

Section A: Statement of Need

The Superior Court of California, County of Alameda established a Family Drug Court Pilot project in Hayward, California in 2006. For 120 families who have participated over the past 6 years, the parent-child reunification rate was 49 percent, an improvement over the statewide rate of 38.2 percent and the countywide rate of 28.3 percent.¹ With this proposal, the Superior Court of California, County of Alameda seeks funding to enhance and expand the program and to add a second service site.

Alameda County, California comprises a highly diverse population of 1.51 million residents. It is an urban county, and an estimated 19.8% of Alameda County residents live below the poverty line.² The racial makeup of Alameda County according to the most recent census, is 34% White/non-Hispanic, 26% Asian, 22% Hispanic, 13% Black, and 5% Mixed/Other.

The geographic focus of the expansion is both Hayward, and Oakland, California. The City of Oakland bears the greatest burden of drug use and poor health outcomes in the County with historically high rates of substance use, poverty, health disparities, and correlating challenges to family reunification. Oakland has the highest rate of child abuse, teen births, and alcohol and other drug-related hospitalizations.³ While Oakland is a city with a high level of need, it is also vibrant, with strong faith-based communities and cultural, educational and vocational opportunities for our families who have the supports to succeed.

Table 1 provides demographic information on children in our target service sites of Oakland and Hayward. Hayward (population 140,030) has 21,744 children in public schools, Oakland (population 399,484) has 46,586 in public schools, and the entire County (population 1.51 million residents), is home to 216,199 public school children. Hayward is located in the South/Central part of the county and Oakland is in North County.

TABLE 1.—*Public School Children by Ethnicity, Language, and Free Lunch Participation*⁴

Public School Children	White/Caucasian	Hispanic/Latino	African American	Asian/Pacific Islanders	Multi-racial	English Learners	Free Lunch Participants
Hayward	8 %	57 %	15 %	19 %	1 %	34 %	53 %
Oakland	6 %	37 %	35 %	16 %	6 %	30 %	64 %
All County	23 %	31 %	14%	28 %	4 %	22 %	28 %

History of the “Parents’ Project”: In response to an alarming increase in the number of children in foster care, accompanied by an unacceptably low family reunification rate, Alameda County agencies convened in 2005 to develop a Systems Improvement Plan. The Alameda County Social

Services Agency and its Children and Family Services Division (“CFS”) identified a high rate of untreated parental substance use in the child custody population, and joined with the Superior Court of California, County of Alameda to implement a Family Drug Court Pilot Project, which came to be known as the “Parents’ Project” operated from the Hayward Hall of Justice. The Court’s office of Collaborative Court Services applied to the state Administrative Office of the Courts (“AOC”)⁵ and was awarded funding of \$32,000 per year, beginning in July 2006. This annual funding stream currently provides the financial resources to pay for a part-time (.5 FTE) Parent’s Project Recovery Specialist (“RS”), and with community support, the project has been able to serve approximately 23 families a year.

The project has produced 6 years of encouraging results in the court of Judge [REDACTED] and after his retirement in 2010, it has continued under Judge [REDACTED]. There are four dependency calendars a week in Alameda County (two in Hayward, and two in Oakland), and Judge [REDACTED] Oakland Juvenile Dependency Court judge, has been eager to begin services to Oakland. Courtroom space, on site drug testing services, and support systems are in place. However, expansion will not take place without financial and technical assistance.

One hundred twenty (120) families entered the program between July 1, 2006 and March 31, 2012; 10 parents are currently in the program, and of 110 participants who exited, 54 (49%) were reunited with their children. At entry, 53% of parents had a concurrent criminal charge and only 23% of parents were employed, all were low or very low income. Participants were primarily female (78%), but 22% were fathers; 43% of participants were white/non-Hispanic, 27% Hispanic, 23% African American, and 7% identified as Asian American, Native American, Pacific Islander, Mixed Race, or other. The Project also assisted 260 children; 26% of participating parents had a child under a year old.⁶ The demographic in the Oakland court is somewhat different: Oakland has far a larger African American population, and parents with a higher number of concurrent charges, longer criminal histories, and a higher level of need for referrals to ancillary services. *Drugs of choice* in the history of our project range from single usage to polysubstance abuse: methamphetamine use (64%), crack/cocaine (4%), Heroin (4%), THC (8%) and alcohol (20%) are the most common. Polysubstance abuse is typical, as are participants presenting with a high level of severity. In Oakland we see a higher level of crack/cocaine usage, and a lower level of methamphetamine use.

Treatment Resources are needed: Alameda County investigates over 10,000 reports of child abuse and neglect every year, and last year CFS brought approximately 1,400 cases to Juvenile Dependency Courts; 860 of these cases were substantiated, and 613 children entered the system.⁷ Current research predicts that more than 60% of substantiated cases involve parental substance use⁸, which could mean that over 500 of our county-wide cases would benefit from parental substance abuse treatment and judicial intervention.

There are a number of reasons why substance abusing parents are currently not getting placed in treatment. The Substance Abuse and Mental Health Agency estimated in a 2010 survey that 9.1 percent of Americans aged 12 or older need specialized treatment for a substance use disorder, but only 11.2 percent of those receive it. Of those who need treatment but do not access it, only 5

percent believe that they need treatment.⁹ Interventions (like the Family Drug Court model) can help motivate parents who need treatment to overcome resistance.

Prompt placement in treatment is critical to success. If families encounter a long wait time, the intervention can fail. Moreover, under the Federal Adoption and Safe Families Act, our eligible parents have limited time to comply with reunification requirements, which include demonstrating recovery from addiction. In our target population, the problem is exacerbated by a lack of access: our parents who are amenable to treatment rarely have private insurance coverage in place for self-pay, and local treatment providers have long waiting lists for publicly-funded placements. Without funding for treatment slots, placement can be delayed. The Parents' Project has operated since 2006 in a quasi-drug court model, *without* funding in place to pay treatment providers for services, relying on the good will of area substance abuse treatment providers to offer placements. Dedicated Court staff contact providers to ask for slots and work to piece together services, but there may be a wait. To expand and become a fully functioning Family Drug Court, funding is needed to secure access to substance abuse and co-occurring treatment slots.

Reunification efforts are important as studies show improvements in child development, education levels, and health of the children is more likely in re-unified families. Durability is important, and our project data suggests a durability of outcomes in the pilot; follow up at year 4 found all first- and second-year completers remained reunified with their families. Alameda County **re-entry rates** into the foster care system are high (20.7%; well above the national median of 15.0%). This may be linked to addiction and parents' lack of access to the appropriate levels of treatment. According to CFS, "the devastating effect of multiple removals on the emotional well-being of children requires urgent attention to resolve the causes of re-entry" and has set a goal to reduce *re-entry* into the system down to 5 percent within the next 5 years. We also want to reduce the number of children who remain in out-of-home care, and we want children to stay local during the reunification process. The high cost of housing in Alameda County (across the Bay Bridge from San Francisco), and low reimbursement rates to foster families¹⁰ means that foster homes are in short supply: only 45.6% of Alameda County's wards last year were placed in county.¹¹ Fortunately, with the CFS initiative that began in 2005, the number of Alameda County children living in out of home care has dropped from a high of over 5,000 children in 2000 to 2,797 in 2005, and now to only 1,481 at the close of 2011.

With this proposal, the Court seeks funding to expand services in order to provide 60 additional parents per year with access to Substance Abuse and Co-occurring Disorder Treatment in a culturally competent, trauma informed system. Court personnel have conducted an assessment that indicates SAMHSA funding can provide services to an additional 60 parents a year, increasing participation from 23 to 83 families. Funds will be used to provide services to approximately 35 families per year in Hayward and 48 per year in Oakland (a combined total of 83 families). Treatment providers in the county confirm that they can create additional treatment slots, if funds are available. As described in this proposal, computer systems to capture data required for the Performance Measures are operational and in place, Drug testing is in place, and the team is prepared to expand.

Addressing Physical Health, HIV/AIDS, Tobacco Use, and Medications: Our Family Drug Court enforcement project will be implemented in collaboration with the county Department of Public Health. The Alameda County Office of Aids Administration has an initiative (aligned with the National HIV/AIDS Strategy and the Affordable Care Act) to increase the number of residents who know their HIV status. This Office provides technical assistance and connections to care for HIV+ individuals; an experienced provider will be brought in to deliver HIV Rapid Testing. California has the second highest HIV/AIDS incidence rate in the United States after New York, and Alameda County is in the top 10 counties in the state. In a county racial comparison, Blacks were 1.7 times more likely and Hispanics 1.4 times more likely to test HIV-positive than non-Hispanic Whites.¹² The majority of our target population comes from communities of color; the incidence of HIV/AIDS is also higher in the IDU (intravenous drug using) and in the formerly incarcerated populations. Early intervention and referrals to care, as well as education for prevention, are important improvements we can make in health care.

Tobacco Cessation is another important area where participants can be connected to improved health outcomes. The evidence in the literature indicates that tobacco use is associated with worsened substance abuse treatment outcomes, with increased depressive and suicidal risk behavior, and is a leading cause of death in patients with psychiatric illness and addictive disorders.¹³ Tobacco Cessation Facilitator training is offered by the local chapter of the American Cancer Society, and group classes led by certified Smoking Cessation counselors are offered by the BHCS Provider Network. The prevalence of tobacco use in our target population is estimated to be 32%; county-wide it is 10.5%.

Health Insurance and Third Party Reimbursement will be used to help the court expand services and to offset the cost of expansion. In California, the federal Affordable Care Act (ACA) has opened multiple policy windows. Specifically, the affirmative inclusion of Substance Use Disorder services as an essential health benefit speaks to the value of these services in achieving general health and wellness. According to the National Association of Drug Court Professionals¹⁴, the ACA “will have significant implications for the addiction treatment system, including for drug courts, and it is important for drug courts to be prepared for the opportunities and challenges presented by health reform.” The work of implementing the ACA, in process in California and Alameda County at this time, has already begun to improve delivery systems and payment structures.¹⁵

The County of Alameda has an initiative of outreach and advocacy for its new public health insurance plan, HealthPAC. HealthPAC is designed to deliver free and affordable health care to low-income residents who are not eligible for, or enrolled in, Medi-Cal (California’s Medicaid) or Medicare. Medication prescribed for the treatment of mental and physical health conditions that are prevalent in our target population can be costly. HealthPAC includes coverage for pharmacy and prescriptions, and Alameda County offers a free discount prescription card. BHCS offers enrollment trainings for providers, and the application process is relatively straight forward. Recovery Specialists will be trained to assist participants in filling out the paperwork and submitting it to the county. If there are difficulties, the Homeless Action Center (HAC) and Bay Area Legal Aid are nonprofits on contract with the Collaborative Court Services Office to provide additional legal and

administrative assistance with benefits. With insurance in place, Third Party Revenue will be used to offset the cost of any billable services, such as primary care visits, mental health therapy sessions, psychiatric visits, medication, and we hope eventually (when the key elements of the ACA are fully implemented in California¹⁶) substance abuse treatment. The court contracts administrator and finance departments will work with BHCS and community based agencies to track revenue realized through reimbursements.

HealthPAC insurance provides access to a number of clinics, including LifeLong Medical Care and Tri-City Medical Care. These two Federally Qualified Health Centers (FQHC's) are also working with BHCS on primary care and behavioral health care integration. LifeLong Medical was recently selected to receive a Center for Medicare and Medicaid CMS Health Care Innovation award from the federal department of Health and Human Services. Tri-City has served the community for over 40 years, and is developing a patient-centered health home model for a collaborative team model of managing care. Both providers have a patient-majority governing board, a core statutory requirement for the FQHC federal funding. Alameda County Behavioral Health Care Services (BHCS) is a SAMHSA "Primary and Behavioral Care Integration (PBHCI)" grantee and a Drug Court partner, and has county-wide initiatives with these and other clinics to place primary care providers in behavioral health care centers. This is a welcome addition to expand access to treatment to participating families.

Section B: Proposed Evidence-Based Service/Practice

The Parents' Project has identified the following goals for this enhancement project:

Goal 1: To decrease the incidence of child abuse and neglect in Alameda County by reducing family risk factors and the likelihood of negative outcomes for children by addressing the substance use of parents. *Substance Abuse Disorder too frequently leads to or exacerbates the abuse and neglect of children, and as the victims of abuse are susceptible to the Disorder themselves they mature.*¹⁷

Goal 2: To improve the health of our families who are involved in dependency proceedings by providing access to culturally competent, trauma-informed, co-occurring enhanced services to drug-involved parents and their children.

Goal 3: To increase public safety and reduce the harm and cost of untreated substance abuse to our community by working to help reduce the incidence of illicit drug use and child protection offenses in our population.

Objectives for enhancements to the program included in this proposal are:

1a. To improve collaboration and strengthen the Family Drug Court team by utilizing all of the ten Key Components of Drug Courts; specifically to include a representative from Children and Family Services and a representative from the District Attorney's Office in weekly case conferences led by the Family Drug Court Judge.

1b. To create a system so that **all** parents involved in dependency court proceedings in the county are screened for substance abuse and co-occurring mental health concerns for *early identification and response* to the problem of parental drug use.

2a. To **increase the number of referrals** to the Parents' Project from the population of approximately 860 parents involved each year in all dependency court proceedings and place 60 *more* families a year who are eligible for reunification in high quality treatment.

2b. To maintain the high levels of *substance abuse treatment retention and completion rates* by working with service providers in a trauma-informed system and to achieve a **target 50 percent or better** reunification rate for participating families and a **lower re-entry rate** of families returning to dependency court and the foster care system.

3a. To provide a schedule of professional training and cross-training opportunities for the team and stakeholders to *enhance collaboration* across agencies and systems.

3b. To provide outreach and advocacy to heighten awareness of Family Drug Court programs and their success, and promote long term sustainability.

Additional measures include improved housing and employment status: 60% of clients will find safe and improved housing as a result of their program involvement, and 60% of clients will find employment, will enroll in training or educational programs that provide job search assistance, or will find meaningful volunteer work (for those who are disabled and cannot work). Improved Physical Health: As a result of improved access to primary and specialty medical care services, 60% of participants with negative health concerns, i.e. metabolic syndrome, diabetes, hypertension, obesity, will report improvement in these measures.

Drug Courts is an Evidence Based Program: Six meta-analyses concluded that Drug Courts significantly reduced crime, and recidivism rates for participants were determined to be, on average, 8 to 26 percentage points lower than for any other justice response. The best Drug Courts reduced crime by as much as 45 percent over other dispositions and reductions were shown to be durable.¹⁸ The Office of Collaborative Court Services is planning a process evaluation of its problem solving courts, based on the "Eight Evidence Based Principals for Effective Interventions" (Center for Effective Public Policy, 2010)¹⁹ and the "Fundamental Principals of Evidence-Based Correctional Practice" recommended by the Bureau of Justice Assistance. The process evaluation will be facilitated by the Evaluation Coordinator, Faith Fuller with assistance from faculty and students at the University of California, Berkeley School of Public Health.

Evidence-Based Programmatic Components for Co-occurring treatment: East Bay Community Recovery Project (EBCRP) in Oakland has been selected as the community based provider to partner on this project. EBCRP is one of the largest and most comprehensive addiction treatment

programs in Alameda County, providing services to persons with substance abuse and other mental disorders since 1989. In California, the requirement to have addiction counselors certified as Registered Recovery workers, working toward their licensure or enrolled in school, encouraged centers in the state to step up staff training. EBCRP's Executive Director implemented weekly onsite training for all staff over a decade ago, with help from federal grants.²⁰ The evidence-based treatment models proposed for our target population by EBCRP is Motivational Interviewing, Integrated Dual Diagnosis Treatment, Celebrating Families, and Seeking Safety. The Evidence-Based Practices/Services chosen for this project were selected because they are a strong fit with the philosophy and planned service matrix.

Motivational Interviewing (MI)/Stages of Change are useful throughout the system of care, and is perhaps the most important change being implemented by state and local correctional agencies in California. **MI** employs extensive motivational strategies and early support to help participants recognize the value of goals that they help set; goals that are developed with the help of questions to resolve ambivalence around change. Recognition of the Stages of Change is built into these early contacts, so that planning begins at the appropriate level.²¹ Many Drug Court participants are initially resistant to entering MH therapy (for example a MH diagnosis in the prison system carries a stigma with peers) so the team will use training in motivational interviewing /motivational enhancement therapy to break down barriers.

Motivational Interviewing/Stages of Change (MI/SOC) was chosen because many of the issues addressed by the Drug Court are lifestyle-related – use and abuse of tobacco, alcohol and other drugs; poor nutrition; lack of exercise – and recovery requires self-directed, sustained behavioral change. MI/SOC are interconnected concepts that have shown to be effective with those with co-occurring mental health/substance abuse disorders, as well as those with primary medical conditions requiring lifestyle change. MI works by activating clients' own motivation for change and adherence to treatment. Patients exposed to MI, as opposed to those exposed only to intervention-focused approaches, have been found in various clinical trials to be “more likely to enter, stay in and complete treatment, to participate in follow-up visits” and to adhere to numerous other health regimens (Rollnick, S., Miller, W., Butler, C., 2008)²². Motivational interviewing has been effective in improving general health status or well-being, promoting physical activity, improving nutritional habits, encouraging medication adherence, and managing mental illness and chronic conditions, such hypertension, hypercholesterolemia, obesity, and diabetes. Motivational interviewing has been efficacious at low doses (2-3 sessions), and applicable in a wide range of situations for diverse populations²³.

Stages of Change is used to assess a client at a particular point in time, to offer a response that will be appropriate for the stage of change that the client is in. For example, it does little good to try to engage a client in discussion of how to avoid taking a drink before they can see that alcohol is a problem. Change is dynamic, and can be impacted by the relationship with a peer, a sponsor, a counselor, or any of the Drug Court team members. Stages of Change informs MI, which requires constant attunement on the part of the counselor to where their client is on that continuum, from

pre-contemplation (denial of the existence of a problem) to maintenance (ongoing activities whose purpose is to sustain change that the client desires and has initiated).

According to Kathryn Tomlin in “Motivational Interviewing and Stages of Change,” MI can be “contextualized” and specific techniques developed that can make MI relevant to a wide variety of cultural groups (Tomlin, Richardson, 2007) and modifications will be made to address the needs of diverse ethnic communities. Tools described by the authors as “Working through Cultural Discrepancies” and “Developing a Positive Cultural Identity” have been effective in forming the therapeutic alliance with culturally-diverse clients in helping them rectify discrepancies with the dominant culture. Adults can experience high levels of psychosocial stress as a result of being marginalized, having limited access to resources, economic and other exploitation, and stigmatization. Dislocation from one’s culture and family can result in feelings of decreased self-efficacy, alienation, and isolation; immigrant populations also suffer from a disproportionate lack of access to high-quality, culturally and linguistically competent mental health care (Alameda County, 2008). MI has also been used successfully to encourage incarcerated Veterans to access substance abuse treatment (Davis, T.M, et al, 2003). Underserved members of an African American community were successfully connected to substance abuse services using MI and dyadic techniques in which communalism and group processes were emphasized (Longshore, D., et al, 1999). A promising study with black churches showed an MI group improving dietary behavior (Resnicow, K., et al 2001).

The primary motivation to address a substance abuse problem is a desire to maintain access to one’s children. The team will use training in MI/SOC to help parents overcome resistance to entering treatment. Our experience is that motivation is strongest at the point of parent/child separation, and it is important to expedite the process of enrolling parents in appropriate treatment modalities when they are in agreement.²⁴ An analysis of retention indicates that clients are most vulnerable to relapse (and dropping out of treatment) in the first 30 days. The RS will try to make a residential treatment placement, if indicated, and/or employ a strategy of frequent contact during this period, with phone calls, meetings, and activities to help them stay engaged. *Strategies* that have been used to improve retention and engagement include the use of **strength based** approaches. Relationships developed between the RS and the participants, and between the Judge and the participants play a key role in engagement and retention, according to surveys of successful completers.

██████████ also uses components of **Integrated Dual Diagnosis Treatment**: (IDDT) is a model of case management services for individuals with severe persistent mental illness and a substance abuse diagnosis. IDDT teaches skills to promote abstinence and expand an individual’s ability to be responsible and productive. The goal is to reduce hospitalizations, incarcerations, and detox admissions. ██████████ uses the IDDT Toolkit, *Integrated Treatment for Co-Occurring Disorders: Evidence Based Practices* as a guideline.

Celebrating Families will be delivered to participants by ██████████ to foster safe, healthy and addiction-free families by increasing resiliency factors, decreasing risk factors, and incorporating

recovery concepts with healthy family living skills. The program supports breaking the cycle of inter-generational substance abuse and increasing family reunification. Feedback from EBCRP clients and their families rank Celebrating Families as relevant, helpful, and positive in its effects.

Effectiveness with population of focus [REDACTED] using these EBPs in existing programs. Staff and clients rated them as relevant, and retention in treatment data attests to their effectiveness. GPRA data outcomes from prior SAMHSA reporting of [REDACTED] programs have shown that these EBPs have contributed to significant positive changes in the population of focus, including: reduced drug use, increased social integration, and improvements in family functioning.

Modifications to the manualized versions of these Evidence Based Practices have been made. They are primarily to increase flexibility in delivery: offering make-up sessions and permitting changes in the order of sessions to allow clients to address what is important to them at the time, and receive the maximum dose of the intervention. The above therapies were chosen by EBCRP over others because they address the attitudes and behaviors targeted to change, and have been studied for effectiveness in population groups similar to our target group.

To develop and implement a trauma-informed system, the Family Drug Court team and evaluators have contacted the SAMHSA-funded Technical Assistance for trauma informed care, and is in the process of submitting an application for Technical Assistance.

In addition to the EBP's that are in place [REDACTED] evidence-based therapy for trauma treatment will be added with this enhancement. With men and women in the military returning from combat, and some of them finding their way into Family Drug Court, the awareness of trauma and the treatment of trauma is something that the Judge wants to address. The team also reports that, anecdotally, the majority of referrals to the court program have experienced violent and traumatic events (gunshot wounds, homelessness, assault, or even incarceration) which can cause Post Traumatic Stress Disorder (PTSD) and symptoms of anxiety. Finding effective treatments for trauma is expected to lower relapse rates and help meet goals for program retention and completion.

Seeking Safety is an evidence-based, present-focused therapy for trauma/PTSD and substance abuse. The treatment is designed for flexible use in group and individual formats, for women, men, and mixed-gender groups, in a variety of settings (outpatient, inpatient, or residential), integrated with substance abuse treatment, with people who have a trauma history, or who meet the criteria for post-traumatic stress disorder (PTSD).

The Family Drug Court will deploy a licensed therapist specializing in **EMDR**, a one-on-one form of psychotherapy that has been shown to reduce trauma related stress, anxiety, and depression symptoms associated with PTSD. EMDR has been proven its effectiveness with Vietnam War Veterans, rape victims, and clients with psychological distress. An advantage of EMDR therapy is that it is delivered in 1 to 3 sessions. When the trauma involves repeated traumatic events, such as combat trauma and repeated physical, sexual, or emotional abuse, additional sessions may be provided. The treatment effectiveness of EMDR on our population will be documented to provide

data to the body of research that exists. With SAMHSA funding, the EBCRP Evaluation department, the Court Evaluation Coordinator, with team support, will be implementing program improvements, and will focus on documenting any modifications while maintaining fidelity to the EBP's.

Diversity of the Client Population

EBP's can be modified to address demographics—race, ethnicity, religion, gender, age, geography, and socioeconomic status; language and literacy; sexual identity, gender identity; and disability. The RS and the Public Defender are bi-lingual. Based on the language, beliefs, norms, values, and socioeconomic factors of the population of focus, the proposed EBP's can be tailored to support effective outreach, engagement, and delivery of services to our identified population.

Language: Services are available in a variety of languages representing the diverse populations of Alameda County. [REDACTED] translators are available to help clients and families who are monolingual or only marginally bilingual, and whose primary language is: Spanish, Russian, Tagalog (Filipino Community), Vietnamese, Cambodian, Laotian, Mong, Somalian, Ethiopian, American Sign Language, Italian, Portuguese or Polish. The Project will take into consideration the diversity of languages in the County, and will translate its educational programs and materials as needed.

Race, Ethnicity, Religion: The broad range of community-based partner agencies represent the distinct ethnic, racial and religious communities of Alameda County, and provide services in a culturally-relevant context that acknowledges the differing views and perceptions of physical and mental health and substance abuse. The professional teams of mental health specialists represent the diversity in Alameda County.

Disability: Drug Court programs and services are accessible to people with physical, mobility, sensory or cognitive disabilities as per the Americans with Disabilities Act and the licensing and certification requirements of the state. [REDACTED] as a designated Disability Access Coordinator whose job is to receive requests for accommodation, inquiries about services and complaints in the case of a consumer who feels that they have been discriminated against based on their disability.

Gender and Sexual Identity: The court hiring policies reflect the diversity of the county's population. In addition, our community based providers work with the Gay and Lesbian Medical Association (GLMA) and other LGBT advocacy groups to assure that services are presented in a non-discriminatory way to members of the LGBT community, which is the 3rd largest in California. Tri-City Health Center began as a women's program and continues to provide comprehensive women centered care.

Veterans: The Collaborative Courts Services Office recently worked with a veteran's group to ascertain the number of Drug Court participants who have served in the military. This data will be used to identify special services that exist in the community for veterans; the team is interested in connecting to a strong advocacy group from nonprofit community based agencies in the Bay Area and representatives from the Veteran's Association.

Racial Disparities: African Americans are disproportionately represented in our child welfare and our criminal justice system; making up 48% of our entries into the CFS system, but representing under 13% of the county’s population. Moreover, across several prevalence indicators it appears that African Americans do not use alcohol and other drugs at levels any higher than other groups. Awareness of this disparity will lay the groundwork for efforts for change. In 2011, the Alameda County Behavioral Health Care Services Agency Cultural Competency Committee completed a Utilization Study Project to address the behavioral health care needs of the African American Community and found that some African American children and youth may be inappropriately diagnosed with serious emotional disturbance and serious mental illness.²⁵ African American children are over-represented in the county’s Child Welfare system, and raising awareness of their needs can help reduce racial and ethnic disparities.

Table II: Child Welfare Disparities, Alameda County, 2011²⁶

Children ages 0 – 17 Alameda County	All Ethnicities	African American	%	Disparity Indices compared to white
Number of Children	340,621	40,932	13%	N/A
Allegations	10,987	3,897	37%	3.3
Substantiated	860	357	42%	3.5
Entries	613	294	48%	3.7
In Care	1481	865	58%	4.5

In addition, misdiagnoses of mental health may be made when children exhibit “problem” behaviors and educators or providers lack the understanding of the cultural context, the root cause, and contributing factors such as trauma. Also, our target population of families may also suffer poor physical health outcomes, and the causes are complex: an in-depth study conducted by the Bay Area Regional Health Inequities Initiative (www.barhii.org) highlights the disparities in access to physical health care for the African American and Hispanic populations, and for those who live in certain neighborhoods. For example, people who live in West Oakland can expect to live on average 10 years less than those who live in the Berkeley Hills. An organizational Self-Assessment toolkit published by BARHII will be used as a resource to establish a baseline measure of capacity, skills, and areas for improvement to support health equity-focused activities and will be incorporated into the planning process for project implementation.

Section C. Proposed Implementation Approach

The mission of the Parents’ Project is to provide timely assessment, referral, and supportive treatment services to parents whose substance abuse is a major factor leading to dependency

proceedings. *The targeted capacity* of the Hayward site (35 families) and the proposed Oakland site (48 families) was arrived at after review of the volume of cases processed by all dependency court Judges, and an analysis of the case management capacity when adding a full time Recovery Specialist (RS) to the existing team.

The Family Drug Court Team		Level of Effort
Judges (Oakland and Hayward)	[REDACTED]	0.4 FTE +
[REDACTED]	[REDACTED]	0.2 FTE +
Service Coordinators/Recovery Specialists	[REDACTED]	1.5 FTE
Mental Health Clinician	(on contract)	.30 FTE
Case Worker from CFS	(currently support team/proposal is to include in weekly conferences)	.30 FTE
Collaborative Court Division Chief	[REDACTED]	.10 FTE
Team Support/Services		
Grants Administrator, Dept. Supervisor, Legal Processing Asst.	[REDACTED]	
Evaluation Coordinator	[REDACTED]	
District Attorney's Office	(team support, proposed)	
Community Based Treatment Providers [REDACTED]	(treatment, direct services, training, proposed)	

Key activities to support the goals and objectives of the project include:

1) The collaborating agencies will participate in implementing a system that will ensure that all parents involved in dependency proceedings are screened for substance use. Parents are assessed by CFS with the SDM (Structured Decision Making instrument), an evidence based practice which provides a suite of assessment instruments to ascertain a child's safety. While this is in place at CFS, and the Recovery Specialist can access the database remotely, an RS needs to be available to provide the information to the Judge, and to re-screen as directed by the Judge at court. The court has identified re-screening dependency court parents for substance use as an enhancement objective, because a screen by the RS can help bring forth valuable information and speed up the process of placement in treatment. The plan proposed is to have an RS co-located in for all four calendars, available to the Dependency Judges to screen or to re-screen parents, as a supplement to the CFS documentation.

2) Representatives from community based treatment (residential, outpatient, pre- and perinatal, mental health) will be included in a Stakeholder Committee charged with developing a schedule of training to create a trauma-informed system through technical assistance and cross-training. *Parents whose patterns of Substance Abuse are fracturing their families often need trauma-informed, co-occurring enhanced treatment if they are to reunite healthfully with their children.* An inclusive approach means meaningful partnerships will be strengthened and communication improved across systems.

3) These relationships and outreach will help inform and educate CFS caseworkers, attorneys, and residents and increase the number of referrals to assessments and treatment. CFS will assign a CFS caseworker to serve as a liaison and to attend Family Drug Court weekly case conferences.

4) Culturally competent behavioral health care services will be provided for children, with clarifying mental health assessments for children with a behavioral health diagnosis, and vertical case management. Our objective is to help ensure that the diagnoses of all children who have experienced trauma are accurate and unbiased. Therefore referrals will be made for *Clarifying Assessments* by East Bay Community Recovery Project (EBCRP, a contracted provider) or to a CFS selected provider. When needed, the Recovery Specialist will assist the family in securing health insurance.

5) Participants and their families will have improved access to services with an increased number of available treatment slots. Community based nonprofit treatment providers will be able to contribute the staff time needed to attend court, to prepare comprehensive reports, and to participate in meetings and case conferences. We know that the demand for available treatment slots may escalate as California goes through “Realignment.”

The Office of Collaborative Court Services has in depth experience utilizing the ten “Drug Court principles” where both the participants and the system are accountable for compliance, recovery, and success. The Family Drug Court model adds a shared value, for the health and welfare of the entire family. Our objective is to enhance the Parent’s Project so that it becomes a true team effort, building the family drug court team to include a dedicated attorney to participate in the weekly case conferences, and a Case Worker liaison from Children and Family Services.

#1 Integrate treatment with judicial processing

When CFS receives an allegation of child abuse or neglect, the agency assigns a Detention Investigator (DI) to conduct interviews and assess the safety of the child. If the case goes to a hearing and the Dependency Court Judge finds that the allegations are substantiated, the child is removed from the home. Our program utilizes an integrated court model, with the Judge overseeing the weekly Juvenile calendar also overseeing the Parents’ Project. This *integrated* Family Drug Court model expedites the time to enrollment. The Parents’ Project also combines a pre-adjudication and post-adjudication program structure for entry into the program, to be as inclusive as possible and to work with parents in every stage in the recovery process.

#2 Use a non-adversarial approach

The Parents’ Project has a Collaborative History: The Social Services Agency (CFS) investigates allegations of child abuse, neglect, and/or abandonment and files dependency petitions in cases where court involvement appears warranted. The Office of the County Counsel represents the Social Services Agency in court proceedings. The Public Defender Dependency Unit provides legal representation to minors involved in the proceedings. Members of the Alameda County Bar

Association (ACBA) Civil Court Appointed Attorney Panel (CCAAP) provide legal representation to parents or guardians named as respondents to the petitions. The District Attorney's Office is charged with protecting public safety. All of these agencies will be included in the planning process for expansion of the Parents' Project, to develop a fully operational Family Drug Court at both locations.

#3 Early identification and placement

Eligibility, Engagement, and Screening: Families can be identified and referred to the Parents' Project at any stage of a dependency proceeding, by any of the agencies. Referrals typically take place at the Dispositional Hearing, when the judge reviews the file and the results of the file and believes that substance abuse is an issue. *Eligibility criteria* for the Parent's Project are adult parents or guardians involved in dependency proceedings who are in danger of losing permanent custody of a child (or children) due to behaviors related to alcohol, drug use or co-occurring disorders. Participation is limited to **nonviolent offenders**. Parents will **not be** excluded solely for use of prescribed medications or prescribed methadone treatment.

Phase I/Detention Investigation: The RS has access to the initial case plan developed by the DI, via database access through CFS. At intake, the RS conducts an assessment/interview and helps the parent develop a written plan that outlines the responsibilities and actions to be taken to address *substance use and co-occurring mental health issues*. The parent will then receive a referral to residential or outpatient treatment.

Engagement Strategies: Building trust and eliciting valid information is essential, and using an RS with a strong background in the field is important; during screening the RS will give the parent an overview of the Parents' Project and explain why providing truthful answers is to the benefit of the parent, who may fear punitive action. A clear benefit of having the RS (an experienced Substance Abuse Treatment Specialist) on staff at the court means that his/her work is fully integrated into the work of the Collaborative Court Services Office, he/she has access to case files and court resources (this includes Drug Testing services on site at the Oakland courthouse and a peer network of collaborative court case management staff). Enrollment of dependency court parents who present with substance use disorders (documented by police reports, criminal records, and/or petitions) will be encouraged until it is accomplished; though most, who do enroll, do so at the initial hearing.

Assessment: By assessing the unique recovery and trauma challenges for participants and their families, services can be selected that increase the chance for successful reunification and reintegration into the community. The RS currently assigned to the Parents' Project is working at a level of effort of .5 FTE and carries a caseload of 10 to 15 parents. The RS currently attends Judge Roger's Dispositional Hearings in Hayward to be available for parent referrals before or after they appear before the Judge. He/she sets up appointments for an assessment, and conducts a clinical review of the file: the substance abuse history, the mental health history, the CFS assessment of the situation, and any criminal history. The assessment interview includes a completion of the following forms: Client Intake, Consent for Disclosure of Confidential Information, Assessment and Referral

forms, and a Participant Agreement/Family Drug Court Treatment Contract. The Parents' Project uses the Addiction Severity Index (ASI Lite) to help determine the level of severity of addiction and suggests an appropriate placement (residential, outpatient, other treatment modality). The ASI covers seven potential problem areas: medical, employment/support status, alcohol, drug, legal, family/social, and psychiatric. The results also inform the process of identifying *specific* services that will best support compliance. The interview process helps educate the parent about substance abuse, mental health, and the availability of treatment to address behavioral issues.

[REDACTED] is promoting and training providers to use the ASAM PPC 2R,²⁷ to ascertain the level of treatment needed, which will be implemented later this year. Studies suggest that matching participants with the appropriate level of treatment can lower recidivism by 30%, whereas matching with the wrong level of treatment may be ineffective,²⁸ so careful consideration has been given to the selection of the tool. BHCS will also train the staff in the use of the PH-9, a short depression screen. A screen for trauma has yet to be selected, pending the application for technical assistance that has been submitted and the development of the plan for referrals to treatment.

#4 Provide access to services

The RS recommends a treatment modality, and calls various treatment centers to try to arrange a placement once CFS, the Judge, and attorneys concur. Parent participation is voluntary, and the parent signs a written agreement to affirm a commitment to recovery. The RS monitors the parent through ongoing contact (once a week or more), collects data for the performance measurement, maintains communication with both the CFS case worker and the treatment provider, and prepares weekly progress reports that incorporate attendance reports from the treatment provider.

Phase II/Family Reunification: Child(ren) eligible for CFS "reunification services" are given a treatment plan developed by a Family Reunification (FR) case worker assigned by CFS to the case. The plan is designed to stabilize and enhance each child's ability to succeed. Concurrently, the FR develops a Parenting Plan with the goal of reunification and shares it with the court. The parent appears in court once a month (or as instructed), and the treatment providers are asked submit progress reports on the parent's efforts. The RS meets with the parent outside of the courtroom for ongoing assessment of the parent's needs. When all components of treatment, and all required parenting classes are completed, the parent attends a hearing where the judge determines whether it is appropriate to be reunified with the children. With a positive determination, the parent graduates. Although each case is unique, the criteria for program graduation are likely to include: Remaining clean and sober; Fulfilling all drug testing requirements; Attending required appointments, meetings, and treatment sessions; Complying with court orders and not breaking the law; Becoming employed or positively moving towards educational/vocational goals; Fulfillment of any additional specific goals of the individualized treatment plan. Program Duration varies with each case – the amount of time a parent spends in Phase I and II of the program (from placement to graduation) is determined by the unique circumstances of each case and the progress made in the individualized

plan, but typically last six (6) months. Treatment completion is generally followed by 6 months of Aftercare. The average length of time between program entry and program exit to date has been 248 days (approximately 8 months). If a parent has a drug relapse, and is motivated to come back and try again, the process is generally extended with permission of the Judge. Treatment is delivered in three Phases, supervised by the Family Drug Court Team.

Phase III/Family Maintenance: Program graduates are encouraged to continue attending 12-step meetings and any after care programs offered by the treatment providers. Most of our participants present with severe levels of addiction, and relapse may be a part of the process. Parents are encouraged to stay in treatment, and are often allowed to return to Phase II to try again if they do not succeed. The length of stay in treatment is important to sustained recovery and permanency outcomes.²⁹ During Phase III, participants are now in the Family Maintenance (FM) phase of CFS proceedings, living with their children, and are assigned to a FM case worker.

Services for Parents: If funded, expanded services will include prompt access to licensed and certified residential treatment for adults, residential treatment for mothers with children, residential for fathers with children, and outpatient treatment. Parenting Classes, Anger Management, Life Skills classes, and Domestic Violence classes may be a part of the treatment case plan, and access will be greatly improved if additional case management is funded. The Alameda County District Attorney has a zero tolerance policy for domestic violence, and classes are required of any parent with DV charges: our participants who do not have the ability to pay will receive financial assistance with access. Many of the parents we meet are survivors of abuse, a predictor of a wide range of problems, including domestic violence, lower self-esteem, victimization, depression, and chronic homelessness.³⁰ The objective of creating a “trauma-informed” system with referrals to mental health care is to address the prevalence of trauma we have seen in our target population and help parents who may “self-medicate”: drink or use drugs to escape the unresolved trauma of the maltreatment.³¹ *Trauma can follow exposure to violence or abuse.* Women with histories of childhood physical or sexual abuse are nearly five times more likely to abuse illicit street drugs and more than twice as likely to abuse alcohol as women who were not mistreated as children.³²

Ancillary Wrap Around Services: The RS is trained to address variations in individual needs and can make referrals to specialized treatment or educational groups, specialized mental health treatment, individual and family counseling, educational/vocational counseling, volunteer work or community service, access to food, clothing, child care, benefits, housing, employment, and support groups. Court staff maintain a detailed “Drug Court Services Event Calendar” online³³ and in printed handouts for participants, listing free educational and support groups in the community: Brother’s Connection, Bipolar Support, Fatherhood, Women with HIV, AA and NA; these can strengthen relationships and leverage limited resources. *Services are Available through CFS referrals* but participants will benefit from encouragement from the RS to participate. For example, a new parent engagement program is starting at the nonprofit “A Better Way” under contract with CFS. They offer CHAT (Communicating History and Transitions) where birth parents and foster parents can exchange information regarding the children. A Leadership Team of parents who have

successfully navigated the Child Welfare System are recruited as Parent Advocates. A Team Decision Making (TDM) program can bring families, case workers and others involved together when there is a crisis or a decision to be made. With an understanding that these programs are available, the RS can help parents connect with services.

Services for Children: We are seeking to address the risk of intergenerational substance abuse and to help reduce disparities. Children of substance using parents may experience physical, intellectual, social, and emotional problems, many of which might not emerge until later in their lives.³⁴ Children in our new target population (our Oakland site will focus on children from high-crime neighborhoods in West and East Oakland) have frequently been exposed to gun violence and gang activity. *Children's Services are available through CFS:* An objective is to reduce ad-hoc and piecemeal services so that children will not encounter a high turnover in public service workers. Developing relationships of trust is often difficult for children in the system, and maintaining caring and consistent relationships is important to the health of the child. Children under 4 can access the CFS "SEED" program, which has sequential case management -- one child welfare worker assigned after the Dispositional Hearing follows the case through dismissal. We will work with CFS to match our children with CASAs (court appointed special advocates) who prepare reports for the judge and advocate for the child throughout the legal process. CASA Alameda County is a partner who can help stabilize and enhance a child's ability to thrive and succeed in the uncertain environment of a dependency proceeding. Many of the children in our population have experienced separation due to their parents' incarceration. Efforts will be made to help the child *maintain* any stable and healthy relationships they have developed with relatives or caregivers. Gang prevention, conflict resolution training, gender-specific programs, recreational and school based programs may be recommended based on the age and identified risk factors. The Child and Adolescent Permanency Support Program in contract with CFS also provides stabilization services to children and their families who are at risk of entering the foster care system. Children will receive educational assessments for developmental delays: testing the child's linguistic, motor, and cognitive processing skills. Adding additional case management support (through the funding of a second RS) will help coordinate care, and help the Parents' Project build multidisciplinary collaboration among agencies, providers, and participating families.

Services for Families: Additional funding for an RS means that extended families can also be linked to services. For example, training for parents, foster parents, relatives, and substitute caregivers is provided by CFS. The RS can help the parent by arranging transportation and scheduling. The RS can help bring in collateral family support, when appropriate, which can provide meaningful assistance to parents in family reunification efforts; families can also attend 12-step meetings (Al-anon or Al-ateen). Referrals to child care, safe housing, public benefits, vocational training, employment, education, and legal services are generally needed by our families. The Court is committed to providing referrals to services that are culturally relevant to parents and children who come from a diverse range of cultural, ethnic, language, racial and faith-based groups. Local community-based providers that are available through the BHCS provider network specialize in services to Asian, Hispanic, and African American populations as well as gender specific programs for men and/or women and LGBT as needed and have demonstrated competence in

providing services to participants with physical disabilities, mental health issues, HIV/AIDS, and specialized services for pregnant or parenting women. “Celebrating Family” is the evidence-based practice used by our provider EBCRP.

#5 Abstinence is monitored

Mandatory Drug Testing and Monitoring is one of the most accurate methods of determining effectiveness of treatment, level of use, and appropriate treatment modality is the use of random and frequent urinalysis testing. Upon acceptance into the project, participants are drug tested at the court location and again at the community based treatment facilities. The results are a baseline in detecting recent drug or alcohol use. The court uses the ReadyTest brand cups with a five panel screening device. The five drugs that are tested for are: amphetamines, opiates, THC, benzodiazepines, and cocaine. The tests provide instant results and positive results are submitted to a toxicology laboratory for additional analysis to confirm the validity of the test and level(s) of drug intoxication. All unexcused failures to test are considered “dirty” which provides an incentive for participants to submit to testing. Positive (dirty) drug tests are reported to the judge, who may decide to impose sanctions. The information gathered from drug testing helps the team gauge treatment needs, sobriety and/or drug use. At a minimum, parents are asked to test monthly in the first six months. Random drug tests are administered by the treatment providers, and reported to the RS.

#7 Ongoing judicial interaction

Judicial Supervision is a critical component of parental accountability. The interaction with the Judge, whose position commands respect, and who has the tools of incentives and sanctions, is an invaluable component of the Drug Court model. Consistent judicial involvement is vital to establishing the principles of accountability and consequences in a Family Drug Court. Drug addiction, substance abuse, and the prevalence of co-occurring mental illness not only contribute to child abuse and neglect; they seriously compromise a parent’s ability to comply with court orders. Research has demonstrated a correlation between the presence of a judicial officer and treatment success.³⁵ The judiciary oversees a collaborative goal to provide a coordinated, strategic response to compliance.

Incentives such as praise and recognition from the judge can reinforce positive behavioral changes. The strongest incentive for participation is that positive performance will result in meaningful steps toward reunification. Incentives take many forms, including a schedule with fewer court appearances, sobriety tokens, or food vouchers. In cases where the parent has a pending charge in another court, successful completion of the program may result in reduction or dismissal of charges, reduced or set aside sentences, lesser penalties, or a combination of these. Most importantly, participants gain the necessary tools to rebuild their lives and help their children and themselves.

Alternatively, **sanctions**, which may include admonishments from the judge, are used to address failures in compliance with the requirements of the court. Sanctions may include increasing the frequency of court hearings, meetings, or drug tests, increasing the duration or intensity of drug treatment, or adding attendance in ancillary services or support groups. Our experience is that program attrition, when it occurs, is most often due to substance use and denial surrounding addiction and/or

resistance to a treatment provider's regulations. If interventions, incentives, and sanctions are not effective, and the judge / case team decides against reunification, the parent is transitioned to a different program. But while reunification is an option, the parent who experiences drug relapse is generally encouraged to come back and try again, and may be placed in a different treatment modality. Dismissal from the program is an available sanction, but is rarely used if the parent demonstrates a willingness to keep trying. Again, the wellbeing of the child(ren) involved is the most critical component in judicial and team decisions. Any questions or issues of concern regarding a child's safety are immediately referred to the appropriate agencies.

#8 Monitoring achievement

Reporting/Information Sharing: The RS works with the treatment provider to ensure that timely and meaningful *progress reports* are provided to the Judge and the attorneys on the participants' status and progress. The Judge reviews the reports and will discuss recommendations with the team. The RS makes contact weekly (by phone with the parent and/or the treatment provider) and reports the following (the desired outcome in parenthesis): Random and scheduled drug tests (all negative); Treatment attendance (no absences); Meetings with the RS (no absences); Support group/12-step (meetings attended); Compliance or non-compliance with treatment provider regulations (full compliance); and Court appearances (no missed court dates). *Dependency Court Hearings* in Alameda County are on a weekly calendar, and the parent participant may be scheduled to make a Parents' Project appearance weekly, and then once a month, or as requested by the family drug court team. Frequency may be decreased for a parent participant who is progressing in recovery and is in compliance with their parenting plan. Any *issues with compliance* are identified and addressed promptly, and failures to attend meetings or hearings are investigated by the RS or other team members. The team's objective is to provide timely support and intervention to assist participating parent(s) who are in danger of falling out of compliance. If the parent relapses or cannot maintain compliance, the team works with the parent to encourage him/her to move to a higher level of treatment.

When **Case Management** responsibilities are shared by the caseworker assigned to the family, the RS, and the treatment provider, collaboration and information sharing is critical. The CFS caseworker is ultimately responsible for managing the family case plan, while the RS focuses on the parent's Substance Abuse and co-occurring Treatment. The ideal caseload for each RS varies with the need level of the participants. To serve 83 parents a year, we anticipate that with attrition, the average caseload of each of our two Recovery Specialists will be 30 families at a time (each RS working .75 FTE).

#9 and #10 Interdisciplinary Education and Partnerships

Staff Training and cross-training will be implemented during expansion of the program and the Court will utilize technical assistance from [REDACTED] via online webinars, on-site consultation, or visiting mentorship courts in California. Representatives of the Parents' Project will attend the Family Drug Courts National Symposium in Anaheim, California in September 2012 in preparation. The team will access support from local networks [REDACTED] Office of Family Relations has a mission to build systems of family support across the community and criminal

justice system. BHCS provides training in best practices such as Educate, Equip and Support (EES), Family to Family, Wellness and Recovery Action Plans (WRAP) and other curriculum, with funding from the California Mental Health Services Act. Our treatment partner EBCRP holds weekly “Training Tuesdays”. Professional development will focus on strategies to recognize Trauma, Co-occurring disorders, and strategies to reduce racial and ethnic disparities. Staff across agencies will receive training in understanding state laws, child safety, recognizing and reporting suspected abuse or neglect, family dynamics, and understanding how ASFA requirements influence decisions regarding treatment and the timetables of a case. The Parents’ Project policies manual details the roles of judges, attorneys, caseworkers, treatment providers, and court staff. The schedule for community involvement, professional development, and training will be coordinated for the team by Collaborative Court Services Coordinator / Project Manager Ken Stewart.

Phase	Goals/Objectives	Time	Responsible Partner	Activity
Planning/ Implemen- tation	Improve Collaboration between Partners	Month 1	Program Manager	Assemble Team: Court Coordinator, Recovery Specialist, Judges, Children and Family Services, Public Defender, Attorneys and support staff for implementation meetings
	Improve outreach, advocacy, public education	Month 2	Program Manager, Support Staff, and Team	Notify public and private stakeholders e.g. treatment providers, caseworkers, police, probation, parole [REDACTED] families. Convene meetings, invite to Stakeholder Meeting and provide Training schedule
	Expand FDC program to Oakland	Month 1-2	Program Manager, Support Staff	Develop operating protocols for the Oakland site; advertise new RS position, conduct interviews, background checks, hire and commence employment
	Expand Availability of Treatment Services	Month 1-3	Program Manager, Grants Administrator	Solicit requests for bid to provide treatment to drug affected parents and children. Review bids, visit programs, negotiate and finalize contracts with treatment partners
	Expand screening for substance use, co-occurring disorders in Juvenile Dependency calendars	Month 2	Program Manager, CFS, Team	Review screening and assessment instruments, select a screen, identify process of implementation
	Improve data collection and communication systems between team and across Agencies	Month 2-3	Program Manager, Team, Evaluator	Review Data Collection and Communication process, and new RS begins training, orientation, instruction on data collection

Inter Agency Training	Create a trauma-informed, co-occurring enhanced system using evidence based practices	Month 2 and following	Team, with Technical Assistance	Develop a schedule of professional training, focusing on evidence based treatment for justice involved parents and children/ Distribute an Executive Summary and a Training Schedule to stakeholders
Program Operations	Begin services at the Oakland Wiley Manuel Courthouse, expand services at The Hayward Hall of Justice	Month 3	Program Manager, Recovery Specialists, Team	Recovery Specialist in Oakland and RS in Hayward conduct screenings to identify candidates, and take referrals from the team of eligible parents that will be accepted with approval of the judge
	Expand availability of screening to all Juvenile Dependency calendars	Month 4	Program Manager, Recovery Specialists, Team	Outreach to all 4 Dependency Court calendars in the county to educate parents, attorneys, parole and probation, caseworkers about the referral process and the program enhancements
Services Provided	Goals/Objectives	Time	Responsible Partner	Activity
	Eligible participants receive assessment, Treatment Plans and Parenting Plans, needs identified, parents placed in treatment.	Month 1 and following	Recovery Specialists	RS schedules participants for intake, assists with transportation, communicates with caseworkers, and work with participants to find the correct placement in treatment/attends hearings with judge and team
	Family counseling and clarifying assessments, referrals to therapy that is trauma-informed, age-appropriate	Month 2 and following	Program Manager, Team, and Treatment Providers	Clarifying assessments, [REDACTED] appropriate, and evidence based practices are provided and monitored in a series of behavioral health services for children
	Stabilizing Families	Month 1 and following	Recovery Specialists, Caseworkers	Referrals to services: health services, food and housing, benefits, as needed, with follow up documenting progress
	Help keep families together and children out of foster care	Month 1 and following	Team	RS and Team encourage parents to stay on track with incentives and sanctions, family counseling and reunification services