



California FIRST

Families in Recovery Staying Together

PROJECT SUMMARY

The State of California's Administrative Office of the Courts (AOC), Department of Social Services (CDSS), and Department of Alcohol and Drug Programs (ADP) partnered in establishing and implementing the California FIRST initiative pursuant to receipt of in-depth technical assistance provided by the National Center on Substance Abuse and Child Welfare (NCSACW). The project was designed to define the threshold combination and timing of interventions, supervision and supports necessary in each of California's 58 counties to achieve the following outcomes for families that have substance abuse disorders as a primary barrier to reunification:

1. Earlier access to quality treatment;
2. Increased treatment completion rates;
3. Higher reunification rates; and
4. Reduced re-entry rates.

Three efforts were identified by the team as necessary to achieve the desired outcomes:

1. Taking proven practices from the Dependency Drug Court (DDC) model to scale throughout all 58 counties;
2. Expanding availability of on-demand alcohol and other drug (AOD) services, especially residential treatment that serves parents with their children; and
3. Establishing a "Collaborative Justice" Academy.

Statewide expansion of DDC was identified by the lead entities for this project as the most appropriate mechanism for achieving the desired objectives because of DDCs' unique position as cross-system collaborative models specifically designed to tackle the co-occurrence of substance use and child abuse or neglect. California's statewide system of DDCs is still in comparatively early stages of development, though significant growth has occurred in the past five years. The first DDCs were established in 1998 and a substantial increase in state funding of \$1.8 million occurred in 2004. Currently, 52 DDCs exist in 33 jurisdictions statewide, and are designed to directly address substance abuse and other barriers to success, provide needed court supervision, incentives and sanctions, and support the family maintenance, permanency or reunification goals of the existing dependency case.

Although DDCs have shown promising results in outcomes for parents and in children, as well as in cost efficiencies, they are often established as intensive court programs that have limited caseloads and a range of operational methodologies. The identified challenge then, was to identify viable mechanisms for expanding this effective model to provide access to the DDC model to most, if not all, child welfare cases that have substance abuse as a key factor leading to juvenile court involvement.



Planned Project Activities

This project was originally organized in four key phases, beginning with an environmental scan process that launched in early 2009, and culminating with a presentation of a cost analysis and budget proposal to the California Legislature for the 2012 session. The specific phases identified were:

Environmental Scan:

This component of the project was designed as a statewide environmental scan to determine the composition and structure of DDC's statewide, as well as to identify the barriers, opportunities and resources present in each county related to providing timely services to families that are under dependency court jurisdiction related to a parental substance use disorder.

Leadership and Stakeholder Activities:

This project component reflected efforts to institutionalize the partnership fostered by receipt of the IDTA grant through the identification of stakeholders, establishment of an Oversight Committee and development of routine mechanisms for briefing upper management in all three partnering agencies on project activities and findings. While the AOC, ADP and CDSS had an established working relationship at the start of this project, having worked collaboratively on prior initiatives, the IDTA grant provided an enhanced opportunity to expand that partnership.

Design Policy and Practice Guidance:

This project component was designed to culminate in the development and promulgation of "best practices" regarding DDC structure, inter-agency collaboration, and operating practices. These materials were to be developed via a series of stakeholder working groups, and were to be formally presented at a December 2010 conference.

Pilot Testing, Evaluation and Cost Analysis:

The pilot testing phase of the project was designed as a vehicle for implementation of dependency drug court performance measures and standardized data collection, evaluation of several different types of DDC models, and the practice of universal screening for substance use disorders. The resulting information was to be used to finalize DDC performance measures, inform development of a statewide data collection system, and development of a 2012 legislative proposal regarding DDC expansion, and would provide the necessary data regarding number of clients to be served, recommended program models to be implemented, and related costs, to justify that proposal.

Project Observations

Environmental Scan:

The IDTA project's environmental scan was comprised of two related but distinct activities. First, an on-line survey, which was designed to collect information about local program standards, practices, operations, goals, caseload, and capacity, was issued.¹ The second component of the environmental scan was a series of program site visits, conducted by teams representing the project partner agencies.

¹ The survey instrument is provided as Attachment 1. Responses were received from 30 DDC programs.

The environmental scan component was critically important given the significant diversity among California's DDCs. A 2009 California Supreme Court decision, *In re Nolan W.*,² which held that contempt of court and jail are not permissible sanctions in the context of juvenile dependency proceedings, resulted in many of the state's DDCs undertaking significant organizational changes during the IDTA project, further exacerbating that diversity. The environmental scan thus allowed the project team to capture as much current information as possible regarding the unique composition and operations of each DDC in the state.

Survey Results

The survey data revealed that in California, all DDC cases are heard in juvenile dependency court and are heard by many different types of judicial officers, ranging from judges to referees. Some counties utilize a unified court approach, or a "one family/one judge" model, where the same judicial officer hears all matters for the parents involved in DDC (juvenile dependency and DDC review hearings). Other courts employ a bifurcated or parallel model where one judicial officer hears all DDC matters and another judicial officer hears the juvenile dependency matters. In terms of capacity, responding DDCs reported serving over 1,100 clients. These programs indicated a capacity to serve over 1,300 clients, which in the majority of instances represented only a fraction of the population responding programs perceived to be eligible for DDC participation. With respect to the frequency of DDC status review hearings, the California courts vary in practice between weekly, bi-weekly, or variable hearing schedules, with that variance typically reflecting a given participant's specific phase—early phase participants come to court with greater frequency.³

All respondent counties identified three common program goals: to "increase reunification rates"; "increase successful treatment completion rates"; and "increase child safety." In addition, ninety-five percent of the counties reported additional program goals of "achieving early access to treatment" and "decreasing recidivism/recurrence of child abuse/neglect incidents". Lastly, 90 percent of the counties reported "timely permanency for children" and "increase family recovery" as program goals. While all programs identified outcome-oriented program goals, very few of those programs indicated an ability to capture the data needed to determine whether or not those goals are in fact being met.

Nearly all courts include a drug court coordinator, judicial officer, and county social service agency representative as members on the drug court team. Eighty percent of the counties reported including treatment providers on their multidisciplinary teams. Not all dependency drug court coordinators are employed by the courts; some are based in other agencies, including county-level Alcohol and Drug Program, Department of Public Health, and other health-related service departments. Aside from the positions being based at different agencies, the composition of each multi-disciplinary team varies from county to county.

Program requirements for successful completion of dependency drug court vary between programs as well. The three most prevalent requirements for successful completion include the following: (1) successful treatment completion (95 percent); (2) required period of program participation (91 percent); and (3) engagement in other recommended services (91 percent). Forty-eight percent of the counties reported having program completion rates of between 50 and 75 percent. Only 9.5 percent of the courts reported having a 75 percent program completion rate or higher. Lastly, only 75 percent of the counties reported having aftercare support (post-program completion or post-family reunification).

² 45 CAL.4TH 1217

³ Survey results with respect to these findings are provided in Attachment 2.

Very few courts reported being able to track information enabling them to measure program efficacy or results.

Site Visit Findings

The environmental scan included site visits to 16 DDCs to observe court proceedings, interview court teams, and garner additional operational and fiscal information regarding individual court practices. A standardized protocol was developed that allowed comparison across sites.⁴ As did the surveys, the site visits revealed a wide variety of models, caseloads, capacities, cost, and effectiveness across the state. Site visit results also reflected the unique timeframe of the IDTA project, which coincided with reorganizations in response to the Nolan W. decision, severe financial stress on the infrastructures in both courts and counties that support DDCs, and inevitable 'growing pains' of newly developing DDCs.

Site visits were particularly useful as related to the compilation of information about the structure and composition of DDC teams. DDC teams can consist of as few as just two members, a judicial officer and a coordinator, or upwards of 30 members including representatives from the bench, parent's and minor's counsel, AOD, DSS, CalWorks, and multiple treatment providers. Generally, teams consisted of a judicial officer, a coordinator, and representatives from the child welfare and alcohol and drug agencies, and the treatment provider community. Typical responsibilities for these primary team members include:

Judicial Officer: leadership and direction

Coordinator: case management and program budget monitoring; typically the "go to" person for DDC issues

CW Agency: identification of clients for program; may contract directly for services

AOD Agency: administer screening and assessment tools; provides treatment provider oversight

Across the many jurisdictions where site visits occurred under the auspices of the IDTA project, common themes emerged with respect to team dynamics and functioning; these themes translate directly to DDC sustainability and operational efficacy.

First, there is a strong need for *institutionalization*, resulting from *routine training* and *enhanced collaboration*. Site visit participants observed varying degrees of judicial involvement in their respective DDCs, and found that few, if any, judicial officers receive DDC-specific training before assuming responsibility for a DDC calendar. Beyond judicial officers, few DDC teams receive routine training collectively, nor are there many formal structures in place to train new team members. Further, although many jurisdictions identify departmental culture/s as barriers to thriving DDC's (for example, child welfare workers who are not supportive of the DDC concept), there are few concrete tools available to teams to address these collaboration challenges. As a result of this lack of systems, many DDCs are personality driven, and can be made or broken based on the personal dynamism and engagement of one or two individuals (often, but not always, a judicial officer).

Second, there is a need for *clear articulation* and *shared understanding* of program eligibility criteria and referral processes. There is a wide variance between the programs as to how eligibility criteria are established, and which team member serves as the arbiter with respect to such determinations. Some programs have extremely restrictive eligibility criteria, which may not be commonly understood by all team members. Similarly, programs vary significantly in how they identify and refer clients to DDC programs. In some jurisdictions this function rests

⁴The protocol is provided as Attachment 3.

with the alcohol and drug agency, in others, child welfare – in still others, attorneys serve as the primary referring party. A related challenge is that very few, if any, jurisdictions have a comprehensive screening and assessment procedure in place, such that all, or a majority, of parents in the dependency system are screened for substance abuse treatment need. A well documented, systematized, and broadly understood eligibility, referral and screening process is integral to a robust DDC client population.

Lastly, most programs do not have the *ability to capture data* that compares outcome measures for dependency court participants that receive DDC services versus those that do not. This inability to capture basic outcomes data makes the programs particularly vulnerable to changes in team composition and court or agency leadership; a solid local evidence base for the merits of a given program would serve to protect the program from the vagaries of changing priorities and direction.

The site visits also allowed the observers to catalog a series of innovative practices being implemented throughout the state. While each jurisdiction identified challenges in meeting their goals or reaching capacity due to a variety of issues such as lack of resources, there were many strategies being carried out that were reported to make a positive substantive difference. One example is the co-locating of treatment and child welfare team members in an effort to increase access. Not only did this result in a centralized service delivery location, it served to improve and increase the team members' knowledge of one another's disciplines.

Leadership and Stakeholder Activities:

This project has made significant strides in strengthening the existing partnership between the AOC, ADP and CDSS. It has created a process for exchanging information and addressing common concerns among the agencies; by creating a forum for open discussion and on-going action planning around key issues, there has been a continuity of information sharing. Additionally, a site visit protocol for information gathering has been developed that will be useful beyond the scope of this grant. Among the other achievements of the stakeholder process has been the cross-sharing of policies and practices gathered during the environmental scan. This has been invaluable in instructing and informing each agencies work DDCs statewide.

As with any project of this magnitude there were also unforeseen challenges and missed opportunities. One such opportunity was the kick-off event scheduled to occur in October of 2009. The event did not occur due to the timing of other activities. In retrospect, this event may have been valuable in garnering the type of project buy-in from partner agency leadership that was needed to sustain the originally intended project scope in light of the serious budget downturn experienced by the state during the IDTA period. While the overall commitment of the three partner agencies continues despite statewide budget cuts, project activities were significantly scaled back as a result of the fiscal climate.

Design Policy and Practice Guidance:

This project component was designed to culminate in the development and promulgation of "best practices" and models as a means of determining the feasibility of substantial expansion of the DDC system. The range of models and the degree of transition of the many DDCs visited did not allow extraction of best practices within the timeframe of the IDTA effort. However, the IDTA project provided a framework to identify and share models, encourage local evaluation and data collection, and provide in depth technical assistance to optimize outcomes.

Existing models were identified as part of the environmental scan, as were key areas for follow-up study. Some DDCs stood out in terms of capacity, utilization and outcomes. These were identified for additional follow-up

evaluation. A plan to develop a statewide evaluation that links cost-benefit data with varied models was identified as a future step. This is expected to help determine the resource impact of substantial expansion of DDCs.

Pursuant to the project, both ADP and the AOC have modified their respective DDC grant reporting requirements to highlight cost and caseload reporting. A plan for implementing a system of interagency site visits to courts receiving funding, was also developed. In this way, interdisciplinary technical assistance can be provided, as well as assistance in developing local interdisciplinary teams. The site visits are also viewed as a means of identifying and promulgating promising practices.

Pilot Testing, Evaluation and Cost Analysis:

Although originally intended to take place at the outset of the IDTA project, the pilot testing, evaluation and cost analysis phase did not occur under the auspices of this effort. The partner agencies experienced a number of obstacles with respect to this anticipated project component, most critically a lack of both human and fiscal resources necessary to carry out the work. Importantly, the resource issue impacted not only the three partner agencies, but the potential study county sites as well, with few jurisdictions being willing to take on piloted implementation of project activities absent new resources to do so.

California's commitment to research, evaluation and the identification of effective DDC practices has also been challenged by the lack of a statewide data collection system. Currently, there is no system in place to track DDC outcomes, measure program performance or even provide basic descriptive data regarding number of participants or services rendered. The creation of such a system is complicated by the fact that DDCs involve multiple collaborating agencies with different data collection needs, requirements and capacities. Like all drug courts, these programs were largely created at the local level and are designed to address local needs and resources. As a result, there is little standardization in terms of practices, procedures or data collection. While some courts have stand alone drug court case management systems in place that house all necessary data, the majority depend upon data contributed from various partner agencies that is often provided in paper files. There are statewide efforts underway that are expected to positively impact this data collection effort, however the timeline for completion does not allow for information to be available for more than a year.

While the project partners were not able to implement the pilot testing phase, the agencies did collaborate on a project to complement the IDTA project and assist in the goals of evaluating outcomes, measuring performance, and determining DDC effectiveness. The DDC Data Collection and Performance Measures Project is a multiphase project that has identified and defined core data elements that all DDCs throughout the state should collect, has established performance measures to be created from these data elements and has tested the feasibility of collecting such data elements in two of California's DDCs⁵. Among other findings, pilot tests results indicated that gathering performance measures, while challenging, is facilitated when there is one electronic system in place. In the absence of such a system, gathering such information places an enormous workload burden on the court and may not be feasible in all settings. The DDC Data Collection and Performance Measure Project will continue its work in identifying, defining and testing collaborative court data elements and performance measures in its effort to create a standard statewide data collection system for DDCs and other collaborative courts throughout the state.

⁵ Orange and San Joaquin County DDCs.

Next Steps

Continue Regular Interagency Team Meetings

The State of California's Administrative Office of the Courts, Department of Social Services, and Department of Alcohol and Drug Programs are committed to further institutionalizing the partnership initiated and supported by the IDTA project. Quarterly meetings will continue with more frequent meetings resuming once a clearer picture of the budget situation is available.

Determination of Population Potentially Eligible for DDC Services

The caseload of families in the dependency system in which substance abuse and child welfare involvement converge needs to be determined through development of a methodology that meets both local and statewide coordination needs. This work will involve exploration of California's ability to use the Structured-Decision Making tool as a method for identifying substance abuse treatment need in the child welfare population, and determination of the feasibility of implementing universal substance abuse screening in volunteer sites.

Collaborate with NCSACW to Access Data from Methamphetamine Grantee Sites

Data collection will revolve around the key areas of interest for the IDTA project:

1. Access to quality treatment;
2. Treatment completion rates;
3. Reunification rates; and
4. Re-entry rates.

Expand and Refocus Dependency Drug Court Training and Technical Assistance

DDCs need enhanced technical assistance in responding to the pressures of reorganizing to comply with the Nolan W. decision, responding to severe financial stressors systemwide, and strengthening newly developing DDCs. DDCs also need enhanced technical assistance to optimize capacity and utilization. Upcoming training and technical assistance efforts conducted by the partner agencies will focus on these areas. In addition, multidisciplinary site visits will continue, with the goal being to identify and promulgate models that result in optimal outcomes.

Determine Feasibility of Expansion of the DDC System:

The determination of feasibility will involve in part the following components:

1. A cost benefit analysis of pilot study DDCs; and
2. A review of local and statewide DDC evaluations to identify effective models and best practices.

As a precursor to conducting a pilot study, sites that represent key DDC models will have to be identified. In addition, efforts that are ongoing to identify standard definitions and data elements will be used in implementing such a study. The data collection tools developed by the AOC for local cost benefit studies of adult drug courts should be modified for data collection and cost benefit analysis of DDCs. This web based system also provides a platform for uniform data collection and implementation of uniform data definitions. As noted earlier the other 'next step' in determining the feasibility of DDC expansion will be determining the potential caseload. Data from these sources should provide the foundation from which to consider expansion.

1. In which county is your program located?

2. Please identify your role.

3. How long has your program been in operation?

4. What are the goals of your program?

5. Who hears your program's cases? (Choose from drop down list)

- Judge
- Referee
- Commissioner
- Pro Tem

6. Which model do you utilize? (Choose from drop down list)

- Same judicial officer hears dependency and DDC case
- Different judicial officers hear the dependency and DDC cases
- Other model

7. How many judicial officers in your dependency court system have an assigned drug court docket?

8. Some courts have a system of assigning all dependency cases involving substance abuse to a program that is similar to drug court, with more serious cases going to an intensive drug court if they don't succeed in the less intensive program. Do you have such a system?

9. Do participants enter and/or exit your program voluntarily?

10. How frequently do you conduct status reviews (including legal hearings) with program participants?

11. What issues are addressed at your program hearings? (Choose from drop down list)

- Treatment needs and progress
- Placement
- Visitation
- All other dependency case issues
- Other

12. Are you familiar with the “Key Components of Drug Courts”?

13. To which of the key components or elements does your program adhere? (Choose from drop down list of ten key components)

14. Who serves on your program’s multidisciplinary team? (Choose from drop down list)

- CPS worker
- Agency Attorney
- Defense Attorney
- Guardian Ad Litem
- Treatment provider(s)
- Parole/Probation
- CASA
- Other: _____

15. Is your program coordinator a court-based position, or based in a different entity/agency?

16. In addition to a multidisciplinary clinical/court team, does your program have a multidisciplinary policy team that is responsible for strategic planning and making policy and programming-related decisions?

17. What criteria are used to qualify participants for your program?

18. What incentives and sanctions does your program utilize?

19. What are the criteria for successful completion of your program?

20. What is the timeframe or duration of your program?

21. How many providers does your program contract with?

22. Do your program participants have a higher priority for available treatment slots in your jurisdiction than non-program participants?

23. Do you have access to sufficient treatment resources for your program participants?

24. In addition to treatment services, what other services do your program participants most often need? (choose from drop down list of services)

25. Does your program build in aftercare support following successful program completion and family reunification?

26. How many participants are currently enrolled in your program? (Point in time analysis)

Attachment 1

27. What is the maximum number of participants your program can enroll?

28. In your perception, what percent of the child welfare cases in your jurisdiction that are eligible for your program are you able to serve?

29. What resources would be needed in order for your program to be able to serve all eligible cases?

30. Please provide additional information below, based on your selections in the previous question.

31. Do you have an active waiting list for your program?

32. Are there plans to expand your program's capacity to serve a greater percentage of eligible cases?

33. What is your program completion rate?

34. What are the greatest strengths of your program?

35. What are the most significant challenges facing your program?

36. Judicial Officer

Name:

Email Address:

Phone Number:

37. Program Coordinator

Name:

Email Address:

Phone Number:

38. Fiscal contact – for information related to funding, program costs, etc

Name:

Email Address:

Phone Number:

	Years Operating	Type of Judicial Officer	Model Utilized	# of Judicial Officers with DDC Docket	Frequency of Status Reviews	# of DDC Participants	DDC Capacity	% of Eligible Families Estimated Able to Serve
Alameda	3	Pro Tem	Other	Other	Varies by Phase	35	Open	30-40%
Contra Costa	7	Judge	Not sure	Other	weekly	n/r	n/r	n/r
El Dorado	4	Judge	Unified	All	Bi-Weekly	22	25	80-90%
Fresno	9	Comm	Unified	1	Bi-Weekly	16	25	30-40%
Lake	3	Judge	Bifurcated	1	Weekly	11	10	20-30%
Los Angeles	4	Comm	Unified	All	Bi-Weekly	60	120	<10%
Mendocino	2	Judge	Unified	n/r	weekly	n/r	30	n/r
Merced	4	Judge	Not sure	1	Varies by Phase	16	20	90%
Modoc	5	Judge	Unified	1	Bi-Weekly	n/r	20	90-100%
Nevada	6	Judge	Bifurcated	1	Bi-Weekly	8	15	n/r
Orange	4	Judge	Unified	6	Varies by Phase	35	90	30-40%
Riverside	6	Comm	Bifurcated	3	weekly	300	276	70-89%
Sacramento	9	Referee	Bifurcated	1	Varies by Phase	n/r	n/r	n/r
San Benito	n/r	Judge	Not sure	1	Weekly	2	3	n/r
San Bernardino	5	Judge/Referee	Bifurcated	2	Weekly	85	85	20-30%
San Diego	11	Judge	Bifurcated	2	Varies by Phase	35	50	40-50%
San Joaquin	8	Judge	Other	n/r	Varies by Phase	170	Open	80-90%
San Francisco	1.5	Comm	Unified	2	Bi-Weekly	20	40	40-50%
San Luis Obispo	3	Judge	Unified	1	Varies by Phase	25	25	20-30%
Santa Barbara	1	Judge	Unified	1	weekly	5	20	60-70%
Santa Clara	10	Judge	Unified	2	Varies by Phase	230	250	30-40%
Santa Cruz	5	Comm	Unified	1	Weekly	45	65	30-40%
Sierra	7	Judge	Unified	1	Bi-weekly	n/r	n/r	n/r
Solano	4	Judge	Unified	1	Bi-weekly	n/r	n/r	n/r
Sonoma	7	Judge	Bifurcated	1	Weekly	15	15	n/r
Stanislaus	8	Comm	Unified	1	Bi-Weekly	10	10	10-20%
Tehama	2	Judge	Bifurcated	1	Weekly	15	15	40-50%
Tulare	9	Pro Tem	Unified	Other	Varies by Phase	27	60	n/r
Tuolumne	9	Judge	Bifurcated	Other	Monthly	40	50	90-100%
Ventura	10	Judge	Unified	1	Varies by Phase	10	Open	90-100%
Totals						1132	1319	

4. What specific evidence-based practices does your DDC use in providing services to DDC clients?

Program Access and Eligibility

5. How is your program's capacity and eligibility for participation determined? Please explain the rationale used to determine your program's exclusionary criteria.
6. Please describe the process for identifying, referring and assessing eligible participants and enrolling them in the program? (timing, agencies/staff involved, waiting list management, screening and assessment instruments utilized, family characteristics, etc.)
7. Do you serve only parents of children in out of home care, or do you also serve parents whose children have not been removed and parents whose allegations have not been substantiated?
8. How do participants learn about your program? Can they self-refer?

Program Evaluation

9. What data do you collect, and how do you use it?

10. What evaluation practices do you have in place?

Treatment and Supportive Services

11. What criteria are used for contracting with community treatment providers? Are contracts in place specifically to ensure that treatment slots are available for DDC participants?

12. How is the quality of treatment assessed and/or reported to the DDC policy team?

13. Is there any difference in the time it takes for child welfare clients to access treatment in your county when comparing DDC clients to non-DDC clients?

Program Structure and Funding

14. What is the role of the DDC or Program Coordinator? Where is this position housed?
15. What funding sources are utilized to fund your DDC, including coordinator and services?
16. Please provide as much information as possible regarding overall program budget and cost, cost per client/family, cost of DDC-specific treatment services, and any other information that would be helpful to inform the State legislature about costs related to operating a DDC.
17. Does your program publish an annual cost analysis as part of an evaluation report? Does your cost data enable you to project the funding required to expand the core and supportive services of the DDC to new clients? Do you break out supportive services and the contracts you have with partner agencies

for services to DDC clients? What is the average cost [or range of costs] for a DDC client in your program?

18. If you operate an aftercare component, please describe what it entails and how it is funded.