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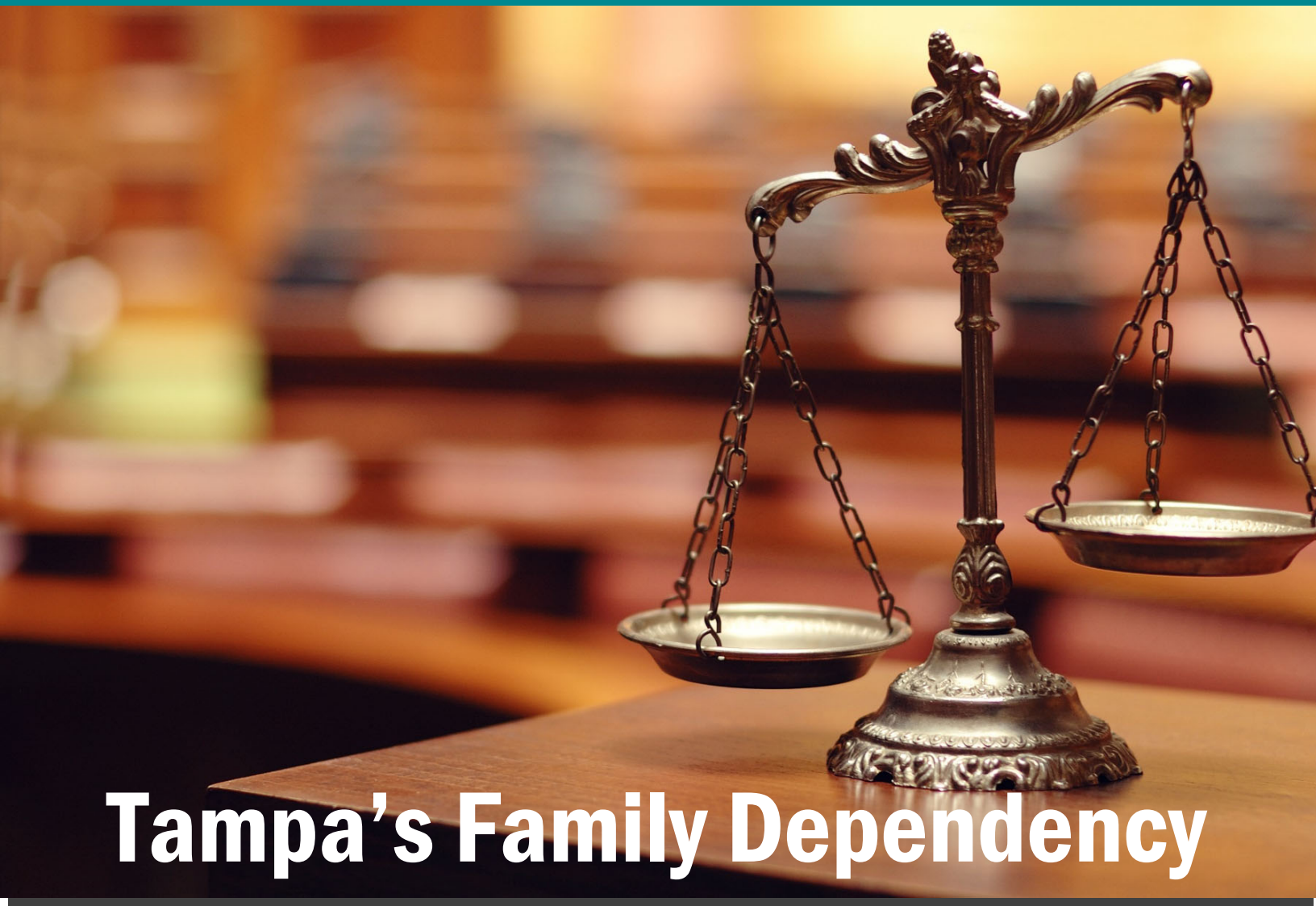


Tampa's Family Dependency Treatment Court Best Practice Assessment

Introduction

Casey Family Programs contracted with Data Savvy Consulting to provide a best practice assessment and cost evaluation to the Tampa Family Dependency Treatment Court, as part of their ongoing efforts to achieve safe reduction in the number of youth in foster care and build communities of hope.

Tampa Family Dependency Treatment Court. In 2012, Hillsborough County (Tampa), Florida, received a SAMHSA/CSAT grant to establish a family treatment court, which provides intensive substance abuse services to families involved in the child welfare court system. The court has been in operation under the leadership of the same judge since its inception. The Family Dependency Treatment Court (FDTC) serves families with serious substance abuse issues in Hillsborough County that are referred to them by line division judges. Hillsborough County had approximately 1,300 cases that entered foster care in 2019, 31% of which had a removal reason of substance abuse. The FDTC had approximately 128 parents in June of 2019 and had served an average of 70 cases per year. The FDTC serves about 18% of the incoming families with substance abuse issues per year. The FDTC has had several outcome evaluations since its inception, all with positive findings. This evaluation will fill in the gaps of the evaluation efforts by answering the following research questions.

Research Questions

1. How does FDTC's current practice align with the National Association of Drug Court Professionals' best practice standards for family treatment drug courts?
2. What are the areas for opportunity/enhancement of practice to better align with best practices?
3. How has COVID-19 impacted FDTC referrals and practices?
4. What types of cases are referred to FDTC, verses those that remain in a line dependency division?
5. How do case management services in FDTC differ from those provided in line dependency divisions?
6. Is the FDTC program cost effective for serving families involved in the child welfare system?

Methodology

A multi-method approach was used to collect appropriate data needed to answer the research questions of interest. This included document review, structured case file review, observation of the FDTC court and a court staffing, review of available program and administrative data, interviews with the professional stakeholders involved in the FDTC, a survey of FDTC professionals, and review of available cost information to determine program expenses. Each data collection methodology is described in more detail below.

Document review. Program staff provided available documentation for review. This included the Problem-Solving Courts Family Dependency Treatment Court Policy and Procedure Manual, a template for treatment status review reports, an outcome evaluation report for the program[1], two journal articles[2] that described the process and findings for outcome evaluations of the Hillsborough FDTC, and the State Florida Adult Drug Court Standards. These documents were reviewed for content and findings relevant to the research questions.

Case File Review. A structured case file review was conducted to answer the research questions. The evaluator asked for a random sample of 30 FDTC cases that opened in 2019, a random sample of 30 FDTC cases that opened in 2020 (to make comparison between pre and post-COVID) and a random sample of 30 substance abuse cases that opened in line division that were not diverted to FDTC for comparison. The structured case file review was used to identify data points such as timing of key court events, frequency of court hearings, parent's participation in their hearings, allegations on the case, and services offered to the family. The final sample consisted of 54 FDTC cases (17 from 2020) and 25 comparison cases as some of the comparison group had actually been admitted to drug court.

Court observation. Structured court observation of the FDTC docket was conducted for two live morning dockets (December 2020) and one full recorded docket day (June 2019). Data collected during court observation included which parties were present, how long the hearing took, what topics were discussed and how the judge interacted with the family. This included observation of 37 hearings, 27 from 2019 (recorded) and 10 "live" observations via telephone for 2020.

Case staffing observation. The evaluator attended a FDTC case staffing prior to one of the observation days. A structured observation instrument was not used. Notes and qualitative impressions were taken with a count of topics discussed and parties who were present for the staffing.

Program data. The evaluator was provided with outcome data that was gathered for a five-year study of the program and an Excel document that included basic descriptive information (e.g., age, case number, race) for families involved in FDTC. In addition, the evaluator was provided with a PowerPoint that included summary descriptive statistics (e.g., frequencies, averages) for

[1] Moore, K., Barongi, M., Young, S., & Kemph, J. (2014). *Evaluation of the Family Dependency Treatment Court Program.* University of Southern Florida.
[2] Chuang, E., Moore, K., Barrett, B., & Young, M. S. (2012). Effect of an integrated family dependency treatment court on child welfare reunification, time to permanency, and re-entry rates. *Children and Youth Services Review, 34,* 1896-1902. Moore, K., Sharp, A., Alitz, P., Yampolskaya, S., Kleinman, M., Carlson, M., & Argerious, A. (2020). Reconsidering success for an integrated family dependency treatment court. *Children and Youth Services Review, 114.*

FDTC administrative data. These data were reviewed to add additional information and context for the research questions.

Administrative data. In addition to program data, Florida administrative data was reviewed. This included utilizing the publicly available Adoption and Foster Care Analysis and Reporting System (AFCARS) data. These data include all the children in foster care in a given time period. Data are reported by state and county (when counties are large enough). AFCARS includes Hillsborough County data for all the youth in foster care. The dataset includes data such as race, removal reason, discharge date and discharge reason. AFCARS data are available for data up to fiscal year 2019.

Interviews. Program management provided a list of contact information for the FDTC core team members. A semi-structured interview guide was developed to ask professionals about their experience in the FDTC. These questions were derived from best practice standards and included questions about how practice has changed due to COVID-19 restrictions as well as cost assessment questions. Eight core FDTC professionals and FDTC and problem-solving court leadership were identified for interviews. Nine interviews (averaging 30 minutes each) were conducted as one professional was unable to coordinate a time that worked within the study's timeframe.

Survey. In addition to the interviews, a short survey was created that identified specific statements related to treatment court best practice standards. The survey was an opportunity for stakeholders to report their perspective on the FDTC's alignment to best practice standards in an anonymous forum. Participants rated their agreement on a series of statements on a 7-point agreement scale ranging from 1=strongly disagree to 7=strongly agree. Seventy-five percent of the core team completed the survey.

Cost Data. Cost data was gathered from several sources. These sources included interview questions, estimated salaries for professionals from Florida public salary data, data provided by the Court Improvement Program, information gathered from prior reports, and data provided by the program coordinator.

FINDINGS

Findings are organized around the research questions. Questions 1-3 focus on the best practice standards assessment and findings related to these questions are reported in Section I. Section II focuses on differences between line division cases and cases that come under the purview of FDTC and answers research questions 4 and 5. Finally, Section III addresses the cost effectiveness of the FDTC.

I -Best Practice Standards Assessment

To answer research questions 1-3 (identified below), data were pulled from all the data collection methods. Findings are reported below by best practice standard. The Center for Children and Family Futures and the National Association of Drug Court Professionals promulgated best practice standards for Family Treatment Courts, which were published in 2019.[3] In addition, Florida has standards for Adult Drug Courts[4] that were reviewed and included, as relevant to national standards. FDTC professionals were asked about their familiarity with both of these standards. All respondents said they were somewhat familiar or very familiar with the national family treatment court best practice standards. However, half of the respondents were not at all familiar (or only a little familiar) with Florida Drug Court best practice standards.

The eight national best practice standards are listed below with a summary of the standard copied verbatim from the NADCP best practice document. When relevant, information from Florida's Adult Drug Court standards is added to these for additional context and comparison. For each of these sections, data from all data collection methods is integrated into the findings to identify the Tampa FDTC strengths and areas of opportunity for each practice standard. When relevant, differences in practice due to COVID-19 restrictions are noted and how it may impact best practices is discussed. Recommendations for enhancement of practice are noted for consideration of the FDTC team. These should be viewed as considerations to better align with best practice standards. The FDTC should review and determine whether these recommendations are appropriate for their court before making any changes to practice.

Research questions answered in Section I

1. How does FTDC's current practice align with the National Association of Drug Court Professionals' best practice standards for family treatment drug courts?
2. What are the areas for opportunity/enhancement of practice to better align with best practices?
3. How has COVID-19 impacted FDTC referrals and practices?

Standard 1: Organization and Structure. *The family treatment court (FTC) has agreed-upon structural and organizational principles that are supported by research and based on evidence-informed policies, programs, and practices. The core programmatic components, day-to-day operations, and oversight structures are defined and documented in the FTC policy and procedure manual, participant handbook, and memoranda of understanding (MOUs).*

[3] Center for Children and Family Futures and National Association of Drug Court Professionals. (2019). *Family Treatment Court Best Practice Standards.* Prepared for the Office of Juvenile Justice and Delinquency Prevention (OJJDP) Office of Justice Programs (OJP), U.S. Department of Justice (DOJ). Available online at https://www.nadcp.org/standards/family-treatment-court-best-practice-standards/

[4] Supreme Court of the State of Florida (2017). *Florida Adult Drug Court Best Practice Standards.* Available online at

Findings: The FDTC has most of the necessary organization and structure in place. There is an oversight committee that meets regularly and discusses the program and program data. There does appear to be a shared mission and vision for the program. All FDTC staff indicated that the staff treat each other with respect.

It is unclear, however, if the program has information sharing protocols in place. While most FDTC staff said there is a process in place to ensure FDTC team members share information timely and securely, some staff indicated that this was not the case. One way that information is shared is through reports. The treatment providers are given a template report form so that they can provide regular reports to the FDTC team about the parents. The template form includes all the information identified in the policy and procedural manual as needed for the family. The case manager provides additional information about case plan needs beyond parents' substance abuse treatment. Observation of court hearings revealed that some, but not all hearings had reports prior to the hearing. It appeared that clients served through DACCO were more likely to have reports than other clients, but this was a qualitative observation and was not systematically captured to record exact numbers. FDTC staff indicated they also communicate regularly through phone calls, and emails, and some through staffings.

Not all team members participate in the FDTC staffings, which limits their opportunities to share information. It was noted that the guardian ad litem attorney and the parent's attorney do not regularly attend the staffings and neither does the judge. Staffings do not occur immediately prior to the hearing, as recommended by standards. They occur on Mondays, prior to Tuesday and Thursday dockets. However, staff indicated that additional information is widely shared via email or telephone if needed outside of staffings.

There are strong partnerships with a variety of treatment providers, to allow opportunities for participants to get access to treatment even if the primary treatment provider (DACCO), does not work for them. FDTC stakeholders mostly agreed that all team members are trained on best practices and key topics such as substance use, trauma and implicit bias. While nearly all respondents said they were familiar with the national best practice standards for dependency treatment courts, most were not familiar with the Florida Adult Drug Court standards, which are cited in the policy and procedural manual.

The primary concerns with the organization and structure of the FDTC is the lack of a program specific/tailored policy and procedural manual and the lack of a FDTC participant manual. While there is a policy and procedural manual for the FDTC, it is actually a broader document for *all* the problem-solving courts. While it defines roles for the FDTC team, includes eligibility criteria, and posits a timeline for the FDTC, at the time of this assessment it did not include phases for the program. It does include discharge criteria, however, staff indicated that participants are not really discharged from the program for non-compliance, only if their cases result in termination of parental rights or closes to some other outcome. There does not appear to be a participant manual.

Impact of COVID-19: Interviews revealed that COVID-19 has impacted information sharing. When hearings were held in person, a copy of the treatment report was provided to all parties at or immediately prior to the hearing. Now, this does not always occur. Attorneys reported not

always getting the reports prior to the hearings. Since hearings are virtual and held by teleconference, there is a not an opportunity to share at the hearing.

Strengths: The oversight committee meets regularly. There are strong community partnerships and good communication between team members. The team clearly respects each other and has an open chain of communication. There is a policy and procedure manual that articulates the key components of the treatment court, the roles of key staff, participant eligibility and discharge criteria, as well as other protocols.

Areas of Opportunity: The policy and procedure manual could be enhanced with more program specific details, particularly regarding phases for participants, discharge criteria, and how and when sanctions and incentives will be used. The manual should be widely disseminated to program staff and ensure that training occurs to be consistent with the manualized practice. In addition, a participant manual could be created to share with parents to articulate expectations in the FDTC (e.g., explain the role of staff/court, identify services available, identify keys to success/criteria for graduation, etc.). Staffings could be enhanced with the presence of the judge, the GAL attorney, and parent's attorneys to ensure robust information sharing and problem-solving. The FDTC would benefit from a clear communications protocol that ensures all parties are provided information in a timely manner and a method for ensuring this communication regularly occurs.

Recommendations:

- Work to enhance information-sharing protocols (fully articulate the means and timing for information sharing to build consistency and enhance communication)
- Consider enhancing participation of all team members (including the judge) in staffings - to facilitate sharing of information and enhanced problem solving, consider expanding participation in staffing for all team members -establish clear guidance about roles in staffing (especially for the judge) and examine the "why's" behind non-participation -does everyone agree? How can full participation be achieved while addressing any concerns?
- Provide education to team members on Florida Adult Drug Court Standards (may provide helpful context since many FDTC participants also have criminal cases and/or experience with those drug courts).
- Develop a participant manual for FTDC parents to facilitate understanding of the program (see text for some ideas of what that would involve).
- Formalize/manualize phases for the FTDC program (builds consistency/fairness in application of the program).
- Tailor and finalize the procedures manual to the Hillsborough County program FDTC.
- COVID: Consider ways to ensure reports are shared before the virtual hearings (via secure file transfer; in chat feature; send out communication re: expectation that reports will be provided prior to hearings and establish an acceptable timeframe)

Standard 2: Role of the Judge. *Judicial leadership is critical to the effective planning and operation of the family treatment court (FTC). The FTC judge works collectively with leaders of partner agencies and other stakeholders to establish clear roles and a shared mission and vision. He or she has the unique ability to engage the leaders and stakeholders in the development, implementation, and ongoing operations of the FTC. The judge is a vital part of the operational team, convening meetings that encourage team members to identify shared values, voice concerns, and find common ground. Additionally, the judge's development of rapport with participants is among the most important components of the FTC.*

Findings: Overall, FDTC participants reported that the judge in the FDTC is a leader in the field, that he demonstrates compassion for the families and that he really cares about the cases before him. They all agreed that the judge works collectively with key partners, considers the input of the multidisciplinary team when making decisions, provides supportive comments to participates and stresses the importance of their commitment to treatment. They also all believed that participants have an opportunity to be heard at hearings. There is judicial continuity of the FDTC, as the judge has overseen FDTC cases since its inception. The judge has been trained on best practices in drug courts and has experience working with other problem-solving courts prior to the FDTC docket. Case file review findings indicate that, for the majority of cases, the judge has parents attending hearings at least once every two weeks at the beginning of FDTC. This does appear to decrease to once a month as the case progresses and parents are near completion of services. The judge does not attend staffings and, for the most part, does not engage directly in problem-solving with the professionals during hearings. When issues arise that need to be resolved, the judge takes a recess to let the other professionals resolve the case issues.

Court observation revealed that the judge typically spends at least 3 minutes per case. The average time per hearing was 7 minutes (median of 5) with a range of 2 minutes to 32 minutes per hearing. The judge interacts with parents in the majority (but not all) of the hearings, and frequently praises or admonishes parents based on their behavior. The judge gave the parents an opportunity to be heard in 67% of the hearings observed when there was a parent present. Opportunities to be heard were fairly limited to yes or no responses to questions. Although sometimes exchanges with parents were more open-ended.

Each participant gets their own hearing, which is slightly different from a typical drug court setting where the courtroom often serves as a "theater." That is, most drug courts operate with a model where all participants are present so that there is an educational opportunity for participants to learn by observing interactions with others. Florida adult drug court standards suggest that all participants get their own status hearing.

Impact of COVID-19: Since COVID-19, staffings and hearings are now held via telephone conference. This has impacted the ability of the program to see parents and build rapport that comes from face to face interaction with families. Further, it is harder to know if parents are using drugs if they are not face-to-face.

Strengths: Staff reported that the judge is compassionate and committed to helping families through the FDTC. The judge spends at least 3 minutes on each case for the majority of hearings.

Areas of Opportunity: The judge does not attend staffings. Best practice guideline (which are supported by research), suggest that the FDTC may be improved if the judge is an active participant in the staffings. Including the judge in staffings would expand the role of the judge to have more input into the overall progress of the case (not only in the legal decisions, but in discussions about the provision of treatment, the use of sanctions and rewards, and necessary services). To facilitate the judge's participation in staffings, information-sharing protocols could be enhanced to ensure they not only meet the information needs of the FDTC team (i.e., serving parents and families appropriately and effectively), but also uphold the due process rights of the parents. Protocols could limit the sharing of information in staffings, for example, to the information that is critical for informed decision-making and treatment planning, while protecting the privacy and due process rights of the parents.

It may also be beneficial to ensure that all participants are given an opportunity to be heard in a meaningful way in the hearing. Research identified in the Florida Adult Drug Court standards suggests that judges spending at least three to seven minutes interacting with the family can enhance outcomes. While hearings averaged at least three minutes, the amount of time the judge spent actually interacting with parents was actually quite minimal (typically less than one minute). Consider whether the "courtroom as theater" model is appropriate and would be beneficial for FDTC participants, particularly those new to the court. Having all FDTC participants attend the hearings affords an opportunity for parents to observe and learn from the interactions taking place, with the aim of shaping their own behavior and building more group support for sobriety.

Recommendations:

- Consider the role of the judge in the FDTC and whether that should be enhanced to include participation in staffings -what are the barriers? Are those legitimate? Are there aspects of the staffings that the judge could attend and others where he should recuse himself? For example, in some jurisdictions, there is discussion among the team without the judge about the cases and then the judge joins near the end of the staffing for updates. Missing staffings means that the judge misses an opportunity to hear from the FDTC team and prepare for the hearing, including what to focus on with the parents and how to respond to behaviors (e.g., encouraging or admonishing).
- Consider hearings as opportunities to more fully engage parents, including other parents involved in the FTDC as observers. Consider whether this model would be appropriate or if individual hearings best meet parent's needs.
- COVID: in virtual hearings it may be even more important to spend time engaging with parents (due to the loss of "face-to-face" in person interaction). Consider whether it is possible to move hearings to virtual face to face platform, such as Zoom so that parents can be seen until hearings can be in-person again.

Standard 3: Ensuring Equity and Inclusion. *Family treatment court (FTC) has an affirmative obligation to consistently assess its operations and those of partner organizations for policies or procedures that could contribute to disproportionality and disparities among historically marginalized and other underserved groups. The FTC actively collects and analyzes program and partner organization data to determine if disproportionality or disparities exist in the program; if so, the FTC implements corrective measures to eliminate them.*

Findings: Stakeholders reported that the FDTC process is fair and race is not considered in eligibility or service delivery. It was reported that the drug court specialists and the community providers employ standards of practice that value the participant's language, beliefs, norms, values, and socioeconomic factors to maximize the success of interventions. Staff are also provided regular trainings on culturally and linguistically appropriate approaches. FDTC leadership works to ensure that staff is diverse and represents a cross section of the local community, including the population of interest. It was also reported that the oversight committee explores admissions, successful discharges and unsuccessful discharge rates by race.

The FDTC program collects race data for the participants so there is an opportunity to determine how similar or different the population is in comparison to the foster care population in Hillsborough County, Florida. Data were explored for three different drug court samples – one from the 2016 Evaluation report, one from a journal article that collected data on participants between 2012- 2015, and race data provided by the FDTC program on their current population. These data were compared to data from the Adoption and Foster Care Analysis and Reporting System (AFCARS), which collects data from every state's child welfare agencies on the foster care population. The AFCARS data reported herein includes the race and ethnicity data for cases coming into the system with a removal reason of drug abuse in Hillsborough County. While not a perfect match, it does provide a reference point for comparison. These data are presented in Table 1.

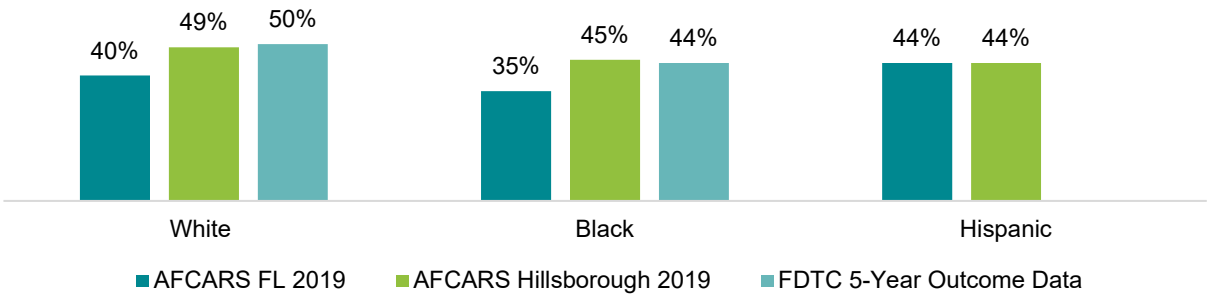
Table 1: Race and Ethnicity of FDTC Participants Compared to County Data

	2016 Evaluation Report	Participants between 2012 & 2015	Current FDTC Population	AFCARS Data 2019
White	80%	82%	84%	73%
African American	11%	15%	13%	22%
Mixed Race or Other	4%	3%	3%	6%
Ethnicity: Hispanic	20%	15%		24%

Data were explored in terms of outcomes. The comparison group included Hillsborough County cases and Florida state cases that came into the system with a removal reason of substance abuse and exited care in 2019. Note, race and ethnicity reported in the program are for the parents and all AFCARS data is about the child. Rates of exit outcomes look similar between

the racial groups and the overall exit outcomes for Hillsborough County for Black and White families. Data were not provided on ethnicity to explore outcomes by ethnicity.

Figure 1: Percent of Cases Closing in 2019 that Came into System with Substance Abuse by Race and Ethnicity



Strengths: The FDTC collects race and ethnicity data for incoming clients. Stakeholders believe that eligibility and service delivery are fair and unbiased.

Areas of Opportunity: It was reported by leadership that race data are presented to the oversight committee for systematic review. It was not clear that this systematic review is occurring or being communicated to the staff. A more robust assessment of race related to entry into the FDTC, discharge, and ultimate permanency outcome would be beneficial to the program. These data should be shared with leadership and staff to inform continuous quality improvement.

Recommendation:

- Ensure there is a process in place to regularly track process and outcomes related to race/ethnicity; regularly collect and disseminate that information; and use in discussions with the team about program implementation.

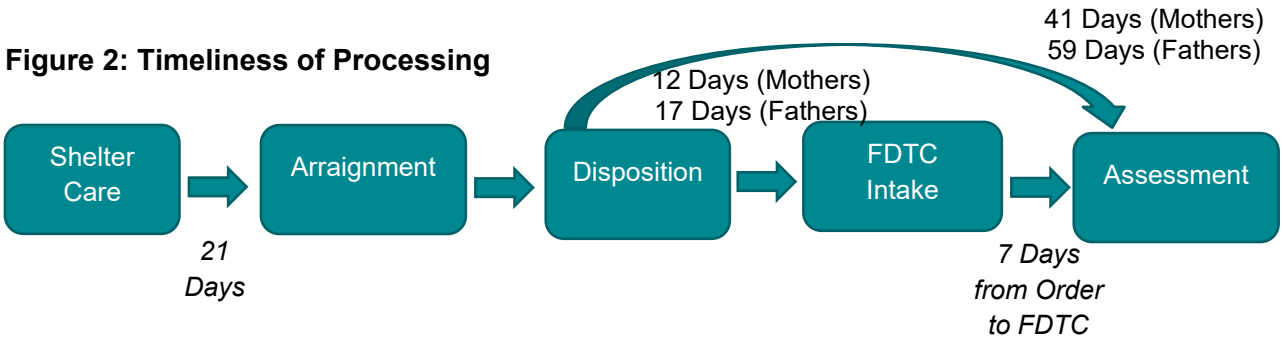
Standard 4: Early Identification, Screening, and Assessment. *The process of early identification, screening, and assessment provides the greatest opportunity to fully meet the comprehensive needs of children, parents, and families affected by substance use disorders (SUDs) that come to the attention of the child welfare system. Family treatment court (FTC) team members and partner agencies screen and assess all referred families using objective eligibility and exclusion criteria based on the best available evidence indicating which families can be served safely and effectively in the FTC. Team members use validated assessment tools and procedures to promptly refer children, parents, and families to the appropriate services and levels of care. They conduct ongoing validated assessments of children, parents, and families while also addressing barriers to recovery and reunification throughout the case. Service referrals match identified needs and connect children, parents, and family members to evidence-based interventions, promising programs, and trauma-informed, culturally responsive, and family-centered practices. FTC team members take on varying roles for this process to occur in a timely and efficient manner.*

Findings: There is no validated or structured screening tool for admission to FDTC. Staff indicated that not all parents who have substance abuse issues are provided an opportunity to participate in the FDTC. The FDTC drug Court Specialists do review incoming cases and indicate whether they may be appropriate for FDTC. They are able to articulate the eligibility criteria. However, whether the cases are referred to the FDTC or not is entirely up to the line division judges who are overseeing the cases. The judges make the decision as to whether to transfer/refer the case to FDTC. Staff did report that cases are identified and transferred to FDTC in a timely fashion.

There does seem to be some structure to the intake information captured by the Drug Court Specialists. This includes whether the parent is employed, highest education obtained, whether parent is on probation, what the parent's drug of choice is, whether the parent is an intravenous drug user, and what medications the parent is currently on. This information was in most of the case files reviewed but was not always consistently documented.

The policy and procedure manual for the FDTC identifies an FDTC pathway with projected timelines. The timelines indicate that screening should occur within 21 days of the Shelter Care Hearing, and then the order to transfer to FDTC should occur at the Disposition Hearing, with an assessment within 7 days from that date. Treatment is supposed to begin within one week from the assessment and then completion of the program should be within 1 year from that date. Case file review yielded some of these dates. Screening dates were not available in the case file review. Additionally, dates such as intake and assessment and treatment start dates were not consistently found in the file. From the information that was available in the files reviewed, parents typically had intake to FDTC in an average of 13 days from the disposition. The assessment occurred a median of 41-59 days after the disposition. The illustration below (Figure 2) demonstrates the median days (above the diagram) and the expected timelines (in italics below the diagram).

Figure 2: Timeliness of Processing



Most FDTC participants are sent to DACCO for an assessment. Assessment scheduled dates (according to the case file review) are nearly always *scheduled* timely from intake but may not always occur timely. According to interviews, DACCO uses a series of validated assessment instruments to identify the unique needs of the parent and get them the appropriate treatment. All treatments provided are evidence-based treatments. Interviews and observation of staffings and court also indicate that the team works together to identify barriers for parents and youth to receive and participate in treatment and problem-solve solutions.

Strengths: There are clearly articulated FDTC eligibiltiy criteria. Drug Court Specialists screen incoming cases and record intake information in a structured way. The assessment used by the primary treatment provider appears to be validated and all the treatment interventions are evidence-based.

Areas of Opportunity: Getting cases to the FDTC and getting cases from disposition to assessment is taking longer than anticipated in the policy manual. It takes parents a median of 41 to 59 days (for mother and fathers respectively) from their disposition to their assessment. This could be because the documentation of actual assessment date is not consistently tracked in the case file review. The court could improvement their documentation in this area, by having a clear space in their case record review to document assessment date, start of treatment, and treatment completion date as well as a space to record the intake information gathered. This information was found in various places in the case file and sometimes not at all.

Recommendations:

- Consider whether a structured screening tool is necessary and consider how it can be implemented so that every substance abuse case is screened and considered for inclusion in the FDTC.
- Consider discussing with the line division judges their reasons for referral and ensuring that all are trained on eligibility criteria, and the positive outcomes related to FDTC.
- Consider ways to improve case documentation of intake information and program timelines (case processing timelines), including having a structured place on the case file forms to include all intake information, treatment start and end dates, and the date the case was screened. Consistency of this information may be helpful in continuous quality improvement efforts to enhance the program.

Standard 5: **Timely, High-quality and Appropriate Substance Use Disorder Treatment.**
Substance use disorder (SUD) treatment is provided to meet the individual and unique substance-related clinical and supportive needs of persons with SUDs. For participants in family treatment court (FTC), it is important that the SUD treatment agency or clinician provide services in the context of the participants' family relationships, particularly the parent-child dyad, and understand the importance of and responsibility for ensuring child safety within the Adoption and Safe Families Act timeline for child permanency. A Treatment provider's continuum of services includes early identification, screening, and brief intervention; comprehensive standardized assessment; stabilization; appropriate, manualized, evidence-based treatment including medications if warranted; ongoing communication with the FTC team; and continuing care. The parent, child, and family treatment plan is based on individualized and assessed needs and strengths and is provided in a timely manner including concurrent treatment of mental health and physical health.

Findings: Participants typically came into intake of the FDTC a median of 75 days after their Shelter Care Hearing. Interviews with the FDTC indicate that the treatment court participants all receive evidence-based and trauma informed treatment that is uniquely tailored to their needs. Interviews suggest that treatments are culturally responsive and that there are unique

treatments based on gender and treatments specifically designed for pregnant women. All participants are drug tested two times per week throughout the duration of the FDTC program to monitor sobriety. A review of the outcome study for the court revealed that FDTC participants achieved permanency faster when the date they began treatment is considered.

Impact of COVID-19: Staff indicated there was a delay in services at the beginning of COVID-19 when there was a shutdown. However, currently all treatment options are available to parents and there is only a slight delay in residential treatment as parents must take COVID-19 tests prior to entry into a residential treatment program. Staff also indicated that parents may be using COVID-19 as an excuse for missing drug testing or treatment appointments, as they can say they have symptoms and then have to wait to get a negative test before attending some treatments.

Strengths: Treatment options are evidence-based and uniquely tailored to the needs of the family. All families are monitored for substance use on a regular and ongoing basis.

Areas of Opportunity: The referral process to FDTC seems to take two to three months, and then the assessment process (while always scheduled timely) is often delayed due to participant behaviors. If referral to the FDTC can occur timelier, participants can get engaged in treatment sooner.

Recommendation:

- Consider whether there are opportunities to get participants involved in treatment faster, through earlier referral to the FDTC.

Standard 6: Comprehensive Case Management, Services, and Supports for Families. *Family treatment court (FTC) ensures that children, parents, and family members receive comprehensive services that meet their assessed needs and promotes sustained family safety, permanency, recovery, and well-being. In addition to high-quality substance use and co-occurring mental health disorder treatment, the FTC's family-centered service array includes other clinical treatment and related clinical and community support services. These services are trauma responsive, include family members as active participants, and are grounded in cross-systems collaboration and evidence-based or evidence-informed practices implemented with fidelity*.

Findings: All FDTC cases have an active dependency case manager, in addition to the Drug Court Specialists who monitor their substance use treatment and drug testing. Interviews with staff indicated that parents are provided a tailored case plan to meet their needs and that the case manager participates in staffings and in the court hearings to update the court about parents' progress. A review of court case files revealed a variety of services offered to parents as part of their case plan, the most common being parenting, housing, and mental health services, which are typically provided concurrently with their substance abuse treatment. Surveys of FDTC staff indicated that parent's comprehensive needs are identified and addressed as part of the case plan. Court observation revealed that there is discussion of both the parent's and child's needs in most cases and judicial reviews typically include more

comprehensive discussion of progress than status reviews. Parents in FDTC are provided reunification supports and are monitored six months post reunification to ensure sobriety and problem solve any challenges. Recovery support has been noted as a challenge for the program. According to interviews with staff, family time is used as an incentive for parents, as their family time increases when they phase up in substance abuse treatment. Past Hillsborough County FDTC outcome research indicates that FDTC cases typically take longer to achieve permanency. FDTC cases take approximately 18 months to achieve reunification.

Strengths: Case plans are comprehensive and include services to treat the family's unique needs. The agency case manager participants in hearings and staffings and works in a coordinated manner with the treatment team.

Areas of Opportunity: Timeliness to permanency is delayed for FDTC cases in comparison to other cases, per the outcome evaluations.

Recommendation:

- Consider exploring the data in more detail to determine if there are ways to improve time to permanency for FDTC cases (e.g., where is delay occurring and what are the reasons for those delays? What are the specific barriers to timely permanency and how might those barriers be overcome?).

Standard 7. Therapeutic Responses to Behaviors. *The family treatment court (FTC) operational team applies therapeutic responses (e.g., child safety interventions, treatment adjustments, complementary service modifications, incentives, sanctions) to improve parent, child, and family functioning; ensure children's safety, permanency, and well-being; support participant behavior change; and promote participant accountability. The FTC recognizes the biopsychosocial and behavioral complexities of supporting participants through behavior change to achieve sustainable recovery, stable reunification, and resolution of the child welfare case. When responding to participant behavior, the FTC team considers the cause of the behavior as well as the effect of the therapeutic response on the participant, the participant's children and family, and the participant's engagement in treatment and supportive services.*

Findings: The FDTC does not have structured phases for parents, although the policy and procedural manner does indicate these are being considered. The FDTC uses the phases through the treatment program as a method of demonstrating progress. Interviews indicate that this may not be sufficient for parents to know when they are making progress. Interviews with staff indicate that treatment is monitored and discussed, and the team engages in problem-solving to make adjustments to the treatment as necessary. Surveys of FDTC staff indicate that staff believe that the behaviors required for successful participation in FDTC are clearly explained to parents. Staff had mixed views on the use of sanctions and incentives for parents. Some indicated that incentives are almost never provided, outside of praise from the judge. Some indicated that there were some incentives available, but not a lot as they must rely on donations for incentives and cannot solicit donations for the program. All believed that sanctions were fairly imposed. Jail is used as a sanction in the program. All staff indicated that the judge uses jail as a detox facility to help get parents clean when there is concern about their sobriety.

If parents are noncompliant with treatment, the judge will enter a bench warrant and may have the parent arrested. Parents then detox in jail and are in jail until a bed is available in residential treatment. Parents may spend more than a month in jail while awaiting a bed. Parents were provided an opportunity to be heard by the judge in about two thirds of cases identified.

Impact of COVID-19: Staff indicated that incentives were more common when hearings were in person. That donations to the court, like sporting event tickets or toys for children, might be given to parents for family outings as incentive. With court being all virtual now, there is not an opportunity for this.

Strengths: Treatment adjustments are considered and made whenever needed for parents as evidenced by case file review, court observation, and stakeholder interviews. Staff indicate that parents are provided information on the expectations of FDTC.

Areas of Opportunity: Phases are not fully articulated for the court, outside of the treatment context (and how participants are phased through treatment). Jail is often used as a sanction for noncompliance. Jail is often used as a detox option, and participants spend an average of 26 days in jail awaiting treatment. This is not inline with best practice standards, which suggest jail should be used sparingly and not for more than 3-5 days. Incentives are also rarely used, particularly now that hearings are not in person.

Recommendations:

- Consider fully articulating structured phases for the FDTC in the procedures and policy manual and communicate those in a participant manual for parents. Doing so will give parents a better understanding of what it takes for them to demonstrate success in the FTDC, to know when they are making progress, and to anticipate what comes next.
- Consider how to enhance use of incentives for parents that are part of the FDTC and implement these incentives fairly and regularly across clients. Consider options for virtual incentives (e.g., virtual gift cards, increased use praise).
- Consider whether the use of jail as a sanction for detox is appropriate, especially as it does not align with best practice standards.

Standard 8: Monitoring and Evaluation. *The family treatment court (FTC) collects and reviews data to monitor participant progress, engage in a process of continuous quality improvement, monitor adherence to best practice standards, and evaluate outcomes using scientifically reliable and valid procedures. The FTC establishes performance measures for shared accountability across systems, encourages data quality, and fosters the exchange of data and evaluation results with multiple stakeholders. The FTC uses this information to improve policies and practices in addition to monitoring the strengths and limitations of various service components. Evaluation results and data are also critical components of effective stakeholder outreach and sustainability helping the FTC "tell its story" of success and needs.*

Findings: The FDTC has an active relationship with a professor at the University of Southern Florida who has been providing significant program evaluation assistance. There were several outcome evaluation reports that demonstrated the effectiveness of the FDTC model. The

program also routinely collects data on demographics of participants that enter into the program and discharges, including discharge reason. The data are routinely reviewed by the oversight committee. It does not appear that the program has a plan for continued best practice assessment or ongoing evaluation, beyond that which has already been done. Findings from evaluation and data collection are not routinely shared with FDTC staff. It is unclear if data and evaluation findings are used in continuous quality improvement efforts, although the FDTC administration indicates that they consider staff ideas for program improvement regularly.

Strengths: The relationship with University of Southern Florida is a strength of the program. Several publications demonstrate FDTC program effectiveness. Data are routinely collected and have been reviewed and summarized at least once during the program's tenure.

Areas of Opportunity: The policy and procedural manual does not include a structured plan for monitoring and evaluation on an ongoing basis. Data and findings from evaluations are not always shared with FDTC staff. Staff should be included in discussion of findings and areas for improvement.

Recommendation:

- Consider manualizing a sustainable plan to provide input back to the program, that includes broadly disseminating findings of evaluations with the FDTC team and allows an opportunity to meaningfully use feedback to improve the program.

Table 2: Summary of Alignment to Best Practices

	Alignment to Best Practice Standards	
	None/ Poor	**High/ Excellent**
Standard 1: Organization and Structure		
Standard 2: Role of the Judge		
Standard 3: Ensuring Equity and Inclusion		
Standard 4: Early Identification, Screening, and Assessment		
Standard 5: Timely, High-quality and Appropriate Substance Use Disorder Treatment		
Standard 6: Comprehensive Case Management, Services, and Supports for Families		
Standard 7. Therapeutic Responses to Behaviors		
Standard 8: Monitoring and Evaluation		

II – Differences in FDTC and Line Division Substance Abuse Cases

The second part of the evaluation explored differences in FDTC and line division substance abuse cases. This part of the evaluation answered the following research questions:

1. What types of cases are referred to FDTC, verses those that remain in a line dependency division?
2. How do case management services in FDTC differ from those provided in line dependency divisions?

To answer these questions, a random sample of incoming substance abuse cases were reviewed. This included 60 FDTC cases that opened in 2019 and 2020 and a comparison of 25 line division cases that were flagged as a substance abuse case. Cases were reviewed for any differences in how they came into the system that would make them ineligible for drug court. All cases that were reviewed had a goal of reunification. Of the cases reviewed, 40% of the line division cases were flagged as appropriate for FDTC but had not been transferred to FDTC at the time of the review. The table below illustrates the differences between FDTC and the comparison cases in terms of how they came into the system. Due to the small sample size, this is not a statistical comparison, rather it illustrates differences of at least 10% between the samples.

Table 3: Comparison of FDTC to non-FDTC (Comparison) Cases

	Higher in FDTC Group	Higher in Comparison Cases	Similar Across Groups
Number of children removed		Yes	
Allegations	Criminal drug charges	Incarceration, domestic violence,	Homelessness, mental health, neglect
History with court or agency		History with the court History with the agency	
Drug(s) Identified	Alcohol, Heroin, Opiates	Cocaine	Methamphetamine, Amphetamine, Marijuana, MDMA
IV Drug User	Yes		

Overall, it appears that cases that were transferred to FDTC were more likely to also include criminal drug charges, include IV drug users (although this was harder to determine from the comparison sample due to lack of documentation) and to include abuse of opiates. It is unclear why some of these cases (especially the 40% that were flagged as eligible) were not transferred to drug court.

In addition to how the cases entered the system differently, the types of case management services offered to families were compared to see how they might differ. These data were gathered from a review of case files. It is important to note that the case files did not include a detailed case plan so data may have been missing from the files. Parents were offered similar services (e.g., parenting, housing assistance, domestic violence, drug and alcohol screening) between groups. When exploring differences in drug treatment services, there were some differences. The table below illustrates the percentage of cases that identified a specific substance related service for parents in the FDTC and comparison cases. It also includes if the service was offered more than once per case. As noted, the FDTC cases were more likely to include all treatment services than the comparison group, indicating that FDTC cases typically include more types of substance use treatment for parents than comparison cases.

Table 4: Services Used Per Case, FTDC vs. Comparison

Services	2019 FTDC Cases (N=34)		Comparison Cases (N=25)	
	% of Cases Using Service	Average Number of Times Used Per Case	% of Cases Using Service	Average Number of Times Used Per Case
Detox	35%	1.417	24%	1.000
Residential Treatment	88%	1.733	28%	1.286
Individual Outpatient	91%	1.355	64%	1.313
Group Outpatient	41%	1.071	16%	1.000
Recovery Support Individual	29%	1.000	8%	1.000
Recovery Support Group	12%	1.000	0%	0

Overall, case management looks similar for non-substance services. However, substance services for families look different. FDTC cases have significantly higher rates of residential and individual outpatient treatment, group outpatient treatment and recovery support than the comparison cases. It is unclear if there substance abuse assessment for the families indicate that FDTC cases need a higher level of treatment or if the model itself requires multiple treatment types and thus, makes cases more likely to engage in more and more intensive treatments.

III – Cost Analysis

The final evaluation question focused on the cost effectiveness (or cost-benefit) of the FDTC program. Administration would like to know "Is the program cost effective for serving families involved in the child welfare system?" Cost-benefit analyses are challenging as they require various analyses of costs to the state, costs to taxpayers, and non-tangible benefits, such as the social benefits to the child and family. The cost-benefit analysis was approached in four ways. First, a salary analysis was conducted to estimate a cost per case. Second, treatment costs were estimated for FDTC cases and compared to non-FDTC cases. Third, the cost of foster care is estimated for both FDTC and comparison cases. Finally, cases were compared on the social benefits to child and family.

Salary Estimates.

The salary estimate section of the cost study was modeled after the cost analysis method employed in the 2018-2019 Early Childhood Court (ECC) Evaluation (see Chapter 4).[5] Court improvement program professionals were able to provide salary data for the major positions in dependency court and these data were used as a reference to make cost estimates. The data in that report is an appropriate reference for the FDTC because the samples are similar – the ECC study compared early childhood court cases to traditional dependency court, and children in Hillsborough County, Florida, with a removal reason of substance abuse by a parent, are typically young, with a median age of 3.

Salary and hours per case data were used in the current study to calculate a "cost per case." Salary data was obtained from the Florida Court Improvement Program and from FDTC court administration. The data provided are salary *estimates* as staff were not asked to report their exact salaries and the data reflect salary ranges. Salary estimates were copied from the ECC study when available for rates that represent without and with fringe. The average hours per case per month for the *traditional model* (non-FDTC) were also copied from the ECC study estimates as the current evaluation did not survey traditional cases for comparison purposes. The roles identified in Table 5 below are those represented at the FDTC court hearing.

To determine hours per case for the FDTC group, staff were asked in their interview to provide an estimate of how many hours they work per case per month. Most of the staff were unable to provide this estimate. However, most staff noted that they were full time in FDTC. Therefore, the average number of cases in FDTC was used to calculate how many hours a person could spend per case in an average 40-hour work week and this was used as a proxy. Judge's hours were extrapolated based on the amount of time the judge spends overseeing the FDTC docket per week and the total number of cases in the FDTC court (as the judge has responsibilities

[5] For more details, see the full report. Magruder, L., Tutwiler, M., & Pryce, J. (2019). *2018-2019 Early Childhood Court Evaluation. Final Report to the Office of Court Improvement.* Tampa, FL: Florida Institute for Child Welfare, Florida State University. Available online at: https://ficw.fsu.edu/sites/g/files/upcbnu1106/files/Final%20Reports/FR%202018-2019%20Early%20Childhood%20Court%20Evaluation%20Final%20Report%20to%20the%20Office%20of%20Court%20Improvement%20081519-.pdf

outside of FDTC). The exception to these calculations was the dependency case manager. The evaluator was not able to determine if the dependency case manager was full time or how many cases the dependency case manager might have. As a result, this evaluation uses the same estimate for the dependency case manager that the original study used for the ECC. It is highlighted in red in Table 5 below to note that it does not reflect an estimate from the current study.

The cost per case was calculated using the average length of time in care. For the traditional (non-FDTC) cases, the original ECC study used an estimate of 22.8 month, which is replicated here. For the FDTC estimate, data were pulled from the five-year outcome study. The data from that study indicated that FDTC cases averaged 26.5 months from removal to case closure.

Table 5: Costs per Case for FDTC and Traditional Court Personnel

	Estimated Hourly Salary		Average Hours per Case Per Month		Average Monthly Cost per Case		Average Total Costs Per Case		
Role	**Without fringe**	**With 31.4% fringe**	**Traditional**	**FDTC**	**Traditional**	**FDTC**	**Traditional**	**FDTC**	**Difference**
Judge/Magistrate	$78	$102	.8	.3	$82	$31	$1,869.60	$821.50	-$1,048.10
Dependency case manager	$16	$21	13.9	7.7	$292	$162	$6,657.60	$4,293.00	-$2,364.60
Parent attorney	$61	$80	1.2	1.6	$96	$128	$2,188.80	$3,392.00	$1,203.20)
Asst Attorney General	$61	$80	2.1	1.6	$168	$128	$3,830.40	$3,392.00	-$438.40
Guardian ad litem attorney	$26	$34	.9	2.1	$31	$71	$706.80	$1,881.50	$1,174.70)
Drug Court Specialist	$18	$24	--	2.1		$50		$1,325.00	$1,325.00)
Total			**18.9**	**18.1**	**$669**	**$570**	**$15,253.20**	**$15,105.00**	**-$148.20**

The cost estimates per case above do not include the problem-solving court director – who provides oversight to multiple problem-solving courts, nor does it estimate costs of administrative bodies who may oversee the traditional dependency courts. Additionally, it does not include the cost of the treatment provider who regularly attends court staffings and hearings to provide updates on the clients. The estimates focus primarily on the court professionals and their time spent on these cases. Exploring cases this way, it appears that the costs are very similar between the traditional model and FDTC, with FDTC costing slightly less (~$150) per case.

There are a lot of limitations to this method of cost study. First, there were no accurate estimates provided for hours per case for the FDTC staff so these data reflect best approximations based on individuals working full time for FDTC clients and the average number of FDTC clients at a given time. Further, it relies heavily on estimates from the prior ECC study

that, also had limitations in gaining accurate information on the hours per case. This also *only* includes court professionals and does not include foster parents, treatment providers, volunteer guardian ad litems and others who may be part of the case. To address these limitations, further cost analyses are conducted in the next sections.

Treatment Costs

Program staff provided estimates of treatment costs per day or per hour (depending on the intervention) to the evaluator. Data from case file review were used to explore the percentage of parents that are successful in treatment and the average length of treatment. These data were compared to parents in the comparison (non-FDTC) cases. For this cost assessment, only successful reunification cases were compared. The estimated time to complete treatment was derived from a small sample of FDTC cases that included treatment start and completion dates. Time for other treatments was assumed to be one time a week for 2 months. These costs were then calculated by multiplying them by the percentage of participants that are successfully reunified and then by the percentage of participants for whom that service is ordered.

For example:

Residential = $107/day x 90.5 days x 47% of participants that are successful in FDTC x 88% of FDTC participants that are ordered this service. [$107 x 90.5 x .47 x .88=$4,005]

Estimated treatment costs are presented in Table 6.

Table 6: Costs of Treatment for FDTC and Comparison Cases

Treatment Type	Cost	Estimated time	FDTC	Comparison	Difference
Residential	$107/day	3 months	$4,005	$1,084	+$2,920
Outpatient individual	$70/hour	2 months 1 /week	$238	$142	$96
Outpatient group	$18/hour	2 months 1 /week	$28	$9	+$18
Recover support individual	$40/hour	2 months 1 /week	$44	$10	+$34
Recover support group	$10/hour	2 months 1 /week	$4	--	+$4
Urine drug screens	$20/collection	2/week for case (74, 55)	$1,391	$880	+$511
Jail (used as a sanction)	$124.47/day	Average of 26 days in 24% of cases)	$1,521		+$1,521
TOTAL			**$7,231**	**$2,127**	**$5,105**

Parents in FDTC are more likely to have more severe substance use issues (typically IV drug users and opiate users) and are more likely to be ordered to more intensive services than the comparison cases observed. The difference in cost for cases that are successful (i.e., result in reunification), based on these estimates, is nearly $5,000. There are several limitations to this

method of cost analysis. The foremost is that it does not rely on *actual* time a person spends in treatment. These estimates were based on a review of several case files that included dates of treatment and estimates were extrapolated from that. Actual treatment may take longer or less time depending on the unique needs of the client. This is meant to be an average assessment and makes quite a few assumptions. A more robust assessment that includes actual time in each service would be beneficial. If this data were captured more routinely in the case files, it would be easier to make assessments.

Outcomes

A third way to explore cost-benefit is to explore the costs of foster care. Foster care is often noted as a taxpayer expense. To explore these costs, estimates were used from recent data in Florida that indicates that young children (aged 0-5) cost $466/day for foster care. Practice in Hillsborough County ensures that the case remains open for at least six months after the child has been reunified to ensure reunification supports are in place. Average time to case closure in FDTC cases is 808 days (regardless of the outcome). This is compared to all Hillsborough County cases that have a removal reason of substance abuse, which have a median time to case closure of 553 days from removal. Time to case closure was calculated for the FDTC sample from the prior data on 5 years of FDTC cases and the data for the timeliness in Hillsborough County was calculated through AFCARS data length of stay for cases that had substance use as a removal reason and exited foster care in 2019.

The cost of foster care for the average FDTC case is more than $100,000 more than standard Hillsborough County substance abuse cases. Additional data was used to explore the percentage of cases that re-enter care, which creates additional costs to the state. According to the outcome research conducted on the FDTC, only 2% of successful FDTC cases re-enter the system. This is in comparison to 11% of cases in the county that re-enter the system in 12 months. Consider this in the context of the number of cases from the sample. If 2% of FDTC cases come back, that is 2% of 75 cases or 1.5 cases compared to 11% of 320 cases (or 35.2 cases). While FDTC are significantly more expensive for the cost of foster care during their first round, they are significantly less expensive in the long run due to much lower re-entry rates. These rates are presented in Table 7.

Table 7: Cost of Foster Care for FDTC and Comparison Cases

	FDTC Average Cases	Hillsborough Substance Abuse Cases	Differences
Cost of foster care	808 days * $466 =$376,528	553 * $466 =$257,698	+$118,830 per case
Number of cases per year (on average)	75	320 (395-75)	
Total per year for these cases	$28,239,600	$82,463,360	-$54,223,760 (across all cases)
Reentry	2% (of 75 FDTC) = 1.5 cases	11% of all cases in Hillsborough re-entry (11% of 320) =35.2 cases	-9% less re-entry
Total Cost of Re-entry	$386,547	$9,070,970	-$8,684,423

The outcome costs data also has several limitations. First, the data are not from the same source. One is using program data and the other is using agency data reported to the federal government and publicly available (AFCARS). The sampling frame for the FDTC is across 5 years of data while the AFCARS is a point in time estimate for fiscal year 2019. Both of the sample are using an exit cohort to explore time in care (length of stay). The data is also limited in that the procedure for foster care is that the family will be reunified for 6 months prior to case closure to provide reunification supports. That means that the estimates may *over estimate* the cost of foster care as the child will be at home. However, this should be the same for program and non-program cases. The final consideration is that one number was used for foster care rates ($466). This is the average daily rate for young children in foster care. This was used because the average age of children in the FDTC sample was 3. However, a more accurate assessment would take into consideration the actual age of each child, as older youth only average $300/day in care.

A summary of the various different methods to examine cost are presented in Table 8. It appears that FDTC is more expensive for treatment and foster care placement but less expensive in the long run, as it is related to reduced re-entry into foster care.

Table 8: Summary of Various Cost Estimates

	FDTC	Comparison	Difference
Average staff salary cost per case	$15,253.20	$15,105.00	-$148.20
Average treatment cost per case	$7,231	$2,127	+$5,105
Average foster care cost per case	$376,528	$257,698	+$118,830
Average cost of re-entry associated with cases	$386,547	$9,070,970	-$8,684,423
TOTAL COSTS	**$785,559**	**$9,345,900**	**($8,560,636)**

Social Benefits

A final consideration for a cost-benefit analysis includes the non-tangible benefits. This includes exploring the benefits to the family. One such benefit is that the substance abuse treatment may be more effective than traditional means. This is evidenced in two ways. The first is that FDTC cases are more likely to reunify than other cases with a removal reason for substance abuse (47% of FDTC cases reunify in comparison to 40% of other cases). In addition, for successful cases, only 2% of the families re-enter the foster care system within 12 months. This is in comparison to the 11% re-entry rate for the county. This indicates the FDTC program may be successful in helping families alleviate their substance use challenges and be able to function as a parent. The primary benefit is that children can return to their biological family. This means fewer children that are aging out of the foster care system to a host of emotional, educational, and behavioral challenges. Further, with a 2% re-entry rate, this reduces the likelihood that children will experience further trauma of removal from their families. A final benefit is that the program is geared to meeting all the needs of the family, including ensuring housing and employment, which may mean more families are able to make meaningful contributions to society. Successfully treating family's substance use and concurrent challenges together creates healthier community with parents who can make meaningful societal contributions, including raising their own children.