BUILDING THE EVIDENCE BASE FOR FAMILY DRUG TREATMENT COURTS: RESULTS FROM RECENT OUTCOME STUDIES

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Family Drug Treatment Courts (FDTCs) are an increasingly prevalent program designed to serve the multiple and complex needs of families involved in the child welfare system who have substance abuse problems. It is estimated that over 301 FDTCs are currently operational in the United States. Few rigorous studies of FDTCs have examined the effectiveness of these programs. This paper reviews current FDTC research and summarizes the results from four outcome studies of FDTCs. Results suggest that FDTCs can be effective programs to improve treatment outcomes, increase the likelihood of family reunification, and reduce the time children spend in foster care. However, further research is needed to explore how variations in program models, target populations, and the quality of treatment services influence effectiveness.

Data collected for the four-site study (Green, Furrer, Worcel, Burrus, & Finigan, 2007) were supported under contract number 270-02-7107 from the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (USDHHS). The views, policies, and opinions expressed are those of the authors and do not reflect the views of SAMHSA or USDHHS.

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ARTICLE SUMMARIES

Family Drug Treatment Courts

[4] Family Drug Treatment Courts (FDTCs) were developed to improve substance abuse treatment outcomes and increase the likelihood of family reunification for substance abusing parents in dependency proceedings.

Research on Family Drug Treatment Courts

[5] Few studies have examined the effectiveness of the FDTC model. Four outcome studies of FDTC programs are summarized here.

Current Studies on Family Drug Treatment Courts

[6] The studies included 739 participants in four FDTCs in California, Nevada and New York. Matched comparison cases were selected from the participating sites or adjacent comparison counties. Outcome data were collected from court, treatment and child welfare records.

Results of Current Studies on Family Drug Treatment Courts

[7] Parents in FDTCs entered treatment more quickly, remained in treatment longer, and were more likely to complete treatment. Their children spent less time in foster care and were more likely to be reunified.

INTRODUCTION

Parents or guardians with substance abuse problems represent the majority of caretakers involved with the child welfare system. Studies have found that 25% to 80% of parents involved with the child welfare system have substance abuse problems (U.S. Department of Health and Human Services [USDHHS], 1999; Magura & Laudet, 1996; Murphy, Jellnick, Quinn, Smith, Poitrast, & Goshko, 1991; National Center on Addiction and Substance Abuse [CASA], 1999). Furthermore, an increase in methamphetamine use over the past decade has been associated with a concurrent rise in rates of reported child maltreatment. This pattern is especially true in the western part of the U.S., although increasingly elsewhere as well (Huddleston, 2005).

Working with families with substance abuse issues who are involved with child welfare continues to be a challenge to the family court and child welfare systems (USDHHS, 1999; Young, Gardner, & Dennis, 1998). These parents tend to have lower rates of successful reunification and their children have longer foster care placements compared to other families involved with dependency courts (Gregoire & Schultz, 2001; Murphy et al., 1991; Tracy, 1994). Federal legislation mandates limited timelines for parents to achieve sobriety and be successfully reunified with their children (*Adoption and Safe Families Act* [ASFA], 1997). These requirements further challenge the child welfare system to adequately protect the safety of the child, provide sufficient resources to the family, and support parents who are struggling to overcome addiction. Given that recovery from addiction is often a lifelong process characterized by cycles of relapse and sobriety, the courts must make difficult decisions concerning parents struggling to attain stability and sobriety (USDHHS, 1999; Young, Gardner, & Dennis, 1998).

[4] In response to these challenges, Family Drug Treatment Courts (FDTCs)—also known as Family Treatment Drug Courts, Dependency Drug Courts, and Child Protection Courts—have dramatically grown in popularity over the past 10 years. As of December 31, 2007, there were 301 FDTCs operating in 38 states in the U.S., almost doubling the number of FDTCs in just three years (Huddleston, Marlowe, & Casebolt, 2008). FDTCs are court-based interventions that were adapted from the adult drug court model. The basic FDTC model includes frequent court hearings and drug testing, intensive judicial monitoring, provision of timely substance abuse treatment and wrap-around services, and rewards and sanctions linked to service compliance (Center for Substance Abuse Treatment [CSAT], 2004; Edwards & Ray, 2005). FDTCs work to provide a non-adversarial judicial milieu in which parents receive intensive monitoring and services through a collaborative drug court team. The team typically includes representatives from the judicial, child welfare, and treatment systems (and sometimes from related systems such as public health and mental health) who work together to support and monitor the parent. Parents appear before the FDTC judge more frequently than in the case of traditional child welfare processing, often with a diminishing schedule of hearings as parents make progress. FDTCs work to facilitate rapid entry into treatment for participants. Close communication is maintained among treatment providers, child welfare caseworkers and the judicial system to monitor progress and provide swift intervention should relapse occur (Wheeler & Fox, 2006). Programs typically last about one year with a graduation ceremony at the end of services.

Although adult drug courts work primarily with criminally involved adults who participate in the drug court in lieu of a criminal record or jail sentence, this is often not the case with parents in FDTCs. Rather, these adults have civil family court charges brought against them. The primary goal is to support parental sobriety and work towards family

reunification while maintaining child safety (Harrell & Goodman, 1999). Thus, the FDTC meets the dual challenges of supporting parents and attending to the protection of the child. It is important to note that although successful reunification of families and child wellbeing are key goals for the courts, in practice many FDTC teams focus primarily on parents' drug treatment and other collateral issues. Indeed, in some FDTCs the family's dependency case and the final decision regarding reunification is not made by an FDTC judge but by a separate judge (Boles, Young, Moore, & DiPirro-Beard, 2007; Edwards & Ray, 2005). This *parallel* model is in contrast to the *integrated* family court model (also referred to as a *unified* family court model) in which the same judge presides over both the parent's drug court proceedings as well as the family's dependency case (Boles et al., 2007).

Although research has garnered sound evidence for the effectiveness of adult drug courts (Belenko, 2001; U.S. Government Accountability Office [GAO], 2005), research on FDTCs is relatively new. A review of the research literature by American University in 2005 cited only four studies of FDTCs. Of those studies, none were in the published literature and only two included comparison groups. Other publications have reported promising graduation rates and reunification rates for FDTCs in the absence of any comparison group data (CSAT, 2004). Although some local evaluation studies may be underway or reported informally, a thorough computer-based search of the literature and internet resources revealed only two additional evaluation reports of FDTCs in Butler County, Ohio (Center for Interventions, Treatment and Addictions Research, 2002)[1] and Billings, Montana (Roche, 2005). This is in addition to the four studies previously noted by American University. Although the Billings report described some positive

[1] This report was primarily a process evaluation and included only limited outcomes relating to the parents (e.g., employment, arrests, and income). Therefore, this study was not included in this review.

outcomes for the FDTC programs (e.g., fewer days in out-of-home placements and reductions in terminations of parental rights), the methodology and results (especially sample detail and significance tests) were not reported sufficiently to allow a clear interpretation of the findings. However, two recent special issues of the journal *Child Maltreatment* focusing on substance abuse included two rigorous outcome studies of FDTCs (Green, Furrer, Worcel, Burrus, & Finigan, 2007; Boles et al., 2007).

In this paper, we summarize the results of previous FDTC outcome studies, including one unpublished report and two published reports. We also summarize results from a recently completed, large-scale outcome study (Worcel, Green, Furrer, Burrus, & Finigan, 2008).[2] Results from these four studies will be discussed in an attempt to understand how differences in the FDTC program model may influence the model's effectiveness. Lastly, areas in need of additional research will be described.

RESEARCH ON FAMILY DRUG TREATMENT COURTS

[5] In 2004, a study of family drug courts in Pima County, Arizona found that families participating in the FDTC had higher rates of treatment completion and were more likely to be reunified compared to parents who refused to participate in the FDTC (Ashford, 2004). Although this study involved a very small sample (N = 33), it was one of the first to find that FDTCs were associated with improvements on both treatment and child welfare outcomes. This study relied on two quasi-experimental comparison groups: parents who refused to participate in the FDTC and parents in dependency proceedings from a geographically matched

[2] Note that the data presented here overlap substantially with data reported in Worcel et al. (2008).

jurisdiction that did not have a FDTC. Although neither comparison group was ideal, the findings were similar across both groups. Specifically, compared to parents who did not participate in the FDTC, parents served in the FDTC were more likely to enter substance abuse treatment (97% vs. 69%) and complete treatment (48% vs. 26%), reached permanency more quickly (mean = 8.4 months vs. 7.7 months), and were more likely to be reunified with their children (52% vs. 30%) (Ashford, 2004).

Green et al. (2007) found similar results in a larger study involving four sites. Using matched comparison samples (n = 50 for the comparison samples and n = 50 for the FDTC samples at each site), it was reported that families in all four sites were more likely to enter treatment and remained in treatment longer if they participated in the FDTC. Additionally, in two of the four sites FDTC parents were more likely to complete treatment. Child welfare outcomes were more mixed across the four sites. In one site, FDTC families were more likely to be reunified (60% vs. 25%). In two sites, FDTC cases were more likely to be closed within 24 months of the initial petition. Finally, in one site the children of parents in the FDTC received a permanent placement within a shorter period of time.

Comparisons at all four sites relied on retrospective pre-FDTC comparison groups. Thus, other historical factors, including potential changes in judicial processes or in the treatment system, could have influenced the results. For example, in one site where permanency was achieved more quickly for FDTC families, the comparison group was comprised of families who came through the family court system prior to the implementation of the ASFA legislation, which mandated a reduced time to permanency. Consequently, the results were potentially influenced by this new legislation or by other changes in child welfare policies.

A recent evaluation of the Sacramento Dependency Drug Court (Boles et al., 2007) found that parents participating in the FDTC had more admissions to treatment; however, their treatment episodes were somewhat shorter in duration. In addition, they were no more likely to complete treatment than were parents whose cases were processed through the traditional dependency court. Child welfare outcomes showed more consistently positive results. Children whose parents participated in the FDTC were more likely to be reunified (42% vs. 27%). More than half of these children spent less time in out-of-home care (mean = 683 days vs. 993 days). This study, like the Green et al. (2007) study, relied on a pre-FDTC comparison group. It is also important to note that the Sacramento Dependency Drug Court involves two separate court processes: one monitoring the child welfare case and one monitoring the parents' recovery. Thus, instead of having an integrated court in which a judge makes decisions both about the parents' recovery status and the child's placement, these issues are handled by separate judges. This parallel model for court processing differs from the integrated model used by three of the four sites studied by Green et al. (2007).

In March of 2007, Worcel and colleagues (Worcel, Green, Furrer, Burrus, & Finigan, 2007) completed a four-year longitudinal study of four FDTCs. The sites included the same programs reported in prior work (Green et al., 2007); however, the researchers used a longitudinal design with a matched comparison group consisting of families who were eligible for the FDTCs, but were not served due to limited program capacity or a lack of appropriate referrals.[3] The methodology for this study is summarized below and described in detail in Worcel et al. (2008).

[3]At the San Diego site, all eligible substance-using families were served by the FDTC program. Therefore contrasts were made against a matched comparison group recruited from a geographically matched county.

CURRENT STUDIES ON FAMILY DRUG TREATMENT COURTS

Program Sites

[6] The four FDTCs were located in San Diego, CA; Santa Clara County (San Jose), CA; Suffolk County (Long Island), NY; and Washoe County (Reno), NV. All four of these programs excluded cases that:

- Involved child fatalities or sexual abuse;
- Involved serious mental illness on the part of the parent or guardian;
- Involved voluntary rather than court-ordered participation with child protective services;
- Were being immediately moved toward termination of parental rights (i.e., "fast tracked"); or
- Involved parental incarceration that would preclude attendance at the FDTC.

Other aspects of the programs varied, including referral and eligibility criteria, the availability of treatment and other resources in the communities, and the structure and procedures of the child welfare and dependency court systems. These differences are briefly described below.

San Diego

The San Diego site offered a unique program for substance-abusing parents known as the Substance Abuse Recovery Management System (SARMS). The SARMS program served every identified substance-abusing parent involved with the child welfare system in a system-wide reform adopted in 1998. SARMS involved two levels of service for parents. "Tier One" services were provided to all parents with substance abuse problems. This included assignment to a specialized case manager, immediate assess-

ment and referral to indicated substance abuse treatment services, and frequent drug testing. Parents who were noncompliant with treatment services in Tier One were court-ordered into the more intensive FDTC, which offered the more traditional array of family drug treatment court services. Approximately 10% of Tier One cases went on to enter the FDTC. Consequently, this site represents the least traditional FDTC model, as a number of clients received case management and recovery support services outside of the judicial context. Only those parents with more serious or treatment-refractory problems received the FDTC intervention. Furthermore, the FDTC followed a parallel judicial model in which dependency decisions were made by a different judge from the one presiding over the parents' drug court proceedings. This site drew from a large pool of treatment services. Parents could be referred to any of several dozen treatment providers, including a variety of residential and outpatient facilities.

Santa Clara County

The Santa Clara site offered a traditional FDTC program, and employed an integrated model in which the same judge supervised both the dependency case and the parents' recovery. Initially, parents participated in weekly court hearings and received support services through a drug court team. In addition to providing immediate assessment and referral to treatment, this program had a substantial transitional housing service and used graduates as mentors for current participants ("Mentor Moms"). Moreover, midway through the study, this program offered a Head Start-like program that provided early childhood services and parenting classes to parents. FDTC clients utilized a variety of treatment services, including short and long-term residential treatment and a variety of outpatient treatment providers.

Suffolk County

The Suffolk County site offered a traditional array of FDTC services and followed an integrated judicial model. However, this program served only cases involving neglect allegations and a relatively large number of families whose children were not (at least initially) removed from the parents' physical custody. In contrast, the majority of children at the other three sites were initially domiciled in out-of-home care. In addition to traditional FDTC services, this program offered Court Appointed Special Advocates (CASAs) who conducted individual family meetings and regular case conferences with Child Protective Services (CPS) and other allied team members. Similar to the California sites, this program referred FDTC parents to a wide variety of treatment providers throughout the county.

Washoe County

Founded in 1994, the final study site in Reno, NV was the first FDTC in the U.S. This court used an integrated judicial model and pioneered the standard array of FDTC protocols and services. In addition to traditional FDTC services, this site used foster grandparents as mentors for the participants and held weekly team meetings to discuss and monitor participants' progress. Unlike the other study sites, the Washoe site used only three treatment providers. All FDTC parents were referred to one of these three providers for residential or outpatient treatment.

Sample Characteristics

San Diego

Four hundred and thirty eight participants were included from the San Diego site (SARMS $n = 334$, FDTC $n = 104$). The comparison group was comprised of a matched sample of 388 parents drawn from two demographically similar counties in

California. Within the FDTC group, the families were 48% Caucasian and 27% Hispanic. Almost half (46%) of the parents did not have a high school diploma or GED, and 23% were currently married. The primary drug of choice for the parents was methamphetamine (57%), followed by marijuana (16%), alcohol (14%), cocaine (5%), and other drugs (7%). Fifteen percent had a prior substance abuse treatment episode. Forty-five percent (45%) had prior referrals to Child Protective Services (CPS).

Santa Clara County

One hundred FDTC parents and 553 comparison parents were included from the Santa Clara site. Within the FDTC group, the families were 33% Caucasian and 53% Hispanic. More than half of the parents (56%) did not have a high school diploma or GED, and only 10% were married. The primary drug of choice was methamphetamine (54%), followed by alcohol (14%), marijuana (9%), cocaine (8%), and other drugs (15%). Nineteen percent of the parents had a prior treatment episode and 34% had prior CPS referrals.

Suffolk County

One hundred and seventeen FDTC participants and 239 comparison participants were included from the Suffolk site. The FDTC parents were 77% Caucasian, 13% African American, and 9% Hispanic. Thirty-nine percent did not have a high school diploma or GED, and 28% were married. The primary drug of choice was alcohol (43%), followed by cocaine (34%), marijuana (9%) and other drugs (15%). Thirty-two percent of the parents had a prior treatment episode and 38% had prior CPS referrals.

Washoe County

Eighty-four FDTC parents and 127 comparison parents were included from the Washoe site. Within the FDTC

group, most of the families were Caucasian (81%) with smaller proportions being African American (6%) or Hispanic (4%). Almost two thirds of the parents (61%) did not have a high school diploma or GED, and 37% were married. The primary drug of choice was methamphetamine (60%), followed by marijuana (14%), alcohol (14%), cocaine (8%), or other drugs (4%). Eleven percent had a prior treatment episode and 51% had prior CPS referrals.

Comparison Samples

Comparison cases within each site were selected if they: (1) met eligibility requirements for the FDTC in that county, (2) had substance abuse problems as a presenting issue on the child welfare petition, and (3) did not receive FDTC services. Two demographically matched counties with no functional FDTC were used to draw a comparison group sample for San Diego and to supplement the comparison sample for Santa Clara. Eligible comparison parents were individually matched to program participants in terms of race, gender, child welfare allegation, and substance abuse history. Analyses indicated very few significant differences between the comparison and FDTC samples across a broad range of demographic and risk factors (see Worcel et al., 2007).

Research Design and Variables

Data were collected on all primary caregivers and children named in the case. Mothers were named as the primary caregiver in 97% of the cases. Fifty-eight percent of the cases included both a mother and a father or father-surrogate figure, and 3% involved only a father. Three primary data sources were used for this study: (1) child welfare records and case files, (2) drug and alcohol treatment records, and (3) court records. Data were collected on each case for two years after the initial petition. The data elements that were collected are described below.

Demographic and Background Information.

Demographic and background data were collected at case inception. Variables included (a) age of the parent (usually a mother), (b) number and age of the children, (c) race and ethnicity of the parent (usually a mother), (d) education level of the parent, (e) employment status of the parent, (f) marital status, (g) history of child welfare system involvement (yes/no), and (h) prior substance abuse treatment (yes/no). Two risk-factor variables were collected as well, one relating to the parent and one relating to the children. Parental risk factors included a history of (a) mental illness, (b) learning disabilities or developmental delays, (c) chronic medical problems, and (d) domestic violence (yes/no for each). Each variable was coded as 1 if the presence of the risk factor was clearly documented, and a summary index was calculated ranging from 0 to 4. Child risk factors were collected in a similar manner and included (a) educational or developmental issues, (b) alcohol or drug abuse, (c) behavioral or emotional problems, (d) prenatal substance exposure, (e) sexual acting out by the child, and (f) sexual abuse of the child. Each variable was coded as 1 if the presence of the risk factor was clearly documented, and a summary index was calculated ranging from 0 to 6.

Substance Abuse Treatment Outcomes

Data were collected on three variables related to substance abuse treatment outcomes for the parents. These variables included the time delay before entering treatment, the number of days in treatment, and treatment completion (yes/no).

Time to treatment was defined as the number of days from the case petition date to the first substance abuse treatment episode beginning post-petition. Parents who did

not access treatment were coded as "missing data" on this variable.[4]

The number of days in substance abuse treatment was defined as the total number of non-overlapping days in treatment between the initial petition date and the date the case was closed or the data-collection window ended, whichever came first. If a treatment episode was still ongoing at the time the case was closed or data collection ended, the discharge date was defined to be the date of case closure or the end of the data-collection window. Parents who did not enter treatment while their case was active were assigned a '0' because they spent zero days in substance abuse treatment.

All treatment episodes were coded as completed or not completed based on the treatment discharge record. Parents received a "1" if they had at least one successful treatment completion and a "0" if they had no successful treatment completion. Parents with an ongoing treatment episode at the end of the data-collection window who did not have any prior successful treatment completions were coded as "missing" in this analysis, because their treatment outcome was not yet known.

Child Welfare Variables.

Three child welfare outcomes were of primary interest: time to permanent placement, permanency outcome, and number of days spent in out-of-home placements.

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[4] For this analysis, we were only interested in the time to treatment for parents who were successfully linked with treatment. Thus, the results should be interpreted as restricted only to parents who actually entered treatment. Survival analysis, which accounted for the censored nature of these data, resulted in comparable results to those presented here (Worcel et al., in press).

Time to permanent placement was defined as the number of days from the case petition to the date the child was placed in a permanent placement. Missing values were assigned to mothers whose children were not removed from their care (i.e., permanent placement was not applicable).

Each child was also coded in terms of whether he or she was reunified with the parent, parental rights were terminated, permanency was not yet reached, or there was another permanent placement (e.g., long term foster care, guardianship, or juvenile detention). Finally, the number of days spent in out-of-home placements included both kinship care and non-relative foster placements.

RESULTS OF CURRENT STUDIES ON FAMILY DRUG TREATMENT COURTS

[7] Outcome analyses used regression models based on linear mixed models that adjusted for cluster-correlated outcomes (i.e., inter-correlated outcomes for children within the same families) and included propensity-score adjustments for any pre-existing differences between the FDTC and comparison groups (Worcel et al., 2008). Table 1 presents substance abuse treatment outcomes for each site.

Table 1. Substance Abuse Treatment Outcomes

		San Diego		Santa Clara		Suffolk		Washoe	
		FDTC	**Comp.**	**FDTC**	**Comp.**	**FDTC**	**Comp.**	**FDTC**	**Comp.**
Days to first treatment entry	Mean (*SD*)	107 (164.7)	101 (229.7)	110 (301.6)	120 (150.4)	58 (121.7)	133 (188.6)	84 (147.3)	114 (119.3)
	n	243	121	77	291	82	117	54	69
	F	*0.2*		*0.6*		*21.3**		*3.2*	
Days in sub stance abuse treatment	Mean (*SD*) *n*	179 (248.4) 437	154 (280.1) 205	298 (527.6) 100	135 (193.2) 553	297 (394.4) 117	172 (252.6) 239	330 (393.0) 84	132 (233.9) 127
	F	*2.4*		*115.2**		*29.5**		*43.9**	

Table 1 continues . . .

Table 1. Substance Abuse Treatment Outcomes

		San Diego		Santa Clara		Suffolk		Washoe	
		FDTC	**Comp.**	**FDTC**	**Comp.**	**FDTC**	**Comp.**	**FDTC**	**Comp.**
Completed at least one treatment episode	Mean % (*SD*)	31% (51.6%)	40% (79.4%)	69% (117.1%)	32% (50.8%)	61% (85.9%)	32% (56.6%)	62% (78.0%)	37% (62.2%)
	n	365	184	83	511	98	201	70	111
	F	*4.7*		*89.4****		*27.4****		*12.2***	

*p < .05, **p < .01, ***p < .001. Comp. = comparison sample

Table 1 indicates that FDTC parents entered treatment significantly more quickly than comparison families at the Suffolk site, with trends in that same direction at the Santa Clara and Washoe sites. The FDTC parents also spent significantly more days in treatment at all sites with the exception of San Diego. The FDTC parents averaged approximately ten months in substance abuse treatment at these sites, whereas comparison parents averaged only about five months in treatment. The length of stay in treatment has been shown to be important to sustained recovery and permanency outcomes (e.g., Green, Rockhill, & Furrer, 2007). Finally, in all sites except San Diego, FDTC parents were significantly more likely to complete treatment than were parents who went through traditional family court proceedings. Approximately one-third of the comparison parents completed at least one treatment episode, whereas twice as many (approximately two-thirds) of the FDTC parents successfully completed at least one treatment episode.

Table 2. Child Welfare Outcomes

		San Diego		Santa Clara		Suffolk		Washoe	
		FDTC	**Comp.**	**FDTC**	**Comp.**	**FDTC**	**Comp.**	**FDTC**	**Comp.**
Days to permanent placement	Mean (*SE*)	286 (11.6)	255 (14.98)	347 (16.9)	243 (9.0)	238 (30.8)	178 (22.2)	278 (20.0)	262 (17.7)
	n	597	354	180	947	55	119	130	179
	F	*2.6*		*29.2****		*2.5*		*0.3*	
Days in parental care	Mean (*SE*)	150 (8.4)	143 (10.8)	207 (16.7)	128 (7.7)	284 (24.1)	269 (17.7)	286 (14.6)	90 (12.2)
	n	788	456	174	1,100	262	495	164	244
	F	*0.2*		*18.4****		*0.3*		*105.6****	
								Table 2 continues . . .	

Table 2. Child Welfare Outcomes

		San Diego		Santa Clara		Suffolk		Washoe	
		FDTC	**Comp.**	**FDTC**	**Comp.**	**FDTC**	**Comp.**	**FDTC**	**Comp.**
Days in out-of-home placements	Mean (*SE*)	477 (12.2)	477 (16.0)	437 (20.9)	504 (10.1)	312 (24.9)	310 (18.1)	301 (21.1)	466 (17.8)
	n	817	457	194	1,112	262	495	164	244
	F	*< 0.01*		*8.1***		*< 0.01*		*35.7****	
% children reunified	Mean (*SE*)	56% (2.6%)	45% (3.5%)	76% (4.5%)	44% (2.1%)	57% (7.2%)	55% (4.3%)	91% (4.9%)	45% (3.9%)
	n	662	393	185	1,001	85	238	144	216
	F	*6.3**		*41.6****		*0.1*		*53.9****	

*p < .05, **p < .01, ***p < .001. Comp. = Comparison sample.

Table 2 reports the child welfare outcomes for the four study sites. Notably, FDTC parents had *longer* wait times to permanency compared to traditional court processing; however, this difference was only statistically significant at the Santa Clara site. On average, in both the Santa Clara and Washoe sites, FDTC children spent more time with their parents and fewer days in out-of-home placements than the comparison group children. The FDTC children were also significantly more likely to be reunified with their families than were the non-FDTC children in the Santa Clara, Washoe and San Diego sites (although the percentage of children reunified in the San Diego program was far less than in the other two sites). Washoe County reunified 91% of the families who participated in the FDTC, compared to only 45% in the comparison group.

DISCUSSION

Results from at least four studies find evidence for the effectiveness of FDTCs in supporting parents to successfully enter, remain, and complete treatment and to be reunified with their children. It appears, however, that different program models may achieve different patterns of outcomes. The Pima County study found positive effects in terms of treatment completion, reunification, and reduced times to permanency. In the longitudinal study conducted by Worcel and colleagues (2007), the Santa Clara and Washoe programs showed consistent positive treatment and child welfare outcomes. However, none of the sites produced reduced times to permanent placements; in fact, the trend appeared to be towards longer times to permanency. The two most successful sites were both longstanding FDTCs whose models align closely with the core program elements supported by organizations such as the National Association of Drug Court Professionals (Wheeler & Siegerist, 2003) and the Bureau of Justice Assistance, and who use an integrated judicial processing system. Although the populations served

by these courts differed to some degree, this did not appear to influence the program's effectiveness. The Suffolk County site revealed evidence of positive treatment outcomes without significant differences in reunification and permanency outcomes. This is potentially a result of the targeted population of children, many of which were never removed from their homes. Interestingly, children in that program were no more likely to spend more days with their parents than were comparison children, despite their parents' treatment success. Because the time period for this study was too short to track longer-term outcomes, and given the levels of treatment success, potential long-term implications for increased stability of these FDTC families remains a question for future research. Finally, results from the Sacramento Dependency Drug Court study also indicated positive outcomes in terms of length of time in substance abuse treatment and permanency. It is interesting to note, however, that 42% of the Sacramento Dependency Drug Court families were unified, a rate similar to the *comparison* groups in the Worcel et al. (2007) study and in contrast to reunification rates of 91% and 76% in the two integrated court sites. This was a favorable statistic within Sacramento, CA context, where only 27% of the comparison families were reunified.

The reasons for these site-level differences are difficult to discern; however, these results suggest that the integrated, traditional family drug court model may be somewhat more effective than other variations. Further research that can begin to identify and systematically test such model differences is needed to build a better understanding of what aspects of the FDTC are most important. Integrated models may capitalize on the importance of close collaboration and communication between service providers and the judge, leading to differences in decision-making that favor reunification (e.g., Green, Rockhill, & Burrus, in press). Integrated sites may also be better able to operationalize the non-adversarial court process that has been hypothesized as critical to effective

FDTCs (Edwards & Ray, 2005). Furthermore, as demonstrated in the adult drug court literature, FDTCs may have larger impacts on families that are at higher risk for negative outcomes (e.g., those in which the child has been placed out of home at the start of the dependency case) (Marlowe, Festinger, Foltz, Lee, & Patapis, 2005; Marlowe, DeMatteo, & Festinger, 2003).

It should be recognized that differences in results in these studies might also be attributed to differences in the methodologies of the studies. Studies using pre-FDTC comparison groups (Boles et al, 2007; Green et al, 2007) revealed mixed results, especially in terms of permanency. Given the national trend towards improving both family court proceedings (see Dobbin, Gatowski, & Maxwell, 2004) and services for substance-abusing families involved in the child welfare system (Green et al, 2007; National Center for Substance Abuse and Child Welfare [NCSACW], 2008), the general dependency court process may be improving its ability to support these parents over time. Thus, it is important to draw concurrent, prospective comparison samples for proper evaluation of the effectiveness of FDTCs. As evidence builds in support of the effectiveness of the FDTC model, research aimed at uncovering *how and for whom* the model works best will be critical areas for future investigation.

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