

**Clark County Family Treatment Court:**  
***Striding Towards Excellent Parents (STEP)***  
**Vancouver, WA**  
***Process, Outcome, and Cost***  
***Evaluation Report***

*Submitted to:*

**DeDe Sieler**

Clark County Department of Community  
Services  
Vancouver, WA

*Submitted by:*

**NPC Research**

Portland, OR



October 2015



NPC Research  
5100 SW Macadam Ave., Ste. 575  
Portland, OR 97239  
(503) 243-2436  
[www.npcresearch.com](http://www.npcresearch.com)



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NPC Research

Katherine Kissick, B.A.

Mark S. Waller, B.A.

Adrian J. Johnson, M.S.W.

Shannon M. Carey, Ph.D.

[www.npcresearch.com](http://www.npcresearch.com)

October 2015



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## EXECUTIVE SUMMARY

**D**rug treatment courts are one of the fastest growing programs designed to reduce drug abuse and criminality in nonviolent offenders in the nation. The first drug court was implemented in Miami, Florida, in 1989. As of June 2014, there were nearly 3,000 drug courts including more than 1,900 adult and juvenile drug courts and 300 family treatment courts in all 50 states, the District of Columbia, Guam, Puerto Rico and the Virgin Islands (NDCRC, 2015).

In a typical drug court program, participants are closely supervised by a judge who is supported by a team of agency representatives that operate outside of their traditional adversarial roles. These include addiction treatment providers, district attorneys, public defenders, law enforcement officers, and parole and probation officers who work together to provide needed services to drug court participants.

Family Drug Treatment Courts (FTCs) work with substance-abusing parents with child welfare cases. FTCs are a “problem-solving” court modeled after the adult drug court approach. Similar to adult drug courts, the essential components of FTCs include regular, often weekly, court hearings, intensive judicial monitoring, timely referral to substance abuse treatment, frequent drug testing, rewards and sanctions linked to service compliance, and generally include wraparound services (Center for Substance Abuse Treatment, 2004; Edwards & Ray, 2005). The FTC team always includes the child welfare system along with the judicial and treatment systems, (Green, Furrer, Worcel, Burrus, & Finigan, 2007). Second, while adult drug courts work primarily with criminally involved adults who participate in the drug court in lieu of jail time, participants in FTCs may not be criminally involved; rather, FTC participants typically become involved in drug court due to civil family court matters.

NPC Research partnered with the Clark County Family Treatment Court to conduct an evaluation of the Family Treatment Court as part of their Children Affected by Methamphetamines (CAM) grant, awarded to Clark County in 2010 by the Substance Abuse and Mental Health Services Administration (SAMHSA). The purpose of the grant was to enhance the FTC program by adding more services for parents and their children, specifically mental health/family counseling, an at home support specialist, parenting assistance (including home, in office one-on-one and group classes around parenting skills) and evidenced based practices for parenting (Triple P and Parent Child Interaction Therapy). Participants opting into CAM services also received a neuropsychological exam intended to help identify participant and family needs to better plan which additional services were most appropriate.

**Process Evaluation Summary.** The Clark County Family Treatment Court was implemented in June 2006. The program was designed to take a minimum of 9 months from participant entry to graduation, although the average time in program for graduates is estimated to be about 14 months. The program takes parents who have experienced a child removal. The general

program population consists of substance abusing parents in the dependency system that wish to regain custody of their children. The primary drug of choice for the CCFTC participants is methamphetamines (50%), followed by opiates/heroin (25%) and then marijuana (12%) and prescription drugs (10%). Only 3% report alcohol as a primary drug. However, the majority of participants are polysubstance users. At the time the CAM grant was awarded, a total of 108 participants had entered the program. There were 18 active participants, 26 participants had graduated, and 62 participants had been discharged unsuccessfully (including terminated and opted out). As of December 2012, (the end of Year 2 of the grant), a total of 133 participants had entered the program, there were 19 active participants, 41 participants had graduated, and 68 participants had been discharged unsuccessfully (including terminated and opted out). These statistics are relevant to the program population that is included in the outcome and cost evaluation presented later in this document.

*Best Practices Results.* The CCFTC has been responsive to the community needs and strives to meet the challenges presented by substance-dependant individuals and their families. This program is demonstrating best practices within all 10 Key Components of Drug Courts and the 10 FTC Recommendations. This program has representation of all key agencies on the team and attending staffing and court sessions including a judge, coordinator, assistant attorney general, parents' attorney, CASA workers, treatment providers, DSHS caseworkers, and community partners (including representatives from the Children's Center and Children's Home Society). There was good communication and sharing of important information among team members. The program offers a full continuum of treatment services for parents and their children (including adding an aftercare phase), conducts frequent drug testing with rapid turnaround time in the first phase, follows good incentive and sanction processes, and has frequent participant contact with the judge with status review hearing every two weeks and appropriate time spent in court with the judge. The CCFTC also has an electronic case management system and collects data needed for both case management and evaluation. Finally, the coordinator and team are committed to ongoing training and program improvement.

At the end of the first year of the CAM grant, the evaluation resulted in several recommendations for implementing additional best practices, including consistent sharing of the neuropsych results and treatment progress with the team for better decision making about responses to participant behavior. Almost all recommendations made in the first year from this evaluation were implemented by the end of Year 2, indicating openness to feedback and a clear dedication to program self-improvement.

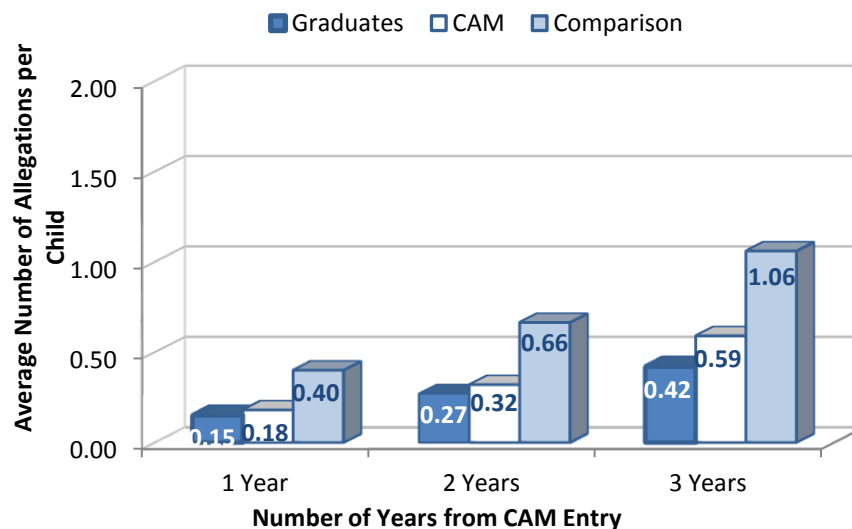
Although the CCFTC program is following the majority of best practices, there are a small number of key suggestions for program enhancements that the program should continue to work on. Specifically, the program should work toward continuing frequent drug testing (at least twice per week) past the first phase and throughout the program. The cost of drug testing for this program is high (\$20 per test). The CCFTC should explore less expensive drug testing

options as well as additional funding sources for testing so they can test more frequently in the later phases. Secondly, the team should ensure that there is a trained back-up judge available for when the current judge is unavailable (e.g., due to vacation or illness) and for the occasion that the current judge chooses to retire from drug court. Third, the team should continue to focus on the neuropsych assessment results of all participants and adjust services to best fit the needs of the parents and the children. Finally, the CCFTC team should review and share these evaluation results. In particular, they should appreciate and congratulate each other on the positive outcomes that have occurred due to their hard work and dedication to this program and the participating families.

**Outcome Evaluation Summary.** The key outcome analyses were based on a cohort of FTC participants who entered the program during a time period when CAM services were implemented from 2010 to 2014 (N=65) and a comparison group of families eligible for the FTC program but who received the traditional family court process (N=61). Additional analyses were performed on a cohort of FTC participants prior to the implementation of CAM services (N=85) and a matched comparison group families eligible for the FTC program but who received the traditional family court process (N=83).

Overall, the results of the outcome analysis for the Clark County FTC-CAM program were exceptionally positive. Compared to child welfare involved parents who experienced the traditional dependency court processes, the FTC-CAM program families (regardless of whether they graduated from the program) had half as many new maltreatment allegations 2 and 3 years after FTC entry (see Figure A).

**Figure A. Average Number of Allegations per Child Over 3 Years<sup>1</sup>**

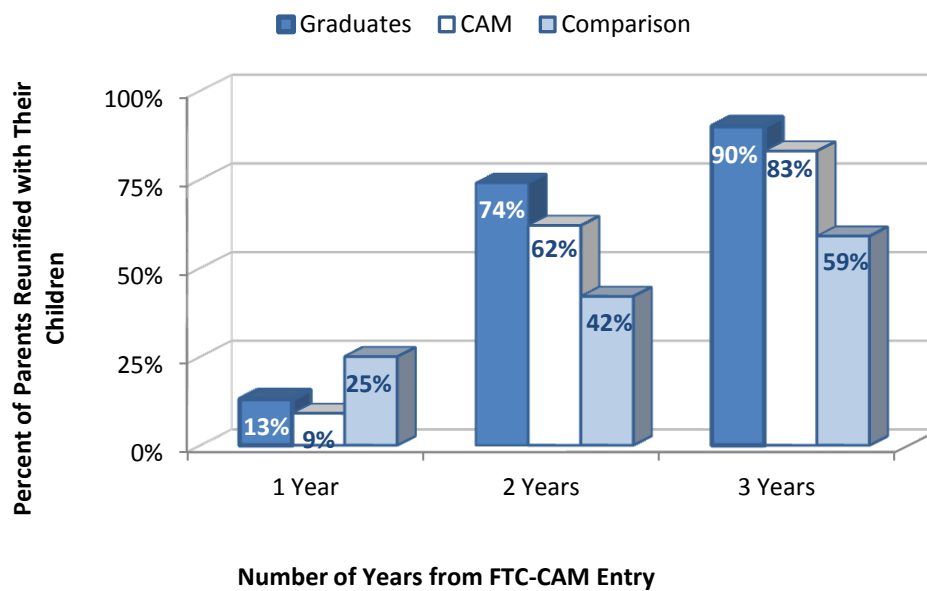


<sup>1</sup> Sample sizes represent number of children by group and time period (1 Year, 2 Years, 3 Years): Graduates  $n = 136, 127, 71$ ; All FTC-CAM Participants  $n = 202, 170, 98$ ; Comparison Group  $n = 199, 169, 142$ .

In addition, compared to child welfare involved parents who experienced the traditional dependency court processes, the FTC-CAM program families:

- Were perpetrators in one-third as many founded allegations 3 years after entry
- Had children spend less time in out of home placements (110 days vs 164 days) in the two years after drug court entry,
- Were over 40% more likely to be re-unified with their children (see Figure B),
- Were half as likely to have a child removed again 2 and 3 years after FTC entry
- Spent 3 times longer in treatment and were more than twice as likely to complete treatment
- Were re-arrested nearly 3 times *less* often for any charge

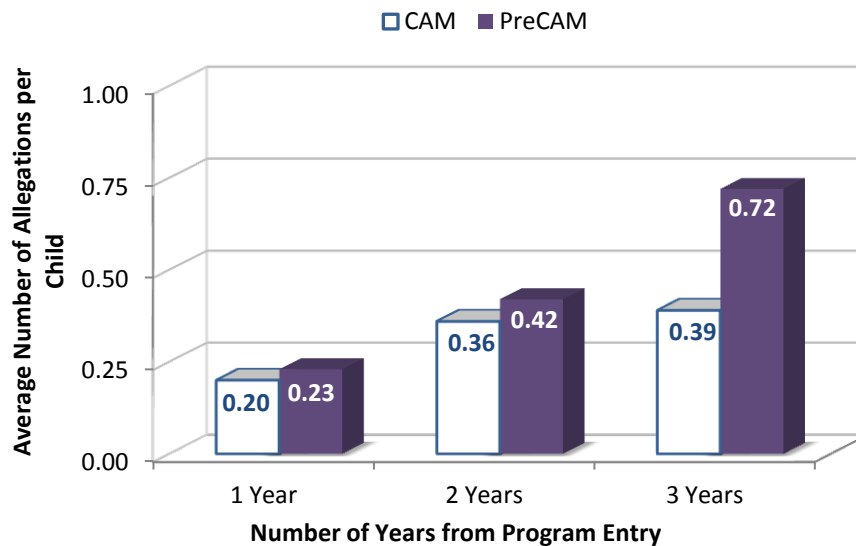
**Figure B. FTC-CAM Parents Were Significantly More Likely to be Reunified with Their Children Over 3 Years**





When compared to FTC parents prior to the implementation of CAM services (FTC-PreCAM), FTC-CAM program families had half as many new maltreatment allegations by 3 years after FTC entry (see Figure C).

**Figure C. Average Number of Allegations per Child Over 3 Years<sup>2</sup>**



In addition, when compared to FTC parents prior to the implementation of CAM services (FTC-PreCAM), FTC-CAM program families:

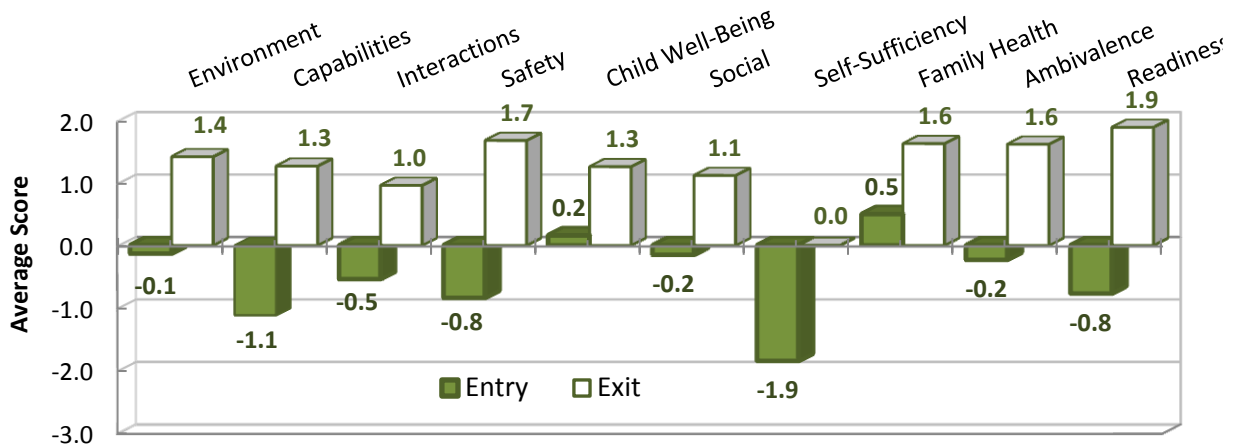
- Spent similar times in treatment but were 22% more likely to complete outpatient treatment and 25% more likely to complete residential treatment
- Were perpetrators more than 25% less often in founded allegations 3 years after entry
- Had children spend less time in out of home placements (123 days vs 157 days) in the 2 years after program entry,
- Had greater placement stability while in out of home care (FTC-PreCAM children had twice as many changes in placement compared to FTC-CAM children)
- Had higher reunification rates (74% compared to 61%, 3 years post entry) (see Figure C)
- Were re-arrested half as often for any charge

<sup>2</sup> Sample sizes represent number of children by group and time period (1 Year, 2 Years, 3 Years): FTC-CAM Participants  $n = 197, 165, 93$ ; FTC-PreCAM Participants  $n = 279, 279, 279$ .

The FTC-CAM program also had several other successes:

- Graduation rates increased steadily each year from the time of CAM implementation
- FTC-CAM families significantly improved family functioning from program entry to exit (as measured by NCFAS scores) on all domains including family environment, parental capabilities, child well-being, family safety and social/community life (see Figure D). Scores range from -3 (Serious Problem) to 2 (Clear Strength). 0 indicates baseline adequacy.

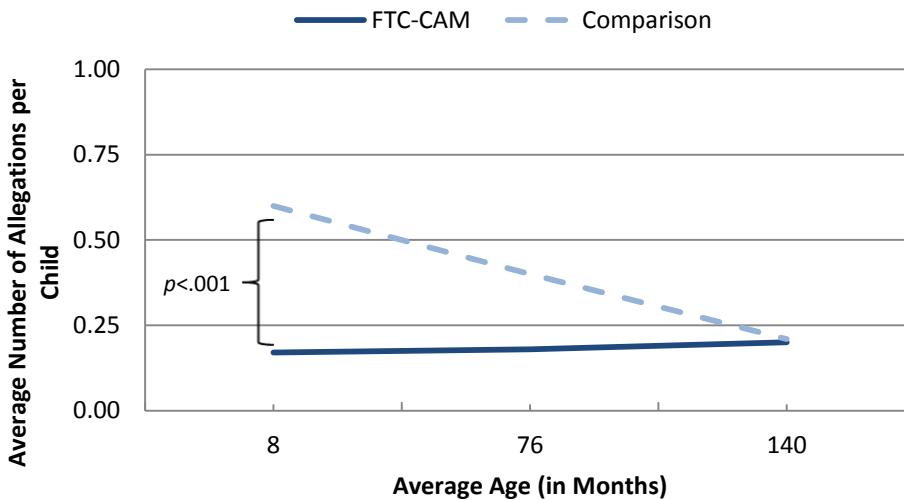
**Figure D. NCFAS Scores Improved Significantly from Entry to Exit<sup>3</sup>**



Finally, to achieve greater understanding of who the program works best for, and what services might lead to program success, an examination of participant and program characteristics that predicted graduation was performed. This analysis revealed that graduates of the FTC-CAM program were more likely to have utilized CAM services, specifically neuropsychological evaluations, family treatment, and home support. Graduates also received more rewards during the first 3 months in the program, were less likely to use heroin, and were less likely to have prior treatment in the 2 years before program entry.

A similar analysis was performed to determine what factors predicted child welfare and/or criminal justice recidivism. Individuals who were perpetrators on a maltreatment allegation within 2 years after program entry were more likely to have been a victim of an allegation as a child, had fewer drug arrests 2 years prior to entry, and had more child removals (i.e., their associated children being removed from the home) in the 2 years prior to entry. An additional finding of particular interest is that families with young children, particularly children under one year, showed significantly more improvement due to FTC-CAM participation than families with older children. Because having younger children is a key risk factor in continued maltreatment, this finding indicates that FTC is particularly effective for higher risk families (see Figure E).

<sup>3</sup> Sample size is 26 adults from 21 families. Some items may have smaller sample sizes, due to missing data.

**Figure E. Average Number of Allegations per Child at 1 Year<sup>4</sup>**

Further, in terms of criminal recidivism, participants who were rearrested within 2 years after program entry were less likely to have completed a neuropsychological evaluation, were more likely to identify heroin or prescription opiates as a drug of choice, had more arrests 2 years prior to entry and scored lower in the Family Interactions domain of the NCFAS.

**Cost Evaluation Summary.** Taken as a whole, the Clark County FTC program, particularly with the implementation of CAM services is highly successful, creating significant improvements in the lives of families struggling with addiction in their community as well as for the community as a whole.

Although the CCFTC is a considerable taxpayer investment, over time it results in substantial cost savings and a return on its investment. The program investment cost is \$21,633 per CCFTC participant. The savings per CCFTC participant over the 2 years included in this analysis came to \$12,009, which does not result in a positive return on the investment over the 2-year outcome time period. However, if we make the assumption that the cost savings will continue to accrue over time, the return on investment will improve over time as the outcome savings continue to accumulate. At 4 years the return becomes positive and at 5 years the cost-benefit ratio comes to 1:1.39. This ratio increases over time as the investment is repaid and the savings continue to accumulate.

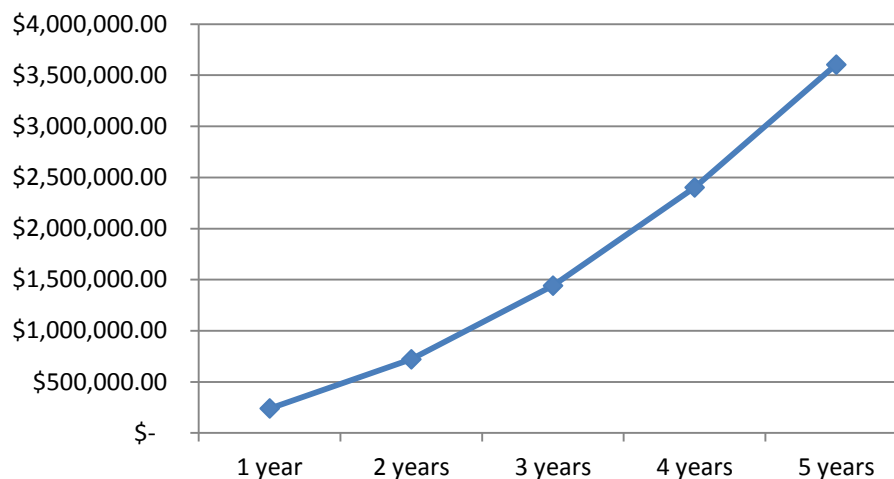
<sup>4</sup> Sample sizes represent number of children by group at 1 Year: All FTC-CAM Participants  $n = 202$ ; Comparison Group  $n = 199$ .

Overall, the CCFTC program had:

- A program cost of \$21,633 per participant.
- A criminal justice system, treatment, and child welfare system cost savings of \$12,009 per participant over 2 years from program entry, and
- A 139% return on its investment after 5 years (a 1:1.39 cost-benefit ratio).

These savings will also continue to grow with the number of new participants that enter the program each year. If the CCFTC program serves the intended cohort of 40 new participants annually, the accumulated savings after 5 years come to over **\$3.6 million (See Figure F)**. The lower numbers of recidivism related events and less child welfare involvement, including lower numbers of person victimizations for CCFTC participants, resulted in substantial cost savings.

**Figure F. Growth in Cost Savings Due to Positive Criminal Justice, Child Welfare and Treatment Outcomes for CCFTC Cohorts Combined Over 5 Years.**



As the existence of the CCFTC continues, and it continues to improve and engage in research based best practices, the savings generated by CCFTC participants due to reduced victimizations, reduced child welfare system involvement, reduced criminal recidivism and other positive outcomes can be expected to continue to accrue, repaying investment in the program and beyond. Taken together these findings indicate that the CCFTC is highly beneficial to participants and beneficial to Clark County and Washington taxpayers.

## BACKGROUND

For the past 25 years in the United States, there has been a trend toward guiding nonviolent drug offenders into treatment rather than incarceration. The original drug court model links the resources of the criminal system and substance treatment programs to increase treatment participation and decrease criminal recidivism. Drug treatment courts are one of the fastest growing programs designed to reduce drug abuse and criminality in nonviolent offenders in the nation. The first drug court was implemented in Miami, Florida, in 1989. As of June 2014, there were nearly 3,000 drug courts including more than 1,900 adult and juvenile drug courts and 300 family treatment courts in all 50 states, the District of Columbia, Guam, Puerto Rico and the Virgin Islands (NDCRC, 2015).

In a typical drug court program, participants are closely supervised by a judge who is supported by a team of agency representatives that operate outside of their traditional adversarial roles. These include addiction treatment providers, district attorneys, public defenders, law enforcement officers, and parole and probation officers who work together to provide needed services to drug court participants. Generally, there is a high level of supervision and a standardized treatment program for all the participants within a particular court (including phases that each participant must pass through by meeting certain goals). Supervision and treatment may also include regular and frequent drug testing.

The rationale of the drug court model is supported by a vast reservoir of research literature (Marlowe, 2010). There is evidence that treating substance abuse leads to a reduction in criminal behavior as well as reduced use of the health care system. The National Treatment Improvement Evaluation Study (SAMHSA/CSAT, 1994) found significant declines in criminal activity comparing the 12 months prior to treatment and the 12 months subsequent to treatment. These findings included considerable drops in the self-reported behavior of selling drugs, supporting oneself through illegal activity, shoplifting, and criminal arrests. In a study using administrative data in the state of Oregon, Finigan (1996) also found significant reduction in police-report arrests for those who completed treatment.

Drug courts have been shown to be effective in reducing recidivism (GAO, 2005; Wilson, Mitchell, & MacKenzie, 2006; Gottfredson, Kearley, Najaka, & Rocha, 2005, 2006) and in reducing taxpayer costs due to positive outcomes for drug court participants (including fewer re-arrests, less time in jail and less time in prison) (Carey & Finigan, 2004; Carey, Finigan, Waller, Lucas, & Crumpton, 2005). Bhati and colleagues found a 221% return on the investment in drug courts (Bhati, Roman, & Chalfin, 2008). Some drug courts have even been shown to cost less to operate than processing offenders through business-as-usual (Carey & Finigan, 2004; Carey et al., 2005).

More recently, over the past 15 years, the drug court model has been expanded to include other types of offenders (e.g., juveniles and domestic violence offenders) and other systems (e.g., child

welfare). Family Drug Treatment Courts (FTCs) work with substance-abusing parents with child welfare cases. FTCs are a “problem-solving” court modeled after the adult drug court approach. Similar to adult drug courts, the essential components of FTCs include regular, often weekly, court hearings, intensive judicial monitoring, timely referral to substance abuse treatment, frequent drug testing, rewards and sanctions linked to service compliance, and generally include wraparound services (Center for Substance Abuse Treatment, 2004; Edwards & Ray, 2005). The FTC team always includes the child welfare system along with the judicial and treatment systems, (Green, Furrer, Worcel, Burrus, & Finigan, 2007). Second, while adult drug courts work primarily with criminally involved adults who participate in the drug court in lieu of jail time, participants in FTCs may not be criminally involved; rather, FTC participants typically become involved in drug court due to civil family court matters.

The first FTC was established in 1995 in Reno, Nevada, and there are now well over 350 programs throughout the United States (Huddleston & Marlowe, 2011; National Association of Drug Court Professionals, 2015). A number of methodologically sound impact evaluations have been completed within the past several years revealing significantly better outcomes in FTC as compared to traditional family reunification services (Green et al., 2007; Marlowe, 2010). Benefits include (1) significantly higher rates of parental participation in substance abuse treatment; (2) longer stays in treatment; (3) higher rates of family reunifications; (4) less time spent in foster care for children; and, (5) less recurrence of maltreatment (Boles, Young, Moore, & DiPierro-Beard, 2007; Green, Rockhill, & Furrer, 2007; Worcel, Green, Furrer, Burrus, & Finigan, 2007; Worcel, Furrer, Green, Burrus, & Finigan, 2008; Marlowe, 2010; Oliveros & Kaufman, 2011; Rodi et al., 2015). One review of the research literature concluded that FTC is among the most effective programs for improving substance abuse treatment initiation and completion in child welfare populations (Oliveros & Kaufman, 2011).

Two evaluations (Carey, Sanders, Waller, Burrus, & Aborn, 2010a, 2010b) examined new criminal arrests as an additional outcome measure. Both studies reported significantly lower arrest rates for the FTC participants as compared to the comparison groups (40% vs. 63%, and 54% vs. 67%, respectively). Several evaluations reported cost savings for FTC resulting from a reduced reliance on out-of-home child placements. Estimated savings from the reduced use of foster care were approximately \$10,000 per child in Maine (Zeller et al., 2007), \$15,000 in Montana (Roche, 2005), \$13,000 in Oregon (Carey et al, 2010b) and £4,000 (\$6,420) in London (Harwin et al., 2011).

## **Process, Outcome, & Cost Evaluation Description and Purpose**

The Clark County Family Treatment Court partnered with NPC Research to conduct an evaluation of the Family Treatment Court as part of the Children Affected by Methamphetamines grant, awarded to Clark County in 2010 by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Located in Portland, Oregon, NPC Research has conducted research and program evaluation for over 25 years. Its clients have included the Department of Justice (including the National Institute of Justice and the Bureau of Justice Assistance); the Substance Abuse and Mental Health Services Administration (CSAP and CSAT in particular); state court administrative offices in Oregon, California, Maryland, Michigan, Minnesota, and Missouri; the Robert Wood Johnson Foundation; and many other local and state government agencies. NPC Research has conducted process, outcome and cost evaluations of drug courts nationally, including Arizona, California, Colorado, Indiana, Maryland, Michigan, Minnesota, New York, Oregon, and Guam. Having completed more than 100 drug court evaluations (including adult, juvenile, DUI and family drug treatment courts), NPC is one of the most experienced firms in this area of evaluation research.

This evaluation was funded through a grant to the Clark County of Washington by the U.S. Substance Abuse and Mental Health Services Administration (the Children Affected by Methamphetamines grant): CFDA #93.243.

The ***process evaluation*** was designed to collect and measure the following information:

- Jurisdictional characteristics of the Clark County Family Treatment Court.
- Description of the eligibility criteria for participants.
- Description of the FTC court team including the roles and responsibilities of each team member.
- Description of the FTC program phases and requirements for completion.
- Description of the practices being performed by the program and the extent to which research-based best practices were being implemented.

The ***outcome evaluation*** was designed to provide the following information.

- Child welfare outcomes of all FTC-CAM court families, from date of entry in the FTC court, and a comparison of those outcomes to matched families that received traditional court monitoring, as well as a comparison of outcomes to FTC participants prior to CAM implementation. Outcomes were tracked over a period of 12, 24, and 36 months.
- Criminal recidivism of all FTC-CAM court participants, from date of entry in the FTC court, and a comparison of those outcomes to a matched group that received traditional court monitoring, as well as a comparison to FTC participants prior to CAM implementation. Outcomes were tracked over a period of 12, 24, and 36 months.
- Engagement in and completion of treatment services by FTC-CAM participants compared to a matched group of non-FTC participants.
- Prediction of successful outcomes based on program and participant characteristics.
- Description of significant predictors of child welfare recidivism at 12, 24, and 36 months.



The **cost evaluation** was designed to gather information that allows the calculation of:

- Program-related costs such as FTC-CAM status review hearings, treatment services, drug tests, case management, etc.
- Outcome- related costs such as days in out of home placement, treatment services, arrests, court cases, jail, and prison for FTC-CAM families and the matched comparison group.

Evaluation activities included administration of an online assessment, interviews performed by telephone and in-person with team members and other key stakeholders, site visits, observations of program activities including staffings and court sessions, focus groups with FTC-CAM participants, program document reviews, agency and county budget reviews, and administrative data collection from multiple agencies.

This report describes the results of the process, outcome and cost evaluation of the Clark County Family Treatment Court. A detailed description of the methodology used in the evaluation of this program is provided in each of the three sections of this report: 1) process, 2) outcome, and 3) cost.



## SECTION I: PROCESS EVALUATION

**T** Research has demonstrated that drug courts that have performed monitoring and evaluation and made changes based on the feedback have significantly better outcomes, including twice the reduction in recidivism rates and over twice the cost savings (Carey, Finigan, & Pukstas, 2008; Carey, Waller, & Weller, 2011; Carey, Mackin, & Finigan, 2012). A process evaluation considers a program's policies and procedures and examines whether the program is meeting its goals and objectives. Process evaluations generally determine whether programs have been implemented as intended and are delivering planned services to target populations. To do this the evaluator must have criteria or standards to apply to the program being studied. In the case of drug treatment courts, some nationally recognized guidelines have been established and have been used to assess drug court program processes. The standards established by the National Association of Drug Court Professionals began with the "10 Key Components of Drug Courts" (NADCP, 1997) and expanded based on a prodigious amount of research in the field to include the Adult Best Practices Standards Volume I (NADCP, 2013) and Volume II (NADCP, 2015), as well as the Guidance to States for developing Family Drug Court Guidelines (Young et al., 2013). Good process evaluation should provide useful information about program functioning in ways that can contribute to program improvement. The main benefit of a process evaluation is improving program practices with the intention of increasing program effectiveness for its participants. Program improvement leads to better outcomes and impacts and in turn, increased cost-effectiveness and cost-savings. In addition, and particularly relevant to this study, a process evaluation should include a detailed description of the program that can be used to assist other jurisdictions in implementing the same program model.

### **Clark County Family Treatment Court Process Evaluation Activities and Methods**

As a part of the process evaluation, NPC staff conducted the following activities with the Clark County Family Treatment Court (referred to as the Clark County FTC, or CCFTC, in the remainder of the report):

1. Employed an online assessment to gather program process information from the FTC coordinator in collaboration with other FTC team members.
2. Conducted a site visit to:
  - a. Observe staffing meetings and FTC court sessions.
  - b. Performed interviews with key FTC team members and other key stakeholders to learn more about the program's policies and procedures and how they were implementing these as they relate to the 10 Key Components and research based best practices for drug courts and FTCs. Interviews assisted the evaluation team in

- focusing on day-to-day operations, as well as the most important and unique characteristics of the CCFTC.
- c. Facilitated a focus group with current program participants and graduates
  3. Reviewed program documents including the CCFTC policy and procedures manual, participant handbook, screening forms, participant contract, participant orientation information, forms used to process participants, and previous evaluation reports, among other documents.
  4. Reviewed a data elements worksheet with program staff to locate/obtain data for the outcome and cost evaluations.
  5. Conducted a detailed review of the program data collection process and data availability (including data available for a comparison group).
  6. Facilitated a discussion of practices observed and enhancement recommendations at a teleconference of FTC staff, court administration, and NPC assessment staff to ensure accuracy and determine feasibility of enhancements.

A synthesis of the information collected through these activities provided NPC with a detailed understanding of the FTC's organization and processes at the time of the SAMHSA CAM grant, assisted the assessment team in determining the direction and content of further questions and technical assistance needs and supports, and informed the outcome and cost evaluations of the program.

This section of the report is a summary of the results from the original process evaluation in Years 1 and 2 of this project. The main time period of the process evaluation in this report is the period when the new CAM services were being implemented and the FTC families in the sample used for the outcome study were participating in the program. This section briefly summarizes program characteristics and practices and analyzes the degree to which the FTC was following guidelines based on the 10 Key Components, the FTC Guidance to States and research based best practices. The commendations and recommendations made for program enhancement during the time period of the CAM grant are also provided.

### **ONLINE PROGRAM SELF-ASSESSMENT**

An online program self-assessment was used to gather initial program process information from key program staff. This assessment, which provides a consistent method for collecting basic structure and process information from family treatment courts, was developed based on five main sources: NPC's extensive experience with different drug courts (including FTC's), the American University Drug Court Survey, a published paper by Longshore et al. (2001) which lays out a conceptual framework for drug courts, the 10 Key Components established by the National Association of Drug Court Professionals (1997) and NADCP's Best Practice Standards (Volume I, 2013 and Volume II, 2015). The assessment covers a number of areas including eligibility guidelines, specific FTC program processes (e.g., phases, treatment providers, urinalyses, fee structure, rewards/sanctions), graduation, aftercare, termination, identification of FTC team members and their roles, and a description of FTC participants (e.g., general

demographics, drugs of use). The use of an online self-assessment allows NPC to begin building an understanding of the program, as well as to collect information that will support a thorough process study and a review of the data collected by the site.

## **SITE VISITS**

NPC evaluation staff members conducted multiple site visits between 2011 and 2015. During these visits, NPC observed the CCFTC status review hearings, advisory board meetings, clinical staffing meetings and FTC team staffing meetings; interviewed key FTC staff; and facilitated focus groups with current FTC participants and graduates. These observations, interviews, and focus groups provided information about the structure, procedures, and routines used in the drug court.

NPC has also been involved in the implementation of the CAM grant. NPC staff members attended all stakeholder and executive meetings as well as any additional meetings where CAM grant implementation and processes were discussed and planned.

## **KEY STAKEHOLDER INTERVIEWS**

Key stakeholder interviews, conducted in person and by telephone, were a critical component of the CCFTC process study (as well as the outcome and cost study). NPC staff conducted detailed interviews with individuals involved in the administration of the drug court, including the current Judge, Drug Court Coordinator, Department of Social and Health Services (DSHS) representatives, Children's Guardian Ad Litem (CASA) Assistant Attorney General and the directors and representatives of all treatment organizations involved with the program and the implementation of the CAM grant (Lifeline Connections, The Children's Center, and Children's Home Society).

Interviews were conducted to clarify and expand upon information gained from the online assessment and to obtain a deeper and more comprehensive understanding of the FTC process. NPC's Drug Court Typology Interview Guide<sup>5</sup> was referenced for detailed questions about the program. This guide was developed from the same sources as the online assessment and provides a consistent method for collecting structure and process information from drug courts. The information gathered through the use of this guide assisted the evaluation team in focusing on the day-to-day operations as well as the most important and unique characteristics of the CCFTC.

## **FOCUS GROUPS**

NPC staff conducted a focus group with current participants (and their partners) as well as graduates (N=14). The group included a multiple participants from each phase, including four participants who successfully graduated. There were 11 women and three men present. The

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<sup>5</sup> The Typology Guide was originally developed by NPC Research under a grant from the Bureau of Justice Assistance and the Administrative Office of the Courts of the State of California. A copy of this guide can be found at the NPC Research Website at <http://npcresearch.com/wp-content/uploads/Drug-Court-typology-guide-NPC-Research-01-26-04-copyrighted.pdf>

focus group provided current and past participants with an opportunity to share their experiences and perceptions regarding the drug court process.

## **DOCUMENT REVIEW**

In order to better understand the context, operations and practices of the CCFTC, the evaluation team reviewed program documents including the original CAM proposal, the Participant Orientation Binder, entry and eligibility documents, and multiple process sheets regarding CAM service integration (see Appendix D). The information gained from these documents was used to develop additional interview questions, provided more detailed description of the program and also served as a template to examine the actual practices engaged in by the program in relation to their intended practices as described in the documents.

## **OTHER DATA COLLECTION**

In addition to the evaluation activities described above, NPC staff assisted the CCFTC staff in the collection of data and the data reporting for the cross-site evaluation conducted by Children and Family Futures (CFF). Data collected included demographics of adults and children receiving CAM services, services assessed and provided, substance abuse treatment assessments and admissions for adults, and child welfare information for children. In addition to these items, the program completed a North Carolina Family Assessment Scale (NCFAS) assessment for each family entering the program at entry and exit. The data collected by the program as well as the assessments were collected and verified by NPC and subsequently uploaded biannually to CFF using an online platform.

## **Process Evaluation Results**

The Clark County Family Treatment Court was implemented in June 2006. The program was designed to take a minimum of 9 months from participant entry to graduation, although the average time in program for graduates is estimated to be about 14 months. The program takes parents who have experienced a child removal. The general program population consists of substance abusing parents in the dependency system that wish to regain custody of their children. The primary drug of choice for the CCFTC participants is methamphetamines (50%), followed by opiates/heroin (25%) and then marijuana (12%) and prescription drugs (10%). Only 3% report alcohol as a primary drug. However, the majority of participants are polysubstance users. At the time of the online survey in Year 1, a total of 108 participants had entered the program. There were 18 active participants, 26 participants had graduated, and 62 participants had been discharged unsuccessfully (including terminated and opted out). As of December 2012, (the end of Year 2), a total of 133 participants had entered the program, there were 19 active participants, 41 participants had graduated, and 68 participants had been discharged unsuccessfully (including terminated and opted out). These statistics are relevant to the

program population that is included in the outcome and cost evaluation presented later in this document.

Team members include a judge, coordinator, assistant attorney general, parents' attorney, CASA workers, treatment providers, DSHS caseworkers, and community partners (including representatives from the Children's Center and Children's Home Society).

In 2010, the CCFTC received funding from SAMHSA under the Children Affected by Methamphetamines grant (CAM) to add new services (particularly for the children of participating families) and to increase the capacity of the existing program. Specifically, existing and incoming CCFTC participants, if found eligible, could opt to receive additional services designed to assist families that have been exposed to methamphetamines. Eligible participants must have a history of methamphetamine use or their child had to have an adult in their life that had a history of methamphetamine use. Additional services include mental health/family counseling, an at home support specialist, parenting assistance (including home, in office one-on-one and group classes around parenting skills) and evidenced based practices for parenting (Triple P and Parent Child Interaction Therapy). Participants opting into CAM services received a neuropsychological exam (referred to by the program as "neuropsych" and noted as such for the remaining of this report). Adults and children receive neuropsych exams as appropriate to their age. This exam was intended to help identify participant and family needs to better plan which additional services were most appropriate. With CAM funding, two agencies were hired to administer these additional services. The Children's Center was responsible for the neuropsych exams and mental health/family counseling as well as the at home support specialist while Children's Home Society provided the parenting assistance (including the home and in office one-on-one and group classes) and the Triple P, Parent Child Interaction Therapy, etc. The program planned to serve 20 adults and 35 children each year. However, after the contract was awarded, Year 1 was amended to serve 18 adults and 31 children, with services increased (and surpassing) the original goals in years 2, 3 and 4.

The program was able to successfully meet the amended service goals. However, full implementation and integration of these services took much of the first year. The CCFTC team along with representatives from the new CAM service agencies began monthly stakeholder meetings, which included representatives from all participating agencies. After Year 1, these meetings were adjusted to every other month and in the alternating months, a smaller group of decision makers at each agency began an "executive meeting." The stakeholder meeting was designed to address current process and implementation issues as well as monitor progress in reaching program goals. Executive meetings were designed for making final decisions about issues that come up from stakeholder meetings as well as address larger policy issues that required administrative personnel in the partnering agencies.

This report provided feedback to specifically address the CAM implementation and process as well as the CCFTC program as a whole during the CAM grant period. The main purpose of

including the process evaluation at the beginning of this report with the outcome and cost results is to provide the context of the program during the time period that the participants in the study sample for the outcome and cost evaluation were actively participating in the program.

### **KEY COMPONENT #1: DRUG COURTS INTEGRATE ALCOHOL AND OTHER DRUG TREATMENT SERVICES WITH JUSTICE SYSTEM CASE PROCESSING.**

The focus of this component is on the integration of treatment services with traditional court case processing. Practices that illustrate an adherence to treatment integration include the role of the treatment provider in the drug court system and the extent of collaboration between all the agencies involved in the program.

Key Component #1 focuses on the collaboration of a variety of agencies, as does Children and Family Futures Recommendation #2. The partnerships include the integration of treatment services with traditional court case processing, and the engagement of various other justice and service agencies, including child welfare, probation, law enforcement, and community partners (employment, housing, transportation, and other groups). Each professional who interacts with the participants observes them from a unique perspective, at different times of the day or week, and under varied circumstances. This offers holistic, useful information for the team to draw upon in determining court responses that will change participant behavior. Participation from all partners contributes to the strength of this model and is one of the reasons it is successful at engaging participants and changing behavior. For these collaborations to be true “partnerships,” regular meetings and collaborations with these partners should occur. If successful, the FTC will benefit from the expertise that resides in all of the partner agencies, and participants will enjoy greater access to a variety of services.

#### National Research

Research has indicated that greater representation of team members from collaborating agencies (e.g., child welfare, treatment, court, wrap-around services, law enforcement, etc.) at team meetings and court hearings is correlated with positive outcomes for clients, including reduced recidivism and, consequently, reduced costs at follow-up (Carey et al., 2005, 2008; Carey & Waller, 2011).

Drug Court research has also demonstrated that drug courts with fewer treatment providers (one or two is optimum) resulted in more positive participant outcomes including higher graduation rates and lower costs (Carey et al., 2008, 2012).

#### CCFTC Process

The following described program process and practices that were in place at the time of the CAM grant period.

- The CCFTC team is composed of a judge, coordinator, assistant attorney general (AAG), parents’ attorney (OPD), Court Appointed Special Advocate (CASA) representative,

Department of Social and Health Services (DSHS) caseworkers, Lifeline Connections substance abuse treatment representatives, Children's Center (CC) representatives and Children's Home Society (CHS) representatives. Over the first 2 years of the CAM grant, representatives from CC and CHS have included a variety of people due to staff turnover. The DSHS caseworkers also experienced turnover and growth, with the original three caseworker slots increase to five to accommodate large caseloads. Lastly, the AAG position rotated multiple times since Year 1, with the most current representative joining in March 2012.

- Staffing meetings where participant progress is discussed are held once per week on Mondays. Those in attendance at these meetings include the judge, coordinator, DSHS caseworkers and supervisor, parents' attorney, CASA representative, treatment representatives, and representatives from both CC and CHS. The assistant attorney general attends these meetings as often as possible, and regularly on the first Monday of the month (when all participants are seen). Staffing meeting attendance has fluctuated greatly for the two CAM specific agencies, CC and CHS. While at least one representative is always present, the agencies and the team have struggled with the best way to represent these agencies without having multiple people attend the meetings.
- CCFTC status review hearings are held in court weekly. The judge, parents' attorney, DSHS caseworkers, CASA representative, treatment representatives, representatives from CC and CHS, the coordinator and the court clerk always attend. The AAG attends when possible.
- The program has partnerships with a number of treatment providers. There is one main adult substance abuse treatment agency, Lifeline Connections. The representative from Lifeline is responsible for collecting verbal reports from other treatment agencies and bringing that information to court.
- The CAM grant has funded two additional agencies, The Children's Center (CC) and Children's Home Society (CHS), to perform additional parenting services and child and family counseling.
- The addition of two new agencies, CHS and CC, has increased the case management duties for multiple members of the team, especially the social workers. Coordination and communication between these two agencies, as well as between these agencies and other CCFTC agencies, has been challenging and is continuing to evolve. It was observed and noted by multiple team members during the first year that roles were unclear and that there was a lack of coordination of tasks and services. During the second year, team members worked to develop better coordination strategies and communication between all agencies, though this is an ongoing struggle for the program.
- In addition to staffing meetings, separate clinical staffings are held every other week to assist in the coordination of services provided by the CAM grant. During one of the two meetings per month, representatives from CC, CHS, DSHS, CASA and Lifeline Connections meet and discuss clinical needs of participants and coordinate services. In the second of these two meeting each month, one of the participants is called in to

meet with this same group, with the intention of discussing their own treatment plan. Observations of these meetings during the first year indicated that the structure is still undefined and that often these meetings were not effectively focused on the intended issues. Team member feedback during the second year indicates that while these meetings have improved and are now better structured and are more effective than in Year 1, there are still improvements that can be made. In order to reduce the burden on all five caseworkers, one-third of all participants are discussed each month and only the caseworker(s) responsible for those clients need attend. In this way, all clients are discussed once every three months in these meetings, at the very least. However, the list of clients discussed each month is often finalized late and caseworkers are not always given ample time to prepare. Due to the timeliness of these meetings, services are often provided for months before a client is actually staffed at a clinical staffing meeting and therefore services are not always coordinated. In addition, as this meeting is the venue where results from the neuropsych exam are discussed in the most detail, services do not always follow from the neuropsych, as originally intended. However agencies do adjust their services, as appropriate, once results are shared.

- In an effort to further open communication and coordinate services, CC and CHS originally planned to meet outside of regularly staffing and clinical meetings. However, logistics and scheduling made meeting in person difficult. Instead, email and phone conversation has increased and communication between agencies is much better than during the implementation phase.
- DSHS caseworkers make home visits and are primarily responsible for case management. However, both CC and CHS workers are heavily involved with CAM participants and influence case management decisions. Team members reported, during the first year, a lack of clarity around who decides which services are appropriate and/or required for program compliance, especially for CAM services. Case management decision making was unclear and the existing system lead to confusion among team members and participants. Successes have been made, primarily through discussions and trainings held during the monthly stakeholder and executive meetings, in the areas of communication and role clarity, which have alleviated much of this Year 1 issue. From observations and reports from team members it is evident that staffing meetings are more effective and decisions around case management are more streamlined during Year 2.
- Observation indicated that the team presents a united front in the courtroom and that DSHS caseworkers, CASA representatives, treatment representatives, CC and CHS representatives, and the coordinator participate, when appropriate, during court sessions.
- As described earlier, for the CAM grant, an Executive Committee and a Stakeholder Committee have been implemented. Each committee meets on alternating months. The Executive Committee includes the family treatment court coordinator, the judge, the CAM grant project director, the CAM grant service coordinator, the FTC prosecuting attorney, the DSHS supervisor, representatives from the service agencies, and a CASA representative. Representatives from the various agencies are intended to have decision making authority for their various agencies. The Stakeholder Committee includes all



members from the executive committee in addition to the parents' attorney, representatives from the substance abuse treatment facility and additional members from the service agencies (Children's Center and Children's Home Society).

- Although the team members from each of the new CAM specific services are included in meetings with the rest of the drug court staff, from observations and interviews with staff, there appeared, during the first year, to be a separation between CAM staff and drug court staff, rather than the CAM staff being included as members of the drug court team. CAM staff had received little to no drug court specific training within the first year of grant implementation. During Year 2, most CAM staff received drug court specific training and efforts were made by the team to better integrate services. For example, the use of FTC and CAM was adjusted to reflect CAM as an included service of FTC, rather than a separate program.
- There are specific policy meetings that meet monthly including the judge, coordinator, attorneys, DSHS advisor and CASA representative. This meeting differs from CAM meetings in that it is mainly focused on drug court specific policy and process (e.g., sanctions and incentives), though all of its members are involved in CAM advisory meetings as well.
- Treatment and services providers that work directly with CCFTC participants include Lifeline Connections, Children's Home Society and The Children's Center. All of these providers use evidence based treatment modalities including Moral Reconation Therapy, Motivational Interviewing, Recovery Training and Self Help, Contingency Management and Healthy Choices. Parenting classes and services for the CAM grant include Triple P, Parents as Teachers, Parent Child Interaction therapy, Family Creating Change, Parent Trust, Circle of Security, and Seeing is Believing.
- DSHS caseworkers communicate with treatment providers weekly, by phone, email and through written progress reports. It was reported that information from the treatment provider is usually given to the court in a timely way. Team members voiced a desire to have regular, standard reports or summaries of all services completed by the service agencies, especially regarding CAM services. While official reports from both CAM agencies, CC and CHS, have not been developed, the neuropsych results are now regularly disseminated to team members. This began late in Year 2.
- DSHS caseworkers' caseloads vary and approached 30 children per caseworker in Year 1. At the end of Year 2, caseworkers were more likely to have 20-25 children. Any one caseworker may have up to half of their clients involved in the CCFTC. The team and DSHS have been working to reduce the number of clients on the caseworker's caseload and have more FTC dedicated caseloads. Specifically, the program is working to implement a program in 2013 that will eliminate movement of parents from FTC to non-FTC caseworkers. For example, once a client is referred to and enters the program, they will be moved to an FTC caseworker and remain there until the end of their dependency case. Additional caseworkers have been added to the program during Year 2 to address the caseload issue as well.

### Commendations

- **The team maintains regular email communication.** The CCFTC team members email each other regularly to share participant updates (using ID numbers to maintain confidentiality) including treatment updates, placement issues and noncompliant behaviors. Research has demonstrated that drug courts that share information among team members through email had better outcomes (including reduced recidivism and lower costs) than drug courts that did not use email (Carey et al., 2012).
- **Team meetings are well attended by treatment representatives, the drug court coordinators, case managers and the judge.** The CCFTC team makes an effort to include all team members in staffing meetings. Drug courts that include all team members at staffing meetings had 50% greater reductions in recidivism than courts that do not include all team members (Carey et al., 2012).
- **Court sessions are well attended by treatment representatives, the drug court coordinator, and case managers.** Team members who attend staffing regularly stay for the entirety of court sessions. Representatives from all treatment and service agencies, include Lifeline Connections, CASA, Children's Center and Children's Home Society, stay for court sessions. Drug courts that have all team members in attendance at court appearances had significantly better outcomes (lower recidivism and higher cost savings) (Carey et al., 2012).
- **Stakeholders have worked to improve communications and role clarity.** Program stakeholders recognize the importance of regular communication as well as clarity in roles and decision making authority. Although this program has struggled with these issues, this would be true in any group that has a variety of very different perspectives coming together around a common goal and the stakeholders continue to work to improve.

### Recommendations

- **Continue to discuss and clarify roles and responsibilities for all team members.** With the addition of the CAM services and the two new agencies to the team, there is more room for disagreement about case plans, treatment management and required services. Multiple team members voiced concerns about roles and decision making. The program should discuss in more detail, possibly during a stakeholder meeting, the roles and responsibilities of each partner agency and the representatives from those agencies. In addition, the team should discuss how CAM staff can be trained in the drug court model, including gaining an understanding of each of the other team roles and becoming fully integrated into the drug court team.
  - **Year 2 Update:** After Year 1's initial recommendation discussion, the program made concerted efforts to share information across agencies, provide cross training at monthly committee meetings, and define roles of all team members. Increased communication along with better understanding of each agency has drastically improved the clarity of roles and the overall interactions between team members in Year 2.

- **Create a template for progress reports from service providers.** For Lifeline Connections, Children’s Home Society, and Children’s Center the team should review current progress reports and ensure that all relevant and useful information from each agency has a place on the report form. For example, multiple team members mentioned the need for a written summary of the neuropsych exam. As services are provided, the multiple agencies need to ensure that all team members are aware of a) what was provided, b) when it was provided and c) the participant’s outcome. Written reports allow team members to be informed in a timely way and cut down on meeting time. This could also help streamline the biweekly clinical staffing meetings, because all parties could be prepared in advance.
  - **Year 2 Update:** CC and CHS do not provide a standard report of services including scheduled, completed and missed appointments, which caseworkers have noted would be helpful. CHS does provide monthly reports of services rendered and both agencies communicate verbally at staffing meetings. All agencies communicate over the phone as well. Neuropsychs and how to disseminate the results were discussed at length throughout Year 2. By the end of Year 2, CC begun disseminating neuropsych reports to all team members on a regular basis in a consistent format. Timeliness is still a factor and most services are still not informed by the results of the neuropsych, as results come out often months after participants begin the program and start receiving services. We recommend that the team discuss how neuropsych reports can be used to inform and make decisions about other services being provided.
- **Provide summaries of clinical staffing to team members.** The clinical staffing meetings are currently the only time where the results from neuropsychs are discussed in detail. Since not all team members attend this meeting, it would be useful to create a summary to disseminate to all team members.
  - **Year 2 Update:** While official summaries are not provided, this information is shared with other team members during regular FTC staffing. Neuropsychs are also shared with all team members and agencies.

## **KEY COMPONENT #2: USING A NON-ADVERSARIAL APPROACH, PROSECUTION AND DEFENSE COUNSEL PROMOTE PUBLIC SAFETY WHILE PROTECTING PARTICIPANTS’ DUE PROCESS RIGHTS.**

This component is concerned with the balance of three important areas. The first is the nature of the relationship between the prosecutor (or the child welfare attorney) and defense/family counsel in drug court. Unlike traditional case processing, drug court case processing favors a collaborative approach. The second focus area is that family drug court programs remain responsible for promoting public, and especially child, safety. The third focus area is the protection of the participants’ due process rights and – in the case of FTCs – the best interest of the child. CFF Recommendations explicitly recognize that the needs of both the parents (#6) and the child (#7) must be addressed in a family drug court.

### National Research

Drug Court research by Carey et al. (2008, 2012) and Carey and Waller (2011) found that participation by the prosecution and parents' attorneys in team meetings and at drug court hearings had a positive effect on graduation rate and on recidivism costs. In addition, courts that included non-drug charges as eligible for participation also showed lower recidivism costs. Finally, courts that imposed the original sentence instead of determining the sentence when participants were terminated had lower recidivism costs (Carey et al., 2008).

Although FTCs are typically not criminal courts, some FTCs, including the Clark County program, do include parents with criminal charges. Further, the reason parents are in a FTC is because of their illicit drug use, which is a criminal activity and requires the purchase of illicit drugs, another criminal activity.

### CCFTC Process

- The parents' attorney, DSHS caseworkers and CASA representative (who represents the child) always attend family drug court team meetings and court sessions. Due to lack of funding, the assistant attorney general attends once per month, and more when possible.
- The assistant attorney generals and parents' attorneys may identify and refer potential family drug court participants.
- Both attorneys are non rotating positions, though individuals in those positions have changed due to resource issues and reassignment in recent years. The assistant attorney general has changed frequently since the CAM award with the current AGG starting in March 2012. The current parents' attorney has been on the team for just over 2 years.
- DSHS works closely with team members to monitor caseloads and takes a non-adversarial approach in team meetings and during court.

### Commendations

- **The CCFTC has a dedicated assistant attorney general and parents' attorney assigned to the program.** Best practices research indicates that this results in more positive participant outcomes including lower recidivism and increased cost savings (Carey et al., 2008). The program is encouraged to keep attorneys as long as possible. It is recommended that this position rotate only when necessary and ideally no more frequently than every 2 years. Less rotation will foster a more consistent team and reduce cost burden.
- **The parents' attorney and assistance attorney general are collaborative.** During observations, the AAG and parents' attorney demonstrated a collaborative approach in team meetings and during court. The observed AAG is no longer with the program and the current AAG has not been observed.

### Recommendation

- **Work with the AG's office to obtain a dedicated AAG for at least 2 years.** The AAG role should not be revolving and the AAG should be strongly encouraged to consistently attend staffings and court sessions. Drug court programs that included the prosecutor at

staffings and at court sessions had significantly higher cost savings. Further, we recommend having a dedicated attorney who is interested in and supportive of the drug court concept. The AAG should be trained in the drug court model and the prosecuting attorney's role in drug court. Because continuity in team roles strengthens relationships, and consequently team functioning, the program should work to maximize tenures to the extent feasible. All team members should be well integrated and have a stake in the program goals. Drug court training early on in the members' tenure will help ensure understanding and acceptance of the non-traditional roles that distinguish drug courts from usual court processing.

- **Year 2 Update:** Due to the works towards a unified docket (discussed in greater detail under Key Component #6 below), both the OPDs and the AG's office have been included in decisions around the FTC docket. This work and education has led to greater buy-in by partners, particularly in the attorneys' offices. The unified docket included the requirement that both attorneys be present at court for dependency case issues, which will occur during FTC status review hearings.

### **KEY COMPONENT #3: ELIGIBLE PARTICIPANTS ARE IDENTIFIED EARLY AND PROMPTLY PLACED IN THE DRUG COURT PROGRAM.**

The focus of this key component is on the development and effectiveness of the eligibility criteria and referral process. Different drug courts allow different types of criminal or child welfare histories. Some drug courts also include other criteria such as requiring that participants admit to a drug problem or other "suitability" requirements that the team uses to determine whether they believe specific individuals will benefit from and do well in the program. Drug courts should have clearly defined eligibility criteria. It is advisable to have these criteria written and provided to the individuals who do the referring so that appropriate individuals who fit the court's target population are referred. Drug courts also differ in how they determine if a client meets these criteria. While drug courts are always targeting clients with a substance use problem, the drug court may or may not use a substance abuse screening instrument to determine eligibility. The same may apply to mental health screens. A screening process that includes more than just an examination of legal eligibility may take more time but may also result in more accurate identification of individuals who are appropriate for the services provided by the drug court. CFF Recommendation #5 also highlights the need to quickly identify and place participants and children in services.

Related to the eligibility process is how long it takes a drug court participant to move through the system from arrest (or child welfare petition) to referral to drug court entry. The goal is to implement an expedient process. The amount of time that passes between arrest/child welfare petition to referral and referral to drug court entry, the key staff involved in the referral process, and whether there is a central agency responsible for treatment intake are all factors that impact the expediency of program entry.

## National Research

Carey et al. (2008) found that courts that accepted pre-plea offenders and included misdemeanors as well as felonies had both lower investment and outcome costs. Courts that accepted additional, non-drug- charges (such as theft and forgery) also had lower costs due to reduced recidivism, though their investment costs in the program were higher.

Those courts that expected 50 days or less from arrest to drug court entry had higher savings than those courts that had a longer time period between arrest and entry (Carey et al., 2012). Further, reducing time between arrest (or other precipitating incident) and the first treatment session has been shown to significantly decrease substance use. Donovan, Padin-Rivera, and Kowaliw (2001) found that in reducing the time to entry approximately 70% of clients entered treatment, and of those that entered 70% completed their assigned treatment. Those who entered treatment showed significant reductions in substance use and improved psychosocial function.

Other research found that drug courts that included a screen for and excluded participants who were found unsuitable had the same outcomes (e.g., the same graduation rates) as drug courts that did not screen for suitability and did not exclude individuals based on suitability (Carey & Perkins, 2008). This indicates that screening participants for suitability does not improve participant outcomes.

## CCFTC Process

- Participants are referred by judges, assistant attorney generals, defense attorneys, probation, DSHS case workers, the public (family members, significant others, etc.), potential participants, and CASA or attorney guardians ad litem.
- There were originally, during Year 1, three caseworkers from Clark County DSHS who provide case plan supervision for family treatment court participants. The number has increased to five during Year 2 to account for additional participants. These caseworkers are part of a specialized unit dedicated to the program, though other case workers can refer to the program and the dedicated caseworkers do have clients who are not in the program as well. The goal with the unified docket and noncompliance docket will be that all caseworkers in the specialized unit will only have FTC participants in the future.
- Participants can be referred from multiple sources. Attorneys and social workers are the most likely referral points. Once a potential participant is identified, one of the FTC caseworkers will meet with the existing caseworker for the family and talk about eligibility. Clients will attend a court session and then meet with the coordinator and a social worker to go over orientation, and talk about whether or not they would like to enter the program. If deemed eligible and the client is interested, the team will discuss and determine if the client will enter the program.
- The specific target population for the CCFTC consists of substance abusing parents in the dependency system that wish to regain custody of their children.

- Child welfare allegations that are eligible for the program include: neglect, endangerment, abandonment, physical abuse, and mental abuse. Sexual abuse is not eligible.
- Prospective participants must be amenable to alcohol and drug treatment to be eligible for the program. The CCFTC program eligibility requirements are written and all agencies or individuals who can make referrals are given a copy of the eligibility requirements.
- Team members estimate that methamphetamine is the number one substance used. Opiates/heroin, marijuana, prescription drugs and alcohol follow respectively. Most participants are poly-substance users, according to team members.
- The CCFTC accepts those who have current and/or prior felonies, who have no drug-related charges, who have current violence or sales charges (on a case by case basis), and those who have prior violence convictions. The program does not exclude potential participants who are dual-diagnosis but without serious mental health issues. The program does, however, exclude those with serious mental health issues or who are using prescription opiates for pain management, or those with sexual abuse charges. In addition, the CCFTC will not accept those who are on narcotic replacement therapy, who are using suboxone, or who are currently using benzodiazepines, in the program.
- CCFTC does not assess participants for risk or “suitability,” such as attitude and readiness-for-treatment. Once placed in the program, a full substance abuse treatment assessment is performed on participants to determine level of care. Lifeline Connections uses the Global Appraisal of Individual Need (GAIN) assessment.
- The CCFTC assesses participants to determine whether they are substance dependent or substance abusers. The program accepts both participants who are substance dependent and substance abusers into their program.
- Participants are screened for co-occurring mental disorders and for suicidal ideation. Team members felt that participants presenting with mental health issues were being identified and treated.
- The estimated time between filing of a complaint and referral to the family treatment court program varies. However, the time from the initial filing to the referral to program is typically 15 to 30 days. The average time from referral to program entry, including a change in social worker, if necessary, is also 15 to 30 days, making the total time from complaint filing to program entry anywhere from one to two months.
- Not all social workers are currently referring participants to the CCFTC. Efforts have been made during years 1 and 2 to solicit more support from other divisions of DSHS so that more units will refer to the program. At one point, referrals (2 per unit) was enforced department wide, however that process had negative repercussions and did not last more than a year. There has historically been a perception that clients would be “moved back and forth” between social workers too frequently and that the program was selecting the easy cases. Work towards the unified docket and the noncompliance docket have led to positive support by many divisions in DSHS and more referrals have resulted.

- The CCFTC capacity is 25 participants. The number of CAM participants is higher as it includes additional adults involved in the family (partners, foster care parents, etc.) who may or may not have a dependency case open. As of December 2012, 19 clients were active in FTC.
- The program has met participation goals for both years 1 and 2 of the CAM grant. Discussion about who is included in the CAM numbers (as opposed to official FTC clients) has been a debate much of Year 2. The team currently agrees that adults and children who received services (mental health, parenting classes, etc.) should be counted as grant recipients. In order to maintain baseline information on all participants, adults and children included in numbers reported to the cross-site evaluation must receive a neuropsych assessment.
- Entry into the CCFTC program does not automatically enter participants into CAM services. CAM services are available to participants who have been affected by methamphetamine usage. This means the CCFTC participant must have a history of methamphetamine use or that the child has an adult in his or her life that has a history of methamphetamine use (spouse/partner/parent/etc. of FTC participant). All participants since CAM implementation have qualified for CAM services.
- Once determined eligible for CAM services, participants (and their family unit) receive a North Carolina Family Assessment Scale (NCFAS). Neuropsychs are administered to adults and children as soon as possible afterward but referral to services (mental health therapy, parenting services, etc.) officially occurs after the NCFAS. The NCFAS and neuropsych exams are both performed at Children's Center. In addition, the Children's Center administers the Ages and Stages Questionnaire (ASQ-3), the Ages and Stages–Social and Emotional (ASQ-SE) and the Child Behavior Checklist (CBCL), which were originally required for the CAM grant. All assessments, except the neuropsych, are administered at entry and exit.
- Parents and children who are eligible for and agree to participate in the additional CAM services are assessed with a neuropsych exam. Neuropsych exams are administered as soon as possible after a participant agrees to CAM participation which may be weeks or months after initial program entry. The results of the neuropsych exam are discussed in detail at CAM clinical staffing meetings and results are disseminated to all agencies. Often the results are discussed and/or disseminated after other services have begun and therefore the intended model (services based on neuropsych results) has not been implemented as intended. Services are modified and appropriately adapted using results from the neuropsych, once they are made available to all agencies.
- As discussed above, under Key Component #1, CAM clinical staffing meetings are intended to aid the coordination of services provided to participants. Due to the frequency of these meetings, participants are discussed at least once every 3 months. Since results of the neuropsych are only discussed in detail at these meetings, services are not tailored to participants based on the results of the neuropsych, as originally intended. Services are often provided to participants prior to neuropsych completion and modified, as needed, after results have been disseminated. Additional services identified by the neuropsych are addressed and participants are now receiving services



that they may not have previously received in addition to services routinely offered to all participants.

### Commendations

- **The neuropsychological exam increases the program's ability to assess participants and determine service needs.** The program is commended for including this service. The neuropsych allows not only the substance abuse treatment provider with valuable knowledge about participants but also allows parenting classes and skills' training to be tailored to meet individual needs.
  - **Year 2 Update:** While the neuropsychs are a valuable tool, the timing of when they are actually administered coupled with the lag of when results are disseminated has prevented immediate determination of needed services. Instead, clients receive services as they would normally, and only after neuropsychs are completed and discussed by the team (sometimes many months after joining the program) are agencies able to tailor their responses. The team should continue to work towards a more timely dissemination of neuropsych results and implementation of recommendations occurring from the assessment.
- **The program allows participants with prior violence charges, on a case by case basis.** Research has shown that drug courts are best suited to high-risk, high-need participants, including participants with past violence. When programs that allow past violence charges are compared to those who do not allow past violence, there is no difference in outcomes, indicating that past violence does not affect the ability of the participant to succeed. In addition, drug courts have clearly shown to reduce recidivism and victimization, making these programs the superior option for protecting public safety.

### Recommendations

- **The team should review and clarify the process for current FTC participants to receive additional CAM services.** Focus group participants and team members alike noted the slow intake process of CAM participants. The team should review each step of the process and determine if there are any ways to make any of the steps more efficient so that parents get into services they need more swiftly. In addition to making the intake process more expedited and efficient, the team needs to be clear what the intake process entails, especially to potential participants. Particularly discouraging is the current misunderstanding among parents around what a neuropsych assessment is and why it is being administered. Parents, by and large, were wary of this evaluation while almost all team members acknowledged the benefits of having this assessment available.
  - *Focus group participants noted the difficult and lengthy process to get started in CAM services. When discussing the various appointments and assessments necessary, one participant said simply, "They made me jump through hoops."*
  - **Year 2 Update:** The program has worked diligently since CAM implementation to make entry into FTC and additional CAM services as seamless as possible. The program has streamlined its orientation process and information is given to clients in a consistent format. Work as also been done around better incorporating CAM

services, including renaming them “Enhanced Services”—a change that has eliminated the perceived stigma that was attached to “CAM” services.

- **Provide additional orientation services to incoming participants.** Staff and focus group participants voiced frustration with the lack of clarity around program requirements during intake. Since the entry procedures, specifically regarding additional CAM protocols, can be confusing and overwhelming, it would be beneficial for participants to receive additional support during this difficult process. Providing materials for scheduling in addition to regular opportunities to ask questions and learn about how the program works will assist participants to succeed in the program.
  - *There was particular concern in the focus group around neuropsych exams being administered to children as well as requiring the children to see a mental health therapist. Parents demonstrated a lack of knowledge about the purpose and function of the neuropsych exam, as evidenced by the following comments:*
    - *One parent noted, “[The children] just got taken from their parents, how can they judge our kids and diagnose them with disorders when they’re traumatized. It’s not a good time to test and evaluate them.”*
    - *Another parent felt that the neuropsych and subsequent evaluations were being used against reunification, “Some kids have emotional and behavior issues and that’s why they’re not going home, it sucks that they can diagnose our kids and then use it against [us].”*
  - **Year 2 Update—Successfully Implemented:** An orientation process for the CAM services, labeled “Enhanced Services” in Year 2 was put in place and has alleviated much of this problem which occurred early on in the implementation process.
- **Review the eligibility and entry process to remove barriers to entry to the CCFTC.** The family treatment court was not operating at capacity and was not originally on track to be meet CAM grant goals for Year 2. By the end of Year 2, new determinations regarding who should be counted (specifically, any adult or child receiving services, with efforts to provide each with a neuropsych) helped reduce this problem.
  - *Focus group participants indicated that it took a long time to get in. Some reported that not all agencies involved in the dependency process were on board with the program, making it difficult to get into the program. One noted, “My lawyer was very receptive [to the program] but my first CPS worker was not.”*
    - *Most parents believed that the neuropsych testing was wrongly diagnosing their children, “they should meet with the kids more than once, get to know the kid, if they’re going to diagnose them.”*
  - **Year 2 Update:** The program has worked on both the unified docket and the noncompliance docket, both beginning in Year 3 (January 2013). These new processes have bolstered the referral stream and will likely remove some barriers to entry into the program. In addition, defining who is being served, specifically by the CAM grant, is an ongoing process; though one that has had recent successes.

#### **KEY COMPONENT #4: DRUG COURTS PROVIDE ACCESS TO A CONTINUUM OF ALCOHOL, DRUG AND OTHER TREATMENT AND REHABILITATION SERVICES.**

The focus of this key component is on the drug court's ability to provide participants with a range of treatment services appropriate to participant needs. Success under this component is highly dependent on success under the first component (i.e., ability to integrate treatment services within the program). Compliance with Key Component #4 requires having a range of treatment modalities or types of service available. However, drug courts must still decide about how wide a range of services to provide, which services are important for their target population and the use of evidence-based treatment. The treatment needs of parents are addressed in the 10KC; however, the needs of the children of substance-involved parents must also be met. CFF Recommendation #7 explicitly states that the needs of the child (#7) must be addressed in a family drug court.

##### National Research

Programs that have requirements for the frequency of group and individual treatment sessions (e.g., group sessions 3 times per week and individual sessions 1 time per week) have lower investment costs (Carey et al., 2005), substantially higher graduation rates, and improved recidivism costs (Carey et al., 2008). Clear requirements of this type may make compliance with program goals easier for program participants and also may make it easier for program staff to determine if participants have been compliant. They also ensure that participants are receiving the optimal dosage of treatment determined by the program as being associated with future success.

A variety of treatment approaches such as ones focusing on individual needs, motivational approaches to engaging clients, cognitive-behavioral therapy approaches, self-help groups, and/or appropriate use of pharmacological treatments can all provide benefits to participants in facilitating positive change and abstinence from alcohol and drug use. Multi-systemic treatment approaches work best because multiple life domains, issues, and challenges are addressed together, using existing resources, skills, and supports available to the participant. It is also crucial to provide aftercare services to help transition a person from the structure and support of the treatment environment back to her/his natural environment (Miller, Wilbourne, & Hettema, 2003).

The American University National Drug Court Survey (Cooper, 2000) showed that most drug courts have a single treatment provider agency. NPC, in a study of 69 drug courts around the U.S. (Carey et al., 2012) found that drug court programs with one or two treatment agencies had significantly better outcomes (lower recidivism and higher cost savings) than programs with more treatment agencies.

Discharge and transitional services planning is a core element of substance abuse treatment (SAMHSA/CSAT, 1994). According to Lurigio (2000), "The longer drug-abusing offenders remain

in treatment and the greater the continuity of care following treatment, the greater their chance for success.”

### CCFTC Process

- A full substance abuse treatment assessment is performed on CCFTC participants to determine level of care. The treatment provider, Lifeline Connections, uses the GAIN assessment.
- Lifeline Connections provides treatment for the majority of the CCFTC participants. Participants are often receiving treatment as part of their case plan in the dependency process prior to entering CCFTC and may choose to stay with their own provider. The program often also refers to two other treatment agencies that (Community Services Northwest and Columbia River Mental Health). All treatment agencies provide written progress reports to the Lifeline Connections representative who is part of the CCFTC team. Providers offer outpatient and intensive outpatient services including individual and group treatment (required for all participants). Residential, detoxification and co-occurring services are available at Lifeline Connections as well as the Drug Abuse Prevention Center (where women are allowed to bring their children).
- Lifelines made available a codependency group in Year 1, a much needed service for the participant population. However this was only one avenue to address team members expressed need for more services related to domestic violence, as many participants experience this as a barrier to reunification.
- Recovery training and self help as well as contingency management are evidence based practices required for all participants while motivational interviewing is required for some participants.
- There were three DSHS caseworkers in Year 1. As of Year 2 there are now five caseworkers who provide case plan supervision to CCFTC participants. Each caseworker has a caseload of around 30 children, with roughly one-third being part of the CCFTC program.
- The CCFTC program originally (in Year 1 and most of Year 2) took approximately 14 months to complete and consisted of three phases and includes a phase when participants learn relapse prevention. At the end of Year 2, an additional phase (aftercare or Phase IV) was added for participants who still have open dependency cases but who would have been considered “successful graduates” of the program previously. In efforts to align the program with the dependency case and create a unified docket, this additional phase is a way to keep clients engaged throughout the length of their case. The graduation after Phase IV, will now be congruent with a terminated dependency case (whether reunified or otherwise).
- In order to graduate, participants are required to have 120 days sobriety (measured by negative drug tests), pay \$100 (or receive the equivalent credit) in court fees, have stable housing and legal employment.
- The minimum length for the first program phase is 8 weeks. During this phase, participants are expected to attend group treatment 3 or more times per week and individual treatment sessions as needed based on the level of care determined by the

treatment provider. Participants are also required to attend self-help group meetings during Phase I.

- The minimum length of the final program phase is 16 weeks. During Phase III, participants are required to attend group and individual treatment as needed according to their treatment provider. Participants are required to attend self-help groups during Phase III.
- The aftercare phase, added late in Year 2, is now the final phase of the program and lasts as long as needed before dependency termination. During aftercare, clients attend court every other month. Treatment and/or any other program or dependency requirements are specific to each participant.
- Job training/vocational program, employment assistance, GED/education assistance, health care, dental care, prescription drugs for substance dependence and transportation are services offered by this program but not required. Health education is required for all participants while family relations counseling and housing assistance are required for some.
- The CCFTC, after implementing the CAM grant is able to provide specific services around parenting as well as services for the children. The Children's Center provides neuropsych exams for all adults and children involved in CAM (thus far, all participants in FTC have been eligible for CAM). Mental health therapy is also available. The Children's Home Society provides a variety of evidence based parenting classes, groups and one-on-one sessions. Access to these services is limited to CAM participants though no participant has yet been considered ineligible for CAM.

### Commendations

- **The program has an array of treatment and wraparound services offered and uses evidence based programming.** The CCFTC is commended for offering a breadth of diverse and specialized services to program participants, including parenting classes, relapse prevention and health care.
  - *Participants were very positive about the services offered by CHS. Triple P and other parenting skill building was noted by multiple focus group participants as being particular helpful.*
- **Coordinates substance abuse treatment through a single organization.** A single alcohol and drug treatment providing agency is related to better program outcomes. The CCFTC is commended for following best practices in this area by having an organization that coordinates an array of treatment services.
- **CCFTC graduation requirements include stable housing and a legal source of income.** Programs that required participants to have stable housing reported lower recidivism than programs that did not and programs that required employment resulted in 83% higher cost savings (Carey et al., 2012).

### Recommendations

- **Clarify the CAM service requirements for the participants.** Focus group participants were specific about which services they felt were beneficial (Triple P) and which were not (the mental health therapy for children). There was evident confusion among the

parents on what was required and what was optional. The team should discuss in greater detail what services are required for all CAM participants and which are optional. In addition, if services are recommended for clients, the team needs to decide who has the authority to make these recommendations required and if they are not required, how that information is made clear to participants. In particular, the explanation of the neuropsych exam and the need for mental health services should be communicated clearly to the parents to help create buy-in from the parents and to ease discomfort with the stigma associated with mental health services.

- *By and large, most focus group participants involved in CAM wanted the process changed. For example, there was a group consensus that participants had no say over what services they could and could not receive.*
  - *One parent stated, “You want to do [the parenting classes], but you don’t want your kids to [be in therapy].”*
  - *Feeling overwhelmed, one participant expressed that, “we’re going to look like bad parents if we try to pull out of the CAM grant because we’re denying our child free services.”*
  - *Parents in the focus group were unhappy with the mental health services being offered through the CAM grant.*
- **Year 2 Update:** As discussed above under Key Component #3, the program put much effort into this area. The orientation process has been streamlined and the marketing of the additional services, now labeled “Enhanced Services” have all worked towards making the process easier and more appealing to participants.
- **Institute an aftercare/continuing care phase.** The CCFTC program should consider requiring aftercare in the last phase of the program to support participants in their transition to the community and off of supervision. This aftercare phase works as an extension of a relapse prevention plan: it includes a plan for avoiding triggers, coping with triggers and developing alternative ATOD-free activities that will help support sustained recovery. Having such a plan in place in the last phase of the program will enhance participants’ ability to maintain the behavioral changes they have accomplished through participation in the CCFTC. Research shows that supervised aftercare results in higher success rates for preventing relapse than unsupervised aftercare plans (e.g., Siegal & Rapp, 2002). Program participants should be asked to write an aftercare and relapse prevention plan that both the participant and the team and judge have a copy of. It can be written with their case manager (or whoever is most appropriate) at the beginning of their last phase in the program and then participants can start “living” the plan in their last phase. The judge can ask about specific parts of the plan at court sessions to see whether the participant is able to successfully follow the plan. This allows participants to get practice doing their aftercare plan (the behaviors and activities they will continue to adhere to throughout their lives) while they still have the support of the program and also allows the team and participants to rethink the plan if they are unable to successfully follow it. Aftercare is a clinical best practice, supporting individuals in their transition to a drug-free lifestyle.

- **Year 2 Update—Successfully Implemented:** The program successfully drafted a plan for an aftercare phase. This process slowly became incorporated in Year 2, as optional for existing participants and required for new participants.
- **Examine DSHS social worker caseload to ensure that caseload sizes are appropriate to the level of supervision.** Caseload standards for intense supervision are no more than 20 clients (Burrell, 2006) in order to meet their multiple case management needs and address their various risk factors. Intensive supervision includes weekly meetings with a caseworker. The drug court program should attempt to stay as close to these guidelines as possible in order to achieve and maintain the structured nature of this program. While the program does spread cases management to the treatment and children services organizations as well, most team members reported that the social workers had too high of a caseload.
  - **Year 2 Update:** The program has added additional caseworkers in Year 2 to address this issue. Though caseload is a problem for the entire DSHS department and not just the specialized FTC unit. Efforts around the unified docket and the noncompliance docket are both contributing towards alleviating this problem.
- **Strive for social workers to have dedicated CCFTC caseloads.** While it may not be possible to have only CCFTC participant caseloads for each of the three social workers on the team, it would benefit the program greatly to work towards a goal of having social workers with a special focus on CCFTC participants. Because the CCFTC program requirements are more intensive and because parents in CCFTC are a specialized population, it may be more efficient for social workers to avoid having to split their attention among differing populations and for the social workers to be specifically trained in the drug court model and the CCFTC population in particular.
  - **Year 2 Update:** In January 2013, during Year 3, the unified docket and noncompliance docket took effect. Both will lead to caseloads that will eventually be dedicated to FTC clients.
- **Encourage the formation of an alumni group.** The CCFTC had an alumni group at one time, but participation has waned in recent years. Some courts have used alumni support groups as a cost effective tool in aftercare planning and members of the alumni group can be used as mentors for new participants. Participation in this group can be required as part of the final phase of drug court to encourage participants to prepare for life after they leave drug court. This is a great venue for family-friendly, substance-free social events. Focus group participants expressed their desire for the formation of an alumni group. The team is encouraged to consider implementation of an alumni group as one of the new coordinator's job duties.
  - **Year 2 Update:** Efforts towards an alumni group have stagnated as clients have not shown interest. However, much discussion around peer mentoring, both by the program and past participants has been fruitful and it is likely that the program will have a peer mentoring program in place by the end of Year 3.

**KEY COMPONENT #5: ABSTINENCE IS MONITORED BY FREQUENT ALCOHOL AND OTHER DRUG TESTING.**

The focus of this key component is the use of alcohol and other drug testing as a part of the drug court or DWI Court program supervision practices. Drug testing is important both for supervision by the court and the team, for participant accountability and it is an essential practice in participants' treatment. This component encourages frequent testing but does not define the term "frequent" so drug courts develop their own guidelines on the number of tests required. Related to this component, and specifically outlined in the principle, is that the drug courts must assign responsibility for testing and community supervision to its various partners, and establish protocols for electronic monitoring, drug test collection, and communication about participant accountability.

The drugs included in abstinence monitoring detection should be a reflection of the substances being abused/used within the community or jurisdiction of the court. The drug testing should be sufficiently comprehensive to ensure adequate coverage of the major abused drug classes (e.g., amphetamines, barbiturates, benzodiazepines, cannabinoids, cocaine, opiates and alcohol).

**National Research**

Research has demonstrated that outcomes are significantly more positive when detection of substance use is likely (Kilmer, Nicosia, Heaton, & Midgette, 2012; Marques, Jesus, Olea, Vairinhos, & Jacinto, 2014; Schuler, Griffin, Ramchand, Almirall, & McCaffrey, 2014) and also when participants receive incentives for abstinence and sanctions or treatment adjustments for positive test results (Hawken & Kleiman, 2009; Marlowe, Festinger, Foltz, Lee, & Patapis, 2005). Therefore, the success of drug courts depends, in part, on the reliable monitoring of substance use.

Participants are unlikely to disclose substance use accurately. Studies find that between 25% and 75% of participants in substance abuse treatment deny recent substance use when biological testing reveals a positive result (e.g., Auerbach, 2007; Harris, Griffin, McCaffrey, & Morral, 2008; Morral, McCaffrey, & Iguchi, 2000; Tassiopoulos et al., 2004). Accurate self-report is particularly low among individuals involved in the criminal justice system, most likely because they are likely to receive punishment for substance use (Harrison, 1997).

Research on drug courts in California and nationally (Carey et al., 2005, 2012) found that drug testing that occurs randomly, at least twice per week, is the most effective model. Because the metabolites of most drugs of abuse are detectable in urine for approximately two to four days, testing less frequently leaves an unacceptable time gap during which participants can abuse substances and evade detection, thus leading to significantly worse outcomes (Stitzer & Kellogg, 2008). In addition, drug test results that were returned to the program in 2 days or less



have been associated with greater cost savings and greater reductions in recidivism (Carey et al., 2012).

#### CCFTC Process

- Drug testing is performed at least 2 times per week in the first phase and is done on a random basis as well as for cause. Drug testing frequency decreases over the time in the program so that participants are tested every other week by the last phase. However, the drug testing is completely random throughout the length of the program.
- The program's drug testing is primarily performed by Lifeline Connections. However the court is also able to perform drug tests.
- Random drug testing is ensured by using a call in system with color assignments. It is policy that all UAs conducted are fully observed. During Year 2, the program started including testing on weekends, which was previously unavailable.
- Participants are drug tested through instant 12 panel urinalyses (UAs). Positive UAs are sent out to a lab to confirm positive results. Hair and breath tests are also available.
- Drug test results are obtained within 24 hours.

#### Commendations

- **Quick drug test turnaround time.** Research has shown that obtaining drug testing results within 48 hours of submission is associated with higher graduation rates and lower recidivism (Carey et al., 2008).
- **Participants are tested at least twice per week.** Research shows that drug courts that test at least twice times per week have better outcomes (Carey et al., 2008, 2012).
- **Drug testing is fully observed.** It is very important for the collection of urine for drug testing to be fully observed as it is easy for individuals to substitute urine from other individuals or otherwise alter their sample. Focus groups with drug court participants in multiple programs have resulted in many admissions of how participants can and do falsify their samples

#### Recommendation

- **Evaluate the frequency of drug testing in later phases.** National drug court researcher Doug Marlowe (2008) suggests that the frequency of drug testing be the last requirement that is ratcheted down as participants progress through program phases. As treatment sessions and court appearances are decreased, checking for drug use becomes increasingly important, to determine if the participant is doing well with more independence and less supervision. A common occurrence in drug court programs is participant relapse soon after moving from one phase to the next. This can be an important clue to let the team know that the participant was not ready for greater independence. The CCFTC should examine its timing of the decrease in the frequency of drug testing and ensure that it does not occur before other forms of supervision have been decreased successfully. Participants have appreciated having the drug tests as a way to demonstrate success to themselves and to the team.
  - **Year 2 Update:** The program has not worked towards increasing the frequency of drug testing during later phases of the program.

**KEY COMPONENT #6: A COORDINATED STRATEGY GOVERNS DRUG COURT RESPONSES TO PARTICIPANTS' COMPLIANCE.**

The focus of this component is on how the drug court team responds to client behavior during program participation, including how the team works together to determine an effective, coordinated, response. Drug courts have established a system of rewards, sanctions and treatment responses that determine the program's response to acts of both non-compliance and compliance with program requirements. This system may be informal and implemented on a case-by-case basis, or this may be a formal system applied evenly to all clients, or a combination of both. The key staff involved in decisions about the appropriate response to participant behavior varies across courts. Drug court team members may meet and decide on responses, or the magistrate may decide on the response in court. Drug court participants may (or may not) be informed of the details on this system of rewards, sanctions and other responses so their ability to anticipate a response from their team may vary significantly across programs.

**National Research**

Nationally, the judge generally makes the final decision regarding sanctions or rewards, based on input from the drug court team. Carey et al. (2008) found that for a program to have positive outcomes, it is not necessary for the judge to be the sole provider of sanctions. Allowing team members to dispense sanctions makes it more likely that sanctions occur in a timely manner, more immediately after the noncompliant behavior, though the entire team should be informed when a sanction occurs outside of court. Carey et al. (2012) showed that drug courts that responded to infractions immediately (particularly requiring the participant to attend court at the next possible session) had twice the cost savings.

In addition, all drug courts surveyed in the American University study confirmed they had established guidelines for their sanctions and rewards policies, and nearly two-thirds (64%) reported that their guidelines were written (Cooper, 2000). Research has found that courts that had their guidelines for team responses to participant behavior written and provided to the team had higher graduation rates and higher cost savings due to lower recidivism (Carey et al., 2008, 2011).

**CCFTC Process**

- The program staff indicates that the following are incentives for participants to enter and graduate from the program: increased likelihood of being reunified with child, increased access to services (especially the newly added CAM services), the possibility of preventing removal, increased contact with the judge, and more access to social workers.
  - *Focus group participants were not in agreement about whether the program made it more likely that the parents would reunify with their children than the normal dependency process. One participant noted, "Stay sanction free, do everything you*

- need to do and stay clean [and you'll get your kids back]" while another called the program "preplanned" meaning kids are returned at the same rate regardless of a parent's compliance or adherence to the program.*
- *Many team members indicated that the program does help parents get reunified with their children more often than the regular dependency process. Team members also, however, expressed frustration around the lack of continuity between FTC and regular dependence court. As the program is not directly tied to the dependency process, expectations and procedures are sometimes unclear.*
  - *Efforts have been made during Year 2 to unify the FTC process with the regular dependency docket. The unified docket is set to begin in January of 2013. Aspects of this shift include tying dependency requirements to FTC requirements, eliminating redundant during official dependency cases (held during the regular docket on Tuesdays), and creating more buy-in from involved agencies (i.e., CASA, AG's office and the OPD's).*
  - The Clark County Family Treatment Court has a variety of tangible and intangible rewards available for participants. The program staff indicated that rewards which seem particularly effective are increased visitations, gift cards, praise/applause and decreased fees. Other rewards include certificates, coins, family gifts (board games, kid's books, etc.), and cards. Witnessing graduation was also reported as a motivator for participants.
  - Rewards are provided by the judge during court sessions and awarded on a case-by-case basis, as well as in a standardized way for specific behaviors. It was reported that participants know what behaviors lead to rewards and are given examples of possible rewards in the participant handbook.
  - Examples of CCFTC responses to noncompliant participant behavior (both sanctions and treatment responses) are: writing essays, sit sanctions, community service, more frequent UAs, more frequent court hearings, returning to earlier phase requirements, increased treatment sessions, residential treatment, and more self-help meetings. The team reported that honesty essays are particularly effective sanctions for their participants.
  - The CCFTC does not use jail as a sanction, and jail is never used as an alternative for detox or residential when detox or residential treatment is not available. Jail was used in the past but was eliminated over 4 years ago in response to participant feedback.
  - The program staff reports that participants know which behaviors lead to sanctions. Participants are given a written list of the behaviors and possible sanctions.
  - Sanctions are discussed among the drug court team and decided as a group at staffing meetings. The team makes recommendations to the judge regarding sanctions, which are usually followed, though the judge has the ultimate authority. Team members are given a written list of the guidelines around court response to participant behavior.
  - Sanctions are imposed immediately after the noncompliant behavior, at the first court session after the non-compliant behavior, and may not be imposed outside of court by team members other than the judge.

- Clark County Family Treatment Court sanctions are sometimes imposed on a case-by-case basis and sometimes standardized, so that the same sanctions are provided for the same types of behaviors. Sanctions are graduated so that the severity increases with more frequent or more serious infractions.
- Behaviors that would prompt removing an individual from participation in the Clark County Family Treatment Court program are new arrests for trafficking or violent offenses, failure to appear in court with no excuse/multiple failures to appear, missing treatment sessions, continued use/ multiple positive drug tests, lack of progress in the program, and/or lack of progress in treatment. The program decides termination on a case by case basis and is more likely to wait for multiple transgressions before terminating.
  - *During Year 2, the team decided on a new path for noncompliant participants. Participants that in the past would be terminated (and then returned to their original caseworker) will no longer be officially terminated from the program. They will instead, as of Year 3 (January 2013), be moved to the monthly “non-compliance” docket where efforts will be made to continually re-engage them in the program. However, they will remain officially part of the program, as with the same caseworker (one of the FTC caseworkers) until their dependency case is terminated.*
- The judge, coordinator, prosecuting attorney, substance abuse treatment providers, and social workers have had training on the use of rewards and sanctions to modify behavior of drug court participants.
- In order to graduate, participants are required to have at least 120 days of continuous sobriety, paid or received credit for \$100 court fees, and have legal employment and stable housing.
- Graduation is held in court, during the first session of the month when all participants will be attending. Treats are provided.
- The program staff indicated that some Clark County Family Treatment Court team members have received training on strength-based philosophy and practices.

#### Commendation

- **The team focuses on rewards for participants who are doing well.** Incentives are key to shaping participant behavior, and it is important that the program find incentives that are meaningful to its participants.

#### Recommendation

- **Work towards aligning the CCFTC process with the dependency process.** The team should continue to explore ways they can have better communication and tie in with the family dependency case process. A facilitated discussion with the evaluation team and possibly with staff from other Family Treatment Court programs who have a combined process may be helpful.
  - **Year 2 Update—Successfully Implemented:** Much of the work during Year 2 by the team was towards a unified docket. Team members are commended for the thoughtful and tireless efforts put into this process. Multiple planning sessions and discussions occurred across agencies and many meetings were held with outside

parties to help obtain buy-in that lead to the successful implementation of a unified docket which began in January 2013.

**KEY COMPONENT #7: ONGOING JUDICIAL INTERACTION WITH EACH PARTICIPANT IS ESSENTIAL.**

The focus of this component is on the judge's role in drug court. The judge has an extremely important function in monitoring participant progress and using the court's authority to promote positive outcomes. While this component encourages ongoing interaction, courts must still decide specifically how to structure the judge's role. As part of addressing the needs of the participants (CFF Guideline #6), courts need to determine the appropriate amount of courtroom interaction between the participant and the judge, including the frequency of status review hearings, as well as how involved the judge is with the participant's case. Outside of the court sessions, depending on the program, the judge may or may not be involved in team discussions, progress reports and policy making. One of the key roles of the drug court judge is to provide the authority to ensure that appropriate treatment recommendations from trained treatment providers are followed.

The judge is the ultimate arbiter of factual controversies in the program, and makes the final decision concerning the imposition of incentives or sanctions that affect participants' legal status or personal liberty. The judge should make such determinations after giving due consideration to the expert input of other team members, and after discussing the matter in court with the participant or participant's legal representative.

National Research

The drug court judge is legally and ethically required to make the final decision regarding sanctions or rewards, based on expert and informed input from the drug court team including information gained from case management. All drug courts surveyed in an American University study reported that they had established guidelines for their sanctions and rewards policies, and nearly two-thirds (64%) reported that their guidelines were written (Cooper, 2000).

The Multisite Adult Drug Court Evaluation (MADCE), found significantly better outcomes for drug courts that had a written schedule of predictable sanctions that was shared with participants and staff members (Zweig et al., 2012). Another study found 72% greater cost savings for drug courts that shared their sanctioning regimen with all team members (Carey et al., 2008, 2012).

The MADCE results also suggest that drug courts should remind participants frequently about what is expected of them in the program and the likely consequences of success or failure (Zweig et al., 2012). Another study showed that when staff members in drug courts consistently reminded participants about their responsibilities in treatment and the consequences that would ensue from graduation or termination they had higher program retention rates (Young & Belenko, 2002).

It is important to avoid having the sanctions and incentives guidelines be overly structured. Two studies reported significantly better outcomes when the drug court team reserved discretion to modify scheduled consequence in light of the context in which the participant behavior occurred (Carey et al., 2012; Zweig et al., 2012).

Drug courts working with addicted offenders should adjust participants' treatment requirements in response to positive drug tests during the early phases of the program rather than imposing sanctions. Participants might, for example, require medication, residential treatment, or motivational-enhancement therapy to improve their commitment to abstinence (Chandler, Fletcher, & Volkow, 2009) and be unable to comply with program abstinence requirements early in the program.

Drug courts achieve significantly better outcomes when they focus more on providing incentives for positive behaviors than they do on sanctioning negative behavior. Incentives teach participants what positive behaviors they should continue to perform, while sanctions teach only what behaviors participants should stop doing. In the MADCE, significantly better outcomes were achieved by drug courts that offered higher and more consistent levels of praise and positive incentives from the judge (Zweig et al., 2012).

Drug courts have significantly better outcomes when they use jail sanctions sparingly (Carey, Fuller, Kissick, Taylor, & Zold-Kilbourn, 2008b; Hepburn & Harvey, 2007). Research indicates that jail sanctions produce diminishing, or even negative, returns after approximately three to six days (Carey et al., 2012; Hawken & Kleiman, 2009). Also, studies better outcomes in drug courts that exert leverage over their participants, meaning the participants can avoid a serious sentence or disposition if they complete the program successfully (Carey et al., 2012; Cissner et al., 2013; Goldkamp, White, & Robinson, 2001; Longshore et al., 2001; Mitchell, Wilson, Eggers, & MacKenzie, 2012).

Finally, drug courts that responded to infractions immediately, particularly by requiring participants to attend the next scheduled court session, had twice the cost savings and programs that required participants to pay fees and have a job or be in school at the time of graduation had significant cost savings compared to programs that did not (Carey et al., 2012).

#### CCFTC Process

- CCFTC participants are required to attend drug court sessions once per week in Phase I, with court attendance requirements reducing over the phases so that participants appear at least once per month by Phase III. The new Phase IV/aftercare, which began at the end of Year 2, requires participants to appear in court bimonthly. The new noncompliance docket, set to begin in January 2013, will require monthly attendance in court.
- Program staff reported that the average length of time of a court session is 60 minutes however observations indicated a range from 30 to 60 minutes, depending on the number of participants being seen. Observations of the court sessions ranged from 2 to

13 participants present who were reviewed, on average for 5 minutes each, though the range was from 4 to 15 minutes each.

- The family drug court judge is assigned to the court indefinitely with no fixed terms imposed. The current judge is the third since inception and joined in January 2011. The previous two judges both served terms of at least 2 years.
- There is currently not a dedicated backup judge.
- The CCFTC judge has attended official FTC training sessions and professional FTC related conferences.
- The CCFTC judge speaks directly to participants during court appearances, provides follow-through on warnings to participants, and follows the recommendations provided by the family treatment team. Observations by the evaluator during court appearances confirmed that the judge is caring yet firm with participants and participants are engaged and respectful during the drug court session. The judge actively listens to participants, offers advice and provides positive verbal reinforcement when appropriate.
- Participants must stay through the entire court session though many participants come and go throughout court. Often participants are meeting with team members to discuss other matters, follow up on previous appointments or confirm upcoming appointments. Participants are often called out of court due to the presence of their children.
- There were a number of young children and infants in the courtroom. Participants were primarily responsible for watching their children, though family members or other support were often present. Children, especially infants, often went up to the review with their parent. It was sometimes difficult to focus on what was happening between participants and the team and participants in the court were not always able to pay attention to the participant currently speaking with the judge.
- Childcare has been identified, during Year 2, as something the team would like to offer during court sessions. During Year 3, the program will provide childcare during court sessions at least during the first week of the month, when the most kids are often present.

### Commendations

- **The judge spends at least 3 minutes speaking to each participant.** The judge's demeanor is encouraging when appropriate and firm when needed. Best practices recommend spending at least 3 minutes with each participant. During observation, time spent speaking to participants averaged at least 3 minutes per participant.
  - *Participants in the focus group had positive feedback regarding the judge. Most felt she was fair and did a good job. Participants also felt that the judge was working towards reunification, "she likes to give more visits and [she likes] giving kids back."*
- **The judge requires participants to stay through the entire court hearing to take full advantage of the hearing as a learning experience for participants.** Because drug court hearings are a forum for educating all participants and impacting their behavior, it is commended that the court requires participants to stay for the entire hearing both to

observe consequences (both good and bad) and to learn how those who are doing well are able to succeed and make positive, healthy choices and changes in their lives.

- **Year 2 Update:** While participants are expected to stay for the entire session, many side conversations and issues with children occur during court. Not all participants are focused 100% of the time on the interaction occurring between the judge and the participant on the stand at any particular point in time. The program should consider limiting side conversations to before or after court. The program is already working towards remedying the distractions caused by children being present by providing childcare during court at least once monthly.
- **The judge is assigned indefinitely.** Programs that assign their judges indefinitely have a 35% higher reduction in recidivism (Carey et al., 2012). In addition, the CCFTC has been able to keep all of its judges for at least 2 years, preventing unnecessary upheaval for the team and participants.

### Recommendations

- **Recruit a backup/ alternate judge as part of the team.** Having a backup judge who is familiar with the drug court model is highly recommended, in the case of illness or vacation of the current judge. Also, if the current judge eventually wishes to leave the program, having a backup drug court judge allows an easier transition from the current to the incoming judge. The backup judge will already understand the drug court model (and understand his/her role in the program).
- **Offer quality childcare during court hearings.** The program may want to brainstorm ways to offer quality childcare to participants during the court hearing. It is sometimes hard to predict how many children and infants will be in the audience. Because the courtroom is where much of the program's education takes place, distractions should be kept to a minimum. Additionally, the participants may appreciate the service.
  - **Year 2 Update:** The program has identified an available option for childcare and will begin providing childcare during court sessions during the first week of the month (the busiest week). This will begin during Year 3 in January 2013.

### **KEY COMPONENT #8: MONITORING AND EVALUATION MEASURE THE ACHIEVEMENT OF PROGRAM GOALS AND GAUGE EFFECTIVENESS.**

This component encourages drug court programs to monitor progress toward their goals and evaluate the effectiveness of their practices. The purpose is to establish program accountability to funding agencies and policymakers, as well as to themselves and their participants. Further, regular monitoring and evaluation provides programs with the feedback needed to make adjustments in program practices that will increase effectiveness. Finally, programs that collect data and are able to document success can use that information to gain additional funding and community support. Monitoring and evaluation require the collection of thorough and accurate records. Drug courts may record important information electronically, in paper files or both. Ideally, drug courts will partner with an independent evaluator to help assess their progress. Lastly, it is important to determine how receptive programs are to modifying their procedures in



response to feedback. To underscore the importance of evaluation, a very similar recommendation (#8) was made by CFF.

### National Research

Like most complex service organizations, drug courts have a tendency to *drift*, in which the quality of their services may decline appreciably over time (Van Wormer, 2010). The best way for a drug court to guard against this drift is to monitor its operations, compare its performance to established benchmarks, and seek to align itself continually with best practices (NADCP, Best Practice Standards, Volume II, 2015). That is, the best way for drug courts to ensure they are following the model is to perform self-monitoring of whether they are engaged in best practices and to have an outside evaluator assess the programs' process, provide feedback, and then make adjustments as needed to meet best practices.

Carey et al. (2008, 2012) found that programs with evaluation processes in place had better outcomes. Four types of evaluation processes were found to be correlated with significant reductions in recidivism and cost savings: 1) maintaining electronic records that are critical to participant case management and to an evaluation, 2) the use of program statistics by the program to make modifications in drug court operations, 3) the use of program evaluation results to make modification to drug court operations, and 4) the participation of the drug court in more than one evaluation by an independent evaluator. Courts that have modified their programs based on evaluation findings have experienced a significant reduction in recidivism and twice the cost savings compared to courts that do no modifications (Carey et al., 2012). The same is true of programs that make modifications based on self-review of program statistics (Carey et al., 2012).

### CCFTC Process

- The CCFTC collects electronic data for participant tracking and case management. The program also using this information to assess whether the program is moving toward its goals. Adjustments in policy or practices have been made based on this information.
- As part of the CAM grant, the program implemented an Access database to track information related to CAM families, separate from the CCFTC database. This database is housed at the court but requires information from DSHS and treatment. The program has completed three uploads, two of which included treatment data from the statewide treatment system. Missing data is reviewed on an ongoing basis and team members are working together to make sure all data is housed in the database for the national evaluation.
- Aside from the evaluation currently underway, the CCFTC has not had an outside evaluator measure whether the program is being implemented as intended. After the Year 1 evaluation and initial recommendations and commendations discussion, the program worked constantly on implementing as many recommendations as possible.

### Commendations

- **The CCFTC collects electronic data and has used it to make adjustments in program practices.** The drug court team should continue to accumulate and analyze data about the drug court participants and use it for program reviews and planning, such as to inform the team about the types of participants who are most and least successful in the program. A list of data important for participant case management, program self-monitoring and evaluation is included in Appendix E.
- **The CCFTC has engaged an independent evaluator for process, outcome and cost evaluation.** As part of the funding awarded for the CAM grant, CCFTC devoted resources to conduct a full evaluation of not only the FTC program but the addition of the CAM services.

### Recommendation

- **Share evaluation and assessment results with the full team.** The team and steering committee members should set aside time to discuss the overall findings and recommendations in this report and determine what program adjustments will be made. Appendix B contains a brief set of guidelines for how to review program feedback and next steps in making changes to the program. In addition, the assessment and evaluation results can be very beneficial to the program if they are looking to apply for grants to fund additional positions, etc., or for local funders/agencies to help them access resources. These results can document needs as well as show how well the program has done in some areas.
  - **Year 2 Update—Successfully Implemented:** The CCFTC has spent most of Year 2 discussing realistic options for implementing many of the recommendations made during Year 1 of the evaluation. The team uses the monthly executive/stakeholder meetings to discuss ongoing successes and challenges and does a good job keeping team members and key stakeholder informed about the ongoing efforts. In addition to the local evaluation, the national evaluation for the CAM grant has completed 2 site visits since the award of the grant. All assessment reports, results and recommendations have been disseminated and discussed by the CCFTC team.

### **KEY COMPONENT #9: CONTINUING INTERDISCIPLINARY EDUCATION PROMOTES EFFECTIVE DRUG COURT PLANNING, IMPLEMENTATION, AND OPERATIONS.**

This component encourages ongoing professional development and training of drug court staff. Team members need to be updated on new procedures and maintain a high level of professionalism. Drug courts must decide who receives this training and how often. This can be a challenge during implementation as well as for courts with a long track record. Drug courts are encouraged to continue organizational learning and share lessons learned with new hires. CFF Recommendation #4 encourages that FTCs “ensure cross-system knowledge.”

In order to add the non-adversarial piece to the traditional (adversarial) roles in the collaborative process, team members must receive role specific training. Team members must not only be fully trained on their role and requirements, but also be willing to adopt the balanced and strength-based philosophy of the drug court. Once understood and adopted,

long-assignment periods for team members are ideal, as it allows for better understanding and full assimilation of the model components into daily operations. This is where ensuring that all team members have a shared vision and mission (CFF Recommendation #1) with respect to the FTC is crucial.

### National Research

Research on the use of evidence-based and promising practices in the criminal justice field has consistently shown that in order to operate effective programs as intended, practitioners must receive the necessary resources to make the program work, receive ongoing training and technical assistance, and be committed to the quality assurance process (Barnoski, 2004; Latessa & Lowenkamp, 2006). Andrews and Bonta (2010) maintain that correctional and court programs must be focused not only on targeting high-risk offenders and matching offenders to appropriate treatment (needs), but must also concentrate on effectively building and *maintaining* the skill set of the employees (in the case of drug courts—team members) that work with offenders and court participants. Training and support allows teams to focus on translating drug court best practice findings into daily operations and builds natural integrity to the model (Bourgon, Bonta, Rugge, Scott, & Yessine, 2010).

Carey et al. (2008) and Carey et al. (2012) found that drug court programs requiring all new hires to complete formal training or orientation and requiring *all* drug court team members be provided with regular training were associated with higher graduation rates and greater cost savings due to lower recidivism.

### CCFTC Process

- In addition to on-the-job training, the following drug court team members have received training or education specifically on the drug court model: the judge, coordinator, substance abuse treatment providers, DSHS caseworkers, and CASA representatives. Within the first year of grant administration most new CCFTC team members did not receive drug court specific training. However, between interviews for this process report and its final product, most new staff have been trained in the drug court model. In addition, during Year 2 multiple team members attended local and national conferences which provided training opportunities.
- CCFTC staff has received training specifically about the target population of the court including age, gender, ethnicity and drugs of choice, and most have also received training on strength-based philosophy and practices.
- The team reports that most drug court team members have attended FTC-related trainings specific to their role on the drug court team, though most representatives from Children's Center and Children's Home Society have not received drug court specific training within their first year being involved with the program. The program worked diligently to provide training opportunities to most team members during Year 2.

- New staff members do not always receive initial training on the drug court model before or soon after joining the team. The program has, however, made efforts to share training opportunities, such as webinars and local conferences, with the entire team.
- The program regularly utilizes the bimonthly stakeholder committee meetings as an opportunity to train each other across discipline and share knowledge. Examples have included reviewing the neuropsych and the effects of substance abuse on brain development, the stages of change model, and topics of sustainability.

#### Commendation

- **Several staff members, including the judge, have received training on the drug court model.** Research showed that programs where team members receive training have significantly better outcomes (Carey et al., 2012).
  - **Year 2 Update:** The program continues to provide opportunities for training to all team members. Most new staff, specifically from CHS and CC, attended the national or local drug court conferences. The program also performs cross training during its bimonthly stakeholder meetings.

#### Recommendation

- **In collaboration with partner agencies, CCFTC should ensure that all team members receive initial and continuing training on the drug court model and on their specific roles on the team.** According to team members, some new CCFTC drug court team members do not get training on the FTC model before or soon after starting work. There should be an expectation of, and encouragement for, staff taking advantage of ongoing learning opportunities (both locally and nationally). To support this goal, a training plan and a log system could be established, the results of which should be reviewed by program administrators periodically. These tools can be useful in keeping track of training activities and in reinforcing the importance of professional development. A source of training materials that exists online at no cost is available on the National Drug Court Institute (NDCI) Website at [www.ndci.org](http://www.ndci.org) or [http://www.ndci.org/sites/default/files/nadcp/14146\\_NDCI\\_Benchbook\\_v6.pdf](http://www.ndci.org/sites/default/files/nadcp/14146_NDCI_Benchbook_v6.pdf). The NDCI Web site is also a good source for training opportunities, some at low or no cost. NDCI recently implemented a free Web-based training curriculum (Webinar).
  - **Year 2 Update—Successfully Implemented:** CCFTC team members are aware of the importance of training and continue to work towards drug court best practices and cross discipline training.

**KEY COMPONENT #10: FORGING PARTNERSHIPS AMONG DRUG COURTS, PUBLIC AGENCIES, AND COMMUNITY-BASED ORGANIZATIONS GENERATES LOCAL SUPPORT AND ENHANCES DRUG COURT PROGRAM EFFECTIVENESS.**

This component focuses upon community support (CFF Recommendation #8) and program sustainability (CFF Recommendation #9). It encourages drug courts to develop partnerships with other criminal justice and service agencies. For these collaborations to be true “partnerships,” regular meetings and collaborations with these partners should occur. If successful, the drug court will benefit from the expertise that resides in all of the partner agencies, and participants will enjoy greater access to a variety of services. Drug courts must still determine what partners are available and decide with whom to partner and how formal to make these partnerships. Other important factors to weigh include who will be considered as part of the main drug court team, who will provide input primarily through advising, and what types of services will be available to clients through these partnerships.

National Research

Results from the American University National Drug Court Survey (Cooper, 2000) show most drug courts are working closely with community groups to provide support services for their drug court participants. Examples of community resource partnerships include self-help groups such as AA and NA, medical providers, local education systems, employment services, faith communities, and Chambers of Commerce. Carey et al. (2005) and Carey et al. (2012) found that programs that had true formal partnerships (i.e., involving MOUs, MOAs and/or contracts) with community agencies that provide services to drug court participants had better outcomes than drug courts that did not have these partnerships.

Additional preliminary findings indicate that drug court programs with an advisory committee that includes members of the community nearly doubled the cost savings (Carey et al., 2012).

CCFTC Process

- Since the implementation of the CAM grant, committees have been set up and include all involved community agencies as well as CCFTC representatives.
- It was reported that the CCFTC has developed and maintained relationships with agencies that can provide services for participants in the community and refers participants to those services when appropriate. Additionally, DSHS caseworkers have a network of service providers that they use for clients.
- The addition of the CAM grant has greatly increased the number of services available to those in the CCFTC program (and their families). Services include parenting classes, groups and one-on-one sessions as well as mental health services and neuropsych testing.
- The CCFTC has a partnership with agencies that provide housing services, specifically related to the Access to Recovery grant. They do not, however, have a partnership with an agency that provides employment or educational services.

- Childcare is offered only when participants are using Children's Home Society services. Court sessions, treatment sessions and other court sanctioned activities do not have associated childcare provided. With leftover CAM grant funding, childcare will be provided at least once a month at court (during the busiest week). This will begin in 2013.

#### Commendation

- **The CCFTC works closely with agencies that can provide services for participants in the community.** Community partners are sometimes included in family treatment court team meetings. Research finds that drug courts that had true formal partnerships with community agencies had better outcomes than drug courts that did not have these partnerships.

#### Recommendation

- **Offer childcare for program participants.** Since this program is focused on parents with children, childcare can be key in allowing parents to participate fully and successfully complete the program. It is highly recommended that the CCFTC look into community support that would allow the program to offer child care while participants are engaged in required program activities such as court appearances and treatment sessions.
  - **Year 2 Update:** The program has worked to find options for child care during court sessions and will begin providing childcare at least once a month beginning in January of 2013.

**Process Evaluation Summary.** The Clark County Family Treatment Court was implemented in June 2006. The program was designed to take a minimum of 9 months from participant entry to graduation, although the average time in program for graduates is estimated to be about 14 months. The program takes parents who have experienced a child removal. The general program population consists of substance abusing parents in the dependency system that wish to regain custody of their children. The primary drug of choice for the CCFTC participants is methamphetamines (50%), followed by opiates/heroin (25%) and then marijuana (12%) and prescription drugs (10%). Only 3% report alcohol as a primary drug. However, the majority of participants are polysubstance users.

As of December 2012, (the end of Year 2), a total of 133 participants had entered the program, there were 19 active participants, 41 participants had graduated, and 68 participants had been discharged unsuccessfully (including terminated and opted out). These statistics are relevant to the program population that is included in the outcome and cost evaluation presented later in this document.

Team members include a judge, coordinator, assistant attorney general, parents' attorney, CASA workers, treatment providers, DSHS caseworkers, and community partners (including representatives from the Children's Center and Children's Home Society).

*Best Practices Results.* The CCFTC has been responsive to the community needs and strives to meet the challenges presented by substance-dependent individuals and their families. This program is demonstrating best practices within all 10 Key Components of Drug Courts and the 10 FTC Recommendations. This program has representation of all key agencies on the team and attending staffing and court sessions, good communication and sharing of important information among team members, offers a full continuum of treatment services for parents and their children (including adding an aftercare phase), conducts frequent drug testing with rapid turnaround time in the first phase, follows good incentive and sanction processes, has frequent participant contact with the judge with status review hearing every two weeks and appropriate time spent in court with the judge. The CCFTC also has an electronic case management system and collects data needed for both case management and evaluation. Finally, the coordinator and team are committed to ongoing training and program improvement. Almost all recommendations made in the first year from this evaluation were implemented by the end of Year 2, indicating openness to feedback and a clear dedication to program self-improvement.

Although the CCFTC program is following the majority of best practices, there are three key suggestions for program enhancements that the program should continue to work on. First, the program should continue frequent drug testing (at least twice per week) after the first phase and through the last phase. The cost of drug testing for this program is high (\$20 per test). The CCFTC should explore less expensive drug testing options and look for additional funding so they can test more frequently in the later phases. Second, the team should ensure that there is a trained back-up judge available for when the current judge is unavailable (e.g., due to vacation or illness) and on the occasion that the current judge chooses to retire from drug court. And third, the team should continue to focus on the neuropsych assessment results of all participants and adjust services to best fit the needs of the parents and the children. Finally, the CCFTC team should review and share these evaluation results. In particular, they should appreciate and congratulate each other on the positive outcomes that have occurred due to their hard work and dedication to this program and the participating families.





## SECTION II: OUTCOME EVALUATION

**T**he main purpose of outcome evaluation is to determine whether the program has improved participant outcomes. In other words, did the program achieve its intended goals for its participants? An outcome evaluation can examine both short and long-term outcomes. Short term outcomes are those that occur while a participant is still in the program, including whether the program is delivering the intended amount of services, whether participants receive treatment more quickly and complete treatment more often than those who do not participate, whether participants are successfully completing the program in the intended amount of time, whether drug or alcohol use is reduced, and what factors lead to participants successfully completing the program. An outcome evaluation can also measure longer term outcomes (sometimes called an “impact evaluation”), including participant outcomes after program completion. In the case of FTC programs, one of the key impacts of interest is child welfare recidivism. Are participants obtaining new maltreatment allegations? Are children being removed from the home after program participation? How often are participants reunified with their children, if removed?

### Outcome Evaluation Methods

For the outcome/impact evaluation, we identified a sample of families who entered the FTC program after CAM services had been implemented, along with a sample of families eligible for the FTC but who received traditional dependency case processing (a policy alternative). It is important to identify a comparison group of families who are eligible for the FTC because those who are not eligible represent a different population of families; thus, any differences that cause families to be ineligible for FTC could also be the cause of any differences found in outcomes. In addition to a matched non-FTC comparison, CAM FTC participants were compared to FTC participants who entered the program prior to the CAM grant to determine whether the additional CAM services made a difference above and beyond participation in the FTC. (Our methods for selecting the comparison groups are described below.)

Data for both program and comparison families were tracked through existing administrative databases for a period of up to 3 years post FTC entry depending on the availability of the data. The evaluation team used child welfare, dependency court, criminal justice, and treatment utilization data sources as described in Table 1 to determine whether FTC families and the comparison group differ in subsequent child welfare involvement (e.g., allegations, removals, days in out of home placements), treatment involvement (e.g., enrollment and completion of treatment) and criminal justice involvement (e.g., arrests).

The outcome/impact evaluation was designed to address the following study questions:

1. What is the impact of FTC and CAM on child welfare outcomes?
  - 1a. Does participation in FTC reduce the average number of maltreatment allegations for FTC parents compared to non FTC parents?
  - 1b. Does participation in FTC reduce the number of allegations where parents are perpetrators? Does participation in FTC reduce the overall maltreatment recidivism rate (the percent of participants who perpetrated subsequent maltreatment) compared with traditional dependency case processing?
  - 1c. Do children whose parents participate in FTC spend fewer days in out of home placements than children of non-FTC parents?
  - 1d. Are there fewer removals post program entry for children of FTC parents than non FTC parents? Are there differences in the reasons for removal for children of FTC parents compared to non FTC parents?
  - 1e. Of children removed, do children of FTC parents have better placement stability than children of non FTC parents?
  - 1f. Of children removed, are there differences in the occurrence of different types of permanency decisions (reunification, adoption, guardianship, or aged out) for children of FTC parents compared to non FTC parents?
  - 1g. Of children removed, what percentage of FTC children were reunified with their parents compared to non FTC children? For children who are reunified, are children of FTC parents reunified sooner than children of non FTC children? Are there fewer subsequent removals post-reunification?
2. What is the impact of FTC and CAM on criminal justice recidivism?
  - 2a. Does participation in FTC reduce the average *number of* all rearrests for those individuals compared with traditional processing?
  - 2b. Does participation in FTC lead to a lower overall *recidivism rate* (the percent of participants who were rearrested) compared with traditional processing?
3. What is the impact of FTC and CAM on substance abuse treatment?
  - 3a. Do FTC parents enroll in substance abuse treatment more often than non FTC parents?
  - 3b. Do FTC parents spend more time in substance abuse treatment than non FTC parents?
  - 3c. Do FTC parents complete substance abuse treatment more often than non FTC parents?
4. How successful is the program in bringing program participants to completion and graduation within the expected time frame?
5. What participant and program characteristics predict successful FTC outcomes? What predicts non-completion (termination or unsuccessful exit from the FTC program)?

6. Has the implementation of new practices and services due to the CAM grant improved participant short and long term outcomes?

### **SAMPLE/COHORT SELECTION**

To ensure a rigorous outcome evaluation, it is necessary to select a cohort of individuals who participated in the FTC and a cohort of similar individuals who did not.

#### ***The FTC-CAM Participant Group***

The FTC-CAM participant sample, or cohort, is the population of individuals who entered FTC from October 2010 to June 2014. There were a total of 65 FTC participants available for analysis. Outcomes are presented in 1-, 2-, and 3-year increments. However, some FTC-CAM participants do not have 2 or 3 full years since the date they entered the program; therefore, the 2- or 3-year outcomes for those individuals were not measured. Three year outcomes are presented in some places in the report as points of interest. However, under half of the sample has outcomes available at 3 years, so these results should be interpreted with caution. In most cases, outcomes (including cost outcomes) are presented only up to 2 years as the majority of the sample has two full years of outcome data available after program entry.

#### ***The Comparison Groups***

##### **Group 1: Historical FTC Participant Comparison Group**

The FTC participant comparison group, or cohort, in this study is the population of individuals who entered FTC from January 2006 to August 2010 (prior to the implementation of CAM services in early 2011). For the purposes of this report, this group will be referred to as FTC-PreCAM. This comparison group is used to examine the impact of the addition of CAM services above and beyond the FTC program. There were a total of 85 FTC participants available for analysis in this group. All 85 participants have a full 3 years of outcome data available.

##### **Group 2: The Matched Non-FTC Comparison Group**

The second comparison group is composed of individuals who are similar to those who participated in the FTC-CAM program (e.g., similar demographics, child welfare history, substance abuse treatment history, and criminal history) but who did not participate in the program. The comparison sample was selected using a quasi-experimental design. Child welfare data was obtained for Clark County from the Department of Social and Health Services (DSHS) (see FAMLINK in Table 1 for more details). The event that triggers referral to the CCFTC is the removal of a child from a parent who has a history of substance abuse. DSHS provided a list of all parents in Clark County who had a child removed between 2006 and 2013 for reasons related to parent drug use and therefore were potentially eligible for CCFTC. CCFTC participants were removed from this group. The remaining parents had not been referred to the CCFTC, generally due to the parent being assigned to a DSHS caseworker who was not supportive of the CCFTC program, or who was not aware of the program. Additional information was gathered from the FAMLINK database as well as the state level criminal justice and treatment

databases that provided indication of whether these parents fit the eligibility criteria for the FTC program. This information included detailed demographics, treatment history and criminal history.

Comparing FTC participants to parents who did not participate in FTC is complicated by the fact that program participants may systematically differ from comparison group members, and those differences, rather than FTC and/or CAM, may account for some or all of the observed differences in the outcome measures. To address this complication, once the potential comparison population was identified, the groups were matched using propensity scores. Propensity scores are a weighting scheme designed to mimic random assignment and provide some control for differences between the program participants and the comparison group (according to the available data on both groups) (Rosenbaum & Rubin, 1983).

CCFTC participants were matched with potential comparison group members on a number of participant characteristics including: 1) race, 2) age, 3) gender, 4) prior child welfare involvement (including parent involvement as a child and prior allegations with parent as perpetrator), 5) prior criminal history, 5) prior substance abuse treatment, and, 6) number and age(s) of children. Due to the manner in which the comparison pool was identified in FAMLINK, we were unable to match precisely on gender. The list provided from FAMLINK only identified the primary adult on a particular case, and an overwhelming majority of the time, this adult was female. Thus, the available males in the comparison pool were not sufficiently similar to the males in the FTC-CAM group to be matched. However, the number of males in both groups was very small and the groups are matched on all other variables. Gender is adjusted for in all subsequent analyses.

**Note:** The same method was used to match the non-FTC comparison families to the FTC PreCAM group in order to further verify the impact of FTC PreCAM compared to FTC-CAM.

## DATA COLLECTION AND SOURCES

### *Administrative Data*

The data necessary for the evaluation were gathered from administrative databases as described in Table 1. The table lists the type of data collected and the source of these data.

**Table 1. NM FTC Evaluation Data and Sources**

<b>Data</b>	<b>Source</b>
<b><i>FTC Program Data</i></b> <i>Examples:</i> <ul style="list-style-type: none"> <li>• Participant demographics</li> <li>• Program start and end dates</li> <li>• Drug Tests</li> <li>• Sanctions and Incentives</li> <li>• Dates of FTC appearances/status review hearings</li> </ul>	FTC Access Database Loryx
<b><i>Child Welfare-Related Data</i></b> <i>Examples:</i> <ul style="list-style-type: none"> <li>• Identifiers</li> <li>• Maltreatment Allegations</li> <li>• Days out of home</li> <li>• Placement setting</li> <li>• Removal/placement discharge status (e.g., reunification, adoption, etc.)</li> </ul>	FAMLINK
<b><i>Criminal Justice-Related Data</i></b> <i>Examples:</i> <ul style="list-style-type: none"> <li>• Incident dates (arrest dates)</li> <li>• Dates of case filings</li> <li>• Charges</li> <li>• Prison entry and exit dates</li> <li>• Jail entry and exit dates</li> </ul>	ICDB (Statewide Court Data Systems) Clark County Jail
<b><i>Substance Abuse Treatment</i></b> <i>Examples:</i> <ul style="list-style-type: none"> <li>• Entry and exit dates of treatment received</li> <li>• Types of substance abuse treatment received</li> <li>• Completion status of treatment episodes</li> <li>• Cost of treatment</li> </ul>	ICDB TARGET

## DATA ANALYSES

Once all data were gathered on the study participants, the data were compiled and cleaned and moved into SPSS 20.0 for statistical analysis. The analyses used to answer specific questions are described below.<sup>6</sup>

Propensity Score Matching was performed with a tool developed in R used in conjunction with SPSS (Ho, D. et al, 2007a and 2007b; Hansen, B. B., 2004; Hansen, B. & Bowers, J., 2008; and Thoemmes, F., 2011).

### RESEARCH QUESTION #1: WHAT IS THE IMPACT OF FTC AND CAM ON CHILD WELFARE OUTCOMES?

***1a. Does participation in FTC reduce the average number of maltreatment allegations for children of FTC parents compared to non FTC parents?***

***1b. Does participation in FTC reduce the number of allegations where parents are perpetrators? Does participation in FTC reduce the overall maltreatment recidivism rate (the percent of participants who perpetrated subsequent maltreatment allegations) compared with traditional processing?***

***1c. Do children whose parents participate in FTC spend fewer days in out of home placements than children whose parents went through traditional processing?***

***1d. Are there fewer removals post program entry for children of FTC parents than non FTC parents? Are there differences in the reasons for removal from children of FTC parents compared to non FTC parents?***

All children associated with FTC participants and comparison group parents were identified and linked in the FAMLINK data system. As child welfare items are typically collected at the child level, all child welfare outcomes were first calculated for each child associated with FTC participants and the comparison group members. When describing differences in child-level outcomes, averages or rates are presented based on all FTC children compared to comparison group children. For adult calculations, child welfare outcomes were aggregated (i.e., added together) across all of their children and the total number of events were attributed to a particular adult, regardless of number of children. For dichotomous indicators of whether a particular outcome (e.g., a maltreatment allegation, or a removal) occurred during the specified time period (used for describing rates), if any associated child had a “Yes” indicator present, the adult would also have a “Yes” – only if *all* associated children had a “No” would the adult also have a “No” for any particular outcome in the specified timeframe.

When comparing average number of events (e.g., number of allegations, number of days out of home), independent sample *t* tests and univariate analysis of covariance (ANCOVA) were

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<sup>6</sup> Analyses that examine outcome time periods greater than 1 year include only participants who have the full outcome time available. For example, analyses that examine outcomes 2 years from FTC entry will only include individuals that have 2 full years of outcome time available. Outcomes are based upon program entry date (or a similarly assigned date for the comparison group).

performed to compare the mean number of the item in question for FTC-CAM participants and/or their children and the comparison group parents and/or their children for each year up to 3 years after program entry.

Means generated by univariate analysis for adults were adjusted in the analysis based on gender, age, race, prior treatment history, number and age of children, child welfare history, and criminal history. Means generated by univariate for children analysis were adjusted in the analysis based gender, age, race, and child welfare history. The non-adjusted means for graduates are included in the results for reference but should not be compared directly with the non FTC comparison group as the comparison group includes an unknown number of individuals who, had they participated in FTC, may have terminated from the program and are therefore not equivalent to FTC graduates.

When comparing rates (i.e., percentages of people in each group with a particular outcome occurring at least once during the specified time period), crosstabs were run to examine differences between FTC-CAM participants and/or their children, and the comparison groups and/or their children, for each year up to 3 years following program entry. Chi-square analyses were used to identify any significant differences in rates.

***1e. Of children removed, do children of FTC parents have better placement stability than children of non FTC parents?***

***1f. Of children removed, are there differences in the occurrence of different types of permanency decisions (reunification, adoption, guardianship, or aged out) for children of FTC parents compared to non FTC parents?***

***1g. Of children removed, what percentage of FTC children were reunified compared to non FTC children? For children who are reunified, are children of FTC parents reunified sooner than children of non FTC children? Are there fewer subsequent removals post-reunification?***

All FTC-CAM participants entered the program after a child was removed. All comparison group members were identified based on a removal as well. However, not all children associated with a particular parent were necessarily removed. In order to determine differences in placement stability, differences in types of permanency decisions, and reunification rates, only the children precipitating the initial program entry were used for these sets of analyses.

Independent sample *t* tests and univariate analysis of covariance (ANCOVA) were performed to compare the mean number placements children of FTC parents and children of comparison group parents for each year up to 3 years after program entry. Means generated by univariate for analysis were adjusted in the analysis based gender, age, race, and child welfare history. The non-adjusted means for graduates are included in the results for reference but should not be compared directly with the non FTC comparison group as the comparison group includes an unknown number of individuals who, had they participated in FTC, may have terminated from the program and are therefore not equivalent to FTC graduates.

Permanency decisions between children of FTC-CAM parents and comparison group parents were compared using crosstabs and chi-square analysis. Logistic regression was used to determine if differences between FTC-CAM children and children and the comparison groups were significant over and above any differences due to gender, age, race, and child welfare history.

A survival analysis was used to examine the time it took for FTC-CAM children to be reunified after their removal date compared the children of the comparison groups. Time to reunification was measured as the difference between the date reunified and the removal date. The opportunity window for each individual was set at 3 years post removal, though not all children had a full 3 years available post removal date. For those children with less than three years, the opportunity window was calculated by subtracting the date of removal from the latest available date of the outcome dataset collected for this study (removal data available through June 9, 2015). The number of months of observation for each child serves as the censor date for those not reunified by 3 years post removal. A Kaplan-Meier estimator and—if appropriate—a Cox Regression were used to determine if there were any significant differences in how quickly reunification occurs between FTC-CAM children and the comparison groups' children.

For the children who were reunified within 3 years post removal, and those who had data available for at least 1 year post reunification date based on the collection date (June 9, 2015), crosstabs were run to examine differences in whether subsequent removals occurred after reunification between FTC-CAM children and the comparison group children. Chi-square analyses were used to identify any significant differences in removal rates between FTC-CAM children and comparison group children.

## **RESEARCH QUESTION #2: WHAT IS THE IMPACT OF FTC AND CAM ON CRIMINAL RECIDIVISM?**

### ***1a. Does participation in FTC reduce the average number of all rearrests for those individuals compared with traditional processing?***

Independent sample *t* tests and univariate analysis of covariance (ANCOVA) were performed to compare the mean number of all rearrests for all FTC-CAM participants and the comparison groups for each year up to 3 years after program entry. Means generated by univariate analysis were adjusted in the analysis based on gender, age, race, prior treatment history, number and age of children, child welfare history, and criminal history.<sup>7</sup> The non-adjusted means for graduates are included in the results for reference but should not be compared directly with the comparison group as the comparison group includes an unknown number of individuals

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<sup>7</sup> Time at risk is NOT controlled for in this or subsequent research questions as the intention of the analysis is to determine whether FTC participation (which typically occurs in the community) reduces recidivism more effectively than business-as-usual, which typically includes at least some incarceration. If incarceration was used for non-FTC participants and was effective in reducing crime, then controlling for this factor would prevent us from determining which path (FTC or business as usual) was more effective.



who, had they participated in FTC, may have terminated from the program and are therefore not equivalent to FTC graduates.

***1b. Does participation in FTC lead to a lower overall recidivism rate (the percent of participants who were rearrested) compared with traditional processing?***

Crosstabs were run to examine differences in recidivism rate (the number/percentage of individuals rearrested at least once during the specified time period) between FTC-CAM and the comparison groups for each year up to 3 years following program entry. Chi-square analyses were used to identify any significant differences in rearrest rates between FTC-CAM and comparison group participants.

A logistic regression was used to determine if differences between FTC-CAM participants and the comparison group were significant over and above any differences due to gender, age, race, prior treatment history, number and age of children, child welfare history, and criminal history.

**RESEARCH QUESTION #3: WHAT IS THE IMPACT OF FTC AND CAM ON SUBSTANCE ABUSE TREATMENT COMPLETION?**

***3a. Do FTC parents enroll in substance abuse treatment more often than non FTC parents?***

***3b. Do FTC parents spend more time in substance abuse treatment than non FTC parents?***

***3c. Do FTC parents complete substance abuse treatment more often than non FTC parents?***

Crosstabs were run to examine differences in treatment completion rate (the number/percentage of individuals who successfully completed at least one substance abuse treatment episode during the specified time period) between FTC-CAM and the comparison groups for each year up to 3 years following program entry. Chi-square analyses were used to identify any significant differences in completion rates between FTC-CAM and comparison group participants.

A logistic regression was used to determine if differences between FTC-CAM participants and the comparison groups were significant over and above any differences due to gender, age, race, prior treatment history, number and age of children, child welfare history, and criminal history.

**RESEARCH QUESTION #4: HOW SUCCESSFUL IS THE PROGRAM IN BRINGING PROGRAM PARTICIPANTS TO COMPLETION AND GRADUATION WITHIN THE EXPECTED TIME FRAME?**

Whether a program is bringing its participants to completion in the intended time frame is measured by program graduation (successful completion) rates, and by the amount of time participants spent in the program. The program graduation rate is the percentage of participants who graduated from the program out of the total group of participants who started during a specified time period and who have all left the program either by graduating or being unsuccessfully discharged (that is, none of the group is still active and all have had an equal

chance to graduate). The FTC graduation rate is included for all participants, by entry year, from January 2006 to December 2014. The average graduation rate (for participants entering between 2006 and 2012, to allow for enough time to complete the program) is compared to the national average for drug court graduation rates, and the differences are discussed qualitatively.

To measure whether the program is graduating participants in its expected time frame, the average amount of time in the program was calculated for participants who had enrolled in the FTC program between January 2006 and December 2014, by FTC entry year, and have been successfully discharged from the program. The average length of stay for graduates and for all participants was compared to the intended time to program completion, and the differences are discussed qualitatively.

#### **RESEARCH QUESTIONS #5: WHAT PARTICIPANT CHARACTERISTICS PREDICT PROGRAM SUCCESS AND DECREASED RECIDIVISM?**

Graduates and unsuccessfully discharged participants were compared on the basis of demographic characteristics, child welfare history, criminal justice history, substance abuse treatment history, and a variety of activities occurring during the program to determine whether any significant patterns predicting program graduation could be found. In order to best determine which factors were related to successful FTC completion, chi-square and independent samples *t* tests were performed to identify which factors were significantly associated with program completion (graduation). A logistic regression was used including all variables in the model to determine if any factors were significantly related to graduation status above and beyond the other factors.

Participant characteristics, child welfare history, criminal justice history, substance abuse treatment history, and program activities were also examined in relation to whether an individual was involved in subsequent child welfare or criminal justice recidivism following FTC entry. Chi-square and independent samples *t* test were performed to identify which factors were significantly associated with recidivism. A logistic regression was used including all variables in the model to determine if any factors were significantly related to recidivism above and beyond the other factors.

#### **RESEARCH QUESTION #6: HAS THE IMPLEMENTATION OF NEW PRACTICES AND SERVICES DUE TO THE CAM GRANT IMPROVED PARTICIPANT SHORT AND LONG TERM OUTCOMES?**

In 2010, the Clark County Family Treatment Court (CCFTC) received an enhancement grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). The grant was focused on Children Affected by Methamphetamines (CAM). The program used this enhancement grant to: 1) Provide additional services and evidence based practices to adults and children in the program, 2) Tailor services to adults and children using a neuropsychological

evaluation, and 3) conducting a program evaluation including process, outcome and cost components.

In order to evaluate the possible effects of the CAM Grant, participants entering the program between January 2006 and September 2010, prior to the grant, were compared to participants entering the program after the grant was received, those entering between September 2010 and June 2014. Participants in the two cohorts were compared to determine if there were any significant changes in the population characteristics (e.g., demographics and risk levels) before and after the CAM grant. Graduation rates for both cohorts were reviewed and independent sample t-tests and chi-square analyses were used to determine differences between the groups.

In addition, child welfare and criminal justice recidivism for both cohorts were reviewed to determine if long-term outcomes differed significantly before and after the CAM grant was received. For average number of incidents (e.g., maltreatment allegations, rearrests), independent sample t-tests and univariate analysis of covariance (ANCOVA) were performed for each year up to 3 years after program entry date. Means generated by univariate analysis were adjusted in the analysis based on gender, age, race, prior treatment history, number and age of children, child welfare history, and criminal history.

To further determine if CAM enhancements were related to improved outcomes for FTC participants, all the above analyses were also performed comparing the preCAM FTC participants to a matched non-FTC comparison group. Any findings of interest are discussed in the interpretation of the results.

## **Outcome Evaluation Results**

Tables 2-4 provide the demographics for the study sample of FTC-CAM participants (all participants who entered FTC between October 2010 and June 2013), the matched comparison group, as well as the historical FTC-PreCAM group (all participants who entered FTC between January 2007 and August 2010) and the comparison group matched to the FTC-PreCAM group. FTC-CAM and FTC-PreCAM populations are not necessarily the same, and significant differences between the groups are noted.

Overall, Table 2 shows that about four-fifths of FTC participants were female, four-fifths were White, and the average age at program entry was 30 years old with a range from 18 to 49 years old. Both groups averaged between 3 and 4 children per adult. Children ranged from 0 to 17 years old, with the average age being between 5 and 6 years. The groups were matched on average age of the youngest child, which was just under 2 years old. Aside from the noted difference between gender in the FTC-CAM and matched comparison group, none of these other characteristics were significantly different in the comparison group or the FTC-PreCAM group.

**Table 2. FTC Participant and Comparison Group Characteristics: Demographics**

	<b>FTC-CAM Participants N = 65</b>	<b>FTC-CAM Comparison Group N = 61</b>	<b>FTC-PreCAM Participants N = 85</b>	<b>FTC-PreCAM Comparison Group N = 83</b>
<b>Gender<sup>a</sup></b>				
<b>Male</b>	21% (13)	7% (5)	14% (12)	12% (10)
<b>Female</b>	79%	93%	86%	88%
<b>Race/Ethnicity<sup>b</sup></b>				
<b>White</b>	83%	78%	81%	88%
Multiracial	8%	3%	6%	6%
Hispanic/ Latino	3%	3%	7%	1%
Black	3%	3%	4%	1%
Other	3%	12%	2%	5%
<b>Age at Entry Date</b>				
<b>Average age in years</b>	30 years	30 years	30 years	31 years
Range	18 – 49	20 – 52	18 – 51	17 – 68
<b>Children</b>				
<b>Number of children at entry</b>	3.3	3.7	3.3	3.5
Average age of youngest child	21 months	23 months	25 months	23 months
Average age of oldest child	99 months	120 months	105 months	118 months
Average age of all children	60 months	72 months	63 months	73 months

<sup>a</sup>Groups were unable to be matched on gender.

<sup>b</sup>Percentages may not add up to 100% due to rounding.

The groups were matched on prior child welfare history including indicators of both the parent's involvement as a child as well as their involvement as an adult (i.e., parent). The FTC families and comparison group were very similar in both regards. Table 3 shows the child welfare history for the FTC participants and the comparison group. There were no statistically significant differences between groups.

**Table 3. FTC Participant and Comparison Group Characteristics: Child Welfare History**

	<b>FTC-CAM Participants N = 65</b>	<b>Comparison Group N = 61</b>	<b>FTC-PreCAM Participants<sup>a</sup> N = 85</b>	<b>FTC-PreCAM Comparison Group N = 83</b>
<b>Adult Involvement as a Child</b>				
<b>Victim of maltreatment allegation <sup>a</sup></b>	2%	2%	8%	4%
<b>Removed from home</b>	15%	12%	16%	12%
<b>Adult Involvement as a Parent (where parent was perpetrator)</b>				
<b>Adult was perpetrator on at least one allegation prior to program entry</b>	89%	89%	93%	91%
<b>Adult was perpetrator on at least one <u>founded</u> allegation prior to program entry</b>	71%	76%	65%	59%
<b>Average number of allegations 2 years prior to program entry</b>	2.38	2.74	3.71	3.80
<b>Average number of <u>founded</u> allegations 2 years prior to program entry</b>	1.22	1.56	0.94	0.79
<b>Average number of <u>abuse</u> allegations 2 years prior to program entry</b>	0.18	0.26	0.19	0.48
<b>Average number of <u>neglect</u> allegations 2 years prior to program entry</b>	2.25	2.50	3.64	3.40

<sup>a</sup>Maltreatment allegations that are not founded are expunged from the system after 6 years. The low percentages for parents maltreated as children are likely due to the parents being victims of unfounded or inconclusive allegations more than 6 years ago that were subsequently expunged from the system.

In terms of prior criminal history, the FTC participants and comparison group were very similar. Table 4 shows the criminal history for the FTC participants and the comparison group. There were no statistically significant differences in criminal history between groups. Note that most parents in all groups had been arrested at least once prior to FTC involvement, and specifically within the two years prior to program entry, 69% of CAM parents, 56% of PreCAM parents and 49% of comparison group parents had been arrested.

**Table 4. FTC Participant and Comparison Group Characteristics: Criminal History**

	<b>FTC-CAM Participants N = 65</b>	<b>Comparison Group N = 61</b>	<b>FTC-PreCAM Participants N = 85</b>	<b>FTC-PreCAM Comparison Group N = 83</b>
<b>Average number of arrests 2 years prior to program entry</b>	1.28	1.03	1.41	0.85
<b>Average number of person arrests 2 years prior to program entry</b>	0.29	0.27	0.32	0.33
<b>Average number of property arrests 2 years prior to program entry</b>	0.26	0.24	0.21	0.14
<b>Average number of drug arrests 2 years prior to program entry</b>	0.17	0.13	0.22	0.15
<b>Average number of misdemeanor arrests 2 years prior to program entry<sup>a</sup></b>	0.69	0.53	0.76	0.55
<b>Average number of felony arrests 2 years prior to program entry<sup>a</sup></b>	0.15	0.17	0.62	0.16

<sup>a</sup>Felonies and misdemeanors do not add up to the total number of arrests as criminal traffic arrests were coded separately and did not have an associated charge level.

Table 5 displays substance abuse treatment history and reported drugs used. The FTC-CAM participants were matched to the comparison group on prior substance abuse treatment. Though FTC participants were more likely to have entered substance abuse history prior to program entry, the differences were not significant. Drug of choice was not used for matching as it was only available for those with treatment assessments. It is presented below to highlight differences between Pre and Post CAM participants, specifically the increase in heroin use in recent years. Methamphetamines remains the most prevalent drug of choice, at close to two-thirds reporting use.

**Table 5. FTC Participant and Comparison Group Characteristics:  
Substance Abuse History**

	<b>FTC-CAM Participants <i>N</i> = 65</b>	<b>Comparison Group <i>N</i> = 61</b>	<b>FTC-PreCAM Participants<sup>a</sup> <i>N</i> = 85</b>	<b>FTC-PreCAM Comparison Group <i>N</i> = 83</b>
<b>Substance Abuse Treatment</b>				
<b>Entered treatment prior to program entry</b>	88%	79%	95%	94%
Entered treatment within 2 years prior to program entry	74%	70%	89%*	81%
<b>Drugs of Choice<sup>b</sup></b>				
Methamphetamines	63%	N/A	69%	N/A
Marijuana	62%		58%	
Alcohol	40%		55%	
Heroin	35%		11%*	
Prescription Opiates	22%		12%	
Cocaine	9%		11%	
Other <sup>c</sup>	8%		14%	

<sup>a</sup> An asterisk indicates a significant difference between this group and FTC-CAM participants.

<sup>b</sup> Numbers do not add up to 100% as participants could report more than one type of substance.

<sup>c</sup> Includes stimulants, benzodiazepines, tranquilizers, and hallucinogens.

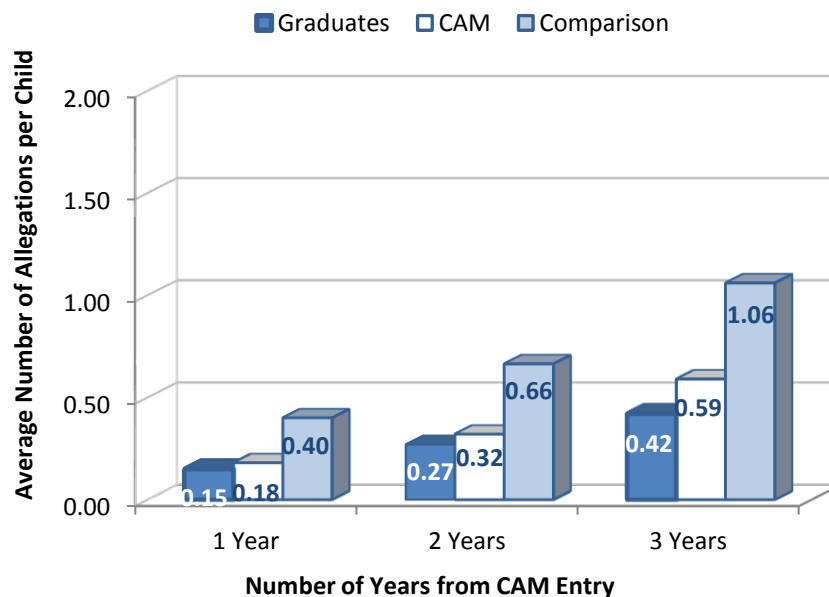
**Note:** As described in the analysis section, results presented in the outcome section of this report are adjusted based on one or more of the following covariates, according to whether a particular covariate had a significant impact in the model: child - gender, age, race, and child welfare history; parent - gender, age, race, prior treatment history, number and age of children, child welfare history, and criminal history. Child covariates were used for child level analyses and parent covariates were used for parent level analyses.

## RESEARCH QUESTION #1: WHAT IS THE IMPACT OF FTC AND CAM ON CHILD WELFARE OUTCOMES?

### *1a. Does participation in FTC reduce the average number of maltreatment allegations for children of FTC parents compared to non FTC parents?*

In the 3 years after program entry, the FTC-CAM children were victims in significantly fewer maltreatment allegations (founded and unfounded) than children of similar parents who never enrolled in FTC (in Years 1 and 2;  $p < .05$ ). Figure 1 shows the average number of maltreatment allegations experienced by children of FTC-CAM graduates, children of all FTC-CAM participants, and comparison group children over a 3-year period.<sup>8</sup> Differences were not significant in Year 3, likely due to the smaller size of the sample. As would be expected, children of FTC-CAM graduates were victims of considerably fewer maltreatment allegations than children of non-graduates and the comparison group.

**Figure 1. Average Number of Allegations per Child Over 3 Years<sup>9</sup>**



Although there were significant differences between CAM families and comparison families on all allegations (as illustrated in Figure 1), the number of *founded* allegations for both FTC and the comparison group was extremely small (an average of just .06 for CAM and .10 for the comparison group after 2 years) and the difference between groups was not significant.

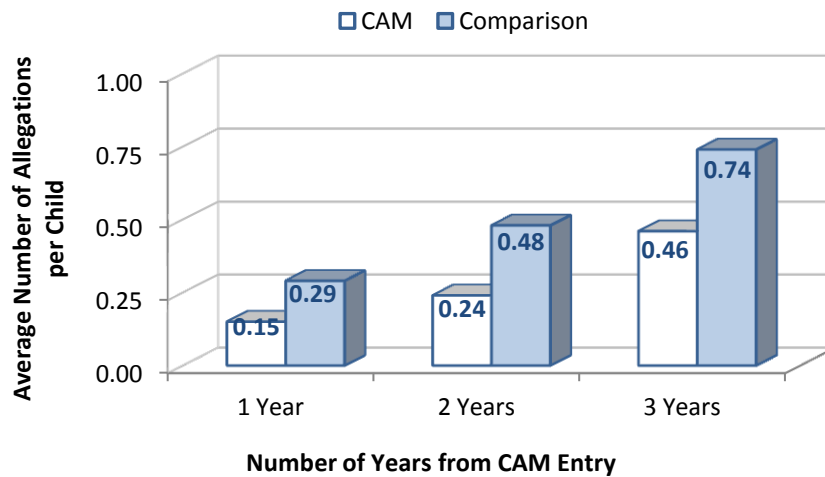
<sup>8</sup> Non-adjusted means were significantly lower for FTC-CAM at every time point ( $p < .05$ ) and are as follows for children by group and time period (1 Year, 2 Years, 3 Years): FTC-CAM Participants – 0.18, 0.33, 0.53; Comparison Group – 0.36, 0.60, 0.95.

<sup>9</sup> Sample sizes represent number of children by group and time period (1 Year, 2 Years, 3 Years): Graduates  $n = 136, 127, 71$ ; All FTC-CAM Participants  $n = 202, 170, 98$ ; Comparison Group  $n = 199, 169, 142$ .



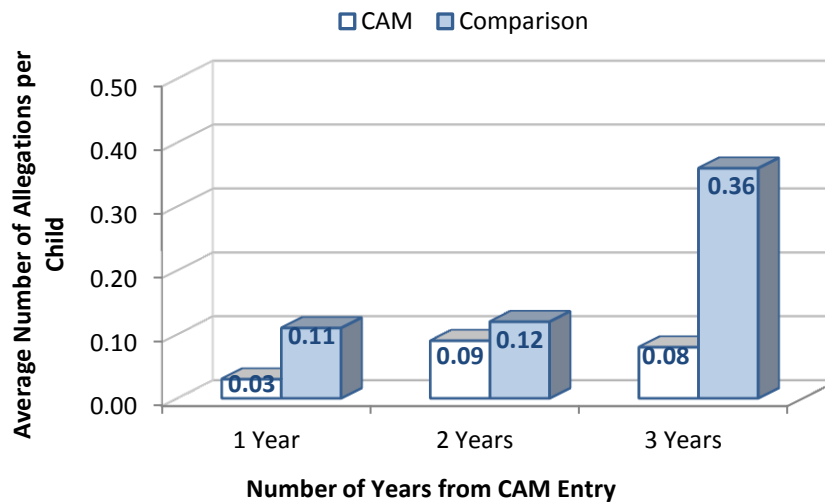
**Neglect.** When reviewing specific types of allegations (abuse and neglect), children of FTC-CAM parents were significantly less likely to be a victim of neglect at 2 years post program entry ( $p < .05$ ).<sup>10</sup> Figure 2 displays the average number of allegations for neglect at 1, 2 and 3 years after program entry.

**Figure 2. FTC-CAM Children were Significantly Less likely to be Victims of New Allegation of Neglect<sup>11</sup>**



**Abuse.** Figure 3 illustrates the average number of allegations for abuse at 1, 2 and 3 years post entry. FTC-CAM children were victim to fewer abuse allegations in Years 1 through 3 than children of the comparison group ( $p < .05$  for years 1 and 3).

**Figure 3. Average Number of Abuse Allegations per Child Over 3 Years<sup>12</sup>**



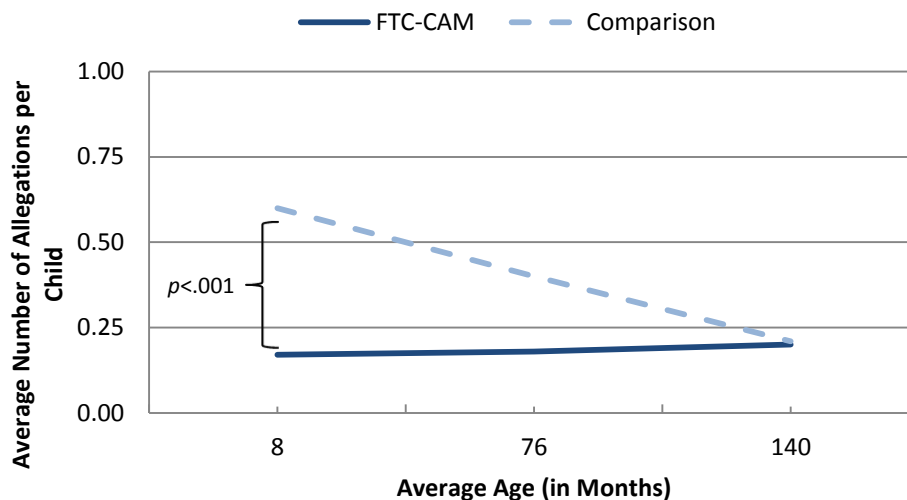
<sup>10</sup> Years 1 and 3 are not significantly different; however see Figure 4 for more information about this finding.

<sup>11</sup> Sample sizes represent number of children by group and time period (1 Year, 2 Years, 3 Years): Graduates  $n = 136, 127, 71$ ; All FTC-CAM Participants  $n = 202, 170, 98$ ; Comparison Group  $n = 199, 169, 142$ .

<sup>12</sup> Sample sizes represent number of children by group and time period (1 Year, 2 Years, 3 Years): Graduates  $n = 136, 127, 71$ ; All FTC-CAM Participants  $n = 202, 170, 98$ ; Comparison Group  $n = 199, 169, 142$ .

**Child Age and Maltreatment.** An examination of whether there were any characteristics of the families (other than their participation in the FTC) that would predict new maltreatment allegations revealed an interaction between participation in the FTC and the child's age. As shown in Figure 4, younger children (particularly those under 1 year) whose parents participated in FTC-CAM had significantly fewer maltreatment allegations than non-FTC children ( $p < .001$ ), but older children of FTC-CAM parents (particularly youth over 11 years) had almost the same number of allegations as non-FTC children. Research in child welfare shows that young children, particularly those under one year, are at substantially higher risk for abuse than older children (Black, Heyman & Smith Slep, 2001; Mraovick & Wilson, 1999).<sup>13</sup> The finding illustrated in Figure 4 indicates that the FTC-CAM program is particularly effective for parents with younger children, that is, those with higher risk for maltreatment.

**Figure 4. Average Number of Allegations per Child at 1 Year<sup>14</sup>**

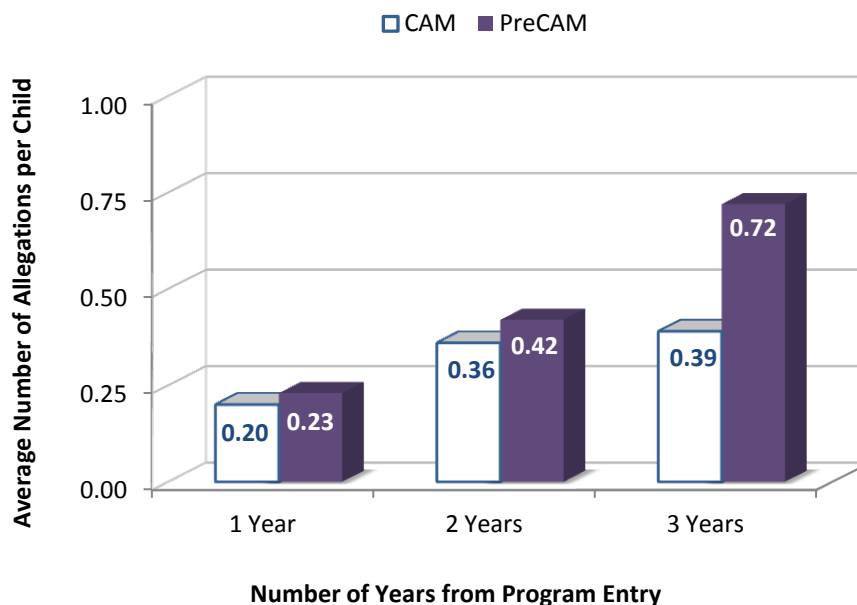


<sup>13</sup> For more information on risk and protective factors in child abuse see <http://www.cdc.gov/violenceprevention>.

<sup>14</sup> Sample sizes represent number of children by group at 1 Year: All FTC-CAM Participants  $n = 202$ ; Comparison Group  $n = 199$ .

**FTC-CAM vs. FTC-PreCAM.** The number of allegations for FTC-CAM children was also compared to FTC-PreCAM children. FTC-CAM children were victims of fewer allegations over time (although this trend was not statistically significant). Figure 5 displays the average number of allegations for both groups over 3 years after entry.<sup>15</sup> This finding provides some indication that the addition of CAM services may have resulted in a more effective program.

**Figure 5. Average Number of Allegations per Child Over 3 Years<sup>16</sup>**



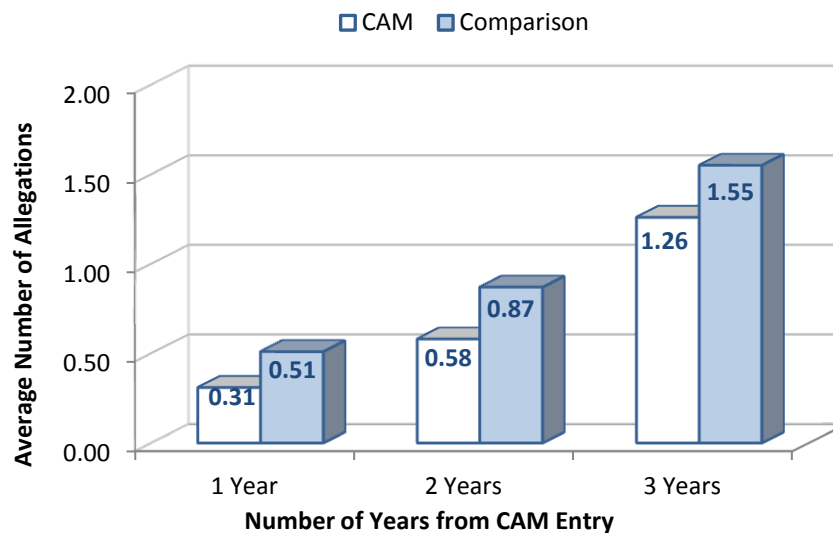
<sup>15</sup> Non-adjusted means are as follows for children by group and time period (1 Year, 2 Years, 3 Years): FTC-CAM Participants – 0.17, 0.30, 0.35; FTC-PreCAM Participants – 0.21, 0.39, 0.63.

<sup>16</sup> Sample sizes represent number of children by group and time period (1 Year, 2 Years, 3 Years): FTC-CAM Participants  $n = 197, 165, 93$ ; FTC-PreCAM Participants  $n = 279, 279, 279$ .

***1b. Does participation in FTC reduce the number of allegations where parents are perpetrators? Does participation in FTC reduce the overall maltreatment recidivism rate (the percent of participants who perpetrated subsequent maltreatment allegations) compared with traditional processing?***

**Differences in Number of Allegations Where Parent is the Perpetrator.** As the children associated with parents in the child welfare system often live with other (non-parent) adults both at home and in out of home care, some maltreatment allegations occur where the biological parent (or the parent of interest in the FTC-CAM or comparison group) is not the perpetrator. An analysis was performed to better understand whether participation in FTC-CAM reduces the number of allegations where the parent in the program was the perpetrator. Figure 6 presents the average number of allegations of subsequent maltreatment for FTC-CAM parents and comparison group parents, showing that fewer FTC-CAM parents were perpetrators compared to non-FTC parents, though the difference was not significant.<sup>17</sup>

**Figure 6. FTC-CAM Parents Were Perpetrators in Fewer Allegations Over 3 Years<sup>18</sup>**

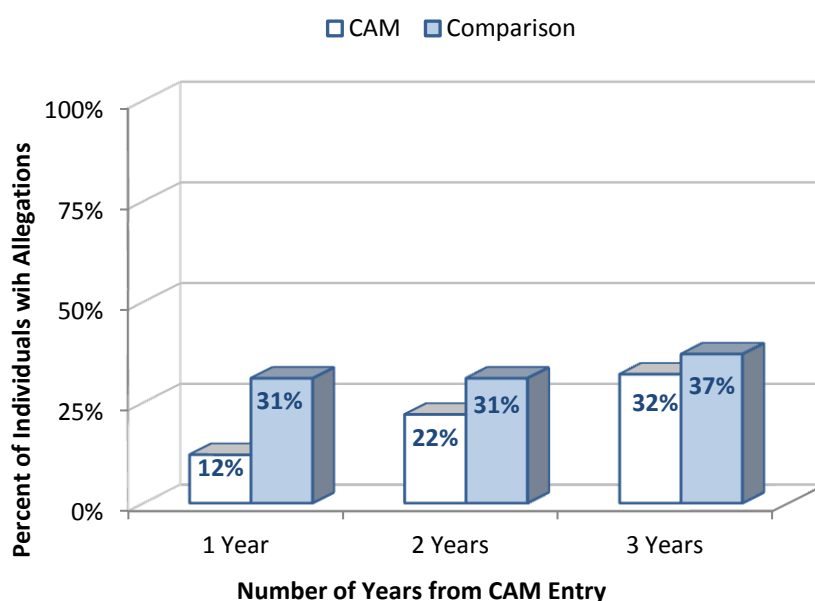


<sup>17</sup> Non-adjusted means by group and time period (1 Year, 2 Years, 3 Years): FTC-CAM Participants – 0.28, 0.67, 0.82; Comparison Group – 0.59, 0.91, 1.87.

<sup>18</sup> Sample sizes represent number of participants by group and time period (1 Year, 2 Years, 3 Years): FTC-CAM Participants  $n = 61, 46, 28$ ; Comparison Group  $n = 61, 51, 40$ .

**Differences in Percent of Parents who were Perpetrators in Allegations.** In addition to examining the average numbers of allegations where parents were perpetrators as described above, it is also useful to look at the number of parents (the percent of parents) from each group who were perpetrators (at least once) over time. Figure 7 illustrates the percent of FTC-CAM participants and comparison group members who were perpetrators on any allegation over a 3-year period following program entry. The percent of FTC-CAM participants who were perpetrators was significantly lower than the comparison group in Year 1 ( $p < .05$ ) during the time the parents were participating in the program. The trend continues in subsequent years, although the differences were not statistically significant.

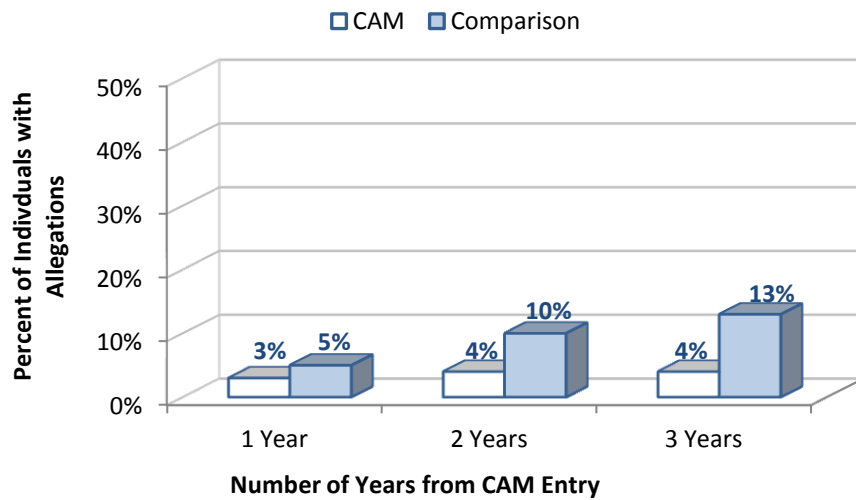
**Figure 7. FTC-CAM Parents Were Perpetrators Less Often than Non-FTC Parents Over 3 Years<sup>19</sup>**



**Percent of Parents Who Were Perpetrators for Founded Allegations.** Figure 8 shows the percent of FTC-CAM participants, and comparison group members who were perpetrators on founded allegation over a 3-year period following program entry. Fewer FTC-CAM participants were perpetrators compared to non-FTC parents over all 3 years, although the differences were statistically significant, likely due to small sample size and so few occurrences of founded allegations. It is important to note that no FTC-CAM graduates were perpetrators in founded allegations up to 3 years post program entry.

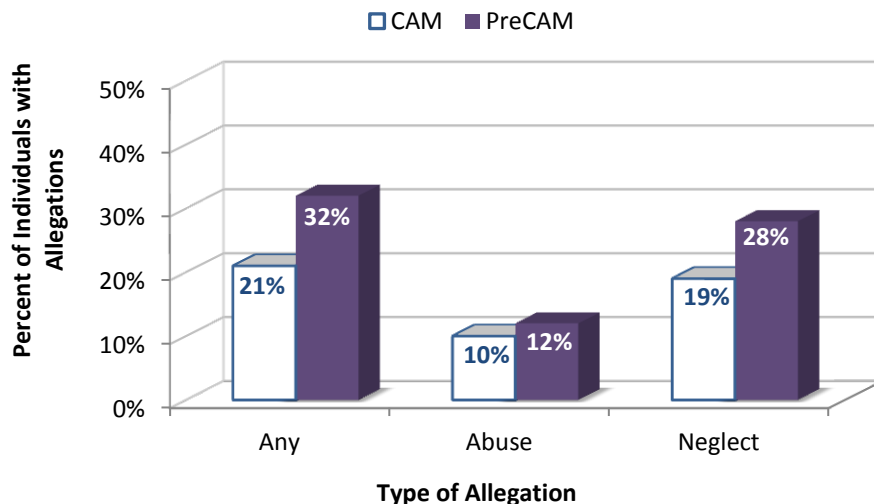
<sup>19</sup> Sample sizes by group and time period (1 Year, 2 Years, 3 Years): Graduates  $n = 36, 33, 20$ ; FTC-CAM Participants  $n = 61, 46, 28$ ; Comparison Group  $n = 61, 51, 38$ .

**Figure 8. FTC-CAM Parents Were Perpetrators in Founded Allegations Less Often than Non-FTC Parents<sup>20</sup>**



**Percent of CAM Parents Who Were Perpetrators Compared to PreCAM.** When comparing FTC-CAM parents to FTC-PreCAM parents, FTC-CAM parents were perpetrators in maltreatment allegations significantly less often than FTC-PreCAM parents at 2 year post entry ( $p < .05$ ). Figure 9 displays the differences between groups for any allegation, abuse allegations, and neglect allegations.

**Figure 9. FTC-CAM Parents were Perpetrators Less Often Than FTC-PreCAM on all types of Allegations at 2 Years Post Entry<sup>21</sup>**



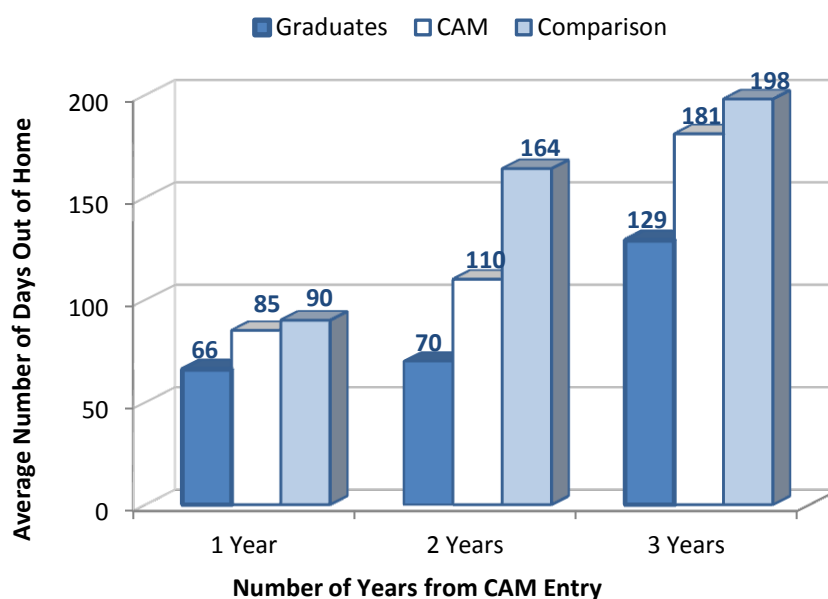
<sup>20</sup> Sample sizes by group and time period (1 Year, 2 Years, 3 Years): Graduates  $n = 36, 33, 20$ ; FTC-CAM Participants  $n = 61, 46, 28$ ; Comparison Group  $n = 61, 50, 39$ .

<sup>21</sup> Sample sizes by group at Year 2: FTC-CAM Participants  $n = 48$ ; FTC-PreCAM Participants  $n = 75$ .

***1c. Do children whose parents participate in FTC spend fewer days in out of home placements than children whose parents went through traditional processing?***

In the 3 years after program entry, the FTC-CAM children spent less time in out of home placements than children of non-FTC parents (though this difference was not statistically significant). Figure 10 shows the average number of days children of FTC-CAM graduates, children of all FTC-CAM participants, and comparison group children spent in out of home placements over a 3-year period.<sup>22</sup> Children of FTC-CAM graduates spend considerably less time out of home. However, the amount of time in out of home care may not be an appropriate measure of the success of an FTC program. It is not always best for children to be returned home quickly if their parents are not yet prepared to care for them. A better measure may be whether children are more likely to eventually be reunified, and whether they successfully stay in the home once they return. The results of analyses on reunification and stability are presented later in this report.

**Figure 10. Average Days Spent in Out of Home Placements Over 3 Years for FTC-CAM and Comparison Children<sup>23</sup>**

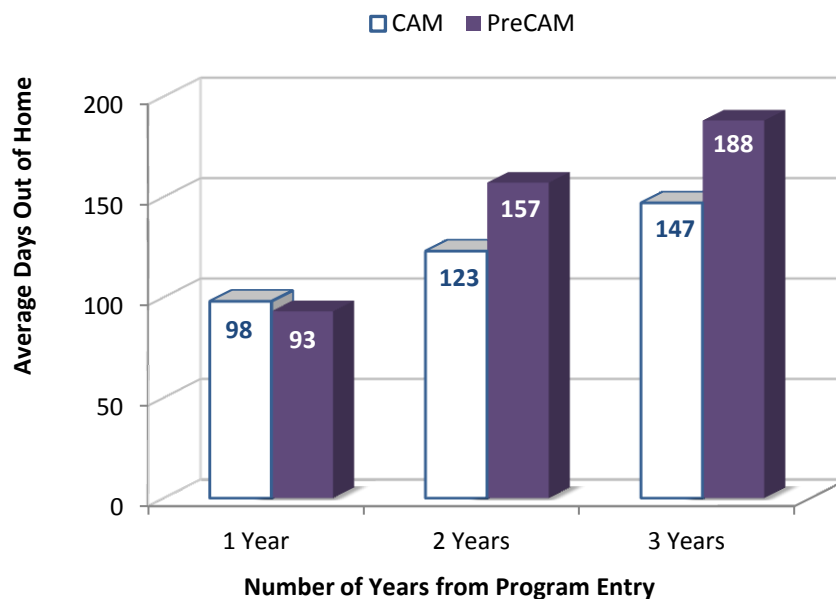


<sup>22</sup> Non-adjusted means are as follows for children by group and time period (1 Year, 2 Years, 3 Years): FTC-CAM Participants – 87, 107, 174; FTC-PreCAM Participants – 83, 155, 194.

<sup>23</sup> Sample sizes represent number of children by group and time period (1 Year, 2 Years, 3 Years): Graduates  $n = 127, 118, 66$ ; All FTC-CAM Participants  $n = 200, 168, 97$ ; Comparison Group  $n = 197, 167, 140$ .

**Time in out of home placement for FTC-CAM versus FTC-PreCAM.** Time in out of home placement for FTC-CAM children was also compared to FTC-PreCAM children. The trend shows FTC CAM children spent fewer days in out of home care over time than FTC PreCAM, though the differences were not statistically significant. Figure 11 displays the average number of days for both groups over 3 years after entry. As discussed earlier, days in out of home care may not be the most appropriate, or meaningful, measure of FTC success.

**Figure 11. FTC-CAM Children Spent Less Time in Out of Home Placements Over 3 Years Compared to FTC-PreCAM<sup>24</sup>**



When the days in out of home placements for all the children of each FTC-CAM parent were combined and compared to the combined days of FTC-PreCAM parents, the difference in days *per parent* did become statistically significant. FTC-CAM *parents* showed significant reduction in days their children spent out of home ( $p < .05$  at 2 years). FTC-CAM parents averaged a total of 363 days out of home for all of their children combined and FTC-PreCAM parents averaged 615 days out of home for all of their children.<sup>25</sup>

<sup>24</sup> Sample sizes represent number of children by group and time period (1 Year, 2 Years, 3 Years): Graduates  $n = 127, 118, 66$ ; All FTC-CAM Participants  $n = 200, 168, 97$ ; Comparison Group  $n = 197, 167, 140$ .

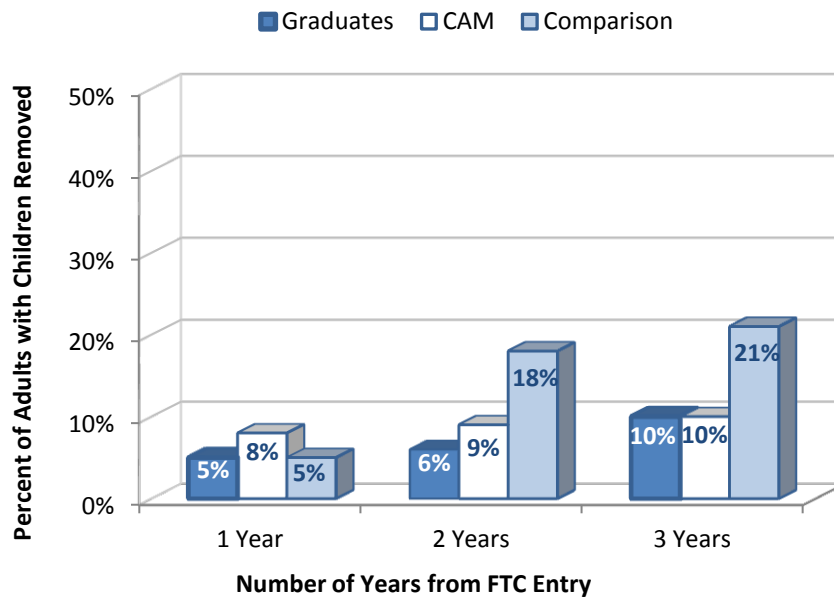
<sup>25</sup> Non-adjusted means: FTC-CAM – 388, Comparison Group – 600.



**1d. Are there fewer removals post program entry for children of FTC parents than non FTC parents? Are there differences in the reasons for removal from children of FTC parents compared to non FTC parents?**

A more meaningful measure of FTC success than time in out of home care may be subsequent child removals (child welfare recidivism). When subsequent removals for children from FTC-CAM parents were compared to subsequent removals for non-FTC parents, FTC-CAM parents were less likely to have children removed again after program entry. Specifically, FTC-CAM parents were half as likely 2 and 3 years after program entry to have a child removed (though the difference was not statistically significant, probably due to the small number of removal events). Figure 12 presents the percent of parents with removals for all FTC-CAM children and comparison group children.<sup>26</sup> While all parents had at least one removal prior to program entry (the removal that led to their participation in the program or that made them eligible for the comparison group), very few subsequent removals occurred for either group.

**Figure 12. FTC-CAM Parents Were Half as Likely to Have Children Removed 2 and 3 Years After FTC Entry<sup>27</sup>**



FTC-CAM participants did better than FTC-PreCAM participants in this outcome as well, though again, the number of subsequent removals was so low that differences were not significant at any time point.<sup>28</sup>

<sup>26</sup> Non-adjusted means by group and time period (1 Year, 2 Years, 3 Years): FTC-CAM – 0.09, 0.13, 0.14, Comparison Group – 0.08, 0.24, 0.29.

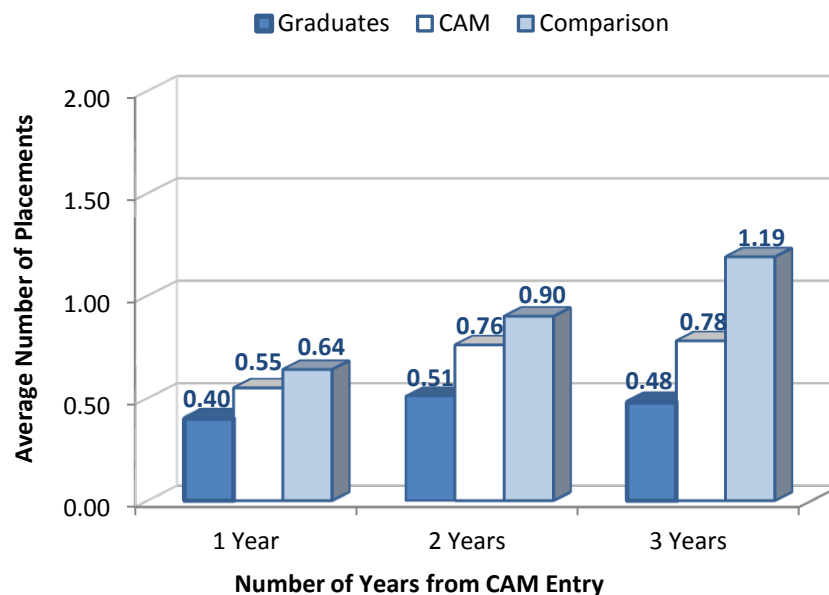
<sup>27</sup> Sample sizes represent number by group and time period (1 Year, 2 Years, 3 Years): Graduates  $n = 38, 34, 21$ ; All FTC-CAM Participants  $n = 65, 47, 29$ ; Comparison Group  $n = 61, 51, 40$ .

<sup>28</sup> Non-adjusted means are as follows for participants by group and time period (1 Year, 2 Years, 3 Years): FTC-CAM Participants – 0.09, 0.11, 0.13; FTC-PreCAM Participants – 0.11, 0.16, 0.28.

***1e. Do children of FTC parents have better placement stability than children of non FTC parents?***

**Placement Stability for FTC-CAM Compared to Non-FTC.** The number of changes in placement for those children who were removed prior to program entry for FTC and non-FTC parents were compared. Results showed a trend for higher number of changes in placement for the children of the non-FTC group while out of home compared to FTC-CAM children, (though these differences between groups are not statistically significant). The average number of subsequent changes in placement are displayed in Figure 13 for FTC-CAM graduates, children of all FTC-CAM participants, and comparison group children.<sup>29</sup> Of those children who were removed prior to program entry, at 2 years post entry, 39% of FTC-CAM children and 43% of comparison children had changed placements.

**Figure 13. Average Number of Placements Over 3 Years<sup>30</sup>**

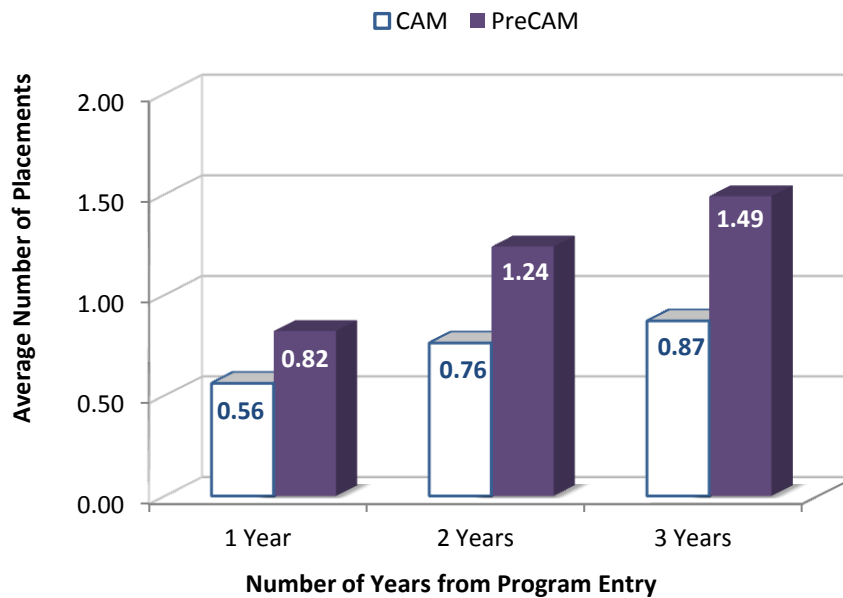


<sup>29</sup> Non-adjusted means are as follows for children by group and time period (1 Year, 2 Years, 3 Years): FTC-CAM Participants – 0.53, 0.73, 0.78; Comparison Group – 0.65, 0.92, 1.22.

<sup>30</sup> Sample sizes represent number of children by group and time period (1 Year, 2 Years, 3 Years): Graduates  $n = 60$ , 53, 33; All FTC-CAM Participants  $n = 101$ , 82, 55; Comparison Group  $n = 98$ , 82, 60.

**Placement Stability for FTC-CAM Compared to FTC-PreCAM.** Comparing FTC-CAM to FTC-PreCAM shows significant differences in number of placement changes (Year 2  $p < .05$ ). Figure 14 illustrates the average number of placements for FTC-CAM and FTC-PreCAM 3 years post entry.<sup>31</sup>

**Figure 14. FTC-CAM Parents Had Fewer Changes in Placement than FTC-Pre\_CAM Over 3 Years<sup>32</sup>**



Moreover, the percentage of FTC-PreCAM children who experienced any changes in placement while out of home was significantly higher than FTC-CAM children each year up to 3 years after entry ( $p < .05$  in Year 1,  $p < .001$  in Years 2 and 3). By Year 2, 39% of FTC-CAM children and 64% of FTC-PreCAM children had been moved from their initial placement.

<sup>31</sup> Non-adjusted means: FTC-CAM – 0.56, 0.75, 0.82 FTC-PreCAM – 0.81, 1.24, 1.51. Non-adjusted means are significant ( $p < .05$ ) at Year 2.

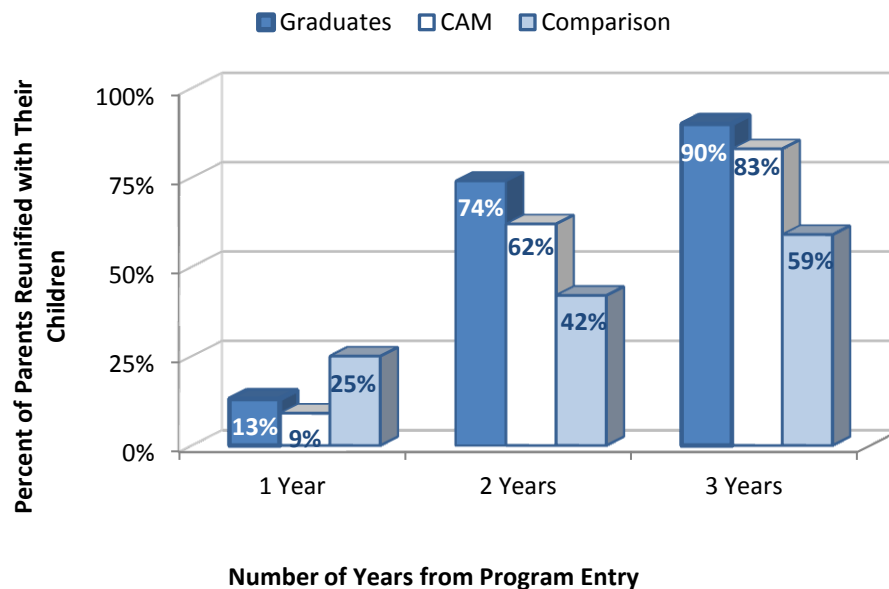
<sup>32</sup> Sample sizes represent number of children by group and time period (1 Year, 2 Years, 3 Years): FTC-CAM Participants  $n = 96, 77, 50$ ; FTC-PreCAM  $n = 134, 134, 134$ .

**1f. Are there differences in the occurrence of different types of permanency decisions (reunification, adoption, guardianship, or aged out) for children of FTC parents compared to non FTC parents?**

Reunification was the most common permanency disposition for children removed prior to program entry. The number of children experiencing other dispositions was so low that it is difficult to conclude whether the program had significant effects on these outcomes. Specifically, by Year 2, more children of Non-FTC parents were released to a guardian than FTC children (3% vs 0%), and no non-FTC children had been adopted compared to 2% of FTC children.

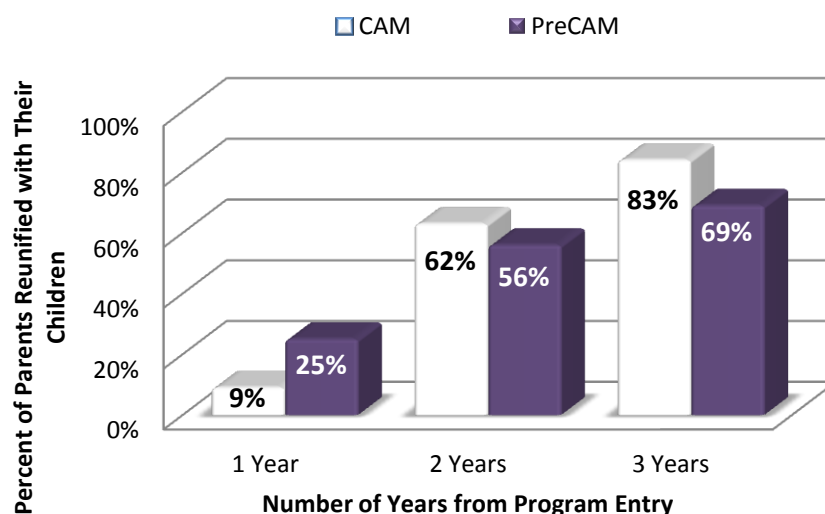
**Reunification Rates FTC-CAM Compared to Non-FTC.** For the children who were removed prior to entry, the rates of reunification were significantly higher for FTC-CAM children than comparison children 2 years post program entry ( $p < .05$ ). Figure 15 presents the reunification rates for the children of FTC-CAM graduates, all FTC-CAM participants, and the comparison group. While fewer FTC children were reunified in Year 1 (when FTC families were participating in the program), more FTC children were reunified with their parents by Years 2 and 3. The Year 3 reunification rates should be interpreted with caution as not all families in the sample had 3 Years of outcome time available, so the Year 3 numbers are for a subset of the full sample.

**Figure 15. FTC-CAM Parents Were Significantly More Likely to be Reunified with Their Children Over 3 Years**



**Reunification for FTC-CAM Compared to FTC-PreCAM.** FTC-CAM also improved reunification rates compared to FTC-PreCAM, though not significantly. Figure 16 shows the rates of reunification between FTC-CAM and FTC-PreCAM children.

**Figure 16. Percent of Parents Reunified with their Children Over 3 Years<sup>33</sup>**

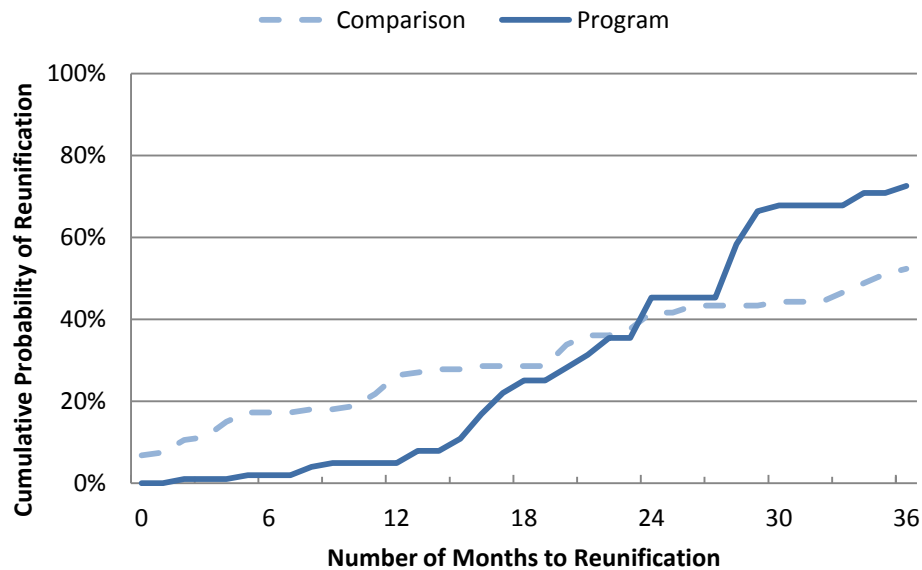


***1g. Of all children removed, what percentage of FTC families were reunified compared to non FTC families? For families who are reunified, are FTC families reunified sooner than non FTC families? Are there fewer subsequent removals post-reunification?***

A survival analysis of for children who were removed prior to parent entry into FTC and who had up to 3 years (presented in months) of outcome data was performed. Results in Figure 17 show that the time to a reunification for FTC-CAM and comparison group children occurred at similar rates until 26 months, at which point FTC-CAM children are still being reunified through the 36 month span and the comparison children level off. The solid blue line represents the FTC-CAM group, and the dashed line represents the comparison group. As the line climbs, this indicates the occurrence of a reunification over time. A steeper rise in the line indicates a greater number of reunifications occurring sooner. The average time to reunification for FTC-CAM children was 26 months and for the comparison children, 25 months (the difference is not statistically significant). However, for those children who had three full years from parent entry into the program, at the end of the 3-year period, 63% of FTC-CAM children were reunified compared to just 49% of comparison children.

<sup>33</sup> Sample sizes represent number of children by group and time period (1 Year, 2 Years, 3 Years): FTC-CAM Participants  $n = 96, 77, 50$ ; Comparison Group  $n = 134, 134, 134$ .

**Figure 17. Probability of Reunification Over Time (Survival Function)<sup>34</sup>**



For those children who were reunified by 3 years, it was possible for them to be removed from home again. After examining the children in both groups who were reunified by 3 years post removal, and who had at least one year available post reunification date, FTC-CAM children were more likely to stay at home than comparison group children, though not statistically different.<sup>35</sup> An overwhelming majority, 95%, of FTC-CAM children remained at home compared to 83% of comparison children.

<sup>34</sup> Sample sizes by group: All FTC-CAM Children  $n = 101$ ; Comparison Children  $n = 133$ .

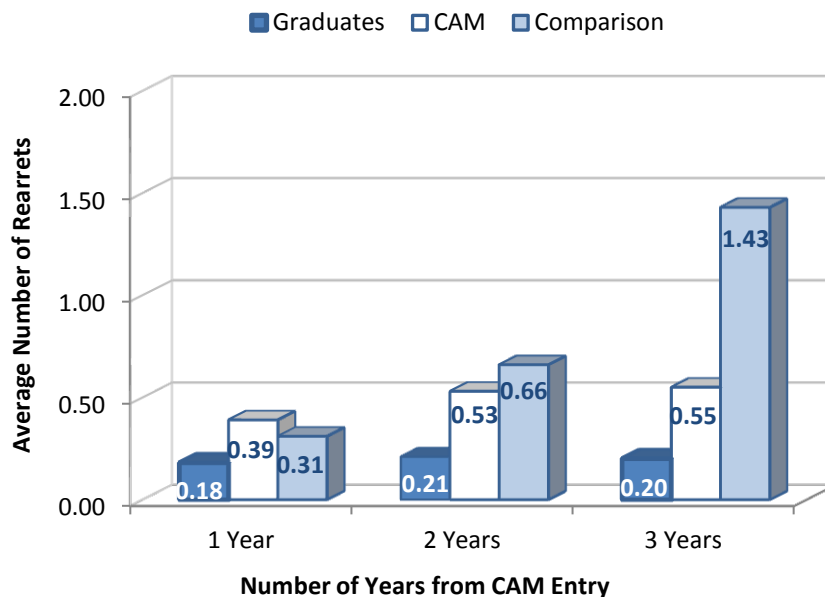
<sup>35</sup> Sample sizes by group: All FTC-CAM Children  $n = 42$ ; Comparison Children  $n = 47$ .

## RESEARCH QUESTION #2: WHAT IS THE IMPACT OF FTC AND CAM ON CRIMINAL RECIDIVISM?

### *2a. Does participation in FTC reduce the average number of all rearrests for those individuals compared with traditional processing?*

**Criminal Recidivism for FTC-CAM compared to Non-FTC Parents.** Figure 18 displays the average number of cumulative rearrests for each year up to 3 years after program entry for FTC-CAM graduates, all FTC-CAM participants, and the comparison group. As illustrated in the graph, FTC participants had a lower number of rearrests than the comparison group 2 and 3 years after program entry. These differences were not statistically significant most likely due to small sample size, and the small number of new arrests in this population in general.<sup>36,37</sup> While not statistically significant, the difference between groups is meaningful. By Year 3 FTC-CAM participants had less than half the recidivism of the comparison group (although by Year 3 this includes a subset of the full sample of FTC-CAM participants). FTC graduates also had substantially fewer rearrests than FTC participants and the comparison group 1, 2, and 3 years after program entry.<sup>38</sup>

**Figure 18. FTC-CAM Parents had Fewer Rearrests than Non-FTC Parents Over 3 Years<sup>39</sup>**



<sup>36</sup> Non-adjusted means are as follows by group and time period (1 Year, 2 Years, 3 Years): All FTC-CAM Participants – 0.38, 0.53, 0.59; Comparison Group – 0.31, 0.66, 1.40.

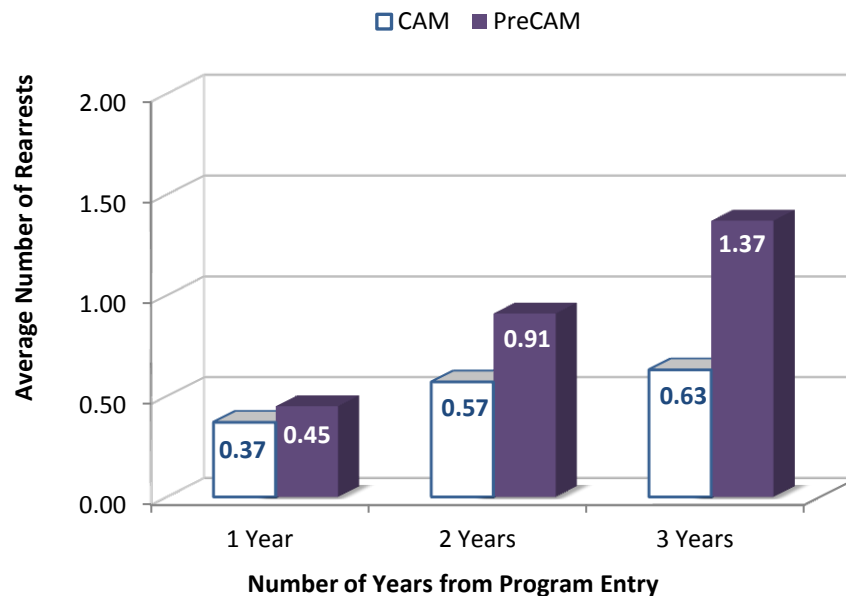
<sup>37</sup> Time at risk is not included in the reported ANCOVA model. The average number of rearrests for each year was reviewed with incarceration time included as a covariate and the findings were similar. At Years 2 and 3, FTC-CAM participants were less likely to be rearrested. Adjusted means by group and time period (1 Year, 2 Years, 3 Years): All FTC-CAM Participants – 0.41, 0.50, 0.59; Comparison Group – 0.29, 0.69, 1.40.

<sup>38</sup> Graduates are not necessarily matched to the entire comparison group and therefore they are not directly comparable to the means of the comparison group, but are provided to add context for differences in outcomes between all FTC-CAM participants and graduates.

<sup>39</sup> Sample sizes by group and time period (1 Year, 2 Years, 3 Years): Graduates  $n = 38, 33, 20$ ; All FTC-CAM Participants  $n = 63, 45, 27$  Comparison Group  $n = 61, 50, 40$ .

**Criminal Recidivism for FTC-CAM compared to FTC-PreCAM Parents.** FTC-CAM participants also had fewer rearrests than FTC-PreCAM participants. Again, these results were not statistically significant, but the difference between groups is large enough to be meaningful in each year post program entry. By the third year after entry, FTC-CAM participants had less than half the number of rearrests compared to FTC-PreCAM. Figure 19 shows the difference in average number of rearrests between FTC-CAM and FTC-PreCAM participants over 3 years.<sup>40 41</sup>

**Figure 19. FTC-CAM Parent had Fewer Rearrests Over 3 Years Compared to FTC-PreCAM<sup>42</sup>**



<sup>40</sup> Non-adjusted means are as follows by group and time period (1 Year, 2 Years, 3 Years): FTC-CAM Participants – 0.36, 0.50, 0.60; FTC-PreCAM Participants – 0.47, 0.94, 1.39.

<sup>41</sup> Time at risk is not included in the reported ANCOVA model. The average number of rearrests for each year was reviewed with incarceration time included as a covariate and the findings were similar. FTC-CAM participants were less likely to be rearrested. Adjusted means by group and time period (1 Year, 2 Years, 3 Years): FTC-CAM Participants – 0.38, 0.53, 0.73; FTC-PreCAM Participants – 0.45, 0.93, 1.34.

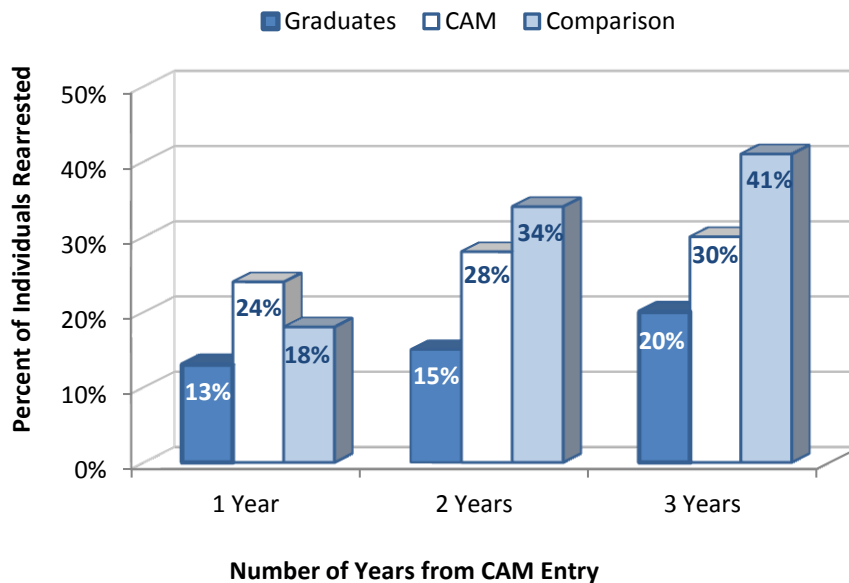
<sup>42</sup> Sample sizes by group and time period (1 Year, 2 Years, 3 Years): FTC-CAM Participants  $n = 65, 47, 29$ ; FTC PreCAM Participants  $n = 80, 80, 80$ .



**2b. Does participation in FTC lead to a lower overall recidivism rate (the percent of participants who were rearrested) compared with traditional processing?**

**FTC-CAM Compared to Non-FTC Parents.** In addition to examining the average numbers of rearrests as described in 2a, it is also useful to look at the number of individuals (percent of individuals) from each group who were rearrested (at least once) over time. Figure 20 illustrates the percent of FTC-CAM graduates, all FTC-CAM participants, and comparison group members who were rearrested over a 3-year period for any charge following program entry. The percent of FTC-CAM participants rearrested was slightly lower than the comparison group in Years 2 and 3 (28% to 34%, and 30% to 41%, respectively), but higher than the comparison group in Year 1 (24% to 18%). Again, the results were not statistically significant, likely due to the relatively small sample sizes. Note that while the percent of comparison parents rearrests increases relatively substantially over time, the percentage of FTC-CAM parents rearrested levels out over time with very small increases after the first year.

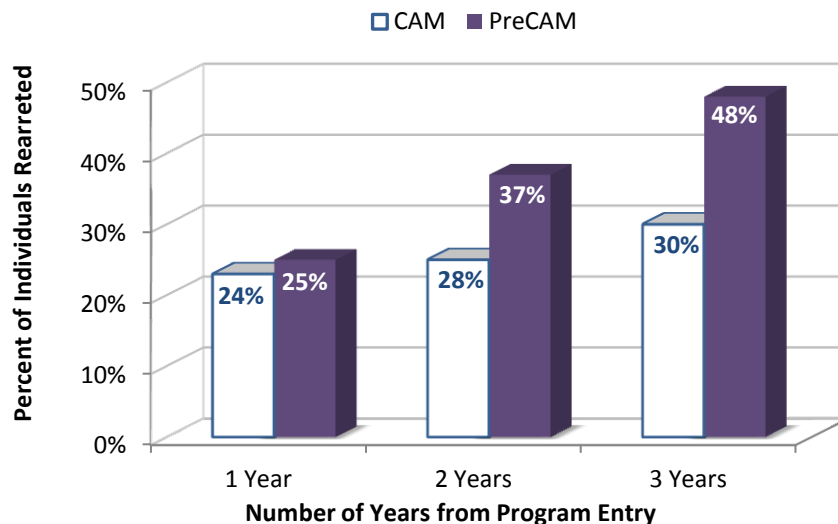
**Figure 20. Percent of Individuals Rearrested for any Offense Over 3 Years<sup>43</sup>**



<sup>43</sup> Sample sizes by group and time period (1 Year, 2 Years, 3 Years): Graduates  $n = 38, 33, 20$ ; All FTC-CAM Participants  $n = 63, 45, 27$ ; Comparison Group  $n = 61, 50, 39$ .

**FTC-CAM Compared to FTC-PreCAM Parents.** FTC-CAM participants had lower recidivism rates when compared to the historical FTC-PreCAM sample. Each year post program entry showed a larger difference between groups, though not statistically significant. Figure 21 presents the percent of FTC-CAM participants and FTC-PreCAM participants who were rearrested over a 3-year period for any charge following program entry.

**Figure 21. Percent of Individuals Rearrested for any Offense over 3 Years<sup>44</sup>**

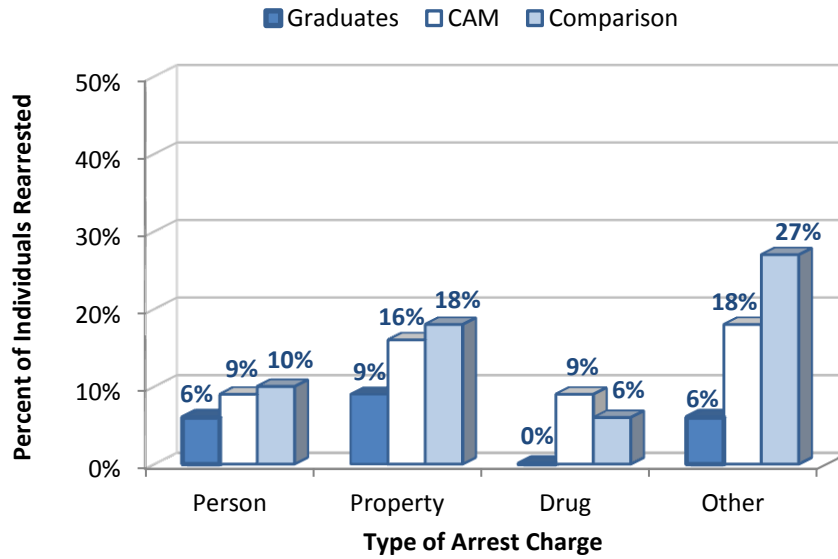


**Subsequent Arrests by Type of Charge.** To present a more descriptive picture of the criminality of the groups, arrests are presented broken out by type of charge including person (e.g., assault), property (e.g., theft), drug (e.g., possession), or other arrest charges (e.g., trespassing) 2 years from program entry in Figure 22.<sup>45</sup> Logistic regressions were run to control for gender, age, race, prior treatment history, number and age of children, child welfare history, and criminal history.

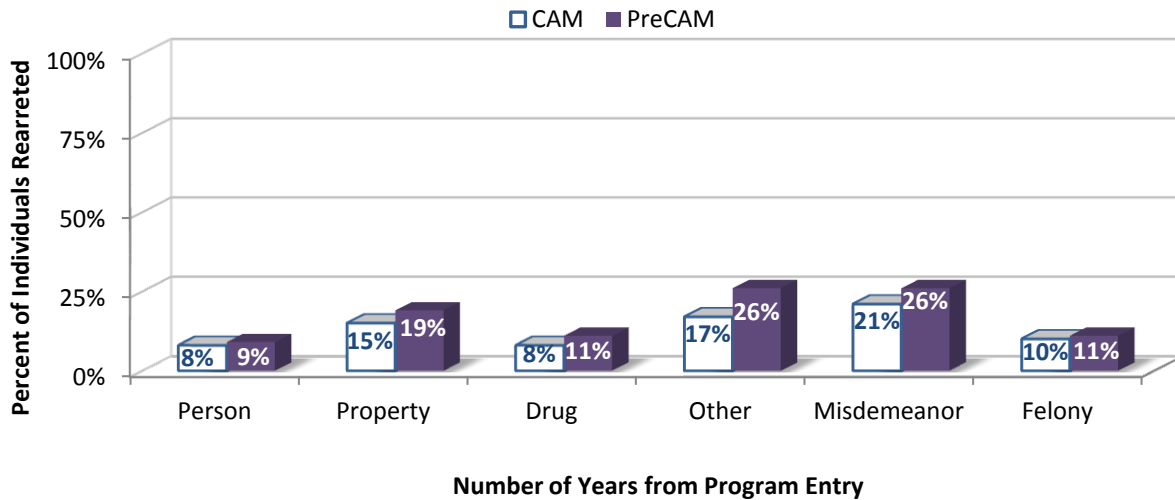
**FTC-CAM Compared to Non-FTC.** Figure 22 demonstrates that FTC-CAM participants had similar arrest rates to the comparison group by type and level. Though a higher rate of FTC-CAM participants were arrested for drug crimes, and a lower rate for “Other” crimes, none of these differences were statistically significant. This is likely due to small sample sizes and small numbers of these events. For example, there were only seven people across both groups who were rearrested for a drug offense 2 years after entry, and none of these individuals were graduates of the program.

<sup>44</sup> Sample sizes by group and time period (1 Year, 2 Years, 3 Years): FTC-CAM Participants  $n = 66, 48, 30$ ; FTC-PreCAM Participants  $n = 85, 85, 85$ .

<sup>45</sup> When an individual received more than one charge per arrest, a single arrest could be coded as both a person and property crime. Therefore, the percents in Figure 22 does not add up to the percent of total arrests reflected in Figure 20.

**Figure 22. Percent of Individuals Rearrested by Arrest Charge at 2 Years<sup>46</sup>**

**FTC-CAM Compared to FTC-PreCAM.** FTC-CAM participants did show a trend for reduction in arrests when compared to FTC-PreCAM participants across all types and levels, though (again) the differences were not statistically significant. Figure 23 displays the differences between groups at 2 years post program entry.

**Figure 23. Percent of Individuals Rearrested by Arrest Type and Level at 2 Years<sup>47</sup>**

<sup>46</sup> Sample sizes by group: Graduates  $n = 33$ ; All FTC-CAM Participants  $n = 45$ ; Comparison Group  $n = 50$ .

<sup>47</sup> Sample sizes by group: All FTC-CAM Participants  $n = 48$ ; All FTC-PreCAM Participants  $n = 85$ .

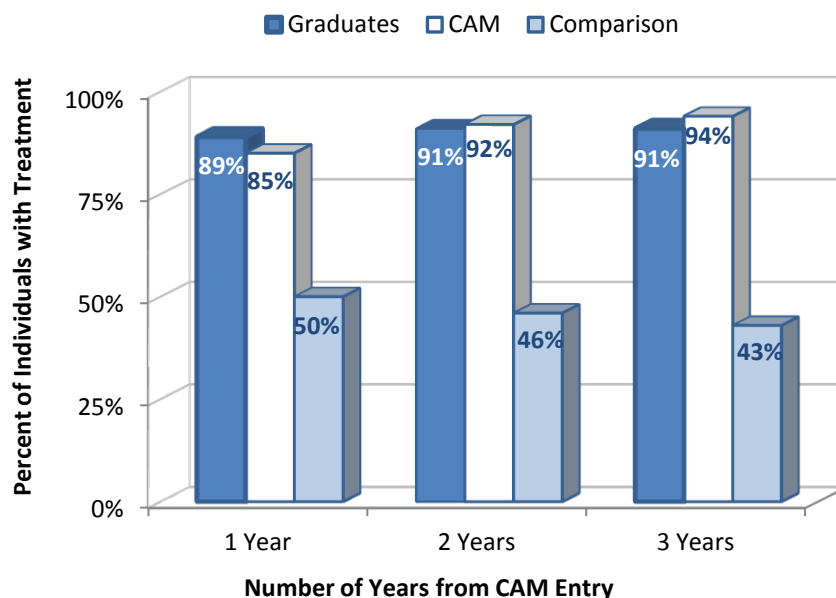
### RESEARCH QUESTION #3: WHAT IS THE IMPACT OF FTC AND CAM ON SUBSTANCE ABUSE TREATMENT COMPLETION?

#### **3a. Do FTC parents enroll in substance abuse treatment more often than non FTC parents?**

Significantly more FTC-CAM parents enrolled in outpatient treatment in the 3 years after the program entry date than non FTC parents. Figure 24 illustrates the percent of FTC-CAM graduates, all FTC-CAM participants, and comparison group members who entered outpatient treatment over a 3-year period. The percent of FTC-CAM participants entering treatment was significantly higher than the comparison group in Years 1, 2, and 3 ( $p < .001$  at every time point). There were no significant differences between FTC-CAM and FTC-PreCAM participants.

It is important to note that all FTC-CAM graduates received substance abuse treatment as part of the program. The percentages below are under-reported as they are from the statewide treatment system and some treatment is not consistently reported. However, it is likely that the under-reporting occurs in the same way for FTC participants and non FTC participants, so the proportional difference between the program and comparison group should be accurate.

**Figure 24. Percent of Individuals Entering Outpatient Treatment Over 3 Years<sup>48</sup>**



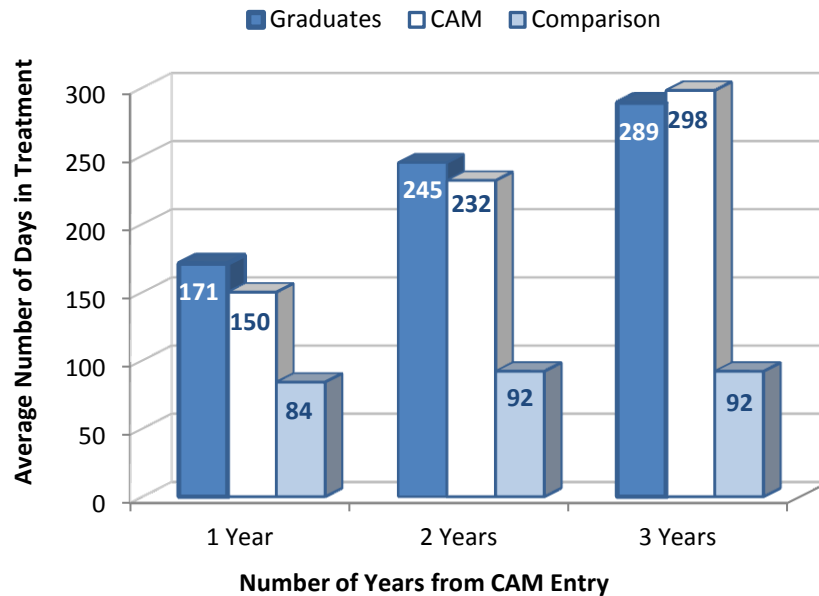
There was no significant difference between FTC-CAM participants and the comparison group in terms of entering *residential* treatment. However, FTC-CAM participants did enter residential treatment at slightly higher rates in Years 1 and 2 (40% to 28%, and 40% to 35%, respectively).

<sup>48</sup> Sample sizes by group and time period (1 Year, 2 Years, 3 Years): Graduates  $n = 38, 35, 23$ ; All FTC-CAM Participants  $n = 65, 50, 31$ ; Comparison Group  $n = 61, 52, 39$ .

**3b. Do FTC parents spend more time in substance abuse treatment than non FTC parents?**

In the 3 years after program entry, the FTC-CAM parents spent over three times as long in outpatient treatment than parents who never enrolled in FTC. Figure 25 shows the average number of days FTC-CAM graduates, all FTC-CAM participants, and comparison group members spent in outpatient treatment over a 3-year period.<sup>49</sup> The number of days was significantly higher than the comparison group in Years 1, 2, and 3 ( $p < .001$  at every time point).

**Figure 25. Average Days Spent in Outpatient Treatment Over 3 Years<sup>50</sup>**

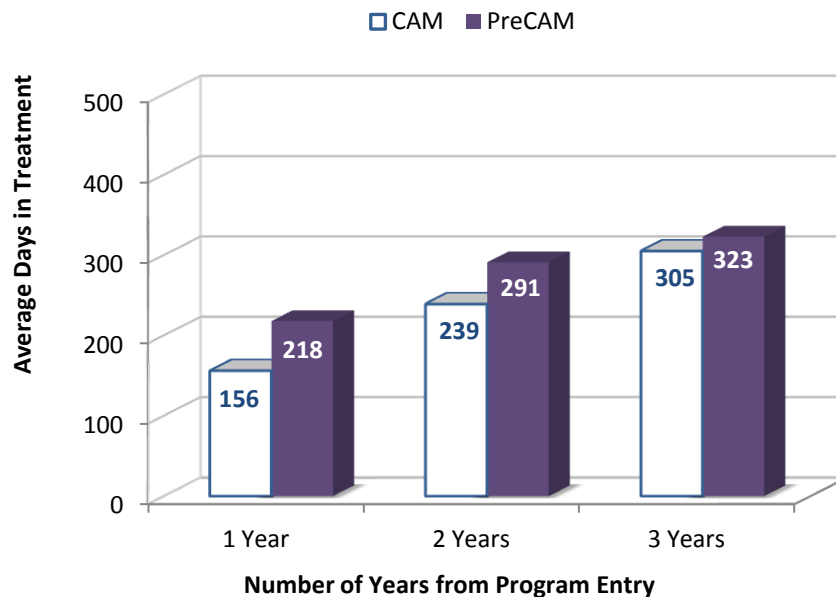


<sup>49</sup> Non-adjusted means are as follows by group and time period (1 Year, 2 Years, 3 Years): FTC-CAM Participants – 152, 236, 299; FTC-PreCAM Participants – 81, 88, 91.

<sup>50</sup> Sample sizes by group and time period (1 Year, 2 Years, 3 Years): Graduates  $n = 38, 35, 23$ ; All FTC-CAM Participants  $n = 65, 50, 31$ ; Comparison Group  $n = 61, 52, 39$ .

**FTC-CAM vs FTC-PreCAM.** A comparison of FTC-CAM to FTC Pre-CAM showed that the average number of days in outpatient treatment was significantly lower for FTC-CAM participants compared to FTC-PreCAM participants in Year 1 ( $p < .01$ ), the year after program entry, but not significantly different in Years 2 and 3.<sup>51</sup> Figure 26 displays the adjusted average number of days in outpatient treatment for FTC-CAM and FTC-PreCAM participants.

**Figure 26. Average Days Spent in Outpatient Treatment Over 3 Years<sup>52</sup>**



While not significantly different, FTC-CAM participants had more days in residential treatment in Years 1, and 2 but not Year 3.<sup>53</sup> It is possible that FTC-CAM participants are being assessed and treated more accurately. For example, if FTC-CAM participants were assessed as needing residential treatment immediately after program entry, which might reduce the number of days in outpatient treatment. Alternatively, FTC-PreCAM participants may have been over treated and attended too much outpatient treatment.

<sup>51</sup> Non-adjusted means are as follows by group and time period (1 Year, 2 Years, 3 Years): FTC-CAM – 160, 246, 309; FTC-PreCAM – 212, 283, 315.

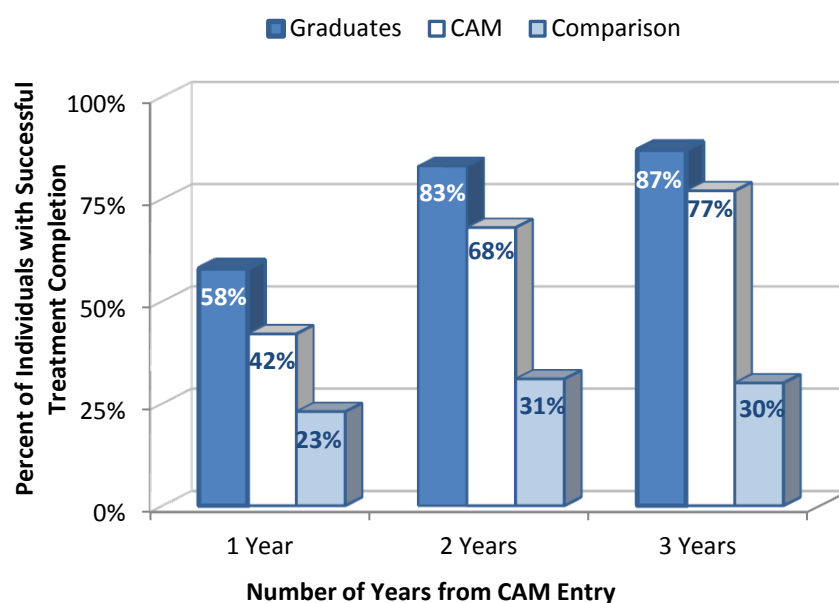
<sup>52</sup> Sample sizes by group and time period (1 Year, 2 Years, 3 Years): FTC-CAM Participants  $n = 67, 52, 33$ ; FTC-PreCAM Participants – 80, 80, 80.

<sup>53</sup> Average days in residential treatment by group and time period (1 Year, 2 Years, 3 Years): FTC-CAM – 18, 22, 10; FTC-PreCAM – 11, 15, 18.

### 3c. Do FTC parents complete substance abuse treatment more often than non FTC parents?

Significantly more FTC-CAM parents successfully completed outpatient treatment after program entry compared to parents who never enrolled in FTC. As demonstrated in Figure 27, over a 3-year period after program entry, 77% of FTC-CAM parents had completed treatment compared to 30% of the comparison group. The difference was significant ( $p < .05$  in Year 1,  $p < .001$  in Years 2 and 3). Further, 87% of FTC-CAM graduates showed completed treatment episodes in the statewide data. (Note this is likely reflective of treatment episodes being under-reported in the state system).

**Figure 27. Percent of Individuals Successfully Completing Outpatient Treatment Over 3 Years<sup>54</sup>**

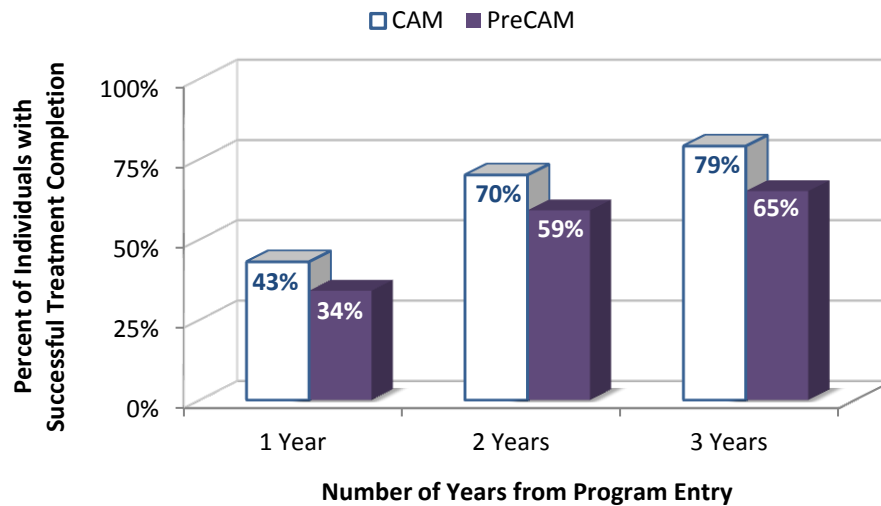


A key purpose of the drug court model is to use the authority of the court and the judge to keep people in treatment long enough to complete a full course of treatment and for significant behavior change to occur. The result of this analysis shows that the FTC-CAM program is fulfilling this purpose.

<sup>54</sup> Sample sizes by group and time period (1 Year, 2 Years, 3 Years): Graduates  $n = 38, 35, 23$ ; All FTC-CAM Participants  $n = 65, 50, 31$ ; Comparison Group  $n = 61, 52, 39$ .

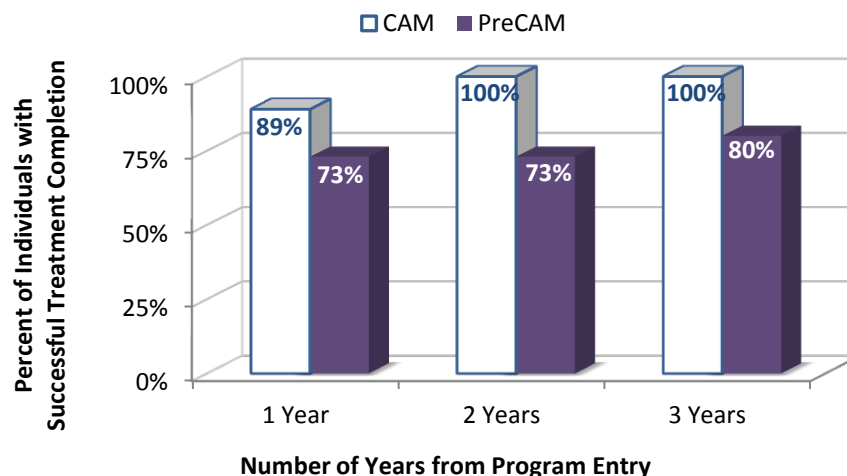
**FTC-CAM vs FTC-PreCAM.** FTC-CAM participants also outperformed FTC-PreCAM participants, though not significantly. Figure 28 displays the difference in outpatient treatment completion between FTC-CAM and FTC-PreCAM participants over 3 years.

**Figure 28. Percent of Individuals Successfully Completing Outpatient Treatment Over 3 Years<sup>55</sup>**



For those program participants who entered residential treatment, FTC-CAM participants were significantly more likely to have successfully completed within 2 years than FTC-PreCAM participants ( $p < .01$ ).<sup>56</sup>

**Figure 29. Percent of Individuals Successfully Completing Residential Treatment Over 3 Years<sup>57</sup>**



<sup>55</sup> Sample sizes by group and time period (1 Year, 2 Years, 3 Years): FTC-CAM Participants  $n = 68, 53, 34$ ; FTC-PreCAM  $n = 85, 85, 85$ .

<sup>56</sup> 20 FTC-CAM participants and 33 FTC-PreCAM participants had entered residential treatment 2 years post program entry. Years 1 and 3 are not significantly different.

<sup>57</sup> Sample sizes by group and time period (1 Year, 2 Years, 3 Years): FTC-CAM Participants  $n = 68, 53, 34$ ; FTC-PreCAM  $n = 85, 85, 85$ .



#### RESEARCH QUESTION #4: HOW SUCCESSFUL IS THE PROGRAM IN BRINGING PROGRAM PARTICIPANTS TO COMPLETION AND GRADUATION WITHIN THE EXPECTED TIME FRAME?

*Is this program successful in bringing program participants to completion and graduation within the expected time frame?*

The average graduation rate for all CCFTC is 50%, which is lower than the national average of 57%. However, for FTC-CAM participants entering between 2010 and 2012 graduated at a rate of 75%, which is considerable higher than the national average.

Whether a program is bringing its participants to successful completion and doing so in the intended time frame is measured by program graduation (completion) rate, and by the amount of time participants spend in the program. Program *graduation rate* is the percentage of participants who graduated from the program, out of a cohort of participants who started during a similar time frame and who have left the program either by graduating or by being unsuccessfully discharged. Active participants are excluded from the calculation. Graduation rate was calculated for each entry year from 2006 to 2014. The program's graduation rate for all participants entering between 2006 and 2012 is 50% (2013 and 2014 were not included because many of the participants were still active). Table 6 shows status outcomes by entry cohort year. Other than a sudden increase in graduations in 2008, the program shows a trend of increasing graduation rates every year since 2007 through 2012. Maybe of the individuals entering in 2013 and 2014 are still active, so the graduation rate for those years is not yet complete. The program exceeded the national average graduation rate of 57% (Huddleston & Marlowe, 2011), many years including 2008, 2011, and 2012.

**Table 6. CCFTC Completion Status by Entry Year**

<b>Program Entry Year</b>	<b>2006 <i>n</i> = 18</b>	<b>2007 <i>n</i> = 21</b>	<b>2008 <i>n</i> = 12</b>	<b>2009 <i>n</i> = 21</b>	<b>2010 <i>n</i> = 23</b>	<b>2011 <i>n</i> = 17</b>	<b>2012 <i>n</i> = 15</b>	<b>2013 <i>n</i> = 22</b>	<b>2014 <i>n</i> = 11</b>
Graduates	56%	29%	67%	38%	43%	59%	73%	55%	0%
Non-Graduates	44%	71%	33%	62%	57%	41%	20%	23%	18%
Actives	0%	0%	0%	0%	0%	0%	7%	23%	82%

Although the CCFTC is doing better at graduating participants compared to the national average, especially since CAM implementation, a program goal is still to continue those practices that are contributing to participant success. In order to graduate, participants must comply with the program practices and requirements. To successfully increase graduation rates, FTC teams must consider the challenges participants face in meeting program requirements, continually review program operations, and adjust as necessary. This can include practices such as ensuring the family basic and practical needs are met such as adequate food, housing,

childcare and transportation. Creative ways can be used to fulfill these needs, such as finding transportation for participants by having participants with cars get rewards for picking up those without transportation and bringing them to treatment and court sessions, or providing bus passes. Or having parents assist other parents with childcare while they participate in program requirements.

It is also important to note that the program has recently made efforts to not terminate participants but rather move them to an inactive docket while trying to reengage them in services. This practice began in 2013 and may increase the graduation rate.

To measure whether the program was following its expected time frame for participant completion, the average amount of time in the program was calculated for participants who had enrolled in the CCFTC program and have graduated from the program. The minimal requirements of the CCFTC would theoretically allow for graduation at approximately 14 months from the time of entry to graduation. The average length of stay in FTC for all participants, both graduates and non-graduates) was 359 days (about 12 months). Graduates spent an average of 499 days in the program, just over 16 months, ranging from 9 months to 2.7 years in the program. Approximately 25% graduated within 12 months, and 75% graduated within 20 months of program entry. Participants who did not graduate spent, on average, around 7 months in the program. Although the program is not graduating the majority of its participants within the 14-month time frame, it is possible that the child welfare system involvement lends itself to more time than the minimum to successfully complete a program that requires substantial life changes. The program changed its model in 2013 to retain participants until the end of their child welfare case, which may take more than 14 months. While many participants are expected to complete substance abuse treatment much earlier on, the remaining time will be focused on their child welfare case and service needs for reunification and permanency decisions.

## RESEARCH QUESTION #5: WHAT PARTICIPANT AND PROGRAM CHARACTERISTICS PREDICT SUCCESSFUL FTC OUTCOMES?

### *Are there participant characteristics that predict program success?*

Overall, graduates of the FTC-CAM program were more likely to have utilized CAM services, specifically neuropsychological evaluations, family treatment, and home support. Graduates also received more rewards during the first 3 months in the program, were less likely to use heroin, and were less likely to have prior treatment in the 2 years before program entry. The details of this analysis are described below.

FTC-CAM Graduates and non-graduates were compared on a variety of factors to determine whether there were any patterns in predicting program graduation. The following analyses included participants who entered the program from 2009 through 2014 and received CAM services.<sup>58</sup> Of those 70 individuals, 15 (21%) were unsuccessfully discharged from the program and 41 (59%) graduated.<sup>59</sup>

Analyses were performed to determine if there were any demographic, child welfare history, criminal history, or program activity of participants that were related to successful drug court completion, including gender, age, ethnicity, drug of choice, length of time in the program, drug tests, prior child welfare involvement as a child and as a parent, and number of arrests in the 2 years before drug court entry. Tables 7-10 show the results for graduates and unsuccessfully discharged participants from chi-square and *t* test analyses. Characteristics that differ significantly between graduates and unsuccessfully discharged participants are in bold text in the tables below ( $p < .05$ ). Additional analyses were performed to determine if any characteristics were significant, holding all other factors constant; however, no characteristic predicted graduation above all other factors (likely due to small sample sizes).

As presented in Table 7, there were no significant differences in demographics between graduates and non-graduates. This indicates that there are no disparities in how the program is treating participants in relation to gender, ethnicity or any other cultural differences. Also similar is the number of ages of children associated with each parent. While non-graduates appear to have younger children, this was not statistically significant. Lastly, each family entering CAM services was administered a NCFAS assessment which scored across multiple items. While these domains varied slightly between graduates and non-graduates, at entry, there were no significant differences. Most scores were negative, indicating that both groups needed to gain assistance and learn skills in the majority of these domains.

<sup>58</sup> CAM implementation occurred in 2010, however, 2 participants entering the program in 2009 received many CAM services and were included for this set of analyses.

<sup>59</sup> The remaining 20% were either active ( $n = 13$ ), or left the program for other reasons (e.g., transferred) ( $n = 1$ ).

**Table 7. FTC-CAM Graduate and Non-Graduate Characteristics: Demographics**

	<b>Graduates <i>n</i> = 41</b>	<b>Non-Graduates <i>n</i> = 15</b>
<b>Gender</b>		
Male	20%	80%
Female	20%	80%
<b>Race/Ethnicity<sup>a</sup></b>		
White	88%	80%
Multiracial	7%	7%
Hispanic/ Latino	0%	7%
American Indian/Alaskan Native	2%	7%
Black	2%	0%
<b>Age at Entry Date</b>		
Average age in years	31	30
<b>Children</b>		
Number of children at entry	4	4
Average age of youngest child	20 months	13 months
Average age of oldest child	102 months	114 months
Average age of all children	61 months	62 months
<b>NCFAS Scores at Entry<sup>b</sup></b>		
Environment	-0.10	-0.31
Parental Capabilities	-1.12	-1.08
Family Interaction	-0.42	-0.62
Family Safety	-0.88	-1.08
Child Well-Being	0.09	0.30
Social/Community Life	-0.46	0.08
Self-Sufficiency	-1.73	-2.00
Family Health	0.49	0.08
Ambivalence	-0.12	-0.17
Readiness for Reunification	-0.90	-1.31

*Note.* The *n* for each category may be smaller than the total group *n* due to missing data.

<sup>a</sup> Numbers do not add up to 100% due to rounding.

<sup>b</sup> Scores range from -3 (Serious Problem) to 2 (Clear Strength). 0 indicates baseline adequacy.

Table 8 displays the child welfare history of graduates and unsuccessfully discharged participants prior to entering the program. There were no statistical differences in prior child welfare involvement between graduates and non-graduates, though non-graduates did have slightly higher rates of abuse as a child (according to the administrative child welfare data) indicating that the history of trauma of the parents may require specific or additional services.

**Table 8. FTC-CAM Graduate and Non-Graduate Characteristics: Child Welfare History**

	<b>Graduates <i>n</i> = 41</b>	<b>Non-Graduates <i>n</i> = 15</b>
<b>Adult Involvement as a Child</b>		
Victim of maltreatment allegation	3%	7%
Removed from home	13%	20%
<b>Adult Involvement as a Parent (where parent was perpetrator)</b>		
Adult was perpetrator on at least one allegation prior to program entry	93%	87%
Adult was perpetrator on at least one founded allegation prior to program entry	73%	80%
Average number of allegations 2 years prior to program entry	2.70	3.67
Average number of founded allegations 2 years prior to program entry	1.40	1.20
Average number of abuse allegations 2 years prior to program entry	0.20	0.47
Average number of neglect allegations 2 years prior to program entry	2.55	3.27

Table 9 shows the criminal history of graduates and unsuccessfully discharged participants prior to entering the program. There were no statistical differences in prior criminality between graduates and non-graduates, indicating that those with more severe criminal histories are graduating at similar rates as those with less extensive prior arrests. However, there were no participants who had a particularly extensive criminal history.

**Table 9. FTC-CAM Graduate and Non-Graduate Characteristics: Criminal History**

	<b>Graduates <i>n</i> = 41</b>	<b>Non-Graduates <i>n</i> = 15</b>
Average number of arrests 2 years prior to program entry	1.56	1.53
Average number of person arrests 2 years prior to program entry	0.27	0.53
Average number of property arrests 2 years prior to program entry	0.22	0.40
Average number of drug arrests 2 years prior to program entry	0.24	0.07
Average number of misdemeanor arrests 2 years prior to program entry <sup>a</sup>	0.59	1.00
Average number of felony arrests 2 years prior to program entry <sup>a</sup>	0.22	0.13

<sup>a</sup>Felonies and misdemeanors do not add up to the total number of arrests as criminal traffic arrests were coded separately and did not have an associated charge level.

Table 10 demonstrates that FTC-CAM graduates and non-graduates, while having a similar overall history of substance abuse treatment, differed significantly regarding treatment 2 years prior to entry. Specifically, all non-graduates had attempted treatment (regardless of successful completion) prior to entry while only 68% of graduates had been to treatment in the 2 years prior to program entry. Graduates and non-graduates, while similar in terms of many drugs of choice, differed significantly on heroin use and notably with prescription drugs, alcohol, and marijuana. Although the program currently allows MAT including methadone, suboxone and Vivitrol, it is possible that these services were not fully implemented at the time these participants were going through the program and they needed more focus on services to handle opioid abuse (both heroin and prescription drugs).

**Table 10. FTC-CAM Graduate and Non-Graduate Characteristics:  
Substance Abuse History**

	<b>Graduates <i>n</i> = 41</b>	<b>Non-Graduates <i>n</i> = 15</b>
<b>Substance Abuse Treatment</b>		
Entered treatment prior to program entry	88%	100%
<b>Entered treatment within 2 years prior to program entry</b>	<b>68%</b>	<b>100%</b>
<b>Drug of Choice<sup>a</sup></b>		
Methamphetamines	66%	60%
Marijuana	68%	47%
Alcohol	39%	60%
<b>Heroin</b>	<b>20%</b>	<b>47%</b>
Prescription Opiates	17%	40%
Cocaine	10%	7%
Other <sup>c</sup>	2%	13%

<sup>a</sup> Numbers do not add up to 100% as participants could report more than one type of substance.

Table 11 displays a variety of activities occurring while in the program. FTC-CAM graduates and non-graduates look similar for most activities, most notably court sessions and drug testing. The program is doing an excellent job of having participants regularly attend court and perform drug tests. Graduates were more likely to have taken advantage of the variety of services made available through the CAM grant. Specifically, graduates were more likely to have had a neuropsychological evaluation, participate in family therapy, and work with a home support specialist. While graduates received more rewards, the team should take note of the very small number of incentives delivered in the first 3 months of the program for both graduates and non-graduates and consider adding more incentive options to the program.

**Table 11. FTC Graduate and Non-Graduate Characteristics: Program Activities**

	<b>Graduates <i>n</i> = 41</b>	<b>Non-Graduates <i>n</i> = 15</b>
<b>Services Received<sup>a</sup></b>		
<b>Neuropsychological Evaluation</b>	<b>95%</b>	<b>67%</b>
Individual Therapy	32%	7%
<b>Family Therapy</b>	<b>71%</b>	<b>7%</b>
<b>Home Support</b>	<b>63%</b>	<b>7%</b>
<b>Program Length of Stay</b>		
<b>Average number of days in program</b>	<b>541</b>	<b>281</b>
<b>Court Sessions</b>		
Average number of court sessions attended in first 3 months in program <sup>b</sup>	11	11
<b>Drug Testing</b>		
Average number of UAs administered in first 3 months in program <sup>b</sup>	18	17
Average number of ETGs administered in first 3 months <sup>b</sup>	5	6
<b>Rewards</b>		
<b>Average number of rewards received in first 3 months in program<sup>b</sup></b>	<b>1.3</b>	<b>0.5</b>
<b>Sanctions</b>		
Average number of sanctions received in first 3 months	2.6	3.9

Note. The *n* for each category may be smaller than the total group *n* due to missing data.

<sup>a</sup> Service information provided by Children's Center, all services added as part of CAM implementation.

<sup>b</sup> For those with available data and participated in the program for at least 3 months. Graduates *n* = 41; non-graduates, *n* = 14.



After reviewing the characteristics listed in Tables 7-11, all items differing significantly were entered into a logistic regression to determine which characteristics were most strongly tied to graduation, above all other factors. Due to the relatively low number of graduates and non-graduates (41 and 15 people, respectively), and the high number of potential influencing factors, there were no significant differences detected between graduates and non-graduates for any one characteristics above others.

### ***Characteristics Related to Child Welfare Recidivism***

Program success can also be measured by whether or not participants are committing subsequent maltreatment. All program participants were reviewed to determine whether any factors or characteristics were related to being a perpetrator on a maltreatment allegation within 2 years after program entry. Individuals who were perpetrators on a maltreatment allegation within 2 years after program entry were more likely to have been a victim of an allegation as a child, had fewer drug arrests 2 years prior to entry, and had more removals (i.e., their associated children being removed from the home) in the 2 years prior to entry ( $p < .05$ ).

### ***Characteristics Related to Criminal Justice Recidivism***

Another indicator of program success is whether or not participants are being rearrested. All program participants were reviewed to determine whether any factors or characteristics were related to being rearrested within 2 years after program entry. Similar to the results detailed between graduates and non-graduates, participants who were not rearrested within 2 years after program entry were more likely to have completed a neuropsychological evaluation and less likely to identify heroin as a drug of choice ( $p < .05$ ). Participants who were not rearrested had fewer misdemeanors 2 years prior to entry and scored higher in the Family Interactions domain of the NCFAS, and were less likely to identify prescription opiates as a drug of choice ( $p < .05$ ). Using heroin, not receiving a neuropsychological evaluation, and lower Family Interaction scores predicted criminal justice recidivism, even when controlling for all other significant factors in a logistic regression ( $p < .05$ ).

**RESEARCH QUESTIONS #6: HAS THE IMPLEMENTATION OF NEW PRACTICES AND SERVICES DUE TO THE CAM GRANT IMPROVED PARTICIPANT SHORT AND LONG TERM OUTCOMES?**

As discussed throughout the outcome section of this report, there are many indications that point to CAM services leading to improved outcomes for FTC participants including fewer maltreatment allegations, fewer days out of home, greater placement stability, and higher rates of reunification. Moreover, FTC-CAM participants showed a decrease in criminal justice recidivism and a substantial increase in treatment completion.

There are very few significant differences between FTC-CAM and FTC-PreCAM participants that would offer explanations for why FTC-CAM participants have better outcomes than FTC-PreCAM, (see Tables 2-5 for details on both samples). However, in order to provide further evidence on whether CAM services led to better outcomes over and above the FTC program alone, all analyses were conducted between not only the FTC-CAM and FTC-PreCAM groups but between the FTC-CAM and their matched non-FTC comparison group as well as FTC-PreCAM and their own matched PreCAM non-FTC comparison group. In all analyses, participants who entered the program after CAM services were implemented out performed FTC participants PreCAM. Before presenting the results of these analyses, the new services performed as a part of the CAM grant and the number of families receiving these services are delineated below.

**Services Provided and Assessments Performed with the Addition of the CAM Grant**

The CAM grant was originally intended to provide much needed family and child-specific services to participants involved with methamphetamines. In order to provide these services, the FTC partnered with two new agencies and included representatives from both agencies on the FTC team. Children's Home Society provided parenting classes and The Children's Center provided neuropsychological evaluations, individual and family therapy, and home support services. The intention was to provide more tailored services both through these agencies as well as through existing partner agencies (e.g., substance abuse treatment, the court, child welfare) using the neuropsychological evaluations as a guide. However, throughout the course of the grant, as discussed in the process section of this report, many other structural improvements came about including more frequent clinical staffing meetings, higher referral rates, and an integrated docket.

Table 12 delineates the services received by adults and children through the CAM grant.

**Table 12. CAM Grant Services Provided**

Service Provided	Number of Adults	Number of Children
Neuropsychological Evaluation	71	94
Individual Therapy	16	57
Family Therapy	38	76
Home Support	21	74
Parenting Classes <sup>a</sup>	Number of Families	
Triple P	27	N/A
Incredible Years	28	
Families Creating Change	29	
Parent Trust	7	

<sup>a</sup>Parenting classes counted at the adult level only.

Also required of the CAM grant, for the national evaluation, was the use of the NCFAS assessment of each family entering the program. Of the 71 participating families through the end of 2014, 55 completed an entry assessment and 21 completed exit assessments. Table 13 shows the average scores for each of the 10 domains at entry and exit. Scores range from -3, a serious problem area, to 2, a clear strength. A score of 0 indicates adequacy in a given domain. As expected, most entry scores are negative, meaning participants could improve in most, if not all, areas. Table 13 shows the scores for everyone who had a NCFAS at entry and everyone who had a NCFAS at exit. Because not all families had an exit assessment the scores listed in Table 13 are for illustrative purposes only and are not directly comparable.

**Table 13. NCFAS Scores**

Family Functioning Domain	Average Score at Entry <i>n</i> = 66	Average Score at Exit <i>n</i> = 26 <sup>60</sup>
Environment	-0.19	1.39
Parental Capabilities	-1.02	1.27
Family Interaction	-0.41	0.96
Family Safety	-0.86	1.69
Child Well-Being	0.21	1.23
Social/Community Life	-0.29	1.12
Self-Sufficiency	-1.76	0.00
Family Health	0.38	1.63
Ambivalence	-0.06	1.62
Readiness for Reunification	-0.94	1.89

For those families with both pre and post assessments, average scores were reviewed to see if there were significant differences. All 10 domains showed significant improvement for the 21 families ( $p < .001$ ). Figure 30 presents the scores at entry and exit across all areas.

**Figure 30. NCFAS Scores Improved Significantly from Entry to Exit<sup>61</sup>**



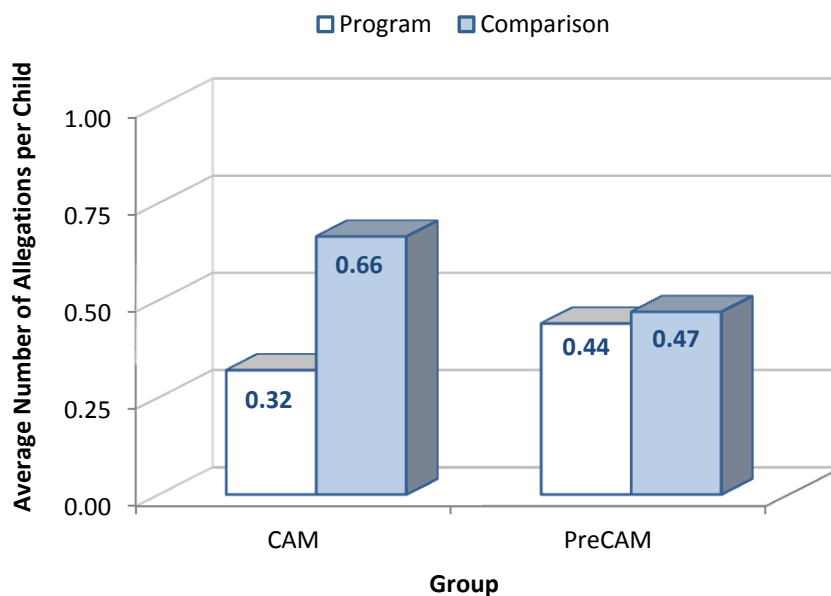
<sup>60</sup> Sample size is 26 adults from 21 families. Some items may have smaller sample sizes, due to missing data

<sup>61</sup> Sample size is 26 adults from 21 families. Some items may have smaller sample sizes, due to missing data.

### ***Child Welfare Recidivism***

Children of FTC participants, both pre and post CAM, were less likely to be victims of maltreatment than children in the comparison group. Figure 31, shows that FTC-CAM children had, on average, half the number of allegations than the children of comparison group parents 2 years after program entry while FTC-PreCAM, on the other hand, reduced the number of allegations by just 6% compared to the PreCAM comparison group.<sup>62</sup>

**Figure 31. Number of Allegations per Child at 2 Years<sup>63</sup>**

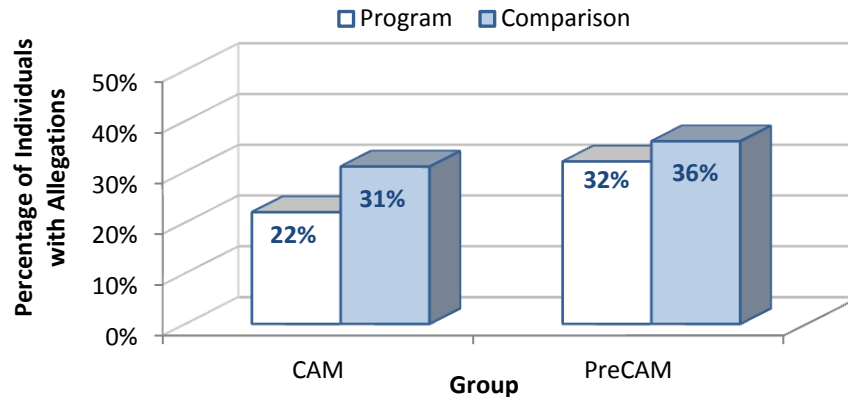


<sup>62</sup>Non-adjusted means by group: FTC-CAM – 0.33, CAM Comparison Group – 0.60; FTC-PreCAM – 0.39; PreCAM Comparison Group – 0.44.

<sup>63</sup> Sample sizes represent number of children by group at Year 2: CAM Graduates  $n = 127$ ; All FTC-CAM Participants  $n = 170$ ; CAM Comparison Group  $n = 169$ ; PreCAM Graduates  $n = 129$ ; All FTC-PreCAM Participants  $n = 278$ ; PreCAM Comparison Group  $n = 223$ .

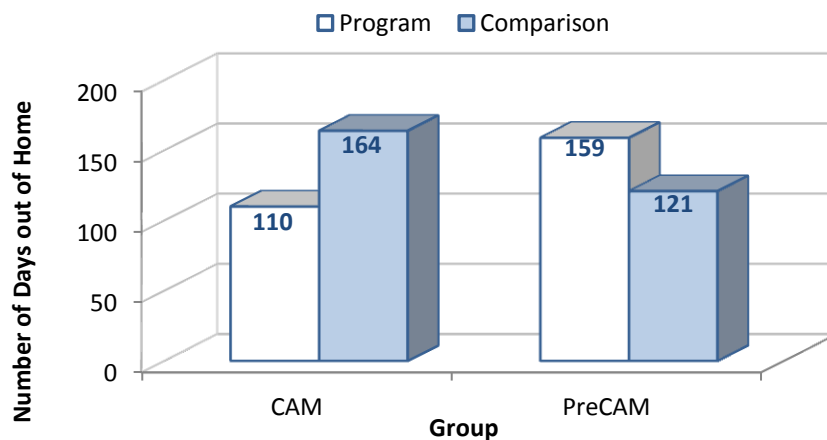
Figure 32 displays the percentage of parents who were perpetrators 2 years after program entry. Parents in the FTC-CAM group were almost 30% less likely to be perpetrators on maltreatment allegations 2 years after entering the program while FTC-PreCAM participants were only 11% less likely to be a perpetrator.

**Figure 32. Percent of Individuals as Perpetrators on Allegations at 2 Years<sup>64</sup>**



Out of home days and placement stability for FTC-CAM children also showed better outcomes than FTC-PreCAM children (see Figure 33). FTC-CAM children spent, on average, fewer days out of home and had fewer changes in placement than children of comparison group parents. FTC-PreCAM children, on the other hand, spent more days out of home and had more changes in placement than children of comparison group parents.<sup>65</sup>

**Figure 33. Average Days Spent in Out of Home Placements at 2 Years<sup>66</sup>**



<sup>64</sup> Sample sizes represent number of adults by group at Year 2: CAM Graduates  $n = 33$ ; All FTC-CAM Participants  $n = 46$ ; CAM Comparison Group  $n = 51$ ; PreCAM Graduates  $n = 30$ ; All FTC-PreCAM Participants  $n = 75$ ; PreCAM Comparison Group  $n = 76$ .

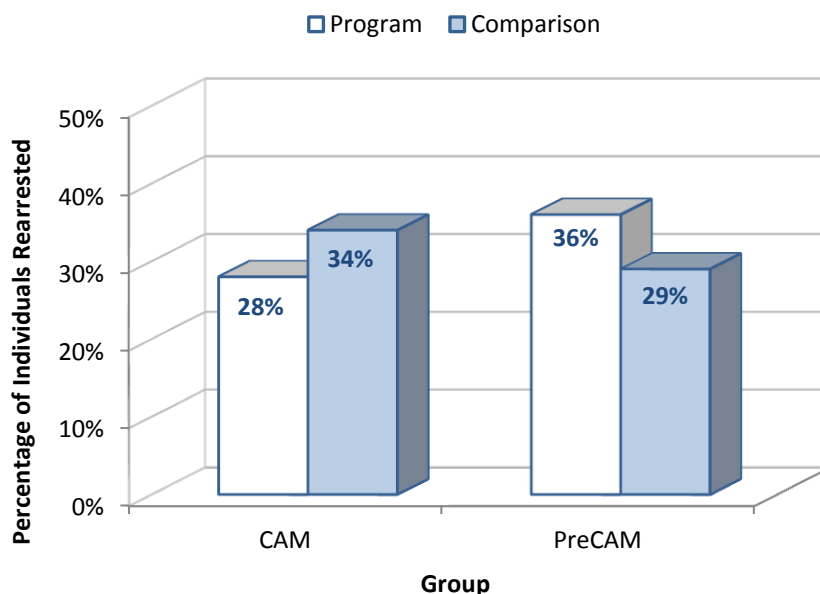
<sup>65</sup> Non-adjusted means by group: FTC-CAM – 107, CAM Comparison Group – 155; FTC-PreCAM – 160; PreCAM Comparison Group – 112.

<sup>66</sup> Sample sizes represent number of adults by group at Year 2: CAM Graduates  $n = 118$ ; All FTC-CAM Participants  $n = 168$ ; CAM Comparison Group  $n = 167$ ; PreCAM Graduates  $n = 112$ ; All FTC-PreCAM Participants  $n = 275$ ; PreCAM Comparison Group  $n = 223$ .

### ***Criminal Justice Recidivism***

As Figure 34 illustrates, FTC-CAM participants showed an almost 20% decrease in average rearrests compared to their matched non-FTC comparison group, while FTC-PreCAM participants had more than a 20% *increase* in average rearrests over their non-FTC comparison group. On average, FTC-CAM participants had 0.53 rearrests at 2 years post program entry while FTC-PreCAM participants had 0.94 rearrests.

**Figure 34. Percent of Individual Rearrested for any Offense at 2 Years<sup>67</sup>**

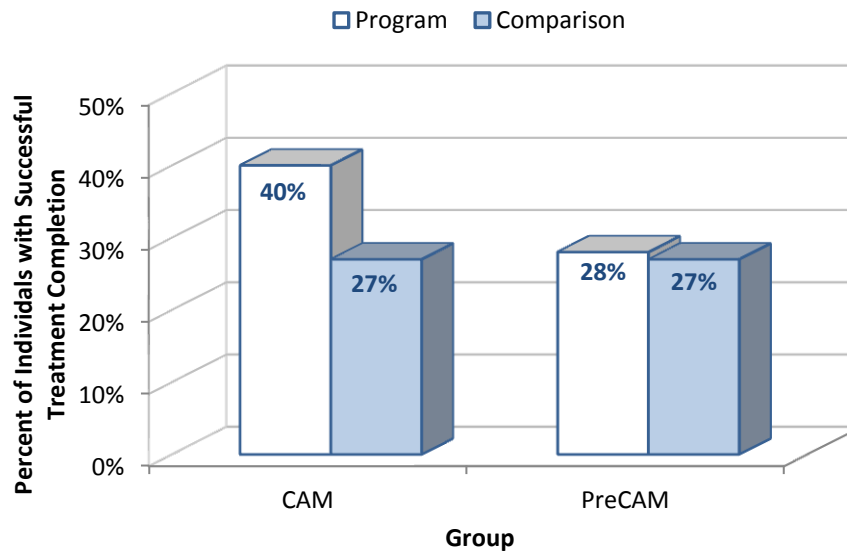


### ***Substance Abuse Treatment***

Both FTC participant groups completed substance abuse treatment at higher rates than their matched comparison groups. However, FTC-CAM participants were more likely to complete both residential and outpatient treatment compared to FTC-PreCAM participants. Figures 35 and 36, below, display the completion rates of residential and outpatient treatment. While FTC-CAM participants were 48% more likely to complete residential treatment than the matched comparison group within 2 years of program entry, FTC-PreCAM participants were only 4% more likely to have completed residential treatment (See Figure 35).

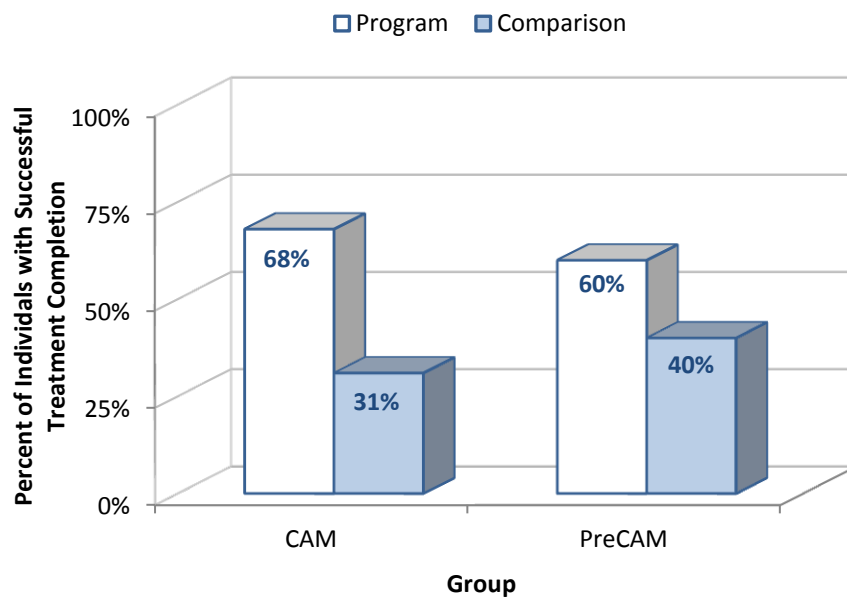
<sup>67</sup> Sample sizes represent number of adults by group at Year 2: CAM Graduates  $n = 118$ ; All FTC-CAM Participants  $n = 168$ ; CAM Comparison Group  $n = 167$ ; PreCAM Graduates  $n = 112$ ; All FTC-PreCAM Participants  $n = 275$ ; PreCAM Comparison Group  $n = 223$ .

**Figure 35. Percent of Individuals Who Completed Residential Treatment at 2 Years<sup>68</sup>**



For outpatient treatment, FTC-CAM participants were more than twice as likely (almost 120% more likely) to complete treatment than their comparison group while FTC-PreCAM participants were just 50% more likely to complete a treatment episode within 2 years of program entry (see Figure 36).

**Figure 36. Percent of Individuals Who Completed Outpatient Treatment at 2 Years<sup>69</sup>**



<sup>68</sup> Sample sizes represent number of adults by group at Year 2: CAM Graduates  $n = 35$ ; All FTC-CAM Participants  $n = 50$ ; CAM Comparison Group  $n = 52$ ; PreCAM Graduates  $n = 33$ ; All FTC-PreCAM Participants  $n = 80$ ; PreCAM Comparison Group  $n = 78$ .

<sup>69</sup> Sample sizes represent number of adults by group at Year 2: CAM Graduates  $n = 35$ ; All FTC-CAM Participants  $n = 50$ ; CAM Comparison Group  $n = 52$ ; PreCAM Graduates  $n = 33$ ; All FTC-PreCAM Participants  $n = 80$ ; PreCAM Comparison Group  $n = 78$ .



## Summary of Outcome Results

The key outcome analyses were based on a cohort of FTC participants who entered the program during a time period when CAM services were implemented from 2010 to 2014 (N=65) and a comparison group of families eligible for the FTC program but who received the traditional family court process (N=61). Additional analyses were performed on a cohort of FTC participants prior to the implementation of CAM services (N=85) and a matched comparison group families eligible for the FTC program but who received the traditional family court process (N=83).

Overall, the results of the outcome analysis for the Clark County FTC-CAM program were exceptionally positive. Compared to child welfare involved parents who experienced the traditional dependency court processes, the FTC-CAM program families (regardless of whether they graduated from the program):

- Spent 3 times longer in treatment and were more than twice as likely to complete treatment,
- Had half as many new maltreatment allegations 2 and 3 years after FTC entry
- Were perpetrators in one-third as many founded allegations 3 years after entry
- Had children spend less time in out of home placements (110 days vs 164 days) in the two years after drug court entry,
- Were half as likely to have a child removed again 2 and 3 years after FTC entry
- Were nearly 30% more likely to be re-unified with their children
- Were re-arrested nearly 3 times less often for any charge

In addition, when compared to FTC parents prior to the implementation of CAM services (FTC-PreCAM), FTC-CAM program families:

- Spent similar times in treatment but were 22% more likely to complete outpatient treatment and 25% more likely to complete residential treatment
- Had half as many new maltreatment allegations by 3 years after FTC entry
- Were perpetrators more than 25% less often in founded allegations 3 years after entry
- Had children spend less time in out of home placements (123 days vs 157 days) in the 2 years after program entry,
- Had greater placement stability while in out of home care (FTC-PreCAM children had twice as many changes in placement compared to FTC-CAM children)
- Had higher reunification rates (74% compared to 61%, 3 years post entry)
- Were re-arrested half as often for any charge

The FTC-CAM program also had several other successes:

- Graduation rates increased steadily each year from the time of CAM implementation

- FTC-CAM families significantly improved family functioning from program entry to exit (as measured by NCFAS scores) on all domains including family environment, parental capabilities, child well-being, family safety and social/community life.

Finally, to achieve greater understanding of who the program works best for, and what services might lead to program success, an examination of participant and program characteristics that predicted graduation was performed. This analysis revealed that graduates of the FTC-CAM program were more likely to have utilized CAM services, specifically neuropsychological evaluations, family treatment, and home support. Graduates also received more rewards during the first 3 months in the program, were less likely to use heroin, and were less likely to have prior treatment in the 2 years before program entry.

A similar analysis was performed to determine what factors predicted child welfare and/or criminal justice recidivism. Individuals who were perpetrators on a maltreatment allegation within 2 years after program entry were more likely to have been a victim of an allegation as a child, had fewer drug arrests 2 years prior to entry, and had more child removals (i.e., their associated children being removed from the home) in the 2 years prior to entry. An additional finding of particular interest is that families with young children, particularly children under one year, showed significantly more improvement due to FTC-CAM participation than families with older children. Because having younger children is a key risk factor in continued maltreatment, this finding indicates that FTC is particularly effective for higher risk families.

Participants who were rearrested within 2 years after program entry were less likely to have completed a neuropsychological evaluation, were more likely to identify heroin or prescription opiates as a drug of choice, had more arrests 2 years prior to entry and scored lower in the Family Interactions domain of the NCFAS.

Taken as a whole, the Clark County FTC program, particularly with the implementation of CAM services is highly successful, creating significant improvements in the lives of families struggling with addiction in their community as well as for the community as a whole.

## III: COST EVALUATION

### Cost Evaluation Design and Methods

NPC conducted a full cost-benefit analysis for the CCFTC to assess the extent to which the costs of the program are offset by cost-savings due to positive outcomes. This section provides the methods and results for the cost-benefit analysis performed for the CCFTC.

The main purposes of a cost analysis for this study were to determine the cost of the program and to determine if the costs due to criminal justice, child welfare, and other related outcomes were lower due to CCFTC participation. This is called a “cost-benefit” analysis. The term “cost-effectiveness” is often confused with the term “cost-benefit.” A cost-effectiveness analysis calculates the cost of a program and then examines whether the program led to its intended positive outcomes without actually putting a cost to those outcomes. For example, a cost-effectiveness analysis of FTCs would determine the cost of the FTC program and then look at whether the number of new arrests were reduced by the amount the program intended (e.g., a 50% reduction in rearrests compared to those who did not participate in the program). A cost-benefit evaluation calculates the cost of the program and also the cost of the outcomes, resulting in a cost-benefit ratio. For example, the cost of the program is compared to the cost-savings due to the reduction in rearrests. In some drug court programs, for every dollar spent on the program, over \$10 is saved due to positive outcomes.<sup>70</sup>

The cost evaluation was designed to address the following study questions:

1. How much does the CCFTC program cost? What is the average investment per agency in a CCFTC participant case?
2. What are the 1- and 2-year cost impacts on the criminal justice and child welfare systems for CCFTC participants compared to individuals eligible for the CCFTC but who received traditional processing?
3. What is the average cost of criminal justice recidivism and child welfare involvement per agency for CCFTC participants compared to individuals eligible for the CCFTC but who received traditional processing for their allegation?
4. What is the cost-benefit ratio for investment in the CCFTC?

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<sup>70</sup> See drug court cost-benefit studies at <http://www.npcresearch.com>

## **COST EVALUATION DESIGN**

### ***Transaction and Institutional Cost Analysis***

The cost approach utilized by NPC Research is called Transactional and Institutional Cost Analysis (TICA). The TICA approach views an individual's interaction with publicly funded agencies as a set of transactions in which the individual utilizes resources contributed from multiple agencies. Transactions are those points within a system where resources are consumed and/or change hands. In the case of FTCs, when a FTC participant appears in court or has a drug test, resources such as judge time, defense attorney time, court facilities, and urine cups are used. Court appearances and drug tests are transactions. In addition, the TICA approach recognizes that these transactions take place within multiple organizations and institutions that work together to create the program of interest. These organizations and institutions contribute to the cost of each transaction that occurs for program participants. TICA is an intuitively appropriate approach to conducting costs assessment in an environment such as a FTC, which involves complex interactions among multiple taxpayer-funded organizations.

### ***Cost to the Taxpayer***

In order to maximize the study's benefit to policymakers, a "cost-to-taxpayer" approach was used for this evaluation. This focus helps define which cost data should be collected (costs and avoided costs involving public funds) and which cost data should be omitted from the analyses (e.g., costs to the individual participating in the program).

The central core of the cost-to-taxpayer approach in calculating benefits (avoided costs) for FTC specifically is the fact that untreated substance abuse will cost various tax dollar-funded systems money that could be avoided or diminished if substance abuse were treated. In this approach, any cost that is the result of untreated substance abuse and that directly impacts a citizen (through tax-related expenditures) is used in calculating the benefits of substance abuse treatment.

### ***Opportunity Resources***

Finally, NPC's cost approach looks at publicly funded costs as "opportunity resources." The concept of opportunity cost from the economic literature suggests that system resources are available to be used in other contexts if they are not spent on a particular transaction. The term opportunity resource describes these resources that are now available for different use. For example, if substance abuse treatment reduces the number of times that a client is subsequently incarcerated, the local sheriff may see no change in his or her budget, but an opportunity resource will be available to the sheriff in the form of a jail bed that can now be filled by another person, who, perhaps, possesses a more serious criminal justice record than does the individual who has received treatment and successfully avoided subsequent incarceration. Therefore, any "cost savings" reported in this evaluation may not be in the form of actual monetary amounts, but may be available in the form of a resource (such as a jail bed, or a police officer's time) that is available for other uses.

## COST EVALUATION METHODS

The cost evaluation involved calculating the costs of the program and the costs of outcomes (or impacts) after program entry (or the equivalent for the comparison group). In order to determine if there were any benefits (or avoided costs) due to CCFTC program participation, it was necessary to determine what the participants' outcome costs would have been had they not participated in the CCFTC. One of the best ways to do this is to compare the costs of outcomes for CCFTC participants to the outcome costs for similar individuals who were eligible for the CCFTC but did not participate. The comparison group in this cost evaluation was the same as that used in the preceding outcome evaluation.

## TICA METHODOLOGY

The TICA methodology is based upon six distinct steps. Table 14 lists each of these steps and the tasks involved.

**Table 14. The Six Steps of TICA**

	Description	Tasks
Step 1:	Determine flow/process (i.e., how program participants move through the system).	Site visits/direct observations of program practice. Interviews with key informants (agency and program staff) using a drug court typology and cost guide.
Step 2:	Identify the transactions that occur within this flow (i.e., where clients interact with the system).	Analysis of process information gained in Step 1.
Step 3:	Identify the agencies involved in each transaction (e.g., court, treatment, police).	Analysis of process information gained in Step 1. Direct observation of program transactions.
Step 4:	Determine the resources used by each agency for each transaction (e.g., amount of judge time per transaction, amount of attorney time per transaction, number of transactions).	Interviews with key program informants using program typology and cost guide. Direct observation of program transactions. Administrative data collection of number of transactions (e.g., number of court appearances, number of treatment sessions, number of drug tests).
Step 5:	Determine the cost of the resources used by each agency for each transaction.	Interviews with budget and finance officers. Document review of agency budgets and other financial paperwork.
Step 6:	Calculate cost results (e.g., cost per transaction, total cost of the program per participant).	Indirect support and overhead costs (as a percentage of direct costs) are added to the direct costs of each transaction to determine the cost per transaction. The transaction cost is multiplied by the average number of transactions to determine the total average cost per transaction type. These total average costs per transaction type are added to determine the program and outcome costs.

Step 1 (determining program process) was performed during site visits, through analysis of CCFTC documents, and through interviews with key informants. Step 2 (identifying program transactions) and Step 3 (identifying the agencies involved with transactions) were performed through observation during site visits and by analyzing the information gathered in Step 1. Step 4 (determining the resources used) was performed through extensive interviewing of key informants, direct observation during site visits, and by collecting administrative data from the agencies involved in the CCFTC. Step 5 (determining the cost of the resources) was performed through interviews with CCFTC and non-CCFTC staff and with agency financial officers, as well as analysis of budgets found online or provided by agencies. Finally, Step 6 (calculating cost results) involved calculating the cost of each transaction and multiplying this cost by the number of transactions. For example, to calculate the cost of drug testing, the unit cost per drug test is multiplied by the average number of drug tests performed per person. All the transactional costs for each individual were added to determine the overall cost per CCFTC participant/comparison group individual. This was reported as an average cost per person for the CCFTC program, and outcome/impact costs due to rearrests, jail time and other recidivism costs, as well as any other service usage, such as out of home placement. In addition, due to the nature of the TICA approach, it was also possible to calculate the cost of CCFTC processing per agency, so that it was possible to determine which agencies contributed the most resources to the program and which agencies gained the most benefit.

## **COST DATA COLLECTION**

Cost data that were collected for the CCFTC evaluation were divided into program costs and outcome costs. The **program costs** were those associated with activities performed within the program. The program-related “transactions” included in this analysis were FTC hearings (including staffing meetings and other activities preparing for the hearings), case management, CAM services, drug tests, drug treatment (such as outpatient and inpatient treatment), and any other unique services provided by the program to participants for which administrative data were available. The **outcome costs** were those associated with activities that occurred outside the CCFTC program. These transactions included child welfare-related events (e.g., foster care and detention), criminal justice-related activities (e.g., new arrests subsequent to program entry, subsequent court cases, jail days, and prison days), treatment events, as well as other events that occurred such as victimizations.

### ***Program Costs***

Obtaining the cost of CCFTC transactions for FTC status review hearings (i.e., court sessions), case management, and CAM services involved asking each CCFTC team member for the average amount of time they spend on these activities (including preparing for staffing meetings and the staffing meetings themselves), observing their activities on site visits and obtaining each CCFTC team member’s annual salary and benefits from a supervisor or financial officer at each

agency involved in the program. As this is typically public information, some of the salaries were found online, but detailed benefits information usually comes from the agency's financial officer or human resources department. In addition to salary and benefits, the indirect support rate and jurisdictional overhead rate were used in a calculation that results in a fully loaded cost per FTC session per participant, cost per day of case management per participant, and cost per day of CAM services per participant. The indirect support rates and overhead rates for each agency involved in the program were obtained from agency budgets that were found online or by contacting the agencies directly.

Drug testing costs were obtained directly from the CCFTC coordinator. The specific details for how the cost data were collected and the costs calculated for CCFTC are described in the results.

Treatment costs for the various modalities used were obtained from the Washington Department of Social and Health Services, Behavioral Health and Service Integration Administration, Division of Behavioral Health and Recovery's Web based management and reporting system (The Treatment and Assessment Report Generation Tool, or TARGET). Treatment costs used in this analysis are actual costs found in the TARGET system for program participants and comparison group members.

### ***Outcome/Impact Costs***

Child welfare costs (including the cost of adoption, various out of home placement care, residential crisis center days, group home days, foster care days, and detention days) were obtained from the Washington Department of Social and Health Services Web site.

For arrest costs, information about which law enforcement agencies typically conduct arrests was obtained by talking with program staff (attorneys and court staff) along with Web searches. The two major law enforcement agencies were included. NPC contacted staff at each law enforcement agency to obtain the typical positions involved in an arrest, average time involvement per position per arrest, as well as salary and benefits and support/overhead rates. NPC used that information in its TICA methodology to calculate the cost of an average arrest episode. Some cost information was obtained online from agency budgets or pay scales. The arrest cost at each law enforcement agency was averaged to calculate the final "cost per arrest" in the outcome analysis.

The cost per court case was calculated from budget information and caseload data from several agencies—the Superior Court, District Court, Municipal Court, Prosecuting Attorney, Public Defender, and the Washington State Court System. Information was found online at each agency's Web site or from agency staff.

Treatment costs were obtained directly from actual costs found in the TARGET system mentioned previously. Note that for program participants, treatment during the program was already included in the program costs. A full 2 years of treatment outcome costs were used in

the outcome cost analysis in order to have a direct comparison to the 2-year treatment services received by the comparison group. In order to avoid double counting the treatment received by CCFTC participants during the program and also in the outcome time period, in the final cost-benefit analysis NPC only included treatment that occurred *after* exit from the program in the outcome costs.

The cost per day of jail was calculated using information found in the Clark County Jail Annual Report and the Clark County Budget. Costs were updated to fiscal year 2015 at the time of the cost calculations using the Consumer Price Index.

The cost per day of prison was found on the Washington Department of Corrections Web site. The cost per day of prison was updated to fiscal year 2015 at the time of the cost calculations using the Consumer Price Index.

Person and property victimizations were calculated from the National Institute of Justice's *Victim Costs and Consequences: A New Look (1996)*. The costs were updated to fiscal year 2015 dollars using the Consumer Price Index.

## **Cost Evaluation Results**

### **COST EVALUATION RESEARCH QUESTION #1: PROGRAM COSTS**

#### ***How much does the CCFTC program cost?***

As described in the cost methodology, program transactions for which costs were calculated in this analysis included FTC status review hearings and staffings, case management, CAM services for parents and children, drug treatment and other related services, and drug tests. The costs for this study were calculated to include taxpayer costs only. All cost results provided in this report are based on fiscal year 2015 dollars or were updated to fiscal year 2015 using the Consumer Price Index.

#### ***Program Transactions***

An FTC session, for the majority of FTCs, is one of the most staff and resource intensive program transactions. These sessions include representatives from the following agencies:

- Clark County Superior Court (Commissioner, Administrative Assistant, Coordinator);
- Office of the Public Defense (Defense Attorneys);
- Washington Department of Social and Health Services<sup>71</sup> (Social Worker, Social Services Specialists);
- YWCA Clark County (CASA Program Specialist);
- Children's Center (Clinical Supervisor, Home Support Specialist, Therapist, Psychologist);
- Lifeline Connections (Treatment Court Case Manager);
- Children's Home Society (Program Manager).

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<sup>71</sup> Hereafter referred to as DSHS throughout this report.



The cost of an **FTC Court Appearance or Status Review Hearing** (the time during a session when a single program participant interacts with the judge) is calculated based on the average amount of court time (in minutes) each participant interacts with the judge during the FTC session. This includes the direct costs for the time spent for each CCFTC team member present, the time team members spend preparing for the session, the time team members spent in staffing, the agency support costs, and jurisdictional overhead costs. The cost for a single CCFTC court appearance is \$233.05 per participant.

**Case Management** is based on the amount of staff time dedicated to case management activities during a regular work week and is then translated into a total cost for case management per participant per day (taking staff salaries and benefits, and support and overhead costs into account).<sup>72</sup> The agencies involved in case management are the Clark County Superior Court, Office of the Public Defense, Washington Department of Social and Health Services, YWCA Clark County, and Lifeline Connections. The daily cost of case management is \$10.11 per participant.

**CAM Services** are based on the amount of staff time dedicated to CAM service activities during a regular work week and are then translated into a total cost for CAM services per participant per day (taking staff salaries and benefits, and support and overhead costs into account, along with the cost of parenting classes and other services). The agencies involved in providing CAM services are the Children's Center and Children's Home Society. The Children's Center provided neuropsychological evaluation, individual and family therapy and home support services. The Children's Home Society provided parenting services including Circle of Security, Families Creating Change, Parent Trust, Parents as Teachers, Triple P and Incredible Years programs. The average daily cost of CAM services was calculated at \$10.25 per participant.

**Treatment Services** for the majority of CCFTC participants are provided by Lifeline Connections, although the program also refers to two other treatment agencies (Community Services Northwest and Columbia River Mental Health). The treatment costs used for this analysis are actual costs obtained from the Washington Department of Social and Health Services, Behavioral Health and Service Integration Administration, Division of Behavioral Health and Recovery's Web based management and reporting system named TARGET. The number of days in each type of treatment modality per participant is shown below, but because total costs per participant were included in the TARGET dataset, the unit costs per day for outpatient treatment days, inpatient treatment days, and medication substitution days did not need to be calculated for this analysis and are reported as average cost per participant instead of unit cost per service received.

**Drug Testing** is performed by Lifeline Connections. Drug testing costs were obtained from the coordinator. The average cost per UA test per participant is \$20.00.

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<sup>72</sup> Case management includes meeting with participants, evaluations, phone calls, referring out for other help, answering questions, reviewing referrals, consulting, making community service connections, assessments, documentation, file maintenance, home/work visits, and residential referrals.

CCFTC participants pay a \$100.00 **Program Fee**, but participants can earn credits to work off that amount during the program. Because NPC had no data on actual fee payments, program fees were not taken into account in this cost analysis.

### **Program Costs**

Table 15 displays the unit cost per program related event (or "transaction"), the number of events and the average cost *per individual* for each of the CCFTC events for program graduates and for all participants who exited the program.<sup>73</sup> The sum of these events or transactions is the total per participant cost of the CCFTC program. The table includes the average for CCFTC graduates (N= 41) and for all CCFTC participants regardless of completion status (N = 56),. It is important to include participants who were discharged as well as those who graduated as all participants use program resources, whether they graduate or not.

**Table 15. Program Costs per Participant**

Transaction	Unit Cost	Avg. # of Events per person for CCFTC Graduates	Avg. Cost per person for CCFTC Graduates	Avg. # of Events per person for all CCFTC Participants	Avg. Cost per person for CCFTC Participants
FTC Court Appearances	\$233.05	41.74	\$9,728	36.20	\$8,436
Case Management Days	\$10.11	541.10	\$5,471	471.41	\$4,766
CAM Services Days	\$10.25	541.10	\$5,546	471.41	\$4,832
Outpatient Treatment Days	N/A <sup>74</sup>	31.71	\$1,488	26.14	\$1,201
Inpatient Treatment Days	N/A	13.88	\$1,500	10.71	\$1,144
Medication Substitute Days	N/A	15.17	\$201	11.11	\$147
Drug Tests	\$20.00	62.25	\$1,245	55.36	\$1,107
<b>TOTAL</b>			<b>\$25,179</b>		<b>\$21,633</b>

<sup>73</sup> Program participants included in the program cost analysis are those who had sufficient time to complete the program and who exited the program either through graduation or termination. Active participants were not included in the analysis as they were still using program services so did not represent the cost of the full program from entry to exit.

<sup>74</sup> Unit costs for treatment were not calculated for this cost analysis because total costs per participant were included in the TARGET dataset.

The unit cost multiplied by the number of events per person results in the cost per person for each transaction during the course of the program. When the costs of the transactions are summed the result is a total CCFTC program cost per participant of \$21,633. The cost per graduate is \$25,179. The largest contributor to the cost of the program is court sessions (\$8,436), followed by CAM services (\$4,832). The CCFTC has a relatively large number of team members that appear at court sessions and team meetings, so it is not surprising that court sessions are the largest portion of program costs. Note that the graduates cost slightly more than the participants in general, as graduates are in the program longer and use more of every resource.

### ***Program Costs per Agency***

Another useful way to examine program costs is by agency. Table 16 displays the cost per CCFTC participant by agency for program graduates and for all participants.

**Table 16. Program Costs per Participant by Agency**

<b>Agency</b>	<b>Avg. Cost per CCFTC Graduate Per Person</b>	<b>Avg. Cost per CCFTC Participant Per Person</b>
<b>Superior Court</b>	\$2,497	\$2,168
<b>Office of Public Defense</b>	\$2,018	\$1,751
<b>Dept. of Social &amp; Health Services</b>	\$5,998	\$5,215
<b>YWCA</b>	\$427	\$370
<b>Children's Center</b>	\$5,038	\$4,378
<b>Treatment Agencies (primarily Lifeline Connections)</b>	\$5,773	\$4,765
<b>Children's Home Society</b>	\$3,428	\$2,986
<b>TOTAL</b>	<b>\$25,179</b>	<b>\$21,633</b>

Table 16 shows that the costs accruing to the Department of Social and Health Services (FTC sessions and case management) account for 24% of the total program cost per participant, which is appropriate given that the DSHS has the largest number people on the CCFTC team and does the majority of case management for participants. The next largest cost (22%) is for Lifeline Connections due to case management, FTC sessions, drug treatment, and drug testing, followed by the Children's Center (20%) for time spent on staffing, court sessions and CAM services.

### ***CCFTC Program Costs Summary***

Total cost for the CCFTC program is estimated at \$21,633 per adult participant. Overall, the largest portion of CCFTC costs is due to resources put into FTC hearings (an average of \$8,436, or 39% of total costs), followed by CAM services (\$4,832 or 22%) and case management (an average of \$4,766, or 22% of total costs). When program costs are evaluated by agency, the largest portion of costs accrues to DSHS (\$5,215 or 24% of total costs), followed by Lifeline Connections (\$4,765 or 22%) and the Children's Center (\$4,378 or 20%).

### **COST EVALUATION RESEARCH QUESTION #2: OUTCOME/RECIDIVISM COSTS**

What is the cost impact on the treatment, criminal justice and child welfare systems of sending individuals through CCFTC compared to individuals eligible for the CCFTC but who received traditional processing for their allegation?

#### ***Outcome Costs***

The Transactional and Institutional Cost Analysis (TICA) approach was used to calculate the costs of each of the criminal justice system and child welfare system outcome transactions that occurred for CCFTC and comparison group participants. As mentioned previously, transactions are those points within a system where resources are consumed and/or change hands.

Outcome transactions for which costs were calculated in this analysis included rearrests, subsequent court cases, drug and other treatment services, jail time, prison time, adoption, out of home placement, residential and group home placement, detention, foster care, and victimizations. Only costs to the taxpayer were calculated in this study. All cost results represented in this report are based on fiscal year 2015 dollars or were updated to fiscal year 2015 dollars using the Consumer Price Index.

The outcome cost analyses were based on a cohort of adults who participated in the CCFTC and a matched comparison group of individuals who were eligible for the CCFTC program through their involvement in the child welfare system, but who did not attend the program. These individuals were tracked through administrative data for 2 years post program entry (and a similar time period for the comparison group). This study compares recidivism, treatment, and child welfare system costs for the two groups over 2 years, as well as the costs by agency.

The 2 year follow-up period was selected to allow a large enough group of both CCFTC and comparison individuals to be representative of the program, as well as to allow more robust cost numbers through use of a follow-up period with as many individuals as possible having at least some time during the follow-up period that represented time after program involvement.

The outcome costs experienced by CCFTC graduates are also presented below. Costs for graduates are included for informational purposes but should not be directly compared to the comparison group. If the comparison group members had entered the program, some may have graduated while others would have terminated. The CCFTC graduates as a group are not the same as a group made up of both potential graduates and potential non-graduates.

The outcome costs discussed below do not represent the entire cost to the criminal justice system and child welfare system. Rather, the outcome costs include the transactions for which NPC's research team was able to obtain outcome data and cost information on both the CCFTC and comparison group from the same sources. However, we believe that the costs represent the majority of system costs.

Outcome costs were calculated using information from the Clark County Superior Criminal Court, Clark County District Court, Clark County Prosecuting Attorney's Office, Washington State Office of Public Defense, Washington Department of Corrections, Washington Department of Social and Health Services, Washington Behavioral Health and Service Integration Administration—Division of Behavioral Health and Recovery, National Institute of Justice, Clark County Sheriff's Office (including the Corrections Branch), Vancouver Police Department, and Washington Administrative Office of the Courts. The methods of calculation were carefully considered to ensure that all direct costs, support costs and overhead costs were included as specified in the TICA methodology followed by NPC.

Finally, note that some possible costs or cost savings related to the program are not considered in this study. These include the number of drug-free babies born, health care expenses, and CCFTC participants legally employed and paying taxes. The gathering of this kind of information is generally quite difficult due to HIPAA confidentiality laws and due to the fact that much of the data related to this information are not collected in any one place, or collected at all. Although NPC examined the possibility of obtaining this kind of data, it was not feasible within the time frame or budget for this study. In addition, the cost results that follow do not take into account other less tangible outcomes for participants, such as improved relationships with their families and increased feelings of self-worth. Although these are important outcomes to the individual participants and their families, it is not possible to assign a cost to this kind of outcome, (it is priceless). Other studies performed by NPC have taken into account health care and employment costs. For example, Finigan (1998) performed a cost study in the Portland, Oregon, adult drug court which found that for every dollar spent on the drug court program, \$10 was saved due to decreased criminal justice recidivism, lower health care costs and increased employment.



## ***Outcome Transactions***

**Child welfare** related costs were obtained from the Washington Department of Social and Health Services Web site (<https://www.dshs.wa.gov>) and the Justice Policy Institute's Cost of Confinement Fact Sheet ([http://www.justicepolicy.org/uploads/justicepolicy/documents/factsheet\\_costs\\_of\\_confinement.pdf](http://www.justicepolicy.org/uploads/justicepolicy/documents/factsheet_costs_of_confinement.pdf)). The cost per adoption was taken from the maximum expense reimbursement per adoption, or \$1,500.00. The cost per Residential Assessment is \$121.35 per day. The cost per Interim Care Extreme 1A Out of Home Placement is \$240.99 per day. The cost per Crisis Residential Center Day is \$186.70. The cost per Secured Crisis Residential Center Day is \$152.00. The cost per Hope Center Day is \$78.54. The cost per Detention Day is \$262.48. The cost per Basic Foster Care Day (Ages 0-5) is \$18.49. The cost per Basic Foster Care Day (Ages 6-11) is \$22.47. The cost per Basic Foster Care Day (Ages 12-20) is \$23.13.

**Arrest** costs were gathered from representatives of the Vancouver Police Department and the Clark County Sheriff's Office (the two main arresting agencies in Clark County). The cost per arrest incorporates the time of the law enforcement positions involved in making an arrest, law enforcement salaries and benefits, support costs and overhead costs. The average cost of a single arrest at the two law enforcement agencies is \$289.61.

**Court Cases** include those cases that are dismissed as well as those cases that result in arraignment and are adjudicated. Because they are the main agencies involved, court case costs in this analysis are shared among the Clark County Superior Court, Clark County District Court, Clark County Prosecuting Attorney's Office, and the Washington Office of Public Defense. Using caseload information obtained from the Washington Administrative Office of the Courts and budget information obtained from the 2013-2014 Clark County Budget, the 2014 Status Report from the Washington State Office of Public Defense, the cost of a Superior Criminal Court Case is \$791.18 and the cost of a District Court Case<sup>75</sup> is \$534.30.

**Treatment** costs used for this cost analysis are actual costs obtained from the Washington Department of Social and Health Services, Behavioral Health and Service Integration Administration, Division of Behavioral Health and Recovery's Web based management and reporting TARGET system. The number of days in each type of treatment modality per participant and per comparison group member is shown below, but because total costs per person were included in the TARGET dataset, the unit costs per day for outpatient treatment days, inpatient treatment days, and medication substitution days were not necessary and were not included in this analysis.

**Prison** costs were found in the Fiscal Year 2014 Average Cost of Incarceration for Prison Offenders Report. The statewide cost per person per day of prison was \$90.84 in 2014. Using the Consumer Price Index, this was updated to fiscal year 2015 dollars, or \$92.04. Note that

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<sup>75</sup> Clark County District Court cases include Vancouver Municipal Court cases, as they are consolidated within the District Court.

prison time was removed from the cost analysis because only two CCFTC participants and a handful of comparison individuals could be found in the prison data and the data appeared inconsistent with our understanding of a typical length of a prison sentence (e.g., some individuals were recorded as having 8 or fewer days in prison).

**Jail** is provided by the Clark County Sheriff's Office- Corrections Branch. The cost of jail was calculated using information from the 2013 Annual Jail Report and the 2013-2014 Clark County Budget. The cost of jail was \$152.31 per day in 2013. Using the Consumer Price Index, this was updated to fiscal year 2015 dollars, or \$157.92.

**Victimizations** were calculated from the National Institute of Justice's *Victim Costs and Consequences: A New Look (1996)*.<sup>76</sup> The costs were updated to fiscal year 2015 dollars using the Consumer Price Index. **Property crimes** are \$13,281 per event and **person crimes** are \$43,024 per event.

### ***Outcome Cost Results***

Table 17 shows the average number of recidivism-related and child welfare-related events per individual for CCFTC graduates, all CCFTC participants (regardless of graduation status) and the comparison group over 2 years. These events are counted from the time of program entry.

<sup>76</sup> The costs for victimizations were based on the National Institute of Justice's *Victim Costs and Consequences: A New Look (1996)*. This study documents estimates of costs and consequences of personal crimes and documents losses per criminal victimization, including attempts, in a number of categories, including fatal crimes, child abuse, rape and sexual assault, other assaults, robbery, drunk driving, arson, larceny, burglary, and motor vehicle theft. The reported costs include lost productivity, medical care, mental health care, police and fire services, victim services, property loss and damage, and quality of life. In our study, arrest charges were categorized as violent or property crimes, and therefore costs from the victimization study were averaged for rape and sexual assault, other assaults, and robbery and attempted robbery to create an estimated cost for violent crimes, arson, larceny and attempted larceny, burglary and attempted burglary, and motor vehicle theft for an estimated property crime cost. All costs were updated to fiscal year 2015 dollars using the consumer price index (CPI).

**Table 17. Average Number of Recidivism, Treatment, and Child Welfare Events per Person over 2 Years from CCFTC Entry**

<b>Recidivism Related Events</b>	<b>CCFTC Graduates Per Person (n = 34)</b>	<b>CCFTC Participants Per Person (n = 48)</b>	<b>Comparison Group Per Person (n = 51)</b>
Rearrests	0.21	0.53	0.66
Superior Criminal Court Cases	0.12	0.27	0.13
District Court Cases <sup>77</sup>	0.12	0.24	0.56
Outpatient Treatment Days	31.55	31.60	9.43
Inpatient Treatment Days	17.24	16.20	26.77
Medication Substitute Days	18.85	13.82	13.79
Jail Days	0.82	6.98	10.56
Adoptions	0.00	0.00	0.05
Residential Assessments	0.00	0.00	0.24
Interim Care Extreme 1A Out of Home Days	0.00	0.00	0.16
Crisis Residential Center Days	0.00	0.09	1.52
Secured Crisis Residential Center Days	0.00	0.00	0.32
Hope Center Days	0.00	0.00	0.40
Detention Days	0.00	0.00	2.42
Basic Foster Care Days (Ages 0-5)	144.53	206.06	228.38
Basic Foster Care Days (Ages 6-11)	75.79	117.83	205.61
Basic Foster Care Days (Ages 12-20)	11.50	40.23	58.42
Property Victimizations	0.15	0.27	0.26
Person Victimizations	0.06	0.16	0.26

Overall, as demonstrated in Table 17, CCFTC participants have fewer rearrests, District Court cases, days in inpatient treatment, days in jail, adoptions, and every other child welfare related event than the comparison group, but more Superior Criminal Court cases, days in outpatient treatment, and days in medication substitution. CCFTC participants also have fewer person victimizations than the comparison group, but slightly more property victimizations.

<sup>77</sup> Note that this includes Vancouver Municipal Court cases.



Table 18 presents the outcome costs for each transaction for graduates, all CCFTC participants (graduates and terminated participants) and the comparison group.

**Table 18. Outcome Costs per Participant over 2 Years**

<b>Transaction</b>	<b>Unit Costs</b>	<b>CCFTC Graduates Per Person (n = 34)</b>	<b>CCFTC Participants Per Person (n = 48)</b>	<b>Comparison Group Per Person (n = 51)</b>
<b>Rearrests</b>	\$289.61	\$61	\$153	\$191
<b>Superior Criminal Court Cases</b>	\$791.18	\$95	\$214	\$103
<b>District Court Cases<sup>78</sup></b>	\$534.30	\$64	\$128	\$299
<b>Outpatient Treatment Days</b>	N/A	\$1,548	\$1,515	\$415
<b>Inpatient Treatment Days</b>	N/A	\$1,863	\$1,637	\$2,977
<b>Medication Substitute Days</b>	N/A	\$250	\$183	\$183
<b>Jail Days</b>	\$157.92	\$129	\$1,102	\$1,668
<b>Adoptions</b>	\$1,500.00	\$0	\$0	\$75
<b>Residential Assessments</b>	\$121.35	\$0	\$0	\$29
<b>Interim Care Extreme 1A Out of Home Days</b>	\$240.99	\$0	\$0	\$39
<b>Crisis Residential Center Days</b>	\$186.70	\$0	\$17	\$284
<b>Secured Crisis Residential Center Days</b>	\$152.00	\$0	\$0	\$49
<b>Hope Center Days</b>	\$78.54	\$0	\$0	\$31
<b>Detention Days</b>	\$262.48	\$0	\$0	\$635
<b>Basic Foster Care Days (Ages 0-5)</b>	\$18.49	\$2,672	\$3,810	\$4,223
<b>Basic Foster Care Days (Ages 6-11)</b>	\$22.47	\$1,703	\$2,648	\$4,620
<b>Basic Foster Care Days (Ages 12-20)</b>	\$23.13	\$266	\$931	\$1,351

<sup>78</sup> Note that this includes Vancouver Municipal Court cases.



Transaction	Unit Costs	CCFTC Graduates Per Person (n = 34)	CCFTC Participants Per Person (n = 48)	Comparison Group Per Person (n = 51)
<b>SUBTOTAL</b>		<b>\$8,651</b>	<b>\$12,338</b>	<b>\$17,172</b>
<b>Property Victimizations</b>	\$13,281.00	\$1,992	\$3,586	\$3,453
<b>Person Victimizations</b>	\$43,024.00	\$2,581	\$6,884	\$11,186
<b>TOTAL</b>		<b>\$13,224</b>	<b>\$22,808</b>	<b>\$31,811</b>

The first subtotal in Table 18 displays the costs of outcomes that occurred in the 2 years after program entry for the CCFTC group and the comparison group (an estimated “program entry date” was calculated for the comparison group to ensure an equivalent time period between groups) not including victimizations. Because victimizations were not calculated using the TICA methodology, the costs for these events are presented separately, with the final total providing the total costs for all events from program entry to 2 years after program entry. This final total illustrates the cost impacts due to participation in the CCFTC program and to individuals eligible for the CCFTC but who received traditional processing for their allegation. Table 18 shows that the difference in the 2-year outcome cost between the CCFTC participants and the comparison group is a positive \$4,834 per participant, indicating that CCFTC participants cost less than the comparison group. When costs due to victimizations are included, the difference increases further with CCFTC participants costing \$9,003 less (per participant) than comparison group members. This difference is the benefit, or savings, due to CCFTC participation. Graduates of the program show substantial savings compared to the comparison group (a savings of \$18,587), however, graduates cannot be fairly compared to the comparison group as some of the comparison group is made up of people who would have terminated. Overall, the cost results show savings for those who participate in the CCFTC due to use of fewer system resources such as jail time, child welfare involvement, and fewer victimizations.

### ***Outcome Costs per Agency***

These same outcome costs were also examined by agency to determine the relative benefit to each agency that contributes resources to the CCFTC program. The transactions shown above are provided by one or more agencies. If one specific agency provides a service or transaction (for example, the Clark County Sheriff’s Office- Corrections Branch provides jail days), all costs for that transaction accrue to that specific agency. If several agencies all participate in providing a service or transaction (for example, the Superior Criminal Court, Prosecuting Attorney’s Office, and Office of Public Defense are all involved in Superior Criminal Court cases), costs are split proportionately amongst the agencies involved based on their level of participation. Table

19 provides the cost for each agency and the difference in cost between the CCFTC participants and the comparison group per person. A positive number in the difference column indicates a cost savings for CCFTC participants.

**Table 19. Outcome Costs per Participant by Agency over 2 Years from Program Entry**

<b>Agency</b>	<b>CCFTC Outcome Costs per Participant</b>	<b>Comparison Outcome Costs per Individual</b>	<b>Cost Difference/ Savings per Individual</b>
<b>Superior Criminal Court</b>	\$70	\$34	(\$36)
<b>District Court</b>	\$54	\$126	\$72
<b>Prosecuting Attorney's Office</b>	\$91	\$70	(\$21)
<b>Office of Public Defense</b>	\$128	\$173	\$45
<b>Law Enforcement</b>	\$153	\$191	\$38
<b>Sheriff's Office</b>	\$1,102	\$1,668	\$566
<b>Dept. of Social &amp; Health Services</b>	\$7,405	\$11,336	\$3,931
<b>Treatment</b>	\$3,335	\$3,574	\$239
<b>SUBTOTAL</b>	<b>\$12,338</b>	<b>\$17,172</b>	<b>\$4,834</b>
<b>Victimizations*</b>	\$10,470	\$14,639	\$4,169
<b>TOTAL</b>	<b>\$22,808</b>	<b>\$31,811</b>	<b>\$9,003</b>

\*These costs accrue to a combination of many different entities including the individual, medical care, etc. and therefore cannot be attributed to any particular agency above.

Table 19 shows that all agencies except for the Superior Criminal Court and Prosecuting Attorney's Office have a benefit, or savings, as a result of the CCFTC. The lack of savings for the Superior Criminal Court and Prosecuting Attorney's Office is related to the greater number of Superior Criminal Court cases for the CCFTC group (mostly due to participants who did not graduate from the program). As demonstrated in Tables 18 and 19, the total outcome cost over 2 years from program entry for the CCFTC per participant (regardless of graduation status) was \$12,338, while the cost per comparison group member was \$17,172. The difference between the CCFTC and comparison group represents a savings of \$4,834 per participant. When costs due to victimizations are added, the difference in costs jumps substantially with CCFTC

participants costing a total of \$9,003 *less* per participant than the comparison group due to fewer person victimizations for participants.

### ***Cost-Benefit Analysis***

Over time, the CCFTC results in significant cost savings and a return on taxpayer investment in the program. The program investment cost is \$21,633 per CCFTC participant. As previously mentioned, for the cost-benefit analysis, only treatment that occurred after program exit was taken into account for the CCFTC participants,<sup>79</sup> as treatment that occurred during the program was already included in the program investment cost. When the cost difference in outcomes between FTC participants and comparison group members is calculated without program related treatment costs, the benefit due to reduced recidivism and child welfare involvement for CCFTC participants over the 2 years included in this cost-benefit analysis came to \$12,009 (as opposed to \$9,003 in the 2 year outcome cost analysis). This amount does not result in a positive return on the investment in the first year after program entry. However, if we make the assumption that the cost savings will continue to accrue over time as has been shown in long term drug court studies (e.g., Finigan, Carey, & Cox, 2008), and as evidenced by the positive outcomes described in the outcome section in Year 3 for this program, the return on investment will increase over time as the outcome savings continue to accumulate. At 4 years the return becomes positive and at 5 years the cost-benefit ratio comes to 1:1.39. These are criminal justice system, treatment, and child welfare system savings only. If other system costs, such as health care were included, studies have shown that an even higher return on investment can be expected, up to \$10 saved per \$1 invested in the program (Finigan, 1998).

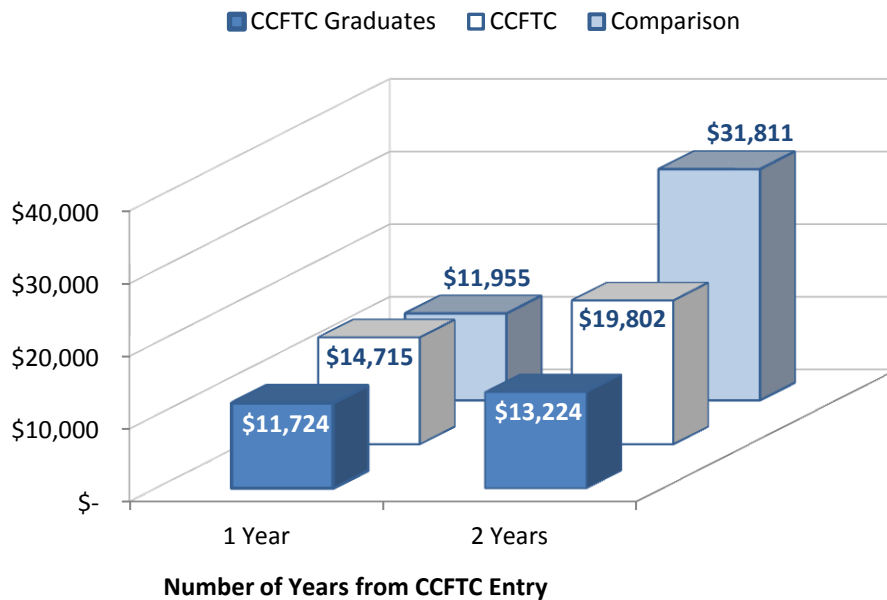
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<sup>79</sup> The cost of treatment per participant after program exit was \$329 per participant, or \$3,006 less than the cost of treatment per participant in the 2 year outcome time period. For this reason, the CCFTC outcome cost per participant used in the cost-benefit analysis was \$3,006 less, or \$19,802.

### Cost Conclusion

Figure 37 provides a graph of the outcome costs for graduates, all participants and the comparison group over 2 years, including victimizations.

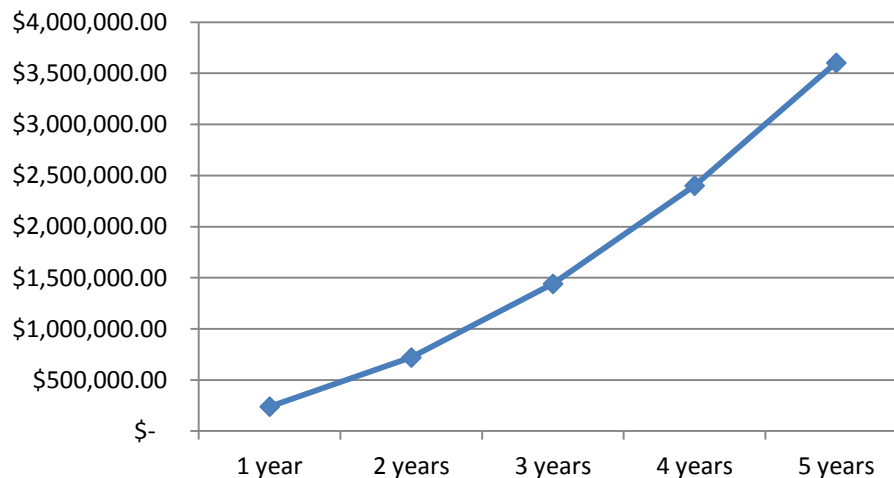
**Figure 37. Criminal Justice Recidivism, Treatment, and Child Welfare System Cost Consequences per Person: CCFTC Participants and Comparison Group Members over 2 Years After Program Entry**



The cost savings illustrated in Figure 37 are those that have accrued through 2 years after program entry. Many of these savings are due to positive outcomes while the participant is still in the program. The slightly higher outcome costs for CCFTC participants in the first year after program entry is due to more rearrests, Superior Criminal Court cases, and property victimizations than the comparison group (which is attributed to unsuccessful participants). By the second year, outcome costs have turned substantially positive for CCFTC participants.

These savings will also continue to grow with the number of new participants that enter the program each year. If the CCFTC program serves a cohort of 40 new participants annually, the savings of \$12,009 per participant (including victimizations) over 2 years from program entry results in a combined savings of \$240,180 per cohort per year, which can then be multiplied by the number of years the program remains in operation and for additional cohorts per year. After 5 years, the accumulated savings come to over **\$3.6 million** (See Figure 38).

**Figure 38. Growth in Cost Savings Due to Positive Criminal Justice, Child Welfare and Treatment Outcomes for CCFTC Cohorts Combined Over 5 Years.**



If CCFTC participants have more positive outcomes in subsequent years, then these cost savings can be expected to continue to accrue over time, repaying the program investment costs and providing further savings in the form of opportunity resources to public agencies. These findings indicate that CCFTC is both beneficial to participants and beneficial to Clark County and Washington taxpayers.

### ***Cost Evaluation Summary***

Although the CCFTC is a considerable taxpayer investment, over time it results in substantial cost savings and a return on its investment. The program investment cost is \$21,633 per CCFTC participant. The savings per CCFTC participant over the 2 years included in this analysis came to \$12,009, which does not result in a positive return on the investment over the 2-year outcome time period. However, if we make the assumption that the cost savings will continue to accrue over time, the return on investment will improve over time as the outcome savings continue to accumulate. At 4 years the return becomes positive and at 5 years the cost-benefit ratio comes to 1:1.39. This ratio increases over time as the investment is repaid and the savings continue to accumulate.

Overall, the CCFTC program had:

- A program cost of \$21,633 per participant.
- A criminal justice system, treatment, and child welfare system cost savings of \$12,009 per participant over 2 years from program entry, and
- A 139% return on its investment after 5 years (a 1:1.39 cost-benefit ratio).

These savings will also continue to grow with the number of new participants that enter the program each year. If the CCFTC program serves a cohort of 40 new participants annually, the accumulated savings after 5 years come to over \$3.6 million. The lower numbers of recidivism related events and less child welfare involvement, including lower numbers of person victimizations for CCFTC participants, resulted in substantial cost savings.

As the existence of the CCFTC continues, and it continues to improve and engage in research based best practices, the savings generated by CCFTC participants due to reduced victimizations, reduced child welfare system involvement, and other positive recidivism results can be expected to continue to accrue, repaying investment in the program and beyond. Taken together these findings indicate that the CCFTC is both beneficial to participants and beneficial to Clark County and Washington taxpayers.





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## **APPENDIX A: CHILDREN AFFECTED BY METHAMPHETAMINES GRANT (CAM) SERVICE MODEL**



## “CHILDREN AFFECTED BY METHAMPHETAMINES GRANT (CAM)” SERVICE MODEL

REVISED SEPTEMBER 2, 2011 – SIDE A (NEXT TWO PAGES)

<b>Point of Entry</b>  <b>Family Treatment Court</b>	<b>Children’s Center (CC)</b>	<b>Children’s Home Society (CHS)</b>	<b>Children’s Administration (CA)</b>
<p>Referral for Family Treatment Court (FTC) is filled out.</p> <p>Primary referral source into FTC is:</p> <ul style="list-style-type: none"> <li>• Defense Attorney</li> <li>• Social Worker</li> <li>• Self-Referral</li> </ul> <p>Client is staffed by FTC team for eligibility.</p> <ul style="list-style-type: none"> <li>• Dependency must be entered</li> <li>• Current substance abuse diagnosis in need of substance abuse treatment.</li> <li>• Volunteer for FTC and abide by program rules</li> <li>• Must be seeking custody of child(ren)</li> <li>• Within 6 months of Dependency being filed (Over 6 months will be taken on a case by case basis)</li> </ul>	<p>Upon receiving a referral from DCFS social workers:</p> <ul style="list-style-type: none"> <li>• CC CAM therapist conducts Intake interviews with the child (consumer), auxiliary caregivers and biological parents.</li> <li>• As part of the intake, CAM therapist or home support specialist shall complete instruments: ASQ-3, ASQ-SE, CBCL, and NCFAS and refers consumer to CC Psychologist, Dr. Holly Crossen for neuro-psych evaluation.</li> <li>• CAM therapist refers the biological parent(s) to CHS for parenting classes and to CC Psychologist, Dr. Holly Crossen for neuro-psych evaluation.</li> <li>• CAM therapist creates tx plan and provides identified services to consumer and auxiliary caregivers.</li> <li>• After concluding a cycle of evidence based parenting at CHS, biological parents begin receiving “Special Needs Parents Parenting Special Needs Children” services at CC CAM specific parenting program, home based coaching and family therapy with the consumer and biological parent(s).</li> </ul> <p>For children already engaged in tx with other</p>	<ul style="list-style-type: none"> <li>• Receive referral from social worker. (brief 2 page, can be completed at court when parenting is identified)</li> <li>• Family will be assigned to a staff person</li> <li>• Family will do Triple P intake with Children’s Home Society (CHS) staff (related to parenting style and history)</li> <li>• Parent receives on-going support and education from CHS staff</li> <li>• CHS staff participates in regular case staffings for the family.</li> <li>• At “pizza” meeting, decide any future additions to parenting education plan</li> <li>• CHS will adjust parent education based on family stage</li> <li>• Erinn Havig – Program Manager</li> <li>• Margaret Grant – Family Educator</li> <li>• Cara Larson – Family Educator</li> </ul>	<p>FTC team is notified of new referral via email from the FTC Coordinator:</p> <ul style="list-style-type: none"> <li>• FTC social workers then identify the assigned SW for the case, and inquire as to any concerns, hx of the case and parent in question. This information is provided to the FTC team at the staffing of the referral (typically the following Monday).</li> <li>• When parent formally opts in to FTC, we notify the assigned social worker, who is expected to prepare the case file for transfer to us. The expectation is that the case is transferred within one week. The DSHS Supervisor identifies which FTC social worker will be assigned the case. We immediately begin working the case, so that we can provide updates to the FTC team in court the following week.</li> <li>• Each social worker has her own style, but typically, we meet with parents early on, to review services and check in. We are required to provide updates to the team every Monday that the clients are in attendance at FTC, and we are responsible for receiving and presenting any requests that the parents submit to the FTC team.</li> <li>• We also conduct the same ongoing case management services for the family that are completed by all social workers in the agency.</li> </ul>



Point of Entry Family Treatment Court	Children's Center (CC)	Children's Home Society (CHS)	Children's Administration (CA)
<p><i>Disqualifying Criteria:</i></p> <ul style="list-style-type: none"><li>• Sex offense—conviction or current allegation</li><li>• Severe mental health issues</li><li>• Serious violent offenses—conviction or current allegation</li><li>• Pending charges with greater than 30 days jail disposition</li></ul> <p>If client has been affected by Methamphetamine use, referral to Children Affected by Methamphetamines (CAM) Grant enhanced services.</p>	<p>providers:</p> <ul style="list-style-type: none"><li>• CC will provide neuro-psychological evaluations of the children and parents. In these instances, the CAM therapist will conduct an abbreviated intake based on information provided by the children's current therapist, the child and the auxiliary caregiver.</li><li>• The parent(s) will be referred to CHS for parenting classes. Upon completion of the CHS parenting program, the parents will participate in the "Special Needs Parents Parenting Special Needs Children" at CC.</li></ul>		

Lifeline Connections	Northwest Professional Consortium (NPC)	Court-Appointed Special Advocates (CASA)	Stakeholders
<p>Provides orientation to FTC tx requirements.</p> <ul style="list-style-type: none"> <li>• Urinalysis procedure</li> <li>• Treatment attendance excusal procedure</li> </ul> <ul style="list-style-type: none"> <li>• Sober support verification procedure</li> </ul> <ul style="list-style-type: none"> <li>• Provides ASI assessment and/or full A/D clinical assessment if pt. not yet in treatment services.</li> </ul> <p>Provides Monthly Family Tx Parenting Education group</p> <p>Provides Monthly case management reviews</p> <p>Acts as liaison between tx facility staff and court staff.</p> <p>Monitors sober support attendance</p> <p>Monitors UA results for the first phase of court</p> <p>Monitors tx compliance</p> <p>Monitors prescription medications</p> <ul style="list-style-type: none"> <li>• After FTC opt-in, pt. attends orientation as described above and receives first case management review</li> <li>• If pt. is already placed in tx, ASI is completed and communication is established with their providing agency</li> </ul>	<p>The Clark County Family Tx Court will contract with NPC to conduct three evaluation components related to this project. This will include; process, outcome and cost evaluations. The goal of the Process Evaluation is to provide evidence-based services to methamphetamine impacted children and families. This effort is designed to increase family reunification and decrease the use of foster care as well as reducing involvement in child protective services and the criminal justice system. Documenting the processes used in our planned services is crucial to program monitoring and improvement. The Outcome Evaluation will compare the effects of being assigned to the Family Tx Court as compared to the traditional family dependency court system. Design of study will provide SAMHSA with a strong comparison between a family drug tx courts and traditional family dependency courts. Key components of evaluation will include; termination of parental rights, time in foster care, likelihood of child abuse/neglect and criminal recidivism. The Cost/Benefit Analysis evaluation will apply Transactional and Institutional Cost Analysis approach to program outcomes to perform a cost analysis of our project. The analysis will include interviews of key informants, analysis of budgets, comprehensive financial reports, agency pay and classification information and review of other pertinent documentation. The goal is to provide a cost-to-the-taxpayer approach that includes both direct and indirect costs. The analysis of cost and savings to</p>	<p>Provides Guardian ad Litem representation for the children whose parents are involved with FTC. CASA/GAL representation includes an independent look at the case situations to gather information and to monitor court orders for compliance, provide information and recommendations to the Court and wraparound teams, assist to facilitate positive communications, and advocate for the children's best interests. If the child is in the jurisdiction, CASA visits the child and at the child's placement and may observe parent-child visits. CASA participates in all Dependency and FTC Court Hearings and trials. CASA's are most often trained/supported volunteers; some children's cases are monitored by CASA Staff.</p> <p>Specific to FTC and the CAM model:</p> <p>CASA provides a staff person as a FTC/CAM Team member. CASA participates in the FTC/CAM policy [and other grant-related meetings and initiatives as time is available]. CASA participates and gives input for the FTC staffings and FTC Hearings regarding parents, with a focus on the children and their needs.</p>	<ul style="list-style-type: none"> <li>• Family Treatment Court</li> <li>• Children's Center</li> <li>• Children's Home Society</li> <li>• Children's Administration (CA)</li> <li>• Lifeline Connections</li> <li>• NW Professional Consortium (NPC)</li> <li>• Court Appointed Special Advocate (CASA)</li> <li>• Consumers</li> <li>• Attorney General's Office</li> <li>• Parents' Attorney/Office of Public Defenders</li> </ul>



Lifeline Connections	Northwest Professional Consortium (NPC)	Court-Appointed Special Advocates (CASA)	Stakeholders
<p>or if within lifeline- with their counselor.</p> <ul style="list-style-type: none"><li>If pt. has no tx in place, ASI and full clinical A/D assessment are arranged as soon as can be scheduled. Pt. may choose where to obtain tx. If chooses LLC, FTC caseworker sets pt. up with an intake to tx as soon as possible and begins the monitoring and reporting described above. If chooses agency, communication established as described above and compliance monitored weekly.</li><li>Tx plans for A/D tx are drawn up by the counselor at the pt.'s chosen agency at the time of their intake to tx.</li></ul>	<p>taxpayers is a key need in maintaining continued support for our therapeutic court programs. This external independent evaluation of savings to taxpayers and avoided negative outcomes such as foster care and criminal recidivism will be assessed. Evaluation services will be paid through an annual contract negotiated with NPC Research. The reduced rate of this contract is a result of other contracted services with NPC Research.</p>	<p>CASA works to identify each child's needs and make those needs known to the FTC Team and Court and advocate for the most appropriate CAM services.</p>	

"CHILDREN AFFECTED BY METHAMPHETAMINES GRANT (CAM)" SERVICE MODEL

REVISED SEPTEMBER 2, 2011– SIDE B (NEXT 2 PAGES)

<p><u>Clark County Department of Community Services (DCS)</u></p> <p><b>de Guzman, Camilo</b>      <b>Service Coordinator</b></p> <p><b>Gerrior, Barbara</b>      <b>Service Coordinator, Alternate</b></p> <p>The Service Coordinator is an employee of the Applicant Agency, Clark County DCS and provides oversight of CAM services. The schism in philosophy and practices between the disciplines of mental health and addiction treatment can thwart attempts to have seamless services (Family to Family DSHS Training, 2002). Experienced professionals and para-professionals recognize that splitting in the team, and other distractions, can subvert the larger endeavor of re-equipping a parent and child with tools to overcome the host of ills that accumulated to becoming indigent and having children removed by CPS. The Service Coordinator will work with members of the FTC to establish and identify linkages for necessary services to promote the well-being of the child/ family. The Service Coordinator oversees the collaborative partnerships developed with Children's Center and Children's</p>	<p><b>Thompson, Cleve</b>      <b>Project Director</b></p> <p><b>Sieler, DeDe</b>      <b>Future Project Director</b></p> <p>The Project Director is responsible for overseeing all aspects of the grant project;</p> <ul style="list-style-type: none"><li>Serves as the primary liaison between the Substance Abuse Mental Health Services Administration (SAMHSA) and the applicant, Clark County Department of Community Services;</li></ul>
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<p>Home Society and ensures CAM services meet grant requirements and are provided in a timely manner.</p> <p>The Service Coordinator will work with the FTC-STEP team to implement the FTC-CAM Project and ensures all GPRA data is entered at the appropriate intervals and within the required seven day time frame. Lastly, this position will work with Dr. Shannon Carey at NPC Research to ensure all CAM Project evaluation needs are coordinated with the FTC.</p> <p><i>Responsible for the implementation of the FTC program. Address and resolve barriers to implementation and system of care coordination with the help of the FTC team.</i></p> <p><b>Smith, Cyndi      Support Staff</b></p> <p>Provides office and clerical support.</p> <p><b>Steen, Heidi      Finance Unit</b></p> <ul style="list-style-type: none"> <li>• Receives approved CAM invoice(s)</li> <li>• Review backup documentation for Allow-ability and enter into Oracle.</li> <li>• Approve invoices to be paid.</li> <li>• On a monthly basis run a monthly expenditure report/reconcile from previous month's billing.</li> <li>• Draw down SAMHSA expenditures on PMS system.</li> <li>• Quarterly, complete a SF 272 to reconcile cash drawdown's from SAMHSA.</li> </ul> <p><b>Curtin, Ron      Contracts Unit</b></p> <p><b>Stein, Brad      Contracts Unit</b></p> <ul style="list-style-type: none"> <li>• Contract Responsibilities to include: All grant requirements &amp; specific terms and conditions to grant number: 1H79TI023353-01</li> <li>• Drafts the Contracts between DCS and Children's Home Society and Children's Center to provide CAM Treatment Services in compliance with SAMHSA grant requirements.</li> <li>• Coordinates CAM Re-Application process.</li> </ul>	<ul style="list-style-type: none"> <li>• Create and negotiate contracts with community-based, nonprofit direct service providers and program evaluation for CAM Grant services. Contracts with Children's Center, Children's Home Society and NPC, Research. Responsible for contract compliance and contract monitoring;</li> <li>• Supervision of all project staff including; Services Coordinator (Camilo deGuzman), Data Coordinator (Gena Foreman), Alcohol and Drug Services Staff, Contracted Treatment Service Provider (Lifeline Connections);</li> <li>• Manages cooperation with DCS fiscal liaison (Heidi Steen), contract liaison (Brad Stein), and billing &amp; services budget staff (Barbara Becker) and Coordination of services with Family Treatment Court Coordinator (Brad Finegood);</li> <li>• Responsible for the development, implementation and utilization of all grant budgets and expenditures;</li> <li>• Responsibilities with other team members for the facilitation of the CAM Coordination Committee;</li> <li>• Responsible for development of a "Children Affected by Methamphetamine" service model designed to out line the roles, responsibilities and services provided by all components of the CAM grant;</li> <li>• Responsible to SAMHSA for all bi-annual reporting requirements, reapplication requirements, budget changes and authorizations of future carry over funding requests;</li> <li>• Responsible for ensuring that all aspects of the CAM project are completed in a timely manner to reach the project goals and objectives.</li> </ul> <p><u>Family Treatment Court</u></p> <p><b>Finegood, Brad   Principal Investigator</b></p> <p><b>Foreman, Gena   Grant Data Coordinator</b></p> <p>Plans, coordinates and administers a specific program within a designated department. Assigned programs typically involve heavy administrative components and require a single incumbent to administer.</p>
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Responsibilities include project/task planning, design, recommendation, implementation and day to day administration of program responsibilities.

Data Collector. Person to be determined (.5 FTE)

Responsible for ensuring GPRA data is collected at baseline, six and 12 months.

Responsible for coordination of data collection with evaluators from NPC Research

Data collector must have degree in Social Service, or data collection field.

Person must have training or be willing to be trained in data collection methods with substance abusing populations.

**Schienberg, Carin**      **Court Commissioner**

Attorney Generals Office

**Rosenbaum, Miriam**

Office of Public Defenders/Parents' Attorney

**Sonju, Scott**

Children's Center

**Beckett, Pat**      **Executive Director**

Therapeutic activities and skill building will focus on safety, de-escalation of agitation states, replacement of violence with containment activities, calming practice, anxiety reduction, preventive structure and prosocial interaction needed for the child to increase trust of adult care, comfort and limits. This will lead to subsequent expansion of positive affective engagement within parent-child dynamics. Specific goals are conceptualized in a phased model of COACHES-EM treatment, which run parallel with the Phase requirements of FTC:

Children's Home Society

**McLeman, Bridget**      **Director**

**Havig, Erinn**      **Program Manager**

**Grant, Margaret**      **Child & Family Educator**

**Larson, Cara**      **Child & Family Educator**

Children's Administration

**Brown, Ross**      **Supervisor**

**Harrington, Tara**      **Social Worker**

**James, Taunya**      **Social Worker**

**Keeney, Charro**      **Social Worker**

Lifeline Connections

**Whitney, Brandy**      **Clinical Director**

**Rush, Ken**      **Program Manager**

**Flint, Sausscha**      **Lead Treatment Provider**



**Crossen, Holly    Neuropsychological Evaluator**

Administer and score evaluations of children and parents. Provide written report with 15 business days. Set a weekly schedule for clinic services based on contractor's availability and program needs. Participate and/or conduct intake interviews with project's clientele as warranted. Provide ongoing feedback to team in weekly meetings and correspondence. Provide hands on coaching and training to parents/caregivers/other involved ancillary services in neurobehavioral strategies. Case consultation and/or in vivo coaching to the agency therapist and his/her client(s). Trainings to team members and other ancillary services in neurobehavioral strategies for children affected by meth. Participation in school and/or community case staffings as requested.

**Sullivan, Helen    Clinical Supervisor****Dees, Nicole    Child/Family Therapist****Richardson, Connie    Home Support Specialist**

Improving the respective adaptive functioning of the child with special needs and their newly clean parent with special needs so that family recovery moves beyond talk, into a new "walk" of practice. This will assist in changes in mindset, communication interactions, and behavior that is stepwise and measurable. Neurocognitive assessment and diagnosis is followed by a program of psychoeducation and neurobehavioral intervention for children from birth through age 17 years, their caregivers (relative/foster care providers), and their birth parents. Maladaptive relational strategies from adult meth use, maltreatment, and trauma will be identified along with compensating strengths.

Northwest Professional Consortium, Inc. (NPC)**Carey, Shannon    Senior Evaluator****Kissick, Katherine Research Coordinator**

Contractor will conduct evaluation components

CASA**Kuzmic, Barabara Director****Roe, Charlie    Program Specialist**