REVISED

JUDICIAL COUNCIL OF CALIFORNIA

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MEMORANDUM

Date
October 16, 2017

To
Collaborative Justice Courts Advisory Committee

From
Sharon Reilly

Subject
2017 Legislation

Action Requested
Informational Item

Deadline
N/A

Contact
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Below is the status of 2017 legislation reviewed by the CJCAC.

AB 103 (Committee on Budget), CH. 17
Effective/Operative Date: Urgency, June 27, 2017
Public safety: omnibus (including: Incompetent to Stand Trial)

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180AB103

JC: Oppose unless amended

Among other things, this Public Safety Budget Trailer Bill shifts authority from the judge to the Department of State Hospitals related to place a defendant who is found incompetent to stand trial into Jail Based Competency Treatment Programs.

AB 154 (Levine), Assembly Vetoed
Effective/Operative Date: January 1, 2018
Prisoners: mental health treatment

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180AB154

JC: No position

Requires a court, upon the conviction of a defendant for a felony resulting in his or her sentencing to state prison, to recommend in writing that the defendant receive a mental health evaluation if the court finds that the defendant at the time of the commission of the offense was suffering from a serious mental illness or has a demonstrated history of mental illness. (PEN 1203.096).

Veto Message:

To the Members of the California State Assembly:

I am returning Assembly Bill 154 without my signature.

This bill requires the sentencing court, after making specified findings, to provide a recommendation to the California Department of Corrections and Rehabilitation to conduct a mental health evaluation on a defendant sentenced to state prison.

While I understand the author's intent, the California Department of Corrections and Rehabilitation already conducts mental health evaluations on every defendant sentenced to state prison, regardless of a recommendation from the court.

Sincerely,

Edmund G. Brown Jr.

AB 532 (Waldron), Vetoed
Effective/Operative Date: January 1, 2018
Drug courts: drug and alcohol assistance

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180AB532

JC Position: Oppose

Provides that, until January 1, 2020, a court may collaborate with outside organizations on a program to offer mental health and addiction treatment services, as defined, to women who are charged in a complaint that consists only of misdemeanor offenses or who are on probation for one or more misdemeanor offenses. Excludes from these provisions a woman who is charged with a felony or who is under supervision for a felony conviction. (HSC 11875)

Veto Message:

To the Members of the California State Assembly:

I am returning Assembly Bill 532 without my signature.

This bill authorizes a court to collaborate with outside organizations to develop a program to offer mental health and addiction treatment services to women charged with specified non-felony complaints.

The programs to assist women in jail contemplated by this bill are laudatory, but the judicial branch already has full authority to develop collaborative courts which address these kinds of treatment services.

Sincerely,

Edmund G. Brown Jr.

AB 665 (Levine), Held in Senate Appropriations
Military personnel: veterans: resentencing: mitigating circumstances

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180AB665

JC Position: Support

Authorizes any person who was sentenced for a felony conviction prior to January 1, 2015, and who is, or was, a member of the United States military and who may be suffering from post-traumatic stress disorder or other forms of trauma conditions as a result of his or her military service to petition for a recall of sentence if the person meets both of the following conditions: A) The circumstance of suffering from sexual trauma, traumatic brain injury, post-traumatic stress disorder, substance abuse, or mental health problems as a result of the person's military service was not considered as a factor in mitigation at the time of sentencing; and B) The person was sentenced prior to January 1, 2015, whether or not the case was final as of January 1, 2015.

AB 720 (Eggman), CH. 347
Effective/Operative Date: January 1, 2018
Inmates: psychiatric medication: informed consent

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180AB720

CJCAC: No position (CJCAC/CLAC Mental Health Subcommittees worked with staff on amendments)

Summary Description of New Law: Authorizes the administration of psychotropic medication on an involuntary basis to county jail inmates who are awaiting arraignment, trial, or sentencing. Imposes additional criteria that must be satisfied before a county department of mental health or other designated county department may administer involuntary medication, including that the jail first make a documented attempt to locate an available bed for the inmate in a community-based treatment facility, under certain conditions, in lieu of seeking involuntary administration of psychiatric medication, and, if the inmate is awaiting resolution of a criminal case, that a hearing

to administer involuntary medication on a nonemergency basis be held before, and any requests for ex parte orders be submitted to, the court where the criminal case is pending. Requires the court to determine by clear and convincing evidence that: the inmate has a mental illness or disorder; as a result of that illness the inmate is gravely disabled; the inmate lacks the capacity to consent to or refuse treatment with psychiatric medications or is a danger to self or others if not medicated; and there is no less intrusive alternative to involuntary medication and the medication is in the inmate's best medical interest. Provides that a court may review, modify, or terminate an involuntary medication order for an inmate awaiting trial, if there is a showing that the involuntary medication is interfering with the inmate's due process rights in the criminal proceeding. Requires the court to review the involuntary medication order at intervals of not more than 60 days to determine whether the grounds for the order remain. Authorizes the court, at each review, to continue the order, vacate the order, or make any other appropriate order. States that these provisions do not prohibit the court, upon making a determination that an inmate awaiting arraignment, preliminary hearing, trial, sentencing, or a post-conviction proceeding to revoke or modify supervision may receive involuntary medication and, upon ex parte request of the defendant or counsel, from suspending all proceedings in the criminal prosecution, until the court determines that the defendant's medication will not interfere with his or her ability to meaningfully participate in the criminal proceedings. Sunsets these provisions on January 1, 2022. (PEN 2603).

SB 8 (Beall), as amended August 21, 2017, Held in Assembly Appropriations
Diversion: mental disorders

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180SB8

JC Positions: Support

Creates a diversion program for defendants whose mental disorder played a significant role in the commission of the charged offense. Authorizes the court, after considering the positions of the prosecution and defense, to grant pretrial diversion to a defendant whose mental disorder played a significant role in the commission of the charged offense. Specifies the eligible offenses are misdemeanors and jail felonies, but excludes specific felonies such as manslaughter. Requires the court to be satisfied that the defendant suffers from a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including, but not limited to: a) bipolar disorder, b) schizophrenia, or c) posttraumatic stress disorder, but excluding: a) antisocial personality disorder, b) borderline personality disorder, and c) pedophilia. The court must also find that the disorder contributed to the involvement of the charged offense. Requires the defense to arrange for a mental health treatment program for the divertee. Before approving the treatment, the court must consider various requests and needs. At least every three months, the mental health provider must provide progress reports to the court, defense, and prosecutor. Requires the court to hold a hearing to determine whether the criminal proceedings should be reinstituted if it appears to the court that the divertee is performing unsatisfactorily in the assigned program.

SB 142 (Beall), as amended June 21, 2017, Held in Assembly Public Safety
Criminal offenders: mental health

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180SB142

JC: Support if amended

Establishes the State Community Mental Health Performance Incentives Fund, which would provide monetary incentives for counties to avoid sending mentally ill offenders to prison. Requires courts to consider, if provided by probation, a defendant's mental health history when determining sentences and whether treatment in the community, including residential treatment, is appropriate in lieu of incarceration.

SB 143 (Beall), as amended February 21, 2017, Held in Senate Appropriations
Sentencing: persons confined to a state hospital

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180SB143

CJCAC: No position

Authorizes a person who is committed to a state hospital after being found not guilty by reason of insanity to petition the court to have the maximum term of commitment reduced to what it would have been had Proposition 36 or Proposition 47 been in effect at the time of the original determination. Requires the petitioner to show that he or she would have been eligible to have his or her sentence reduced under the relevant proposition and to file the petition prior to January 1, 2021, or at a later date with a showing of good cause.

SB 339 (Roth), CH. 595 (Also reviewed as AB 296)
Effective/Operative Date: January 1, 2018
Veterans treatment courts: Judicial Council assessment and survey

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180SB339

JC: Support

Summary Description of New Law: Requires the Judicial Council to conduct a study of veterans and Veterans Treatment Courts that includes a statewide assessment of those courts, including the number of participants and program outcomes. Requires the study to include a survey of counties that do not operate Veterans Treatment Courts that identifies barriers to program implementation and assesses the need for Veterans Treatment Courts in those jurisdictions. Also requires the council to report the results of the study to the Legislature on or before June 1, 2020, including recommendations regarding expansion of Veterans Treatment

Courts or services to counties without those courts and the feasibility of designing regional model Veterans Treatment Courts. (GOV 68530)

SB 684 (Bates), CH. 246
Effective/Operative Date: January 1, 2018
Incompetence to stand trial: conservatorship: treatment

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180SB684

CJCAC: No position

Authorizes a prosecutor, in felony cases involving alleged death, great bodily harm, or a serious threat to the physical well-being of another person, to request a probable cause hearing at any time before or after a defendant is determined to be incompetent to stand trial in order to establish probable cause that the defendant committed the crime for purposes of establishing a "Murphy" conservatorship; and codifies that certain persons may be conserved under either a "Murphy" conservatorship or Lanterman-Petris-Short conservatorship. (PEN 1368.1, 1370; WIC 5008)

SB 725 (Jackson), CH. 179
Effective/Operative Date: Urgency, August 7, 2017
Veterans: pretrial diversion: driving privileges

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180SB725

CJCAC: No position

Authorizes a trial court to grant military pretrial diversion on a misdemeanor charge of driving under the influence of alcohol and/or drugs (DUI). (PEN 1001.80)

AB-689 Juvenile proceedings: competency. (2017-2018)

Date Published: 03/17/2017 04:00 AM

AMENDED IN ASSEMBLY MARCH 16, 2017

CALIFORNIA LEGISLATURE— 2017–2018 REGULAR SESSION

ASSEMBLY BILL **No. 689**

Introduced by Assembly Member Obernolte

February 15, 2017

An act to repeal and add Section 709 of the Welfare and Institutions Code, relating to juveniles.

LEGISLATIVE COUNSEL'S DIGEST

AB 689, as amended, Obernolte. Juvenile proceedings: competency.

Existing law authorizes, during the pendency of any juvenile proceeding, the minor's counsel or the court to express a doubt as to the minor's competency. Existing law requires proceedings to be suspended if the court finds substantial evidence raises a doubt as to the minor's competency. Existing law requires the court to appoint an expert, as specified, to evaluate whether the minor suffers from a mental disorder, developmental disability, developmental immaturity, or other condition and, if so, whether the condition or conditions impair the minor's competency.

This bill would revise and recast these provisions to, among other things, expand upon the duties imposed upon an expert during his or her evaluation of a minor whose competency is in doubt, as specified. The bill would authorize the district attorney or minor's counsel to retain or seek the appointment of additional qualified experts with regard to determining competency, as specified. The bill would require the Judicial Council to adopt a rule of court relating to the qualifications of those experts, as specified.

The bill would also add provisions that would require a minor's competency to instead be determined at an evidentiary hearing, and would establish a presumption of mental competency, unless it is proven by a preponderance of the evidence that the minor is mentally incompetent, except as specified. The bill would require the court, upon a finding of incompetency, to *immediately* refer the minor to services designed to help the minor attain competency, as specified. If the court finds that the minor will not achieve competency within a reasonable period of time, the bill would require the court to dismiss the petition. The bill would authorize the court to allow specified persons and agencies to discuss any services that may be available to the minor after the court's jurisdiction is terminated, and would require the court to make certain referrals for the minor. The bill would require, among others, the presiding judge of a juvenile court, the probation department, and the county mental health department to develop a written protocol describing the competency process and a program to ensure that minors who are found incompetent receive appropriate remediation services.

By imposing additional duties on local officials, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 709 of the Welfare and Institutions Code is repealed.

SEC. 2. Section 709 is added to the Welfare and Institutions Code, to read:

709. (a) (1) Whenever the court has a doubt that a minor who is subject to any juvenile proceedings is mentally competent, the court shall suspend all proceedings and proceed pursuant to this section.

(2) A minor is mentally incompetent for purposes of this section if he or she is unable to understand the nature of the proceedings, including his or her role in the proceedings, or unable to assist counsel in conducting a defense in a rational manner, including a lack of a rational and factual understanding of the nature of the charges or proceedings. Incompetency may result from the presence of any condition or conditions, including, but not limited to, mental illness, mental disorder, developmental disability, or developmental immaturity. Except as specifically provided otherwise, this section applies to a minor who is alleged to come within the jurisdiction of the court pursuant to Section 601 or 602.

(3) During the pendency of any juvenile proceeding, the court may receive information from any source regarding the minor's ability to understand the proceedings. The minor's counsel or the court may express a doubt as to the minor's competency. The receipt of information or the expression of doubt of the minor's counsel does not automatically require the suspension of proceedings. If the court has a doubt as to the minor's competency, the court shall suspend the proceedings.

(b) (1) Unless the parties stipulate to a finding that the minor lacks competency, or the parties are willing to submit on the issue of the minor's lack of competency, the court shall appoint an expert to evaluate the minor and determine whether the minor suffers from a mental illness, mental disorder, developmental disability, developmental immaturity, or other condition affecting competency and, if so, whether the minor is competent.

(2) The expert shall have expertise in child and adolescent development and forensic evaluation of juveniles for purposes of adjudicating competency, shall be familiar with competency standards and accepted criteria used in evaluating juvenile competency, and shall have received training in conducting juvenile competency evaluations.

(3) The expert shall personally interview the minor and review all of the available records provided, including, but not limited to, medical, education, special education, probation, child welfare, mental health, regional center, and court records, and any other relevant information that is available. The expert shall consult with the minor's counsel and any other person who has provided information to the court regarding the minor's lack of competency. The expert shall gather a developmental history of the minor. If any information is unavailable to the expert, he or she shall note in the report the efforts to obtain that information. The expert shall administer age-appropriate testing specific to the issue of competency unless the facts of the particular case render testing unnecessary or inappropriate. In a written report, the expert shall opine whether the minor has the sufficient present ability to consult with his or her counsel with a reasonable degree of rational understanding and whether he or she has a rational and factual understanding of the proceedings against him or her. The expert shall also state the basis for these conclusions. If the expert concludes that the minor lacks competency, the expert shall make recommendations regarding the type of remediation services that would be effective in assisting the minor in attaining competency, and, if possible, the expert shall address the likelihood of the minor attaining competency within a reasonable period of time.

(4) The Judicial Council, in conjunction with groups or individuals representing judges, defense counsel, district attorneys, counties, advocates for people with developmental and mental disabilities, state psychologists and psychiatrists, professional associations and accredited bodies for psychologists and psychiatrists, and other interested stakeholders, shall adopt a rule of court identifying the training and experience needed for an expert to

be competent in forensic evaluations of juveniles. The Judicial Council shall develop and adopt rules for the implementation of the other requirements in this subdivision.
(5) Statements made to the appointed expert during the minor's competency evaluation, statements made by the minor to mental health professionals during the remediation proceedings, and any fruits of those statements shall not be used in any other hearing against the minor in either juvenile or adult court.

(6) The district attorney or minor's counsel may retain or seek the appointment of additional qualified experts who may testify during the competency hearing. The expert's report and qualifications shall be disclosed to the opposing party within a reasonable time before, but no later than five court days before, the hearing. If disclosure is not made in accordance with this paragraph, the expert shall not be allowed to testify, and the expert's report shall not be considered by the court unless the court finds good cause to consider the expert's report and testimony. If, after disclosure of the report, the opposing party requests a continuance in order to further prepare for the hearing and shows good cause for the continuance, the court shall grant a continuance for a reasonable period of time.

(7) If the expert believes the minor is developmentally disabled, the court shall appoint the director of a regional center for developmentally disabled individuals described in Article 1 (commencing with Section 4620) of Chapter 5 of Division 4.5, or his or her designee, to evaluate the minor. The director of the regional center, or his or her designee, shall determine whether the minor is eligible for services under the Lanterman Developmental Disabilities Services Act (Division 4.5 (commencing with Section 4500)), and shall provide the court with a written report informing the court of his or her determination. The court's appointment of the director of the regional center for determination of eligibility for services shall not delay the court's proceedings for determination of competency.

(8) An expert's opinion that a minor is developmentally disabled does not supersede an independent determination by the regional center regarding the minor's eligibility for services under the Lanterman Developmental Disabilities Services Act (Division 4.5 (commencing with Section 4500)).

(9) Nothing in this section shall be interpreted to authorize or require either of the following:

(A) Placement of a minor who is incompetent in a developmental center or community facility operated by the State Department of Developmental Services without a determination by a regional center director, or his or her designee, that the minor has a developmental disability and is eligible for services under the Lanterman Developmental Disabilities Services Act (Division 4.5 (commencing with Section 4500)).

(B) Determinations regarding the competency of a minor by the director of the regional center or his or her designee.

(c) The question of the minor's competency shall be determined at an evidentiary hearing unless there is a stipulation or submission by the parties on the findings of the expert. It shall be presumed that the minor is mentally competent, unless it is proven by a preponderance of the evidence that the minor is mentally incompetent. With respect to a minor under 14 years of age at the time of the commission of the alleged offense, the court shall make a determination as to the minor's capacity, pursuant to Section 26 of the Penal Code prior to deciding the issue of competency.
(d) If the court finds the minor to be competent, the court shall reinstate proceedings and proceed commensurate with the court's jurisdiction.

(e) If the court finds, by a preponderance of evidence, that the minor is incompetent, all proceedings shall remain suspended for a period of time that is no longer than reasonably necessary to determine whether there is a substantial probability that the minor will attain competency in the foreseeable future, or the court no longer retains jurisdiction. During this time, the court may make orders that it deems appropriate for services. Further, the court may rule on motions that do not require the participation of the minor in the preparation of the motions. These motions include, but are not limited to, all of the following:

(1) Motions to dismiss.

(2) Motions regarding a change in the placement of the minor.

(3) Detention hearings.

(4) Demurrers.

(f) Upon a finding of incompetency, the court shall *immediately* refer the minor to services designed to help the minor attain ~~competency immediately.~~ *competency.* Service providers and evaluators shall adhere to the standards stated in this section and the California Rules of Court. Services shall be provided in the least restrictive

environment consistent with public safety. Priority shall be given to minors in custody. Service providers shall determine the likelihood of the minor attaining competency within a reasonable period of time, and if the opinion is that the minor will not attain competency within a reasonable period of time, the minor shall be returned to court at the earliest possible date. The court shall review cases every 15 days until remediation services begin. After remediation services have commenced, the court shall review cases every 30 days.

(g) (1) Upon receipt of the recommendation by the remediation program, the court shall hold an evidentiary hearing on whether the minor is remediated or is able to be remediated unless the parties stipulate to, or agree to the recommendation of, the remediation program. If the recommendation is that the minor has attained competency, and if the minor disputes that recommendation, the burden is on the minor to prove by a preponderance of evidence that he or she remains incompetent. If the recommendation is that the minor is unable to be remediated and if the prosecutor disputes that recommendation, the burden is on the prosecutor to prove by a preponderance of evidence that the minor is remediable. If the prosecution contests the evaluation of continued incompetence, the minor shall be presumed incompetent and the prosecution shall have the burden to prove by a preponderance of evidence that the minor is competent. The provisions of subdivision (c) shall apply at this stage of the proceedings.

(2) If the court finds that the minor has been remediated, the court shall reinstate the proceedings.

(3) If the court finds that the minor has not yet been remediated, but is likely to be remediated within a reasonable period of time, the court shall order the minor to return to the remediation program.

(4) If the court finds that the minor will not achieve competency within a reasonable period of time, the court shall dismiss the petition. The court may invite persons and agencies with information about the minor, including, but not limited to, the minor and his or her attorney, the probation department, parents, guardians, or relative caregivers, mental health treatment professionals, the public guardian, educational rights holders, education providers, and social services agencies, to the dismissal hearing to discuss any services that may be available to the minor after jurisdiction is terminated. If appropriate, the court shall refer the minor for evaluation pursuant to Article 6 (commencing with Section 5300) of Chapter 2 of Part 1 of Division 5 or Article 3 (commencing with Section 6550) of Chapter 2 of Part 2 of Division 6.

(h) The presiding judge of the juvenile court, the probation department, the county mental health department, the public defender and other entity that provides representation for minors, the district attorney, the regional center, if appropriate, and any other participants that the presiding judge shall designate, shall develop a written protocol describing the competency process and a program to ensure that minors who are found incompetent receive appropriate remediation services.

SEC. 3. To the extent that this act has an overall effect of increasing certain costs already borne by a local agency for programs or levels of service mandated by the 2011 Realignment Legislation within the meaning of Section 36 of Article XIII of the California Constitution, it shall apply to local agencies only to the extent that the state provides annual funding for the cost increase. Any new program or higher level of service provided by a local agency pursuant to this act above the level for which funding has been provided shall not require a subvention of funds by the state or otherwise be subject to Section 6 of Article XIII B of the California Constitution.

However, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

AB-935 Juvenile proceedings: competency. (2017-2018)

Date Published: 09/15/2017 09:00 PM

ENROLLED SEPTEMBER 15, 2017

PASSED IN SENATE SEPTEMBER 12, 2017

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AMENDED IN SENATE SEPTEMBER 01, 2017

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AMENDED IN ASSEMBLY MAY 30, 2017

AMENDED IN ASSEMBLY MAY 01, 2017

AMENDED IN ASSEMBLY APRIL 06, 2017

AMENDED IN ASSEMBLY MARCH 28, 2017

CALIFORNIA LEGISLATURE— 2017–2018 REGULAR SESSION

ASSEMBLY BILL No. 935

Introduced by Assembly Member Mark Stone

February 16, 2017

An act to amend Section 709 of the Welfare and Institutions Code, relating to juveniles.

LEGISLATIVE COUNSEL'S DIGEST

AB 935, Mark Stone. Juvenile proceedings: competency.

Existing law authorizes, during the pendency of any juvenile proceeding, the minor's counsel or the court to express a doubt as to the minor's competency. Existing law requires proceedings to be suspended if the court finds substantial evidence raises a doubt as to the minor's competency. Upon suspension of proceedings, existing law requires the court to order that the question of the minor's competence be determined at a hearing. Existing law requires the court to appoint an expert, as specified, to evaluate whether the minor suffers from a mental disorder, developmental disability, developmental immaturity, or other condition and, if so, whether the condition or conditions impair the minor's competency.

This bill would revise and recast these provisions to, among other things, expand upon the duties imposed upon the expert during his or her evaluation of a minor whose competency is in doubt, as specified. The bill would

authorize the district attorney or minor's counsel to retain or seek the appointment of additional qualified experts with regard to determining competency, as specified. The bill would require the Judicial Council to adopt a rule of court relating to the qualifications of those experts, as specified. The bill would require the minor's competency to be determined at an evidentiary hearing, except as specified, and establish a presumption of competency, unless it is proven by a preponderance of the evidence that he or she is incompetent. If the minor is found incompetent and the petition contains only misdemeanor offenses, the bill would require the petition to be dismissed. The bill would require the court, upon a finding of incompetency, to refer the minor to services designed to help the minor attain competency. If the court finds that the minor will not achieve competency within 6 months, the bill would require the court to dismiss the petition. The bill would authorize the court to invite specified persons and agencies to discuss any services that may be available to the minor after the court's jurisdiction is terminated, and would require the court to make certain referrals for the minor. The bill would require, among others, the presiding judge of a juvenile court, the probation department, and the county mental health department to develop a written protocol describing the competency process and a program to ensure that minors who are found incompetent receive appropriate remediation services. The bill would prohibit secure confinement from extending beyond 6 months from the finding of incompetence, however, under specified conditions, the bill would authorize the court to order secure confinement for an additional 6 months, not exceeding one year. The bill would prohibit the total remediation period from exceeding one year from the finding of incompetence. By imposing additional duties on local officials, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 709 of the Welfare and Institutions Code is amended to read:

709. (a) (1) Whenever the court has a doubt that a minor who is subject to any juvenile proceedings is mentally competent, the court shall suspend all proceedings and proceed pursuant to this section.

(2) A minor is mentally incompetent for purposes of this section if he or she is unable to understand the nature of the proceedings, including his or her role in the proceedings, or unable to assist counsel in conducting a defense in a rational manner, including a lack of a rational and factual understanding of the nature of the charges or proceedings. Incompetency may result from the presence of any condition or conditions, including, but not limited to, mental illness, mental disorder, developmental disability, or developmental immaturity. Except as specifically provided otherwise, this section applies to a minor who is alleged to come within the jurisdiction of the court pursuant to Section 601 or 602.

(3) Notwithstanding paragraph (1), during the pendency of any juvenile proceeding, the court may receive information from any source regarding the minor's ability to understand the proceedings. The minor's counsel or the court may express a doubt as to the minor's competency. The receipt of information or the expression of doubt of the minor's counsel does not automatically require the suspension of proceedings. If the court has a doubt as to the minor's competency, the court shall suspend the proceedings.

(b) (1) Unless the parties stipulate to a finding that the minor lacks competency, or the parties are willing to submit on the issue of the minor's lack of competency, the court shall appoint an expert to evaluate the minor and determine whether the minor suffers from a mental illness, mental disorder, developmental disability, developmental immaturity, or other condition affecting competency and, if so, whether the minor is incompetent as defined in paragraph (2) of subdivision (a).

(2) The expert shall have expertise in child and adolescent development and forensic evaluation of juveniles for purposes of adjudicating competency, shall be familiar with competency standards and accepted criteria used in evaluating juvenile competency, shall have received training in conducting juvenile competency evaluations, and shall be familiar with competency remediation for the condition or conditions affecting competence in the particular case.

(3) The expert shall personally interview the minor and review all of the available records provided, including, but not limited to, medical, education, special education, probation, child welfare, mental health, regional center, and court records, and any other relevant information that is available. The expert shall consult with the minor's counsel and any other person who has provided information to the court regarding the minor's lack of competency. The expert shall gather a developmental history of the minor. If any information is unavailable to the expert, he or she shall note in the report the efforts to obtain that information. The expert shall administer age-appropriate testing specific to the issue of competency unless the facts of the particular case render testing unnecessary or inappropriate. The expert shall be proficient in the language preferred by the minor, or, if that is not feasible, the expert shall employ the services of a certified interpreter and use assessment tools that are linguistically and culturally appropriate for the minor. In a written report, the expert shall opine whether the minor has the sufficient present ability to consult with his or her counsel with a reasonable degree of rational understanding and whether he or she has a rational and factual understanding of the proceedings against him or her. The expert shall also state the basis for these conclusions. If the expert concludes that the minor lacks competency, the expert shall give his or her opinion on whether the minor is likely to attain competency in the foreseeable future, and, if so, make recommendations regarding the type of remediation services that would be effective in assisting the minor in attaining competency.

(4) The Judicial Council, in conjunction with groups or individuals representing judges, defense counsel, district attorneys, chief probation officers, counties, advocates for people with developmental and mental disabilities, experts in special education testing, psychologists and psychiatrists specializing in adolescents, professional associations and accredited bodies for psychologists and psychiatrists, and other interested stakeholders, shall adopt a rule of court identifying the training and experience needed for an expert to be competent in forensic evaluations of juveniles. The Judicial Council shall develop and adopt rules for the implementation of the other requirements in this subdivision.

(5) Statements made to the appointed expert during the minor's competency evaluation and statements made by the minor to mental health professionals during the remediation proceedings shall not be used in any other hearing against the minor in either juvenile or adult court.

(6) The district attorney or minor's counsel may retain or seek the appointment of additional qualified experts who may testify during the competency hearing. The expert's report and qualifications shall be disclosed to the opposing party within a reasonable time before, but no later than five court days before, the hearing. If disclosure is not made in accordance with this paragraph, the court may make any order necessary to enforce the provisions of this paragraph, including, but not limited to, immediate disclosure, contempt proceedings, delaying or prohibiting the testimony of the expert or consideration of the expert's report upon a showing of good cause, or any other lawful order. If, after disclosure of the report, the opposing party requests a continuance in order to further prepare for the hearing and shows good cause for the continuance, the court shall grant a continuance for a reasonable period of time.

(7) If the expert believes the minor is developmentally disabled, the court shall appoint the director of a regional center for developmentally disabled individuals described in Article 1 (commencing with Section 4620) of Chapter 5 of Division 4.5, or his or her designee, to evaluate the minor. The director of the regional center, or his or her designee, shall determine whether the minor is eligible for services under the Lanterman Developmental Disabilities Services Act (Division 4.5 (commencing with Section 4500)), and shall provide the court with a written report informing the court of his or her determination. The court's appointment of the director of the regional center for determination of eligibility for services shall not delay the court's proceedings for determination of competency.

(8) An expert's opinion that a minor is developmentally disabled does not supersede an independent determination by the regional center whether the minor is eligible for services under the Lanterman Developmental Disabilities Services Act (Division 4.5 (commencing with Section 4500)).

(9) This section shall not be interpreted to authorize or require either of the following:

(A) The placement of a minor who is incompetent in a developmental center or community facility operated by the State Department of Developmental Services without a determination by a regional center director, or his or her designee, that the minor has a developmental disability and is eligible for services under the Lanterman Developmental Disabilities Services Act (Division 4.5 (commencing with Section 4500)).

(B) Determinations regarding the competency of a minor by the director of the regional center or his or her designee.

(c) The question of the minor's competency shall be determined at an evidentiary hearing unless there is a stipulation or submission by the parties on the findings of the expert. It shall be presumed that the minor is

mentally competent, unless it is proven by a preponderance of the evidence that the minor is mentally incompetent. With respect to a minor under 14 years of age at the time of the commission of the alleged offense, the court shall make a determination as to the minor's capacity pursuant to Section 26 of the Penal Code prior to deciding the issue of competency.

(d) If the court finds the minor to be competent, the court shall reinstate proceedings and proceed commensurate with the court's jurisdiction.

(e) If the court finds, by a preponderance of evidence, that the minor is incompetent, all proceedings shall remain suspended for a period of time that is no longer than reasonably necessary to determine whether there is a substantial probability that the minor will attain competency in the foreseeable future, or the court no longer retains jurisdiction and the case must be dismissed. Prior to a dismissal, the court may make orders that it deems appropriate for services. Further, the court may rule on motions that do not require the participation of the minor in the preparation of the motions. These motions include, but are not limited to, all of the following:

(1) Motions to dismiss.

(2) Motions regarding a change in the placement of the minor.

(3) Detention hearings.

(4) Demurrers.

(f) If the minor is found to be incompetent and the petition contains only misdemeanor offenses, the petition shall be dismissed.

(g) Upon a finding of incompetency, the court shall refer the minor to services designed to help the minor attain competency, including, but not limited to, mental health services, treatment for trauma, medically supervised medication, behavioral counseling, curriculum-based legal education, or training in socialization skills, consistent with any laws requiring consent. Service providers and evaluators shall adhere to the standards stated in this section and the California Rules of Court. Services shall be provided in the least restrictive environment consistent with public safety, as determined by the court. Service providers shall determine the likelihood of the minor attaining competency within the foreseeable future, and if the opinion is that the minor will not attain competency within six months, the minor shall be returned to court at the earliest possible date. The court shall review remediation services at least every 30 calendar days for minors in custody and every 45 calendar days for minors out of custody prior to the expiration of the total remediation period specified in paragraph (3) of subdivision (h). If the minor is in custody, the county mental health department shall provide the court with suitable alternatives for the continued delivery of remediation services upon release from custody as part of the court's review of remediation services. The court may make any orders necessary to assist with the delivery of remediation services in an alternative setting to secure confinement.

(h) (1) Upon receipt of the recommendation by the designated person or entity, the court shall hold an evidentiary hearing on whether the minor is remediated or is able to be remediated unless the parties stipulate to, or agree to the recommendation of, the remediation program. If the recommendation is that the minor has attained competency, and if the minor disputes that recommendation, the burden is on the minor to prove by a preponderance of evidence that he or she remains incompetent. If the recommendation is that the minor is unable to be remediated and if the prosecutor disputes that recommendation, the burden is on the prosecutor to prove by a preponderance of evidence that the minor is remediable. If the prosecution contests the evaluation of continued incompetence, the minor shall be presumed incompetent and the prosecution shall have the burden to prove by a preponderance of evidence that the minor is competent. The provisions of subdivision (c) shall apply at this stage of the proceedings.

(2) If the court finds that the minor has been remediated, the court shall reinstate the proceedings.

(3) If the court finds that the minor has not yet been remediated, but is likely to be remediated within six months, the court shall order the minor to return to the remediation program. However, the total remediation period shall not exceed one year from the finding of incompetency.

(4) If the court finds that the minor will not achieve competency within six months, the court shall dismiss the petition. The court may invite persons and agencies with information about the minor, including, but not limited to, the minor and his or her attorney, the probation department, parents, guardians, or relative caregivers, mental health treatment professionals, the public guardian, educational rights holders, education providers, and social services agencies, to the dismissal hearing to discuss any services that may be available to the minor after jurisdiction is terminated. If appropriate, the court shall refer the minor for evaluation pursuant to Article 6

(commencing with Section 5300) of Chapter 2 of Part 1 of Division 5 or Article 3 (commencing with Section 6550) of Chapter 2 of Part 2 of Division 6.

(5) (A) Secure confinement shall not extend beyond six months from the finding of incompetence, except as provided in this section. Only in cases when the petition involves an offense listed in subdivision (b) of Section 707, may the court consider whether it is necessary and in the best interest of the minor and the public's safety to order secure confinement of a minor for up to an additional six months, not to exceed one year. In making that determination, the court shall consider all of the following:

(i) Where will the minor have the best chance of obtaining competence.

(ii) Whether the placement is the least restrictive setting appropriate for the minor.

(iii) Whether alternatives to secure confinement have been identified and pursued and why alternatives are not available or appropriate.

(iv) Whether the placement is necessary for the safety of the minor or others.

(B) If the court determines, upon consideration of these factors, that it is in the best interest of the minor and the public's safety for the minor to remain in secure confinement, the court shall state the reasons on the record.

(i) The presiding judge of the juvenile court, the probation department, the county mental health department, the public defender and other entity that provides representation for minors, the district attorney, the regional center, if appropriate, and any other participants that the presiding judge shall designate, shall develop a written protocol describing the competency process and a program to ensure that minors who are found incompetent receive appropriate remediation services.

SEC. 2. To the extent that this act has an overall effect of increasing certain costs already borne by a local agency for programs or levels of service mandated by the 2011 Realignment Legislation within the meaning of Section 36 of Article XIII of the California Constitution, it shall apply to local agencies only to the extent that the state provides annual funding for the cost increase. Any new program or higher level of service provided by a local agency pursuant to this act above the level for which funding has been provided shall not require a subvention of funds by the state or otherwise be subject to Section 6 of Article XIII B of the California Constitution.

However, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

OFFICE OF THE GOVERNOR

OCT 13 2017

To the Members of the California State Assembly:

I am returning Assembly Bill 935 without my signature.

This bill revises the procedure to determine the mental competence of a juvenile charged with a crime, and limits the time a juvenile who is found to be incompetent can be incarcerated.

I applaud the author for addressing a subject that is in need of review, and I support finding a solution to address any gaps in the procedures for juveniles who are found not to be competent to face court proceedings.

I am concerned, however, with the rare instances in which youth are accused of very serious crimes. I encourage further review as to how these situations may be accounted for while preserving the author's underlying intent.

Sincerely,

Edmund G. Brown Jr.

CALIFORNIA ASSOCIATION C.A.Y.C. of YOUTH COURTS

JUDICIAL COUNCIL OF CALIFORNIA
OPERATIONS AND PROGRAMS DIVISION
CENTER FOR FAMILIES, CHILDREN & THE COURTS

,

REGISTER NOW!

Thursday, November 16, 2017
10:30 am – 3:00 pm
Juvenile Justice Campus
3333 E. American Ave.
BLDG 701, Suite A, 2nd Floor
Fresno, CA

Creating Alternatives in Juvenile Justice

The California Association of Youth Courts, in collaboration with the Judicial Council Center for Families, Children & the Courts is hosting an all-day roundtable on youth courts. The purpose of the roundtable is twofold. First, to highlight promising practices in youth courts and second, to address truancy and discipline issues in school.

Youth acting out in school can be an early indicator of future behaviors, and schools are eager to find ways to reduce crime, bullying and hate-related incidents. Youth court empowers youth to be leaders and engage in civic responsibility. Join the discussion on elevating youth courts as a way to address these growing issues.

Designed to educate youth about the juvenile justice system while addressing each juvenile's accountability to his or her community and peers, youth courts provide an alternative approach to the traditional juvenile justice system for first time, non-violent offenders.

There is no fee to attend, but registration is required. Please register here:
https://www.surveymonkey.com/r/YCRfresno

For additional information, contact Donna Strobel at donna.strobel@jud.ca.gov or (415) 865-8024

Online CJER educational materials related to mental health as of 10-17-17. Materials accessible via the Judicial Resources Network.

- General Reference
  - Judges' Guide to Mental Illnesses in the Courtroom
  - Mental Health Courts: An Overview
  - Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report
  - A Mental Health Guide for Judges
  - Mental Illness in the Courtroom (slides)
  - Mental Illness in the Courtroom (Video: #6790, June 2012, 89 min)
  - Common Mental Health Calendar Dates
  - Common Mental Health Rulings
  - Psychology and the Law (Video: #6684, July 2010, 45 min)
  - ADA Awareness: Mental Health Disability (Video: #6822, January 2013, 60 min)
  - Developmental Disability (Video: #6786, June 2012, 62 min)
  - Mental Health Professionals in Family Law (Oct 2015)
  - Handling a Collaborative Court Assignment (#6468) (2009) Hon. Phil Pennypacker talks about the importance of collaborative courts and how to make them work effectively. (18 min)
  - Methamphetamine and Prescription Drug Abuse (Video: #6315, May 2008, 91 min)

- Competence (PC 1368)
  - Competence To Stand Trial [essential if new to assignment] (Benchguide 63)
  - Introduction to Competency to Stand Trial (Video: #6629, March 2011, 82 min)
  - Criminal Competence Script
  - Penal Code §§1368–1369 Incompetent to Stand Trial (IST)
  - Penal Code §1368 Procedure When Judge Has Doubt Regarding Mental Competence of Criminal Defendant
  - Sample Order: Order to Appear and Show Cause Re: Admission Delay
  - Sample Proof of Service for Order to Appear And To Show Cause
  - Sample Order: Penal Code §1370(b)(1) Return Defendant From State Hospital
  - Sample Order: Penal Code §1372 Return Defendant from State Hospital to County Jail—Competency Restored
  - Sample Proof of Service for Order to Appear And To Show Cause
  - *Faretta* Request and Competency to Self-Represent Under *People v. Johnson*
  - Doubt Regarding The Mental Competence Of A Criminal Defendant (Mar 2016)
  - Introduction to Competency to Stand Trial (Video: #6629, March 2011, 82 min)

- Insanity
  - The NGI Scripts

- Penal Code §1026.2 Hearings for Restoration of Sanity and Outpatient Treatment Facility Request
- Penal Code §1026.5(B) *Et Seq*. Two-Year Extension Hearing
- Penal Code §1027 Appointments and Reports
- Penal Code §§1608–1609: Revocation of Outpatient Status
- Sample Voir Dire Questions for Mental Health Case
- Script for Entry of NGI Plea

- Involuntary Medication
  - Penal Code §1370 Administration of Antipsychotic Medication

- Mentally Disordered Offender (MDO)
  - Penal Code §2970: Petition for One-Year Extension & Penal Code §2972 Hearing
  - Hon. Maria E. Stratton, Superior Court of Los Angeles County: Mentally Disordered Offender Case List

- Veterans
  - Justice-Involved Veterans: A decision map of Penal Code section 1170.9
  - Military Sexual Trauma Information Sheet

- Conservatorship
  - Benchguide 300: Conservatorship: Appointment and Powers of Conservator
  - Benchguide 301: Conservatorship Proceedings
  - Conservatorships: When Criminal Matters Intersect With Conservatorship (Video: #7112, June 1, 2016, 93 min)

- Lanterman-Petris-Short Act (LPS) Conservatorship and Mental Health Issues:
  - Benchguide 120: LPS Proceedings
  - Checklist: Court-Ordered Evaluation for 72 Hours (Welf & I C §§5200–5213)
  - Checklist: Court-Ordered Evaluation for Criminal Defendant Afflicted With Chronic Alcoholism or Drug Abuse (Welf & I C §§5225–5230)
  - Checklist: Certification Review Hearing After 14-Day Hold Ordered (Welf & I C §5254)
  - Establishing LPS Conservatorship (Welf & I C §5350)
  - Involuntary Holds Under the LPS Act
  - Burdens of Proof at Mental Heath Hearings
  - Due Process Rights at LPS Act and Mental Health Trials
  - *Roger S.* Hearings
  - LPS Conservatorships: Safety Net for the Mentally Ill (Apr 2015)
  - Introduction to LPS Holds and Conservatorships (Video: #6624, February 2011, 86 min) [essential if new to assignment]
  - Gun Returns and Restoration of the Right to Bear Arms (Video: #6785, June 2012, 38 min)

- Treatments
  - Electroconvulsive Shock Therapy (Video: #6784, June 2012, 30 min)
  - Coercion or Motivation: What Actually Changes Behavior? (10/5/2017) In this introductory video, Dr. Igor Koutsenok discusses what has been scientifically proven to motivate people, including criminal offenders, to make positive behavioral change.
  - Judicial Perspectives on Medication Assisted Treatment for Opioid Abuse, Part 1 (24:30 min) July, 2016
    Featuring Judge David Danielsen, San Diego County Superior Court, in conversation with Alexandra Nielsen, a substance abuse researcher at Portland State University. This episode is part 1 of a 3 part series.
  - Judicial Perspectives on Medication Assisted Treatment for Opioid Abuse, Part 2 (21:50 min) September, 2016
    Featuring Judge David Danielsen, San Diego County Superior Court, in conversation with Alexandra Nielsen, a substance abuse researcher at Portland State University. This episode is part 2 of a 3 part series.
  - Judicial Perspectives on Medication Assisted Treatment for Opioid Abuse, Part 3 (19:03 min) December, 2016
    Featuring Judge David Danielsen, San Diego County Superior Court, in conversation with Alexandra Nielsen, a substance abuse researcher at Portland State University. This episode is part 3 of a 3 part series.

Code of Civil Procedure 384.

(a) It is the policy of the State of California to ensure that the unpaid cash residue and unclaimed or abandoned funds in class action litigation are distributed, to the fullest extent possible, in a manner designed either to further the purposes of the underlying class action or causes of action, or to promote justice for all Californians. The Legislature finds that the use of funds for these purposes is in the public interest, is a proper use of the funds, and is consistent with essential public and governmental purposes.

(b) (1) Except as provided in subdivision (c), whenever a judgment, including any consent judgment, decree, or settlement agreement that has been approved by the court, in a class action established pursuant to Section 382, provides for the payment of money to members of the class, any unpaid cash residue or unclaimed or abandoned class member funds shall be distributed in accordance with this section unless for good cause shown the court makes a specific finding that an alternative distribution would better serve the public interest or the interest of the class. If not specified in the judgment, the court shall set a date when the parties shall submit a report to the court regarding a plan for the distribution of any moneys pursuant to this section.

(2) The court shall make any orders necessary and appropriate for the payment, administration, supervision, and accounting of any unpaid cash residue or unclaimed or abandoned class member funds.

(3) Any unpaid cash residue or unclaimed or abandoned class member funds generally attributable to California residents, plus any accrued interest that has not otherwise been distributed pursuant to order of the court, shall be transmitted as follows:

(A) Twenty-five percent to the State Treasury for deposit in the Trial Court Improvement and Modernization Fund, established in Section 77209 of the Government Code, and subject to appropriation in the annual Budget Act for the Judicial Council to provide grants to trial courts for new or expanded collaborative courts or grants for Sargent Shriver Civil Counsel.

(B) Twenty-five percent to the State Treasury for deposit into the Equal Access Fund of the Judicial Branch, to be distributed in accordance with Sections 6216 to 6223, inclusive, of the Business and Professions Code, except that administrative costs shall not be paid to the State Bar or the Judicial Council from this sum.

(C) Fifty percent to one or more of the following: nonprofit organizations or foundations, to support projects that will benefit the class or similarly situated persons, further the objectives and purposes of the underlying class action or cause of action, or promote the law consistent with the objectives and purposes of the underlying class action or cause of action; child advocacy programs; or nonprofit organizations providing civil legal services to the indigent. Notwithstanding subparagraph (B), additional funds may be allocated by the court to the Equal Access Fund of the Judicial Branch, to be distributed in accordance with Sections 6216 to 6223, inclusive, of the Business and Professions Code.

(4) The court shall ensure that the distribution of the balance of any unpaid cash residue or unclaimed or abandoned class member funds derived from multistate or national cases shall provide substantial or commensurate benefit to California consumers that is roughly proportional

to the number of California class members or amounts available from the judgment to California class members in the multistate or national class.

(c) This section shall not apply to any class action or cause of action brought against any public entity, as defined in Section 811.2 of the Government Code, or against any public employee, as defined in Section 811.4 of the Government Code. However, this section shall not be construed to abrogate any equitable cy pres remedy that may be available in any class action with regard to all or part of the cash residue or unclaimed or abandoned class member funds.

(Amended by Stats. 2017, Ch. 17, Sec. 4. Effective June 27, 2017.)

*in*sights **Volume XIII,** Summer 2017

California Child Welfare Co-Investment Partnership

A Matter of Substance

Challenges and Responses to Parental Substance Use in Child Welfare

According to national data, parental substance use disorder (SUD) is one of the leading underlying factors contributing to the finding of neglect as the basis for child removal.[1] While the number of children in foster care nationally has dropped significantly over the last decade, recent data is showing an upward trend associated with the opioid epidemic, which includes both prescription drugs as well as illegal drugs, such as heroin. Child welfare removals have increased in some California counties, though case file reviews suggest that opioids may not be the primary contributing factor.

In this issue of *in*sights, we present California's methods for capturing and reporting SUD-related child welfare entries, as well as other sources that measure the impact of parental substance use in California and nationally. After discussing the potential number of families affected by substance use disorder, we look at how much the state's efforts to integrate child welfare services with behavioral health, the courts, and Alcohol and Other Drugs (AOD) programs have supported family reunification even in the face of an upward trend of SUD in some California counties. And finally, we discuss ways to keep moving forward with focused state efforts during a time of possible rollbacks on health care coverage and other social services.

1 "Substance abuse and child maltreatment," Wells, 2009. https://www.ncbi.nlm.nih.gov/pubmed/19358920

IN THIS ISSUE:

- **Data on children affected by parental substance use disorders**
- **Promising strategies for prevention and treatment**
- **Moving forward**

"When the crack epidemic hit our state, agencies and the courts were not as focused on keeping families together, which had ripple effects for a generation. The good news is we are more integrated and prepared now for what may be coming."

State Sen. Holly J. Mitchell, Chair of the Senate Budget Committee

"For years California did not have a very robust system to respond to substance use disorders. The Affordable Care Act allowed us to expand. Right now we are implementing a whole new service delivery program, a new dynamic of care, which will have an impact on the child welfare system."

Karen Baylor, Deputy Director of Mental Health and Substance Use Disorder Services, California Department of Health Care Services

Substance Use Disorder (SUD) Definition

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and/or failure to meet major responsibilities at work, school, or home. A diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.

> "When reviewing these data, consider that only a handful of states have a standardized screening tool used to detect parental substance use disorders during investigations of child abuse and neglect. Additionally, very few states have statewide policies and protocols on how the results of investigations regarding parents' substance use are to be recorded in states' information systems."[3]
>
> ***Nancy Young, Director, Children and Family Futures***

National Data

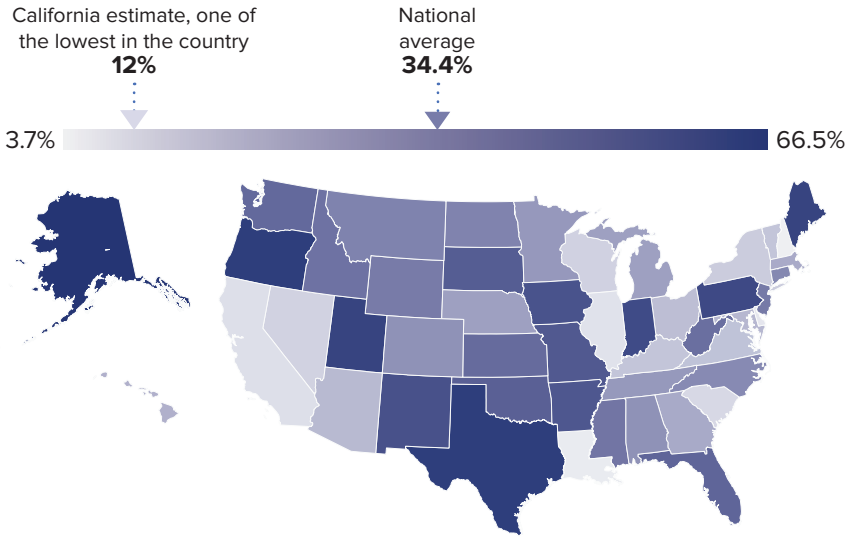
The primary source for national data on the correlation of substance use and child welfare is from the Adoption and Foster Care Analysis and Reporting System (AFCARS), which collects case-level information on all children in foster care and those who have been adopted with Title IV-E waiver involvement. However, there are still flaws in the use and consistency in measurement and reporting of substance abuse in AFCARS across states.

In 2015, the percent of children entering care with substance use as the documented circumstance of removal was 34.4 percent. Parental substance use is often reported as a removal reason in conjunction with neglect, which is the most common category of maltreatment for young children nationally and in California (more than 85 percent in 2015).[2]

The map below indicates significant state level variation, with California showing only 12 percent of children entering care in 2015 with substance use as a reason. It should be noted that state data is not necessarily comparable for a number of reasons. For example, states have different category options available in their data systems to capture this information, and local investigation and data entry practices vary. In addition, California law is clear that parental substance abuse, in the absence of neglect or other abuse, is not a basis to detain a child in the child welfare system.

Another national source of data is the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Center on Substance Abuse and Child Welfare where the most recent reports show that each year, an estimated 400,000-440,000 infants (1 in 10 births in the U.S.) are affected by prenatal alcohol or illicit drug exposure.

Percentage of Children Entering Care Due to Parental Substance Use, 2015



Source: AFCARS Report for fiscal year 2015.[4] Estimates based on all children in out-of-home care at some point during the fiscal year.

2 "First Entries into Foster Care, by Reason for Removal" kidsdata.org, 2016. http://www.kidsdata.org/topic/16/fostercare-entries-reason/table
3 "Examining the Opioid Epidemic: Challenges and Opportunities," Feb. 2016. https://www.finance.senate.gov/imo/media/doc/23feb2016Young.pdf
4 "AFCARS Foster Care File 2015: Dataset 200" NDACAN, 2016. http://www.ndacan.cornell.edu/datasets/dataset-details.cfm?ID=200

California Data

The Child Welfare Services/Case Management System (CWS/CMS) is a statewide case management tool that supports the child welfare system of services in California. When a parent or caregiver is reported for possible child abuse or neglect, the referral is entered into CWS/CMS and goes to an intake social worker. About a quarter of these children have no further inquiry in a given year. For those that do result in a case filed, an emergency response worker will indicate suspected abuse or neglect (300 codes) and initiate an investigation within 24 hours for urgent responses and with an allowance of up to 10 days for less severe allegations. There are some legally mandated fields that must be entered as the investigation progresses, e.g., severe neglect, sexual abuse, and physical abuse. However, substance use is not a mandated field, as it is not a legal reason for removing a child from a home.

Caseworkers can indicate substance use as an underlying factor in CWS/CMS, but this is an optional data field. This may partially explain why a sample of CDSS case file review data shows that only between 15-20 percent of removals include reference to substance use, a percentage much lower than other states (50-70 percent).

In addition to CMS/CWS, Structured Decision Making (SDM) is a tool for assessing safety and risk during CPS investigations, and includes a screening for parental substance use. SDM is currently used in all 58 California county child welfare agencies. SDM and case plan reviews are two ways to ascertain how often substance use disorders are an underlying factor for removal in California counties. Corroborating case reviews and estimates from child welfare workers on SUD involvement in neglect cases, a 2015 report based on SDM completions by social workers, found that 58 percent of the families screened in California had substance use intervention identified as a family need.

Beyond Child Welfare: California Data Collection on SUD

Although the CWS/CMS system does not currently provide data that can confirm or refute a clear link between SUD and child welfare entries, other datasets can be used to further analyze the possible linkage.

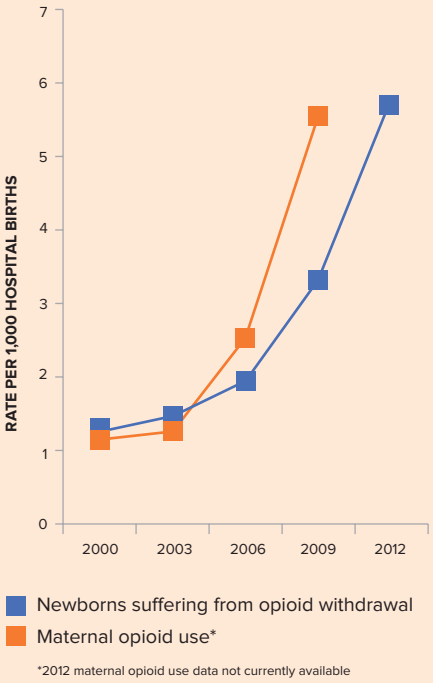
Office of Statewide Health Planning (OSHPD): OSHPD collects data from individual, licensed health care facilities to produce reports on newborns affected by drugs transmitted via placenta or breast milk. Reports show a 95 percent increase between 2008 (1,862) and 2015 (3,633).[5]

> "For more accurate data, you would want to get substance use identifiers into CWS/CMS. As a former social worker, I am sure that the levels of substance use in child welfare cases are 70 percent or higher, similar to what we see in the service plans."
>
> ***Nancy Taylor, Principal Manager, Center for Families, Children & the Courts***

> "The good news is that these concerns about data collection are being addressed with our new case management system, CWS/CMS-NS, which will both bring us into compliance with federal law as well as give counties and the state the data we need to accurately respond and plan to meet the needs of our families and children affected by substance use disorders."
>
> ***Greg Rose, Deputy Director, California Department of Social Services***

5 "Newborns Affected by Drugs Transmitted Via Placenta of Breast Milk," OSHPD 2006 - 2015. https://www.documentcloud.org/documents/3552873-3633.html

Neonatal Abstinence Syndrome and Maternal Opioid Use in the U.S.



*2012 maternal opioid use data not currently available

There was a five-fold increase in the proportion of babies born with NAS from 2000 to 2012, when an estimated 21,732 infants were born with NAS. Source: The Kids Inpatient Database 2000-2012.

California Department of Public Health (CDPH)'s Prescription Drug Overdose Prevention Initiative: While not specific to child welfare, this initiative offers another source of substance use data with its California Opioid Overdose Surveillance Dashboard, which provides county-level non-fatal and fatal opioid-involved overdose and opioid prescription data. The dashboard is the result of ongoing collaboration between CDPH, OSHPD, Department of Justice (DOJ), and the California Health Care Foundation (CHCF). Although a preliminary inquiry into dashboard data and CMS/CWS suggested a likely relationship, examining the contribution of opioid use requires a more complex examination that accounts for other factors and social determinants known to be associated with CPS outcomes.

Also resulting from the collaboration, CDPH's statewide workgroup on opioid safety recently added a task force to address maternal and neonatal opioid exposure. The multidisciplinary group will look to address the need for medication-assisted treatment for women of childbearing age, early screening, and responding to the CARA act requiring DSS to address infant exposure to opioids.

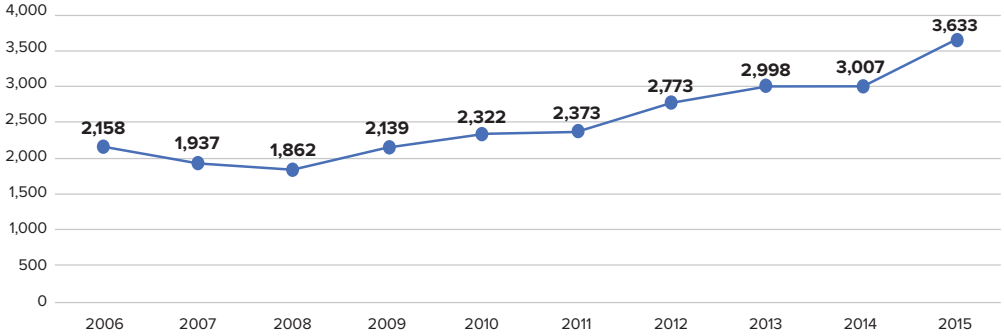
Indicators of Prenatal Substance Use Disorders

Infants exposed to alcohol and drugs during pregnancy run the risk of suffering from birth defects, low birth weight, premature birth, small head circumference, sudden infant death syndrome (SIDS), and subsequent developmental and behavioral delays and/or challenges.

Fetal Alcohol Spectrum Disorders (FASD) include a range of changes to the brain resulting from alcohol exposure in utero that impacts the child's ability to function.

Neonatal abstinence syndrome (NAS) is a group of problems that occur in a newborn who was exposed to addictive drugs, specifically opiates in utero. Drugs such as heroin, codeine, oxycodone, methadone, and buprenorphine pass through the placenta and cause the baby to become dependent on the drug along with the mother. After birth, the baby experiences withdrawal symptoms that may include excessive crying, fever, poor feeding, rapid breathing, trembling, and vomiting. NAS has been on the rise nationwide.

California Newborns Affected by Substance Use* Transmitted Via Placenta or Breast Milk



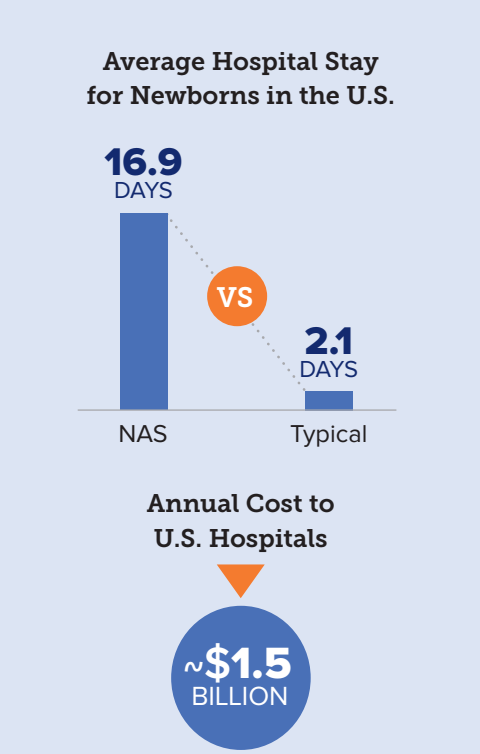
*Includes cocaine, hallucinogenic agents, other narcotics, other drugs of addiction, or noxious substances, or those that displayed withdrawal syptoms of the same.
Souce: Inpatient Discharge Data, 2006-2015; Office of Statewide Health Planning and Development

California has seen a 68% increase in newborns affected by NAS since 2006.

Nationally, in 2012, newborns with NAS stayed in the hospital an average of 16.9 days (compared with 2.1. days for other newborns), costing U.S. hospitals an estimated $1.5 billion; the majority of these charges (81 percent) were paid by state Medicaid programs.[6] These rates may be related to not only prevalence of SUD among lower income parents, but also variations in screening practices in public hospitals in comparison to private institutions which may screen less frequently. The rising frequency (and costs) of drug withdrawal in newborns points to the need for more measures to prevent exposure to opiates, specifically early detection and treatment for pregnant mothers and, more generally, women of childbearing age. Additionally, researchers have called for more study into the effects of punitive and intervention approaches to deter maternal substance use and potential increases this may cause to the likelihood that a mother will avoid detection by avoiding medical care.[7]

In California, data from the California State Inpatient Databases, show the rate of infants born with NAS per 1,000 delivery hospitalizations more than tripled between 2008 and 2013, from a rate of 2.9 to 6.4.[8] Similarly, a recent study underwritten by the California Health Care Foundation found a significant increase in California babies born with NAS from 2008 to 2012, with much higher instances of NAS being reported in African American births and Medi-Cal births.

While federal law under the Child Abuse Prevention and Treatment Act (CAPTA) requires that states have policies in place for reporting NAS and other prenatal substance exposure, the law is clear that this does not necessarily constitute child abuse or neglect.[9] California State Statute indicates that a report of a substance-exposed infant only occurs when "other factors are present that indicate risk to a child." This policy leaves it up to the discretion of the medical practitioner as to what constitutes sufficient reason to report the prenatal substance exposure to CPS, and it remains unclear the extent to which race or ethnicity biases may affect medical decisions to report (see "Equity Lens," next page). Experts stress the importance of providing support and treatment options, and not further stigmatizing or penalizing women struggling with substance use.



> Incorporating CARA requirements into CAPTA is a work in progress with states so that plans for safe care are consistent and supportive of child well-being. We'd like to see the system evolve to where safe care is woven into maternal and child health, and social and family support statutes, instead of a child abuse and neglect statute."
>
> ***Bruce Lesley, President, First Focus***

6 "Increasing incidence and geographic distribution of neonatal abstinence syndrome: United States 2009 to 2012," Patrick et. al., Aug. 2015. http://www.nature.com/jp/journal/v35/n8/full/jp201536a.html
7 "Pregnant women and substance use: fear, stigma, and barriers to care," Stone, Feb. 2015. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5151516/
8 Federally Available Data (FAD) Resource Document of State Inpatient Databases, Health Resources and Services Administration, Aug. 2016. https://www.hrsa.gov/about/organization/bureaus/mchb/fad-resource-document.pdf
9 Article 2.5. Child Abuse and Neglect Reporting Act [11164 - 11174.3] https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=PEN&division=&title=1.&part=4.&chapter=2.&article=2.5.

> We get very few referrals from affluent hospitals. All of our tox-positive tests come from the county hospital."

Judy Webber, Deputy Director, Ventura County DCFS

> To address the bias, we need universal testing and I believe this is the right climate to advocate for this, especially as the opioid epidemic is hitting states which may have considered this not their problem."

Debi Moss, Director, Marin County Child Welfare

Equity Lens: Does the Data Show Disproportionality?

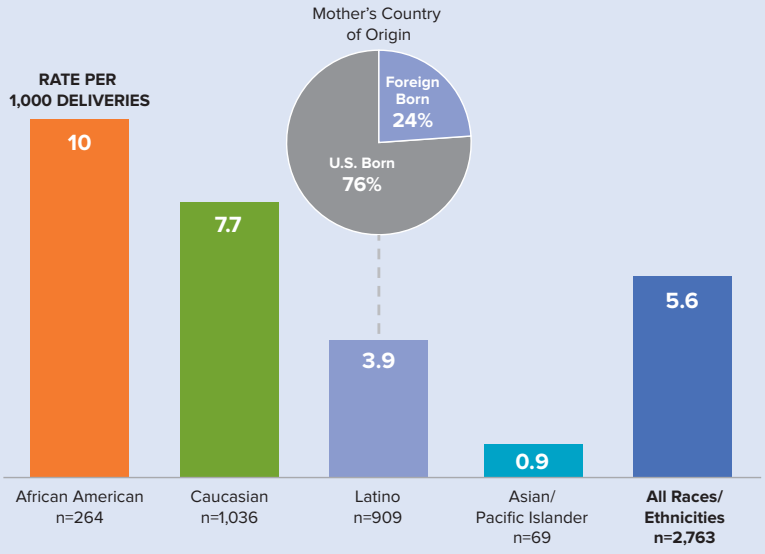
There is some evidence that the Medi-Cal population (lower income Californians) is more likely to get screened and referred to CPS.

- A 2011 study on California births found that due to a variety of socioeconomic factors, substance use was detected at rates up to nearly four times higher among mothers on Medi-Cal.[10]
- National research from *JAMA Pediatrics* found large differences in rates of NAS diagnosis between rural and urban births, rates for rural children being nearly 70 percent higher. Furthermore, rural patients in lower income quartiles had much higher rates of NAS than the higher incomes, while in urban areas income quartiles showed less disproportionality.

A recent study published in *Pediatrics*, found that among all infants neonatally reported to Child Protective Services (CPS) in California, 40.6 percent had been diagnosed with substance exposure at birth. After adjusting for sociodemographic differences, black and Hispanic newborns with identified prenatal substance exposure were no more likely than white infants to be reported for maltreatment.

Infants Born with Neonatal Abstinence Syndrome

By Race/Ethnicity, California, 2014



Source: California Health Care Almanac, "Maternity Care in California: Delivering the Data", Jun. 2016.[11]
Not included: Other (rate 18.1 n=485).

10 "Racial and Ethnic Disparities: A Population-Based Examination of Risk Factors for Involvement with Child Protective Services," Putnam-Hornstein, et. al., Jan. 2011. https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=263879

11 "Maternity Care in California: Delivering the Data," California Health Care Foundation, Jun. 2016. http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20M/PDF%20MaternityCareCalifornia2016.pdf

Addressing Bias in Screening and Reporting

Hospital screening practices may be introducing bias for those in lower socio-economic income brackets, which is often correlated with race and ethnicity. That noted, there are differing points of view on policy options, such as universal screening.

Universal screening would address some of the bias that is seen in the disproportionate number of referrals from public hospitals. Some physicians in San Diego County have taken this step prompted by a dramatic national increase in the number of newborns affected by drugs transmitted by the placenta or breast milk between 2014 and 2015 (page 4). These physicians have now begun automatically conducting urine toxicology screens on all mothers.

Focus on Family Preservation

Children who have experienced neglect or abuse in families affected by substance use disorders have been found to remain in substitute care placements for significantly longer periods of time, and experience significantly lower rates of family reunification relative to almost every other subgroup of families in the child welfare system.[12] That noted, removing a child from his or her home can be one of the most traumatic events a child can experience and placement in out-of-home care has been linked to poor behavioral, physical, and mental health outcomes.

There are promising strategies that can ensure safety as well as reunify families. And many experts and studies suggest that children will potentially fare better by remaining in their parents' care as part of a family-focused drug treatment program rather than by being removed from the family. Avoiding removal can reduce trauma, produce cost savings, and result in better short- and long-term outcomes for children and families.[13]

> "There are some strong arguments to be made on both sides. But I do worry about false positives, the expense, and that without the proper treatment options, universal testing might do nothing more than create a punitive health surveillance system in which some women avoid needed health care and services because of fear of criminalization or losing their child."
>
> ***Emily Putnam-Hornstein, Associate Professor and Director, Children's Data Network, USC***

12 "Families in Child Welfare Affected by Substance Use: issue 1," Vol. 94, No. 4, 2015. http://www.acbhcs.org/providers/SUD/docs/perinatal/CWJ_2015Vol94_4.pdf
13 "Epidemiological perspectives on maltreatment prevention," Wulcyzn, 2009. https://www.ncbi.nlm.nih.gov/pubmed/19719022

Medication Assisted Treatment (MAT)

MAT–prescription of a recovery drug such as buprenorphine, methadone, or suboxone, administered along with counseling and other addiction treatment supports–is expanding across the state, with the number of providers waivered to prescribe these drugs (prescription requires a training and a license/waiver from the DEA) steadily increasing.[15] Studies have shown that buprenorphine treatment yields a 50-60 percent recovery rate compared to less than 10 percent with drug-free (abstinence and counseling) treatment.[16] New efforts by California DHCS to increase availability of buprenorphine statewide and increase MAT utilization for tribal communities begin this year with the help of new federal funding under the State Targeted Response to the Opioid Crisis Grant program.

> "I have a client now on buprenorphine with a very violent past, she got herself on it and has been a completely different person. She's calm and has been able to manage her recovery."
>
> ***Lynette Lefort, Recovery Specialist, Alameda County***

Treatment on Demand

The sooner a parent or caregiver enters substance use treatment the more likely it is that their children who have been removed can be reunified with the caregiver.[14] Expansion of evidence-based treatments, such as medication-assisted treatment, may also be offered under the Drug Medi-Cal Organized Delivery System, which is being piloted and implemented by the California Department of Health Care Services (see page 13).

Create and Implement a Recovery Plan

Implementation of the American Society of Addiction Medicine (ASAM) placement criteria in many treatment programs in California has helped create manageable case plans for parents in recovery, and has helped to increase the likelihood that a parent and his or her removed child will be reunified. Recovery plans can include a variety of supports including 12-step programs, residential treatment, establishing connection to faith-based organizations, or use of a recovery coach to assist in accessing these services.

> "[ASAM] is very focused on a person-centered approach. It doesn't deal with simply the person's drug of choice, but it brings in personal, lifestyle factors. If someone is homeless for instance, they will look at that criteria, and try to get that person social supports. Very comprehensive. It's a good wrap-around approach."
>
> ***Tom Renfree, Deputy Director, Substance Use Disorder Services, County Behavioral Health Directors Association of California***

Recovery Coaches

In tandem with the parent struggling with substance use, a coach works with the caseworker, treatment provider and other parties to facilitate a successful recovery. In trials, recovery coaches were seen to increase reunification rates by 14 percent and increase foster care case closure rates (reunification and other) by 15 percent, saving the child welfare agencies an average of $2,500 per child in families they assist.[17]

Community-based Treatment

Community-based treatment includes outpatient programs, which may or may not have clinical services, or sober-living and detox facilities. These treatment programs can draw on a variety of funding sources and can be more flexible in their approach, and they are often in communities that may not have the funds or ability to sustain a residential treatment facility.

14 "Does substance abuse treatment make a difference for child welfare case outcomes?" Green et. al., 2007. http://www.sciencedirect.com/science/article/pii/S0190740906001782
15 "DATA-Certified Physicians," Accessed May, 2017. https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/certified-physicians?field_bup_us_state_code_value=CA
16 "SAMHSA Opioid STR." Accessed May, 2017. http://www.dhcs.ca.gov/individuals/Pages/State-Targeted-Response-to-Opioid-Crisis-Grant.aspx
17 "Recovery Coaches for Substance-Abusing Parents," Coalition for Evidence-Based Policy, Jan. 2012. http://evidencebasedprograms.org/wp-content/uploads/2012/12/Recovery-Coaches.pdf

Prevention

> We can have better health outcomes for parents and children when substance using parents are referred to counseling and preventative treatment, rather than punitive approaches that promote the removal of a child and prosecution."
>
> ***Amy Price, Program Executive, Zellerbach Family Foundation***

Wraparound and Safety Organized Practice

Team-driven service and support models such as Wraparound, Safety Organized Practice, and Team Decision Making have been adopted in counties across California.[18] These promising practices, used in the Title IV-E Waiver project, use youth and family engagement to support recovery and reunification and include system partners (such as substance use treatment providers) in the planning, delivery, and management of necessary services.

Treatment and Recovery

Family Treatment Drug Courts (FTDCs) are specialized courts with integrated substance use disorder treatment and child welfare services. Their goal is to facilitate early child reunification and many believe that they represent a less adversarial intervention which supports participants' likelihood to seek treatment. This is a voluntary program, led by the presiding judge in each county. That noted, family drug treatment courts have grown exponentially in California in the past two decades from only 2 programs in 1995 to 33 in 2017.[19]

> The best interventions I've seen are the family drug courts. These courts bring the providers into the courtroom, with the goal of helping the parent become a safe parent by stopping the drug abuse."
>
> ***Honorable Leonard Edwards, Mentor Judge, Judicial Council of California***

Priority Access to Services and Supports

The Priority Access to Services and Supports (PASS) task force has developed a protocol to guide counties to facilitate priority access, coordination and quality to appropriate behavioral health services and supports for parents in reunification, which include mental health and substance use disorder services. Ventura County has been piloting the PASS protocols since 2016.

> Of the 118 parents screened for the PASS pilot, 60 percent had two referrals, for either specialty mental health, the Beacon program (ACA funded), or an alcohol and drug treatment program. However, not enough time has passed to see outcomes, and we have considerable difficulty with follow through, which is not surprising with addiction."
>
> ***Judy Webber, Deputy Director, Ventura County DCFS***

18 All County Letter No. 16-84, CA DHCS, Oct. 2016. http://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information%20Notices/ACL16-84_MHSUDSIN16-049_CFTGuidelines(4).pdf

19 "Fact Sheet: Collaborative Justice Courts" Judicial Council of California, Mar. 2017. http://www.courts.ca.gov/documents/CollaborativeCourts_factsheet.pdf

> Family Treatment Drug Court funding in California is very decentralized and challenging to keep up with. In Alameda, the majority of funding is through SAMHSA grants, Sacramento on the other hand has braided funding structures together from a variety of sources to meet the needs of its families. Riverside county has traditionally used title IV-B funding, Medi-Cal and support from local organizations."

Phil Breitenbucher, Program Director, Children and Family Futures

> Coming into regular dependency court, the parent may be intoxicated, skeptical of government and our intention, and oppositional to social services. But if this is what it will take 'to get my baby back' and we have the recovery specialists, they will engage."

Honorable Charles Smiley, Superior Court Judge, Alameda County

FTDCs use different eligibility criteria in identifying and assessing clients. Some FTDCs focus on early intervention, while others focus on intensive services for adults, and team-based services. There are counties, like Sacramento and Los Angeles, that have multiple family drug courts that address the needs of various populations, or child-age groups.

Sacramento has shown particularly strong results. According to a 2011 study, 45 percent of families who participated in the program were reunited with their children, nearly twice as high as the countywide average of 27 percent for all children in out-of-home placement during that same time period.[20]

Alameda County Family Drug Court

Over the past three years, parents participating in the Alameda family drug court have been 45.4 percent African American. Communities of color tend to experience a greater burden of mental health and substance use disorders often due to poorer access to care; inappropriate care; and higher social, environmental, and economic risk factors. A critical role of The Alameda Family Drug Court is to address these disparities by providing parents access to quality treatment.

The Alameda County Family Drug Court has a $325K annual budget, with the primary funding source from a time limited grant. With this budget, which includes evaluation, they serve 75 family groups annually, with graduation rates at 40 percent, and of those who graduate, 95 percent reunify.

Sobriety Treatment and Recovery Teams (START)

START is a teaming approach used in several states and is included on the California Evidence Based Clearinghouse. Originating in Kentucky in 2006, this community-based treatment model encourages shared decision-making among caseworkers, parent mentors, and parents, to create a holistic assessment of the parents' needs and get them into timely treatment. Participating parent mentors are themselves in recovery with at least three years of sobriety and experience with the child welfare system. Under the START program, studies have shown that mothers achieved sobriety at nearly twice the rate of mothers in typical services, and their children were placed in out-of-home care at half the typical rate for mothers in treatment.

20 "Research Update on Family Drug Courts," National Association of Drug Court Professionals, May 2012. http://www.nadcp.org/sites/default/files/nadcp/Reseach%20Update%20on%20Family%20Drug%20Courts%20-%20NADCP.pdf

Parent-Child Assistance Program (PCAP)

PCAP is an evidence-based home visitation case-management model for mothers who abuse alcohol or drugs during pregnancy. The program goals are to help mothers build healthy families and prevent future births of children exposed prenatally to alcohol and drugs.

In 2012, the Lake County Tribal Health Consortium began implementation of PCAP, focused on preventing substance-exposed pregnancies and births, as well as reducing the prevalence of Fetal Alcohol Spectrum Disorder, two of the primary health concerns within the tribal population. The program is funded by a Tribal Maternal Infant Early Childhood Home Visiting grant created by the Affordable Care Act. A combination of home visitation services, medical services, and community supports were created through the program with the goal of strengthening families while incorporating cultural activities and tribal learning. Since services began, there have been decreased entries of Native American youth into care and overall increased rates of contact with health services and safety planning.

Residential Treatment

Residential treatment is available in 39 of California's 58 counties (see page 12), but services and availability of beds differ greatly by county.

- 24 counties have residential treatment available to women with accompanied children, though only 3 treatment facilities in the state list women and youth as their target populations, meaning that many times older children cannot accompany their parents to treatment.
- Only seven counties, including Los Angeles and San Francisco, have residential treatment programs where children can accompany fathers. Often these programs have a very limited number of beds, and openings can be competitive.
- Even large counties such as Alameda, Orange, and Sacramento lack a full continuum of services. Additionally, both large and small counties may lack an appropriate number of beds per the size of their population, for example San Joaquin county only has 236 residential treatment beds for a population of 685,306.
- Some counties do not have long-term residential treatment available, but do have facilities that provide short term residential detoxification for patients.[21]

> "Addiction is a chronic disease that requires a whole-person approach, and a lot of the problems with relapse stem from sending people out into the world without ongoing recovery supports. This is why we need to support families through the recovery and reunification process."
>
> ***Tom Renfree, Deputy Director, Substance Use Disorder Services, CBHDA***

> "We are not able to meet the demand for treatment in San Francisco and a particular challenge is trying to find places that can take parents with their children."
>
> ***Sylvia Deporto, Child Welfare Director, San Francisco County***

21 "Fact Sheet: Collaborative Justice Courts" Judicial Council of California, Mar. 2017. http://www.courts.ca.gov/documents/CollaborativeCourts_factsheet.pdf

Access to Treatment Varies Across Counties

- Counties with residential treatment for men or women with or without accompanied children
- Counties with residential treatment for women with or without accompanied children and men without accompanied children
- Counties with residential treatment for men or women without accompanied children only
- Counties with no residential treatment available
- Counties with Family Treatment Drug Courts

Nineteen counties in California have no access to residential drug treatment. And while there are 33 FTDCs in California, they are in less then half of California counties and are often affected by budget shortfalls.

Source: California Department of Health Care Services [22] and the Judicial Branch of California, 2017. [23]

22 Department of Health Care Services Licensing and Certification Section Status Report, Dec. 2016. http://www.dhcs.ca.gov/provgovpart/Documents/Status_Report_December_2016.pdf

23 "Fact Sheet: Collaborative Justice Courts" Judicial Council of California, Mar. 2017. http://www.courts.ca.gov/documents/CollaborativeCourts_factsheet.pdf

SHIELDS for Families

One of the leading model programs nationally, SHIELDS for Families has helped vulnerable children and families in Los Angeles County for the past 25 years. Their programs encompass the full spectrum of human needs—from housing and transportation, to substance use treatment to child protective services.

SHIELDS addresses substance use disorders from early intervention to drug courts to long-term residential treatment programs. Their programs bring a strong emphasis on family strengthening and preservation. SHIELDS' prenatal programs allow adult pregnant and parenting women with children to live together while they are completing their treatment programs.

SHIELDS funding is maintained by a combination of federal block prenatal funding, state mental health funding, and child welfare grants from both the state and federal government.[24] On average, the cost is approximately $25,000 per family, with a 12-18 month duration. The first step is intensive, with gradual step down.

> "Whether you are a mother or father. Addiction is a family disease; it affects the children as much as the parents. If we want to stop this intergenerational abuse we have to make sure the programs and funding follows."
>
> ***Dr. Kathryn Icenhower, CEO and Co-Founder, SHIELDS for Families***

Funding for Residential Treatment

As part of the Affordable Care Act (ACA) roll-out, states could apply for a waiver to eliminate federal restrictions on funding residential treatment through Medicaid.[25] California was granted the waiver in 2014, as well as several other states, however, the restriction still applies for facilities with fewer than 16 beds. ACA also requires covering drug treatment services as essential coverage through any form of insurance, thereby enabling almost all insured patients with either public or private coverage, to have access to and coverage for residential treatment services. Statewide efforts are underway in California to reorganize systems of care to deliver a larger array of services across California through the new Drug Medi-Cal Organized Delivery System. However, some providers are concerned that counties that opt in to the waiver will now be obligated to use a "medical necessity" criteria which could limit the length of treatment to six months, when studies indicate that longer term support is a key factor in recovery.

24 "Funding Family-Centered Treatment for Women With Substance Use Disorders," Children and Family Futures, Inc., May, 2008. https://www.samhsa.gov/sites/default/files/final_funding_paper_508v.pdf

25 "States Seek Medicaid Dollars for Addiction Treatment Beds," The Pew Charitable Trusts, Apr. 2017. http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2017/04/05/states-seek-medicaid-dollars-for-addiction-treatment-beds

> Medi-Cal is the primary source of funding for treatment, and with the ongoing threat to repeal and replace the ACA, SUD treatment is in serious jeopardy. This would have far-reaching and serious implications for our child welfare system and its ability to support reunification."
>
> ***Frank Mecca, Executive Director, CWDA of California***

> There aren't a lot of resources for after-care, to support a person dealing with the challenges of everyday life that happen one day at a time, for the rest of your life. This is particularly true about housing here in Alameda County. Because of the cost of living, some families have to move out of county, without their community of support, or find shared housing where they sometimes may be drawn back into their addiction by their roommates."
>
> ***Brittany Walker Pettigrew, Program Manager, Alameda County Social Services***

Access to Services

Many counties report challenges to accessing services, including treatment on demand and residential treatment, particularly facilities that include fathers and/or non-infant children.

Funding Uncertainty

Chief among the challenges of expanding promising strategies is funding for treatment services. Many federal supports to SUD treatment on demand, Family Treatment Drug Courts, and residentially based services have seen reduced funding in recent years, with some grants sun-setting.

Support for Parents to Complete Treatment

Parents involved with the child welfare system who use substances typically demonstrate low rates (10-22 percent) of substance use treatment completion. Lack of child care and the need to balance competing demands of parenting and working toward recovery are major barriers to seeking and completing treatment.[26] There is also a ripple effect for these parents as they may lose their Medi-Cal coverage when they lose their child, and fall deeper into their disorder.

> With all the challenges (child care, jobs, etc.) facing parents working through addiction, I actually don't know how any of them are able to complete treatment programs."
>
> ***Shelby Boston, Child Welfare Director, Butte County***

Aftercare for Parents Who Recover and Reunify

Recovery from addiction can be a lifelong challenge. Notably in California, lack of affordable housing may necessitate relocation within the state, disconnecting the parent with his or her local support network. National studies frequently cite inadequate housing, food instability, utility disconnection, unemployment, and general financial stress as common difficulties making recovery more difficult for parents even after completing treatment.[27]

26 "Completing Substance Abuse Treatment in Child Welfare: The Role of Co-Occurring Problems and Primary Drug of Choice," Choi et. al., 2006. http://journals.sagepub.com/doi/abs/10.1177/1077559506292607
27 "Families in Child Welfare Affected by Substance Use: issue 1," Vol. 94, No. 4, 2015. http://www.acbhcs.org/providers/SUD/docs/perinatal/CWJ_2015Vol94_4.pdf

Collaboration Challenges

Coordinated, effective family interventions are often hampered as parents are served in one system while their children are served through another, and insufficient mechanisms exist to ensure communication, collaboration, and compliance across the systems.

Child Welfare Mandates and Recovery "Clocks" are Misaligned

Research on policy and practice across systems reveals wide misunderstandings about addiction. Studies show that courts often require parents struggling with addiction to complete more tasks than parents without substance use disorder and in a timeframe, that does not reflect an understanding that relapse is a normal part of the recovery process.

> "The law allows for up to 18 months of family reunification services, and then the process of terminating parental rights begins."

Greg Rose, Deputy Director, California Department of Social Services

Addressing Stigma

Research from a federally-funded demonstration project included clinicians reporting that "most state courts and case managers hold negative opinions of parents with substance abuse." Project clinicians described these perceptions of parents with substance use disorders as "judgmental, shaming, lacking empathy, and casting parents as criminals." One clinician said that parental substance use was viewed as a sign that the parent did not love their child(ren), particularly if the parent relapsed later in the life of the case.

Stigma can also inhibit parents with addiction from seeking treatment and support, particularly when they have had previous child welfare involvement.[28]

> "I gave up everything to go into residential rehab and drug dependency court to get my son back. And yet, four weeks after I got him back, I relapsed. The pressure of raising a 2-year-old and working on my own stuff was just too much. Luckily, I was still in the residential rehab program and they got me back on track right away. Today, four years out of rehab, I still struggle every day, and admittedly, sometimes I fail."

Anthony, in recovery from SUD, father of an 8-year-old son

> "We need to shift from seeing parents as the 'bad people' doing drugs to 'bad drugs' taking over people. Our approach should be about strengthening families and not trying save children from their parents."

Haydée Cuza, Executive Director, California Youth Connection

Child Welfare and Recovery Clocks

28 "Predictors of foster care exits to permanency: A competing risks analysis of reunification, guardianship, and adoption," Akin, 2011. http://www.sciencedirect.com/science/article/pii/S0190740911000193

The California Child Welfare Co-Investment Partnership is a collaboration of private and public organizations working to improve outcomes in the child welfare system. The Partnership comprises four philanthropic organizations (Casey Family Programs, Conrad N. Hilton Foundation, Walter S. Johnson Foundation, and Zellerbach Family Foundation) and the California Department of Social Services, the Judicial Council of California's Center for Families, Children & the Courts, and County Welfare Directors Association. *in*sights is an ongoing publication of the Partnership that examines the links between data, policy, and outcomes for our state's most vulnerable children and families. Download previous editions of *in*sights and find out more about the Partnership at co-invest.org.

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RISK-NEED ASSESSMENT

CAN YOU APPLY COLLABORATIVE PRINCIPLES ACROSS AN ENTIRE SYSTEM?

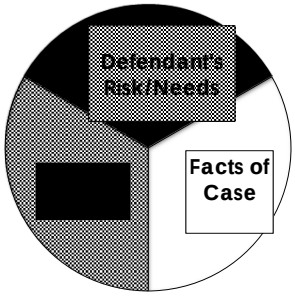
Presenter: Scott Brown, Special Projects Manager
San Diego Superior Court

CORE ELEMENTS TO REDUCE RECIDIVISM

(Council of State Governments Justice Center, 07/2015)

- **Target the right people.**
  To have a significant impact on reducing recidivism, programs must target people who have a moderate to high probability of reoffending.
- **Use evidence-based programs.**
  Research has demonstrated that programs that adhere to the principles of risk, need, and responsivity and use a cognitive behavioral approach are the most effective at reducing recidivism.
- **Monitor the quality of program delivery.**
  Well-run programs that closely follow a proven model for reducing recidivism are essential to achieving desired outcomes. Programs that receive high scores on assessments such as the Correctional Program Checklist and Correctional Program Assessment Inventory that evaluate the quality of programs are likely to reduce recidivism.

EMBEDDING RISK, NEED, RESPONSIVITY IN AN ADVERSARIAL LEGAL SYSTEM



- ***Risk Principle*** (Who): Match defendant's assessed level of risk to re-offend with level of services and supervision.
- ***Needs Principle*** (What): Treatment plan targets defendant's assessed characteristics that have greatest effect his/her likelihood of re-offending.
- ***Treatment Principle*** (What works): Target the defendant's most critical risk factors and utilize cognitive behavioral strategies (e.g. evidence-based practices, cognitive behavioral therapy).
- ***Responsivity Principle*** (How): The intervention must be matched to certain critical characteristics of defendant (e.g. gender, literacy, language, intelligence).

RISK OF WHAT?

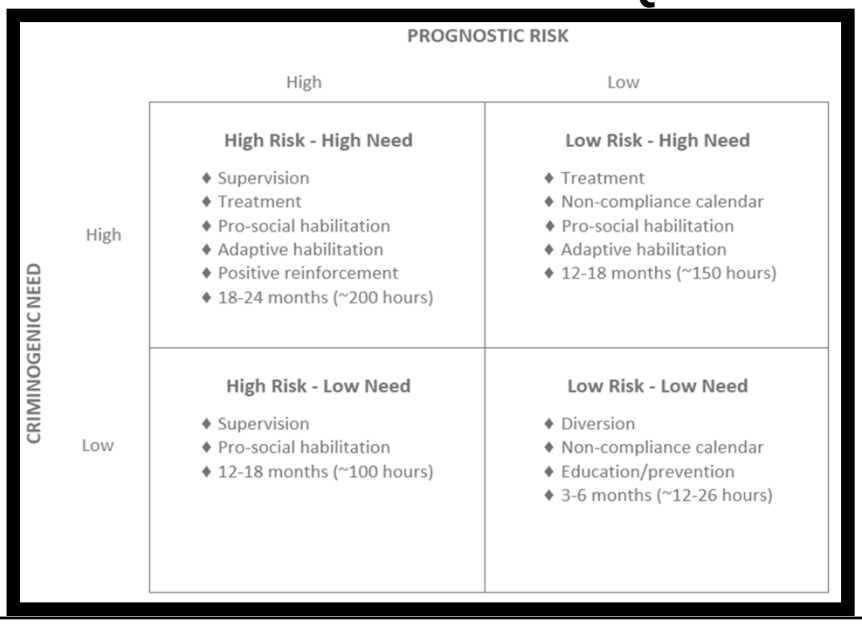
- **RECIDIVISM:** The factors making up this scale MIGHT involve prior criminal history, criminal associates, drug involvement, and early indicators of juvenile delinquency problems.
- **VIOLENCE:** The scale MAY input history of violence, history of non-compliance, vocational/educational problems, the person's current age, and the person's age-at-first-arrest.
- **PRETRIAL RELEASE**: The most common risk factors include current charges, pending charges, prior arrest history, previous pretrial failure, residential stability, employment status, community ties, and substance abuse (SB 10 / AB 42).

CRIMINOGENIC NEEDS

Criminogenic needs are Characteristics, traits, problems, or issues of an individual that directly relate to the individual's likelihood to re-offend and commit another crime.

8 Criminogenic Risk/Needs	
History of criminal behavior	**Family/marital problems**
Antisocial personality pattern	**School/work Failure**
Pro-criminal attitudes	**Lack of pro-social activities**
Antisocial associates	**Substance abuse**

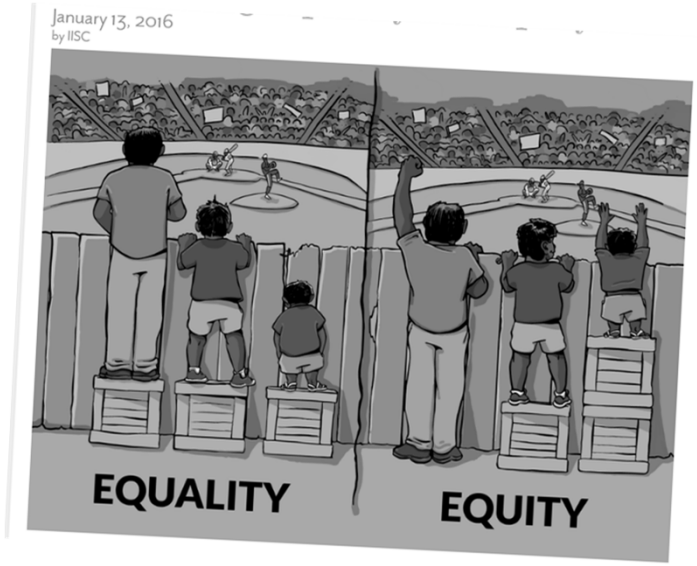
DR. MARLOWE/NDCI RISK-NEED QUADRANTS



IN PRACTICE…CAN THERE BE QUADRANT-BASED SENTENCING?

CRIMINOGENIC NEED	PROGNOSTIC RISK: High	PROGNOSTIC RISK: Low
High	**High Risk-High Need** **Probation or 1170(h) Split** ♦ Collaborative Court ♦ Structured treatment ♦ Constant Supervision ♦ Accountability (incentives) ♦ Regular court appearances ♦ 18-24 months of treatment	**Low Risk-High Need** **Moderate Supervision** ♦ Refer to treatment programs ♦ Drug/Alc. Treatment (PC1210) ♦ Compliance court calendar ♦ Mental Health referral ♦ Vocational/Employment ♦ 12-18 months programming
Low	**High Risk-Low Need** **Custody or High Supervision** ♦ High Supervision ♦ Cognitive Behavioral Therapy ♦ Vocational/Educational ♦ Abstinence/Compliance ♦ 12-18 months programming	**Low Risk/Low Need** **Probation to Court (Summary)** ♦ Diversion ♦ Community Service ♦ Minimal supervision ♦ Refer to educational programs ♦ Threat of custody is deterrent ♦ 3-6 months of programming

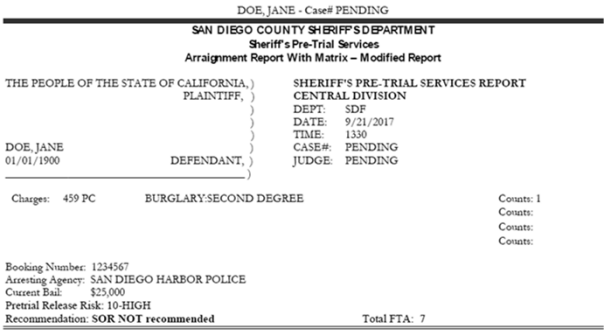
CHALLENGES…



EQUAL PROTECTION vs. FAIR AND REASONABLE

- Should dynamic risk-need assessment tools be used for setting conditions of supervision?
- Validation of the tool? Is it "normed" to your population? Is it used on the correct population?
- Transparency of the tool? Does it explain highs/lows?
- Systems should ensure that statements made during an assessment are not used to support charges, revocation, or other adverse action.
- Systems should ensure they have community programming for assessed needs (drug treatment, cognitive behavioral therapy, pro-social).

SAMPLE PRETRIAL RELEASE REPORTS



DOE, JANE - Case# PENDING

SAN DIEGO COUNTY SHERIFF'S DEPARTMENT
Sheriff's Pre-Trial Services
Arraignment Report With Matrix – Modified Report

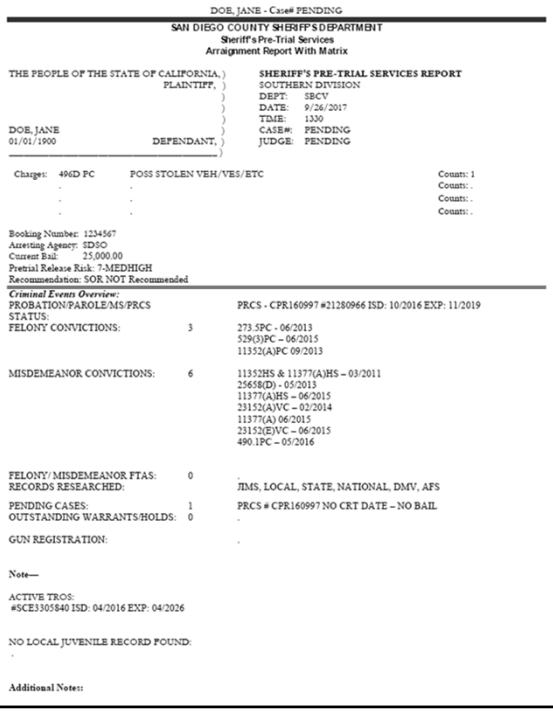
THE PEOPLE OF THE STATE OF CALIFORNIA, PLAINTIFF,
DOE, JANE
01/01/1900 DEFENDANT,

SHERIFF'S PRE-TRIAL SERVICES REPORT
CENTRAL DIVISION
DEPT: SDF
DATE: 9/21/2017
TIME: 1330
CASE#: PENDING
JUDGE: PENDING

Charges: 459 PC BURGLARY:SECOND DEGREE Counts: 1

Booking Number: 1234567
Arresting Agency: SAN DIEGO HARBOR POLICE
Current Bail: $25,000
Pretrial Release Risk: 10-HIGH
Recommendation: SOR NOT recommended Total FTA: 7

Additional Notes:



DOE, JANE - Case# PENDING

SAN DIEGO COUNTY SHERIFF'S DEPARTMENT
Sheriff's Pre-Trial Services
Arraignment Report With Matrix

THE PEOPLE OF THE STATE OF CALIFORNIA, PLAINTIFF,
DOE, JANE
01/01/1900 DEFENDANT,

SHERIFF'S PRE-TRIAL SERVICES REPORT
SOUTHERN DIVISION
DEPT: SBCV
DATE: 9/26/2017
TIME: 1330
CASE#: PENDING
JUDGE: PENDING

Charges: 496D PC POSS STOLEN VEH/VES/ETC Counts: 1

Booking Number: 1234567
Arresting Agency: SDSO
Current Bail: 25,000.00
Pretrial Release Risk: 7-MEDHIGH
Recommendation: SOR NOT Recommended

Criminal Events Overview:

PROBATION/PAROLE/MS/PRCS STATUS: PRCS - CPR160997 #21280966 ISD: 10/2016 EXP: 11/2019

FELONY CONVICTIONS: 3
273.5PC - 06/2013
529(3)PC – 06/2015
11352(A)PC 09/2013

MISDEMEANOR CONVICTIONS: 6
11352HS & 11377(A)HS – 03/2011
25658(D) - 05/2013
11377(A)HS – 06/2015
23152(A)VC – 02/2014
11377(A) 06/2015
23152(E)VC – 06/2015
490.1PC – 05/2016

FELONY/ MISDEMEANOR FTAS: 0
RECORDS RESEARCHED: JIMS, LOCAL, STATE, NATIONAL, DMV, AFS

PENDING CASES: 1 PRCS # CPR160997 NO CRT DATE – NO BAIL
OUTSTANDING WARRANTS/HOLDS: 0

GUN REGISTRATION:

Note—

ACTIVE TROS:
#SCE3305840 ISD: 04/2016 EXP: 04/2026

NO LOCAL JUVENILE RECORD FOUND:

Additional Notes:

SAMPLE RISK AND NEED ASSESSMENT REPORT

Case Number: SCD263462 **Court:** San Diego RANT

Needs	Risk: High	Risk: Low
High		X
Low		

This individual was classified as **low risk and high need**. Such individuals typically require a combination of services involving intensive treatment and close monitoring for relapse.

The following risk factors were identified:

- **Unemployment.** The failure to maintain regular employment or to engage in comparable productive activities such as school or housework is generally associated with a failure to meet supervisory obligations and conditions.
- **Prior felony or serious misdemeanor convictions.** Prior felony or serious misdemeanor convictions predict a greater likelihood of recidivism.

The following needs factors were identified:

- **Chronic substance-related medical condition.** This individual suffers from a chronic medical illness or disability that was caused or exacerbated by substance use and that requires ongoing medical treatment.
- **Major mental illness.** This individual suffers from a serious psychiatric illness that requires substantial clinical intervention.

Case Number: SCD263620 **Court:** San Diego RANT

Needs	Risk: High	Risk: Low
High	X	
Low		

This individual was classified as **high risk and high need**. Such individuals typically require a combination of services involving intensive treatment, close monitoring, and accountability for their actions.

The following risk factors were identified:

- **Unemployment.** The failure to maintain regular employment or to engage in comparable productive activities such as school or housework is generally associated with a failure to meet supervisory obligations and conditions.
- **Age of onset of criminal activity ≤ 15 years.** An earlier onset of crime or delinquency generally predicts a more chronic course and poorer response to interventions unless there is close supervision and accountability.
- **Prior felony or serious misdemeanor convictions.** Prior felony or serious misdemeanor convictions predict a greater likelihood of recidivism.
- **Prior involvement in drug rehabilitation.** Previous involvement in rehabilitation or treatment predict a poorer response to subsequent episodes unless there is more intensive monitoring and services.
- **Deviant peer affiliations.** Associating with other offenders or substance abusers predicts a poorer response to treatment and supervision requirements.

The following needs factors were identified:

- **Physical addiction to drugs or alcohol.** This individual suffers from a loss of control over substance use that requires substantial clinical intervention.
- **Major mental illness.** This individual suffers from a serious psychiatric illness that requires substantial clinical intervention.

Screening and Assessment

in

Family Drug Courts

Jane Pfeifer, MPA
Senior Program Associate

NATIONAL FAMILY DRUG COURT TTA Program

Center for Children and Family Futures
Strengthening Partnerships, Improving Family Outcomes

October 20, 2017

National Leadership

Cross-Agency Coordination

Technical Assistance Resources

Acknowledgement

This presentation is supported by:

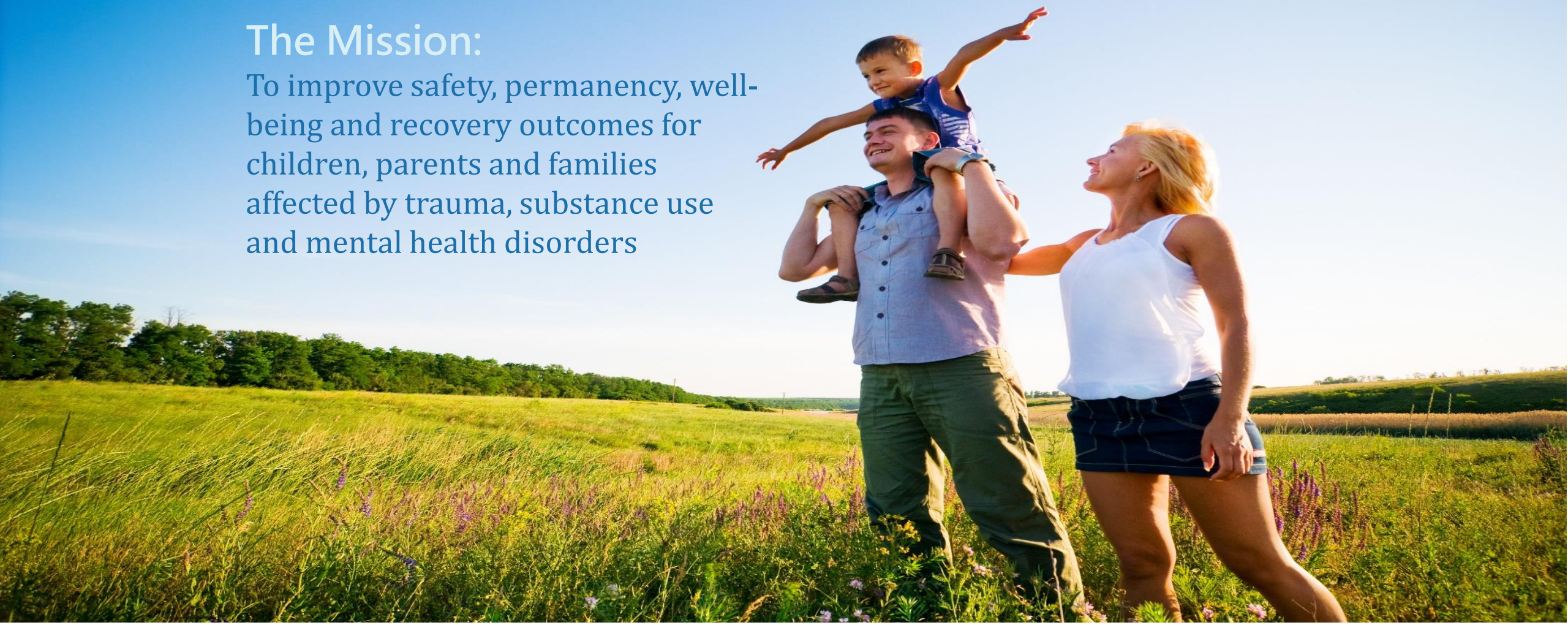
The Office of Juvenile Justice and Delinquency Prevention Office of Justice Programs
(2016-DC-BX-K003)

Points of view or opinions expressed in this presentation are those of the presenter(s) and do not necessarily represent the official position or policies of OJJDP or the U.S. Department of Justice.

Children and Family Futures

The Mission:

To improve safety, permanency, well-being and recovery outcomes for children, parents and families affected by trauma, substance use and mental health disorders



Children and Family Futures

25371 Commercentre Drive, Suite 140, Lake Forest CA 92630 | www.cffutures.org

Important Practices of FDCs

7

- System of identifying families
- Timely access to assessment and treatment services
- Increased management of recovery services and compliance with treatment
- Improved family-centered services and parent-child relationships
- Increased judicial oversight
- Systematic response for participants – contingency management
- Collaborative non-adversarial approach grounded in efficient communication across service systems and court

Sources: 2002 Process Evaluation and Findings from 2015 CAM Evaluation

Screening and Assessment: Opening the Door to Substance Use Treatment

Early Identification

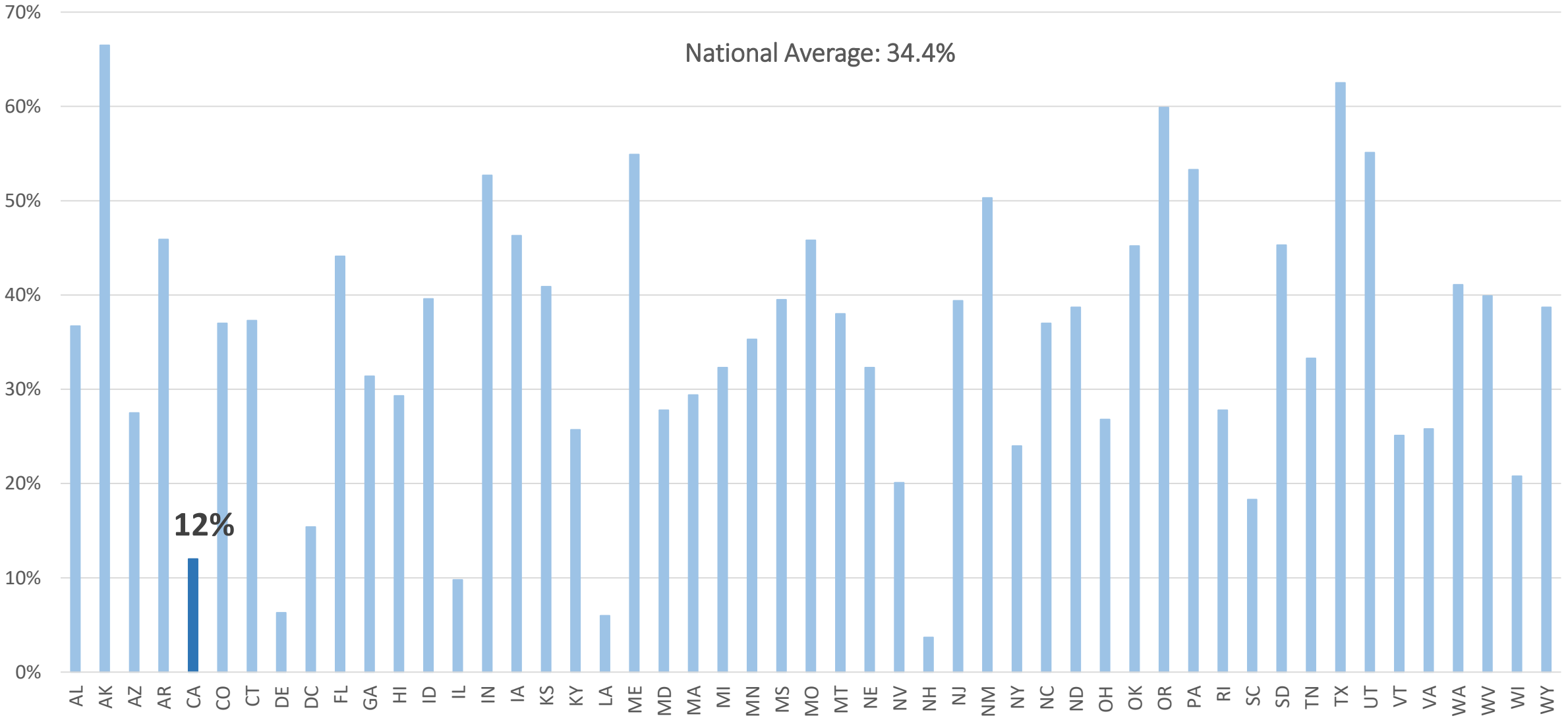
- Screening: Determine the presence of an issue (e.g. substance use)
- Assessment: Determines the severity and recommends treatment course
- Determine the needs and strengths of parents, children and families and identify the most appropriate treatments and other services

Warm Hand-Off

- Improve access to, engagement in and retention in substance use treatment

Active Efforts in Clinical Engagement

Parental Alcohol or Other Drug Use as a Reason for Removal by State, 2015



Note: Estimates based on all children in out of home care at some point during Fiscal Year

Source: AFCARS Data, 2016

Statement of the Problem

How many children in the child welfare system have a parent in need of treatment?

- Between 60–80% of substantiated child abuse and neglect cases involve substance use by a custodial parent or guardian (Young et al., 2007)
- 61% of infants, 41% of older children who are in out-of-home care (Wulczyn, Ernst, and Fisher, 2011)
- 87% of families in foster care with one parent in need; 67% with two (Smith, Johnson, Pears, Fisher, and DeGarmo, 2007)

Timely and structured screening and identification of parental substance use in child welfare cases is critical.

- 61% of confirmed drug or alcohol dependence among substantiated abuse or neglect cases are missed by front line CWS social workers (Gibbons, Barth, Martin, 2005)
- There is no time to lose given the ASFA, recovery, and child development time clocks

Studies Show Equivalent or Better Outcomes:

- Co-occurring mental health problems
- Unemployed
- Less than a high school education
- Criminal history
- Inadequate housing
- Risk for domestic violence
- Methamphetamine, crack cocaine, or alcohol
- Previous Child Welfare Involvement

(e.g., Boles & Young, 2011; Carey et al., 2010a, 2010b; Worcel et al., 2007)

Screening and Assessment

An Ongoing Process

Presence & Immediacy

Is there an issue present?

What is the immediacy of the issue?

Nature & Extent

What is the nature of the issue?

What is the extent of the issue?

Developing & Monitoring Case Plans

What is the response to the issue?

Are there demonstrable changes in the issue?

Is the family ready for transition?

Did the interventions work?

Process	Primary Question | Tools
Screening	*Is substance use a factor? Yes or No?* UNCOPE, CAGE
Assessment	*How severe is the substance use disorder?* DSM-5 Criteria
Treatment	*Does level of treatment match the identified need?* ASAM Continuum of Care

Frequently Asked Questions

Identifying a tool to determine whether substance use is a factor in child welfare cases

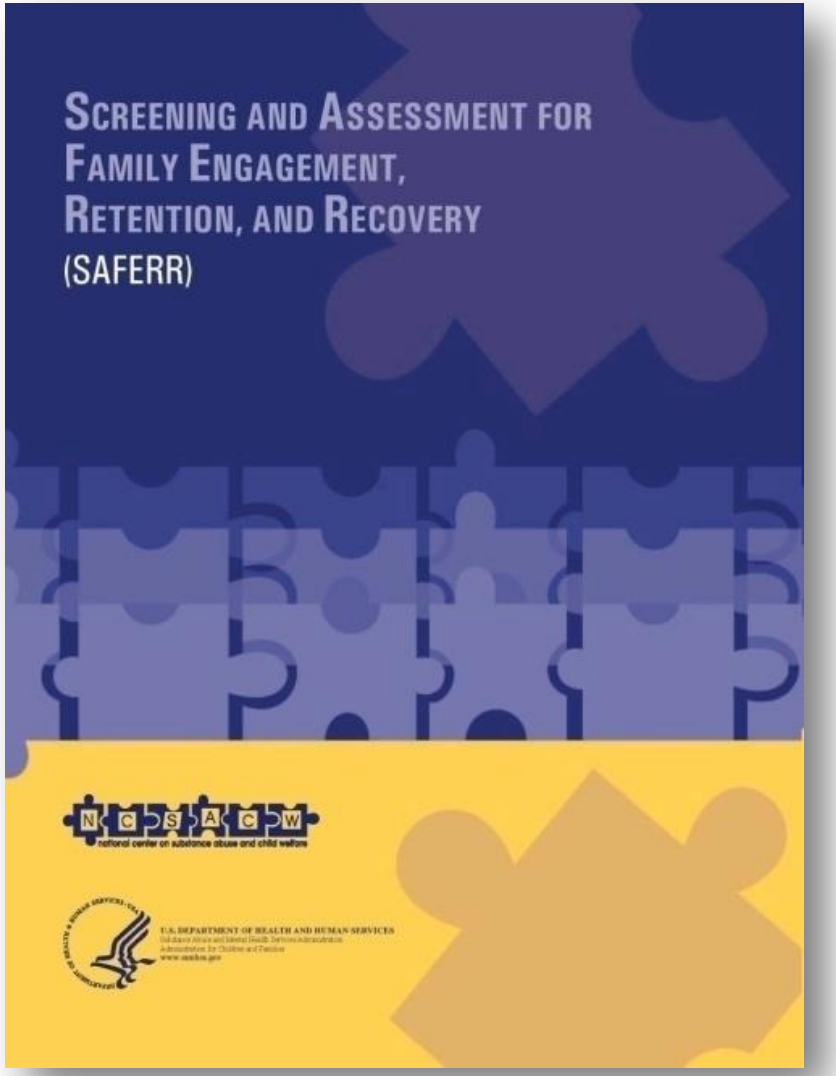
It's the *team*, not the tool.

Understanding how to respond to cases involving substance use

No single agency can do this alone.

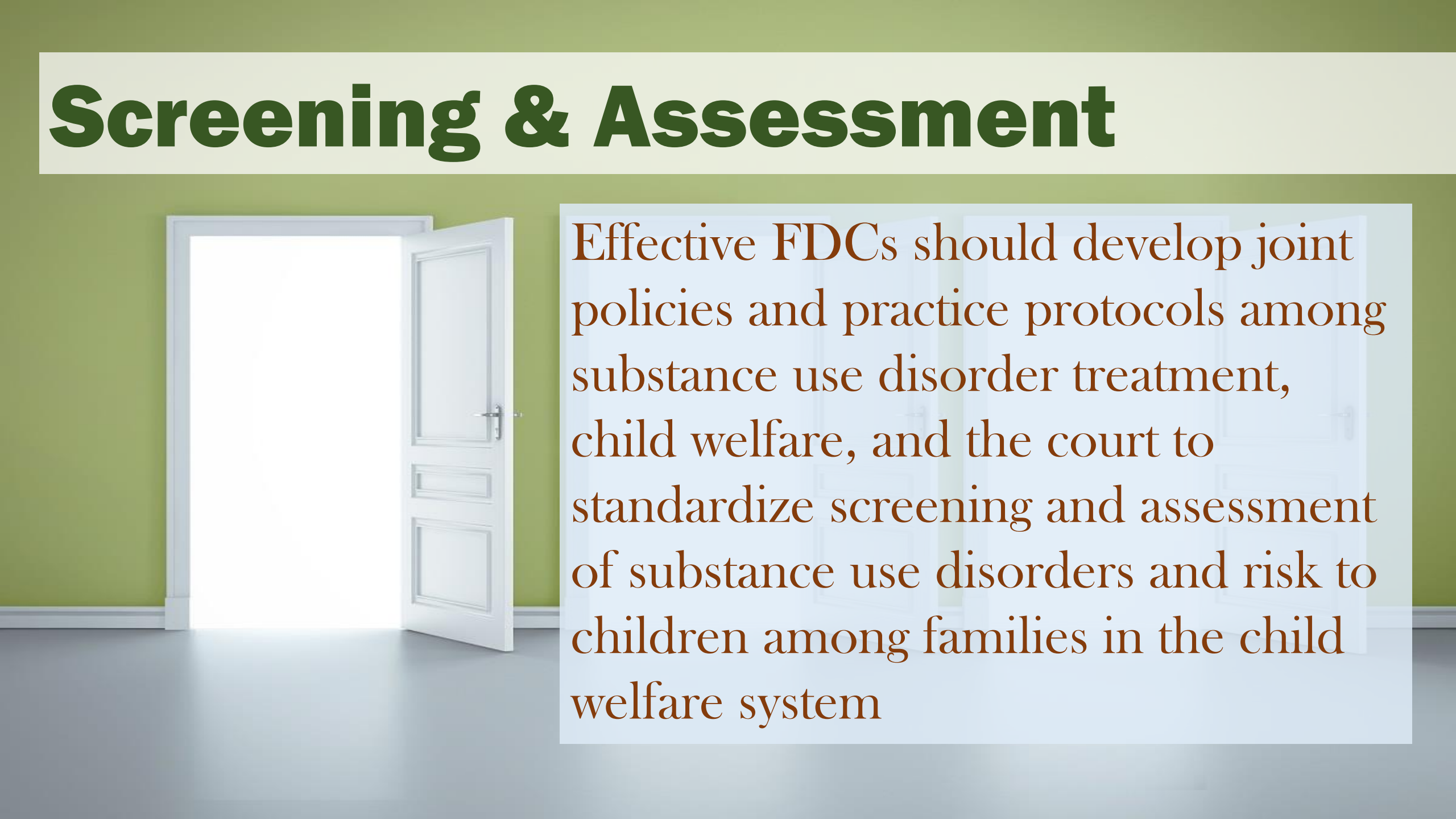
Problems don't come in discrete packages.

It requires an *ongoing* process.



https://ncsacw.samhsa.gov

Screening & Assessment



Effective FDCs should develop joint policies and practice protocols among substance use disorder treatment, child welfare, and the court to standardize screening and assessment of substance use disorders and risk to children among families in the child welfare system

Key Elements

4 Prong – Screening

- ❑ Tool
- ❑ Signs & symptoms
- ❑ Corroborating reports
- ❑ Drug screen

Yes

to any

Proceed to assessment

Screening: Is substance use a factor in the case?

- Generally results in a “yes” or “no”
- Determines whether a more in-depth assessment is needed
- Standardized set of questions to determine the risk or probability of an issue
- Brief and easy to administer, orally or written
- Can be administered by a broad range of people, including those with little clinical expertise
- Examples: UNCOPE; GAIN; AUDIT; CAGE
- Practice Principle – It’s the team, not the tool

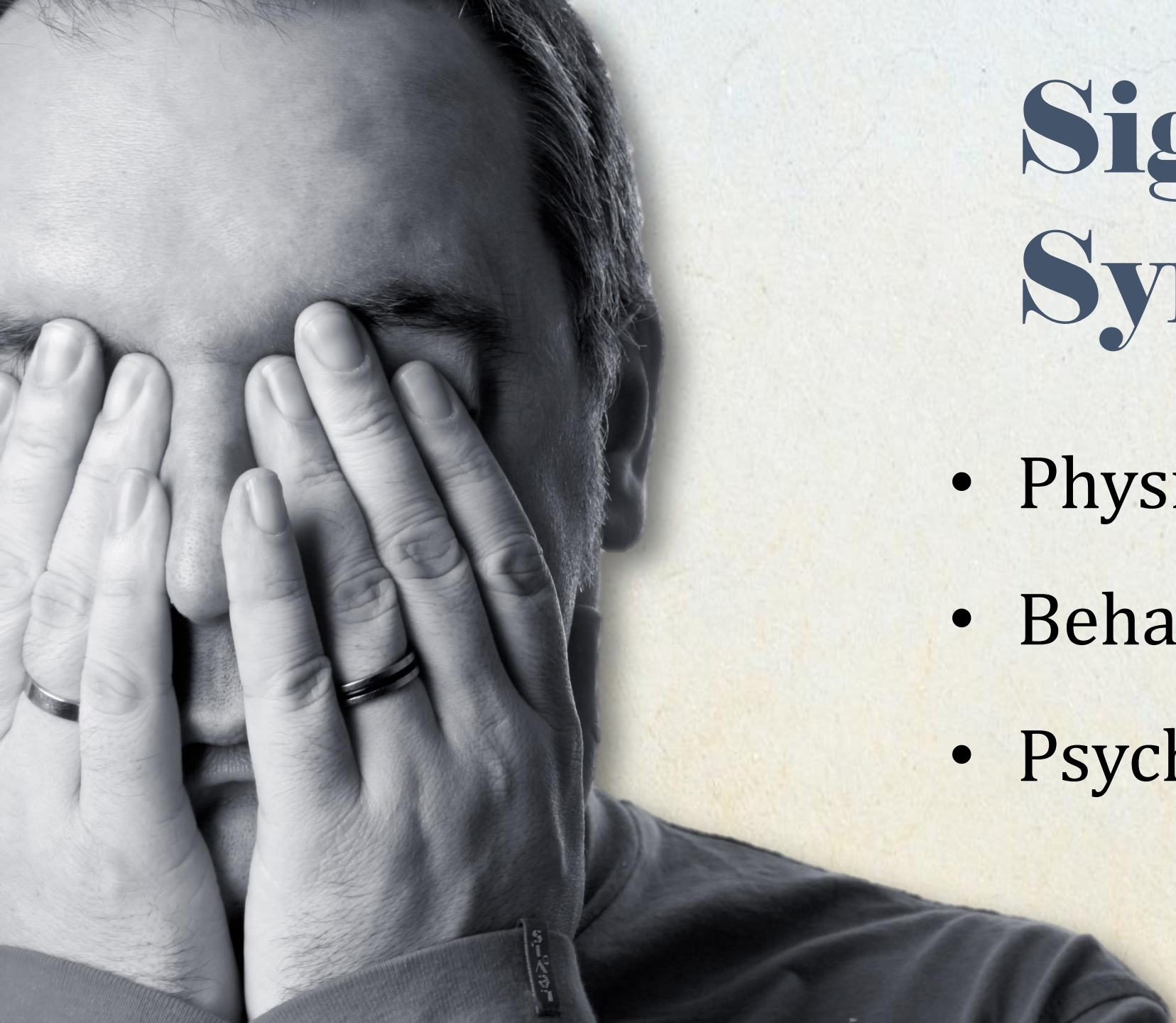
https://www.ncsacw.samhsa.gov/resources/SAFERR.aspx

TOOL EXAMPLES

- **GAIN-SS (Global Appraisal of Individual Needs Short Screener)**: Composed of 23 items to be completed by the client or staff and designed to be completed in 5 minutes
- **UNCOPE**: 6-item screen designed to identify alcohol and/or drug substance use and designed to be completed in 2 minutes
- **CAGE**: 4-item screen designed to identify alcohol and/or drug substance use and designed to be completed in 2 minutes

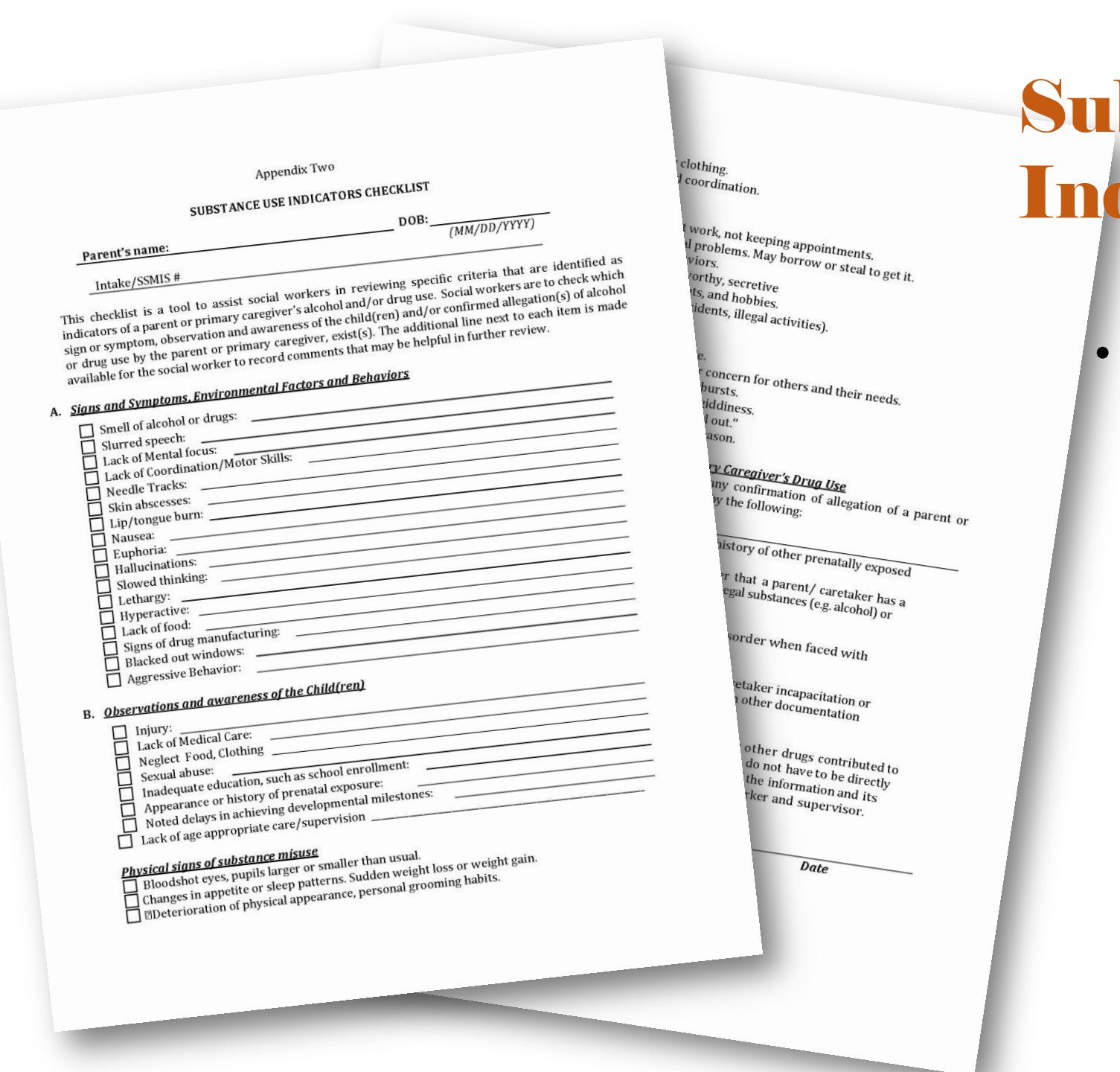
It's Not the Tool, It's the Team!

https://www.ncsacw.samhsa.gov/resources/SAFERR.aspx



Signs & Symptoms

- Physical
- Behavioral
- Psychological



Appendix Two

SUBSTANCE USE INDICATORS CHECKLIST

Parent's name: _____ DOB: _____ (MM/DD/YYYY)

Intake/SSMIS # _____

This checklist is a tool to assist social workers in reviewing specific criteria that are identified as indicators of a parent or primary caregiver's alcohol and/or drug use. Social workers are to check which sign or symptom, observation and awareness of the child(ren) and/or confirmed allegation(s) of alcohol or drug use by the parent or primary caregiver, exist(s). The additional line next to each item is made available for the social worker to record comments that may be helpful in further review.

A. ***Signs and Symptoms, Environmental Factors and Behaviors***

- ☐ Smell of alcohol or drugs: _____
- ☐ Slurred speech: _____
- ☐ Lack of Mental focus: _____
- ☐ Lack of Coordination/Motor Skills: _____
- ☐ Needle Tracks: _____
- ☐ Skin abscesses: _____
- ☐ Lip/tongue burn: _____
- ☐ Nausea: _____
- ☐ Euphoria: _____
- ☐ Hallucinations: _____
- ☐ Slowed thinking: _____
- ☐ Lethargy: _____
- ☐ Hyperactive: _____
- ☐ Lack of food: _____
- ☐ Signs of drug manufacturing: _____
- ☐ Blacked out windows: _____
- ☐ Aggressive Behavior: _____

B. ***Observations and awareness of the Child(ren)***

- ☐ Injury: _____
- ☐ Lack of Medical Care: _____
- ☐ Neglect Food, Clothing _____
- ☐ Sexual abuse: _____
- ☐ Inadequate education, such as school enrollment: _____
- ☐ Appearance or history of prenatal exposure: _____
- ☐ Noted delays in achieving developmental milestones: _____
- ☐ Lack of age appropriate care/supervision _____

Physical signs of substance misuse

- ☐ Bloodshot eyes, pupils larger or smaller than usual.
- ☐ Changes in appetite or sleep patterns. Sudden weight loss or weight gain.
- ☐ Deterioration of physical appearance, personal grooming habits.

clothing.
coordination.

work, not keeping appointments.
problems. May borrow or steal to get it.
viors.
worthy, secretive
ts, and hobbies.
idents, illegal activities).

e.
concern for others and their needs.
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cy Caregiver's Drug Use
ny confirmation of allegation of a parent or
y the following:

history of other prenatally exposed

r that a parent/ caretaker has a
egal substances (e.g. alcohol) or

sorder when faced with

etaker incapacitation or
other documentation

other drugs contributed to
do not have to be directly
the information and its
rker and supervisor.

Date

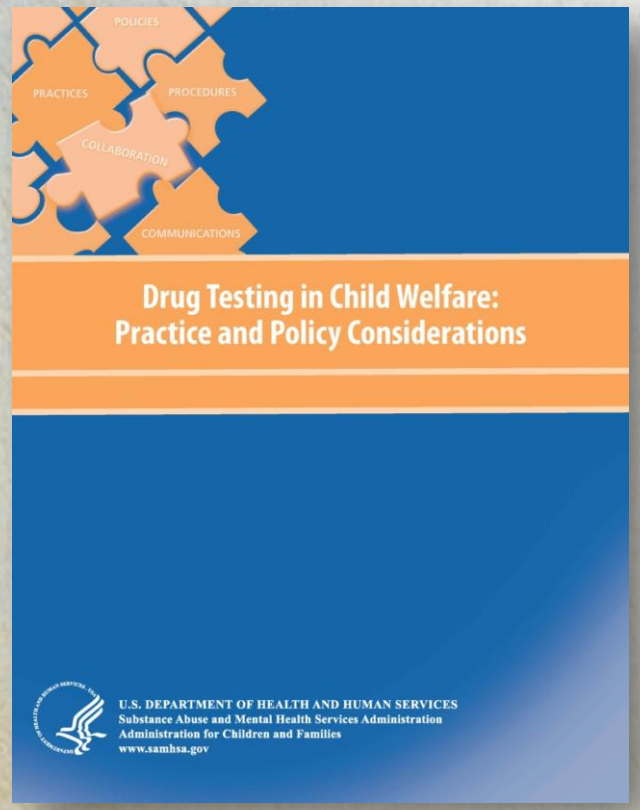
Substance Use Indicators Checklist

- Assist social workers in ***reviewing specific criteria that are identified as indicators*** of a parent or primary caregiver's alcohol and/or drug use:
  - *Environmental Factors and Behaviors*
  - *Observations and awareness of the Child(ren)*
  - *Physical, behavioral and psychological signs of substance misuse*
  - *Other – Confirmed allegations of a Parent or Primary Caregiver's Drug Use*

Corroborating Reports

- Police
- CWS
- Hospital

Drug Testing



- Drug testing is most frequently used indicator for substance use in CWS practice
- Test results may influence decisions on child removal, reunification, and Termination of Parental Rights
- Courts often order drug testing as a standard protocol for parents in the child welfare system
- Lack of standardized recommendations for drug testing in child welfare practice

http://www.ncsacw.samhsa.gov/files/DrugTestinginChildWelfare.pdf

What Questions Can Drug Testing Answer? …& What Can it Not?

- Whether an individual has used a tested substance within a detectable time frame
- A drug test alone cannot determine the existence or absence of a substance use disorder
- The severity of an individual's substance use disorder
- Whether a child is safe
- The parenting capacity and skills of the caregiver

Key Elements

What Do We Mean by Timely Assessments & Referral

Timely

- Clearly defined protocols and procedures with timelines and communication pathways (who needs to know what and when)
- Eligibility criteria based on clinical and legal assessments
- Match appropriate services to identified needs

Assessment & Referral

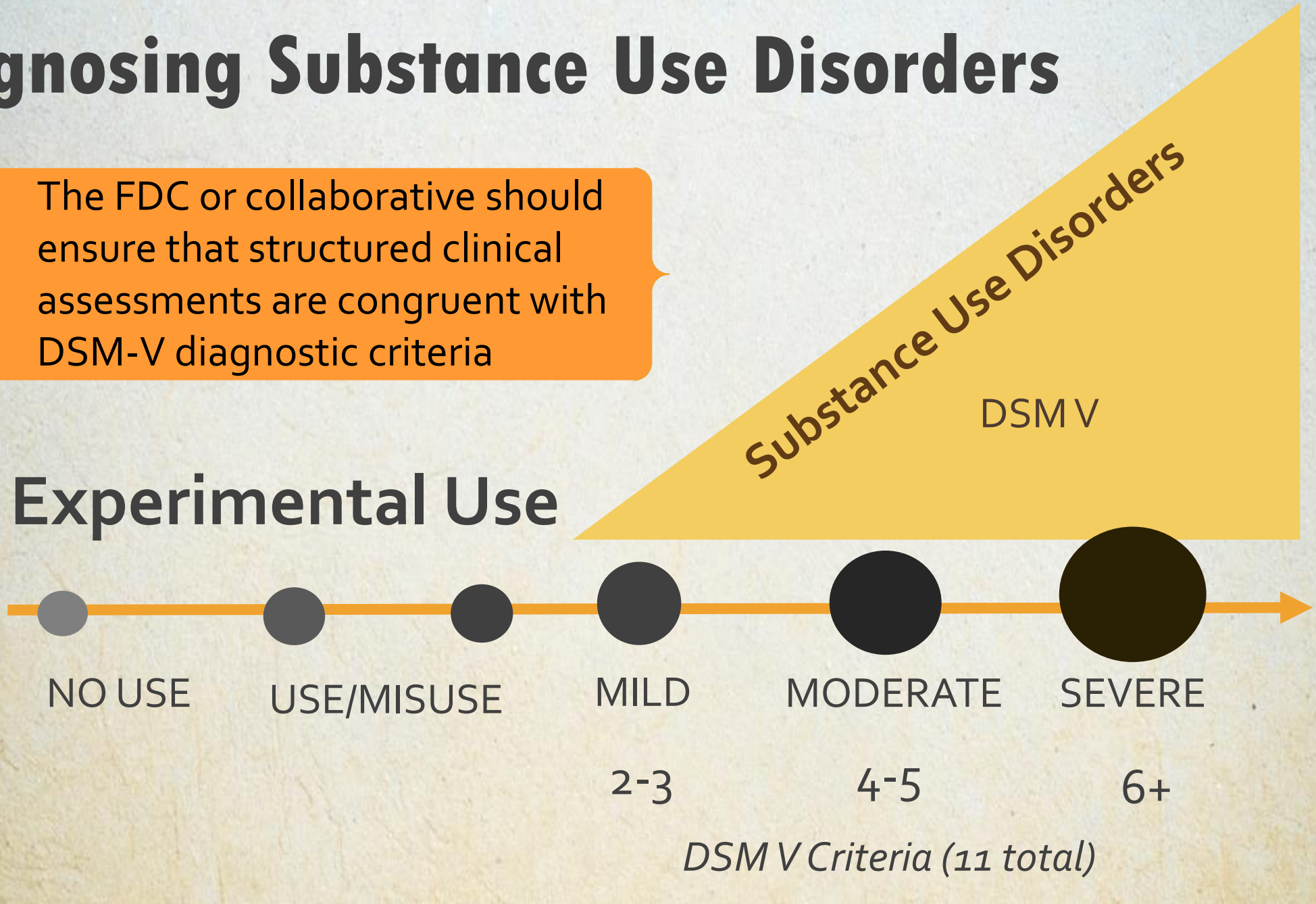
- *I refer all my clients to FDC because I know the people there*
- *I only refer clients who really want to participate*
- *Let me know when you get in the program*
- *I prefer to refer clients who are doing well on their CWS case plan*
- *I refer all my clients with a drug history to the FDC*

Assessment: What is the nature and extent of the substance use issue?

- Process of information gathering to diagnosis and determine treatment needs
- Multidimensional assessment: Standardized set of questions on an individual's functioning, needs, and strengths to determine the level of care and needed services
- Conducted by trained clinicians

Diagnosing Substance Use Disorders

The FDC or collaborative should ensure that structured clinical assessments are congruent with DSM-V diagnostic criteria



Questions to Consider with an Assessment Protocol

- How is the individual referred for assessment?
- On an average, how long does it take to go from referral to assessment?
- Who conducts the assessment and what tools are used?
- What additional information from child welfare and other partners would be helpful in understanding the needs of the parent, child, and family?
- How is information communicated to the parent? To the child welfare staff? To the courts? Are the appropriate consents in place and consistently signed?
- What happens if the parent doesn't show for assessment?
- What are the next steps if treatment is indicated? If treatment is not indicated?
- If the persons/systems/agencies conducting the assessments are not the same as the ones providing treatment, is there a warm hand-off?

Recovery Support

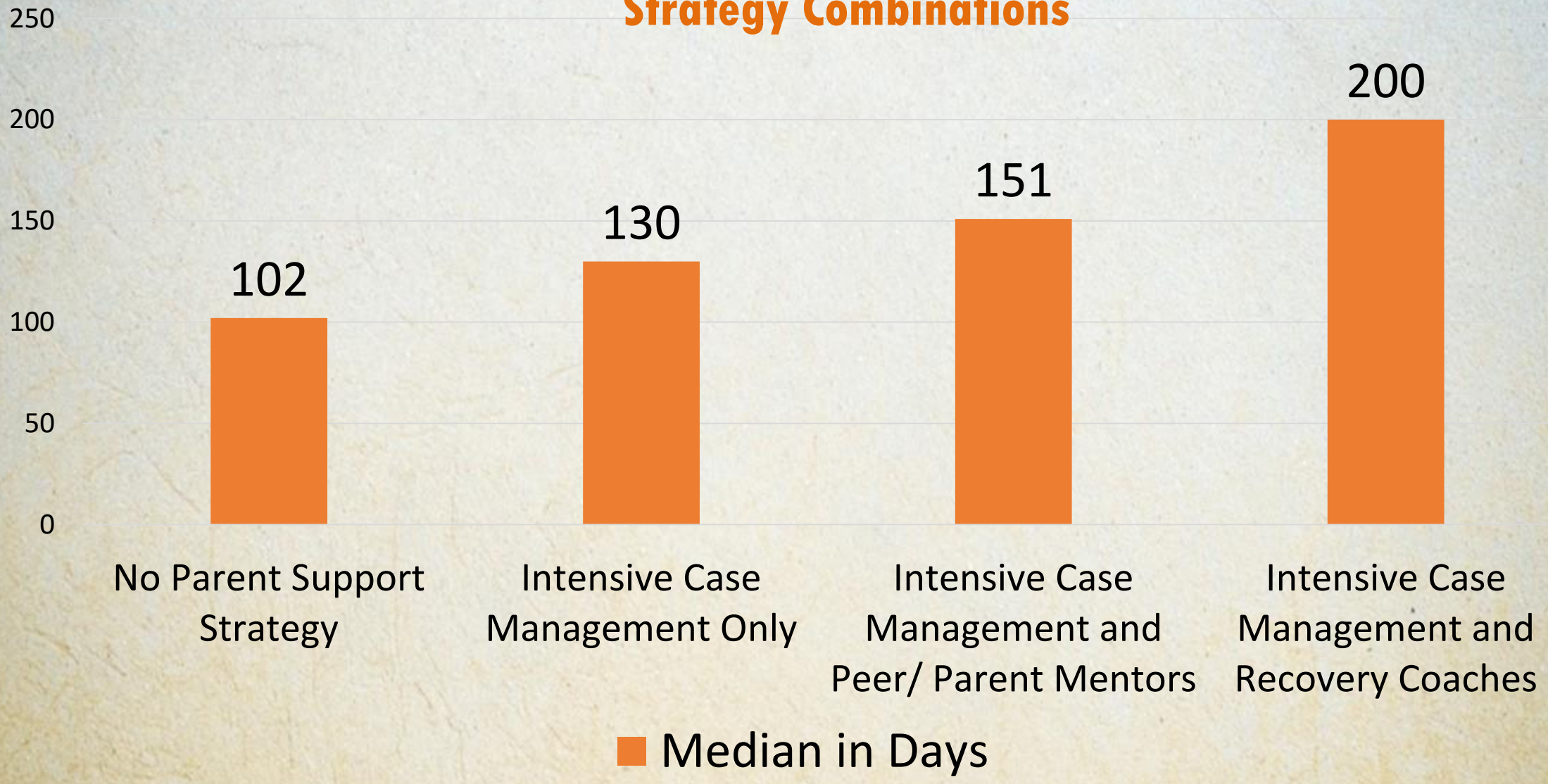
- Peer Mentor
- Peer Specialist
- Peer Providers
- Parent Partner

Experiential Knowledge, Expertise

- Recovery Support Specialist
- Substance Abuse Specialist
- Recovery Coach
- Recovery Specialist
- Parent Recovery Specialist

Experiential Knowledge, Expertise + Specialized Trainings

Median Length of Stay in Most Recent Episode of Substance Use Disorder Treatment After RPG Entry by Grantee Parent Support Strategy Combinations



Q&A

Resources

Family Drug Court *National Strategic Plan*

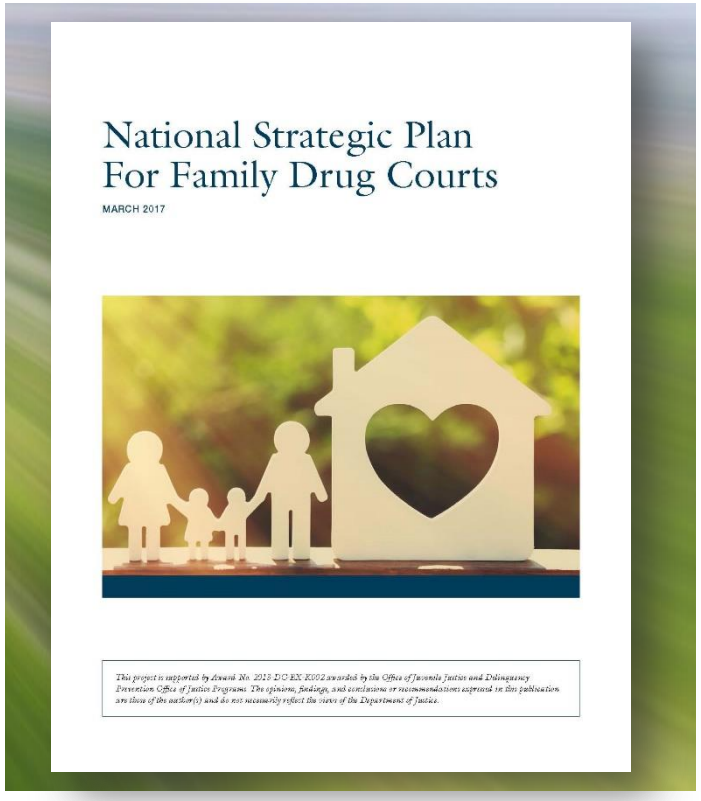
Vision:

Every family in the child welfare system affected by parental/caregiver substance use disorders will have timely access to comprehensive and coordinated screening, assessment and service delivery for family's success.

Ensure Quality Implementation

Expansion of FDC Reach

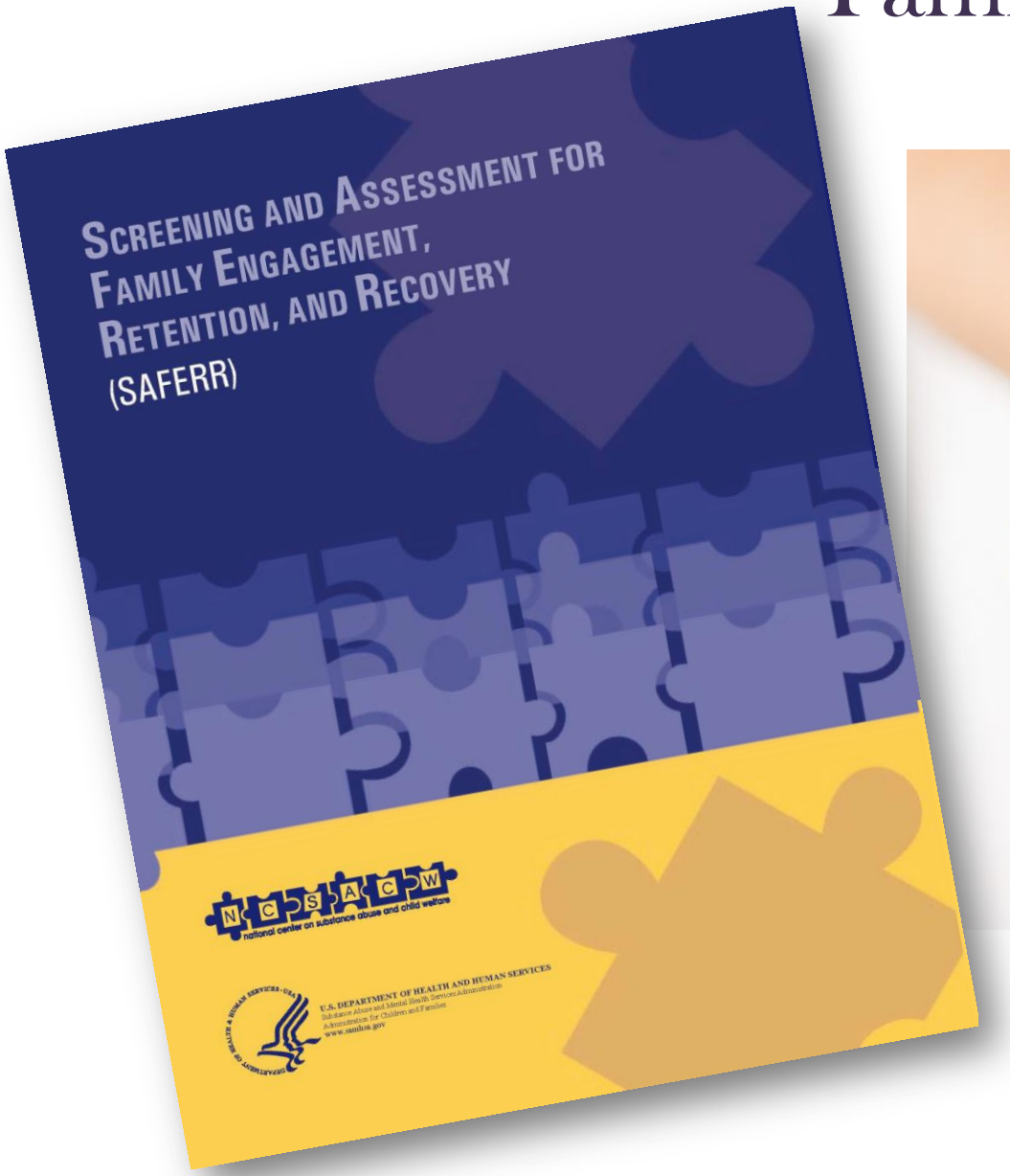
Build Evidence Base



NATIONAL FAMILY DRUG COURT TTA Program

www.cffutures.org/fdc

Resource: Screening and Assessment for Family Engagement, Retention, and Recovery (SAFERR)



To download a copy, please visit:

http://www.ncsacw.samhsa.gov/files/SAFERR.pdf

Family Drug Court *Learning Academy*

- Over 40 webinar presentations
- 5 Learning Communities along FDC development
- Team Discussion Guides for selected presentations

www.cffutures.org

Family Drug Court *Blog*

- Webinar Recordings
- FDC Resources
- FDC News

www.familydrugcourts.blogspot.com

Discussion Guide *Understanding Treatment*

NATIONAL FAMILY DRUG COURT TTA Program

- For Child Welfare and Court Professionals
- Build stronger partnerships with treatment
- Ensure best treatment fit for families

www.cffutures.org

Family Drug Court *Online Tutorial*

- Self-pace learning
- Modules cover basic overview of FDC Model
- Certificate of Completion

www.cffutures.org

NATIONAL FAMILY DRUG COURT TTA Program

Family Drug Court *Guidelines*

2nd Edition – Research Update

NATIONAL FAMILY DRUG COURT TTA Program

@ www.cffutures.org/fdc/

FAMILY DRUG COURT PEER LEARNING COURT PROGRAM

CONTACT US FOR MORE INFORMATION: fdc@cffutures.org

Family Drug Court *Orientation Materials*

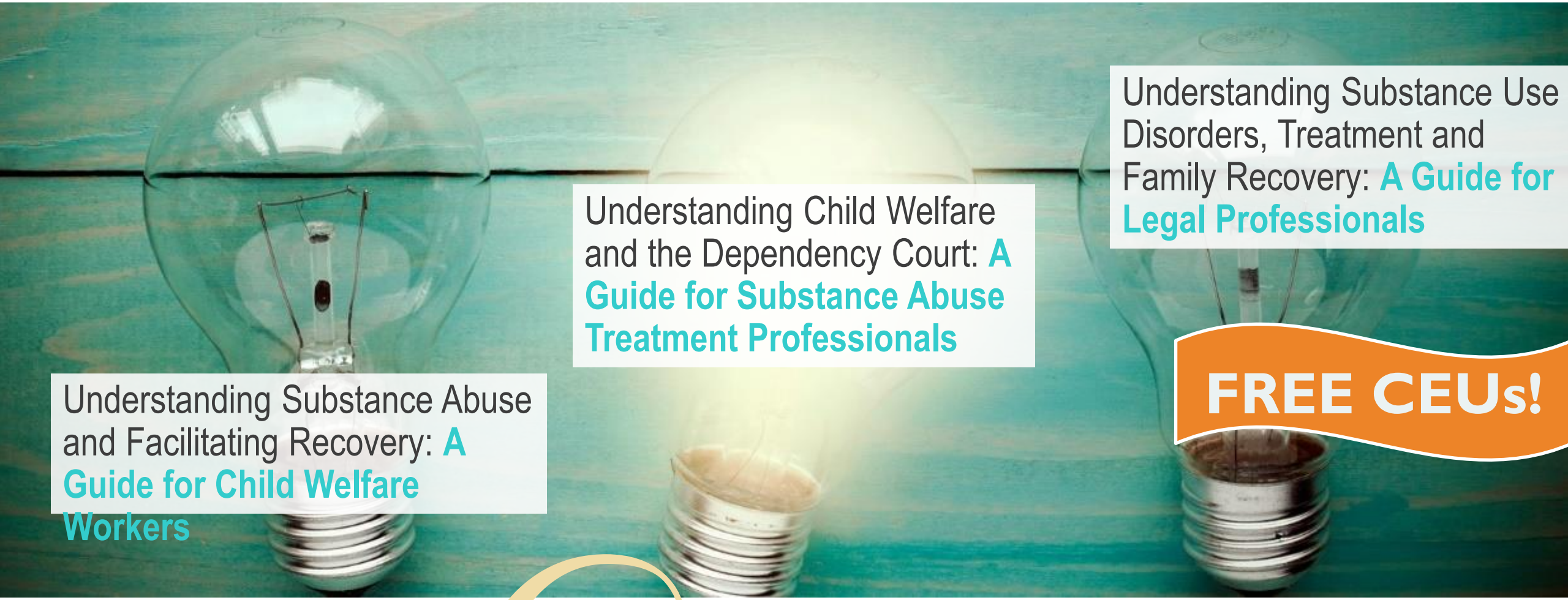
NATIONAL FAMILY DRUG COURT TTA Program

Discipline Specific

Child Welfare | AOD Treatment | Judges | Attorneys

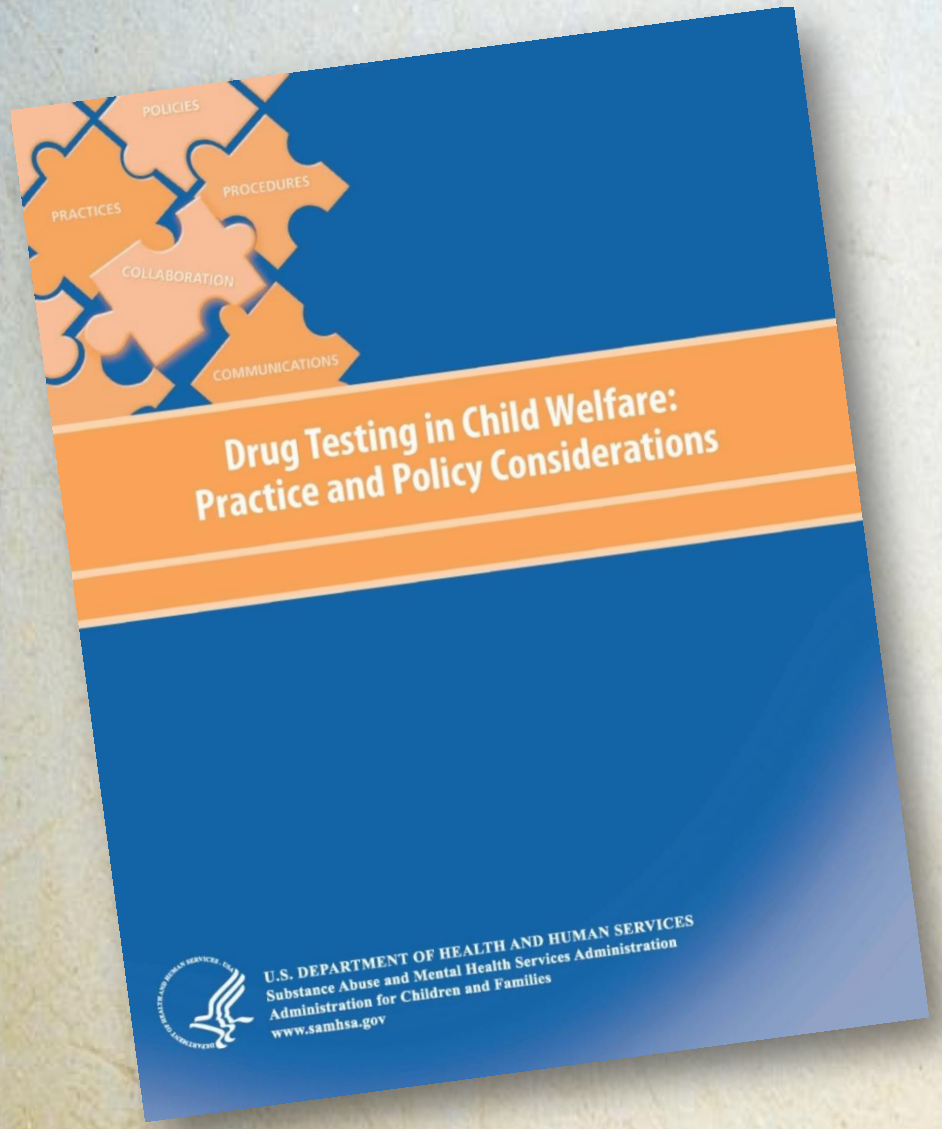
www.cffutures.org/fdc

NCSACW Online Tutorials *Cross-Systems Learning*



www.ncsacw.samhsa.gov/.org

Resource: Drug Testing in Child Welfare: Practice and Policy Considerations



To download a copy, please visit:

http://www.ncsacw.samhsa.gov/files/DrugTestinginChildWelfare.pdf

Contact Information

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jpfeifer@cffutures.org

NATIONAL FAMILY DRUG COURT TTA Program

JUDICIAL COUNCIL OF CALIFORNIA

455 Golden Gate Avenue • San Francisco, California 94102-3688
Telephone 415-865-4200 • Fax 415-865-4205 • TDD 415-865-4272

MEMORANDUM

Date
January 20, 2017

To
Presiding Judges of the Superior Courts
Executive Officers of the Superior Courts
Fiscal Contacts of the Superior Courts

From
Doug Kauffroath, Director
Branch Accounting and Procurement

Subject
Finance Memo TC 2017-02
Restriction on travel to states with discriminatory laws

Action Requested
Review and implement effective January 20, 2017: Restriction on travel to states with discriminatory laws

Deadline
N/A

Contact
Paul Fontaine, Fiscal Supervisor
Judicial Council of California
415-865-7785 phone
paul.fontaine@jud.ca.gov

On January 20, 2017, the Judicial Council approved a policy that prohibits judicial branch-funded or judicial branch-sponsored travel to a state that after June 26, 2015, has enacted a discriminatory law. This policy affirms the Judicial Branch's intent to follow the restrictions outlined in Government Code 11139.8.

The link to the Attorney General's website that lists the states is https://oag.ca.gov/ab1887.

Restricted Travel to States with Discriminatory Laws

The Judicial Branch will follow the restrictions in Government Code 11139.8 as outlined below for Executive and Legislative branches:

Government Code 11139.8.
(a) The Legislature finds and declares all of the following:

(1) California is a leader in protecting civil rights and preventing discrimination.
(2) California's robust nondiscrimination laws include protections on the basis of sexual orientation, gender identity, and gender expression, among other characteristics.
(3) Religious freedom is a cornerstone of law and public policy in the United States, and the Legislature strongly supports and affirms this important freedom.
(4) The exercise of religious freedom should not be a justification for discrimination.
(5) California must take action to avoid supporting or financing discrimination against lesbian, gay, bisexual, and transgender people.
(6) It is the policy of the State of California to promote fairness and equality and to combat discrimination.
(b) A state agency, department, board, authority, or commission, including an agency, department, board, authority, or commission of the University of California, the Board of Regents of the University of California, or the California State University, and the Legislature shall not do either of the following:
(1) Require any of its employees, officers, or members to travel to a state that, after June 26, 2015, has enacted a law that voids or repeals, or has the effect of voiding or repealing, existing state or local protections against discrimination on the basis of sexual orientation, gender identity, or gender expression or has enacted a law that authorizes or requires discrimination against same-sex couples or their families or on the basis of sexual orientation, gender identity, or gender expression, including any law that creates an exemption to antidiscrimination laws in order to permit discrimination against same-sex couples or their families or on the basis of sexual orientation, gender identity, or gender expression.
(2) Approve a request for state-funded or state-sponsored travel to a state that, after June 26, 2015, has enacted a law that voids or repeals, or has the effect of voiding or repealing, existing state or local protections against discrimination on the basis of sexual orientation, gender identity, or gender expression, or has enacted a law that authorizes or requires discrimination against same-sex couples or their families or on the basis of sexual orientation, gender identity, or gender expression, including any law that creates an exemption to antidiscrimination laws in order to permit discrimination against same-sex couples or their families or on the basis of sexual orientation, gender identity, or gender expression.
(c) Subdivision (b) shall not apply to travel that is required for any of the following purposes:
(1) Enforcement of California law, including auditing and revenue collection.
(2) Litigation.
(3) To meet contractual obligations incurred before January 1, 2017.
(4) To comply with requests by the federal government to appear before committees.
(5) To participate in meetings or training required by a grant or required to maintain grant funding.
(6) To complete job-required training necessary to maintain licensure or similar standards required for holding a position, in the event that comparable training cannot be obtained in California or a different state not affected by subdivision (b).

(7) For the protection of public health, welfare, or safety, as determined by the affected agency, department, board, authority, or commission, or by the affected legislative office, as described in subdivision (b).
(d) The prohibition on state-funded travel described in this section shall continue while any law specified in subdivision (b) remains in effect.
(e) (1) The Attorney General shall develop, maintain, and post on his or her Internet Web site a current list of states that, after June 26, 2015, have enacted a law that voids or repeals, or has the effect of voiding or repealing, an existing state or local protection against discrimination on the basis of sexual orientation, gender identity, or gender expression, or have enacted a law that authorizes or requires discrimination against same-sex couples or their families or on the basis of sexual orientation, gender identity, or gender expression, including any law that creates an exemption to antidiscrimination laws in order to permit discrimination against same-sex couples or their families or on the basis of sexual orientation, gender identity, or gender expression.
(2) It shall be the responsibility of an agency, department, board, authority, or commission described in subdivision (b) to consult the list on the Internet Web site of the Attorney General in order to comply with the travel and funding restrictions imposed by this section.

Santa Maria - North County

Veterans helping veterans - vet housing opens in Santa Maria

Veterans finding hope

By: Sean Larsen

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SANTA MARIA, Calif. - Veterans helping veterans - struggling vets have been moving into the new "La Casa de Flores" - also known as "Camp Flores" in Santa Maria.

This morning was the grand opening. Camp Flores is a place where veterans can find hope. Earlier we spoke with a vet who was just recently homeless.

"He's a good baby, doesn't cry much, sleeps most of the time," Navy veteran Anthony Ibarra said, talking about his new baby.

Navy veteran Anthony Ibarra and his girlfriend Desiree just moved into "Camp Flores" about a month ago. Then about half a month later...

"This guy came along," Ibarra said, referencing his baby.

All five pounds, five ounces of him.

"Small.. 19 and a quarter inches long," Ibarra said.

Ibarra now has a new home and a new baby, who he calls a blessing - but recently, he wasn't feeling so blessed.

"I was at the Good Samaritan shelter over there behind Santa Maria High," Ibarra said.

Ibarra was just a little down on his luck.

"Couldn't find anywhere to stay or anything, rents pretty expensive," Ibarra said. "Luckily I was working and I had a job..as well as my girlfriend."

Ibarra lives in one of two detached apartments that can house a veteran family like his or a single veteran. The main house can house up to eight veterans.

"It's designed to help displaced veterans, low income or homeless vets," Army veteran Mario Alvarez said.

Army veteran Mario Alvarez recently moved in and is helping run the house.

"We also lift each other up and support each other, if there's something going on in someone's mind we will sit down and talk about it," Alvarez said.

The camp is named after Judge Rogelio Flores, who started the first "Veteran's Court" in Santa Barbara County - that helps vets who get into trouble, get back on track.

"When they come back, we need to step up for them..we can't stop fighting for veterans because they never stopped fighting for us," Santa Barbara County Superior Court Judge Rogelio Flores said.

Reporter: How you feeling?
"Good..happy," Ibarra said.

Camp Flores, located off of West Church Street and Thornburg Street, is funded by a private donor - who is a veteran - and government assistance.

http://www.keyt.com/news/santa-maria-north-county/veterans-helping-veterans-vet-housing-opens-in-santa-maria/625135950