Evaluation of the Lewiston Family Treatment Drug Court

A Process and Intermediate Outcome Evaluation

Prepared for

The Maine Judicial Branch
Family Division

Prepared by

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Executive Summary

Today, nearly four out of five substantiated child abuse and neglect cases involve substance abuse by parents or other caregivers. Many of these cases will result in a termination of parental rights because these caregivers are significantly less likely to enter into or complete court-ordered treatment services. The inability to either access or complete court-ordered treatment services is often due to treatment barriers such as inadequate or unstable housing, co-occurring mental disorders, lack of motivation, transportation and unemployment, to name a few.

Family drug courts were developed as a means to respond to the complex problems posed by substance abuse among parents involved in the child welfare system. Through a combination of intensive judicial oversight, case management supervision, drug testing and treatment, the family drug court represents a nexus between the court, child welfare and substance abuse treatment systems. The overarching goal of the family drug court is to protect the safety and welfare of the child, while at the same time providing parents the opportunity to enter into treatment and learn the skills they need to become healthy, responsible caregivers.

At the end of 2006, there were 191 family drug courts in operation in all 50 states, with another 82 either in the early implementation or planning stages. Consistent with national trends, the first family drug court program in Maine became operational in October, 2002. Today there are three family drug courts operating in Maine, with locations in Belfast, Augusta and Lewiston. As of November 30, 2007, 22 parents have successfully completed these programs and graduated, 48 have been expelled, and 24 were still actively participating in the program.

The Maine Judicial Branch, through funding from the Bureau of Justice Assistance, wanted to examine how the Lewiston Family Drug Court Program (LFDC) operates and, if possible, determine whether or not the program is more effective than traditional court settings in reducing substance abuse among parents, thereby increasing the likelihood of successful parent-child reunification.

The evaluation performed by Hornby Zeller Associates, Inc. (HZA) examines the core functional and operational components of the Lewiston Family Drug Court. It does so using performance benchmarks outlined in *The Ten Key Components,* which guide the best practices, designs and operations of drug court programs nationally.

The report provides information pertaining to a variety of process measures including an assessment of the court, productivity, admissions-related procedures, drug testing practices, use of sanctions and incentives, substance abuse treatment participation and ancillary service utilization. Using comparison groups, the program is assessed along a variety of intermediate outcome measures such as treatment access, participant retention, outcomes of drug and alcohol use, and a variety of system-level court and child welfare outcomes.

Key findings presented throughout the report include the following:

- The Lewiston Family Drug Court has developed a strong integrated model, reflective of accepted best practice in the field of drug court programming.

- The Lewiston Family Drug Court (LFDC) is by far the most productive of Maine's family drug court programs, processing more than 60 percent of all referrals statewide in the shortest amount of time. Comparatively, the LFDC has the highest retention and program completion rate.

- Family drug court participants are more likely to enter into and subsequently complete treatment than comparison groups who received conventional case processing.

- More frequent, randomized, and monitored drug and alcohol testing cut the overall rate of positive tests and the number of participants testing positive in half.

- Once returned to the home, children of family drug court participants are less likely to experience a subsequent removal from the home.

- Because of enhanced supervision and increased knowledge about cases in the family drug court, cases that were most likely to result in a permanency plan other than reunification reached permanency sooner having gone through the family drug court process.

- Children of family drug court participants spent less time in foster care, generating lower foster care costs than the comparison groups. The likelihood of even greater cost-savings will result with expanded program capacity.

- Five drug-free babies were born to mothers participating in the family drug court program.

As a result of the major findings, HZA would like to encourage the Family Division of the Maine Judicial Branch and key stakeholders in the Lewiston

Family Drug Court to consider the following recommendations, which are designed to improve the performance of the system and ultimately to generate better outcomes:

Recommendation 1:
Expand the capacity of the Lewiston Family Drug Court Program

Since implementation, the Lewiston Family Drug Court program identified and referred 116 families with substance abuse problems for program participation. Of these 116 referrals, only 38 parents ultimately chose to participate in the program. Among non-participants, only ten percent were rejected because they did not meet program eligibility requirements. However, the remaining 70 families who elected not to participate were equally likely to have benefited because: 1) there is an overall 50/50 chance of successfully completing the program and graduating; 2) outcomes for non-participants fared worse than for those in the family drug court; and 3) the length of time to case resolution took longer for non-participants than for parents enrolled in the family drug court.

In light of the relatively large pool of parents eligible for program participation, family drug court team members responsible for future program recruitment ought to convey these and other findings to encourage greater participation in the program. Anecdotal evidence from key actors in the family drug court program indicate that many parents elect not to participate because of the projected length of time it takes to successfully complete each of the various program phases. In addition, the family drug court may want to consider revising the handout that describes the various program phases to include actual timelines using data in this report. For example, program graduates averaged three to four months in each phase of the program and successfully completed the program in about 14 months. This is far less than the projected three to six months in each phase, or a maximum of 20 months to program graduation.

Recommendation 2:
Continue efforts aimed at reducing the amount of time it takes to be admitted into the Lewiston Family Drug Court.

It is well established that the sooner an individual is placed into treatment, the better his or her long-term odds of achieving success become. For this reason, the third *Key Component* of drug courts is to identify eligible participants early in the process and promptly place them into the program. According to the Lewiston Family Drug Court policy and procedures manual, the Orientation Phase of the program (time between referral and admission) is designed to take no more than 45 days to successfully complete.

Initially, the LFDC was struggling to get participants to complete a clinical assessment, a process which must be done before anyone can be formally accepted into the program. The LFDC then began to offer financial incentives (e.g., $25 if the assessment is completed in two weeks, $15 if it is completed within a month) to encourage participants to complete their clinical assessment in a timely manner, thereby reducing admission delays and strengthening program retention.

As a result of these efforts, the LFDC was able to reduce the length of time participants spent in the Orientation Phase from an average of 105 days to 48 days; this closely approximates the 45-day window, or the maximum amount of time targeted for completion. The LFDC should consider other strategies to continue reducing the amount of time it takes to get admitted into the drug court. Informing defense attorneys, generally, about the benefits of program participation, as well as providing this information to parents at the Informational Session may also help to encourage more timely entry into the program.

Recommendation 3:
Narrow the range of sanctions imposed for certain violations of the family drug court contract.

The sixth *Key Component* of drug courts suggests the implementation and use of a system of graduated sanctions and incentives to ensure compliance with program requirements. The Lewiston Family Drug Court has outlined a complex system of graduated incentives and sanctions in its policy and procedures manual that controls for the type of behavior, as well as for the length of time of program participation. The system is tailored to allow for a range of options so as to more appropriately respond to the individual, while at the same time preserving a sense of fairness among the LFDC group as a whole.

For the most part, the real world application of the incentives and sanctions menu employed by the LFDC seems to be working with, perhaps, one possible exception: sanctions for unexcused appointments. As a result, the drug court team should consider narrowing the wide range of possible sanctions that can be employed for participants with unexcused absences.

Recommendation 4:
Collaborate with treatment agencies to expand the range of treatment options for family drug court participants.

Despite participating in the drug court for lengthy periods of time (an average of 172 days), some expelled participants received no substance abuse treatment whatsoever and among those who did, a significant amount of time was spent in intensive outpatient (IOP) treatment. This may very well suggest that the expelled group required more intensive treatment services than they

were able to get (e.g., partial hospitalization, residential), or that completion of an IOP was set forth as a condition of drug court participation and failure to complete the IOP ultimately translated into program expulsion.

However, it is well known that there are exceptionally long wait lists in Maine for the few residential treatment slots available for those in need of more intensive treatment interventions. Instead of creating more readily available treatment beds for this population, family drug court participants in need of such intensive services wind up getting plugged into whatever treatment services are immediately available (such as IOP), working on the assumption that some interim treatment is better than no treatment at all.

It is recommended that the family drug court work with treatment providers and treatment agencies to expand the range of available treatment options. The cost of paying for interim treatments that have been deemed inadequate to meet the needs of the individual — on top of the cost of providing the needed intervention at some later date — is an inefficient and costly use of very limited resources.

Background and Context

This report provides a process and intermediate outcome assessment of the Lewiston Family Drug Court Program (LFDC). The LFDC is a specialized civil court proceeding responsible for handling child protective custody cases involving substance abuse by parents or other caregivers. Through comprehensive supervision, drug testing, integrated substance abuse treatment services and routine court appearances before a designated program judge, the goals of the LFDC are to protect the safety and welfare of the children while providing parents the opportunity to enter into treatment and learn the skills they need to become more healthy and responsible caregivers.

The emergence of family drug courts resulted largely from the well-documented effectiveness of their adult drug court counterparts, which expanded considerably throughout the United States during the 1990s. Faced with dockets that include increasing numbers of cases involving substance abuse among parents, family and dependency court judges began to apply the drug court model to their child protective custody caseload. While the first family drug court program originated in Reno, Nevada in 1995, the real growth and expansion of these programs began only a few years ago. At the end of 2006, there were 191 family drug courts operating in all 50 states, with another 82 such courts either in the early implementation or planning stages.

Maine began implementing family drug court programs in October, 2002. Maine now has three operational family drug court programs serving seven of Maine's 16 counties located in Rockland, Augusta and Lewiston. The Hon. Joseph Field presides over the family drug court in Rockland, which covers Waldo, Lincoln and Knox counties. The family drug court program serving Kennebec County is presided over by the Hon. Richard Mulhern in Augusta, and the Hon. John Beliveau presides over the family drug court in Lewiston, which serves Franklin, Oxford and Androscoggin counties.

Despite this recent and rapid growth in the number of family drug courts operating across the country, little is known about the effectiveness of these programs or how well the drug court model works in a dependency and family court setting. Preliminary findings from a recently released national study of four established family drug courts suggest some promising outcomes. Researchers found that family drug courts can be more effective in reducing the length of time it takes parents to enter treatment, thereby increasing the likelihood that parents complete treatment, as well as generating more family reunifications than similar comparison groups. However, most other court and child welfare system outcomes were found to be mixed and site-specific.

Hence, this study marks an innovative development in contributing to the literature on the effectiveness of family drug court programs. It compares differences in parent, child and parent-child intermediate-level outcomes (e.g., treatment retention, days spent in out-of-home placement, reunification) between family drug court participants and two different comparison groups. The two comparison groups include parents with substance abuse problems involved in the child welfare system being served in a comparison court jurisdiction (one that does not have a family drug court), and parents with substance abuse problems involved in the child welfare system in the year prior to the implementation of the LFDC.

The following key questions will be addressed throughout the course of this report:

1. How does the Lewiston Family Drug Court Program (LFDC) operate?

2. How does the LFDC measure up against the performance benchmarks that guideline the best practices in drug court programming?

3. What is the productivity of the LFDC and how does it compare to other family drug courts in Maine?

4. How are sanctions and incentives being utilized? Are they graduated? Do they make sense?

5. What are the types of treatment services delivered to LFDC participants? Are there some services used more than others? If so, by whom?

6. How effective is the LFDC in improving access to treatment and retaining participants in treatment?

7. What is the impact of the LFDC on reducing the length of time children spend in foster care and the amount of time parents spend in the court?

8. What are the relative costs and savings associated with the LFDC?

Research Design and Methodology

One of the unique challenges in assessing family drug court programs is that there are multiple levels of outcomes to be assessed across various domains. For example, there are parent-level outcomes (e.g., treatment completion, service-order compliance), child-level outcomes (e.g., repeat maltreatment), system-level outcomes (e.g., time to case closure, days spent in out-of-home placement) and parent-child level outcomes (e.g., reunification). All outcome levels need to be measured in order to adequately assess the effectiveness of a family drug court program.

Where possible, this study will involve the use of three comparison groups to assess and measure intermediate outcomes of the Lewiston Family Drug Court Program (LFDC). The first comparison group is cross-jurisdictional, where we use protective custody case data from a court jurisdiction that does not have a family drug court program. The District Court located in Biddeford will serve as the comparison court for this evaluation. It was chosen because its caseload and the demography of the population it serves approximates that of the Lewiston District Court, which is currently under investigation. The second comparison group consists of parents with substance abuse problems who were processed through the Lewiston District Court in the year prior to the date of implementation of the family drug court program. The third comparison group will consist of parents with substance abuse problems who were referred to the family drug court but were not admitted to the program[1].

The study relies principally on administrative data derived from the Maine Drug Treatment Court Information System (DTxC), supplemented with information gleaned from an administrative data extract from the Department of Health and Human Services' Maine Automated Child Welfare Information System (MACWIS) and information gathered from protective custody case files maintained in both District Court locations.

One major limitation is worth noting when interpreting data presented throughout the report. The total number of discharged cases from the Lewiston Family Drug Court Program is small, consisting of 10 graduates and 14 expulsions as of November 30, 2007. Among these discharges, nearly half occurred within the six months immediately preceding the cut-off date for the data collection (November 30, 2007), making it impossible to have a sufficient window of opportunity (time-at-risk) and case base to adequately assess long-term program outcomes (e.g., rate of new petition filings), or other measures of recidivism

[1] Parents who are referred to but do not enter the family drug court generally fall into two categories: those who declined to participate and those who did not meet the eligibility requirements of the program. It must be emphasized that when subjects are selected or self-selected into such groupings, there is a likelihood that the groups will differ on characteristics such as motivation, social support, intelligence, or any number of uncontrolled factors that could influence differences in outcomes.

whether it be child welfare, criminal or clinical in measurement. We suspect that it will be at least another two years before the LFDC can be independently assessed along these domains[2].

[2] To get a sense of the direction where such outcomes may lead for the LFDC, refer to the January 2007 Maine Family Drug Court Evaluation Report released by Hornby Zeller Associates, Inc., in which these outcomes were measured for the three family drug court programs combined.

Results

This section of the report is dedicated to an examination of the core functional and operational components of the Lewiston Family Drug Court Program (LFDC). Here, we use as measurements the performance benchmarks outlined in *The Ten Key Components*, which guide the best practices, designs, and operations of various types of drug court programs nationally. Specifically, the report provides information pertaining to a variety of process measures, including an assessment of the court, its productivity, admissions-related procedures, drug testing practices, use of sanctions and incentives, substance abuse treatment participation and ancillary service utilization. Throughout the report we will also be providing results of the LFDC on intermediate outcome measures, making comparisons where possible. Examples of intermediate outcomes will include, but are not limited to measures such as program completion, drug and alcohol use, and court and child welfare system-level outcomes (e.g., frequency of placement changes, time to court case closure).

Description of the LFDC

In order for any drug court program to be successful at achieving its goals and objectives, the program must be implemented in accordance with the guidelines and principles set forth in *The Ten Key Components*. To do so requires a strong commitment by all drug court team members to invest in the significant amount of time that is necessary to build a true model program. Since its inception, the evaluation team has observed the evolution of the program and provided guidance and technical assistance throughout the program's development. Today, it is safe to say that the LFDC is an exemplar among the nation's family drug court programs, having developed a strong integrated model that is firmly founded in the principles that constitute best practices in the field of drug court programming.

The LFDC was founded in 2004 through a two-year grant awarded to the Maine Judicial Branch from the U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance. As a result of that funding, the LFDC was able to develop an integrated team of drug court practitioners that includes a single assigned family drug court judge, dedicated treatment and caseworker assignments, a drug court case manager, and a drug court coordinator as well as support staff. The family drug court team meets every week to review the progress of each drug court participant, and the LFDC holds regularly scheduled status hearings on a biweekly basis.

Among the many accomplishments of the LFDC is the development of a comprehensive set of policies and procedures that now serves as the basis upon which other Maine family drug court programs strive to operate. The LFDC also founded the statewide family drug court steering committee. This committee consists of a wide array of key stakeholders in the community, including

representatives from the defense bar, medicine, area businesses, numerous community-based providers, child welfare agency representatives, as well as a dedicated State legislator.

In order to preserve a sense of fairness among LFDC participants while at the same time ensuring appropriate responses to individual behaviors, the LFDC developed a comprehensive system of graduated incentives and sanctions that controls for the type of behavior as well as the amount of time the participant has been in the program. LFDC participants are also closely monitored while they are participating in the program through random drug screens, phone calls or home visit checks. The LFDC has implemented sound drug testing protocols. Referred to as the "drug line," this automated message system randomly selects participants on a daily basis to provide a sample to the drug court case manager. Drug testing is also conducted frequently and monitored as well.

The LFDC has attempted to become more integrated into the fabric of the regular child protective custody court docket. Currently, all petitions for orders of preliminary protection are screened for allegations of substance abuse. These cases are in turn referred to the family drug court judge. Ultimately, the goal of the family drug court program is to have all cases in the regular child protective docket that involve substance abuse managed in much the same way as participant cases are handled in the LFDC track.

In terms of "Drug Court Theatre," the LFDC provides a relaxed atmosphere for its participants, promoting a therapeutic relationship between themselves and the drug court team while maintaining a general sense of encouragement, accountability and confidentiality.

The LFDC has also gained widespread community support and publicity largely as a result of the efforts of the drug court team. The team conducted more than a dozen speaking engagements at a wide variety of local, community-based organizations; one of these events drew an audience of more than 300 people, which is significant given the population in this area. Many area businesses make donations to the LFDC indirectly through Volunteers of America, which provides case management services for the drug court. Donations routinely include daily planners/organizers for participants, gift certificates to be used as incentives, and provision of catering for drug court graduation ceremonies.

Through each of these efforts as well as many others, the LFDC now operates in a manner that is entirely consistent with the essential elements of best-practice drug court programming. As a result, it has been awarded state funding support for ongoing sustainability.

Productivity of the LFDC

We now turn to an examination of the productivity of the LFDC and compare their results with the other two family drug court programs in Augusta and Rockland. Referring to Table 1 below, as of November 30, 2007 there were a total of 116 parents in the dependency track of the Court who were identified as having a substance abuse issue and were referred to the Lewiston Family Drug Court Program (LFDC). Of these 116 referrals, a total of 38 parents elected to participate in the program. Of these 38 parents, ten successfully completed the program and graduated, 14 were expelled and another 14 were still actively participating in the program as of November 30, 2007. Among those who were referred to the LFDC but were not admitted to the program, only ten percent of these referrals did not meet program eligibility requirements.

When comparing the LFDC to the other two family drug court programs in Maine, the LFDC is by far the most productive, processing more than 60 percent of all referrals statewide in the shortest amount of time. It is important to note that the LFDC also has the highest retention rate (63.2%) and highest program completion rate (41.7%) as well.

Table 1: Productivity of Maine's Family Drug Treatment Courts

	Lewiston	Augusta	Rockland	Total
Year of Inception	2005	2005	2002	N/A
Total Referred	116	20	57	193
Not Admitted	78	2	19	99
Total Enrollments	38	18	38	94
Admission Rate	32.7%	90%	66.7%	48.7%
Discharged- Expelled	14	9	25	48
Discharged- Graduated	10	4	8	22
Currently Active	14	5	5	24
Retention Rate	63.2%	50.0%	34.2%	48.9%
Completion Rate	41.7%	30.7%	25.3%	31.4%

LFDC System Flow

The Lewiston Family Drug Court process begins when a petition for a child protection order, which most often includes an Order of Preliminary Protection, is filed with the Court by the Maine Department of Health and Human Services (DHHS). Upon receipt of the petition, the Clerk of the District Court and/or the Judge reviews the affidavit for allegations of substance abuse[3]. If a petition is flagged for substance abuse involvement, the designated LFDC judge is notified, and the parent may be ordered to attend a LFDC Informational Session should the judge determine that substance abuse was a major contributing factor underlying the petition filing. The LFDC Informational Session typically occurs on the same day as the Preliminary Hearing and is conducted by the LFDC case manager who provides the parent with a brief 5 to 10 minute overview outlining the benefits of program participation. While parents may be ordered to attend an LFDC Informational Session, participation in the LFDC is completely voluntary.

It is through this process that the majority of referrals are made to the LFDC program. However, referrals may come from a variety of other sources besides the LFDC judge. Referring individuals may be prosecutors, defense attorneys, caseworkers, family or friends; a parent can even make a self-referral to the program. Proportionately, these types of referrals make up about 25 percent of all referrals to the program, with the LFDC judge's referrals accounting for the remaining 75 percent.

Before anyone can be formally admitted to the LFDC, several things must occur. First, parent(s) must meet both legal and clinical eligibility requirements. To pass legal eligibility requirements, a parent cannot have a substantial criminal or child welfare history, a lengthy history of violence, domestic violence, or incarceration, and the presenting case cannot exhibit any aggravating factors as defined by Maine State Statute (Title 22, MRSA §4002(1)(b)). In order to meet clinical eligibility requirements the parent must have a diagnosis for substance abuse or dependence as defined by the DSM-IV-TR. Parents with a severe mental disorder are also not eligible for participation in the LFDC unless they have demonstrated successful compliance with their treatment plan.

Other eligibility requirements include observing an LFDC session and attending all court sessions that would otherwise be required as a condition of the traditional dependency track[4]. Acceptance into the program is ultimately determined by a full case review of the LFDC Team, which consists of the LFDC

[3] Petitions may also be flagged by the LFDC DHHS caseworker.

[4] The LFDC is a dual-track program, which means that any parent who is accepted into the program must also continue to participate along the traditional dependency track. Graduation from the LFDC will help towards—but not necessarily guarantee—reunification.

judge, assigned DHHS caseworker(s), representatives from treatment, and the LFDC case manager. This entire process is referred to as the Orientation Phase of the program and is designed to take no more than 45 days to successfully complete.

One of the *Key Components* of drug courts is that eligible participants are identified, screened, and placed into the drug court program as quickly as possible. The reason for this principle is well established throughout the literature: the sooner one is placed into treatment, the better his or her long-term odds of achieving success. Referring to Table 2, information is presented about the time it took the average participant to progress through the LFDC admissions process as well as the amount of time spent in various phases of the program.

Overall, the amount of time that elapsed between initial referral to the LFDC from the date a protection order was filed averaged 9 days for the 38 participants who were enrolled in the LFDC. While the time between petition filing and initial referral to the LFDC varied between active participants, graduates and among those expelled from the program, the general overall direction of the data suggests that the LFDC has been successful in shortening this process over time.

Table 2: Key Points in the Flow of the LFDC Program (Median Days)

	Petition Filing to Referral	Referral to Admission	Length in Phase I	Length in Phase II*	Length in Phase III*	Length in LFDC
Active	6	39	91	238	NA	NA
Graduates	9	58	115	133	91	416
Expulsions	13	86	126	343	88	172
Overall	9	61	110	165	90	274

*As of November 30, 2007 there were two active participants in Phase II and two that were active in Phase III. Only two out of the 14 expulsions made it as far as Phase II and only one of those made it as far as Phase III.

As noted above, the Orientation Phase of the program — the time from initial referral to final admission — is designed to take approximately 45 days to successfully complete. For the LFDC group as a whole this entire process averaged 61 days, with participants expelled from the program having taken the longest amount of time (86 days), versus the currently active group of participants who were enrolled in an average of 39 days. Again, the overall direction of the data suggests that the LFDC has streamlined this process and has been successful in reducing delays in the admissions process.

Upon completion of the program's Orientation Phase, participants are formally accepted into the drug court and enter into Phase 1 of the program. To graduate from the LFDC, participants must go through three separate phases, each of which is designed to take between three and six months to successfully complete. To move from one phase to the next, parents must: 1) comply with

program guidelines; 2) abstain from drugs and/or alcohol; 3) participate in requisite treatment and related services; 4) improve parenting and other life skills; and 5) make advancements along housing, employment, education or vocational outcomes. In order to graduate from the program, parents will have demonstrated maintenance of a stable lifestyle, sustained abstinence from substance use and significant progress towards reunification.

Information presented in Table 2 shows the amount of time participants spent in the three main phases of the family drug court program. On the whole, program graduates took an average of 416 days (about 14 months) to successfully complete the program, spending between three and four months within each of the three phases of the program. Most of the expelled group did not make it past Phase 2 of the drug court, and averaged 172 days of total program participation.

Drug Testing and Associated Outcomes

One of the *Key Components* of drug courts is the frequent and effective use of randomized and monitored drug and alcohol testing. Drug testing is essential to the success of drug court programs, because it serves as a deterrent, thereby providing greater assurance that clients are complying with the abstinence requirement of the program. In addition, drug testing provides treatment professionals valuable information about participant substance use and aids in the modification of individualized treatment plans.

The Lewiston Family Drug Court operates a "drug line," which is an automated message system that participants are required to call each day to see whether or not they must meet with the case manager to provide a sample. Generally, participants are supposed to be tested about two times per week, with some exceptions (less frequent testing) for those in the latter phases of the program. With the drug line, the LFDC helps to ensure that testing is both frequent and randomized. In addition, LFDC's policy that all tests must be administered in the presence of a same-sex observer helps to ensure that drug testing is carefully monitored as well.

Referring to Table 3, we examine the LFDC's drug testing protocol as it relates to each of these domains by comparing two time intervals (March 30, 2005 to July 31, 2006 and August 1, 2006 to November 30, 2007) which represent the first and last 16 months of the program's operation. Overall, there were 2,240 separate testing events that occurred for the 39 people active in the program during this 32-month period. Results of the testing data reveal that the LFDC is in compliance with its own policy and procedures, with participants being tested twice per week and the majority of testing events both randomized and monitored.

Table 3: Drug Testing and Related Outcomes

	Number of Testing Events	Tests Per Person Per Week	Overall Percent Positive	People Testing Positive	Percent Randomized	Percent Monitored
First Period	1,021	1.8	17.6%	88.2%	74.7%	82.7%
Second Period	1,219	2.2	7.2%	47.1%	80.2%	92.5%
Overall	2,240	2.0	11.9%	67.6%	77.2%	88.2%

It is interesting to note that over the two time intervals, while more tests were observed and randomized and the number of testing events increased in frequency, the rate of positive test results and the number of people testing positive decreased by approximately fifty percent. The rate of positive test results decreased from 17.6 percent in the first sixteen months of the programs operation to just over 7 percent in the most recent sixteen months.

Since implementation, the LFDC has developed a number of additional AOD testing protocols to ensure that participants adhere to the abstinence requirement of the program. For example, in July 2006, the LFDC began using more sophisticated tests (EtG[5] versus breathalyzers) for detecting alcohol use among drug court participants. After the LFDC began using EtG tests, the detection rate for alcohol use more than doubled, increasing from 13.4 percent (breathalyzers) to 38.9 percent (EtG). Given that the overall rate of positive tests decreased over the same time period, these findings suggests that use of ETG has been an effective deterrent on AOD use overall — a finding that key actors in the LFDC, at least anecdotally, believe to be true as well.

Another example pertains to use of prescription narcotics. LFDC participants who take prescription drugs for pain or anxiety must have a signature from the prescribing doctor, who certifies in writing that he or she understands that the participant is in a drug court program, is being drug tested and that the medication is a medical necessity. Participants who test positive for prescribed medications without this notice are subject to a sanction for a positive test result. Anecdotally, LFDC key actors have noticed a sharp decline in the number of emergency room visits made by participants for drug-seeking purposes, and an increase in the number of participants who are taking non-narcotic pain relievers.

[5] EtG is a method of testing for ethyl glucuronide (a direct metabolite of ethyl alcohol) which can be detected in a urine sample for up to 80 hours after exposure or use. LFDC participants must sign a "urine abstinence testing and incidental alcohol exposure contract" explaining what incidental exposure is and reminding them that it is their responsibility to limit exposure to alcohol based products. A 500ng/ml cutoff on the EtG ensures that the LFDC is treating and sanctioning for purposeful alcohol consumption.

Sanctions and Incentives

Another *Key Component* of drug courts suggests the use of graduated sanctions and incentives to ensure compliance with program requirements. Theoretically, a system of sanctions and incentives has the potential to be an effective tool in a program of behavioral management and change.

The Lewiston Family Drug Court has outlined a complex system of graduated incentives and sanctions in their policy and procedures manual. The LFDC system provides a grid of possible sanctions and incentives that control for the type of behavior (positive or negative), as well as for the amount of time the participant has been in the program. The incentives and sanctions system developed by the LFDC is not fixed (in that if one does *X*, one must necessarily receive *Y*), but rather customized to allow for a range of options. In this way, the drug court team is able to respond appropriately to the individual's particular situation, while at the same time preserving a sense of fairness among the LFDC group as a whole.

We now turn to an examination of how sanctions and incentives have been used by the LFDC. Referring to Figures 1 and 2 below, we find that the LFDC employs a wider array and range of sanctions than it does incentives. Sanctions ranged from the use of 30-day suspensions (11%) to increased reporting requirements (25%) and "other" types of sanctions such as imposing fines or conducting intensive reviews with participants (14%). On the other hand, tangible rewards (e.g., gift cards, movie passes, medallions, certificates of achievement) made up half of all incentives followed by verbal praise (29%) and program phase advancements (15%).

Figure 1: Overall Distribution of Sanctions

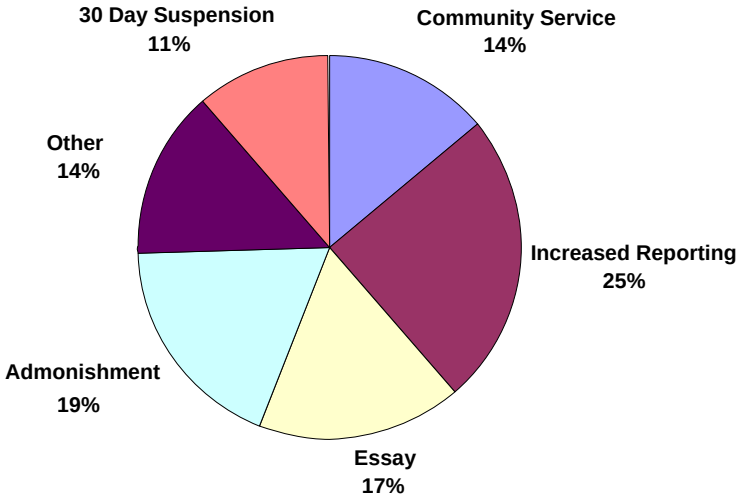
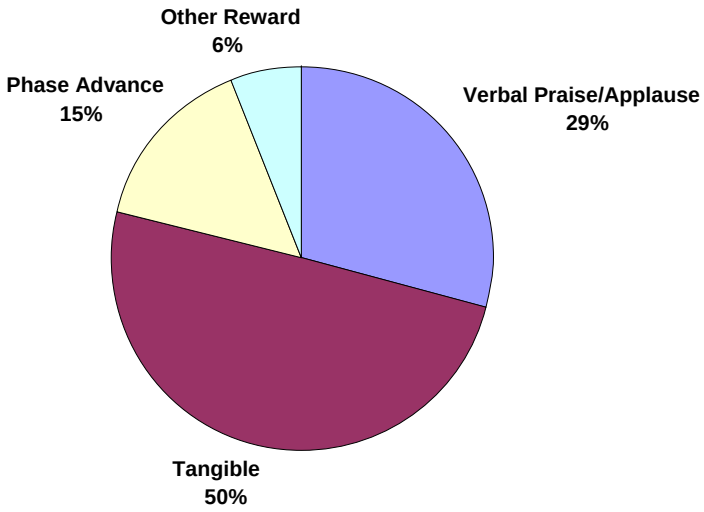


Figure 2: Overall Distribution of Incentives



Generally, incentives are given to clients who are doing well in the program, typically when they reach major milestones (e.g., phase advancement, achieving *X* number days sobriety); they are also given to encourage other positive behaviors. The general rule of thumb accepted in the literature for programs such as the LFDC is that incentives should outnumber sanctions by a factor of four to one. The current ratio of rewards to sanctions for the LFDC is approximately two to one.

A good example of how the LFDC has embraced this philosophy came about after its first 18 months of program operations. At that time, the LFDC was struggling to get participants to attend treatment in order to get their clinical assessment completed in a timely manner (recall that a clinical assessment must be completed before one can considered for formal acceptance into the program). LFDC stakeholders were noticing that many of these participants were falling by the wayside at a time when enrollments were low.

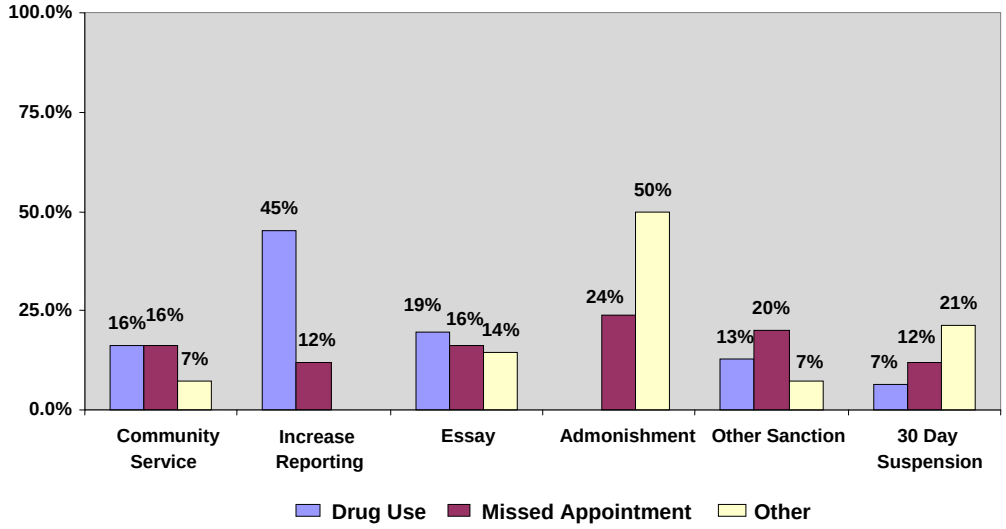
Instead of sanctioning participants, the LFDC shifted gears and started to offer financial incentives for potential participants (e.g., $25 if clinical assessment is completed within two weeks, $15 if completed within a month). The result of the experiment worked and the length of time participants spent in the orientation phase of the program decreased significantly, from an average of 105 days to 48 days between the two time intervals (see section describing LFDC System Flow on page 8 for more information).

More detailed information showing reasons why participants in the LFDC get sanctioned and how they were sanctioned is presented in Figure 3. In general, most participants are sanctioned for either alcohol or drug use, or for missing scheduled appointments; these missed appointments might involve case management, treatment, or scheduled sessions of the LFDC. Other types of sanctionable behavior include things like not following through with recommendations of the drug court team, or associating in negative peer relationships.

Drug court participants who test positive or admit to using drugs or alcohol are typically required to report more frequently to the drug court case manager or treatment (45%), followed by a written assignment (19%), or conduct some form of community service (16%). Rarely does anyone receive a 30-day suspension from the program for using alcohol or drugs (7%).

Sanctions for missing a scheduled appointment without advance notice, on the other hand, are more mixed. They can result in a wide variety of possible sanctions, with verbal admonishment from the drug court judge being the most prevalent among them (24%). Other sanctionable behaviors typically yield verbal admonishment as well (50%), and 30-day suspensions (21%) are given to those who participate in more egregious actions (e.g., failure to appear for LFDC or any criminal conduct). For the most part, LFDC sanctions seem to make sense, although the drug court team should consider narrowing the wide range of sanctions for participants who miss scheduled appointments without notice.

Figure 3: Relationship Between Negative Behaviors and Sanctions Imposed



Treatment and Adjunctive Services

Nationally, it is estimated that six million children currently reside with a parent or caregiver who abuses alcohol or other drugs. Indeed, parental substance abuse is one of the major reasons why so many children are removed from their homes and placed into protective custody (Office of Applied Studies, 2003). It is also well documented in the literature that very few parents with substance abuse problems involved in the child welfare system either enter into or complete substance abuse treatment (SAMSHA, 2002). According to a recent study of custodial mothers with substance abuse problems, only 20 percent either completed or were enrolled in a substance abuse treatment program (Ryan, 2006).

Research consistently indicates that treatment completion is one of the most significant predictors of successful family reunification among parents with substance abuse problems involved in the child welfare system (Smith, 2003; Maluccio and Ainsworth, 2005). For this population, the literature also identifies many common predictors that typically inhibit or delay reunification efforts including: the age of the child, mental illness, frequency of placements, type of placement and length of time in placement.

Policymakers aiming for a reduction in parental substance abuse, thereby reducing the level of child maltreatment, are faced with many challenges. These include the lack of specialized treatment services for women with children, poor coordination between agencies, and difficulties of engaging and retaining parents in treatment services, to name a few. For these reasons, substance-abusing parents in the child welfare system require significantly more outreach and support to engage in and complete the treatment process.

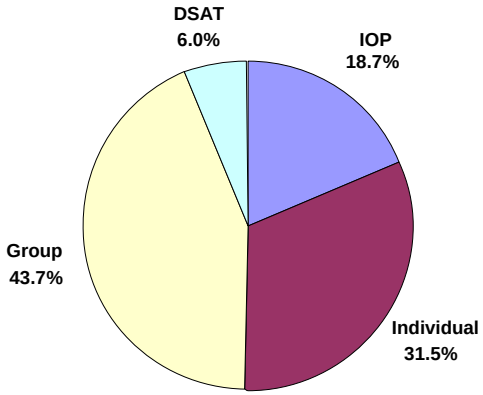
Unlike the traditional family or dependency court system, one of the many benefits of the family drug court model is the coordination of treatment, case management and child protective services in making sure that needed services are available, while at the same time holding parents accountable by ensuring compliance to service requirements.

In this section of the report, we examine differences between family drug court participants and the two comparison groups of parents with substance abuse problems involved in the child welfare system. Although not always rising to a level of statistical significance, findings indicate that family drug court participants fared better than both comparison groups along all outcome measures.

Our final outcome measure concerns the number of adjunctive services that were received by each group of families. Although not statistically significant, we find that families in drug court were also more likely to receive a greater number of adjunctive services.

Information presented in Figure 4 provides a breakdown of the most frequently used substance abuse treatment modalities attended by family drug court participants aside from residential treatment. Treatment sessions that are in group format are the most common making up more than two out of every five sessions attended. About one-third attended individual treatment and the remaining twenty-five percent attended either intensive-outpatient treatment or Differential Substance Abuse Treatment (DSAT). DSAT is a structured manualized treatment delivery system that is exclusively used by offenders participating in the adult (criminal) drug court and by some probationers in adult community corrections.

Figure 4: Distribution of Types of Treatment Sessions Attended



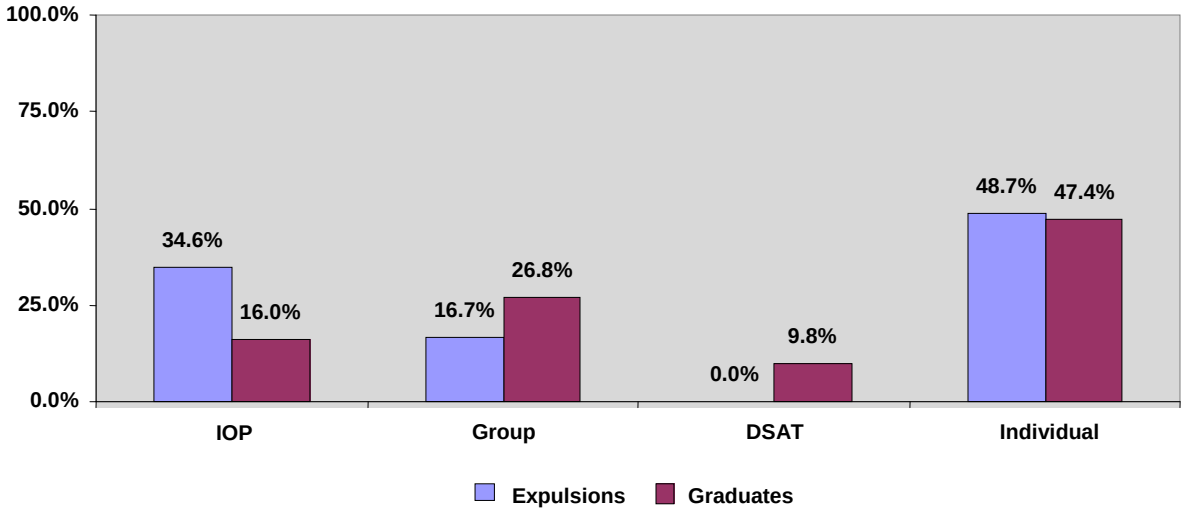
This pattern holds true when we examine the number of participants receiving various types of substance abuse treatment. Virtually all of the graduates received some combination of individual and group treatment during their participation in family drug court with about half receiving some other type of treatment in addition such as IOP, DSAT or residential. As expected, attendance at treatment for the expelled group is more mixed with four people not receiving any substance abuse treatment whatsoever. Lastly, all of the drug court graduates were connected to at least one type of ancillary service above and beyond participation in substance abuse treatment of which a few received co-occurring mental health treatment services.

Table 4: Treatment and Ancillary Service Utilization

	Expulsions N=14		Graduates N=10		All Discharges N=24	
	N	Percent	N	Percent	N	Percent
Individual	8	57.1%	9	90.0%	17	70.8%
Group	2	14.2%	8	80.0%	10	41.7%
IOP	5	35.7%	4	40.0%	9	37.5%
Residential	3	21.4%	5	50.0%	6	25.0%
DSAT	0	0.0%	3	30.0%	3	12.5%
No Treatment	4	28.6%	0	0.0%	4	16.7%
Ancillary Services	3	21.4%	10	100.0%	13	54.2%
Mental Health Tx	2	14.2%	4	40.0%	6	25.0%

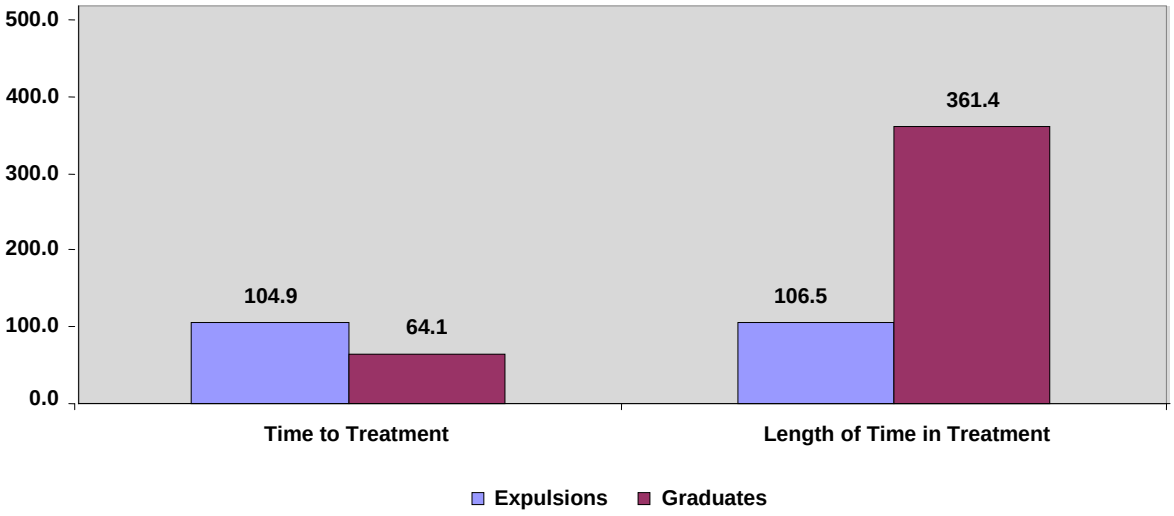
When examining the percentage of total time spent in one or more of the various treatment modalities mentioned above, we find some rather important differences between those who graduated from the program and those who did not, particularly with respect to the amount of time spent in IOP versus group therapy. The amount of time spent in group therapy was higher among graduates compared to the expelled group who spent a much greater amount of time in intensive outpatient treatment. This finding may be explained by the fact that the expelled group required more intensive treatment services than they were able to get (e.g., partial hospitalization, residential) or that completion of an IOP was set forth as a condition of drug court participation, and failure to complete the IOP ultimately translated into program expulsion. Indeed, it may very well be a combination of both of these factors.

Figure 5: Percent of Total Treatment Attended



It is well established throughout the literature that the sooner one is placed into treatment, the better his or her long-term odds are of achieving success. Figure 6 shows long it took for participants in family drug court to enter into treatment after having been referred to the program. Drug court graduates took about 64 days to enter into treatment after referral and once they entered into treatment they stayed in treatment for an average 361 days. This is in stark contrast to the expelled group who, as expected, were likely to have much poorer outcomes.

Figure 6: Average Length of Time to Enter Treatment and Time Spent While in Treatment (in Days)



Using information gleaned from protective custody court case files at the two sites, we were able to generate some general treatment outcomes for comparative purposes. As shown in Table 5 on the following page, family drug court participants were more likely to enter into treatment (83%) than the comparison group of parents from the comparison court (24%); they were also more likely to enter into treatment than parents who were ordered to treatment prior to the implementation of the drug court program (53%).

Among those who entered into treatment, family drug court participants were also more likely to complete their treatment regimen (50%) compared to parents in the comparison court (12%) or parents who went to treatment prior to the drug court program (33%). Overall, these outcomes are consistent with the national literature that suggests parents enrolled in family drug court are significantly more likely to enter into and complete substance abuse treatment than similarly situated parents in comparison groups.

Table 5: Comparative Treatment Outcomes

	Expulsions		Graduates		Discharges Combined		Lewiston Comparison		Biddeford Comparison	
	N	**Percent**	**N**	**Percent**	**N**	**Percent**	**N**	**Percent**	**N**	**Percent**
No Treatment	4	28.6%	0	0.0%	4	16.7%	14	46.7%	19	76.0%
Some Treatment	10	71.4%	10	100.0%	20	83.3%	16	53.3%	6	24.0%
Completed Treatment	2	14.3%	10	100.0%	12	50.0%	10	33.3%	3	12.0%

Child Welfare Outcomes

The overarching goal of the family drug court is to protect the safety and well-being of the child by providing parents with substance abuse problems the support, treatment, and services they need to successfully reunite with their children. The questions we ask in this section focus on the impact of the family drug court on child and parent-child level outcomes. These include: frequency of placement changes, reunification rates, subsequent removals from the home, and days spent in out of home placement.

Placement Changes

Results of a recent study of children in foster care indicate that more than half of all children will experience at least one placement change while in custody, and that risk of placement change increases both with the child's age and type of placement (Connell et al., 2006). Referring to Table 6, we find across groups that children in this sample are significantly more likely to experience at least one placement change (73%, not shown). Contrary to the national literature, more than half of the children in this sample (53%) experienced at least two placement changes.

Table 6 compares differences in the frequency of placement changes between the children of family drug court participants and the children of parents in the two comparison groups: children in the protective custody docket prior to the family drug court implementation, and children in another court jurisdiction that does not have a family drug court program.

Overall findings indicate that children of family drug court participants had fewer placement changes (an average of 2.6) than the children of parents in the other court jurisdiction (average of 4.1); however, there was virtually no difference in the frequency of placement changes among children preceding the family drug court's implementation (2.6). Thus we must conclude that along this measure, the family drug court program has had no impact on this intermediate outcome measure, with differences between the two court jurisdictions attributable to some unknown artifact.

Where there *is* a difference, however, is along the outcome measure pertaining to subsequent child removals from the home. We define a subsequent removal as any incident in which the child was removed from the home after having been returned to his or her parent or other primary caregiver (including trial placements). While there may be many reasons why a child has been removed from the home (e.g., new allegations of abuse/neglect or unruly child behavior), it is nonetheless an important indicator of family functioning. As Table 6 shows, family drug court participants (18.7%) had far fewer subsequent removals than children in the comparison court jurisdiction (38.5%), as well as fewer such removals than the children in the protective custody docket prior to the drug court's implementation (27.3%).

Table 6: Placement Changes

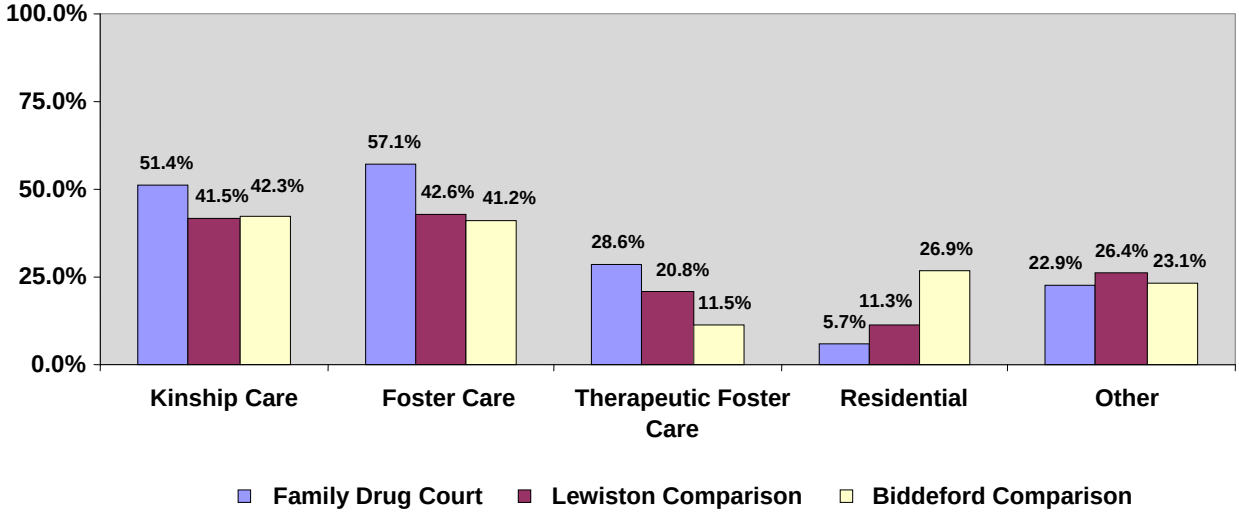
	Family Drug Court (n=35)	Lewiston Comparison (n=53)	Biddeford Comparison (n=36)
Average Number of Different Placement Changes	2.59	2.55	4.08
Percent with More than One Placement Change	71.9%	66.7%	92.3%
Percent with More than Two Placement Changes	43.7%	51.5%	76.9%
Subsequent removal if child was ever returned to the home at any point	18.7%	27.3%	38.5%

Placement Types

Figure 7 compares differences in the types of foster care settings between children of family drug court participants and children of parents in both comparison groups. Children of family drug court participants were more likely to have been placed in a relative foster care setting (51.4%) than children involved with the child welfare system prior to the implementation of the drug court (41.5%).

The children of family drug court participants were also more likely to have experienced placement in a traditional foster care setting (57.1%) compared to children of parents in the comparison court jurisdictions (41.2%), as well as compared to children of parents who were involved with the child welfare system before the family drug court program was implemented (42.6%).

Figure 7: Placement Settings



Child Welfare and Court System Outcomes

One of the many goals of the family drug court program is to reduce both the amount of time parents spend in the court and the amount of time children spend in the foster care system. In this section of the report, we examine differences between family drug court participants and the two comparison groups across three domains related to system involvement: time to court case closure; time spent in out-of-home placement and foster care expenditures resulting from differences in placement settings.

National studies on family drug court programs have found mixed results in terms of the amount of time it takes to resolve a case in the family drug court against comparison groups. Nationally, findings have shown no significant differences between the two groups and, for the most part, most programs show slightly longer amounts of time to resolve cases in the family drug court setting. While FDCs are not reaching their original goal of reducing time to case closure, this may not necessarily be a negative finding. It may very well be that the process needs to take longer to account for the amount of time it takes to deliver more appropriate treatment options as more is learned about the participant and his or her own special needs.

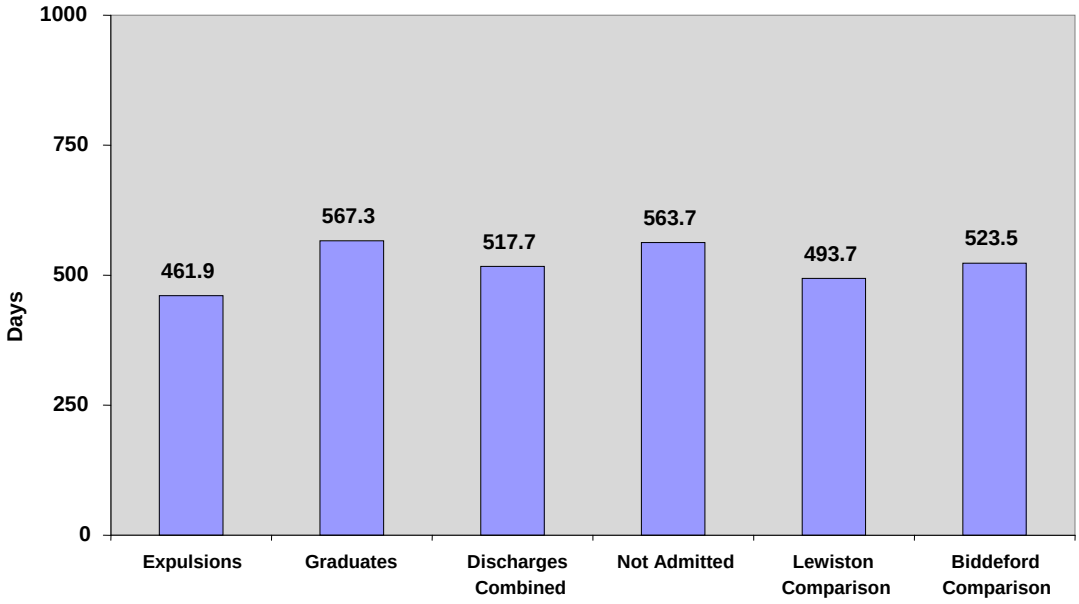
Referring to Figure 8, we also find similar outcomes. On the whole, Lewiston family drug court participants fared no better than comparison groups on the amount of time to court case closure. From the point of petition filing to date of court dismissal, family drug court participants averaged 518 days, compared to 524 days for the comparison court jurisdiction and 494 days against those cases resolved prior to the implementation of the family drug court program.

However, when separating out differences between graduates, expulsions, and the group of parents who were referred to the family drug court but did not participate in the program, there are some important and notable differences. First, the amount of time it took to resolve a case for those parents who were expelled from the LFDC was far shorter, averaging 462 days compared to graduates (567 days). More importantly, there was no difference between LFDC graduates and the comparison group of parents not admitted to the program (564 days).

This is suggestive of four very important outcomes. First, it suggests that because of enhanced supervision and increased knowledge about cases in the family drug court setting, those cases that were most likely to terminate regardless of circumstances, terminated more quickly as a result of having gone through the family drug court process. Second, it is not unreasonable to expect a longer time to case resolution among program graduates, given the amount of time that is often required to complete a treatment regimen (e.g., residential substance abuse treatment). Third, those who were not admitted to the family drug court took the same amount of time to resolve their case as program graduates. This means that a large pool of parents with substance

abuse problems can be encouraged to participate in the program because, in the best case scenario, their case is not likely to be resolved any faster whether they choose to participate or not. Finally, there appears to be an upward shift in the amount of time it takes to resolve protective custody cases that involve substance abuse in the Lewiston District Court as a whole. Whether this is attributable to the implementation of the drug court program or not is unknown.

Figure 8: Time to Court Case Closure from Petition Filing



Overall, family drug court participants fared slightly better on child welfare system outcomes. Children of family drug court participants spent less time in foster care (466 days) than children in the comparison court jurisdiction (510 days), and about the same amount of time as children involved with the child welfare system prior to the implementation of the drug court (471 days).

The last child welfare system outcome measure pertains to foster care expenditures resulting from differences in placement settings[6]. It will be recalled from the previous section that children of parents in the family drug court were more likely to be placed in relative foster care than children in the two comparison groups, whereas, children in both comparison groups were more likely to have been placed in a residential foster care setting, a far more expensive placement. Given that children of family drug court participants also spend less time in foster care, these findings, when combined, should result in lower foster care costs for the family drug court and higher foster care costs for the two comparison groups.

[6] Cost estimates were derived from the State of Maine, Department of Human Services. "Rules for Levels of Care for Foster Homes." 10-148. Chapter 14.

Referring to Table 7, we find this to be true. The average cost of foster care for the children of drug court participants ($13,380) is significantly lower than the cost of foster care for the children in the comparison court jurisdiction ($18,924); it's also lower than the cost of care for children in foster care prior to the implementation of the family drug court ($15,602).

Table 7: Days Out-of-Home Placement and Associated Costs

	Family Drug Court (n=35)	Lewiston Comparison (n=53)	Biddeford Comparison (n=36)
Average Days in Foster Care	466	471	510
Average Foster Care Costs	$13,380	$15,602	$18,924
Average Daily Foster Care Costs	$28.71	$33.13	$37.10

Dispositional Outcomes

Nationally there were approximately 287,000 children who exited the foster care system in 2005. Of these, approximately 54 percent (n=155,608) were reunified with their parent(s) or primary caregiver(s)[7]. In contrast, substance-abusing families in the child welfare system have historically achieved very low rates of reunification, ranging anywhere from 11 to 22 percent. For example, among substance-exposed infants who entered care in 1994, only 14 percent of those children were ultimately reunified with their parents after a seven year timeframe (Budde and Harden, 2003). As shown in Table 8, reunification rates across all groups in this sample are generally higher than reported elsewhere.

Table 8 provides information about the dispositional outcomes for the family drug court participants and the corresponding comparison groups. Even though most of the graduates did achieve reunification and most of the expelled group resulted in a termination of parental rights, combining the outcomes for both program graduates and expulsions (29%) yields no major differences in reunification rates against the comparison court jurisdiction (26%) or the comparison group prior to the implementation of the drug court program (30%).

Overall findings support the notion that graduation from family drug court does not necessarily mean reunification will occur, and that expulsion does not necessarily guarantee a termination of parental rights. However the family drug court will always yield more positive outcomes than conventional court settings. At the end of the day, increased supervision and judicial oversight always allows for more informed decision-making, thereby serving the best interests of the child in every case.

Table 8: Dispositional Outcomes – Reunification with at Least One Child

	Expulsions		Graduates		Discharges Combined		Not Admitted		Lewiston Comparison		Biddeford Comparison	
	N	Percent	N	Percent	N	Percent	N	Percent	N	Percent	N	Percent
Reunification	2	14.3%	6	60.0%	8	33.3%	7	35.0%	8	29.6%	5	26.3%
Custody to Relative	1	7.1%	1	10.0%	2	8.3%	2	10.0%	5	18.5%	3	15.8%
TPR	10	71.4%	3	30.0%	13	54.2%	11	55.0%	13	48.1%	10	52.6%
Change of Venue	1	7.1%	-	-	1	4.2%	-	-	1	3.7%	1	5.2%
Total	14	100%	10	100%	24	100%	20	100%	27	100%	19	100%

[7] The AFCARS Report: Preliminary FY 2005 Estimates as of September, 2006.

Estimating Costs and Savings

According to the National Center on Addiction and Substance Abuse, more than 20 percent of the $24 billion dollars states spend annually on prevention and treatment will ultimately go to child welfare costs related to substance abuse. Such costs occur because children of substance-abusing parents typically have longer stays in foster care than children of non-substance abusing parents. This is due, in part, to the low rate of reunification among parents with substance abuse problems. By providing more supervision, drug testing and integrated substance abuse treatment services, family drug court programs were designed to help families reunite by providing parents with substance abuse problems the added support, treatment and services they need to become healthy, responsible caregivers.

However, the decision to operate a family drug court ultimately requires resources above and beyond those required for conventional court case processing. It is estimated that it will cost at least $92,000 per year to operate the Lewiston Family Drug Court program. These funds pay for case management services, drug testing and administrative costs. With limited state resources, policymakers are interested in knowing whether or not family drug courts can reduce costs, and researchers have been hard-pressed to identify costs associated with their outcomes.

There are a number of ways people have estimated the relative costs or savings of family drug court programs. Some argue that the net benefit of the family drug court can be shown by the number of drug-free babies that are born to parents who completed substance abuse treatment and stayed sober throughout their participation in the program.

For example, in the Lewiston Family Drug Court, five mothers gave birth to five children, all of whom were born drug-free. It is estimated that over the course of a lifetime it costs taxpayers anywhere from $750,000 to $1,400,000 (depending on the drug) for every infant that is either born drug-addicted or with fetal alcohol spectrum disorder (Kalotra, 2002). Multiply the conservative end of that range for each of the five drug-free infants born, and this represents a total savings of $3,750,000. Subtract the cost of the family drug court program ($92,000) and this equals $3,658,000 in net savings to the public over the lifetimes of these children.

However, we also know that there were mothers in the comparison groups who entered into and successfully completed their treatment regimen. We do not know how many of these comparison-group mothers, if any, gave birth to a drug-free baby, which would also represent a savings to the taxpayer. Any cost savings estimate which includes the savings from the drug-free babies born in the family drug court, but excludes savings from the drug-free babies born in the comparison group would unfairly skew the numbers in favor of the family drug court program.

Another way to estimate costs and savings is to compare differences in the use of resources (e.g., the cost of foster care) between the children of participants in the family drug court program and the children of parents adjudicated through traditional case processing. *Ceteris paribus*, if we were to annualize the cost of providing foster care for the family drug court and both of the comparison groups using the information that was provided earlier in this report, we could calculate a net savings of $56,465 for drug court. If this were the only savings, however, the cost of the court ($92,000) would exceed the foster care cost savings ($56,465) by $35,535, representing a net loss, whereas differences in the cost of foster care for the comparison court ($107,182) would yield a net benefit of $15,182 for the family drug court program.

Conclusions

The overall goal of this evaluation is to determine whether the Lewiston Family Drug Court (LFDC) is more effective than traditional court settings in helping parents with substance abuse problems achieve better parent and parent-child outcomes. Findings along intermediate outcome measures suggest that the program is generating positive results along most short-term measures, with improvements in some areas (e.g., treatment access, retention, and time to case closure), and not in others (e.g., final case disposition). However, because the LFDC was implemented early in 2005 and has limited overall numbers, insufficient time has elapsed to independently assess the effectiveness of the program on any long-term outcomes.

Nevertheless, when compared to traditional court settings, the family drug court program will always better serve the interests of the child simply by allowing key stakeholders to make decisions based on the availability of more comprehensive information, whether it be through increased drug testing, case management supervision, or increased judicial monitoring.

The following is a summary of key findings detailed throughout this report:

- The Lewiston Family Drug Court has developed a strong integrated model, reflective of accepted best practice in the field of drug court programming.

- The Lewiston Family Drug Court (LFDC) is by far the most productive of Maine's family drug court programs, processing more than 60 percent of all referrals statewide in the shortest amount of time. Comparatively, the LFDC also has the highest retention and program completion rate.

- Family drug court participants are more likely to enter into and subsequently complete treatment than comparison groups who received conventional case processing.

- More frequent, randomized and monitored drug and alcohol testing cut the overall rate of positive tests and the number of participants testing positive in half.

- Once returned to the home, children of family drug court participants are less likely to experience a subsequent removal from the home.

- Because of enhanced supervision and increased knowledge about cases in the family drug court, cases that were most likely to result in a permanency plan other than reunification reached permanency sooner having gone through the family drug court process.

- Children of family drug court participants spent less time in foster care, generating lower foster care costs than the comparison groups. The likelihood of even greater cost-savings will result with expanded program capacity.

- Five drug-free babies were born to mothers participating in the family drug court program.

Recommendations

As a result of the major findings, HZA would like to encourage the Family Division of the Maine Judicial Branch and key stakeholders in the Lewiston Family Drug Court to consider the following recommendations, which are designed to improve the performance of the system and ultimately to generate better outcomes:

Recommendation 1:
Expand the capacity of the Lewiston Family Drug Court Program

Since implementation, the Lewiston Family Drug Court program identified and referred 116 families with substance abuse problems for program participation. Of these 116 referrals, only 38 parents ultimately chose to participate in the program. Among non-participants, only ten percent were rejected because they did not meet program eligibility requirements. However, the remaining 70 families who elected not to participate were equally likely to have benefited because: 1) there is an overall 50/50 chance of successfully completing the program and graduating; 2) outcomes for non-participants fared worse than for those in the family drug court; and 3) the length of time to case resolution took longer for non-participants than for parents enrolled in the family drug court.

In light of the relatively large pool of parents eligible for program participation, family drug court team members responsible for future program recruitment ought to convey these and other findings to encourage greater participation in the program. Anecdotal evidence from key actors in the family drug court program indicate that many parents elect not to participate because of the projected length of time it takes to successfully complete each of the various program phases. In addition, the family drug court may want to consider revising the handout that describes the various program phases to include actual timelines using data in this report. For example, program graduates averaged three to four months in each phase of the program and successfully completed the program in about 14 months. This is far less than the projected three to six months in each phase, or a maximum of 20 months to program graduation.

Recommendation 2:
Continue efforts aimed at reducing the amount of time it takes to be admitted into the Lewiston Family Drug Court.

It is well established that the sooner an individual is placed into treatment, the better his or her long-term odds of achieving success become. For this reason, the third *Key Component* of drug courts is to identify eligible participants early in the process and promptly place them into the program. According to the Lewiston Family Drug Court policy and procedures manual, the Orientation

Phase of the program (time between referral and admission) is designed to take no more than 45 days to successfully complete.

Initially, the LFDC was struggling to get participants to complete a clinical assessment, a process which must be done before anyone can be formally accepted into the program. The LFDC then began to offer financial incentives (e.g., $25 if the assessment is completed in two weeks, $15 if it is completed within a month) to encourage participants to complete their clinical assessment in a timely manner, thereby reducing admission delays and strengthening program retention.

As a result of these efforts, the LFDC was able to reduce the length of time participants spent in the Orientation Phase from an average of 105 days to 48 days; this closely approximates the 45-day window, or the maximum amount of time targeted for completion. The LFDC should consider other strategies to continue reducing the amount of time it takes to get admitted into the drug court. Informing defense attorneys, generally, about the benefits of program participation, as well as providing this information to parents at the Informational Session may also help to encourage more timely entry into the program.

Recommendation 3:
Narrow the range of sanctions imposed for certain violations of the family drug court contract.

The sixth *Key Component* of drug courts suggests the implementation and use of a system of graduated sanctions and incentives to ensure compliance with program requirements. The Lewiston Family Drug Court has outlined a complex system of graduated incentives and sanctions in its policy and procedures manual that controls for the type of behavior, as well as for the length of time of program participation. The system is tailored to allow for a range of options so as to more appropriately respond to the individual, while at the same time preserving a sense of fairness among the LFDC group as a whole.

For the most part, the real world application of the incentives and sanctions menu employed by the LFDC seems to be working with, perhaps, one possible exception: sanctions for unexcused appointments. As a result, the drug court team should consider narrowing the wide range of possible sanctions that can be employed for participants with unexcused absences.

Recommendation 4:
Collaborate with treatment agencies to expand the range of treatment options for family drug court participants.

Despite participating in the drug court for lengthy periods of time (an average of 172 days), some expelled participants received no substance abuse treatment whatsoever and among those who did, a significant amount of time

was spent in intensive outpatient (IOP) treatment. This may very well suggest that the expelled group required more intensive treatment services than they were able to get (e.g., partial hospitalization, residential), or that completion of an IOP was set forth as a condition of drug court participation and failure to complete the IOP ultimately translated into program expulsion.

However, it is well known that there are exceptionally long wait lists in Maine for the few residential treatment slots available for those in need of more intensive treatment interventions. Instead of creating more readily available treatment beds for this population, family drug court participants in need of such intensive services wind up getting plugged into whatever treatment services are immediately available (such as IOP), working on the assumption that some interim treatment is better than no treatment at all.

It is recommended that the family drug court work with treatment providers and treatment agencies to expand the range of available treatment options. The cost of paying for interim treatments that have been deemed inadequate to meet the needs of the individual — on top of the cost of providing the needed intervention at some later date — is an inefficient and costly use of very limited resources.

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