

## Family Drug Courts

Family drug courts (FDCs) are specialized courts within the justice system, which handle cases of child abuse and neglect that involve substance use by the child's parents or guardians (Brook et al. 2015; Chuang et al. 2012). FDCs are one method of addressing parental substance use disorders and parenting issues within the court and child welfare systems, using a collaborative, family-centered approach (Children and Family Futures 2015). Also called family treatment courts, family treatment drug courts, or family dependency treatment courts, FDCs operate as alternatives to traditional family courts or dependency courts and work to balance the rights and needs of both parents and children (Brook et al. 2015). The overall goal of FDCs is to reduce child maltreatment by treating parents' underlying substance use disorders through a coordinated and collaborative approach that involves a multitude of agencies and professionals such as the court system, child protective services (CPS) or child welfare, substance use treatment providers, and the attorneys involved in the case (Pach 2008; Gifford et al. 2014).

Modeled after adult drug courts, FDCs were developed by communities in the mid-1990s as a response to the estimated high percentage (60–80 percent) of substantiated child abuse and neglect cases that involved substance use by a parent or guardian (Marlowe and Carey 2012; National Council of Juvenile and Family Court Judges 2016). The court programs were designed to address the parental substance use and child neglect connection in an appropriate, but timely manner (van Wormer and Hsieh 2016). FDCs were also created to help keep families together and address the poor outcomes of family reunification programs that left many children in foster care for years instead of being raised in stable, permanent homes (Marlowe and Carey 2012). In addition, at around the same time that FDCs emerged in communities, the drug court model was being adapted by tribal communities. The first Tribal Healing to Wellness Court was established in 1997, and later, Tribal Family Health to Wellness Courts also emerged (Bureau of Justice Assistance, 2014) (further discussion on the similarities and differences of FDCs and tribal healing wellness courts is provided below).

In addition, FDCs were established to respond to new requirements by the Adoption and Safe Families Act (ASFA) of 1997<sup>1</sup>, which Congress passed in an effort to decrease the amount of time children spent in non-permanent placement settings. As Traube and colleagues explained, ASFA regulations “require permanency hearings to take place within 12 months of a child being placed in foster care, making parents with substance use disorders particularly vulnerable to losing their parental rights” (2015, p. 47). Although ASFA increased the need for the system to provide treatment to parents, this need was not always met. For example, only 31 percent of families who needed

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<sup>1</sup> The Adoption and Safe Families Act of 1997, 42 U.S.C. §§ 670-679

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treatment received it in the year ASFA became law (Powell et al. 2012). However, because FDCs ultimately strive for family reunification (if in the best interest of the child), they are designed to address the treatment needs of parents and meet the requirements set by ASFA to increase the chances of reunification, while assuring that children are receiving the developmental services they need (Bureau of Justice Assistance 2004a; Marlowe and Carey 2012).

To achieve the aim of ASFA and to address the high number of dependency cases of child maltreatment and neglect that involve parents with a substance use disorder, FDCs identify and assess parents' needs, provide access to treatment, attempt to remove barriers that may impact successful completion of treatment (such as helping parents to develop skills to achieve recovery), and provide ongoing monitoring of parental compliance (Pach 2008). FDCs also help parents to become emotionally and financially self-sufficient and provide them with tools to become responsible parents (Brook et al. 2015; Office of Justice Programs Drug Court Clearinghouse and Technical Assistance Project [DCCTAP] 1998). Children's needs are simultaneously addressed, as the likelihood of reunification is increased when family and children's services are provided at a high level in substance use treatment (Grella et al. 2009).

Alternatively, if reunification is not in the best interest of the child, the courts develop a different placement plan. To do so, CPS is brought into the process to terminate parental rights and find a permanent home for the child. This process must be completed within a developmentally appropriate timeframe and conducted in a manner that is the least harmful and most beneficial to the child (Pach 2008; DCCTAP 1998). The court and child welfare components of this process occur simultaneously, as permanency for the child is one of the collaborative goals of the FDC team along with safety and well-being of children and parents in recovery (Children and Family Futures (2015).

## Target Population

FDCs assist families that have been disrupted by parental substance use, which has led to allegations of child neglect and abuse. Parents and guardians are generally eligible to participate in FDCs when they have an abuse, neglect, or dependency case pending before the court and the contributing factor to maltreatment substantiation is a diagnosed substance use disorder. Participation in the program is usually voluntary; parents and guardians can refuse to participate (Gifford et al. 2014).

Local FDC programs may vary in their eligibility criteria and requirements. However, research suggests that FDCs may benefit from having the least amount of exclusionary criteria. For example, Worcel and colleagues (2007) found that FDCs have the same or slightly better outcomes when serving parents with co-occurring mental health issues, and other challenges such as unemployment.

## Characteristics of Family Drug Courts

FDCs are not separate legal entities that operate outside the court system. Instead, they operate within family courts, specifically addressing issues related to parental substance abuse (Pach 2008). In 2013, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) developed a list of 10 recommendations for implementing FDCs (Children and Family Futures 2015). These recommendations focused on the need for a centralized mission, collaborative partnerships in public and community-based agencies, and ensuring that the needs of both parents and children are considered (Brook et al. 2015; Children and Family Futures 2015).

The characteristics and operations of FDCs can vary by jurisdictions, and they can differ on program elements such as eligibility criteria, whether the case is overseen by one or two judges, composition of the court team, requirements for successful completion of the program, and the quality and availability of substance abuse treatment services (Brook et al. 2015).

Despite these variances, certain components are central to most FDCs. Given that these courts are modeled after criminal drug courts, they began using the same 10 key components as drug courts (Bureau of Justice Assistance 2004b) as a starting point for the provision of services. More recently, however, the following 10 recommendations were developed specifically for FDCs (Children and Family Futures 2015):

1. Create shared mission and vision.
2. Develop interagency partnerships.
3. Create effective communication protocols for sharing information.
4. Ensure interdisciplinary knowledge.
5. Develop protocols for early identification and assessment.
6. Address the needs of parents.
7. Address the needs of children.
8. Garner community support.
9. Implement funding and sustainability strategies.
10. Evaluate for shared outcomes and accountability.

FDCs use an interdisciplinary team that works to address the needs of both the parent and child. Through this collaborative approach, the child can avoid long-term placement in the foster care system, and parents have the opportunity to show the court they can become responsible caregivers (Brook et al. 2015; Children and Family Futures 2015).

In addition, although the drug court and FDC models are similar, there are some important differences between the two. First, the majority of participants in adult criminal drug court programs tend to be men, while the majority of FDC participants are women, which could have implications for gender-specific treatment needs (Powell et al. 2012). Second, drug court programs handle cases that involve criminal offenses and may employ criminal sanctions (if necessary), while FDCs handle non-criminal cases of abuse and neglect and generally do not use criminal sanctions; rather, they use the prospect of family reunification as a motivating factor for participants (Marlowe and Carey 2012). As Worcel and colleagues explained (2007, 2), “Put another way, the ‘threat’ for adult drug court participants is incarceration, while the ‘threat’ for [family treatment drug court] participants is losing custody of their children, often permanently.” Finally, FDCs deal with the complexities of family issues and focus on the needs of the parents and children, while adult criminal drug courts tend to focus only on the needs of the adult participant.

As mentioned previously, another problem-solving court that shares similar characteristics to FDCs is a Tribal Healing Wellness Court (THWC). THWCs also use the drug court model, but they incorporate concepts of wellness to address the specific substance abuse needs of each tribal community in a non-adversarial process (Bureau of Justice Assistance 2014). Similar to FDCs, THWCs began by using the 10 components of drug courts as a starting point to guide treatment and services for program participants. However, specific guidance has been published for THWCs, which incorporate information about the

importance of focusing on children and family in cases of child abuse and maltreatment due to parental substance abuse (Bureau of Justice Assistance 2014). A further adaptation, Tribal Family Healing to Wellness Courts, are also based on the THWC and FDC models; however, since it is unclear how many Tribal Family Healing to Wellness Courts are currently operating in the country, little research on the program is currently available.

FDCs generally come in three types: 1) parallel; 2) integrated (one family, one judge); and 3) dual-track/two-tiered (also referred to as “hybrid model”). In a *parallel* FDC, one judge oversees the child welfare part of the client’s case, while another judge oversees the client’s substance use disorder treatment progress and assists in coordinating family and children’s services. Parallel FDCs are less common than *integrated* FDCs (Green et al. 2009). As the name suggests, in a “one family, one judge” integrated FDC, one family court judge oversees the child welfare case while also ensuring parental compliance with the substance abuse treatment order (Brook et al. 2015). Finally, the *dual track/two-tiered* FDC is essentially a hybrid of the other two models (Powell et al. 2012). The first track includes recovery-management services and access to substance abuse treatment for child abuse and neglect cases in which there is an allegation of parental substance use. The second track is a separate FDC for parents who fail to comply with court orders. The FDC then operates in a separate court than the child welfare case, with separate judges overseeing the two cases, and is primarily concerned with ensuring parents’ compliance with treatment orders (Boles et al. 2007; Powell et al. 2012).

## Outcome Evidence

There have been fewer evaluation studies (less than 20) conducted on the effectiveness of FDCs, compared with the number of studies (more than 50) of adult drug courts (Gifford et al. 2014; van Wormer and Hsieh 2016). Although parents and guardians participate in the program and receive substance use treatment, evaluations of FDCs have generally focused on the programs’ direct impacts on children. For example, evaluations have focused on outcome measures related to ASFA requirements, including dependency outcomes, treatment completion, number of days in out-of-home care, and reentry into care (Gifford et al. 2014; Substance Abuse and Mental Health Services Administration 2014; van Wormer and Hsieh 2016). Many of the outcomes examined in studies of FDCs relate to the goals of the ASFA (van Wormer and Hsieh 2016). When changes in parental behavior are measured, outcomes generally include rearrest rates, treatment completion, substance abuse following treatment, and measures of family functioning (Dakof et al. 2010; Carey et al. 2010).

To reach the desired outcomes of the FDC, evaluation research has shown the importance of serving the needs of parents, children, and families. For example, a descriptive study of the Children Affected by Methamphetamine (CAM) grant program found that comprehensively addressing families’ needs and adding child-focused services with adult recovery-support services was associated with better outcome measures of child safety, permanency, adult recovery, and family well-being. Specifically, when child-focused services with adult recovery-support services were offered in the FDC setting, parental substance use was reduced, parents’ participation in substance use disorder treatment was improved, children were subjected to less neglect and abuse, and out-of-home placements were shorter (Rodi et al. 2015). Overall, the results of the study suggested that FDCs should focus on providing appropriate services that aim to improve outcomes for parents, children, *and* families; however, the study authors did note the implementation challenges that jurisdictions may face in order to address the complex and diverse needs of family members (Rodi et al. 2015).

Despite the limited number of studies available, there are a number of evidence-based FDC programs. Below is a discussion of three such programs.

***Jackson County Community Family Court (CFC).*** The Jackson County CFC in Oregon is an FDC program for parents with admitted substance abuse allegations whose children are wards of the state and are in the custody of the Oregon Department of Human Services. The CFC was designed to coordinate services and interventions that help to rehabilitate court-involved parents and their families. The goal of the program is to work toward parental sobriety, family reunification, and child safety (Carey et al. 2010).

A program evaluation by Carey and colleagues (2010) found that the children of parents who participated in CFC spent significantly less time in foster care in the 4 years after entering the program than children of non-CFC parents. Children of CFC parents were also returned significantly sooner, were significantly more likely to be reunited with their parents, and experienced significantly fewer adoptions and termination of parental rights. However, not all child welfare outcomes were positive. There were no significant differences in placement stability (i.e., how often children moved from one foster care placement to another). Also, children of CFC parents had significantly more new foster care episodes, compared with children of non-CFC parents. Finally, parents who participated in CFC were significantly less often rearrested over the 4 years from program entry, compared with non-CFC parents.

***Baltimore City Family Recovery Program (FRP).*** The Baltimore City FRP is an FDC designed to serve families involved with child welfare due to parental substance use. The program provides comprehensive case management and immediate, intensive substance abuse services for parents involved in proceedings for Children in Need of Assistance. The program serves parents with substance use disorders that led to the placement of their children in foster care after removal from the home. The goal of FRP is to encourage sobriety and improve quality of life for parents to increase the likelihood of reunification for families and decrease the length of stay in foster care for children (Burrus, Mackin, and Finigan 2011).

A study by Burrus, Mackin, and Aborn (2008) found that FRP cases resulted in significantly more reunifications and significantly fewer placements in longer-term foster care, compared with non-FRP cases. Children whose parents attended FRP spent significantly less time in non-kinship foster care than children whose parents did not participate. In addition, FRP parents entered treatment more rapidly and completed treatment more often than non-FRP parents. However, there was no statistical difference between the number of FRP cases and non-FRP cases that reached permanency and no difference in the number of days children spent in non-kinship foster care.

***The Engaging Moms Program (EMP).*** The EMP in Miami, Florida, is a gender-specific, family-based intervention designed to help substance-abusing mothers who participate in drug court maintain their parental rights. The program helps mothers demonstrate that they can be reunited with their children. It provides mothers the tools and services to comply with all court orders, attend court sessions, remain drug free, and demonstrate the capacity to parent their children, thereby helping them to succeed in drug court. EMP was adapted for use in FDCs, based on the theory and method of multidimensional family therapy (Dakof et al. 2010).

A study by Dakof and colleagues (2010) showed that there was a statistically significant difference between mothers who participated in EMP and mothers who received intensive case-management services. The EMP mothers were more likely to have positive child welfare outcomes (defined as welfare dispositions that led to sole custody, joint custody, or permanent guardianship with family members, without termination of the mother's parental rights). However, there were no statistically significant differences between the two groups on measures of maternal substance use, psychosocial functioning, and family functioning.

For more information on the programs, please click on the links below.

[Jackson County \(Ore.\) Community Family Court](#)  
[Baltimore City \(Md.\) Family Recovery Program](#)  
[Engaging Moms Program](#)

## Conclusion

FDCs have grown in popularity in the last decade, due to the increasing impact of parental substance use disorders in child welfare cases. As of 2013, there were over 300 FDCs in operation across the country (Children and Family Futures 2015). However, there are some challenges in assessing these programs. These include several methodological limitations such as a lack of rigorous study designs, small sample sizes, absence of comparison groups or use of inappropriate comparison groups, inclusion of only program graduates in the outcome data, and lack of appropriate statistical controls when calculating results (Brook et al. 2015; van Wormer and Hsieh 2016).

Future research on FDCs could aim to overcome these limitations. Furthermore, future research could focus on other important aspects of the programs that may impact parent- and child-related outcomes such as the effect of the type of substance use disorder treatment that parents receive, the factors that are related to improving the start and completion of treatment, and the comparative effectiveness of the three types of FDCs (Chuang et al. 2012; Gifford et al. 2014). Research could also examine ways to improve family engagement throughout the process and the factors related to successful implementation of FDCs.

For more information about developing an FDC program, see the guidebook produced for the OJJDP, [Guidance to States: Recommendations for Developing Family Drug Court Guidelines](#) (Children and Family Futures 2015). Or check the Children and Family Futures Web site to learn more about [Family Drug Court Peer Learning Courts](#).

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