available. The TCFDTC continues to seek additional funding and community partners to level the quality and availability of services for fathers to that of mothers. However, due to the collaborative nature and consistent staffing of TCFDTC cases, fathers involved in a child welfare case but not a part of the TCFDTC, when the mother is a participant, seem to have the most unequal opportunities in their child welfare cases. The TCFDTC team attempts to alleviate this problem by diligently updating the non-participant father of any relevant matters and refraining from addressing issues requiring input from the non-participant father during staffings or hearings with the participant in the TCFDTC.

Other obstacles the TCFDTC experiences includes finding the best services and community partners for common issues the participants face such as mental health and dual-diagnosis programs. Legal obstacles for the TCFDTC include problems with deadlines in conservatorship cases, confidentiality in TCFDTC hearings, and contempt of court/jail time as a sanction for participants. Each FDTC

seems to handle these situations differently and many times the way the obstacles are handled depends on state laws. For the TCFDTC, the policy has become to accept only those eligible cases in which court intervention can be limited to Court Ordered Services cases not requiring temporary conservatorship, thus eliminating the obstacle of deadlines which limit the time a parent has to work through the program. Unfortunately, the TCFDTC is not in a jurisdiction with statutes or standing orders that protect the confidentiality of the TCFDTC hearings and thus, all information shared or revealed during those hearings becomes relevant and are used in the traditional child welfare case. Issues with using jail time as a sanction continue to require the diligence of the attorneys to assure due process for the participants, despite many other team members in different disciplines who advocate for more liberal use of the sanction.

Attorney Roles in FDTCs

The Judge

The Judge is a significant part of a FDTC program. The Judge sets the tone of the program and interaction between the Judge and participant is of utmost importance. The TCFDTC has had 3 different primary judges and with each judge came a different feel to the program.

A Judge presiding over a FDTC must be informed about recovery, the services provided to participants, and the community issues affecting the participants. With a highly informed judge comes highly successful participants.

Concerns surrounding the Judge's role in FDTCs are usually regarding ex parte communication and sua sponte actions that may possibly be taken due to the Judge's intimate involvement with the participant's case. Some FDTCs have Judge's involved in the staffings and others do not.

The Attorney Ad Litem

Most FDTCs have limited involvement of the children but many have attorney ad litems and/or guardian ad litems that participate in the staffings and are a part of the team so that the child/ren's interests are not overlooked. However, conflict may arise in determining the level of participation a child/ren should have in a drug court system. Additionally, as an attorney ad litem there may also be consideration for how much direction from their client is beneficial and what level of information should be provided to a child client regarding their parent's recovery and sobriety. These issues may only become difficult with older child clients but are still matters to be considered in this role.

Obviously, there are some great reasons for attorney ad litems to be a part of the team, particularly for the collaborative nature of FDTCs. Also, it is important so that attorney ad litems can be as informed as other parties about a parent's progress and hard work or lack thereof. This information assists an attorney ad litem in making recommendations to the court in the child welfare case, if statutes and local rules allow. Some FDTCs have actually incorporated the child welfare hearings and FDTC hearings onto the same docket thus, in those situations, an attorney ad litem's participation would be a necessity.

The Prosecutor

It is also quite important to have the prosecutor as part of the team. For the participant, knowing that the prosecutor is part of the team that is working collaboratively to preserve or reunify their family contributes tremendously to the participant's "buy-in" and confidence in the program.

For the team, the prosecutor plays a major role in allowing for a complete legal dialogue, when necessary, so that all options for each participant's case is explored as challenges arise. While a state child welfare agency social worker is an obvious necessary part of the team, the prosecutor is the other piece of that role that is just as important. In jurisdictions where the prosecutor represents the state child welfare agency's interest, the prosecutor may provide a more formal position of the state child welfare agency during FDTC proceedings. However, in these situations some conflict may arise when the prosecutor and their client have differing

opinions and it must be clear whether the two must resolve their differences and tender one vote or if they each receive a separate vote on the team when making decisions. Depending on the team, the situation may differ.

The Defense Attorney

One of the most important attorney roles on a FDTC team is the role of the defense attorney. However, many drug courts reduce the level of involvement of the defense attorney, particularly during the drug court hearings, since the interaction between the participant and the Judge is an essential part of the drug court format.

Regardless, the defense attorney plays a major role on the team during staffings. Participants do not attend staffings and, therefore, the defense attorney is the voice of the participant on the team. There then becomes a difficult balancing act of understanding the client's needs and position and advocating for them as well as maintaining a collaborative approach with the other members of the team. Several ethical considerations come into play for the defense attorney.

The first challenge a defense attorney faces is establishing an attorney-client relationship with the participant. Many times a client and defense attorney may have their first communication while the client is under the influence or in a drug treatment facility. Establishing a relationship under those circumstances becomes difficult. With a client who is under the influence, a defense attorney has to assure the client understands and is aware of the decisions and communications they are making at the onset of the program. When a client is in a drug treatment facility, the level of access a defense attorney may have to their client could possibly be limited and having confidential communications may be challenging.

Beyond the logistical complications of initiating the attorney-client relationship, the more difficult task is of building trust with the client. Most people dealing with addiction have come to maintain a very low level of trust for everyone and they then have an even lower level of trust with those who represent, to them, any form of authority figure. When the defense attorney then explains the FDTC program and the defense attorney's role on the team, a client may find it difficult to allow themselves to trust the defense attorney and it may take some time for the client to be able to distinguish the difference between the defense attorney's role as their advocate and the defense attorney's role as a team member. Therefore, the defense attorney, themselves, must understand their role well enough to explain and continue to explain the difference to the client.

Competence

ABA Model Rule 1.1 reads:

> A lawyer shall provide competent representation to a client. Competent representation requires the legal knowledge, skill, thoroughness and preparation reasonably necessary for the representation.

As an attorney for a participant in a drug court, attaining the level of competence to properly represent the client could require additional research, training, and education. There are various areas in which a defense attorney must be educated including:

- Education on the disease of addiction
- Education about how certain drugs affect the mind and body
- Education about recovery programs
- Education about drug testing procedures and policies
- Education about related issues affecting people with addiction
- Education about working with adults suffering from trauma

While most defense attorneys are either with a government agency or are court appointed, it can be difficult to find both the time and resources to educate themselves on all the necessary topics. This education is of utmost importance in representing the client and it is key to a successful drug court. In reality, not just the defense attorney, but all professionals, should have as much education as possible on these

topics. Grants and scholarships are usually available to assist with costs for education.

Aside from the formal education and training, there is also a necessity for the defense attorney to have knowledge of the community resources and services available to the client. ABA Model Rule 2.1 provides:

> In representing a client, a lawyer shall exercise independent professional judgment and render candid advice. In rendering advice, a lawyer may refer not only to law but to other considerations such as moral, economic, social and political factors, that may be relevant to the client's situation.

Client's recovering from addiction, and who are usually indigent, deal with unique life situations that demands an expanded knowledge of the defense attorney to properly advise the client, considering the client's situation.

In working with the population of people generally involved in FDTCs several issues become reoccurring such as issues with mental health, housing, and domestic violence. Community resources then become a vital part of the success a client may be able to achieve and a defense attorney must be prepared to advise the client of such.

The decision to become a defense attorney in a FDTC should take into consideration the amount of education and training that may be needed. Many times a defense attorney goes into this practice with some knowledge base but the available education, training, and community resources continually changes and the defense attorney must also stay updated with these changes.

Confidentiality

The aspect of confidentiality is one of the most important ethical responsibilities of defense attorney working with a FDTC. While all lawyers understand the importance of keeping communications and information received from clients confidential, when working with a FDTC, the expectations of the team can become problematic in relation to this responsibility.

FDTCs work as a collaborative effort and the professionals are considered a "team." It takes multidisciplinary training for the professionals to understand he unique duties a defense attorney has. They do not always understand that confidentiality of the client cannot be compromised, even for the team.

ABA Model Rule 1.6 relates to confidentiality and reads as follows:

> (a) A lawyer shall not reveal information relating to the representation of a client unless the client gives informed consent, the disclosure is impliedly authorized in order to carry out the representation or the disclosure is permitted by paragraph (b).
>
> (b) A lawyer may reveal information relating to the representation of a client to the extent the lawyer reasonably believes necessary:
>
> (1) to prevent reasonably certain death or substantial bodily harm;
>
> (2) to prevent the client from committing a crime or fraud that is reasonably certain to result in substantial injury to the financial interests or property of another and in furtherance of which the client has used or is using the lawyer's services;
>
> (3) to prevent, mitigate or rectify substantial injury to the financial interests or property of another that is reasonably certain to result or has resulted from the client's commission of a crime or fraud in furtherance of which the client has used the lawyer's services;
>
> (4) to secure legal advice about the lawyer's compliance with these Rules;
>
> (5) to establish a claim or defense on behalf of the lawyer in a controversy between the lawyer and the client, to

establish a defense to a criminal charge or civil claim against the lawyer based upon conduct in which the client was involved, or to respond to allegations in any proceeding concerning the lawyer's representation of the client;

(6) to comply with other law or a court order; or

(7) to detect and resolve conflicts of interest arising from the lawyer's change of employment or from changes in the composition or ownership of a firm, but only if the revealed information would not compromise the attorney-client privilege or otherwise prejudice the client.

(c) A lawyer shall make reasonable efforts to prevent the inadvertent or unauthorized disclosure of, or unauthorized access to, information relating to the representation of a client.

Throughout representation of a client in FDTC, certain situations may arise in which the defense attorney has to closely analyze the rules regarding confidentiality to decide how to proceed. For instance, a client may have relapsed on drugs and/or alcohol during the program and revealed this information to the defense attorney. From the team's perspective, they would want the defense attorney to reveal this information at staffing so that decisions regarding further treatment, services, and consequences can be discussed and determined. However, unless the client specifically authorizes the defense attorney to reveal this information, generally, the defense attorney cannot share the relapse with the team. Team members may be upset at the withholding of information by the defense attorney and this may affect the collaborative feel to the FDTC but it is the attorney's duty to keep such information confidential, in accordance with the rules.

Given the severity of the information that could be revealed in each such situation, a defense attorney should take common practice to further assess the situation to determine if there is an exception to the rule of confidentiality which would then allow or require the attorney to share such information. If, for example, the client shared that the relapse occurred while their child was in the home or in a manner that put the client or the child in harm, the defense attorney may not be required to keep such information confidentiality.

If the defense attorney finds that revealing the information will prevent reasonable substantial bodily harm, they may be excepted from the rule of confidentiality. The defense attorney has to determine what "substantial bodily harm" is though. Regarding the danger to the child, certain other state mandatory reporting statutes may come into effect as well and then the defense attorney has to determine whether the information from the client would result in and require the mandatory reporting of child abuse and/or neglect. Additionally, if the confidentiality of the client must be broken, the client should be informed of this and made aware of the reasons why, in order to still try and preserve the trust in the attorney-client relationship.

If such a situation does arise when a client discloses facts, such as a relapse, to the defense attorney and no other exceptions for disclosure of this information by the defense attorney seem to apply, the defense attorney must still be aware of another rule that may apply if the client, themselves, do not maintain candor with the court. ABA Model Rule 3.3(a)(3) reads as follows:

(a) A lawyer shall not knowingly:

(3) offer evidence that the lawyer knows to be false. If a lawyer, the lawyer's client, or a witness called by the lawyer, has offered material evidence and the lawyer comes to know of its falsity, the lawyer shall take reasonable remedial measures, including, if necessary, disclosure to the tribunal. A lawyer may refuse to offer evidence, other than the testimony of a defendant in a criminal matter, that the lawyer reasonably believes is false.

A client must be made aware that if they attempt to make false statements to the court that the defense attorney knows to be false that the defense attorney may have to disclose this information to the court. In a FDTC it is not uncommon for a participant to be asked by the court whether or not they have used drugs and alcohol and whether or not they have relapsed. In some instances, especially if a participant is still active in their addiction, attempts to falsify a drug test may occur, and if the defense attorney is aware of this, ABA Model Rule 3.3 may apply.

The defense attorney must be equipped to advise the client if such a disclosure is made and another important aspect of having a knowledgeable defense attorney is so that the defense attorney can advise the client regarding most situations in a way that conforms to the philosophies and practices of their recovery program.

In the Alcoholics Anonymous, Twelve Step program, step Ten reads:

> Continued to take personal inventory and when we were wrong promptly admitted it.

The meaning of Step Ten is that the addict must check up on themselves daily and be honest. It is important to the client's recovery to be honest and admit when they attempt not to be. A defense attorney well versed in the Twelve Steps or any other program their clients engage in will have better capability to advise their client in a helpful and healthy manner, which ultimately benefits the drug court and child welfare case.

Collaboration in Litigation

Ultimately, in most FDTCs there is risk of a participant losing parental rights to the child/ren due to their addiction. The State is usually involved on some level or is aware and prepared to take proper action if the participant is proving not to be successful in the FDTC program. Thus, it becomes the responsibility of the defense attorney to prepare and work a client's case both in a collaborative manner and as a regular child welfare case in litigation. A defense attorney's counsel to the client must also take these two approaches into consideration. This can prove to contradictory in nature at times and the defense attorney must know their FDTC program and child welfare litigation docket both well enough to pursue and accomplish this dual preparation.

In traditional child welfare litigation cases, while a client may be open and honest enough to successfully complete services, it is not always advised by their defense attorney to maintain complete and open candor with the parties regarding all aspects of their case. That is just the nature of litigation. However, in the collaborative FDTC process, complete and open candor is highly encouraged, even when the facts of the case are particularly damaging for the client. The uniqueness of the FDTC is that the goals of FDTC can allow some leniency in dealing with particularly damaging facts while still progressing to a path of preservation or reunification of the participants with their children. At some point, however, there is a line. It is the job of the defense attorney to recognize this line and accordingly advise and protect their client from going past that line. This is especially true in jurisdictions where there are no statutes or local rules to protect the confidentiality of the FDTC proceedings.

Scope of Representation

As mentioned previously, most participants in FDTCs are indigent and receive appointed counsel. The defense attorneys are usually appointed from a government office or through an appointment list comprised of private attorneys. Either way, depending on the court, the defense attorney's role may be limited in scope to just the FDTC case or may also include the child welfare case. Representation does not usually go beyond this for court appointed counsel.

Unfortunately, as is the case with most addicts, the issues affecting the participants are not usually limited to just the substance abuse and child welfare matters. Many participants will have outstanding warrants, pending criminal charges, judgments from outstanding debt, impending evictions, surcharges on their driver's license, and many other legal matters needing

resolution. Often a participant's progress and recovery may be jeopardized due to the strain, both mentally and financially, on the participant because of these other matters.

At this point, it becomes essential for the defense attorney to draw on their knowledge of community resources, particularly from the legal community, to advise their client of resources that may be made available to them to resolve the other legal matters outside the defense attorney's scope of representation. Forging partnerships with other legal groups or organizations provides the benefit for ease of access to legal services from community providers.

Work-Life Balance

Just as all attorneys struggle to find a work-life balance, this balance can be particularly difficult to find and maintain for the defense attorney who is intricately involved in their client's case and genuinely cares about their client's well-being and progress. The nature of addiction is that in which many defense attorneys will, at some point, represent clients in FDTCs who do not stop abusing drugs and/or alcohol and who may eventually be incarcerated long term, lose their parental rights, or even suffer fatality.

It is never healthy to be weighed down with such tragic realities but it is sometimes the experience of the defense attorney. Therefore, it is absolutely essential that the defense attorney utilizes any resources available to alleviate these stresses so that they are better able to function and maintain their duty to their clients. Recommended resources included Al-Anon Family Groups, for which meetings are held nation-wide, as well as each state's individual Lawyer Assistance Program.

Conclusion

All attorneys who have undertaken the challenging work of child welfare cases and working with people suffering from addiction are indispensible in the lives of the children affected. The cases are tremendously challenging but the rewards are well worth the effort. For additional professional support in working with drug courts, attorneys should take special note of the resources attached.

RESOURCES

"Guidance to States: Recommendation for Developing Family Drug Court Guidelines", Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs. http://www.cffutures.org/files/publications/FDC-Guidelines.pdf

"Defining Drug Courts: The Key Components", U.S. Department of Justice, Office of Justice Programs, https://www.ncjrs.gov/pdffiles1/bja/205621.pdf

Official Travis County Family Drug Treatment Court website: http://www.co.travis.tx.us/health_human_services/children_services/welfare/family_drug_court.asp

"Model Rules of Professional Conduct", American Bar Association, http://www.americanbar.org/groups/professional_responsibility/publications/model_rules_of_professional_conduct/model_rules_of_professional_conduct_table_of_contents.html

"The Twelve Steps Illustrated", Alcoholics Anonymous General Service Conference, http://www.aa.org/pdf/products/p-55_twelvestepsillustrated.pdf

Al-Anon Family Groups, http://al-anon.alateen.org/home

National Association of Drug Court Professionals, http://www.nadcp.org/nadcp-home/

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, National Center on Substance Abuse and Child Welfare, http://www.ncsacw.samhsa.gov/resources/resources-drug-courts.aspx

Parenting in Recovery Program: Participant Responses and Case Examples

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Approximately 80% of children served by child welfare agencies have parents who abuse or are dependent on alcohol or illicit drugs. Despite the devastating effects on children from living in substance abusing families, child protective service practitioners have limited options available to assist these families. The Parenting in Recovery program was created to address the needs of substance-abusing mothers involved in child welfare. This manuscript describes this program and perceptions of participants concerning its effectiveness.

Many communities across the United States are struggling to meet the needs of children whose families are dealing with substance abuse. It is estimated that 11% of U.S. children (8.3 million) reside with a substance-abusing parent (Child Welfare Information Gateway [CWIG], 2003). Children of alcohol and drug abusers are often subjected to extreme household disorganization, neglectful/abusive parenting, and economic hardship (Grant, 2000). Parents impaired by addiction are less likely to appropriately nurture, supervise, and care for their children (O'Connor, 2005) and substance abuse is a contributory factor for 30%–66% of children involved with child protective services (CSIG, 2003). Child welfare cases with parents who abuse substances generally include younger children who are more likely to be severely abused and neglected.

Parental substance abuse affects the child in many significant ways, including multiple incidents of child maltreatment, removal to foster care with a potential for multiple moves within the foster care system, delayed permanency, failed reunification, maladaptive behaviors, and potentially the loss of the parent due to termination of parental rights. Living with a substance abusing parent places children at risk for poorer developmental outcomes (physical, intellectual, social, and emotional) than other children (Berger, Slack, Waldfogel, & Bruch, 2010). Children exposed to drugs or alcohol in utero may experience fetal anomalies, delays in infants' gross and fine motor skill development, and neonatal withdrawal symptoms (Clark, 2001; Singer, Minnes, Short et al., 2004). The result is a greater likelihood of placement of these young children in out-of-home care and longer lengths of stay in foster care than other children in the child welfare system (Carlson, 2006).

The complexities of serving families with parental substance abuse and child maltreatment require interventions that are comprehensive, holistic, and coordinated across multiple agencies (Clark, 2001; Kinard, 2002). Comprehensive services that include education and employment; housing security; parenting classes; ongoing substance abuse treatment and recovery for mothers; and targeted services for children's educational, behavioral, and emotional needs appear most appropriate (McApline, Marshall, & Doran, 2001; Smith, 2003).

Services must be linguistically or culturally appropriate (McAlpine et al., 2001) and address the long-term needs associated with the multiple challenges faced by these families (Berger et al., 2010). Residential or intensive outpatient substance abuse treatment that allows mothers to retain parental interaction with their children while providing the child(ren) with additional supports has been shown an optimal choice (Einbinder, 2010).

One major challenge in assisting women with substance abuse and their children is the divergent priorities and perceptions of substance abuse treatment providers and child welfare workers. Child welfare workers rarely have the clinical background to diagnose or treat substance abuse; substance abuse providers may not understand the time pressures or legal mandates under which child welfare caseworkers operate (Semidei, Radel, & Nolan, 2001; McAlpine et al., 2001). Other potential conflicts include identification of the client (child versus adult) and defining outcomes and successes. For example, in the substance abuse treatment field, success is typically defined by reductions in drug use with the optimal outcome of abstinence. From the child welfare perspective, a parent could be abstinent but remain incapable of providing a safe and adequate environment for the child's development and well-being.

Women who are dependent on alcohol/drugs and who are involved with child welfare often lack effective collaborative treatment planning between child welfare and substance abuse treatment providers. Even among those who receive residential substance abuse treatment, upon discharge many have difficulty locating safe, affordable housing; those with few financial resources have limited options and often must return to environments that contributed to their instability and substance abuse. Women in this situation generally have limited employment skills, a history of domestic violence, trauma experiences, and strained family relationships (Kovalesky, 2001). They also may have a criminal history, which further complicates their ability to locate housing as landlords are reticent or refuse to rent to individuals with a criminal record. Additionally, affordable child care is difficult to locate (Semidei, et al., 2001). The combination of these

factors contributes to heightened stress at discharge from substance abuse treatment and increases the risk of relapse and losing parental rights if CPS determines the child is not assured of safety in their parent's home. Thus, it is clear that drug-affected families in the child welfare system are often more complex and challenging for case workers due to the wide range of problems and challenges.

In an attempt to address the issues of parental substance abuse and child welfare involvement, a collaborative intervention project, funded by the Administration for Children, Youth, and Families, was developed. The Parenting in Recovery (PIR) program aimed to address parental substance abuse and child well-being among families involved in the child welfare system. This project brought together a coalition of community service providers to deliver a flexible, comprehensive continuum of services to drug/alcohol dependent women with children under the age of five who were involved in the state child welfare system. The core objectives of the PIR program were to assist mothers of young children in recovering from substance dependence, maintaining/regaining custody of their children, and establishing safe and healthy homes for their children.

This study aimed to delineate preliminary qualitative findings of the program from the perspective of participants. Focus groups with mothers engaged in the program were conducted to understand their perceptions of the program, provide information about the various challenges they faced in their lives, discuss what services and supports assisted their recovery and parenting, and gain insight as how the program might need to be modified in the future. Individual case descriptions are also provided as exemplars of the challenges faced by participants of the program and the successful and unsuccessful outcomes of four PIR participants.

Methods

Participants and Procedures

The target population was women with child(ren) who had been identified as substance-dependent by a CPS investigator. As a

component of this program, CPS investigators were trained in conducting standardized assessments for substance dependency. Identification and entry into PIR required the mother's substance abuse to be a major contributing factor to her child's maltreatment and the child(ren) had to be newborn to 5 years of age. The mother was immediately eligible if she gave birth to a drug-positive infant. Caseworkers responded to referrals within 24–72 hours; the mother's eligibility for enrollment into PIR and placement of the child(ren) was determined at that time. PIR participant children either remained in the care of their mother or were placed in out-of-home care with a relative.

Once a family's eligibility requirements were confirmed, CPS caseworkers described the PIR program to the mother during a family team meeting. Consent procedures, as authorized by the affiliated university's Institutional Review Board for the protection of human subjects, were described and recruitment sought. A comprehensive collection of services was available to participants over the course of approximately 18 months of program participation, including:

1. Admission to comprehensive residential substance abuse treatment in a timely fashion (typically within 7 days of CPS involvement) and for up to 90 days in-patient care. A specialized unit at the treatment facility was designed for mothers to have up to two children under 5 years or age remain with them in treatment.
2. Participation in Family Drug Treatment Court was required. Mothers attended weekly sessions and interacted with case managers and a judge with substance use treatment experience. They also interacted with other PIR program participants and listened during court while the judge and other team members commented on each participant's successes and challenges.
3. Parenting classes and in-home visitation once mothers moved from residential substance abuse treatment.
4. Individual counseling and psychiatric services to address mental health issues.

5. Employment, workforce and educational support services were available and encouraged to increase employment skills or complete the General Equivalency Diploma (GED).
6. Health care was provided and mothers were assisted in registering for Community Health Center services.
7. Dental care was provided for mothers as they frequently had not had dental care for years and included needed extractions or full-mouth dentures.
8. Intensive outpatient substance abuse treatment and referral to 12-step programs was provided following discharge from residential substance abuse treatment services.
9. Rental assistance with a case manager was provided when the mother and her children transitioned from substance treatment into community housing.
10. Assistance with daycare costs and transportation needs were provided.

The children also received wraparound services based on an initial assessment to identify unmet needs and recommend service supports; they received ongoing medical and dental care, educational/developmental support, access to licensed child-care, therapeutic interventions associated with behavioral and emotional difficulties, and activities aimed at enrichment and general well-being. Supporting the mother in efforts to retain custody of her child(ren) was a fundamental effort of the program; when this was not possible, children were placed with appropriate family members/kin.

Data Collection Procedures

Three focus groups were held with mothers who were participating in the Parenting in Recovery Program. As effective focus groups cover a maximum range of relevant topics and foster interactions between group members, focus group participants ($n = 27$) were asked a set of questions by two facilitators (one was a PIR staff member, the other was not). Questions had been developed for other focus groups held nationally that sought perceptions of participants concerning program strengths and challenges; however, facilitators were encouraged

to allow participants to discuss topics and issues they felt were important to them. Core questions for the focus groups included: (1) Why did you decide to join PIR?; (2) What services or supports did you utilize and how much did they help or did not help you?; (3) What has been your biggest support/challenge while in the program?; and (4) What are your thoughts about the program?

Data from the focus groups were collected through taking notes and recording specific quotes of participants during the discussions. This qualitative information was transcribed and text was analyzed by two coders using an iterative process to develop themes, as suggested by Morgan (1997). A high-inference coding process (axial coding) focused on reading through each report multiple times to develop a list of major themes, which included: (1) reasons for participating in PIR; (2) services and supports, including substance abuse services, employment and financial resources; (3) challenges with program requirements; and (4) overall perceptions about PIR. Coders then examined individual coding units (i.e. word, phrase, sentence that pertained to a single concept stated by an individual) and coded each statement into one theme by discussing and reaching consensus. In addition to these focus groups, 4 individual case studies were developed as examples of the challenges and outcomes of participants.

Results

The PIR program has served 97 women and 157 children to date; nearly half tested positive for drugs at the time of the birth of a child. Approximately 37% are of Hispanic origin and completed an average of 11 years of education. Seventy-one percent were never married and 86% were unemployed at program admission. Mothers had 1–2 children on average and 86% of these children were under the age of 5; most of children were confirmed victims of physical abuse (67%) or neglect (21%). Fifty-seven percent of the children were placed into kinship care when the mother was admitted to substance abuse treatment; however, 37% remained with their

mothers in the specialized program for substance abusing mothers and their children. PIR programs participants completed an average of 70 days residential substance abuse treatment. Focus group participants represented a cross-section of these mothers.

Focus Group Themes

Reasons for Participating in PIR

Participants noted that they agreed to engage in the Parenting in Recovery program not necessarily to help themselves, but because they believed it would allow them to keep their children or be reunited with their children more quickly, for example: "It was the only way to keep my kids." Another mother described being in the hospital after the birth of her child: "I was told right up front that I had the option to keep my baby. I was still in the hospital and it made me feel good because I wasn't going to give my third baby to CPS or to a family member." Several participants noted that their original motivation for PIR participation and substance abuse treatment admission had little to do with a desire to become clean and sober. Rather, they were willing to do anything to keep their children, even if that included admission to 90 days of intensive residential substance abuse treatment. Some noted that they agreed to become involved to avoid a criminal investigation, arrest or jail. One mother said, "going to inpatient treatment was better than going to jail."

Services and Supports

Substance abuse services. Mothers discussed at length the issues of inpatient substance abuse treatment, agreeing that it was only after they were discharged that they recognized the value of what they had learned during residential treatment. One participant noted that "going to treatment is a lot of hard work. It's a lot of structure and rules, but there are lots of benefits at the end of it. You will get out of it what you put into it." Mothers who completed residential inpatient substance abuse treatment overwhelmingly voiced a genuine desire to remain clean and sober and work a program of recovery in order to be a good parent to their children. These revelations strengthened

understanding of the importance of promoting reunification if participants made progress in treatment.

Participants were required to attend 12-step program meetings throughout their enrollment in PIR. Some used the requirement to become strongly connected with Alcoholics Anonymous/Narcotics Anonymous "home groups" and the recovery community in general. Others resisted attending 12-step meetings as they did not agree with the principles expressed in the meetings. However, virtually all participants, regardless of their attitudes toward the 12-step process, spoke about the difficulty they had complying with the requirement to attend "90 meetings in 90 days" following completion of intensive outpatient substance abuse treatment.

Employment services. Most participants came into the program with very limited education and few had ever been employed. Few participants did obtain jobs or were successful in moving toward self-sufficiency during their time in the program; however, a few participants took advantage of PIR service options to obtain job training and certifications. Two participants obtained certification as nurses' aides and were registered with local home health care agencies. Focus group members described how not having a job made it even more difficult to remain clean and sober; they desired employment that would allow them to be self-sufficient and care for their children independent of others. Participants suggested that finding adequate employment was one of the most significant barriers to being independent, especially due to their lack of well-developed educational skills.

Financial resources. Those who qualified for entitlement programs appeared to have a small advantage financially, but many PIR participants reported that they did not qualify for these benefits. The overwhelming majority of participants felt that if they were able to maintain or regain strong family relationships, they could rely on family to help. One participant noted how financial support from her partner had helped the family and her own recovery. Other participants agreed that those who had an employed partner that contributed financially to the family allowed them to fully invest in their recovery. One participant reported that because her husband worked

full-time, she was able to attend to her own career training. She had previously completed about one-third of a beauty college curriculum; PIR helped her complete that curriculum. On the other hand, many participants voiced a lack of reliable and supportive family connections; they continued to work toward regaining the trust of their family members and receiving tangible or emotional support from them. Few families could be called upon for financial supports.

Challenges with PIR Program

Participants of focus groups discussed at length their frustrations with the uniformly high, and often unreasonable, expectations of the PIR program. Participants described spending their first three months in residential treatment, then moving into sober housing for three months and beginning six weeks of intensive outpatient (IOP) treatment, which required attendance four mornings per week. Few participants had private transportation; reliable, accessible, affordable public transportation was scarce and contributed to difficulties in attending program meetings and taking children to daycare. By the time they completed residential and IOP treatment, they are essentially five months into the program and were expected to begin contributing financially to rent and other living expenses within six months of entering the program. While engaged in these activities, they were learning to parent their children; attending drug court and CPS hearings; participating in parent training sessions, peer recovery coaching meetings, and individual therapy; and receiving home visits from a variety of service providers, including CPS. For many of the participants, they wondered, "When do I have time to train for a job, look for a job, and work at a job if I find one?" One woman stated, "You may think you're pushing me forward, but you're really pushing me toward the edge."

They also had difficulty with their CPS caseworkers. They felt these relationships were superficial and overwhelmingly negative. For example, one mother said, "Even though I've been clean since I went into treatment, it seems like it's never good enough. She's always coming up with things that she thinks are not good

enough...She focuses on the small stuff and seems like she is requesting perfection." Another noted, "They need to focus more on what we are doing right instead of what we're doing wrong...She never focuses on what I have accomplished."

Overall Perceptions about PIR

Many participants described their feelings when they first entered the program as being overwhelming. For example, one young woman said: "I just wanted to turn around and run;" another said, "people just need to know it's not a walk in the park." Even though they felt uncertain about successfully completing the program, most participants indicated they had achieved a great deal. Expectations of the program requirements were often difficult to achieve. As one woman suggested, she especially appreciated that the program did not require her to find a job right away; it helped her feel less overwhelmed with the need to be totally self-sufficient while also trying to parent her child and work on her recovery from substance abuse. Many participants discussed their gratitude for having the opportunity to be involved in PIR. They felt it gave them a chance to "make a new start" and make better decisions. As one of the greatest fears was the unknown associated with living on their own after being discharged from substance abuse treatment, they found that PIR was helpful in "every aspect of getting back on my feet." It seemed less overwhelming when there was a system in place to provide ongoing support.

Individual Case Examples (False Names)

Judy faced significant challenges when she entered the PIR Drug Court program. She had Axis I diagnoses that included methamphetamine dependence, major depression, and post-traumatic stress disorder, the latter resulting from severe physical and sexual abuse as a child and domestic violence as an adult. She had numerous physical health issues, including serious dental problems that discouraged her from smiling or speaking in public. She also was the primary caregiver for her young child, who had medical challenges of his own. This participant remained isolated and remote throughout much of

the program; she seldom interacted or connected with other program participants. She described being discouraged and hopeless, leading her to seek discharge from the program on several occasions. She stated that she could not cope with the demands and expectations of the program. However, with intense support and assistance from program team members, she eventually developed confidence and optimism for the future. PIR helped her access resources and provided her with needed services she had not had access to previously. In addition to residential and outpatient substance abuse treatment, she obtained safe permanent housing, worked one-on-one with a parenting coach, participated in trauma-informed individual psychotherapy, and received significant dental reconstruction. Once becoming motivated, she complied with court orders, progressed through program phases at a steady pace, and successfully completed and graduated from PIR in 14 months. Although she declined to be photographed, she smiled and spoke in front of a group of her peers at her graduation. She voluntarily joined a group of alumni who had participated in the program and has successfully maintained her sobriety and parenting of her child.

Nancy was a 27-year-old participant with an infant son. Both mother and son tested positive for cocaine at the time of his birth. Nancy scored below 70 on IQ testing, had never held legitimate employment, and had never obtained housing in her own name. She read at a first-grade level and had been in self-contained special education classrooms throughout her childhood. She had a lengthy history with both the juvenile and adult criminal courts. Nancy was a victim of childhood abuse by a mother who also suffered from drug addiction; Nancy also experienced domestic violence at the hands of her son's father. She had lost three previous children to the child welfare system and reported continuing grief over their loss and her mother's death a few years prior. Nancy had a strong dedication to parenting her newborn son and a very deep love and affection for him. Although she started parenting training with one of the lowest scores on standardized parenting measures that the team had ever seen, she listened intently to her parenting trainer, responded to feedback, and

followed through with suggestions. By the time she successfully completed parenting training, Nancy had a very high score on the same standardized test and was very proud of her progress. Nancy's other strengths included her ongoing willingness to seek support, her continued affection and support for other women in the program, and her resiliency despite adversity. Nancy was also fortunate to have the support of her sister, who cared for Nancy's son when she attended services and 12-step meetings. While in the program, Nancy had six separate admissions for substance abuse treatment—three in residential and three in intensive out-patient programs. PIR staff identified her for unsuccessful discharge from the program on three different occasions due to relapses on cocaine and alcohol; however, because she continued to sincerely seek help, staff felt committed to continue working with her. Program staff helped Nancy pursue Social Security Disability, which she obtained on her first try. About six months prior to completing the program, she reunited with a previous significant other (not her son's father) who was stable and sober and moved into his home. At her program graduation, Nancy reported gleefully to the PIR team and her peers that she had been asked to speak to young mothers at a local high school about her struggles and successes. She loved this experience and felt that being in the role of educator and mentor was a truly unique and rewarding experience for her. She continues to be clean and sober, happy, and grateful to be a full-time mother who is successfully caring for her child.

Trisha was a 36-year-old mother of two. She successfully completed 90 days of residential treatment one week before her mother unexpectedly passed away. Because her father was an active alcoholic, she handled all of the funeral arrangements and provided comfort to her family, including her children. One month after her mother's death, her husband died in an automobile accident. Again, she took charge and managed all the arrangements, despite the fact that her husband had two grown sons who were his business partners. After the funeral, these men promptly broke all ties with Trisha and refused to allow her access to anything associated with the business. PIR staff gave her intensive support during and following these crises. She

spoke with one staff member almost every day, and other program participants visited her at home at least once per week. These tragic events and their aftermath interrupted what would have been Trish's normal participation in PIR services and activities. She bypassed a step-down to intensive outpatient treatment and relied instead on a weekly aftercare groups and community-based recovery support meetings. She obtained a strong AA sponsor and attended a minimum of three AA meetings per week, which in itself was challenging as she lived about 40 miles outside of the metropolitan area. She stayed clean and sober throughout the process and continued to care for her two children, both of whom received therapeutic services provided through PIR. About three months prior to successfully completing PIR, Trish opened her own small landscaping business and hired one of her peers from the program to work with her. She oftentimes arrived at morning program meetings having worked since sunrise. Since graduation, she has maintained contact with program staff; her children are thriving, and her business is successful to the extent that she is fully self-sufficient and employs two assistants.

Helen was a 24-year-old mother of three children—ages five, three, and one—who was referred to PIR at the beginning of two different child welfare cases. She declined participation the first time but agreed to enroll the second time when she tested positive for heroin at the birth of her third child. At the beginning of the case, all three children were voluntarily placed with their great grandmother while the client entered residential treatment. After one week in treatment, she transferred into a short-term residential psychiatric hospital where she was stabilized and released back to the substance abuse treatment program. She participated for a short time but was discharged for creating disturbances and repeated rule violations. She then entered another treatment facility outside of the metropolitan area that focuses services more narrowly on clients with co-occurring psychiatric and substance abuse disorders. She left that treatment center three weeks later, against medical advice, with a male resident whom she met at the facility. She did not contact PIR staff and could not be located for two months, at which time she was unsuccessfully

discharged from the program. She eventually reconnected with PIR program staff and moved in with her mother, who was also a heroin addict. She died of a heroin overdose a short time later. Her children remain with their great-grandmother.

Discussion

The goals of the PIR program aimed to serve mothers by removing barriers associated with multiple physical, mental, emotional, and life skills needs in order to achieve sobriety and retain custody of their children, despite child protective service involvement. Core elements of the program included residential substance abuse treatment, safe and stable housing, training in appropriate parenting, and encouraging mothers to move quickly toward self-sufficiency.

Most PIR participants, like most individuals who abuse substances generally, entered the program with limited understanding of the extent of their addiction and its effect on their families (Einbinder, 2010). They experienced a variety of challenges, including severe addiction, limited work skills, poor employment histories, limited access to transportation, low educational levels, and felony/misdemeanor convictions that disqualified them from many forms of employment and housing options. With multiple personal and environmental barriers to achieving sobriety, self-sufficiency, and appropriate parenting (Kovalesky, 2001), these mothers represent one of the most challenging segments of the substance-using population.

During the course of PIR program delivery, it became clear that the process of personal growth and change takes a great deal of time, especially among those who had limited experiences with independence and self-reliance. Significant and meaningful change developed slowly as they moved through denial of the addiction, began the process of recovery, and learned basic living and parenting skills. They gained access and utilized a wide variety of essential services that they may not have had without being involved in the program. As significant internal and external personal challenges require much more time and effort to overcome (Kovalesky, 2001), the changes in attitudes,

beliefs and lifestyle were profound. With encouragement, patience, and flexibility of PIR service providers, participants confronted barriers that had previously appeared insurmountable.

Intensive service provision within a collaborative continuum of care providers who are flexible and committed to the success of participants appears to be the core process needed by this population of mothers. Staff encouraged active participation of the women in developing their goals and provided encouragement and support without threatening their independence. Although some women felt frustration with the program's high, possibly unreasonable, expectations of participants to address their substance dependency while becoming self-sufficient and a good parent, many rose to the challenge.

Limitations and Recommendations for Future Research

The findings from the qualitative focus groups present various limitations that must be noted. The sample included a group of participants engaged in PIR, which may be very different in terms of service access among other populations of substance dependent mothers who are involved with child welfare services. Even though several programs have been developed in the past few years that provide drug treatment to parenting women (e.g. Metsch, et al., 2001; McApline, et al., 2001), further research is needed to corroborate these results among other similarly situated women in other locations across the country. In addition, the sample size is small and likely reflects those most willing to participate in the focus groups. Focus group methodology was chosen because of the efficiency of data collection and capacity to incorporate group interactions (Krueger, 1994); however, these strengths also create concerns as groups have a tendency to create conformity among some members. This results in some members not discussing issues that they might in one-on-one interviews. "Polarization " may also occur where some participants express more extreme views in a group situation than they would in individual settings (Sussman, Burton, Dent, Stacy, & Flay, 1991).

Recognizing these limitations of this study, it does add to existing understanding of the profound challenges faced by women who

are involved in child protective services and who are substance dependent. Although child welfare professionals are charged with protecting the welfare and safety of children, it is important for workers to recognize issues associated with addictions and have more information concerning effective and efficient methods of service provision to these multi-problem families. Effective evidence-based practices are needed that focus on the child's well-being while providing assistance to parents struggling with addiction. Recognizing how issues of substance abuse, economic hardship, and mental illness impact these families are areas of training for child welfare workers (Semidei et al., 2001; McAlpine et al., 2001). On the other hand, substance abuse treatment providers require training and understanding of the issues associated with addiction recovery among parents who have children in the child welfare system. Extant research suggests that appropriate training improves worker's ability to identify, refer, and provide more effective treatment (Meyers, Apodaca, Flicher, & Slesnick, 2002).

In sum, these families require services that address the challenging and multi-problem areas of substance abuse, poverty, poor education, inadequate housing, unemployment/ underemployment, and difficulties with transportation and child care. If these concrete problems are not attended to, the likelihood that the child is removed from his/her home increases. Through collaboration between child welfare and substance abuse treatment systems, the needs of these highly vulnerable families may be addressed.

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