MIDD Briefing Paper

ES 8: Family Treatment Court (with Modifications)

Existing MIDD Program/Strategy Review MIDD I Strategy Number 8A (Attach MIDD I pages)
New Concept ☐ (Attach New Concept Form)
Type of category: Existing Program/Category MODIFICATION

SUMMARY: It is the vision of King County Family Treatment Court (KCFTC) to promote the health, safety and welfare of children in the dependency system by actively intervening to address the drug, alcohol and other service needs of families through integrated, culturally competent and judicially managed collaboration that facilitates timely reunification or an alternative permanency plan. King County Family Treatment Court has four primary goals:

1. To ensure that children have safe and permanent homes within permanency planning guidelines or sooner;
2. To ensure that families of color have outcomes from dependency cases similar to families not of color;
3. To ensure that parents are better able to care for themselves and their children and seek resources to do so; and
4. To ensure that the cost to society of dependency cases involving substances is reduced[1].

KCFTC receives MIDD I funding under existing MIDD strategy 8A, Expand Family Treatment Court and Support to Parents. This briefing paper suggests modifications to the original MIDD funded KCFTC program elements to include the previously budgeted but not funded MIDD I positions and several expansion positions.

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The following questions are intended to develop and build on information provided in the New Concept Form or gather information about existing MIDD strategies/programs.

A. Description

1. Please describe the New Concept or Existing MIDD Strategy/Program: Please be concise, clear, and specific. What is being provided to whom, under what circumstances? What are the New

[1] http://www.kingcounty.gov/courts/JuvenileCourt/famtreat.aspx

Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an existing MIDD strategy? If so, how?

It is the vision of King County Family Treatment Court (KCFTC) to promote the health, safety and welfare of children in the dependency system by actively intervening to address the drug, alcohol and other service needs of families through integrated, culturally competent and judicially managed collaboration that facilitates timely reunification or an alternative permanency plan. King County Family Treatment Court has four primary goals:

5. To ensure that children have safe and permanent homes within permanency planning guidelines or sooner;
6. To ensure that families of color have outcomes from dependency cases similar to families not of color;
7. To ensure that parents are better able to care for themselves and their children and seek resources to do so; and
8. To ensure that the cost to society of dependency cases involving substances is reduced[2].

KCFTC receives MIDD I funding under existing MIDD strategy 8A, Expand Family Treatment Court and Support to Parents. This briefing paper suggests modifications to the original MIDD funded KCFTC program elements to include the previously budgeted but not funded MIDD I positions and several expansion positions.

The currently funded MIDD positions are:

- 1.0 Program Supervisor
- 1.0 Court Specialist
- 1.0 CASA Supervisor
- 1.0 Parents for Parents Coordinator
- 2.0 Treatment Specialist

The expanded positions would add an additional:

- 1.0 Treatment Specialist
- 1.0 Court Specialist
- 2.0 Family Recovery Support Specialist
- 0.5 CASA attorney

These proposed modifications will incorporate unfunded program needs from the first 2009 proposal as well as accommodate a 2017 expansion to a full day in south King County. An expansion is being requested due to the increase in overall dependency filings from 608 petitions in 2008 to 937 petitions in 2014. As of December 2015, 75% of those filings took place in south King County where the demand for this program has created a waitlist of over 50 children.

Over 50 percent of the families entering KCFTC are homeless and in need of transitional and/or permanent housing and 90 percent are unemployed. The majority of female parent participants have been victims of domestic violence (FTC Access Database). The KCFTC program will help the parents recover from a SUD and work toward reuniting parents with their children.

[2] http://www.kingcounty.gov/courts/JuvenileCourt/famtreat.aspx

KCFTC's goals are: 1) to ensure that children have safe and permanent homes within permanency planning guidelines or sooner; 2) to ensure that families of color have outcomes from dependency cases similar to families not of color; 3) to ensure that parents are better able to care for themselves and their children and seek resources to do so; and 4) to reduce the societal cost of dependency cases involving parental SUD.
KCFTC is organized around the ten key components that define a drug court: 1) integrated systems (child welfare, SUD treatment services and the court); 2) protection and assurance of legal rights, advocacy and confidentiality; 3) early identification and intervention; 4) access to comprehensive services and individualized case planning; 5) frequent case monitoring and drug testing; 6) graduated responses and rewards; 7) increased judicial supervision; 8) deliberate program evaluation and monitoring; 9) a collaborative, non-adversarial, cross-trained team; and 10) partnerships with public agencies and community-based organizations.

State legislation, RCW 26.12.250(1) states, "Every county that authorizes the tax provided in RCW 82.14.460 shall, and every county may, establish and operate a therapeutic court component for dependency proceedings designed to be effective for the court's size, location, and resource. Any county that establishes a therapeutic court or receives funds for an existing court under this section shall develop an evaluation component of the court…" This allows for the local imposition of a sales tax requiring that any county doing so needs to operate and evaluate a family drug court. Since receiving their first federal grant in 2004 to start the first King County Family Drug Court, KCFTC has been able to leverage local funding sources to maintain the program. The King County Mental Illness and Drug Dependency Plan (MIDD), implemented in 2009, allowed for the first expansion of KCFTC by providing extensive resources to support therapeutic courts, SUD services and mental health services.

2. Please identify which of the MIDD II Framework's four Strategy Areas best fits this New Concept/Existing MIDD Strategy/Program area (Select all that apply):

☐ Crisis Diversion ☒ Prevention and Early Intervention
☒ Recovery and Re-entry ☒ System Improvements

Please describe the basis for the determination(s).

This proposal crosses over Recovery and Re-Entry, Prevention and Intervention and System Improvements:

KCFTC is a recovery based child welfare intervention. Parents join KCFTC to receive help in obtaining and maintaining sobriety as well as family services that support a recovery based lifestyle, including mental health treatment when applicable. Many of the court's parents have a history of incarceration and KCFTC supports their re-entry into mainstream services. It is an improvement to the current way child welfare cases are handled in the dependency court system. It is also a prevention and early intervention program, working with both the parent and the child to prevent future involvement in the criminal and juvenile justice systems and address the health and well-being of child welfare involved families.

B. Need; Emerging, Promising, Best, or Evidence Based Practices; Outcomes

1. Please describe the Community Need, Problem, or Opportunity that the New Concept Existing MIDD Strategy/Program addresses: What unmet mental health/substance use related need for what group or what system/service enhancement will be addressed by this New

Concept/Existing MIDD Strategy/Program? What service gap/unmet need will be created for whom if this New Concept Existing MIDD Strategy/Program is *not* implemented? Provide specific examples and supporting data if available.

Children are placed with increasing frequency in foster care because their parents are suffering from a Substance Use Disorder (SUD). Nationally, it is estimated that 60 percent to 90 percent of child welfare cases involve SUD of a parent[3]. Many children also have been born to mothers who abused alcohol or drugs while pregnant. Equally concerning is the number of these same children in foster care who end up using alcohol or drugs despite the fact that their own families were torn apart by SUD. In 2014, three hundred and seventy (370) children, or 40 percent of the 937 annual dependency petitions filed in King County Superior Court (KCSC), were drug related (FTC Access Database).

Currently, there are 1,829 children with open dependencies cases in King County. In 2013, there were 1,034 substantiated child abuse and neglect cases and 1,027 children were removed (Division of Children and Family Services (DCFS), Washington State Department of Social and Health Services). Reporting practices in King County changed in 2009, limiting the ability to track definitively all the cases designated for entry into child welfare due to substance use. Under the new reporting system, in 2014, there were 924 new open child welfare cases, 370 were filed due to allegations of SUD, and only 94 of them could be served by KCFTC due to capacity issues highlighting an increasing access problem for substance abusing parents in child welfare in King County (Partners for our Children[4], KCFTC Access Database). In 2013, there were 47,666 SUD treatment admissions in King County; 1,288 of them were referrals from the child welfare system (Division of Behavioral Health and Recovery's Treatment Assessment Report Generation Tool (TARGET) System) that again highlights an underuse of SUD services for the child welfare population. Of those cases in the child welfare system due to SUD, only 34 percent of them reunify, contrasted with 58 percent in the KCFTC program (Bruns, et al., 2012[5]). KCFTC has been serving families since 2004 and works actively to address substance use disorder needs of families through integrated, culturally competent and judicially managed collaboration that facilitates timely reunification or an alternative permanency plan.

KCFTC was created specifically for families facing court dependency actions due to SUD problems as the when it was recognized that the special and extensive needs of this group were beyond what the normal dependency process could handle. King County Superior Court recognized the value of this model for families and began KCFTC in 2004 through a limited federal grant and has continued this work with MIDD funding beginning in 2009. MIDD funding has sustained the program and allowed a partial expansion to south King County, but by 2010 this program was at capacity and a growing waitlist ensued. This waitlist is at a critical level with over 50 children on the list waiting to enter KCFTC. The need continues, and if not funded, for those children currently in KCFTC and waiting to enter, KCFTC will be unable to:

1. Ensure that children have safe and permanent homes within the permanency planning guidelines or sooner;

[3] Young, N., Boles, S., & Otero, C. (2007) "Parental Substance Use Disorders and Child Maltreatment: Overlap, Gaps, and Opportunities," *Child Maltreatment*, 12, 137-149.

[4] http://partnersforourchildren.org/data-portal

[5] Bruns, E. J., Pullmann, M. D., Weathers, E. S., Wirschem, M. L., & Murphy, J. K. (2012). Effects of a multidisciplinary family treatment drug court on child and family outcomes: Results of a quasi-experimental study. *Child Maltreatment, 17*(3), 218-230. doi: 10.1177/1077559512454216

2. Ensure that families of color have outcomes from dependency cases similar to families not of color; and
3. Ensure that parents are better able to care for themselves and their children.

Initially, the KCFTC program included MIDD supported positions that were not fully funded, as noted above. FTC staff indicate that without those positions, KCFTC cannot maintain the high quality of services provided to families. KCFTC reached and maintained capacity since 2010 during the initial expansion to serve south county residents. KCFTC has had a waitlist since 2011, which means over 50 families a year are denied access to a program that is 70 percent more likely to return children to their parents. If KCFTC ceased to exist, even more children would remain in the foster care system and more parents would lack access to case managed comprehensive SUD treatment. It would also have an even greater impact on families of color, as KCFTC is the only dependency court intervention proven to positively impact the disparate outcomes found in the child welfare system (Bruns, et al., 2012[6]).

2. Please describe how the New Concept/Existing MIDD Strategy/Program Addresses the Need outlined above.

KCFTC addresses the need above by providing an integrated research based dependency court reform strategy that:

1. Increases priority access to SUD and mental health treatment for child welfare involved parents;
2. Increases retention rates and successful completion of treatment, including specific referrals to evidence based trauma treatment for both parents and children;
3. Helps children find safe and permanent homes in order to safely exit the child welfare system sooner;
4. Increases the likelihood that a child will be returned home to their parent; and
5. Provides equally successful outcomes in all the noted categories above for both white families and families of color.

KCFTC uses an integrated model of service and is an early permanency court, meaning children exit the child welfare system in a safe and permanent home faster than in the regular dependency system. Parents are asked to engage early in treatment, and the Adoption and Safe Families Act (ASFA) guidelines are explained and referred to throughout the life of a case. KCFTC is effective in addressing the special needs of families and striving to fulfill the court's goals by focusing efforts to achieve the following objectives: integrating systems; promoting early and efficient intervention; providing comprehensive services; increasing judicial supervision; taking a holistic approach to strengthening family functioning; individualizing case planning and management through the wraparound process; ensuring legal rights, advocacy, and confidentiality; reducing caseloads for social workers assigned to KCFTC enrolled families; regularly scheduling staffing and court reviews to improve coordination, using graduated sanctions and incentives tied to treatment progress; continually measuring program outcomes; building a collaborative, non-adversarial, cross-trained team; and providing active judicial leadership. Through this model, KCFTC provides early

[6] Bruns, E. J., Pullmann, M. D., Weathers, E. S., Wirschem, M. L., & Murphy, J. K. (2012). Effects of a multidisciplinary family treatment drug court on child and family outcomes: Results of a quasi-experimental study. *Child Maltreatment, 17*(3), 218-230. doi: 10.1177/1077559512454216

permanency for children, greater success and access to SUD services for parents, and improved outcomes for families of color.

3. What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published research, reports, population feedback, etc. Why would this New Concept/Existing MIDD Strategy/Program be expected to work? If this is an existing MIDD I strategy, please provide evidence of the results from existing MIDD evaluation reports, including who has/has not benefited from this strategy.

Family Treatment Court has obtained two process evaluations, one outcome evaluation, and one proportionality evaluation conducted by the University of Washington's Division of Public Behavioral Health and Justice Policy. The outcome report presents findings from a quasi-experimental study comparing 72 parents and 89 children enrolled in the King County Family Treatment Court (KCFTC) to a statistically matched comparison group of 182 parents and 235 children families eligible for KCFTC but served by the regular dependency court. Lifetime administrative data on substance use treatment and child welfare involvement was obtained from the Washington State Department of Social and Health Services (Bruns, et al., 2012[7]).

- *KCFTC parents were more likely to be admitted to and use treatment services than comparison group parents, with statistical significance.*
    - After the index petition was filed, 88 percent of KCFTC parents were admitted to treatment through DSHS, compared to only 54 percent of comparison parents. (p<.001)
    - Of those who received any treatment, KCFTC parents were more likely than comparison parents to be admitted to long-term residential treatment and/or the Recovery House, and to receive individual therapy and/or childcare services. (p<.001)
    - KCFTC parents had more treatment events (p<.001) from a broader service array (p=.07)
- *KCFTC parents entered treatment faster, remained in treatment longer, and were more likely to be successfully discharged, with statistical significance.*
    - Of those parents entering treatment who were not already in treatment at the index petition, the median average time until entry for KCFTC parents was 51 days, compared to 115 days for comparison parents. (p<.001)
    - Of those parents who entered treatment, KCFTC parents remained in treatment for a median average of 109 days, compared to 53 days for comparison parents. (p=.03)
    - Of those parents who entered treatment, 74 percent of KCFTC parents were successfully discharged, compared to only 54 percent of comparison parents. (p=.04)
- *KCFTC children spent less time in out-of-home placements and less time in the child welfare system, with statistical significance.*
    - Children whose parents were in the KCFTC spent a median average of 481 days in out-of-home placements, compared to 689 days for the comparison group. (p=.03)
    - Children whose parents were in the KCFTC spent a median average of 729 days between initial petition and end of child welfare supervision, compared to a median of 819 days for the comparison group.
- *At the end of the study, KCFTC children were more likely to be permanently reunified with their parent or be on a trial home visit with their parent, with statistical significance.*

[7] Bruns, E. J., Pullmann, M. D., Weathers, E. S., Wirschem, M. L., & Murphy, J. K. (2012). Effects of a multidisciplinary family treatment drug court on child and family outcomes: Results of a quasi-experimental study. *Child Maltreatment, 17*(3), 218-230. doi: 10.1177/1077559512454216

  - Fifty-eight percent of KCFTC children were returned home (returned to custody--dependency dismissed, reunified, or trial home visit) with their parent or had their dependency dismissed, compared to 34 percent of comparison children.
  - Twenty-one percent of KCFTC remained in out of home placement, compared to 46 percent of comparison children.
- *Analyses of differences by race/ethnicity generally indicated that families of color in the KCFTC had more positive outcomes than families of color in the comparison group; comparisons with white families in KCFTC were mixed.*
  - Of those parents entering treatment who were not already in treatment at the time of the index petition, parents of color in KCFTC entered treatment faster (median = 51 days) than parents of color in the comparison group (81 days; p<.001) and equal to white parents in KCFTC (49 days; p=.461).
  - Children of color in the KCFTC group were more likely to be permanently placed than children of color in the comparison group (57% vs. 41%; p=.018) and roughly equally as likely as white children in KCFTC (66%; p<.10).
  - Children of color in KCFTC were more likely to be returned home (dependency dismissed, reunified, trial home visit) than children of color in the comparison group (54% vs. 35%, p=.018) and roughly equally likely as white children in KCFTC (66%, p>.10).

In 2014 KCFTC program was recognized as a Peer Learning Court through Children and Family Futures and the Office of Juvenile Justice and Delinquency Prevention for their adherence to best practices and being a leader among Family Drug Courts nationally.

Symptom Reduction reported from The *Third MIDD Annual Report, p. 22 (February 2011) stated*: Of the 17 parents exited from the program, five (29%) were clean and sober for a consecutive six month period, were consistently attending sober support programs, and were engaged in relapse prevention. Additionally, the *Fifth MIDD Annual Report, p. 32 (February 2013)* showed*:* External academic evaluations suggest that participants experienced significant positive gains in both their attitudes (trust and understanding) and their behaviors (engagement, compliance, and visitation). Of the 28 parents with end dates between October 2011 and September 2012, 10 graduated (36%) and two had their cases dismissed. Children were returned home in all but one of these cases. Of the 47 parents for whom SUD data was available, 12 (28%) listed methamphetamine as their drug of choice, followed by cocaine and alcohol at 19 percent apiece. More data are needed to examine change over time.[8]

4. Please specify whether this New Concept/Existing MIDD Strategy/Program is a/an: Promising Practice Please detail the basis for this determination. Please include a citation or reference supporting the selection of practice type.

Family Drug Courts (FDC) oversees cases of child abuse and neglect involving parental substance use disorders. Their purpose is to protect child safety, ensure permanency in caregiving environments, and promote the well-being of children through family recovery. The court operates collaboratively, drawing on community partners' expertise in child welfare, SUD treatment and other community services to address the needs and build on the strengths of each family member. The partners ensure timely access to behavioral health treatment and other needed services for parents, children, and families through better communication and efficiencies across service systems. In comparison with standard services, FDC outcomes have shown that parents achieve faster access to SUD treatment, increased reunification

Kimmerly, L. (2015) Symptom Reduction and Initiative Linkages by Strategy by Year, MIDD Annual Report

rates and decreased re-entries to child welfare services.[9] FDCs aid parents or guardians in regaining control of their lives and promote long term stabilized recovery to enhance the possibility of family reunification within mandatory legal timeframes (Huddleston, Freeman-Wilson, Marlowe, & Roussell, 2005)[10]. This creates substantial cost savings.[11] As quasi-experimental studies are often the only evaluation method available for FDC, they are considered a promising practice with clear and convincing evidence of the effectiveness, and partner with evidenced based treatment programs for both parents and children as one of the foundational guidelines for FDC (Douglas B. Marlowe, J.D., Ph.D., 2001[12]). The family drug court model has been determined and labeled as a "Model Program" by the Office of Juvenile Justice and Delinquency Prevention.

Forty percent of children in KCFTC are under the age of three and all have been exposed to substance use in the home these children are all referred for an early intervention developmental assessment upon entrance into the program. This is because nationally, 50percent or more of children age 0-5 in the child welfare system have developmental delays or behavioral problems that would qualify them for services as compared to 13percent of the total population[13]. KCFTC also refers families to three national evidence-based models for Home Visiting Early Learning: Early Head Start (EHS), Parents as Teachers (PAT) and The Parent-Child Home Program (PCHP). EHS is a comprehensive early learning program serving children birth to three, pregnant women and families and is delivered in the home or is center-based. PAT provides in home assistance with child development needs for families with young children. PCHP focuses on school readiness, parent/child verbal interaction and increased social and emotional skills by matching home visitors to the families cultural and language needs. KCFTC also refers families to three major research or evidence-based early learning programs: Early Childhood Education and Assistance Preschool Program (ECEAP), Educare, and Head Start. ECEAP is funded by Washington State to provide school readiness for three and four year olds from low income families who are at risk due to developmental and environmental factors, such as substance abusing parents and involvement in the child welfare system. Educare is a nationwide model that prepares young, low-income children for school. Head Start is a federal program that promotes school readiness for children birth to five from low-income families and is responsive to each family's ethnic, cultural and linguistic heritage.

MHCADSD contracts with outpatient SUD and mental health treatment agencies, which ensures that King County provides co-occurring, gender-responsive, and family friendly treatment to its residents. Six of the 29 SUD agencies are culturally specific in whom they serve. Most of the agencies have gender specific groups and three of the 29 serve women with children or women only. At least 12 treatment centers offer childcare and/or allow parents to bring their children into treatment groups and offer parenting classes within the context of SUD treatment, such as Breakthrough Parenting. There are 144 clinicians trained in administering the Global Appraisal of Individual Needs (GAIN), which is a

[9] Young, N. K., Wong, M., Adkins, T., & Simpson, S. (2003). Family Drug Treatment Courts: Process documentation and retrospective outcome evaluation; Children and Family Futures. Irvine, CA.

[10] HUDDLESTON, C.W.; FREEMAN-WILSON, K.; MARLOWE, D. B.; ROUSSELL, Painting The current picture: A national report card on drug courts and other problem solving court programs in the United States, Alexandria, VA: National Drug Court Institute, v.1, n.2., Maio 2005.

[11] Young, N. K., Wong, M., Adkins, T., & Simpson, S. (2003). Family Drug Treatment Courts: Process documentation and retrospective outcome evaluation; Children and Family Futures. Irvine, CA.

[12] Marlowe, D. B. (2001). The verdict on drug courts and other problem-solving courts.
23 Chapman Journal of Criminal Justice, 2(1), 57-96.

[13] Journal Issue: Children, Families, and Foster Care Volume 14 Number 1 Winter 2004, **Children, Families, and Foster Care: Analysis and Recommendations,** Authors: Sandra Bass Margie K. Shields Richard E. Behrman

requirement for the youth population and encouraged in the adult population in King County. Certain trained therapists offer specific evidence-based practices (like Dialectical Behavior Therapy), but only Seeking Safety and Moral Reconation Therapy (MRT) are consistently identified as agency wide practices at SUD treatment facilities. Seeking Safety has been adapted for men and women dealing with trauma and SUD issues. MRT addresses thinking patterns associated with SUD and mental health issues for men and women.

Additionally, MHCADSD can link KCFTC clients to other mental health evidence-based practices including Common Elements Treatment Approach (CETA) to treat adults suffering from depression, anxiety and post-traumatic stress disorder (PTSD); Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for both children and parents who are having behavioral issues related to traumatic life experiences; Cognitive Processing Therapy (CPT) commonly used for adults with PTSD; and Eye Movement Desensitization Reprocessing (EMDR) also for treating PTSD.

5. What OUTCOMES would the County see as a result of investment in this New Concept/Existing MIDD Strategy/Program? Please be as specific as possible. What indicators and data sources could the County use to measure outcomes?

The primary performance measurement and evaluation questions focus on the three major goals of the KCFTC: 1) Ensuring that children have a safe and permanent home within the permanency planning guidelines or sooner; 2) Ensuring that families of color have outcomes from dependency cases similar to white families; 3) Ensuring that parents are better able to care for themselves and their children and seek resources to do so.

The KCFTC has a well-established, preexisting process for collecting and reporting on client and court performance measures. Data are regularly recorded in a KCFTC Access Database, including fields for demographics on individuals served (both parent and child), referral outcomes, incentives and sanctions, hearings and attendance, SUD and mental health treatment services, exit outcomes for parents, permanency outcomes, housing and housing stability. The database includes the ability to run automatic reports and analyses; in addition to providing a flexible platform for on-the-fly analysis, as well as permitting data downloads into more sophisticated analysis software. Data are analyzed regularly, stratified by performance-to-date, quarterly, and annually, and shared internally within the court, the larger KCFTC team and KCFTC Oversight Committee for input. Because racial proportionality in outcomes is one of the three major goals of the KCFTC, all analyses are presented as totals as well as disaggregated by race/ethnicity. The database is also used for developing and monitoring individual client plans and progress.

KCFTC also contracts with an evaluation team who brings experience in collecting, merging, processing, and analyzing complex relational and longitudinal data for the KCFTC from administrative datasets including Medicaid, Superior Court, and Children's Administration (Bruns et al., 2012[14]; Pullmann et al., 2014[15]). This process involves requesting data to be delivered to the UW, linked via proxy identifiers provided by the KCFTC, which maintains client protections and confidentiality. Analytic datasets are maintained on secure, password-protected servers at the University of Washington.

[14] Bruns, E. J., Pullmann, M. D., Weathers, E. S., Wirschem, M. L., & Murphy, J. K. (2012). Effects of a multidisciplinary family treatment drug court on child and family outcomes: Results of a quasi-experimental study. *Child Maltreatment, 17*(3), 218-230. doi: 10.1177/1077559512454216

[15] Pullmann, Michael, Spencer Hensley, and Eric Bruns. (2014). *King County Treatment Court Racial and Ethnic Proportionality Assessment 2007-2012*.

The MIDD Annual or Adjusted Targets and Performance Outcome Report was utilized throughout the initial evaluation and could be used and refined for the future.

C. Populations, Geography, and Collaborations & Partnerships

1. What Populations might directly benefit from this New Concept/Existing MIDD Strategy/Program: (Select all that apply):

- ☒ All children/youth 18 or under
- ☐ Children 0-5
- ☐ Children 6-12
- ☐ Teens 13-18
- ☒ Transition age youth 18-25
- ☒ Adults
- ☐ Older Adults
- ☒ Families
- ☐ Anyone
- ☒ Offenders/Ex-offenders/Justice-involved
- ☐ Other – Please Specify:
- ☒ Racial-Ethnic minority (any)
- ☒ Black/African-American
- ☒ Hispanic/Latino
- ☒ Asian/Pacific Islander
- ☒ First Nations/American Indian/Native American
- ☒ Immigrant/Refugee
- ☒ Veteran/US Military
- ☒ Homeless
- ☒ GLBT
- ☒ Women

Please include details about this population such as: individuals transitioning from psychiatric hospital to community; individuals judged incompetent by the court; children of drug users who are in foster care, etc.

For 11 years, KCFTC has served children of drug users who are in the child welfare system. Specifically from 2004 to 2014, KCFTC has served a total of 269 chemically dependent parents and 382 of their children. Of all the parents served, 82 percent (221) were female and 18 percent (48) were male. Of this group, 55 percent (149) were Caucasian, 16 percent (42) were African American, 13 percent (34) were Native American, nine percent (23) identified as biracial, three percent (9) were Hispanic, three percent (8) identified as multiracial, one percent (2) were Asian/Pacific Islander. Currently over 30 percent of KCFTC participants identify as Native American, representing five federally recognized tribes (Blackfeet, Chippewa, Objibwe, Northern Cheyenne, Native Village of Curyung).

The majority of parents, 55 percent (144) are between 20-30 years old, with the second largest age cohort of 31-40 comprising 33 percent (90) of all parents served. Only one percent (2) fall within an age range of 18-19 years old, the same percentage as for parents 51 years and older. The remaining 11 percent (30) are ages 41-50.

At intake into the program, 90 percent (246) of all parents were unemployed, compared to an overall unemployment rate for King County at five to 9.6 percent, throughout the period of 2004 through 2014.[16] Though data on mental health, domestic violence involvement and veteran status only started to be collected in 2008, 52 percent (140) of parents have been documented to have been involved in domestic violence cases, 60 percent (162) have been diagnosed with a mental health issue and one percent (4) are of veteran status.

[16] Washington State Employment Security Department, King County Profile. Updated September 2014.

Upon intake into the KCFTC program, 36 percent (97) of parents were living in a house or apartment, while 25 percent (66) were homeless and 20 percent (55) were residing in residential treatment. An additional 13 percent (36) were either living in subsidized housing (9%, 24) or transitional housing (4%, 12).
Of the 382 children served, 41 percent (158) have been under the age of two, 21 percent (79) from ages two to four, 12 percent (45) from four to six, and the remaining 26 percent being ages six and older.

2. Location is an important factor in the availability and delivery of services. Please identify whether this New Concept/Existing MIDD Strategy/Program addresses a specific geographic need in the following area. Please provide additional that discusses the basis for the selection: County-wide

The MIDD I expansion brought the KCFTC program to south county residents by providing a half-day extension of the Seattle based KCFTC program at the Maleng Regional Justice Center. This expansion effectively provided access countywide. However, since that expansion in 2009, not only have regular dependency filings increased from 608 in 2009 to 924 in 2014, but dependency filings in Kent have increased from 40 percent to 60 percent, making the need for a full day KCFTC program in Kent even more valuable.

3. What types of COLLABORATIONS and/or PARTNERSHIPS may be necessary to implement this New Concept/Existing MIDD Strategy/Program, and with whom (other jurisdictions & cities, law enforcement, first responders, treatment providers, departments within King County, housing, employers, etc.)? Please be specific.

KCFTC is reliant on its existing relationships with partner organizations and agencies to effectively serve both parents and children referred to the court.

King County MHCADSD is a crucial partner for connecting clients with specific mental health and SUD treatment services. MHCADSD manages the system of care for publicly funded individuals in King County and is responsible for the delivery of SUD treatment, mental health treatment, co-occurring treatment, prevention and community organizing throughout King County. The County works in partnership with other departments within the county, the City of Seattle, and the Washington State Division of Behavioral Health and Recovery (DBHR) in planning and implementing programs. There are many programs that make up the SUD (and co-occurring) services continuum of care for low income and indigent citizens within the community. Having been in operation for over ten years, KCFTC has a relationship with most treatment providers in King County. KCFTC staff has personally visited each agency to learn about whom they specialize in serving and described the KCFTC program and how all parties can best partner together. For example, KCFTC has developed relationships with culturally specific agencies, such as Cowlitz Tribal Health to work with Native American clients. Cowlitz recently honored KCFTC for working with Native clients and the continued partnership with culturally respectful treatment. KCFTC also has fostered a close working relationship with New Traditions, a gender specific SUD agency for women. They provide same day assessments for women in KCFTC regardless of payment. As over 80 percent of KCFTC's population is women, this is a valuable relationship. KCFTC also contracts directly with the Harborview Sexual Assault and Traumatic Stress Center (HSATSC) who provides evidence-based trauma treatment for KCFTC clients, another invaluable resource for both men and women who otherwise could not afford to get treatment.

Washington State's Department of Human Social Services (DSHS): The KCFTC is reliant on its partnership with Washington State's Department of Human Social Services (DSHS) to enroll new parents into the court as KCFTC's capacity is determined by the children on a DSHS' social worker's caseload.
Dependency CASA Program: The Court Appointment Special Advocates (CASA) Program is an essential partner in the functioning of KCFTC. The Dependency CASA Program serves children up to age 11 who have allegedly been abused and/or neglected. The process focuses on the best interests of the child. The court will try to reunite a family if conditions at home improve sufficiently. A CASA is a trained volunteer who represents the best interests of children as they are taken through the legal process. These trained volunteers investigate the case and inform the court; help identify resources to address a child's special needs; and recommend temporary and permanent plans for the child. Volunteers are represented in court by program attorneys and assisted by paralegals and social work staff. The Washington State Office of the Attorney General is a significant partner as it represents DSHS in dependency proceedings.
King County Department of Public Defense: The King County Department of Public Defense also commits attorneys to specifically represent dependency cases that go through KCFTC. This relationship is critical for the proper and effective functioning of the Court.

University of Washington: The University of Washington has served as the local evaluator of the KCFTC project since 2005. The lead evaluator, Michael Pullman, Ph.D., provides technical assistance to the KCFTC team on data collection and reporting.

Washington State Attorney General: The Washington State Office of the Attorney General is a significant partner as it represents DSHS in dependency proceedings. The Attorney General will provide an Assistant Attorney General, also known as prosecution services for KCFTC.

D. Drivers, Barriers, Unintended Consequences, and Alternative Approaches

1. What FACTORS/DRIVERS, such as health care reform, changes in legislation, etc. might impact the need for or feasibility of this New Concept/Existing MIDD Strategy/Program? How?

The Behavioral Health Care Integration that will take place on April 1, 2016 could impact the number and quality of SUD and mental health treatment services FTC clients receive for both inpatient and outpatient services. It could also have an impact on the ability for clients to have timely access to these services. It is unclear at this time if the health care reforms taking place across Washington State will positively or negatively impact drug court clients.

2. What potential BARRIERS, if any, might there be to implementation? How might these be overcome? Who would need to be involved in overcoming them?

There are no barriers to implementations as KCFTC has been in operation since 2004. However, in order to expand services to a full day in south King County, dependency calendars will need to be realigned to accommodate the Attorney General's Office resource needs, Children's Administration will need to provide additional social workers dedicated to FTC cases, and the Department of Public Defense will need to assign additional counsel.

3. What potential UNINTENDED CONSEQUENCES might exist if this New Concept/Existing MIDD Strategy/Program is implemented? Please be specific---for whom might there be consequences?

There are no unintended consequences foreseen for the KCFTC to be implemented as this is an already functional strategy. However, if the expansion to a full day in Kent is implemented and funding sources for partners are unexpectedly reduced, KCFTC may not be able to complete the full implementation strategy.

4. What potential UNINTENDED CONSEQUENCES might there be if this New Concept/Existing MIDD Strategy/Program is *not* implemented? Please be specific---for whom might there be consequences?

If KCFTC ceased to exist:

1. All of the MIDD strategies could not be implemented under this funding structure as RCW 26.12.250(1)* requires the operation and evaluation of a family drug court commensurate with the size of the county to impose the 0.1% sales tax.
2. SUD and mental health providers would lose the partnership with the KCFTC to help guide and support parents through treatment. Treatment providers get better outcomes when their clients are involved with KCFTC.
3. Children of parents experiencing a SUD are much less likely to be re-unified with their parents and linger in the child welfare system without a safe and permanent home.
4. Parents involved in child welfare will have less access to SUD and mental health treatment and experience less success in treatment.
5. All of these outcomes would disproportionality impact families of color, especially children.
6. The county would lose almost one million dollars in federal funding to expand and enhance treatment services for parents and children via KCFTC.

5. What ALTERNATIVE APPROACHES currently exist to address this need apart from this New Concept/Existing MIDD Strategy/Program? At a high level, how does this New Concept/Existing MIDD Strategy/Program compare to those other approaches in terms of cost, feasibility, etc. Could this New Concept/Existing MIDD Strategy/Program be merged with one or more of the alternatives? What are the pros/cons of merging?

There is no known or identified alternative approach to this problem. It is the only current innovation in King County that specifically addresses SUD within the dependency court system. The only alternative process is for families to receive support via the regular dependency process, which produces inferior outcomes, especially for families of color. In a cost/benefit analyses there is on average a $5,000 cost savings per Family Drug Court participant for Family Drug Courts who have outcomes similar to KCFTC. (Burrus, S. W. M., Mackin, J. R., & Finigan, M. W.[17]). These were cost savings distributed among reductions in foster care days for the state, and reductions in criminal justice involvement, probation/parole caseloads, and court cases for the county.

E. Countywide Policies and Priorities

1. How does this New Concept/Existing MIDD Strategy/Program FIT within the CONTINUUM of care, and within other county initiatives such as Behavioral Health Integration, Health and

17 Burrus, S. W. M., Mackin, J. R., & Finigan, M. W, Show Me the Money: Child Welfare Cost Savings of a Family Drug Court Juvenile and Family Court Journal, 62 (3), 1-14. Summer 2011

Human Services Transformation, Best Starts for Kids, All Home, the Youth Action Plan, and/or the Vets and Human Services Levy or any other County policy work?

1. Continuum of Care: All KCFTC involved families are assessed by a CDP for the appropriate level of care and then offered a continuum of services from long term inpatient treatment on through to relapse prevention and aftercare services. They are also referred for mental health assessments and treatment, including specific evidence based treatment for trauma symptoms. Every client is matched according to client voice and choice regarding cultural, gender and sexual identify.
2. Best Starts for Kids: KCFTC aligns with the Executive's stance on Best Starts for Kids. With over 62 percent of the children in KCFTC under the age of four and at risk, KCFTC instituted a mandatory referral for all children under the age of three for an Early Intervention assessment. KCFTC supports the work of the Best Starts for Kids Initiative by already partnering with Early Learning Programs, schools and treatment agencies throughout the county. KCFTC has also partnered with Children's Home Society who consults on each case to provide information on what type of early intervention services KCFTC children should be referred to.
3. The Youth Action Plan: KCFTC serves children of all ages who have been neglected by their parents. These children are mainly children of color, living in abject poverty, who are at greatest risk for becoming involved in the juvenile offender system. KCFTC partners with state and local agencies to provide food, school supplies, developmental assessments and interventions, clothing, and safe and stable homes.
4. Health and Human Service Transformation: KCFTC upholds all three tenets of the HHST by
    a. Building Equity – KCFTC is the only court program that has proven to positively impact the disparate outcomes that families of color receive in the child welfare and treatment systems for both adults and kids.
    b. Working in New Ways – KCFTC is at its core a new way of handling court cases in that it tasks all the court parties to work with each other in a relational and non-adversarial manner to provide the best outcome for kids and parents. It is a revolutionary idea that has been proven to work.
    c. Investing in What Works: There is no other MIDD strategy that has been more evaluated than KCFTC. With four high quality evaluations to date, it continues to produce superior outcomes in treatment, child welfare and equity arenas.

One of the main reasons RCW 26.12.250 was set up with KCFTC as the catalyst for acquiring MIDD dollars, is that our clients intertwined with so many systems and KCFTC is a model that helps pull people out of silos and reaches across agency and department boundaries to enhance communication among all systems to best serve our mutual clients.

2. How is this New Concept/Existing MIDD Strategy/Program rooted in principles of recovery, resiliency, and/or trauma-informed care?

KCFTC is rooted in the principles of recovery, resiliency and trauma-informed care. According to SAMHSA's definition: Resilience develops over time and gives an individual the capacity not only to cope with life's challenges, but also to be better prepared for the next stressful situation. This is one of the foundational goals of KCFTC, that families are better able to care for themselves and their children and can seek the resources to do so. They learn how to do this through failures and successes within the KCFTC program model. Parents are supported through barriers and crises and are encouraged and

congratulated when enacting an appropriate solution. SAMHSA has also delineated four major dimensions that support a life in recovery: Health, Home, Purpose, and Community. KCFTC supports health by using client voice and choice in the determination of the appropriate treatment services for both themselves and their children. KCFTC has worked with the Community Services Division and Washington State to obtain permanent housing vouchers and support families in accessing transitional housing opportunities, due to many homeless participants. Services are placed in these homes to stabilize the families who are also offered budgeting support through KCFTC staff. In order to graduate KCFTC, parents need to have a life plan initiated, whether that is finding a job, going back to school or a vocational program or applying for SSI. Staff often check in with parents about any volunteer position held within the AA/NA system or ask them to give back by mentoring someone currently in the KCFTC program on a particular issue. Finally, as part of the requirements of the KCFTC program, parents participate in sober supports in their community to reduce isolation and involve friends and family members in the court process. KCFTC also engage Alumni as peer mentors.

The KCFTC program has modeled itself around SAMHSA's "four Rs" (Realize, Recognize, Respond, and Resist Re-traumatization) of trauma-informed care, starting with realization and, with expansion funding, would continue to provide the same model. The current KCFTC team has all been trained on the definition, prevalence and impact of trauma in the child welfare system and new staff will receive trauma training. The second R, recognize, was addressed in the application process for KCFTC. KCFTC uses the Modified Mini Screen and asks collateral sources for information regarding a history of traumatic experiences for the parent and child. KCFTC staff also inquire about what community and cultural supports are available for the family, as well as what services were most effective in past interventions and why. KCFTC uses this knowledge as the team staffs cases, identifying behaviors that are observed and assumed to be related to traumatic experiences, acknowledging any gender and historical trauma factors, and when appropriate, KCFTC will discuss the development of responses and case management based on that knowledge. This is both an effort to respond and resist re-traumatization - the last two Rs of trauma-informed care.

After attending a trauma informed training on the visual impact courtroom design and décor can have, KCFTC also changed the signage and layout of the courtroom to be welcoming and non-threatening. The team has received training on recognizing their own symptoms of secondary trauma and why self-care is critically important when working with this population. KCFTC receives consultation from the Harborview Sexual Assault and Traumatic Stress Center (HSATSC) on cases, looking to avoid possible re-traumatization through the court process and contract with HSATSC directly to provide Common Elements Treatment Approach (CETA) and Cognitive Processing Therapy (CPT) therapy for KCFTC clients.

3. How does this New Concept/Existing MIDD Strategy/Program enact and further the County's EQUITY and SOCIAL JUSTICE work?

Maintaining and/or expanding KCFTC services to South King County is a perfect way to help execute ESJ Ordinance 16948 – the ESJ Office determined that this south King County region has the highest density of people of color, people with low income and people with low life expectancy.

King County's FTC is well evaluated programs with two process evaluations, a highly rigorous outcome evaluation and equity and social justice evaluation. FTC demonstrates better outcomes for families in Dependency Court in every category such as:

- faster entry into treatment;
- more successful outcomes in treatment ; and

- more children returned home to their parents than in regular dependency.

These positive outcomes were equivalent for white families and families of color. Families of color fared better in each of these outcomes compared to families of color in the regular dependency system, making KCFTC one of the few programs proven to have a positive impact on disparity within the justice system.

F. Implementation Factors

1. What types of RESOURCES will be needed to implement this New Concept/Existing MIDD Strategy/Program (staff, physical space, training, UA kits, etc.)?

8a Expand Family Treatment Court (FTC) Services/Supports to Parents:
The unfunded portions of the original staffing model for expanded FTC services in 2009 were to include:

- Fund 4.0 FTE wraparound Facilitators: each FTE trained in the implementation of the 10 principles and the phases of Wraparound for children and families in a Wraparound model of care. High Fidelity Wraparound is a model of care that follows principles, values, and methodologies as set forth in the National Wraparound Initiative (NWI). The model specifies a caseload size of 15 to 23 families per facilitator per year, with flex funds managed at the child and family team level and a detailed evaluation process that includes input from the child, families, and stakeholders. Each facilitator assures the creation of an Individualized Wraparound Care Plan: a plan specific to each family, written in easy-to-understand language that addresses the family's prioritized needs across multiple life domains. The plan is developed using the NWI guidelines and indicates goals, steps to achieve those goals, timeframes, and parties responsible for actions.

- 4.0 FTE Parent Partners: a person who has personal experience with Wraparound due to a child in his or her care being involved in Wraparound in the past 10 years; or an adult caregiver who has experience with a child/youth in his or her care being involved in the mental health, SUD, juvenile justice, or child welfare system(s) in the past 10 years. The Parent Partner is trained in the implementation of the 10 principles and the phases of Wraparound for children/youth and families in a Wraparound model of care.

- 1.0 Administrative Specialist III: The responsibilities of this classification include providing office management and administrative support services and/or direct supervision of general and/or technical clerical personnel. Duties include selecting and training employees and/or performing specialized and expert technical clerical work such as interpreting policies, procedures or office guidelines in support of individuals, organizational units and/or programs.

The above positions represent the original portion of the 2008 MIDD KCFTC budget that were not funded, for a total of $787,050.

In addition, include access to a family assistance fund to assist with non-categorical supports for these families which has been in place for wraparound in the original MIDD.
KCFTC has been operating understaffed since the economic downturn in 2008. However, given the needs of the program and best practice developments in the last eight years, this proposal is for the following staffing model below instead.

With the current need for a second expansion of FTC to provide equivalent services for south county residents, the following staffing model is required to accommodate both the original underfunded 2008 expansion and new 2017 expansion services:

KCFTC 2017 Request
Continue Funding for MIDD I KCFTC Positions Below:

- Program Supervisor: This position oversees daily operations, manages all FTC cases by facilitating case coordination/communication, staffs all policy development and team meetings, responsible for record keeping, statistical reporting, personnel issues, grant writing/management, serves as a full member of the FTC decision making team, provides testimony regarding case status, compliance and recommendations on behalf of the decision making team, and works as the FTC liaison to the community.
- 2.0 Treatment Specialist: This position acts as the first point of contact with the program and conducts program eligibility, reports on participant progress and compliance with treatment, helps participants access treatment, conducts team meetings for participants who do not have wraparound services, oversees sober supports and program compliance and provides clinical knowledge to team regarding addiction and recovery processes. Insert cost here.
- 1.0 Court Specialist: This position maintains court calendar, distributes court calendar to the team, prepares cases for court including maintaining participant files, scheduling phone hearings, and setting up appropriate incentives and responses, coordinates and administers staffings and hearings each week, assists Program Supervisor in maintaining court demographics/statistics, assists in planning and organization of meetings including team trainings, graduations, and other team events, supports team by performing duties such as maintaining email distribution lists, maintaining master lists, and assisting in communication with program evaluators.
- 1.0 CASA Supervisor: This position supervises Court Appointed Special Advocates who are volunteers that represent the best interests of the child, conduct an independent investigation of the case, provide reports to the court and serves as a full FTC team member.
- 1.0 Parents for Parents Coordinator: This position interviews, selects and trains Parent Ally volunteers to work with parents who have an open dependency case to help them understand and navigate the dependency court system. They serve as a large referral source for Family Treatment Court and administer peer support meetings for FTC clients.

Additional Expansion Positions Requested:

- 1.0 Treatment Specialist: This position acts as the first point of contact with the program and conducts program eligibility, reports on participant progress and compliance with treatment, helps participants access treatment, conducts team meetings for participants who do not have wraparound services, oversees sober supports and program compliance and provides clinical knowledge to team regarding addiction and recovery processes. Insert cost here.
- 1.0 Court Specialist: This position maintains court calendar, distributes court calendar to the team, prepares cases for court including maintaining participant files, scheduling phone hearings, and setting up appropriate incentives and responses, coordinates and administers staffings and hearings each week, assists Program Supervisor in maintaining court demographics/statistics, assists in planning and organization of meetings including team trainings, graduations, and other team events, supports team by performing duties such as maintaining email distribution lists, maintaining master lists, and assisting in communication with program evaluators.

- 2.0 Family Recovery Support Specialists/Peer Partners: These positions will engage and retain participants to Family Treatment Court program using experiential knowledge and motivational interviewing techniques. Act as a liaison (bridging, brokering/negotiating, partnering) between individual participants, family members, FTC team members, and treatment organizations to eliminate obstacles to recovery and child well-being. Provide assertive linkages to communities of recovery and treatment agencies through transportation assistance, accessing public benefits, concrete resources, attendance at treatment intakes and sober support meetings, and sober leisure events. Provide recovery-focused skill training and connections aimed at full community participation (education, employment, housing, leisure, budgeting, worship and pro-recovery family and social relationships). Assess concrete needs of the child during reunification and assist in obtaining needed resources. Assist parents in coordinating, scheduling and obtaining children's services, including attending IEP meetings, doctor's appointments, calling providers and empowering parents to advocate for their child's special needs.
- 0.5 CASA Attorney: This position is needed to represent a CASA advocate. A CASA advocate is a trained volunteer who is tasked with representing the best interest of the children who are brought to court in dependency cases based on allegations of abuse or neglect. A half-time attorney is needed for accommodating the additional Court calendar demands with the predicted increase in children and their associated dependency cases.

This proposed staffing model would replace original 2008 staffing model (both funded and unfunded) positions with the model above that more closely aligns with current best practices for Family Drug Courts nationally.

2. Estimated ANNUAL COST. $501,000-$1.5 million Provide unit or other specific costs if known.

2016 Base Budget for FTC: $724,900

Expansion Cost plus Base Cost:
2017: $935,200
2018: $1,025,600 (SAMHSA grant ends in 2018)
2019: $1,254,800

3. Are there revenue sources other than MIDD that could or currently fund this work? Clarify response, citing revenue sources.

No known revenue sources other than MIDD are available regarding the current existing strategy. To address the growing need for KCFTC services in Kent, in collaboration with MHCADSD, KCFTC successfully applied for a $975,000 federal SAMHSA grant to expand and enhance treatment services to KCFTC families. This money will be available from October 2015 through September 2018, however, this funding is not enough to cover the KCFTC costs of partner agencies at Department of Public Defense, Attorney General's Office and Children's Administration and KCFTC program needs. Without resource accommodations for these partners, KCFTC will be unable to fully utilize the entire grant funds awarded to King County.

4. TIME to implementation: Currently underway
   a. What are the factors in the time to implementation assessment? None.

b. What are the steps needed for implementation? None.

c. Does this need an RFP? No.

G. Any OTHER INFORMATION that would assist reviewers with making recommendations about this New Concept/Existing MIDD Strategy/Program? (optional). Do you have suggestions regarding this New Concept/Existing MIDD Strategy/Program?

1. KCFTC has was not fully funded due to lower than expected funds in 2009 when MIDD implementation took place. Four positions remain unfunded.

2. As provided under state statute, MIDD is the primary funding sources supporting all therapeutic courts in King County.

Mental Illness and Drug Dependency Plan
Strategy Overview - Template

Strategy Name/#: 8a, Family Treatment Court Expansion
Sequential Intercept points: *(specify criminal justice or hospital and intercept 1-5)*- The model envisions a series of points of interception at which an intervention can be made to prevent individuals from entering or penetrating deeper into the criminal justice system.
Identify where within the Sequential Intercept model, the MIDD strategy intercepts.
(select the intercept point(s) addressed by the strategy)

	1. Intercept 1 • Local Law enforcement and other first responders
	2. Intercept 2 • Arrest, Jail/Detention Booking, Initial detention, Initial Court Appearances
	3. Intercept 3 • Specialty Courts, Pretrial Hearings, Deferred Prosecution, Trial Court, Forensic Evaluations & Forensic Commitments
	4. Intercept 4 • Reentry, Jail/Detention-Sentence
	5. Intercept 5 • Probation, Community Corrections, Community Supports

County Policy Goal Addressed:

(select the policy goal(s) addressed by the strategy)

	1. A reduction in the number of mentally ill and chemically dependent people using costly interventions like jail, emergency rooms, and hospitals.
#1	2. A reduction in the number of people who recycle through the jail, returning repeatedly as a result of their mental illness or chemical dependency.
#1	3. A reduction of the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.
	4. Diversion of mentally ill and chemically dependent youth and adults from initial or further justice system involvement.
	5. Explicit linkage with, and furthering the work of, other council directed efforts including, the Adult and Juvenile Justice Operational Master plans, the Plan to End Homelessness, the Veterans and Human Services Levy Service Improvement Plan and the King County Mental Health Recovery Plan.

Year started: 2009

Budget (amount spent/year): 694,300

FTE (county/community):

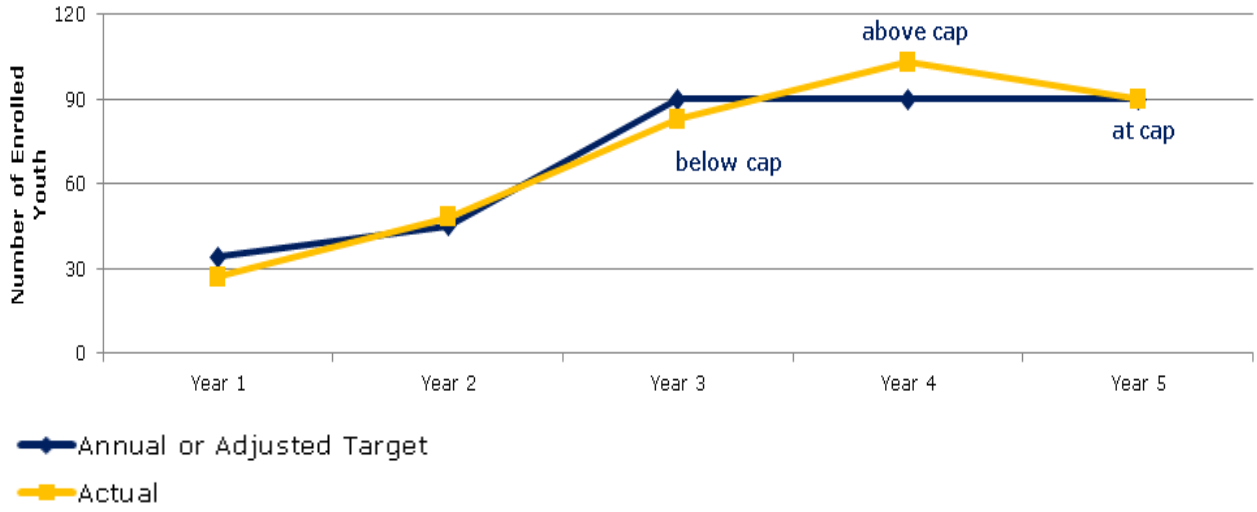
Narrative (strategy overview): When parental SUD results in removal of children from their home by the state, Family Treatment Court (FTC) provides an opportunity for families to ultimately be reunited. Enrolled individuals are closely monitored by this specialized therapeutic court for their SUD recovery, with the goal of minimizing their children's involvement with the child welfare system.

Population of Focus: FTC serves King County parents involved in the child welfare system identified as being chemically dependent and who have had their children removed due to their substance use.

Total number served (and Numbers Served annually):

Performance[18]

[18] MIDD Sixth Annual Report



Outputs (annually): In its third year at full capacity, the FTC continued to be monitored for adherence to two service caps: 1) serve no more than 90 children (weighted) per year, and 2) serve no more than 60 children at any one time. In MIDD Year Five, 57 parents took part in FTC's therapeutic court services. Within their families were 83 unique children, with a total weighted value of 90.5. The average daily maximum number of children was 60. (FTC calculates its own cap figures on a calendar-year basis per agreement, rather than the MIDD evaluation timeline). The figure below shows the percentage of parents and children who were newly enrolled after September 2012. Children with Native American heritage are counted toward the cap at 1.3 each. For this period, 32 % of FTC parents were Native American, much higher than the 3% rate in MIDD's general population.

New vs. Continuing FTC Participants N=140[19]

Strategy Title: Expand Family Treatment Court

Strategy No: 8a – Expand Family Treatment Court Services and Support to Parents

County Policy Goals Addressed:

- Diversion of youth and adults with mental illness and chemical dependency from initial or further justice system involvement.
- A reduction of the number of people with mental illness and chemical dependency using costly interventions like jail, emergency rooms and hospitals.

1. Program/Service Description

◊ *A. Problem or Need Addressed by the Strategy*

[19] MIDD Fifth Annual Report

With increasing frequency, children are placed in foster care because their parents are addicted to alcohol or drugs. Many children also are born to mothers who abused alcohol or drugs while pregnant. Equally concerning is the number of children in foster care whose families are torn apart by SUD who subsequently abuse alcohol or drugs themselves. Two hundred ninety (290) children, or 43% of the 675 annual dependency petitions filed in King County Superior Court (KCSC), are drug related.

Family Treatment Court (FTC) is a special program designed to ensure that children live in safe and drug free homes. This program is designed to serve individuals who have an abuse or neglect case against them with associated alcohol or SUD allegations. Over 50% of the families entering FTC are homeless and in need of transitional and/or permanent housing. Eighty-five percent are unemployed and the majority of female parent participants have been victims of domestic violence. The FTC program will help the parents recover from alcohol or SUD and work toward reuniting parents with their children.

◊ *B. Reason for Inclusion of the Strategy*

Keeping families whose lives have been devastated as a result of SUD together and/or encouraging early reunification is good for families and the community. The majority of children who enter foster care eventually return to their parents. However, in recent years an increasing number of children leave foster care only to re-enter the system at a later date as a result of parental SUD.

◊ *C. Service Components/Design*

FTC is organized around the ten key components that define a drug court: 1) integrated systems (child welfare, SUD treatment services and the court); 2) protection and assurance of legal rights, advocacy and confidentiality; 3) early identification and intervention; 4) access to comprehensive services and

individualized case planning; 5) frequent case monitoring and drug testing; 6) graduated responses and rewards; 7) increased judicial supervision; 8) deliberate program evaluation and monitoring; 9) a collaborative, non-adversarial, cross-trained team; and 10) partnerships with public agencies and community-based organizations.

◊ *D. Target Population*

FTC serves King County parents involved in the child welfare system who are identified as being chemically dependent and who have had their children removed due to their substance use.

◊ *E. Program Goals*

FTC's goals are: 1) to ensure that children have safe and permanent homes within permanency planning guidelines or sooner; 2) to ensure that families of color have outcomes from dependency cases similar to families not of color; 3) to ensure that parents are better able to care for themselves and their children and seek resources

to do so; and 4) to reduce the societal cost of dependency cases involving parental chemical dependency.

◊ *F. Outputs/Outcomes*

45 new children will be served in the program, doubling the current capacity to a total of 90 children. Expected outcomes include a reduction in the use of substances and in juvenile justice system involvement.

2. Funding Resources Needed and Spending Plan

The continuation and expansion of Family Treatment Court will have an annual cost of $694,300.

The spending plan is as follows:

Dates	Activity	Funding
Sept – Dec 2008	Provide ongoing funding of existing services and start-up of program expansion (staff hiring and training)	$522,000
	Total Funds 2008	$522,000
Jan – Dec 2009	Continued start-up and program funding	$694,300
	Total Funds 2009	$694,300
2010 and onward	Ongoing Family Treatment Court costs	$694,300
Ongoing Annual	Total Funds	$694,300

3. Provider Resources Needed (number and specialty/type)

◊ *A. Number and type of Providers (and where possible FTE capacity added via this strategy)*

Type of Provider:	Description:
Treatment Liaison (1.0 FTE)	• This position serves as a liaison between FTC and chemical dependency treatment agencies, monitors parent's progress and compliance, and provides therapeutic case coordination services to FTC families.
Recruitment Specialist (1.0 FTE)	• This position actively identifies and recruits new participants, provides orientation, conducts chemical dependency and mental health screenings, makes referrals to treatment agencies, serves as a liaison between the court and treatment agency and provides case coordination services to FTC parents.

Type of Provider:	Description:
Parent-to-Parent Coordinator (.5 FTE)	• Goal of the Parent-to Parent Program is to increase parental engagement in hearings and the dependency process by connecting parents newly involved in the dependency court process with parents who have successfully reunited with their children. Coordinator guides veteran parents in helping new parents, organizes the schedule for shelter care hearings and facilitates "Dependency 101" classes. Will coordinate with FTC Alumni veteran parents to attend court hearings, conduct Dependency 101 classes and identify potential FTC participants.
Wraparound Coordinator (*Contracted* 1.0 FTE)	• Coordinates on-going wraparound meetings for families in FTC that include both natural and professional supports involved with the parents and/or children. Facilitates wraparound meetings and leads the team in the development of a unified care plan consisting of strengths, normalized needs, measurable goals, and assigned tasks to complete these goals across ten different life domains. Develops a Strength, Need, & Cultural Discovery with the parent to be used in the development & implementation of the care plan. Assists the team in developing family/professional partnerships.

◊ *B. Staff Resource Development Plan and Timeline (e.g. training needs, etc.)*

Recruitment Specialist and Treatment Liaison positions will be recruited, hired and trained by KCSC 7/1/08 – 9/15/08. Increases in public defense, CASA Supervisor and AG time assigned to FTC will be developed by 12/31/08. The design and implementation of the parent-to-parent program will be conducted in collaboration with DSHS and MIDD Strategy #1f. Ongoing FTC team building and training activities will be conducted.

◊ *C. Partnership/Linkages*

Partnerships and linkages have already been developed with the Department of Children and Family Services, Children's' Administration, treatment providers and the court system. Linkages to the Wraparound initiative 6a will occur as well.

4. Implementation/Timelines

◊ *A. Project Planning and Overall Implementation Timeline*

Phase:	Timeline:	Strategies:	Target # of children:
Build to current capacity levels	09/15/08 - 12/31/08	• Referral at 72-hour hearing to observe FTC by judicial officer (started 2/08) • Hire Treatment Liaison by 9/15/08	45

Phase I	09/15/08 - 12/31/08	• Hire/Contract for Parent-to-Parent Program Coordinator to start by January 2009 • Hire Recruitment Specialist by 9/15/08 • Contract for additional Wraparound Coordinators to meet the need of the existing participants so they are in place by January 2009	60
Phase II	01/01/09 - 06/30/09	• Implement Dependency 101/Parent-to-Parent Program • Contract for an additional Wraparound Coordinator so they are in place by July 2009 • Identify potential space needs	75
Phase III	06/30/09 - 12/31/09	• Identify remaining needs to move to full capacity	90

◊ *B. Procurement of Providers*

There is no current plan for procurement of services to accompany program expansion.

◊ *C. Contracting of Services*

Current FTC Wraparound Coordinator contract amended for continuation by 9/1/08. Additional Wraparound Coordinator positions to accommodate program expansion to be procured and contracted through MIDD Strategy 6a.

◊ *D. Services State Date(s)*
Services to clients will begin to increase September 2008.