

To: Pam Baston  
From: Nicolette M. Pach  
Re: Essex County Family Drug Court Policy and Procedure Manual  
Date: November 24, 2009

I have reviewed the Policy and Procedure Manual you forwarded. I have noted below potential barriers to participation that arise in the process. I will need your assistance in developing a strategy to raise these issues in a constructive manner. First, it might be appropriate to determine if there have been any changes in the process since it was revised in 2007. The features which draw my attention are the multiple “review and approve” steps and the in depth clinical assessment done by FDC before the participant is admitted to FDC.

The Essex County FDC intake process is multi layered. The entry process has 14 or is it 17 steps before the parent is even referred for treatment. There are multiple requirements for review and recommendation by team members and others as to the acceptability of a particular individual. The process goes well beyond determining whether the parent has a SUD and what level of treatment is appropriate into exploring (evaluating?) clinical/psychological factors which may be better addressed in a clinical setting after a clinical assessment informs a strategic treatment plan.

#### Essex Intake process steps and additional events in FDC

1. DYFS preliminary Screening of parents of
  - a. Pos. Tox Babies
  - b. Children removed for SUD related neglect
2. Case work supervisor approves
  - a. Flags case
  - b. Sends case packet to FDC through Child in Court Team
3. Court Personnel check
  - a. FACTS
  - b. Promis Gavel
4. Judge determines
  - a. Whether there are grounds for emergency removal
  - b. Parent Suitability for FDC
5. Screened by FDC interdisciplinary team
  - a. Accept/Reject
  - b. Schedule for 1<sup>st</sup> FDC hearing
6. If accepted FDC Screening team reviews (or is this the same as 5?)
7. Parent’s attorney is notified
8. Parent’s attorney meets with parent to explain
  - a. Provisional recommendation
  - b. Rights and waivers
  - c. Waiver of fact finding & stipulation to grounds to establish neglect case
9. DYFS caseworker reviews and recommends
10. Law Guardian reviews and recommends
11. Parent meets with attorney prior to return of OSC (is this the same as 8?)
  - a. Signs provisional application

- b. Given handbook
- c. Given date for assessment
- 12. Assessment by CADC team and Caseworker (why?)
- 13. Assessment submitted to FDC Team and Judge
  - a. Review and approve
  - b. Judge signs order to enter FDC
- 14. Parent appears on return date and completes application
- 15. Family Case Conference is convened by FDC team leader
- 16. 1<sup>st</sup> FDC Court hearing
- 17. Treatment conducts independent evaluation of each parent being considered for FDC (when and where?)
- 18. Treatment and Service plan developed by CADC, FDC, DYFS and treatment)
- 19. CPRB review within 45 days of placement
- 20. Six month progress review
- 21. Return of child (normally 6-12 months)
- 22. Phases and treatment levels (these are mixed together like apples and oranges - more later)
- 23. Request for graduation
- 24. Team considers request
- 25. Exit interview

Part of the entry process is an extensive evaluation of “clinical eligibility” using the battery of tests. I think this is step 12 above. In addition to the Addiction Severity Index (ASI), before the parent is admitted to FDC or enters treatment are required to undergo:

- Beck Depression Inventory
- Clinician Administered PTSD Scale
- Evaluation of lifetime stressors
- Parent- child relationship inventory
- Trauma Assessment for Adults
- Psychiatric Research Interview for Substance Abuse and Mental Health Disorders

Is it clinically appropriate at this stage? Is FDC staff qualified to administer them? Would this be more appropriate if and when treatment determines it is clinically necessary? These questions arose when I read the note on page 18 of the Policy and Procedures manual referencing the need to:

- have supervision and support mechanisms in place if a crisis is precipitated by disclosures
- inform clients that talking about such issues might create discomfort
- Access ( do they mean assess?) sources of social and emotional support available to clients

Defense counsel might well advise against participating in such an in depth assessment both on clinical grounds and out of concern as to how the results might be used in the dependency case.

Some FDCs utilize the following simpler approach:

1. determine the presence of an SUD,
2. clinically determine the appropriate level of treatment, and
3. determine whether there is information in the CPS case history which would mitigate against using this scarce resource of FDC for a particular parent ( for instance prior involuntary TPRs and a motion by DYFS to be relieved of making reasonable efforts).

Once those three items are evaluated other psychological concerns are left to the treatment provider and mental health providers to determine and integrated into the service and treatment plans .

Additional Notes:

#### Appendix II

Parents are placed on probation. Is this the normal course of events in a neglect case or is this just for FDC cases? If yes is it a deterrent to participation? Do they use jail sanctions upon a violation of probation?

#### Treatment levels and FDC Phases

While clinically established treatment levels will not necessarily coincide with phase accomplishments in FDC they are conflated in this manual. Treatment level is a clinical decision as are changes in treatment level and completion of treatment.

Phase requirements and goals should embody concrete benchmarks. In this Essex P & P manual they are not. If they are concrete and measurable then parents themselves know if they have reached these goals, all members of the FDC team will have shared expectations and there will be consistency from participant to participant. Expectations as to the duration of compliant behavior should also be set out. (For example: No unexcused absences from treatment and negative drug tests are required for a consecutive period of two months in order to be advanced from phase I to phase II.) The protocols should also differentiate between the expectations on the parent and what the FDC will offer in each phase. For example (at p. 25) “Be given their treatment recommendation and placement” is something the FDC staff will be doing. The expectation for the parent should be that they will regularly attend the treatment program recommended by the FDC staff.