

TRANSITIONING TO A FAMILY CENTERED APPROACH:

Best Practices and Lessons Learned
from Three Adult Drug Courts



Children and Family Futures
National Drug Court Institute



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This project was supported by Grant No. 2016-DC-BX-K007 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Department of Justice's Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime, and the SMART Office. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

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Summary

This case study looks at three adult drug courts (ADCs) from Florida, Michigan, and Montana that are in the process of transitioning from a traditional ADC to one that has expanded services to families and children of program participants. These courts had begun the transition process less than five years earlier and were at various stages in their transitions. The purpose of this case study was to obtain information about the ADC core team members' experiences and perceptions of the ADC processes as well as the programs' successes and challenges as they increased their services to address the needs of children and families. A semistructured interview process was used to obtain an in-depth understanding of the ADC regarding its collaboration, communication, shared knowledge, method of addressing the needs of families and children, funding, sustainability, and outcomes. Interviews with ADC participants were also conducted to better understand their views of the programs' strengths and challenges.

The case studies found ten key strategies for implementing a family-focused approach: (1) ensure strong judicial and coordinator leadership to guide the shift from a participant-focused court model to a family-focused one; (2) engage cross-system partners to revise the court mission, vision, and protocols to reflect the transition to a family-centered model; (3) develop community partnerships to expand comprehensive services to meet the needs of the entire family; (4) ensure strong communication and information sharing for effective coordinated service delivery to participants and their children and families; (5) develop cross-system training to ensure that partners understand the needs of parents, children, and families affected by substance use disorders; (6) conduct screening and assessment to identify the needs of parents, children, and families, and refer them to appropriate services; (7) provide evidence-based services to children and parents; (8) implement responses to behaviors that are sensitive to the needs of parents and families; (9) develop sustainability plans that account for funding services to children and families; and (10) conduct program evaluations to identify parent, child, and family outcomes.



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Background

Drug courts were established to counteract the increased incarceration rates and overrepresentation of individuals with substance use disorders in the criminal justice system.¹ The first drug court was established in 1989 in Miami-Dade County, Florida.² By December 2014, there were 3,057 drug courts nationwide.³ The purpose of drug courts is to reduce the number of individuals with substance use disorders in the criminal justice system by offering therapeutic treatment rather than using a punishment-oriented means of rehabilitation.⁴ These therapeutic courts use a multidisciplinary approach to treatment that has been shown to be effective in reducing recidivism and cost, reducing family conflict, and improving socioeconomic well-being.^{5,6,7,8,9}

Various types of drug courts exist across the United States, including family drug courts, veteran treatment courts, juvenile drug courts, and DWI courts. This case study focuses on adult drug courts (ADCs), specifically three ADCs that are expanding their scope to offer services to families and children of program participants. Of the 3,057 drug courts in the United States as of December 2014, 1,540 were ADCs. Traditional ADCs aim to reduce drug relapse and criminal recidivism by offering risk and needs assessments; judicial interaction, monitoring, and supervision; graduated sanctions and incentives; substance use disorder treatment; and other support services.¹⁰ ADCs have been shown to produce better outcomes for participants with substance use disorders who are considered high-risk and in greater need of intensive supervision, behavioral accountability,

and evidence-based treatment services.¹¹ The Ten Key Components of the drug court model offer best practice guidance that leads to improved effectiveness.¹²

Traditional ADCs focus their service delivery efforts primarily on the individual.¹³ However, many ADC participants have children and families. Nationwide, approximately 8.3 million children live with one or more parents who are dependent on alcohol or need treatment for illicit drug abuse.¹⁴ Considering the effects that substance use disorders have on the entire family (for example, children can experience behavioral issues, school difficulties, and developmental delays), it is important for ADCs to identify participants who are parenting and to address the needs of the children and families. One study found that when ADCs provide parenting classes, they see a 65% greater reduction in criminal recidivism and 52% greater cost savings than ADCs that do not provide parenting classes.¹⁵ A recent study of family drug courts across the nation demonstrated that child, parent, and family well-being outcomes improved when a comprehensive, family-centered approach was used to address specific needs of children and families in addition to the parent's recovery.¹⁶

There is a growing body of knowledge gained from evidence-based practice, collaborative practice models, and field research on how best to serve families that are both affected by substance use and involved in the child welfare system. These lessons can inform the family-centered work being done in ADCs.



Research and practical experience have demonstrated that:

■ ***The parenting role of both women and men with substance use disorders is a complex matter that cannot be separated from their treatment.***

Effective treatment programs integrate parenting practices into their treatment models. Attachment-based treatment practices for parents and their children have been shown to produce positive outcomes for women and their children, both within a residential program and in outpatient programs.^{17,18,19} After participating in attachment-based parenting interventions in a residential treatment setting, mothers were found to have significant improvements in maternal sensitivity, reflective functioning, and parent-child bonding.²⁰

■ ***Addressing the needs of both parents and children (individually and as a family unit) contributes to successful family outcomes.***

Family-focused treatment has been found to produce improvements in treatment retention, parenting attitudes, and psychosocial functioning.²¹

■ ***Parents do better in treatment when their children remain with them.*** In a cross-site evaluation of residential treatment programs for substance-using pregnant and parenting women, it was found that postpartum women who had their infants living with them in treatment had the highest

treatment completion rates and overall longer stays in treatment, when compared with women whose children did not live with them.²²

■ ***Two-generation interventions for parents and children affected by substance use disorders also save money.*** The Strengthening Families Program (SFP) demonstrated that, with an average out-of-home care rate of \$86 per child per day in the Midwest state in which it was implemented, SFP saves approximately \$16,340 per participating child in out-of-home care costs.²³ From a cost-benefit perspective, every dollar invested in SFP yields an average savings of \$9.83 in this state.

These examples highlight the importance to ADCs of incorporating a more comprehensive and collaborative family approach into their programs. More research is needed on ADCs that are serving families and children to capture their process and outcomes with this population. The ADCs in this case study are among the few that are taking a family-centered approach and building partnerships with family drug courts, community partners, other service providers, and systems to better serve families and children.

Many families with parental substance use do not come to the attention of child welfare. However, for those families that do, effectively and collaboratively addressing

substance use disorders and other co-occurring challenges, such as mental health, domestic violence, and housing, is critical. Past studies have shown that between 60 percent and 80 percent of substantiated child abuse and neglect cases involve substance use by a custodial parent or guardian.²⁴ These parents are often unable to provide a stable, nurturing home environment; they have a low likelihood of successful reunification with their children; and their children tend to stay longer in the foster care system than the children of parents without substance use disorders.^{25,26,27}

Family drug courts (FDCs) were developed to use a multidisciplinary, collaborative approach to oversee cases of child abuse and neglect in which parental substance use disorders are a factor.²⁸ Well-functioning FDCs bring together substance use treatment, mental health agencies, and social services agencies to meet the diverse needs of these families. FDCs seek to provide safe environments for children, intensive judicial monitoring, and interventions to treat parents' substance use disorders and other co-occurring risk factors.²⁹ Compared to standard services, FDC outcomes include significantly higher rates of parental participation in substance use treatment, longer stays in treatment, higher rates of family reunification, and less time spent by children in foster care.^{30,31,32,33} FDCs have demonstrated better outcomes for families with more serious challenges, such as criminal histories, inadequate housing, and domestic violence, than those without those challenges.

Published in 2013 and revised in 2015, *Guidance to States: Recommendations for Developing Family Drug Court Guidelines* provides information on best practices and collaborative principles to develop and sustain FDCs and incorporates up-to-date research supporting key strategies.³⁴ Although the recommendations were developed for FDCs, they provide guidance to ADCs that are working toward incorporating a comprehensive and collaborative family approach to services. These ADCs strive for some of the same goals and outcomes as FDCs related to improving services to families and children to reduce or eliminate substance use and child maltreatment and strengthening overall family functioning. The *Guidance to States* document provides FDCs with direction on how to improve court operations, policies and practices, collaboration, and evidence-based services for families and children. For a complete description of the recommendations, please visit:

<http://www.cffutures.org/resources/publications/guidance-states-developing-family-drug-court-guidelines>.

The following is a brief description of each recommendation:

- 1. Create a shared mission and vision.** The development of the mission and vision of an FDC should be a collaborative effort across systems, and partners should work together to develop shared goals and identify conflicting values. The mission and vision should encapsulate the family dynamic by understanding that treating only a single member of the family is not enough.
- 2. Develop interagency partnerships.** The families in the FDC are in need of various services to address the multitude of issues affecting healthy family functioning. FDCs should develop partnerships with community providers such as mental health treatment providers, domestic violence agencies, Court Appointed Special Advocates (CASA) for children, primary and oral health care providers, child care, housing, transportation, and employment-related services.
- 3. Create effective communication protocols for sharing information.** FDCs need to create effective communication protocols at the case and systems level to have comprehensive information sharing with all partners and across systems.
- 4. Ensure interdisciplinary knowledge.** Cross-training is an important element for effective bridging of systems that are collaborating to better serve families and children. Cross-training establishes an integral and unified understanding of the effects of substance use on child abuse and neglect; the most up-to-date research and science on the relevant topics affecting the systems; the legal requirements of each system; and the goals, objectives, and operational components of the FDC.
- 5. Develop a process for early identification and assessment.** Due to requirements that limit the time parents have to reunify with their children, it is important to streamline the process of screening and assessment. Screening for parental substance use disorder and whether it was a factor in alleged child neglect and abuse should occur as soon as, or before, a dependency case is filed in family court.

6. *Address the needs of parents.* Engagement, retention, and meeting the needs of parents is a collaborative effort that needs to be reflected in coordinated child welfare case plans and treatment plans, as well as increased partnerships within the community and the FDC, so that comprehensive services and supports can be established.
7. *Address the needs of children.* Children of parents in drug court may have been affected by prenatal and postnatal exposure to substance use and trauma that could result in deficits, delays, and concerns of a neurological, physical, social-emotional, behavioral, or cognitive nature. FDCs need to collaborate with community partners to provide comprehensive services for children to meet their varied needs.
8. *Garner community support.* It is important for an FDC to develop community partnerships, whether formal or informal, to comprehensively serve children and families while building a network of collaboration at the organizational level.
9. *Implement funding and sustainability strategies.* FDCs should ensure sustainability by assuring adequate resources through funding and the optimal use of existing resources; reviewing and modifying the policies and procedures to optimize program effectiveness; and developing community outreach, education, and partnerships.
10. *Evaluate shared outcomes and accountability.* The entire FDC team is responsible for evaluation and accountability. The team establishes mutual performance measures, and each team member is then responsible for evaluating these measures within their organization and sharing the outcomes with the rest of the team.

The *Guidance to States* recommendations were used as the framework for this case study. The ten recommendations were grouped into five overarching categories or domains of practice:

- Mission, vision, and principles
- Collaboration and communication
- Staff development and training
- Screening, assessment, and needs of parents, children, and families
- Funding, sustainability, evaluation, and outcomes

Purpose of This Study

This case study included three ADCs that are in the process of transitioning from a traditional ADC to one that has expanded services to families and children of program participants. The ADCs include:

- 11th Judicial Circuit, Miami-Dade Adult Drug Court in Miami, Florida
- 13th Judicial District Drug Court (13th JDDC) in Billings, Montana
- Van Buren County Circuit Court in Paw Paw, Michigan

These three courts had been undergoing the transition process for less than five years at the time of the study and were at various stages in their transitions. All three are continuing to work diligently to enhance their programs with the help of their varied formal and informal partners, to improve services to families and children. See Appendix A, “Court Descriptions,” for a detailed description of each court.

The purpose of these case studies was to obtain information about the ADC core team members’ experiences and perceptions of the ADC processes, as well as the programs’ successes and challenges as they increased their services to address the needs of children and families. The case study team used a semi-structured interview process to obtain an in-depth and well-rounded understanding of the ADC regarding its collaboration, communication, shared knowledge, method of assessing and addressing the needs of families and children, funding, sustainability, and outcomes. For a detailed description of the case study methodology, see Appendix B, “Case Study Methodology.” The case studies also included interviews with ADC participants to glean their experiences and perceptions of the programs’ strengths and challenges. The general trends and lessons learned may be used to help drug courts of all types serve participants’ children and families more comprehensively.

This case study answers the following questions:

1. What are the perceptions and experiences of the ADC team in providing services to ADC participants and their families?
2. What are the perceptions and experiences of the ADC participants in participating and receiving services from the ADC?
3. How do ADC team members communicate and collaborate to address the needs of ADC participants and their families?
4. How do ADCs provide staff development and training to the team members as they relate to serving children and families?
5. What funding and sustainability strategies exist in ADCs, and how do the ADCs evaluate these resources and other program practices to improve outcomes for participants and their families?

Results

The processes and lessons learned from the three courts in this case study can contribute a great deal of knowledge to other ADCs planning to transition to a more family-centered approach. A qualitative review of findings pinpointed the key practices that ADCs incorporate to serve the entire family. These key practices are organized by the five overarching domains of the *Guidance to States*. Courts may use these results to garner practical strategies and learn from the years of experience these courts have had. The box below lists the key strategies identified through this case study.

ADCs that are transitioning from a focus on the participant to a focus on the entire family may incorporate these practical strategies to assist with the transition process. The sections that follow describe each of the key strategies in detail, including case examples.

ADC Strategies for Implementing a Family-Focused Approach

1. Ensure strong judicial and coordinator leadership to guide the shift from a participant-focused court model to a family-focused one.
2. Engage cross-system partners to revise the court mission, vision, and protocols to reflect the transition to a family-centered model.
3. Develop community partnerships to expand comprehensive services to meet the needs of the entire family.
4. Ensure strong communication and information sharing for effective coordinated service delivery to participants and their children and families.
5. Develop cross-system training to ensure that partners understand the needs of parents, children, and families affected by substance use disorders.
6. Conduct screening and assessment to identify the needs of parents, children, and families, and refer them to appropriate services.
7. Provide evidence-based services to children and parents.
8. Implement responses to behaviors that are sensitive to the needs of parents and families.
9. Develop sustainability plans that account for funding services to children and families.
10. Conduct program evaluations to identify parent, child, and family outcomes.



Mission, Vision, and Principles

Strategy 1

Ensure strong judicial and coordinator leadership to guide the shift from a participant-focused model to a family-focused one.

Judicial Leadership

One of the themes that came up across the three courts in regard to transitioning to a family-centered approach was the importance of the judge advocating from the bench. Having a judge who understands the value of taking a family-centered approach and has the view of substance use disorder as a disease that needs to be addressed therapeutically was found to be beneficial. A judge who asks about the participant's family and children and takes an interest in each participant's life has helped identify barriers and issues that participants are experiencing. It is important to note that this is not the only method of gaining information, but it is one important way to advocate for families and children. One core team member stated that inquiring about participants' families, and not just about their addiction, is one way for judges to let participants know that they care about the participants and the well-being of their families. It is also a method of identifying additional needs. Another core team member stated that the judge spends a few minutes during the progress hearing with each participant and asks about their family struggles, encouraging participants to spend time with their family when possible. Because some participants may be noncustodial parents or otherwise have limited access to their children, having the judge and team find ways to support parent and child interaction can help participants increase their involvement.

The case study found that strong judicial leadership is very helpful in creating accountability and teamwork within the ADC core team. Having a judge who can take leadership of the team and hold them accountable for their roles and responsibilities is very important. While this is true in any drug court setting, it is particularly important in assuring that additional services and supports are available to children and family members. It can be beneficial to have a judge who can bring a team together when there is conflict and when team members appear to be drifting from their roles and responsibilities related to this expanded focus. The study also found that it is

beneficial for the judge to have open communication with both core team members and participants, so that they communicate their needs and the needs of participants' families and children appropriately and honestly.

Coordinator Leadership

Coordinator leadership was also found to be important in creating accountability and teamwork within the ADC core team as well as with the ADC participants. The coordinator plays a large role in being the bridge between the members of the core team and various formal and informal partners. When core team members are having difficulties or disagreements, the coordinator is the one who can arrange a meeting to help the team work through their differences and ultimately keep the ADC running smoothly and effectively. The coordinator and the judge have a shared role in creating an effective, communicative, and collaborative team. The coordinator also has a large role in building the infrastructure of the ADC and creating and strengthening partnerships in the community to support the family component. This study showed that the coordinator has the role of training ADC core team members to better understand the family component. The coordinator can also be a bridge between partners and can play a role in coordinating the work between the ADC and child welfare, for instance, to identify common goals and a shared mission of serving families and children more effectively and comprehensively.

At the client level, the coordinator can have a leadership role in serving as a resource for participants when they are experiencing difficulties with their recovery, especially after they have graduated from the ADC program.

Case Study Example

The interviews with the Van Buren County core team highlighted the importance of coordinator leadership. The coordinator for the ADC had been at the court for many years before the ADC decided to begin serving families and children more comprehensively. This decision came after the ADC team became aware of the potential benefits of addressing family needs. The coordinator has a strong child welfare background and connections

within that system and within FDCs and ADCs. As part of helping the ADC team better understand the value of this expanded service delivery, she arranged trips to observe FDCs in other counties. This ADC has also created a path for families to participate in ADC and FDC when there are cases in both criminal and delinquency court. These dual cases have helped families coordinate their requirements and ultimately meet the expectations of both programs.

Participant Experiences of Judicial and Coordinator Leadership

Participants stated that the judge, coordinator, and other core team members did not shame them for their behavior and understood that addiction is a disease, which helped them to admit their relapses and seek help from the ADC team. One participant stated that he was used to being shamed, but that the ADC team members showed they cared and wanted to help him get back to where he needed to be. This type of response allowed participants to reach out and seek help without fear of being shamed or discharged from the program. Several participants noted that when they relapsed, they contacted the coordinator to seek help because they knew they would not be shamed and would be understood. The coordinators in these cases were able to help the participants get back into treatment and other supportive services in order to continue moving forward in their recovery. From the ADC participant interviews, it appears very beneficial to have ADC coordinators who can spread the message, within ADC staff and participants, that substance use disorder is a disease and that responding to relapse in a therapeutic manner, rather than reacting punitively, is the best approach.

Another participant stated that she felt she was treated as “a human being” and appreciated being asked how she was doing and what she and her children needed. A participant stated that in his past experience in the criminal justice system he did not feel as though he was understood. He stated that it was not until entering the ADC that he felt understood and that people were on his side. This participant stated that being in front of a judge used to make him nervous, but with the ADC judge he felt that he was part of a family and that the team just wanted him to do better. During court observations for this case study, the judge asked about the participants’ children and related issues, such as employment and day care.

Strategy 2

Engage cross-system partners to revise the court mission, vision, and protocols to reflect the transition to a family-centered model.

Transitioning from a traditional ADC to one that also serves families and children was not an easy shift for any of the three programs. Courts in this study are at various stages of their transition, but all have had the same challenge with engaging some core team members, private attorneys, and other judges in the court. One challenge is that although all three ADCs have changed their practice to be more family centered, none of them have yet updated their written program mission, vision, and protocols to reflect the transition to a family-centered model. This could be because they are still in the process of implementing the transition. When dealing with challenges such as limited staff, conflict between staff perspectives and priorities, limited training, and limited funds, updating the mission, vision, policies, and protocols can be seen as unnecessary, thereby making the transition process slower and less consistent. Creating a shared mission and vision is a key step in ensuring buy-in from all team members to work together toward the same goal of supporting the entire family. ADCs should develop consensus on the mission and vision, and these should be reflected in the court protocols.

Without the buy-in of all ADC partners, referrals and participant commitment to the ADC program can be compromised. It is important for the team to consider this expansion of focus in the context of the ADC’s goals, making sure that all team members understand the link between a family-centered approach and improving ADC outcomes, including reducing multiple treatment episodes and other cost offsets. In one of the ADCs in the study, the defense attorneys were initially not on board with the transition to a family approach. They were concerned that it would create more barriers to reunification for participants who also had an open child welfare case. The attorneys did not understand why the judge required the participants to bring in the family members they lived with or who were a support system to them. They were initially advising their clients not to enroll in the ADC program. These challenges can be overcome, but it requires a great deal of collaboration and team discussion, highlighting the value of revisiting the mission and vision statements.

Collaboration and Communication

Strategy 3

Develop community partnerships to expand comprehensive services to meet the needs of the entire family.

The ADCs were strong in partnering formally, as well as informally, with community agencies and private partners. These partnerships assist the ADCs in meeting the needs of participants and their families. Services provided by formal and informal partners included housing, school liaison for children, child developmental assessments, mental health services (including psychiatric and trauma services for participants and families), drug testing, substance use disorder treatment (including medication-assisted treatment), primary health care, HIV services, case management, family therapy, assistance with parenting time, wellness centers, evidence-based parenting for mothers and fathers, participant and family activities, job placement and preparation, and community-based self-help groups.

Case Study Example

The 13th JDDC partnered with Family Promise, an agency that is part of the Interfaith Hospitality Network, which is formed by churches in Billings to provide temporary housing to families. Through this network, families can stay with churches until they find a permanent place to live. This network has also helped ADC participants find transportation and enroll in college. Several core team members also highlighted the support that Family Promise offered for a case in which a parent had school-age children who were having problems at school. The coordinator and other core team members, the parent, the principal, and the school counselor had a productive meeting in which they set a plan in action to assist the family. The father was involved with Family Promise, and a counselor from the program became the school liaison for this family and worked closely with the ADC. With this collaboration, they were able to assist the family and lessen the problems at school. Moving forward, the counselor may attend ADC staffing and serve as the school liaison for all

ADC participants who have children. She visits each school to obtain progress reports and shares this information with the ADC team. The ADC is now seeking funding to formalize the position. At the time of the interview, the ADC was in the process of allowing the school liaison access to the database management system.

ADC and FDC Collaboration

Collaboration across all courts in the community is an important element in better serving children and families. Collaboration within the court system can assist in matching a family to the appropriate drug court and sharing resources when appropriate. For example, one ADC participant was not eligible for participation in the FDC; however, she was able to receive FDC-level services while in the ADC because the two programs were held in the same court and seen by the same judge. This coordination across court programs helps to provide additional services to address the needs of the family.

Collaboration between the ADC and FDC was a main theme in Van Buren County and the 13th JDDC. These two courts are in rural areas where there is a greater need to share court resources. The courts share information primarily by email and through a database management system. In the case of Van Buren County, the core team for the FDC was the same as for the ADC, and this made collaboration between the courts occur more smoothly.

Case Study Examples

With a population of approximately 150,000, Yellowstone County has six drug courts. One core team member from the 13th JDDC stated that in smaller communities, collaboration with other courts is key in being able to meet the needs of participants. One way they collaborate is to transfer participants between courts in order to get them the services they need. For example, if a participant is in need of services that the ADC does not offer, they will transfer him or her to an FDC, if eligible. Or a participant may be referred to the ADC from an FDC that has a long waiting period.

One example given by a core team member involved a mother who is not able get into the FDC immediately because her child is not “adjudicated as a youth in need.” The mother would have to wait nearly four months to be eligible to receive FDC services. To avoid this wait, if the mother has a criminal offense, she will be referred to the ADC to start the program and engage in treatment services immediately.

Due to the size of the population of Van Buren County, the FDC and ADC are held concurrently. A women’s and men’s court session are held in separate courtrooms and are presided over by two different judges, and the FDC and ADC participants are all in one courtroom. An individual can be enrolled as an ADC participant and later transition into the FDC if he or she meets the FDC eligibility criteria. One core team member stated that the “perfect example” of this happening is in cases of methamphetamine labs when children are involved. In such cases, child protective services (CPS) will immediately refer the participant to the FDC, while criminal charges may not be filed for another three to four months due to the investigation process. Immediate referral to the FDC allows for faster service delivery, as the participant does not have to wait three to four months to begin ADC services. Another example of ADC/FDC collaboration is being able to refer an ADC participant to the FDC. A core team member noted that FDC referrals increased when the team started looking at the participants in their ADC through a family lens and realized that they needed additional family-centered services. Once they identify families in ADC, they screen for FDC eligibility and transfer them to that program if there is an open CPS or foster care case. Several core team members stated that participants in these dual cases appear to “fly through the program,” as they are getting comprehensive services and support for their criminal charges and for the child welfare case. The challenge, however, is to be sure there is no duplication of effort or conflicting direction. Since the dual FDC and ADC program has been streamlined, it has appeared to be working well in providing participants with families additional needed services that they would not be getting otherwise. It was stated that the FDC grant

has paid for programs such as Celebrating Families! and gas cards for the participants, and that with the dual ADC and FDC program, the ADC participants can also obtain these resources.

Strategy 4

Ensure strong communication and information sharing for effective coordinated service delivery to participants and their children and families.

Strong communication and information sharing are a cornerstone of effective coordinated service delivery to participants and their children and families. The three sites in the study use a range of communication methods. One court is implementing a new electronic database that has improved its ability to share expanded information about the strengths, needs, and progress of participants and their children and families. All three sites have implemented a database and are at different stages of incorporating it within the core team and formal partners in the community. These databases are important in the process of sharing information, as one team member noted that if a case or treatment plan is not shared immediately, they are unable to refer participants to services as quickly as they would otherwise. This step becomes even more critical if the participant also has an open child welfare case with a strict timeline to meet.

Case Study Example

Miami-Dade has recently switched to using the Florida Drug Court Case Management System (FDCCM). The core team members have access to this system, and as of now most of the providers (e.g., treatment providers) can formally access and use this system. They use this system to send reports so that they can get immediate access to much of the information they need about their clients.

Staff Development and Training

Strategy 5

Develop cross-system training to ensure that partners understand the needs of parents, children, and families affected by substance use disorders.

The ADCs all provide various general training opportunities for the team. In some cases, it is delivered in-house or in the community on topics such as substance use disorders, poverty, medication-assisted treatment, and trauma. Other training events are held at state or national conferences. Considering that the ADCs are in transition to serving families and children more comprehensively, there is a notable lack of specific training in ways to more effectively serve families and children, and the courts also lack formalized plans for orienting team members to a family-centered approach. To address this challenge, ADCs could partner with community agencies that serve children and families to offer cross-training on the effect of substance use disorders on family relationships and strategies for addressing the needs of children and families. Examples of community partners that could offer cross-training include early childhood education providers, early intervention specialists, and mental health and substance use disorder treatment agencies. It is crucial to formalize a training plan and resources and to revisit it periodically to serve as orientation for new court team members.

One source of free online tutorials is the National Center on Substance Abuse and Child Welfare (NCSACW). Topics include understanding substance use disorders, treatment, and family recovery. These free trainings provide both child welfare professionals and legal professionals with an overview of the treatment process and effective treatment elements for families involved with child welfare.

Case Study Examples

Van Buren/Cass District Health Department hosted a Bridges Out of Poverty training, to which it invited Department of Health and Human Services staff and the ADC core team. The training was presented by United Way. The Bridges Out of Poverty training stems from the book *Bridges Out of Poverty: Strategies for Professionals and Communities* by Ruby K. Payne, Philip DeVol, and Terie Dreussi Smith. The training contains ten modules, with module 5 focusing on family structure and modules 8 and 9 focusing on building relationships with regard to social capital, mentoring, and resiliency resources. A core team member stated that they discussed how substance use disorders affect the individual as well as others.

The coordinator at the 13th JDDC court has provided a variety of trainings across systems but stated that more training on families is needed. For dependency cases, the court put together several trainings on strategies for visitation when a parent has a substance use disorder. These trainings were across systems, and the ADC core team was invited. Another training included inviting an M.D. to present on “Drug Testing and the Neurobiology of Effects on the Brain.”

Screening, Assessment, and Needs of Parents, Children, and Families

Strategy 6

Conduct screening and assessment to identify the needs of parents, children, and families, and refer them to appropriate services.

For an ADC to address the parenting needs of the participant and the needs of the children and family, screening and assessment must be done in a timely manner to refer families to the appropriate services. Ideally, a family assessment would be completed early on in participation to first identify which participants have children and then identify the needs of all family members. However, the ADCs in this study have found this to be a challenge, in part due to the time necessary to complete a family assessment. The first step for any ADC in becoming more family centered is to determine how many participants are parents and then how many of the children are under 18 (the 13th JDDC reports 70%, Miami-Dade estimates 50%, Van Buren County reports 49%). This first step alone can help the ADC gain a better understanding of actual need. While one of the three ADCs is currently assessing for family needs once the participant has been accepted into the program, none of them has a specific family needs screening tool to begin the process. Some of the screening that is occurring includes the prosecutor conducting a legal screening for criminal history and other legal issues, and a case manager screening for mental health and substance use disorder issues as well as childhood and adult trauma at intake. The 13th JDDC has recently focused on identifying potential program candidates much earlier in the process, sometimes as early as arraignment, thereby identifying needs and referring participants and families to services months earlier than before.

Two of the three courts are not formally assessing for family and children's needs or other detailed family and child dynamics. Participants are not formally screened or assessed for child welfare involvement, past or current, unless they are in the FDC or FDC/ADC dual program, as in the case of Van Buren County. The 13th JDDC has implemented a family needs assessment, but at the time of the interviews it was having challenges administering

the tool (see the case study example on the next page). The courts conduct formal assessments for housing, mental health, psychosocial, trauma, and substance use risk and needs. Informally, by speaking with participants during case management or probation meetings, or in judges' interactions with the participants, the courts do assess the home if they do home visits, and they ask participants about their family and child dynamics.

The following are examples of screening and assessment tools the courts use:

- **Addiction Severity Index:** This tool screens for adult substance use, and it has a family domain that provides a comprehensive view of the family.
- **Adverse Childhood Experience (ACE):** This tool screens for aversive childhood experiences and provides an ACE score and resilience score. It identifies past trauma.
- **PTSD Checklist for DSM-5 (PCL-5):** This tool is a 20-item self-report that is used to screen for post-traumatic stress disorder (PTSD). It helps providers find out if and why trauma interventions are needed.
- **Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) Risk and Needs Assessment System:** This tool contains 200 questions but is not given periodically throughout the program. The COMPAS tool was developed with the capability to follow changes in behavior over time and would be beneficial to track participants' risk and needs from the beginning to the end of the program. It is a risk and needs tool to assist in making pretrial placement as well as to track the participant over time to assist in supervision and case management decisions about the participant.
- **Risk and Needs Triage (RANT):** This tool is used to find out the level of risk and needs for participants and to be able to place them in the appropriate track or phase at the ADC.
- **Texas Christian University–Client Evaluation of Self and Treatment (TCU-CEST):** This is an assessment tool that measures risk, needs, and progress in treatment over time. It has helped to assess treatment, participants' desire, and whether they are benefiting from the treatment program.



- Behavioral Substance Abuse Assessment (BSAP): This is an electronic tool that asks about medical history, substance use, education, and family situation, among other factors.

Case Study Example

The 13th JDDC has implemented the Family Strengths and Needs Survey (FSNS), which, like the North Carolina Family Assessment Scale for General Services and Reunification, is a very detailed family assessment tool that goes into detail regarding the exact needs of the family, parent, and child and the services appropriate for them. The tool must be administered in person and used as a discussion tool and should not be filled out by the participants themselves. The main domains are participant demographics; family demographics, history, and current dynamic; emotional support system; substance use impact; family medical and mental health history; child care; parenting; education; employment and financial status; and trauma. This tool was developed in coordination with the Montana statewide coordinator of specialty courts and Children and Family Futures. It has a short and long version. The coordinator at the 13th JDDC stated that they found the long version very useful

but that they had to stop using it due to staffing issues with the case manager at the treatment center. They are now working on hiring another case manager and will be training the case manager to properly administer the FSNS.

Strategy 7

Provide evidence-based services to children and parents.

As a court transitions from a focus on the participant to addressing the needs of the family, it will need to expand its service array and the community partners at the table who can support the recovery of the entire family.

The study found that the goal of the ADCs is to have more comprehensive programs and services for families and children. However, all three ADCs faced various challenges in trying to meet this goal in a comprehensive manner. As they continue to transition to serve this population, they will work on building a family systems approach within and outside of the court. They are turning to their community partners to obtain services for their participants' families and in the process are identifying service gaps in the community. For example,

at one site there is a need for evidence-based parenting services that are offered in both English and Spanish and that also fit the individualized needs of their families. Another example is the lack of adequate housing. It was noted that in rural areas, finding family housing can be more of a challenge, as there are few, if any, shelters and very few subsidized housing programs in general. There was also a range of approaches used by substance use disorder treatment providers. Although some treatment centers already had a family systems approach to services or were able to transition to that focus easily, others continued to see the participant as the only client and did not see the need to link families and children to services. At this time, the majority of family and children's services are referred out to the community, and even then, more of these services are needed, particularly in rural areas. The 13th JDDC mentioned that it is having participants enroll themselves and their children in Medicaid to enable them to access more services.

The ADCs in this case study noted that participants' children experience a host of challenges, such as behavioral issues, difficulty in school (i.e., reading below grade level), parentification, developmental delays, and need for immunizations. The ADCs also noted that children's behavioral challenges often increase as parents progress in recovery. Children's services needs include individual therapy, daycare, developmental services, nutritional support, and supplies such as winter clothes and bedding.

The prominent needs of parents and families were supplies, such as diapers and food; primary health care, including HIV testing; employment; housing; transportation; financial support; and therapeutic services to break negative associations, heal from guilt, and improve upon decision-making skills. Additional needs included increased parenting time, education for family members to learn about addiction as a disease, child welfare services, healing family relationship issues, addressing trauma, hygiene, services for learning disabilities, domestic violence services, immigration services, and other legal services. Parents also noted challenges with having multiple responsibilities (e.g., ADC, FDC, child welfare, treatment, therapy, and children).

In general, whether participants had children or not, their needs included engagement and retention in services, relapse prevention and supports, medication-assisted

treatment, trauma services, cognitive services, domestic violence resources, treatment for opioid use, and support systems.

Creating a family-centered approach to an ADC can include bringing into court family members or others that are part of the participant's support system, such as spouses, parents, siblings, and children. The family and friends may also be asked to take a drug test, under the perception that a family member or friend who is using can be a negative influence in the participant's recovery without proper treatment and support. Also, if the participant has a family member, such as a significant other, who is using, the entire family unit is being negatively affected by substance use disorder, and this can be identified early on to provide the entire family with substance use treatment and other needed services.

Case Study Examples

The Linda Ray Intervention Center is used by the Miami-Dade ADC. A core team member stated that the center has been providing comprehensive family and children's services such as medical care, social services, and a nutritional supplement program. The core team member stated that it is easier to get the family referred if they have a dependency case open, but that they can assess parents who might be in the ADC and connect them to these services.

The Miami-Dade ADC also advocated for its treatment partner to provide family therapy. It found that the parents in the court greatly needed this service due to the multitude of issues they were experiencing (e.g., homelessness, substance use disorders, trauma from past abuse, and family discord). The ADC was able to communicate to its treatment partner that it needs to view the ADC participant through a family lens and that if the participant is having certain issues, then so is the family. The treatment partner understood the need and began to provide family therapy. This has allowed the ADC and the treatment provider to track family outcomes as well.

The 13th JDDC ADC refers its families and children to the Center for Children and Families, but stated that this center has a long waiting list.

Strategy 8

Implement responses to behaviors that are sensitive to the needs of parents and families.

Incentives and sanctions are important in motivating and rewarding participants for making necessary behavior changes and following through with the program and treatment requirements. Two of the three courts have written incentives and sanctions information that is provided to participants as they enter the program. When deciding on sanctions, the three ADCs do take into consideration whether the participant has a family, to ensure that he or she is given an appropriate sanction that does not negatively affect the children.

All three courts indicated that one of the major shifts in practice from a participant-focused court to a family-focused one was consideration of the effect that sanctions have on participants' children. Jail time has been reduced in all three courts and does not exceed six days. Core team members from all three ADCs stated that they take into consideration whether the participant has children and may consider an alternative sanction to jail time, because this separation can be detrimental to the family as a whole. The challenge then is to help participants who are not parents understand why they are getting what may feel like a greater consequence than someone else in the program simply because they do not have children.

Courts identified that it is difficult to obtain funding to purchase tangible incentive items. For example, the 13th JDDC is having issues in funding its incentives, as it cannot use general funds from the state, so it has to come up with alternatives. Van Buren County has a grant that pays for bus passes, but these are not a useful incentive due to a limited public transportation system and lack of available bus routes. Therefore, the court uses the funds to purchase gas cards.

Case Study Example

Van Buren County has a Policy Council that has set up a best practices committee that adheres to the NADCP's *Best Practice Standards*, Volumes I and II. One responsibility of the committee is to go over the sanctions and incentives periodically to ensure that they meet best practices. At the time of the interview, Van Buren was about to have a two-hour sanction revision meeting to revise its incentives and sanctions chart.



Funding, Sustainability, Evaluation, and Outcomes

Strategy 9

Develop sustainability plans that account for funding services to children and families.

ADCs that are transitioning to serve families and children find themselves in a unique situation. They are running a traditional ADC while at the same time transitioning to one that incorporates the needs of families. This takes substantial time, effort, and funding. When ADCs rely on grants for their primary funding source, they face numerous challenges. For example, positions and programs can be lost when grants end. With the addition of the focus on families and children, many ADCs are concerned that they must search for extra funds to support the services being added; however, the majority of these services are already available in the community, and participants and their children are typically eligible for the services at low or no cost. There are, however, gaps in services in all communities, particularly in rural areas, and this challenge was found across all three courts. When ADCs are able to demonstrate that they are reducing future costs by avoiding participants' reentry into substance use disorder treatment and other systems, they position themselves to obtain stronger, more permanent funding sources. Another strategy that has been used to help defray program costs is to minimally charge participants in the ADC. For example, the judge may order participants to pay \$5 for every drug screen and \$25 each month they are enrolled in the program. This practice is common but has the potential to affect participants with children more significantly. None of the three ADCs has a formal sustainability plan, but they are implementing sustainability strategies to acquire funding that goes beyond the use of grants. Strategies include obtaining permanent county and state funding and using Medicaid expansion, if applicable. Dissemination of the ADC outcomes is another method of promoting the program. Van Buren County, for example, reports on the "healthy babies being born and raised" on a quarterly basis. Ultimately, tracking broader child and family outcomes that occur through shared accountability will allow ADCs to make the case for additional funding.

Case Study Examples

The Van Buren/Cass District Health Department has used state Women's Specialty funding to cover costs for pregnant women, women with children under age 18, and women who are working at regaining custody. This funding source also pays for fathers, if they are primary caregivers and the mother is not in treatment. A core team member stated that Women's Specialty helps fund services at the treatment center, such as case management and day care. The treatment center also has a dental and immunization clinic, and the Women's Specialty funds can be used to pay for these services for eligible participants.

The successes of the Miami-Dade ADC in acquiring funding have primarily been through grants and partnering with other organizations. The Miami-Dade ADC has been working with the Friends of Drug Court, which is a nonprofit that helps the ADC raise money. They use these funds to pay for halfway housing for homeless participants, medical expenses, and educational expenses, and to fund some positions at the ADC. Another source of funding comes from treatment providers charging ADC participants a small fee of \$5 or \$10 a week. This money can be used to pay for treatment-related services that are not paid by the grant or other funding sources. The Miami-Dade ADC reported that in early 2016, for the first time in ten years, they completed a funding inventory with the assistance of the Administrative Office of the Courts. They were able to complete a priority list of the necessary and most important positions at the ADC. On a positive note, the countywide budget cuts have in some way brought the county treatment provider to be less resistant and more willing to work with the ADC to come up with solutions to provide services to participants, families, and children. As one core team member stated, even though the ADC has had to cut its staff by half, it has been able to focus more on evidence-based practice, and the county treatment provider has been able to come up with funding for

trauma interventions and counseling for participants, families, and children. With regard to sustainability, the ADC does not have a sustainability plan, but it has been working to look beyond using grants for funding and turning to the county or the state for more permanent funding assistance. One core team member stated that the county is starting to see that grants will not sustain the ADC in the long run and is more willing to push to fund the ADC. The Miami-Dade ADC will find out at the end of the 2016 if its positions will be funded by the county or the state.

Strategy 10

Conduct program evaluations to identify parent, child, and family outcomes.

Two ADCs, Miami-Dade and the 13th JDDC, have a data specialist or evaluator as part of the core team. Van Buren has an outside evaluator that provides annual evaluation of the ADC. All three ADCs have grants from the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) and are required to collect and report data, including completion of the Government Performance and Results Act (GPRA) requirements. The outcomes collected across the three ADCs vary. For example, although all three ADCs evaluate ADC and treatment outcomes, it appears that only one is fully tracking child welfare outcomes. All three are also collecting participant-level data on demographics, graduation rates, recidivism rates, and mental health.

It does appear that all three courts are collecting information on child and family outcomes, some more informally than others. In some cases this is done by speaking with participants during case management meetings, but information is also collected during court hearings, from court reports and court orders, and during meetings with other core team members. If information is not being collected formally and consistently, the information obtained may not be shared consistently with the core team, which will weaken the case for funding and sustainability.

Sharing outcomes is done across all three courts and by disseminating results at meetings with the core team and presentations to the community or other outside partners. A challenge reported by one site is that it is not always obtaining timely treatment data from the treatment providers.

At this time, all three sites have focused on evaluating their own program but have not come together with their core team members (e.g., treatment providers) to evaluate shared measures. This collaborative evaluation is lacking in each program to some extent, as it seems a difficult aspect of their transition to serving families and children. Making the transition to serving families and children, as well as coming together to evaluate shared outcomes, is affected by barriers such as limited staff, conflict between staff perspectives and priorities, limited training, and limited funds. The core team members are responsible for their roles in the ADC, and the additional role of serving families and children is considered by some to be extra work on top of their existing ADC roles and responsibilities.



Conclusion

These three courts are in the forefront of a crucial transition from overlooking the family characteristics of ADC participants to a new awareness that responding to those characteristics and needs can improve ADC outcomes, as well as the lives of the children and families involved. It is likely that more ADCs will move in this direction, as evidence of its effectiveness continues to persuade ADCs to adopt these family-focused methods. As shown by these three examples, ADCs can adapt the ten strategies described in this policy brief. The strategies are not a checklist, but are interwoven, especially the need for assessing the needs of clients (strategy 6) and responding with services (strategies 3 and 7), and the need for information sharing (strategy 4)

and evaluation capacity (strategy 10), as these contribute to funding and sustainability strategies (strategy 9).

Each of these three ADCs came to understand that its mission—improving the lives of its adult clients—was also about the lives of its clients’ family members, when those clients had families. The challenges and successes these courts encountered in modifying their procedures to take families into account were made possible by their own innovations and the resources and support they received from other agencies and community groups. These changes meant that the ADCs were able to achieve their basic mission while widening their focus on what that mission required for the families of their clients.



Appendix A

Court Descriptions

11th Judicial Circuit, Miami-Dade Adult Drug Court (Miami, Florida)

Background and Mission

The ADC in Miami-Dade was established in 1989 under Chief Judge Honorable Gerald Wetherington. Currently Judge Jeri Cohen is the presiding judge for the ADC and FDC. The court was established with the notion that *an arrest is a significant triggering event providing an opportunity to influence a defendant to pursue treatment, including untreated addiction, mental illness, and trauma.* The court uses early assessment and drug testing to identify the substance use disorder and determine the required level of treatment to break the damaging cycle of addiction and crime.

The mission of the Miami-Dade Drug Court is to provide treatment to drug-addicted offenders involved in the court system as an alternative to incarceration by offering court-monitored treatment to decrease the prevalence and cyclical nature of drug addiction and drug-related crime.

The ADC provides services to those who are legally and clinically eligible for the program. The services provided are evidence-based treatment as well as wraparound services to meet the needs of the participants. There are frequent drug testing screens, and the ADC judge is responsible for ensuring that they are in treatment and are compliant, and also motivates the participants to continue in their recovery.

Participant Population

The ADC participants include individuals charged with felony possession or purchase of a controlled substance, prescription fraud, or any other nonviolent third-degree felony. The defendants are assessed by the ADC's intake specialist to determine the presence of a substance use

disorder and to identify the needs of each client. The intake specialist evaluates each participant's need for treatment and determines the modality. Case managers are also assigned to participants who represent a high risk for relapse and noncompliance or a high need for wraparound services.

Participants engage in evidence-based treatment services and frequent toxicology screenings. The ADC team reports participant progress at each court hearing. The judge oversees treatment progress and compliance and encourages recovery through frequent monitoring hearings.

Team Members

The ADC consists of a core team composed of the following members:

- Judge
- Assistant prosecutor
- Defense attorney
- Drug court coordinator
- Case managers
- Intake specialists
- Administrative assistant
- Treatment providers
- Court liaison
- Bailiff
- Judicial assistant
- Department of Corrections
- Pretrial services
- Data specialist

13th Judicial District Drug Court (Billings, Montana)

Background and Mission

The 13th Judicial District Drug Court (13th JDDC) was developed to restructure judicial participation in cases involving offenders with substance use disorders. The purpose of the program is to redirect participants into comprehensive treatment for substance use disorders and other services.

The mission of the 13th JDDC is to provide nonviolent offenders with substance use disorders court and treatment services to give them the tools and incentives necessary to conquer their substance abuse problems and become productive, law abiding citizens. The goals are to assure participants will have more success in maintaining law abiding behavior, reducing the number and duration of relapses while increasing the duration of their sobriety, and increasing their life skills.

The drug court treatment team provides participants with comprehensive drug and alcohol treatment and other services to meet the needs of individuals for whom substance use disorders have precipitated legal involvement. The team implements a *cooperative, comprehensive, structured, and centralized system of multidisciplinary community providers.*

The court Policy and Procedures Manual indicates the follow statement of empowerment:

It is the underlying treatment philosophy of the 13th JDDC that participants are best served when treatment team members and service providers work WITH them in accessing services and responding to social and treatment requirements, but do not complete these tasks FOR participants (when the participant is capable of performing these tasks themselves). Long-term success is dependent on the participant's ability to be

self-sufficient and empowered, not to be enabled and sheltered from decisions both in their services and the services their children and/or families require.

Participant Population

Participants of the 13th JDDC include individuals charged with a felony offense (nonviolent offenses) related to drug or alcohol use. Participants must be identified as having a substance use disorder and have no evidence of significant drug dealing. Participants are referred to the program by attorneys, judges, probation and parole officers, and other community agencies. Upon referral and background check, potential participants are referred for treatment screening to determine acceptance into the drug court, after which participants receive an assessment for treatment.

Team Members

The ADC consists of a core team composed of the following members:

- Judge
- Drug court coordinator
- Chemical dependency treatment provider/licensed addiction counselor
- Community policing officer – law enforcement
- Data management specialist/treatment court clerk
- Deputy county attorney
- Defense counsel
- Probation and parole
- Program evaluator
- Drug testing representative

Van Buren County Drug Treatment Court (Paw Paw, Michigan)

Background and Mission

The Van Buren County Unified Drug Treatment Court is a five-phase intervention program for adults who have pled guilty to one or more felony or misdemeanor offenses, and who are having difficulty staying clean and sober. The Drug Treatment Court team provides consistent supervision and services tailored to the needs of the participants. The program aims to shift the focus of the criminal justice system from adversarial to therapeutic by providing early entry into a contingency-based treatment system with structured performance criteria. *Actively engaging in the Drug Treatment Court will allow participants to break the drug-driven cycle of recidivism, thereby increasing public safety, decreasing the drain on community resources, ultimately producing a healthier and more productive citizen, by holding participants accountable for their actions.*

The Mission Statement is to provide Van Buren County with cost-effective, evidence-based substance abuse treatment to rehabilitate lives, thereby reducing the strain on our legal system and alleviating taxpayer expense.

Participant Population

Participants of the Drug Treatment Court include individuals with nonviolent felony and misdemeanor offenses whose substance use disorders caused or

contributed to their current involvement with the criminal justice system. Drug Treatment Court staff contact referred individuals within one week and conduct screening within two weeks of referral to determine eligibility. The court offers a continuum of substance use disorder treatment services, ranging from self-help groups and outpatient treatment to long-term residential care. Participants receive an assessment to determine the appropriate level of services, taking into consideration the primary drug used, the frequency and length of use, mental health disorders, and other challenges.

Team Members

The ADC consists of a core team composed of the following members:

- Judges
- Prosecuting attorney
- Defense attorney
- Case manager
- Treatment provider
- Probation officer
- Sheriff's deputy/department
- Program coordinator
- Substance abuse testing technicians

Appendix B

Case Study Methodology

A qualitative approach was used for this study, which included in-depth interviewing and the collection of documents at each site. This approach provided an opportunity to gain in-depth knowledge of the policies and practices of ADCs that are in the process of transitioning from a traditional ADC to one that has broadened its services to families and children of program participants.

This study applies the framework published in *Guidance to States: Recommendations for Developing Family Drug Court Guidelines* to examine ADC core team members and their partners, policies, and practices involving collaboration, communication, shared knowledge, method of addressing the needs of families and children, funding, sustainability, and outcomes. In-depth interviewing and document analysis were the data collection components of the study.

Sites and Sample Size

The three ADCs were Miami-Dade Adult Drug Court in Miami, Florida; 13th Judicial District Drug Court in Billings, Montana; and Van Buren County Circuit Court in Paw Paw, Michigan. The ADCs self-identified as transitioning to becoming an ADC that serves families and children more comprehensively, and each court is at a different stage of this process. Once the courts were selected, a participation email was sent to each judge or coordinator that briefly explained the case study purpose and asked them to participate in the study. A conference call recruitment meeting was then held with each interested court to provide more information about the purpose of the case study, the data collection process, confidentiality, and the development of technical assistance tools that would stem from this case study. They were also told that the case study would take place at their court for a two-day site visit.

All three sites agreed to participate in the study. The coordinators chose a two-day period that worked best for their team, and an agenda template was sent to them. Each coordinator developed the agenda by scheduling the interviews with the core team and a few ADC participants. They also scheduled staffing and court observation as part of the agenda.

The sample consists of the core team and/or ADC participants at each court. Miami-Dade had a total of ten study participants (eight core team members and two ADC participants), the 13th JDDC had a total of ten study participants (eight core team members and two participants), and Van Buren County had a total of ten study participants (ten core team members).

Data Collection Procedures

The case study team facilitated two-day site visits during which they conducted semi-structured interviews in a private setting that was convenient for each staff member and ADC participant. The interviews ranged from 25 to 60 minutes each. The interviews were recorded, with permission from the participant. During the interview, the interviewer took notes to clarify what was being stated and to emphasize main points.

Interview Guide

The team used a semi-structured interview guide for this case study. The guide contains 32 open-ended questions with probes. The questions were developed using *Guidance to States: Recommendations for Developing Family Drug Court Guidelines* (a description of each recommendation is given in the “Background” section). These recommendations are for FDCs, but they also relate to ADCs that are striving to serve families and children, because they are also working on collaborating with certain partners inside and outside of the courts (e.g., treatment, child welfare, and mental health) in order to build a more cohesive program. In addition, they are working to bring evidence-based practices to their court. The ten-recommendation framework fits this case study in that it conceptualizes what ADCs can incorporate into their practice to more comprehensively serve children and families. The ADC participant interview guide consisted of ten questions that asked about their overall experience in the ADC, their progress, whether they had child welfare involvement and what that experience was like, how they were oriented to the drug court, and what services they and their family receive.

Analysis

Interviews

As stated in the “Background” section, *Guidance to States: Recommendations for Developing Family Drug Court Guidelines* was used to frame this study. The ten recommendations were grouped into five overarching domains that answer the related questions listed in the “Purpose of This Study” section:

1. Mission, vision, and principles (Research Question [RQ] 2)
2. Collaboration and communication (RQ3)
3. Staff development and training (RQ4)
4. Screening, assessment, and needs of parents and children (RQ1 and 2)
5. Funding, sustainability, evaluation, and outcomes (RQ5)

Thematic analysis was used to analyze interview data. Thematic analysis is an effective method when looking to identify and interpret themes in the data that relate to the questions of a study. Once the themes were found, they were then organized into one of the overarching domains listed above.

Staffing/Court Observations

With permission from each ADC, staffing and court observations were done at each ADC to supplement the interviews and to get an overall picture of what was occurring at the ADC staffing and court hearings. It was a way to view the actual operation of the staffing and court process and view who was present. These observations were used to supplement the narratives of the interview themes.

Documents

Each ADC provided documents to serve as examples of guidelines, policies, or practices that pertain to families and children or to the ADC regular operations. Some examples of these documents are the policy and procedure manuals, memoranda of understanding (MOUs), confidentiality agreements, cross-system documents, evaluation reports, screening and assessment tools, homework assignments given to participants, and tracking templates. These documents were reviewed and used to supplement the narratives of the interview themes.

Acknowledgments

Children and Family Futures and the National Association of Drug Court Professionals gratefully acknowledge the many people who have contributed to the development of this publication. Special thanks to the three adult drug courts that participated in this case study and that are serving drug court participants and their families. Nancy K. Young, PhD, served as project director. Anna Rosales, MA, MSW, Jane E. Pfeifer, MPA, and Phil Breitenbucher, MSW, co-authored and edited the final draft. Carolyn Hardin, MPA, and Nancy Hansen, MSW, provided expert review and comment. Amanda Kellerman, MSW, created draft versions of the publication, and Sid Gardner, MPA, provided invaluable assistance in summarizing the findings. Copyediting was performed by Rebecca Pepper.

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