Family Treatment Court Best Practice Standards

NATIONAL FAMILY DRUG COURT TTA Program

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

NADCP
National Association of Drug Court Professionals

Family Treatment Court Best Practice Standards

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Terms Used in This Document

The Family Treatment Court Best Practice Standards (FTC Standards) have been written to reflect the practice shift toward person-centered, strengths-based, family-focused, and action-oriented practices. This document includes terminology that is used across the FTC's collaborative partners. The language throughout the FTC Standards embraces the fundamental principle of working with the entire family affected by substance use disorders (SUDs) or co-occurring disorders with a goal toward long-term recovery and reunification through healing and wellness.

Dependency Court

The term "dependency court" is used throughout the document to identify the court with jurisdiction in cases of child abuse or neglect. The name for this court varies in different jurisdictions. For instance, in some jurisdictions these cases are managed in the juvenile court with a dependency docket or perhaps a family court with a child in need of assistance docket.

Disparity

This term is used to describe the inequitable differences in the services received or outcomes experienced by race, gender, or other characteristic.

Disproportionality

This term is used to describe the over- or under-representation of a group compared with the percentage of that same group in the population of interest.

Family and Parenting Time

The terms "parenting time" and "family time" are used in this document to identify the time parents and children spend together when the child is placed out of the home. These terms reflect the purpose and importance of family-centered practices and the parent-child relationship. It should be noted that "visitation" remains the legal term.

Family Treatment Court

The term "family treatment court" (FTC) is used throughout this document. An FTC is defined as a juvenile or family court docket for cases of child abuse or neglect in which parental substance use and often co-occurring mental health disorders are contributing factors. Judges, court personnel, attorneys, child protective services, treatment professionals, and other community partners collaborate on and coordinate services with the goal of ensuring that children have safe, nurturing, and permanent homes; family members receive the needed supports and services; and parents achieve stable recovery within mandatory time frames. FTCs are also referred to as the following: family drug courts, family dependency treatment courts, family recovery courts, family drug treatment courts, and family healing to wellness courts.

Fidelity

The term fidelity is used throughout this document to direct practitioners to maintain adherence to the prescribed policies, procedures, and methods described (e.g., FTC model, evidence-based practices).

Historically Marginalized Groups

This term is used to describe those who have experienced sustained discrimination or reduced social opportunities because of their race, ethnicity, gender, sexual orientation, sexual identity, physical or mental disability, religion, socioeconomic status, or citizenship status.

Judge

The term "judge" in this document refers to the judicial officer who presides over the FTC. This is intended to encompass the various terms, such as magistrate or commissioner, used to describe the individual who can legally decide matters pertaining to abuse and neglect cases in dependency.

Provision

The term provision is used to describe clearly written mandates for FTCs which are designed to be directive and measurable.

Race and Ethnicity

Terms associated with race and ethnicity are complicated by history, power, and positionality. With the exception of research citing studies with specific populations, we use the following terms:

- ***Person of color*** – Any person of Black, African American, Latino/a, Asian, Pacific Islander, American Indian, Alaska Native, or other racial or ethnic heritage who is not White or Caucasian.
- ***White*** – Anyone who is not a person of color.
- ***Black*** – Anyone who self-describes as such, regardless of nationality, to include African Americans.
- ***Latino/a*** – Anyone of Latin or Hispanic heritage.
- ***American Indian/Alaska Native (AI/AN)*** – Anyone to include Native Americans, tribes, tribal nations, Native communities, Native, and Indigenous people inclusive of the 573 federally recognized tribal nations and the more than five million people in the United States who identify as American Indian and/or Alaska Native.

Standard

The term standard is used to define specific practices and actions FTC practitioners should adopt to ensure fidelity to the FTC model.

Executive Summary

The following executive summary includes the primary descriptive paragraph and a list of the provisions for each of the eight standards. This summary captures the core directives of each standard and the information required to implement that standard effectively.

1. Organization and Structure

The family treatment court (FTC) has agreed-upon structural and organizational principles that are supported by research and based on evidence-informed policies, programs, and practices. The core programmatic components, day-to-day operations, and oversight structures are defined and documented in the FTC policy and procedure manual, participant handbook, and memoranda of understanding (MOUs).

Provisions

- A. *Multidisciplinary and Multisystemic Collaborative Approach*
- B. *Partnerships, Community Resources, and Support*
- C. *Multidisciplinary Team*
- D. *Governance Structure*
- E. *Shared Mission and Vision*
- F. *Communication and Information Sharing*
- G. *Cross-Training and Interdisciplinary Education*
- H. *Family-Centered, Culturally Relevant, and Trauma-Informed Approach*
- I. *FTC Policy and Procedure Manual*
- J. *FTC Pre-Court Staffing and Court Review Hearing*

2. Role of the Judge

Judicial leadership is critical to the effective planning and operation of the family treatment court (FTC). The FTC judge works collectively with leaders of partner agencies and other stakeholders to establish clear roles and a shared mission and vision. He or she has the unique ability to engage the leaders and stakeholders in the development, implementation, and ongoing operations of the FTC. The judge is a vital part of the operational team, convening meetings that encourage team members to identify shared values, voice concerns, and find common ground. Additionally, the judge's development of rapport with participants is among the most important components of the FTC.

Provisions

- A. *Convening Partners*
- B. *Judicial Decision Making*
- C. *Participation in FTC Pre-Court Staffing*
- D. *Interaction with Participants*
- E. *Professional Training*
- F. *Length of Judicial Assignment to the FTC*

3. Ensuring Equity and Inclusion

Family treatment court (FTC) has an affirmative obligation to consistently assess its operations and those of partner organizations for policies or procedures that could contribute to disproportionality and disparities among historically marginalized and other underserved groups. The FTC actively collects and analyzes program and partner organization data to determine if disproportionality or disparities exist in the program; if so, the FTC implements corrective measures to eliminate them.

Provisions

- A. *Equitable FTC Admission Practices*
- B. *Equitable FTC Retention Rates and Child Welfare Outcomes*
- C. *Equitable Treatment*
- D. *Equitable Responses to Participant Behavior*
- E. *Team Training*

4. Early Identification, Screening, and Assessment

The process of early identification, screening, and assessment provides the greatest opportunity to fully meet the comprehensive needs of children, parents, and families affected by substance use disorders (SUDs) that come to the attention of the child welfare system. Family treatment court (FTC) team members and partner agencies screen and assess all referred families using objective eligibility and exclusion criteria based on the best available evidence indicating which families can be served safely and effectively in the FTC. Team members use validated assessment tools and procedures to promptly refer children, parents, and families to the appropriate services and levels of care. They conduct ongoing validated assessments of children, parents, and families while also addressing barriers to recovery and reunification throughout the case. Service referrals match identified needs and connect children, parents, and family members to evidence-based interventions, promising programs, and trauma-informed, culturally responsive, and family-centered practices. FTC team members take on varying roles for this process to occur in a timely and efficient manner.

Provisions

- A. *Target Population, Objective Eligibility, and Exclusion Criteria*
- B. *Standardized and Systematic Referral, Screening, and Assessment Process*
- C. *Use of Valid and Reliable Screening and Assessment for Parents and Families*
- D. *Use of Valid, Reliable, and Developmentally Appropriate Screening and Assessment for Children*
- E. *Identification and Resolution of Barriers to Recovery and Reunification*

5. Timely, High-Quality, and Appropriate Substance Use Disorder Treatment

Substance use disorder (SUD) treatment is provided to meet the individual and unique substance-related clinical and supportive needs of persons with SUDs. For participants in family treatment court (FTC), it is important that the SUD treatment agency or clinician provide services in the context of the participants' family relationships, particularly the parent-child dyad, and understand the importance of and responsibility for ensuring child safety within the Adoption and Safe Families Act timeline for child permanency. A Treatment provider's continuum of services includes early identification, screening, and brief intervention; comprehensive standardized assessment; stabilization; appropriate, manualized, evidence-based treatment including medications if warranted; ongoing communication with the FTC team; and continuing care. The parent, child, and family treatment plan is based on individualized and assessed needs and strengths and is provided in a timely manner including concurrent treatment of mental health and physical health.

Provisions

- A. *Timely Access to Appropriate Treatment*
- B. *Treatment Matches Assessed Needs*
- C. *Comprehensive Continuum of Care*
- D. *Integrated Treatment of Co-Occurring Substance Use and Mental Health Disorders*
- E. *Family-Centered Treatment*
- F. *Gender-Responsive Treatment*
- G. *Treatment for Pregnant Women*
- H. *Culturally Responsive Treatment*
- I. *Evidence-Based Manualized Treatment*
- J. *Medication-Assisted Treatment*
- K. *Alcohol and Other Drug Testing Protocols*
- L. *Treatment Provider Qualifications*

6. Comprehensive Case Management, Services, and Supports for Families

Family treatment court (FTC) ensures that children, parents, and family members receive comprehensive services that meet their assessed needs and promotes sustained family safety, permanency, recovery, and well-being. In addition to high-quality substance use and co-occurring mental health disorder treatment, the FTC's family-centered service array includes other clinical treatment and related clinical and community support services. These services are trauma responsive, include family members as active participants, and are grounded in cross-systems collaboration and evidence-based or evidence-informed practices implemented with fidelity.

Provisions

- A. *Intensive Case Management and Coordinated Case Planning*
- B. *Family Involvement in Case Planning*
- C. *Recovery Supports*
- D. *High-Quality Parenting Time (Visitation)*
- E. *Parenting and Family-Strengthening Programs*
- F. *Reunification and Related Supports*
- G. *Trauma-Specific Services for Children and Parents*
- H. *Services to Meet Children's Individual Needs*
- I. *Complementary Services to Support Parents and Family Members*
- J. *Early Intervention Services for Infants and Children Affected by Prenatal Substance Exposure*
- K. *Substance Use Prevention and Intervention for Children and Adolescents*

7. Therapeutic Responses to Behavior

The family treatment court (FTC) operational team applies therapeutic responses (e.g., child safety interventions, treatment adjustments, complementary service modifications, incentives, sanctions) to improve parent, child, and family functioning; ensure children's safety, permanency, and well-being; support participant behavior change; and promote participant accountability. The FTC recognizes the biopsychosocial and behavioral complexities of supporting participants through behavior change to achieve sustainable recovery, stable reunification, and resolution of the child welfare case. When responding to participant behavior, the FTC team considers the cause of the behavior as well as the effect of the therapeutic response on the participant, the participant's children and family, and the participant's engagement in treatment and supportive services.

Provisions

- A. *Child and Family Focus*
- B. *Treatment Adjustments*
- C. *Complementary Service Modifications*
- D. *FTC Phases*
- E. *Incentives and Sanctions to Promote Engagement*
- F. *Equitable Responses*
- G. *Certainty*
- H. *Advance Notice*
- I. *Timely Response Delivery*
- J. *Opportunity for Participants to Be Heard*
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- M. *Use of Addictive or Intoxicating Substances*
- N. *FTC Discharge Decisions*

8. Monitoring and Evaluation

The family treatment court (FTC) collects and reviews data to monitor participant progress, engage in a process of continuous quality improvement, monitor adherence to best practice standards, and evaluate outcomes using scientifically reliable and valid procedures. The FTC establishes performance measures for shared accountability across systems, encourages data quality, and fosters the exchange of data and evaluation results with multiple stakeholders. The FTC uses this information to improve policies and practices in addition to monitoring the strengths and limitations of various service components. Evaluation results and data are also critical components of effective stakeholder outreach and sustainability helping the FTC "tell its story" of success and needs.

Provisions

- A. *Maintain Data Electronically*
- B. *Engage in a Process of Continuous Quality Improvement*
- C. *Evaluate Adherence to Best Practices*
- D. *Use of Rigorous Evaluation Methods*

Introduction

Children grow up in safe and stable families with nurturing, capable, and healthy parents.

This statement is particularly relevant for children who come to the attention of child welfare due to abuse and neglect associated with parent/caregiver substance use and other co-occurring disorders. Expert and empathic support, services, treatment, and monitoring are essential to improve the safety, health, and well-being of families affected by substance use disorders (SUD). Vulnerable children, parents, and family members require the intensive collaborative efforts of child welfare, dependency court, treatment providers, and other community agencies to make this vision possible. Family treatment courts (FTCs), recognized as a proven and effective intervention to achieve positive outcomes for the families they serve, are in their third decade of operation. As the number of FTCs continues to grow, the need for a universal set of standards that define quality practice is clear.

The Family Treatment Court Best Practice Standards (FTC Standards) represent the accumulated knowledge of over 25 years' practice experience and scholarly research. FTCs have grown from a bold experiment to one of the broadest improvements undertaken in the judicial, child welfare, SUD treatment, and children and family services fields. From relatively small caseloads in rural communities to hundreds of children and families enrolled in the largest FTCs, the evidence of the effectiveness of FTCs is building. The FTC Standards are the foundation for FTC adoption of best practices in child welfare, treatment, the courts, and child and family well-being. Each standard provides clear practice guidance; an FTC demonstrates its commitment to quality practice when it implements the standards with fidelity. The FTC Standards provide practitioners with a shared definition of the elements required in quality practice and establishes a common language across various systems and programs that work with families.

What Is a Family Treatment Court?

Family treatment court is a juvenile or family court docket for cases of child abuse or neglect in which parental substance use and often co-occurring mental health disorders are contributing factors. Judges, court personnel, attorneys, child protective services, treatment professionals, and other community partners collaborate on and coordinate services with the goal of ensuring that children have safe, nurturing, and permanent homes within mandatory permanency time frames; parents achieve stable recovery; and each family member receives needed services and supports *(1)*.

The Need for Best Practice Standards

National implementation of the FTC Standards is urgent. A 2018 study by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) of the U.S. Department of Health and Human Services raised an alarm among federal agencies, states, tribes, and local jurisdictions. "After more than a decade of sustained declines in the national foster care caseload, the number of children in foster care began to rise in 2012. Between 2012 and 2016, the number of children in foster care rose by 10% from 397,600 to 437,500" *(2)*. The recent rise of opioid use is just the latest in our nation's public health crisis, challenging communities to respond effectively to families affected by substance use and mental health disorders.

Children who experience abuse, neglect, and time in foster care are at higher risk for a wide variety of negative outcomes *(3,4)*. Roughly half of youth involved in child welfare have significant emotional or behavioral problems *(5)*. Studies have found that youth who experienced foster care had significantly more mental health problems than youth who did not experience foster care. They had twice the number of conduct symptoms, were 4 times more likely to report suicide attempts, 8 times more likely to report anxiety, 7 times more likely to present with disruptive behavior disorders, and 5 times more likely to receive a drug dependence diagnosis *(6)*. Adverse childhood experiences related to abuse, neglect, or dependency are also linked to an increase in delinquency and crime *(7–9)*. These children are also less likely to graduate from college *(10,11)*. Missing the opportunity to intervene can mean permanent loss of parental rights, resulting in further loss and trauma for the children *(12,13)*. With so much at stake, it is

critical that local communities, states, and federal agencies have the benefit of standards reflective of academic research and practice experience.

The child welfare system and FTCs face complex challenges meeting the varied needs of children, parents, and family members. Contributing to the challenges are a set of competing time lines associated with (1) the length of time it takes for a parent to achieve stable recovery, (2) the expedited child permanency time lines mandated by federal and state law, and (3) a child's time to meet developmental milestones *(14–16)*.

Effectiveness of FTCs

As an intensive, community-based collaboration of the court, the child welfare system, SUD and mental health treatment providers, and other health and community social services, an FTC is a highly effective intervention to address the public health crisis while improving outcomes for families and communities *(17–19)*. FTCs work to provide children, parents, and family members with early access to comprehensive care, increased case management, and intensive judicial oversight to protect children, support and monitor parents, stabilize families, and, when possible, prevent traumatic experiences of out-of-home placement to improve children's longer-term outcomes.

In 2019, approximately 500 FTCs operate in 48 states, the District of Columbia, and the territories of Puerto Rico and Guam, with additional FTCs operating in the United Kingdom and Australia *(20)*. FTCs continue to expand in response to the need to support families affected by substance use or co-occurring disorders who are involved with the child welfare system.

When FTCs intervene effectively, the results can be dramatic. A meta-analysis of 16 evaluations examining FTC outcomes found that families that participated in an FTC were 2 times more likely to reunify than families receiving conventional services *(21)*. Prior evaluations have consistently found that, compared with parents receiving conventional child welfare and dependency court interventions, parents participating in FTCs enter treatment more quickly, are retained in treatment, and complete treatment at higher rates, receive more court review hearings, and are more likely to be reunified with their children. The children of parents participating in FTCs spend less time in out-of-home placement and enter permanent placements more quickly *(17–19,21)*.

FTCs as a Collaborative, Family-Centered Intervention

FTCs are a highly complex intervention that must simultaneously operate at multiple collaborative levels: at the case or family level and at the system or agency level. Professionals from multiple service systems attend to the treatment and service requirements of children, parents, and family members with multiple challenges and needs. Often, they must also help the family obtain employment, reliable

transportation, and safe, affordable housing. No single agency has the skill or capacity to meet all of these needs. The FTC builds on the skills and networks of each of the component systems operating within the larger system of care for children, parents, and their families. This is only possible with strong cross-systems collaborative relationships and a formal cross-systems governance structure. The power of FTCs rests in its collaborative, family-centered approach.

> *Throughout the FTC Standards, "FTC" is intended to underscore the critical synergy among the dependency court, child welfare, SUD treatment, mental health treatment, children's developmental services, and related health, educational, and social service systems.*

FTCs cannot effectively operate in isolation of the larger child welfare and treatment systems, neither can they achieve the FTC Standards on their own. The full commitment of the larger team—courts and child welfare, treatment, and other partnering agencies and organizations—is needed to implement and achieve fidelity to the standards. Throughout the FTC Standards, "FTC" is intended to underscore the critical synergy among the dependency court, child welfare, SUD treatment, mental health treatment, children's developmental services, and related health, educational, and social service systems. The equality of partners in the FTC is key.

Key Milestones in the Evolution of the FTC Model

The first FTCs were developed in the mid-1990s, when court systems across the country were inundated with parents whose substance use resulted in alarming rates of removal of children and placement in kinship and foster care. Inspired by the collaborative, multidisciplinary approach of the adult drug court model, pioneering judges in Nevada and Florida called on other stakeholders from the court, child welfare, treatment systems, and community-based agencies to join them in developing an effective intervention to meet the complex needs of families in child welfare dockets with substance use or co-occurring disorders.

The result was a multidisciplinary, multisystemic, court-based intervention that sought to meet the needs of highly vulnerable children, parents, and families and to provide support to assist them in fulfilling the requirements of their child welfare and treatment case plans. These early FTCs built upon the key components of the adult drug court model *(22)*, practice experience in child welfare, and direction from model dependency court guidelines *(23)*. To capture the essence of their original work, record their collective knowledge, professional experience, and day-to-day operations, and clarify the unique characteristics of the FTC model, the earliest FTC practitioners were convened. This 1999 focus group, the first forum to devise a national strategy for advancing FTCs, documented 12 Common Characteristics of FTCs in the monograph *Family Dependency Treatment Courts (FDTC): Addressing Child Abuse and Neglect Cases Using the Drug Court Model (24)*. The early work of FTCs launched the field forward to apply these shared characteristics in family and juvenile court and child welfare practice. These common characteristics have "proved enduring and further writing on these forms of alternative child welfare courts has remained largely theoretically consistent" *(25)*.

During the next decade, several critical efforts spearheaded by the National Association of Drug Court Professionals (NADCP) and the Center for Children and Family Futures (CCFF) further defined effective FTC components and guided substantial federal, state, and tribal investments that expanded FTCs across the United States and into other countries *(1, 24–32)*. With the growth in FTCs came more research, and early works were refined and updated to move the field forward. *Guidance to States: Recommendations for Developing Family Drug Court Guidelines*, initially published in 2013 and updated in 2015, provided guidance to states and local FTCs for implementing and assessing effective strategies in 10 key practice areas *(1)*. The FTC Standards are the result of this early treatment court heritage and continued research.

Family Treatment Court Mission

To protect children from abuse and neglect associated with the substance use of a parent or caregiver by addressing the comprehensive needs of children, parents, and family members through an integrated, court-based collaboration of court, child welfare, treatment and social service providers who work as a team to achieve timely decisions, coordinated treatment and ancillary services, judicial oversight, and safe and permanent placements *(24)*.

Recognizing the effectiveness of FTCs in improving child, parent, and family outcomes, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) funded the development of the National Strategic Plan for Family Drug Courts. Released in 2017, the plan outlines a national strategy to enhance and expand FTCs *(31)*. It sets out three broad goals: (1) improve the effectiveness of the existing family drug court network by ensuring it operates with fidelity to the family drug court model, (2) expand the reach of family drug courts to keep families together and reduce child maltreatment, and (3) continue to build the evidence base about what works for family drug courts to improve outcomes for children and their parents *(31)*. Creation of the FTC Standards is the first strategy of the first goal. As a tool to meet the goals set out in the strategic plan, the FTC Standards establish a framework that FTC practitioners, policymakers, and funders should work to adopt.

FTC practitioners have witnessed substantial growth in research about what works in dependency court case processing, child welfare practice, substance use and mental health disorder treatment, behavior modification techniques, collaborative practice models, juvenile delinquency prevention, and family well-being. It is on this foundation that the FTC Standards are built.

Date	Milestone/Event
Mid-1990s	First FTCs began in Nevada and Florida
1997	*Defining Drug Courts*: *The Ten Key Components* released
1999	12 common characteristics of Family Dependency Treatment Courts identified
2002	7 Essential Ingredients of FTCs; core elements of effective FTC practice identified
2003	10 Element Framework; identified to advance collaborative efforts of FTCs
2004	*Family Dependency Treatment Courts (FDTC): Addressing Child Abuse and Neglect Cases Using the Drug Court Model* released

Date	Milestone/Event
2012	FTC Peer Learning Court program implemented
2013	*Adult Drug Court Best Practice Standards Volume I* released
2013	*Guidance to States: Recommendations for Developing Family Drug Court Guidelines* released (revised 2015)
2015	*Adult Drug Court Best Practice Standards Volume II* released
2017	*National Strategic Plan for Family Drug Courts* released
2018	*Family Treatment Court Planning Guide* released
2019	*Family Treatment Court Best Practice Standards* released

Process to Develop the FTC Standards

The development of the FTC Standards was a logical next step in realizing the goals of the National Strategic Plan. Under the leadership of the Office of Juvenile Justice and Delinquency Prevention—and with the assistance of representatives from the Children's Bureau and the Substance Abuse and Mental Health Services Administration—the Center for Children and Family Futures and the National Association of Drug Court Professionals established an Advisory Group to begin and oversee the development process. The Advisory Group included FTC professionals representing the research community, judges, attorneys, coordinators, treatment and child welfare practitioners, tribal policy advisors, state coordinators, and federal partners.

Beginning in June 2017, the Advisory Group embarked on the process to develop the FTC Standards, including identifying, reviewing, and selecting research-based strategies and practice-based evidence from dependency court, child welfare, SUD treatment, mental health treatment, children's developmental services, and related health, educational, and social services. The development process and draft FTC Standards were introduced and broadly described to the FTC field at the NADCP annual conference in May 2018. The FTC Standards were disseminated for peer review and public comment in December 2018. Peer reviewers provided in-depth responses, and survey responses were received through the public comment process to ensure they met rigorous academic standards for research-based and research-informed practice and the practical needs of local FTC professionals. The Advisory Group was instrumental throughout the 2-year FTC Standards development process in providing feedback on both the FTC Standards process and content.

The development of the FTC Standards included a review of the existing literature and current practice. Although FTCs have been operational since the mid-1990s, the research base specific to their operation remains limited. Therefore, much of the research cited draws from studies in a broad array of disciplines such as dependency court, child welfare, dependency court, substance use and mental health disorder treatment, juvenile and criminal justice, behavioral psychology, health, and implementation science. Consistent with the National Strategic Plan, adoption of the FTC Standards will lead to additional

research to learn more about the particular effect of each standard, the elements within each standard, and the adoption and implementation of the standards as a whole.

How to Use the Standards

These eight FTC Standards provide clear practice mandates and outline specific practices and actions. Each standard is discussed using the following organizational framework:

Provisions — Clearly written mandates for FTCs designed to be directive and measurable.

Rationale — High-level statements summarizing the applicable research supporting each provision. The rationale draws upon empirical studies from a wide range of related fields and practice-based wisdom.

Key Considerations — Additional information and considerations to assist in the understanding and implementation of the standard.

References — References are included at the end of each standard for readers who want to know more about particular studies (e.g., sample size, location, population).

The FTC Standards are interdependent and intended to be followed in whole as much as possible. For example, the process of screening and assessment (Standard 4) is a necessary precursor to accessing quality SUD treatment (Standard 5), which is part of a holistic treatment plan that may need to include trauma-specific treatment services (Standard 6). Together, the quality of these interventions is dependent on a well-conceived community system of care (Standard 1). While some provisions within a given standard are relatively easy to implement, others are more difficult or take more time to fully develop.

The FTC Standards are designed to support stakeholders in their efforts to assess and improve the safety, permanency, and well-being of children; the comprehensive well-being of parents; and the stability of families. Other goals are community transformation to meet the needs of all families who would benefit from these services, and to broaden the scope of comprehensive services families need in the years ahead. Whether the objective is to plan a new FTC or enhance an existing one, the FTC Standards are a blueprint for implementing best practice. While the FTC Standards provide clear directives to communities about the critical elements of a high-functioning FTC, they are not a detailed, step-by-step manual for implementation. FTCs should use the standards as a benchmark for self-assessment to ensure the implementation of effective, collaborative practice for children, parents, and family members in the child welfare system who are affected by SUDs and mental health disorders,

by reviewing the quality of their operations, the depth of their evaluations of effectiveness, and the areas where they may need more training and technical assistance. Specifically,

- *Direct service practitioners, management, and leadership* use the FTC Standards to direct and enhance their work with children, parents, family members, and communities.
- *Community leaders* use the FTC Standards as a tool for capacity building within their community.
- *Policymakers* adopt the FTC Standards to establish expectations for quality practice for children, parents, and family members involved with the child welfare system and affected by substance use disorders or co-occurring disorders.
- *Funders* apply the FTC Standards to the requirements in requests for proposals, performance monitoring, and quality assurance.

A Call to Action — The Future of Family Treatment Courts

The FTC Standards reflect the rigorous research and rich practice experience accumulated during the first 25 years of treatment court operations. Treatment court practice has taught the field that there are always opportunities to increase engagement of participants, enhance interventions, and improve outcomes. Given this, the current knowledge base of effective practice will continue to grow as FTCs expand and evolve. Practitioners are encouraged to actively collect and analyze data to engage in a process of continuous quality improvement and to partner with researchers to critically evaluate practice innovation. As innovations are proved effective, the FTC Standards will be reexamined and amended to reflect the expanded knowledge base.

The FTC Standards provide opportunities for all partners to examine their practice, both through the narrow lens of their own system and their clients and through the expanded lens of the larger multidisciplinary, comprehensive, family-centered system of care that is the FTC. As one FTC moves from a process of planning to implementation to continuous quality improvement and adherence to the standards, it becomes a catalyst for high-quality practice within the treatment court but also produces change in the partners' broader systems. As the methods of collaboration prove more effective through shared outcomes, the best practices of FTCs begin to affect the rules, resources, and results of the system components because they are working together more closely. High-quality, family-centered, collaborative practice becomes the expectation instead of the exception.

The promise of the FTC Standards rests on the dedicated work and ongoing commitment of local family treatment court professionals, states, tribes, national organizations, and federal agencies. Together, we can realize the safe and stable recovery, reunification, and permanency of thousands of children, parents, and families where children grow up in safe and stable families with nurturing, capable, and healthy parents.

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1. Organization and Structure

The family treatment court (FTC) has agreed-upon structural and organizational principles that are supported by research and based on evidence-informed policies, programs, and practices. The core programmatic components, day-to-day operations, and oversight structures are defined and documented in the FTC policy and procedure manual, participant handbook, and memoranda of understanding (MOUs).

Provisions

A. Multidisciplinary and Multisystemic Collaborative Approach

The FTC is a coordinated, multidisciplinary, and multisystemic response to address the comprehensive needs of children, parents, and families involved in the child welfare system and affected by parental substance use disorders (SUDs). It operates within the existing framework of the court, child welfare, SUD treatment, mental health treatment, children's services, and related health, educational, and social service systems. Organization executives responsible for administering these systems collaborate to ensure that the FTC's structure and operations adhere to the mandates of each system to improve outcomes across systems for children, parents, and families.

B. Partnerships, Community Resources, and Support

The FTC functions through established partnerships between court, child welfare, SUD treatment, mental health treatment, child/adolescent services, and related health, educational, vocational, recovery and reunification support services, and other social service systems to access, define, and provide services for children, parents, and families. FTC partner organizations work collaboratively to leverage resources to better serve children, parents, and families and improve outcomes across systems. The FTC formalizes these partnerships through MOUs that describe the roles, responsibilities, functions, services provided, and outcomes to be achieved across each partner agency.

The partner organizations identify a broad group of community stakeholders to jointly assess the scope of needs and identify, enhance, and further develop appropriate and sufficient resources for the FTC to operate efficiently and meet those needs. The FTC identifies, strengthens, and expands governmental leadership and community support to foster its success.

C. Multidisciplinary Team

A multidisciplinary team of professionals comprising representatives from partner organizations administers the ongoing operations of the FTC. This team includes the judge, FTC coordinator, child welfare agency/state's attorney, parent's attorney, child's attorney, guardian ad litem and/or court-appointed special advocate, child welfare caseworker, SUD treatment provider, mental health treatment provider, child and adolescent services providers, and related agencies such as health, educational, vocational, recovery and reunifications support, law enforcement, and probation that provide essential services for the children, parents, and families the FTC serves.

D. Governance Structure

The FTC's governance structure includes an oversight body, steering committee, and operational team. Partner organizations are represented on each level and meet regularly. The oversight body, whether already in existence to meet oversight functions of other initiatives or newly formed, comprises partner organization executive-level staff and other community leadership and elected officials. The steering committee comprises supervisory-level staff, while the operational team consists of staff who have direct contact with and/or provide direct services for the children, parents, and families in the FTC. The function of each entity, the roles and responsibilities of the agencies and professionals, and the communication protocols within and between agencies are clearly defined in the FTC policy and procedure manual and in MOUs.

E. Shared Mission and Vision

The FTC's mission and vision statements are jointly developed by partner organizations and reflect each system's mandates, perspectives, and values. The FTC collaboratively identifies goals and objectives to measure the achievement of its shared mission and vision.

F. Communication and Information Sharing

The FTC team shares information in a timely manner to support both recovery and family reunification efforts; monitor the progress of children, parents, and families; and review and respond to participant behavior. The FTC has established information-sharing protocols to ensure communication is effective, continuous, accurate, and in compliance with all FTC partners' confidentiality requirements and ethical rules, requirements of the Health Insurance Portability and Accountability Act (HIPAA), the federal confidentiality regulations listed in 42 Code of Federal Regulations (CFR) Part 2 (§§ 2.35, 2.52–2.53, and 2.61–2.67), all confidentiality laws applicable to FTC partners, and any state law that includes more or additional restrictions or requirements. The team uses a secure and confidential email protocol to communicate case information.

G. Cross-Training and Interdisciplinary Education

FTC team members are competent within their own disciplines and engage in a process of continuous interdisciplinary education. Team members understand their own professional responsibilities and ethics, and learn about the responsibilities and ethics of professionals from partner organizations. The FTC maintains a team education plan that identifies and addresses education and training needs, and offers ongoing and annual cross-training and interdisciplinary education for the FTC oversight body, steering committee, and operational team members as well as other community agencies. The FTC provides or arranges for formal training and orientation for new operational team, steering committee, and oversight body members as soon as possible after they join the FTC.

H. Family-Centered, Culturally Relevant, and Trauma-Informed Approach

The FTC and its partner organizations address the comprehensive needs of children, parents, and families with family-centered, culturally relevant, and trauma-informed policies and practices in their daily operations and interactions with the people they serve. All staff involved—from managers to those who deliver services—address the needs of the entire family; recognize and respond to the signs and symptoms of trauma; and are alert to culturally relevant factors.

I. FTC Policy and Procedure Manual

Developed collaboratively by partner organizations, the policy and procedure manual describes the FTC's policies, procedures, day-to-day operations, and team member roles and responsibilities. The manual contains the FTC's mission, vision, goals, eligibility criteria, referral and entry process, phase structure, monitoring, recovery and reunification support services, drug and alcohol testing procedures, coordinated responses to behavior, and protocols to determine necessary treatment and complementary services for children, parents, and families. All partner organization team members have an up-to-date copy of the manual and are familiar with the policies and procedures of the FTC.

J. FTC Pre-Court Staffing and Review Hearing

Operational team members including the judge, FTC coordinator, child welfare agency/state's attorney, parent's attorney, child's attorney, guardian ad litem and/or court-appointed special advocate, child welfare social worker/caseworker, SUD treatment provider, mental health treatment provider, and children's services providers consistently attend FTC pre-court staffings and review hearings. Related health, educational, vocational, probation, law enforcement, and recovery and reunification support services, and other social service agencies that deliver services or monitor the progress of children, parents, and families participate in pre-court staffings and court review hearings as determined by the roles and responsibilities agreed upon in the MOUs.

The pre-court staffing prepares the operational team for the FTC review hearing. During the staffing, the operational team discusses the progress and needs of the children, parents, and family and other information that is critical to each case. In preparation for the staffing, a progress report is developed and disseminated to all team members, who are expected to have reviewed the report before meeting. The team members report information critical to recovery and reunification of children, parents, and families; identify participant behaviors that warrant a response; and recommend a coordinated response to participant behavior. The FTC court review hearing occurs on the same day, immediately after the staffing.

Rationale and Key Considerations

A. Multidisciplinary and Multisystemic Collaborative Approach

Rationale

Fundamental differences in the mission, approach, and ethical responsibilities of partners present complex barriers and challenges to the implementation of joint initiatives *(1–5)*. Child safety and permanency, parental recovery, and family well-being improve when agencies work together to address the complex needs of families at the intersection of SUD treatment and child welfare *(6)*.

The ability of the dependency court, child welfare, and SUD treatment systems to collaborate effectively is paramount to successfully serving families with a parent who has an SUD and child welfare involvement *(7)*. When systems work together, child safety and permanency, parental recovery, and family well-being outcomes are more likely to improve *(6)*. When adult drug courts work with a broad range of partners to address participant needs, they can reduce recidivism and save taxpayer money. Studies of adult drug courts have shown that well-organized treatment court teams are able to communicate and collaborate effectively, helping participants to recover and reconnect to their communities and families, reducing participant recidivism, and increasing cost-effectiveness *(8)*. It is reasonable to assume that the same is true of FTCs.

FTC partners have a unique ability to work together to improve individual-, family-, and system-level outcomes because they share certain core values, such as the importance of child safety *(7)*. When child welfare, SUD treatment, and dependency court systems communicate clearly and frequently with parents, then parents are more likely to make timely progress toward recovery and completion of their child welfare case plans. When FTC services are coordinated and integrated, women remain in treatment longer and are more likely to reduce their substance use and be reunified with their children *(7,9)*. In one study, FTC graduates demonstrated significant decreases in domestic violence and overall case risk ratings *(10)*. In two other studies, FTC participants were more likely to enter and complete treatment than their non-FTC counterparts, and to enter treatment sooner *(11,12)*.

> *Child safety and permanency, parental recovery, and family well-being improve when agencies work together to address the complex needs of families at the intersection of SUD treatment and child welfare.*

Key Considerations

Implementing an FTC that addresses the needs of each system and the mandates to improve outcomes across systems, and has the support of all levels within each partner organization, is complex and time-consuming. Identifying and garnering support to effect change and ensure collaboration within and between partner organizations require proper planning and relationship building. Clearly recognizing the importance of organizational readiness helps determine how effectively programs and practices are implemented within health care systems *(13)*. The professionals with decision-making authority within each partner organization must be engaged and buy into the process for the FTC to succeed. The policies, practices, time lines, and day-to-day operations between organizations may not always be consistent. FTC partners can benefit from the use of a readiness assessment tool *(13–16)*, as well as a values assessment tool *(17)* to

determine the opportunities for and challenges to interagency collaboration. An efficient and comprehensive planning and implementation process is critical to FTC's effective operation *(18)*. Upon implementation of the FTC, the partner organizations maintain ongoing oversight to ensure fidelity to the science and research *(See Governance Structure, Provision D)*.

Among the many critical decisions to be made prior to implementation, the court, in consultation with the child welfare system and other stakeholders, must determine whether a single judge will preside over both the FTC reviews and the dependency case proceedings or whether these will be managed by different judges. When different judicial personnel and attorneys will manage aspects of the case, clear protocols are established detailing what information will be shared by the parties to the case and when it will be shared.

B. Partnerships, Community Resources, and Support

Rationale

Children, parents, and families served by the FTC require an array of services to address the complex challenges impeding healthy family functioning. These services are delivered by public and community-based providers through formal partnerships. For example, families need wraparound services to address the entire family's needs identified through evidence-based assessments and input from family members. Families served by FTCs often face a multitude of challenges, including mental health, domestic violence, parenting, medical, legal, educational, housing, and employment. Without appropriate services, all of these obstacles can interfere with an FTC participant's recovery, compliance with child welfare case and SUD treatment plans, and the well-being of children and other family members. Adult drug courts that have formal partnerships (i.e., involving MOUs and/or contracts) with community agencies providing services to participants experience better outcomes than drug courts that do not *(19)*.

Key Considerations

Children, parents, and family members often require services from a myriad of agencies and community partners. The FTC therefore establishes partnerships with a variety of clinical treatment and community supportive services that best meet the needs of families in the FTC. The FTC enters into an MOU with each partner organization to formalize the partnership. Community partners can include community-based medical providers, local school systems, housing providers, employment services, faith communities, transportation agencies or companies, cultural centers, and chambers of commerce. Many FTCs also develop relationships with local colleges and universities, which then provide research and evaluation services and educational and vocational services to FTC participants, and college students for internships in the FTC. In many locales, community service organizations and corporations with local ties donate funds to the FTC and assist with fundraising.

FTC team members work together in a systematic way to identify the broadest possible list of community resources and potential partners. For example, a community mapping exercise assists the team in identifying new resources, aligning and streamlining available services, and discovering funding opportunities *(20,21)*. As a result of this exercise, FTC partners engage stakeholders in a process to develop a shared mission and vision, identify shared desired outcomes, request their commitment to collaborate with the FTC, and align programs and services to meet the needs of children, parents, and families. An FTC reevaluates its available resources annually to respond to changes in the community and enable the FTC to grow.

Support for the FTC may come through a variety of formal and informal methods. FTC team members often act as leaders for their agencies and educate the community about the ways that the FTC operates to improve child, parent, and family well-being and contribute to the community's health and economy *(20)*. It is also important to educate state, tribal, and local officials about the needs, best practice standards, and outcomes of the FTC so that these stakeholders can support the FTC through enactment of legislation, rules, and funding. The oversight body continually identifies, strengthens, and expands sources of political support.

Often, team members serve on advisory boards or community coalitions, which provides excellent opportunities to educate partners on the FTC's success and communicate resource needs. Presentations on reductions in child maltreatment and substance use accompanied by systemwide cost savings are effective in setting the stage for long-term community commitment and sustainable funding. Team members also build community partnerships and support by inviting community stakeholders to planning sessions and court hearings.

C. Multidisciplinary Team

Rationale

FTC participants and their children and families have better outcomes when multidisciplinary team members work together to meet their needs. Child welfare–specific studies indicate that consistent, coordinated communication between team members and parents ensures that expectations are clearly defined for parents and provides the needed support to children, parents, and families within the construct of a team setting *(7)*. Drug court teams have better outcomes when their members have strong working relationships *(22)*. The attendance of key multidisciplinary operational team members at pre-court staffings and court review hearings helps produce positive outcomes and is part of the core approach of drug courts *(8)*. In adult drug courts, continual input from several professional disciplines is necessary to intervene effectively with high-risk, high-need participants *(23)*.

Research on team-based organizations emphasizes the importance of clearly defined roles and responsibilities for achieving goals *(24)*. FTC team members provide critical information and recommendations within the scope of each member's expertise, ensure delivery of a continuum of services, and monitor participant progress and compliance.

> *FTC team members provide critical information and recommendations within the scope of each member's expertise, ensure delivery of a continuum of services, and monitor participant progress and compliance.*

Key Considerations

Identifying an FTC team member to participate in the multidisciplinary operational FTC team takes careful thought and consideration for each partner agency. Each agency is responsible for determining which staff member, in the role required, possesses the expertise to meet the complex needs of children, parents, and family members affected by substance use, mental health, and other co-occurring disorders; is willing to attend training to enhance his or her skills and understanding to ensure fidelity to the FTC model; and maintains the interest and ability to participate in a multidisciplinary team managing the operations of the FTC. Clearly, it is critical that each member of the FTC team demonstrate professional competence and, more importantly, embody a commitment to the values and principles of the FTC model. Implementation research suggests that individuals be selected to reflect the values of an organization; an individual can be trained to do a particular job but cannot necessarily be trained to believe in a particular value. FTCs operate on the basis that strengths-based, family-centered, quality,

collaborative practice will result in safe and stable recovery, reunification, and well-being of families. FTC team members must believe in the values set forth in the FTC vision, mission, and operating principles.

In addition to the core disciplines recommended, FTC may include other agencies that provide essential services for children, parents, and families in the pre-court staffing and court review hearing, such as related health, educational, vocational, recovery and reunification support, law enforcement, housing, and probation. FTC partner organizations determine specifically which of these related agency representatives are required to attend pre-court staffing and court review hearings and how often they must attend. If the parent is currently on probation, on parole, or under another form of court supervision, the supervision officer participates in the operational FTC team.

The FTC's operational team is responsible for the FTC's day-to-day operations and, more importantly, monitoring of the participants' day-to-day activities. The team uses communication methods that make information about participants, their children, and their families readily available to all team members. The team also closely monitors the services available to participants and ensures that they are timely and effective. Furthermore, team members share information within their areas of expertise that is relevant to each case. If peer support staff and/or peer mentors are part of the operational team, they are given direction regarding the information they are expected to provide, including the types of information that could violate confidentiality requirements.

D. Governance Structure

Rationale

The oversight body, which meets quarterly, includes partner organization executive leadership, elected officials, and senior officials from community agencies. This group focuses its efforts on the broader goal of improving outcomes for child welfare–involved families (e.g., making significant policy decisions, identifying broad community trends, acquiring needed resources, and assuring sustainability). As a collaborative entity for achieving that goal, the FTC falls within the purview of the oversight body, which provides leadership, guidance, and direction. Notably, drug courts with an oversight committee that includes members of the community save nearly twice as much money as drug courts that do not have such a committee *(8,25)*. The steering committee meets monthly or every other month; it consists of middle-management representatives from all partnering organizations who provide direction and solutions to identified barriers. The members of the steering committee set policy and have authority to make decisions for their organizations. The operational team membership includes those professionals who directly interact with the children, parents, and families and who attend staffings and review hearings. The operational team meets weekly or every other week prior to review hearings and participates in additional monthly meetings to discuss administrative issues related to policy, procedures, and any barriers to family participation.

Key Considerations

In some jurisdictions, team members may be responsible for the duties identified with more than one or all of the governing groups mentioned. There may be a group comprising the same individuals and/or an existing management infrastructure similar to the recommended practice. Consequently, some communities, especially in rural and tribal jurisdictions, may determine that a three-tiered governance structure is unrealistic. What is critical

is that the FTC have a governance structure that includes a formal policy-setting committee meeting at least quarterly to address the broader goal of improving outcomes for child welfare–involved families.

States should consider convening or identifying a state-level advisory committee with membership reflective of the local level that can work to make shared funding requests, encourage legislative support for the work of treatment courts, and develop statewide responses to family well-being (e.g., the opioid crisis, Medicaid expansion).

E. Shared Mission and Vision

Rationale

Mission and vision statements shape the FTC's approach and agreed-upon process and outcome measures. Identifying common goals and values strengthens the collaboration and provides a direction on which participating organizations are best positioned to make key decisions about resources and policies. Business and organizational psychology literature suggests that clearly defined mission statements with measurable goals have a positive impact on organizational performance *(26,27)*. Motivational mission statements are also associated with increased organizational innovation *(28)*.

Key Considerations

All levels of the FTC governance structure review the shared mission, vision, goals, and objectives at least annually to ensure their continued relevance in addressing emerging research on how best to meet the needs of highly vulnerable children, parents, and families. These same groups also revisit the mission and vision statements when new partners are formally added to the team to ensure that the statements are consistent with the team's new membership.

> *To ensure the FTC is utilizing the latest research to meet the needs of highly vulnerable children, parents, and families, the governance structure reviews the shared mission, goals, and objectives annually.*

F. Communication and Information Sharing

Rationale

The operational team has access to timely, appropriate, accurate, and complete information about participant progress and child, parent, and family needs *(29)*. Timely communication includes pre-court staffing reports as well as regular electronic communication in between FTC review hearings. The FTC relies on effective communication among the operational team members to optimize the quality of case monitoring and team members' ability to provide resources to the people they serve *(8,17,30)*. The FTC develops clear information-sharing protocols to ensure both the effective and legal communication of data related to participating children, parents, and family members *(31)*.

Team members share information that is critical to the success of each family and the integrity of the FTC. One team member, typically the FTC coordinator, has primary responsibility for facilitating the sharing of consistent and relevant information *(17,32)*. In addition, this person ensures that the FTC's information-sharing protocols are consistent with team members' confidentiality requirements, ethical mandates, and professional duties. These assurances are most

effectively established through formal MOUs or agreements.

Before entering the FTC, participants sign a participation agreement that meets the requirements of the Health Insurance Portability and Accountability Act (HIPAA), the federal confidentiality regulations listed in 42 Code of Federal Regulations (CFR) Part 2, all confidentiality laws applicable to FTC partners, and any state law that includes more or additional restrictions or requirements *(33)*.

Participants sign a consent for the exchange of confidential information to permit treatment information disclosure during staffings. The consent must identify each person, by name, whom the participant authorizes to receive this information. The consent can either list a specified amount of time or extend until the occurrence of a specified, ascertainable event, such as discharge from the FTC *(33)*. The FTC may release information or records to operational team members for discussion about any person who has been referred, assessed, diagnosed, or treated if that participant provides written consent or is under other limited, legally defined circumstances such as a medical emergency, court order, or suspicion of child abuse or neglect. If a visitor attends a staffing, the visitor signs a nondisclosure agreement.

Federal regulations require that the scope of information disclosed about participants be limited to information necessary to carry out the purpose of the disclosures *(33)*. Therefore, information protocols never require and rarely permit a treatment provider to reveal a client's entire case file. Instead, the disclosed information is limited to items that are specified in the consent, but may include details such as treatment attendance, level of engagement, compliance, and progress as described in the participant's treatment plan *(33)*. The consent includes information deemed necessary for the operational team to monitor and support children, parents, and families toward stable recovery and reunification, permanency, and completion of the child welfare case plan.

These federal confidentiality laws and regulations apply to a "treatment program," which the legislation defines broadly as an individual or entity that provides a diagnosis of SUD or a referral to treatment or rehabilitative services. Therefore, although not considered a treatment program, the FTC must abide by federal confidentiality laws because the clinicians and social workers on the team and their agencies are covered entities. For example, when an operational team member determines that a participant has an SUD or refers a participant to SUD treatment, that FTC is considered a treatment program and is subject to the federal confidentiality regulations *(33)*. The requirements of 42 CFR cover any information regarding the participant's treatment or that could identify the participant, directly or indirectly, as a person with an SUD or as receiving SUD treatment. Therefore, an FTC may not even acknowledge that an individual is a participant to anyone who is not authorized by the participant's written consent to receive that information; such acknowledgment would effectively identify the individual as having an SUD.

Key Considerations

Determining in advance who is responsible for communicating different types of information improves the efficacy and efficiency of FTC operations. For example, determining who is responsible for communicating with treatment providers when a participant misses a treatment session ensures that only one person does this.

The FTC creates an MOU with each partner agency of the multidisciplinary team describing the team member's roles and responsibilities as well as expectations regarding confidentiality and adherence to federal and state confidentiality laws, including those related to redisclosure. The FTC reviews its MOUs annually to to develop new or update existing MOUs.

Responses to participant behaviors sometimes require multidisciplinary team members to exchange information beyond the reports they submit before each staffing. In particular, when an incident (e.g., child protective services call, missed visit, return to substance use) has occurred, the relevant direct service provider immediately informs all team members so that they can respond as necessary. For example, team members may require the participant to attend an upcoming court hearing or connect the participant to additional treatment and support services *(See Standard 7)*.

Depending on the FTC's structure, the operational team m may include direct service providers who regularly interact with participants as well as liaisons who work with or supervise the direct service providers. When an agency liaison rather than a direct service provider attends a staffing, the agency must develop information-sharing protocols to ensure that the liaison has access to timely and substantive participant updates.

MOUs are signed by the executives of each partner organization represented on the multidisciplinary team. The information-exchange MOU can be a separate agreement or part of a broader MOU that describes the minimum expectations for each team member organization. The information-exchange MOU provides a structured process for sharing information—for example, by requiring all operational team members to submit weekly progress reports to other team members by email before pre-court staffings. These reports describe interactions with the participant as well as any emergency, incident, or other time-sensitive or need-to-know information. In addition, information-exchange agreements cover the confidentiality requirements for handling participant information.

At times, participants or family members may also have criminal justice involvement, and care must be taken to ensure that treatment court staff steer clear of the investigation of new crimes *(34)*. Use of confidential information outside the specifics of the waiver and intended use can subject persons to criminal or civil liability at the state or federal level.

G. Cross-Training and Interdisciplinary Education

Rationale

Research has consistently shown that to operate effective drug court programs, partners must receive ongoing training and technical assistance to build and maintain their skill sets *(35–37)*. Even long-standing FTCs need to provide ongoing training to address emerging best practices and to educate new team members. Orientation for new team members increases positive outcomes and minimizes disruptions in the FTC process when there are changes to the multidisciplinary team *(8)*. The operational team also needs training on roles and responsibilities, best practice standards, and the FTC's operational structure to ensure that implementation maintains fidelity to the model and is based on research.

Successful collaboration between SUD treatment and child welfare systems typically includes cross-training *(17,38)*. FTCs build relationships through cross-training on the Adoption and Safe Families Act (ASFA) and/or other relevant child welfare legal standards, and on SUD treatment and recovery principles to help bridge differences in perspectives and approaches *(7)*. A basic understanding of the child welfare system and of tribal, state, and federal mandates, such as ASFA, Child Abuse Prevention and Treatment Act (CAPTA), and Indian Child Welfare Act (ICWA), is important for SUD treatment professionals *(7,39)*. Child welfare and legal professionals also need a basic

> *The research is clear; to operate effective drug court programs, ongoing training and technical assistance is critical for professionals to build and maintain their skills.*

understanding of the complex biopsychosocial and behavioral processes involved in substance use, trauma, and other mental health disorders and of effective treatment approaches *(32,40)*.

Initial and ongoing training strengthens system linkages and builds collaborative capacity. Training ensures that all members of the operational team are familiar with the FTC's mission, vision, goals, objectives, policies, procedures, and outcomes; helps maintain a high level of professionalism; promotes team member commitment and collaboration; and develops a shared understanding of court operations, accountability, and treatment approaches *(18)*.

Key Considerations

All operational team members receive training and education on issues that affect the FTC population, including evidence-based and -informed approaches for children, parents, and families. Furthermore, operational team members provide outreach and education to community groups and other community partners to engage, inform, and promote FTC sustainability.

To contain training costs and enhance interagency collaboration, each agency represented can teach other team members about issues within its areas of specialization. These cross-training sessions help build the team's knowledge base and strengthen relationships among team members. Some jurisdictions find that cross-training brown bag lunches taught by team members, service providers, or community partners are cost-effective *(41)*.

A structured orientation process for new operational team members sets the tone for the new member's collaboration with other team members, conveys the FTC's mission and vision, explains the differences between FTC and other dependency court processes, reviews relevant policies, and introduces the rest of the team. Upon joining the operational team, a new member reviews the FTC's policies and procedures manual and observes an FTC pre-court staffing and review hearing. This also allows the new member to observe the roles of other members. Existing team members meet with the new team member to discuss information not included in the policies and procedures manual. The FTC gives the new team member a list of resources, webinars, and online tutorials including those available from the Office of Juvenile Justice and Delinquency Prevention's training and technical assistance network *(42,43)*. An effective ongoing practice that provides training and ensures sustainability of the FTC is for each team member to select and mentor a colleague to serve as a backup in the case of vacation or illness and to ensure a smooth transition in the event of a change in job status, such as retirement or a new position.

H. Family-Centered, Culturally Relevant, and Trauma-Informed Approach

Rationale

Family-centered care ensures that each member of the family has an opportunity to have his or her safety, health, and treatment needs identified and a treatment plan implemented. FTCs use a family-centered approach to support positive outcomes for entire families *(41)*. In one study of 1,940 families in 12 FTCs, comprehensively addressing families' needs was associated with better outcomes than were experienced by a comparison group of families in a similar situation in the grantee community *(44)*.

National and international organizations recognize the importance of assessing and treating individuals in the context of their cultural identity (*See Standard 3*). The American Psychological Association and the American Counseling Association

have professional policy and practice guidelines specifically addressing the needs of participants from underserved communities, including LGBTQ populations *(45–49)*. The Cultural Formulation Interview, which is included in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders, helps professionals collect culturally relevant clinical information and organize this information for use during diagnostic and clinical case planning *(50)*.

One of the most important predictors of positive outcomes for racial and ethnic minority participants in SUD treatment is culturally sensitive attitudes in treatment staff, especially managers and supervisors *(51,52)*. When managers value diversity and respect their clients' cultural backgrounds, clients remain significantly longer in treatment and these programs deliver services more efficiently *(53)*. Cultural sensitivity training can enhance counselors' and supervisors' understanding of the importance of diversity and the need to determine their clients' cultural backgrounds and influences *(54,55)*.

Trauma-informed policies and practices recognize that many children and parents in child welfare services have experienced significant traumatic experiences. Each year, more than 45 million children in the United States are affected by violence, crime, abuse, or psychological trauma *(56–58)*. This chronic exposure often leads to toxic stress reactions and severe trauma, which is compounded by historical trauma *(58,59)*. Trauma exposure has a particularly negative effect on children and families involved in the child welfare system because most have experienced multiple traumas.

A trauma-informed approach ensures that staff recognize signs and symptoms of trauma and respond by actively resisting retraumatization of clients and children in court processes. Trauma-responsive care seeks out individuals' strengths to build resilience and hope *(60–62)*. It can give participants with a history of trauma a sense of safety and help prevent certain consequences of traumatic stress *(63)*. The benefits of trauma-responsive practices in FTCs include enhanced provider awareness of trauma, sensitivity to and respect for parents, and understanding of trauma survivor stressors *(61)*. Trauma-informed care can also decrease participants' emotional reactions, decrease crises in programs, enhance participants' sense of safety, and expand collaboration among service providers *(64–67)*. Child welfare workers who are not trauma-informed might misunderstand a child's or parent's experience of trauma, which can damage the client-caseworker relationship *(68)*.

Trauma-responsive practices help team members better understand the effect of trauma exposure on participants' actions, provide structural supports and opportunities for participants to control decisions as appropriate, and promote participant resilience by leveraging social supports and making referrals for mental health treatment. Understanding the effects of trauma on FTC participants and their families and using trauma-informed skills can help the multidisciplinary team improve outcomes *(69,70)*. For example, one state's initiative to implement a trauma-responsive child welfare system significantly improved child welfare staff members' ratings of their trauma-responsive knowledge, attitudes, and practices *(71)*.

Trauma-responsive practices help team members better understand the effect of trauma exposure on participants' actions, provide structural supports and opportunities for participants to control decisions as appropriate, and promote participant resilience by leveraging social supports and making referrals for mental health treatment.

Key Considerations

Culturally relevant services and culturally sensitive attitudes in treatment staff, especially managers and supervisors, ensure that clients remain in treatment longer and services are delivered more efficiently.

The FTC integrates trauma awareness, knowledge, and skills into its organizational policies and practices while working to prevent retraumatization of children, parents, families, and staff members *(72)*. A trauma-responsive approach can be implemented in any type of service setting, agency, or organization and is distinct from trauma-specific services, which treat the consequences of trauma and facilitate healing. A trauma-informed strategy includes screening and assessments of participants, their children, and their families to identify trauma histories and symptoms, as well as referrals, as indicated, to appropriate evidence-based, trauma-specific treatments. Within the FTC, it is critical that the operational team consider whether participant behaviors might be attributable to the individual's trauma history when deciding how best to respond to those behaviors.

Collaboration and coordination among the multidisciplinary team members is a key principle of trauma-informed practice *(32)*. Therefore, multidisciplinary team members need to collect and share information to support their FTC participants as appropriate and within legal limits. The benefits of information sharing include preventing participants from having to repeat their reports on their trauma histories to multiple agencies or providers, ensuring that all involved parties understand trauma's effect on participants and tailor their services accordingly, and increasing providers' ability to understand participants' behaviors or challenges.

The FTC and its partners should adhere to the following six principles for a trauma-responsive approach based on research, practice, and survivor knowledge *(73)*:

- Safety: Ensure the physical and emotional safety of clients and staff;
- Trustworthiness and transparency: Provide clear information about what the client can expect in the program, ensure consistency in practice, and maintain boundaries;
- Peer support: Provide support from persons with lived experiences of trauma to establish safety and hope and to build trust;
- Collaboration and mutuality: Emphasize partnering and meaningful sharing of power and decision making with clients;
- Empowerment, voice, and choice: Build on clients' strengths, empower clients and staff to have a voice, support clients in shared decision making and goal setting, and cultivate self-advocacy; and
- Responsiveness to cultural, historical, and gender issues: Move past cultural stereotypes and biases, offer gender- and culturally responsive services, and address historical trauma.

Examples of trauma-responsive practices for FTCs *(58,69,70)*:

- Use of sanctions that take into consideration behaviors precipitated by trauma (e.g., noncompliance with drug testing because testing triggers memories of sexual abuse);
- Adjustments in treatment levels of care and services for participants who do not engage in or respond to present treatment but otherwise comply with FTC requirements (i.e., individual may require a change in treatment due to interference of trauma responses);
- Implementation of security procedures (as appropriate) that minimize participant exposure to potential triggers, such as handcuffs or restraints and the presence of security personnel with guns in the courtroom;
- Implementation of practices and requirements in ways that do not overwhelm participants;

- Provision of clear information about what participants can expect and opportunities for participant choice when possible; and
- Delivery of services in physical and social environments that reduce stress.

All operational team members receive formal training in trauma-responsive principles and practices. Trauma-responsive strategies that acknowledge and normalize the participant's reactions to trauma and provide support and access to needed care have been shown to reduce stress and help prevent the longer-term consequences of trauma *(57)*. Failure by staff at the FTC and its partner agencies to understand and address trauma has been shown to lead to failure of participants to engage in SUD treatment services, exacerbation of symptoms, retraumatization, increase in rate of return to substance use, participant withdrawal from the service relationship, and poor treatment outcome *(72,74)*.

Although trauma-responsive principles apply to all participants in the FTC, regardless of gender, the FTC and its partners are aware that trauma may present differently and be harder to identify in men because they are less likely than women to seek help *(75–77)*.

Trauma-responsive practices and policies also reflect an understanding of differences between cultures *(78)*. For example, the FTC and its partners are aware of and sensitive to the historical, multigenerational, and cultural trauma experienced by certain populations, including American Indians and Alaska Natives, African Americans, Latinos/as or Hispanics, immigrants, and refugees. These past experiences can result in fear, mistrust, and misunderstanding of the FTC and its partners *(79,80)*.

A trauma walkthrough—an organizational assessment and change process—with all levels of staff from the FTC and its partners is extremely valuable *(74)*. It helps organizations and individuals examine how trauma responsive they are by identifying potential practices and procedures that may retraumatize clients and implementing strategies to mitigate them. The walkthrough process enables the FTC to better understand its care through participants' eyes; helps staff members comprehend how they might inadvertently reenact trauma dynamics; uncovers assumptions, inconsistencies, and limitations; and generates ideas for improving processes *(60)*. It may also generate ideas on how to identify an individual's strengths, which can be used to build resilience for the individual and family.

In addition, the FTC and its partners are aware of and implement strategies to effectively address vicarious trauma (also referred to as secondary trauma) among staff working with FTC participants, children, and families *(81)*. Vicarious trauma is the cumulative effect on an individual's physical, emotional, and psychological health of constant exposure to traumatic stories or events when working with others in a helping capacity *(82)*.

I. FTC Policy and Procedure Manual

Rationale

The FTC policy and procedure manual is designed to support, guide, educate, and ensure effective communication, coordination, and collaboration among FTC team members and other community partners. It provides a framework for the operational team's collaborative work to support participants and families *(8)*. The manual details the evidence-informed policies and procedures that provide guidance and structure for the FTC's day-to-day operations, and clearly describes all roles and responsibilities of each operational team member.

Documentation of FTC operations within a policies and procedures manual is crucial to future institutionalization of the FTC. FTC partner organizations within each level of the governance structure review the FTC's processes, rules, and procedures at least annually to ensure that they enhance the FTC's viability and success to help children, parents, and families achieve recovery, reunification, and permanency *(31)*.

> *The FTC policy and procedure manual is designed to support, guide, educate, and ensure effective communication, coordination, and collaboration among FTC team members and other community partners.*

Key Considerations

Referral agencies/sources have access to a current version of the policies and procedures manual to ensure that they appropriately refer children, parents, and families to the FTC.

FTCs are at the intersection of multiple disciplines and systems. FTC partners develop and reach consensus on the essential components of the FTC, describe protocols to ensure that the efficient operation of the FTC is based on best practice standards, and document these protocols within the policies and procedures manual *(8)*. Including the FTC's vision, mission, goals, and outcomes to be achieved helps operational team members make decisions about issues not covered by an FTC policy. The manual also specifies when each operational team member is to submit reports along with the type of information these reports are to provide.

As it does with the FTC's mission and vision statements, the operational team reviews and updates the FTC's policies as new data and research findings become available or to address a staff concern that an existing policy does not address. The manual is a living, working document, but is not changed without consideration and discussion. It is updated with multidisciplinary team input. The FTC develops a plan for when and how to update the manual and who decides whether the manual needs an update.

J. FTC Pre-Court Staffing and Review Hearing

Rationale

Adult drug court research indicates that the composition of the drug court team has a substantial influence on outcomes. For example, drug courts are much more cost-effective when the multidisciplinary operational team participates in pre-court staffings and court review hearings *(8,83–85)*. The multidisciplinary FTC team holds a staffing immediately before each court review hearing to discuss the most up-to-date information about the children, parents, and family members *(17)*. The pre-court staffing report is provided to all team members for review prior to the staffing, and the team members are expected to have reviewed the report before meeting. During the staffing, the multidisciplinary team provides timely information on the participants' progress to the FTC judge to support the judge in making an informed decision.

Key Considerations

Operational team members submit written reports in a timely manner before each staffing. The type of information each team member shares depends on his or her role and interactions with participants. These reports provide objective information rather than opinion and are limited to previously agreed-upon data to be exchanged, for example *(17)*:

- Details on pre-entry interactions with potential FTC participants, including referrals, screening and assessment outcomes, and relevant case histories;
- Interactions over the previous week with participants;
- Participants' treatment attendance, level of engagement, and progress;
- Services provided to children and family members, level of engagement, and progress;
- Child visitation and parenting time attendance and level of engagement;
- Drug testing results;
- Home visiting and parenting training, engagement, skill development, and outcomes;
- Compliance with other FTC requirements;
- Details on positive participant performance and issues warranting attention; and
- Participants' current phase, completion of specific benchmarks or milestone within the phase, and overall length of time in the FTC.

It is possible to share too much information and to overwhelm fellow team members with extraneous, duplicative, or otherwise irrelevant details. The goal in writing a staffing report is to provide the information that clarifies the participant's compliance with treatment court expectations and progress toward meeting goals.

A staffing provides the opportunity to report objective information about events or changes that have occurred since the written reports were submitted. These may include new details on the participant's children and their current placements, housing, and other critical needs, and treatment and other required service participation.

An FTC's capacity to serve participants can be restricted by the time allotted for pre-court staffings and review hearings. The operational team needs enough time to thoroughly discuss the progress and challenges of each participant and their children and families during the pre-court staffings. To ensure time is used efficiently, team members use the written report to guide its discussions and strive to spend equal amounts of time discussing each participant. However, the team has flexibility to devote extra time to develop effective responses to address particularly challenging needs.

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2. Role of the Judge

Judicial leadership is critical to the effective planning and operation of the family treatment court (FTC). The FTC judge works collectively with leaders of partner agencies and other stakeholders to establish clear roles and a shared mission and vision. He or she has the unique ability to engage the leaders and stakeholders in the development, implementation, and ongoing operations of the FTC. The judge is a vital part of the operational team, convening meetings that encourage team members to identify shared values, voice concerns, and find common ground. Additionally, the judge's development of rapport with participants is among the most important components of the FTC.

Provisions

A. Convening Partners

The FTC judge convenes the necessary representatives from child welfare and treatment systems, community partners, and stakeholders to collaboratively develop, implement, and manage the FTC's ongoing operations and achieve the FTC's mission and vision. The judge holds meetings of the operational team, guides the team, and ensures that all members' contributions are considered in reaching important decisions.

B. Judicial Decision Making

In preparation for each FTC review hearing (also known as a status hearing), the judge and other operational team members receive information about participant attendance, progress, engagement in treatment, complementary services received, children's needs and services, and compliance with dependency court and child welfare agency requirements. During the pre-court staffing, the judge and the rest of the operational team thoroughly discuss the recommended responses for each participant. The judge makes the final decision about the court-ordered response to be delivered.

C. Participation in FTC Pre-Court Staffing

The judge attends the pre-court staffing along with the FTC coordinator, child welfare agency/state's attorney, parent's attorney, child's attorney, guardian ad litem and/or court-appointed special advocate, child welfare social worker/caseworker, substance use disorder (SUD) treatment provider, mental health treatment provider, and children's services providers. Related health, education and social service agencies may also participate, providing updates critical to the recovery and reunification of children, parents, and families, as well as updates on behaviors that might benefit from a response. The judge is aware of all applicable judicial canons, the code of ethics, and case law relating to ex parte communication and the appropriate use of information.

D. Interaction with Participants

The FTC judge convenes the necessary representatives from child welfare and treatment systems, community partners, and stakeholders to collaboratively develop, implement, and manage the FTC's ongoing operations and achieve the FTC's mission and vision. The judge holds meetings of the operational team, guides the team, and ensures that all members' contributions are considered in reaching important decisions.

E. Professional Training

In preparation for each FTC review hearing (also known as a status hearing), the judge and other operational team members receive information about participant attendance, progress, engagement in treatment, complementary services received, children's needs and services, and compliance with dependency court and child welfare agency requirements. During the pre-court staffing, the judge and the rest of the operational team thoroughly discuss the recommended responses and adjustments for each participant. Then the judge makes the final decision about the court-ordered response, which may include a judgment that reasonable efforts have or have not been made to provide parents with the services needed to avoid termination of parental rights.

F. Length of Judicial Assignment to the FTC

The judge presides over the FTC for at least 2 consecutive years to maintain continuity for children, parents, and families.

Rationale and Key Considerations

A. Convening Partners

Rationale

The judge does not provide services but rather convenes service providers and other stakeholders. The FTC's operational team and community partners support the successful completion of dependency court–ordered child welfare case plans. Effective interventions for families include connections to an array of support services *(1,2)*. Families in the child welfare system and FTCs often struggle with housing, education, employment, child care, financial, medical, and many other challenges. If these problems remain unaddressed, they can lead to return to use and, in some cases, recurrence of child maltreatment. Community partners provide services and supports to address many of these challenges.

By virtue of their position, all drug court judges typically have the power, influence, and ability to bring together a multidisciplinary team with representatives of government and community-based organizations *(3)*. This allows FTC judges to convene providers who can provide the services children, parents, and families need while participating in the FTC and after case closure *(1,4)*.

Key Considerations

> *The judge has a critical role in bringing community-based providers together to provide these services and is uniquely positioned to lead the team in addressing problems as they arise.*

In collaboration with and based on the expertise of the rest of the operational team, the judge identifies the support services that children, parents, and families need. The judge has a critical role in bringing community-based providers together to provide these services and is uniquely positioned to lead the team in addressing problems as they arise.

B. Judicial Decision Making

Rationale

The judge is ethically bound to exercise independent discretion and make independent decisions after hearing from all parties and reviewing the relevant facts and applicable laws *(5)*. Delegation of decision-making authority by the judge to the operational team or a member of the team undermines the integrity and fairness of the judicial process, and violates the judge's duty to make decisions.

Key Considerations

The collaborative nature of FTC, the frequency of pre-court staffings and review hearings, and direct communication with participants give FTC judges more information than is available to judges handling traditional court assignments. The code of judicial responsibility does not necessarily require recusal when a judge can be fair and impartial, and judges are trained to exclude evidence at trial that they may be aware of but is not tendered as evidence at trial. However, recusal may be considered when there are grounds to do so. The dependency judge, who also presides over the FTC, may also make reasonable efforts findings if warranted.

C. Participation in FTC Pre-Court Staffing

Rationale

Pre-court staffing is critical to the success of FTC hearings and the judge's interactions with participants. The judge attends each staffing to learn about the progress the children and the participant are making, and to discuss responses to behavior, treatment adjustments, and safety concerns. The judge is present to guide the discussion and ensure all operational team members are heard and all critical information is shared and discussed. Equipped with information about the participant, the judge can better engage the participant during the hearing, make important decisions, and issue appropriate court orders.

Research has shown that outcomes are significantly better in adult drug courts when the judge regularly attends pre-court staffings *(6,7)*. It allows the judge to hear from and consider each team member's perspective as important decisions are made about a case *(8)*. Observational studies suggest that when judges do not attend pre-court staff meetings, they are less likely to be adequately informed about or prepared for interacting with participants during review hearings *(9,10)*.

Key Considerations

Although treatment information is shared in pre-court staffings, the judge does not have the appropriate training to make clinical diagnoses or other treatment-related decisions and therefore does not make diagnoses, select treatment interventions, or determine treatment levels of care. Instead, the judge relies on treatment experts to discuss specifics in the pre-court staffing and to make clinical decisions. As necessary, the judge asks questions of the treatment expert to ensure an understanding of the diagnosis and recommended treatment. The judge also asks questions of the participant to be sure the participant understands and is willing to comply with the provider's recommendations. The judge supports the recommendations of service providers by ordering participants to comply with their directives and with ongoing therapeutic adjustments during their participation in the FTC program.

D. Interaction with Participants

Rationale

Drug court judges have a unique and substantial effect on outcomes in drug courts *(7,11–14)*. Research involving adult drug courts found that when the judge spends an average of 3 minutes with each participant, outcomes are improved and greater outcomes occur as the average increases *(6,7)*. A study found that participants need a caring judge and the opportunity to communicate directly with the judge on an ongoing basis *(15)*. Ongoing judicial interaction with each drug court participant has long been viewed as essential to any drug court *(16)*. Participants are more likely to comply with treatment and have better outcomes when the judge gives them opportunities to voice their perspectives and when he or she communicates respect and support to participants *(17)*. When FTC participants were asked to identify the most important elements of the FTC, participant/judge rapport ranked among the top six responses *(15)*.

Key Considerations

At FTC review hearings, the judge discusses the participant's level of engagement in treatment, other services critical to recovery and family reunification (e.g., mental health treatment, domestic violence programs, family therapy, parenting training services), and compliance with treatment, child welfare, and FTC case plans. The judge offers the participant encouragement and praise based on the participant's engagement level and commitment to treatment, recovery, and reunification. When appropriate, the judge encourages the participant to make a greater effort.

> *The judge encourages participants to honestly discuss their successes and challenges with parenting as well as their relationships with their children in their efforts to achieve long-term recovery, reunification, and permanency for children.*

Both the quality and the quantity of judicial interactions with participants are important. Frequent contact and meaningful engagement enhance the ability of the judge and the participant to build an effective rapport with each other. The judge gives all participants the opportunity to share thoughts about their progress, seek clarification, express concerns, and explain their behaviors, especially when responses to behavior, treatment adjustments, or child safety interventions are, or might be, imposed. The judge encourages participants to discuss their children, including any educational, medical, emotional, and developmental concerns. The judge and participant also jointly explore case plan requirements to facilitate reunification or, if the children are in the home, case plan requirements to maintain in-home placement. The judge encourages participants to honestly discuss their successes and challenges with parenting as well as their relationships with their children in their efforts to achieve long-term recovery, reunification, and permanency for children. At all times, the judge adheres to judicial, ethical, and legal requirements related to interactions with parents.

E. Professional Training

Rationale

Research demonstrates that outcomes for adult drug court participants are significantly better when adult drug court judges attend annual training conferences on evidence-based practices in SUD and mental health treatment *(6,7,18)*. It is reasonable to infer that the same is true of FTC participants and FTC judges.

Key Considerations

FTC judges can obtain FTC-relevant training from local, state, or national organizations and associations. Annual conferences offer rich training opportunities for judges. Some states stage their own specialty court or FTC conferences, and these events enable prompt dissemination of relevant research and innovative strategies as well as opportunities for judges to share ideas and network with other FTC judges. Several organizations provide online webinars on FTC-related topics at no cost to participants. The topics critical to FTC judges include evidence-based assessment and treatment approaches, trauma-informed treatment, child development, effects of child maltreatment, SUDs, co-occurring mental health disorders, Motivational Interviewing and strategies, procedural fairness, cultural competence, and legal, constitutional, and ethical considerations for FTCs and other drug courts.

F. Length of Judicial Assignment to the FTC

Rationale

When a single judge presides throughout a child welfare case, the parents are more likely to feel that the dependency court cares about their child and the outcome of their case; having a single judge also increases the likelihood that the parents will perceive the FTC process as fair *(19)*.

Best practice dictates that the FTC judge be familiar with the FTC's policies and procedures, and have an in-depth knowledge of the FTC model. A 2-year term as FTC judge is the minimal amount of time for gaining this knowledge and working effectively with participants and stakeholders. A judge's commitment to preside over the FTC for at least 2 years provides consistency and continuity for children, parents, and families served by the FTC.

Studies have shown that when judges presided over criminal drug courts for at least 2 consecutive years, the courts saved nearly 3 times as much money and recidivism rates were significantly lower *(6,7)*.

> *A judge's commitment to preside over the FTC for at least 2 years provides consistency and continuity for children, parents, and families served by the FTC.*

Key Considerations

In some jurisdictions, court policy requires judges to rotate their assignments every 2 years. Where this is policy, judicial leaders are advised to consider allowing a longer term in FTC because of the evidence that participants experience improved outcomes when judges remain assigned to FTC for 2 years or longer. Succession planning, to begin as soon as practical, is also advised for judges interested in serving on the FTC. Such planning includes identifying interested judges, providing training in core areas, and allowing opportunities for the judges to observe pre-court staffings, review hearings, and the team process.

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3. Ensuring Equity and Inclusion

Family treatment court (FTC) has an affirmative obligation to consistently assess its operations and those of partner organizations for policies or procedures that could contribute to disproportionality and disparities among historically marginalized and other underserved groups. The FTC actively collects and analyzes program and partner organization data to determine if disproportionality or disparities exist in the program; if so, the FTC oversight body, steering committee, and operational team implement corrective measures to eliminate them.

Provisions

A. Equitable FTC Program Admission Practices

The FTC examines its eligibility criteria, screening, referral, entry and assessment processes, and other entry processes at least annually to ensure that bias, subjective decision making, or other factors do not contribute to disproportionate access to the FTC and its services. This examination seeks to identify and correct processes that might contribute to inequitable access.

B. Equitable FTC Retention Rates and Child Welfare Outcomes

The FTC acts strategically to increase the likelihood that participants from historically marginalized groups are offered and successfully engage in services, are discharged from the FTC, and achieve permanency and well-being outcomes at rates equivalent to or better than the overall child welfare population.

C. Equitable Treatment

The FTC delivers family-centered, gender-responsive, trauma-informed, and linguistically and culturally relevant treatment to meet participants' needs, resulting in equivalent outcomes across groups. It ensures that all participants and their children and family members receive assessment-driven services based on their individual and family needs and that the intensity, dosage, quality, and relevance are consistent with their needs and preferences.

D. Equitable Responses to Participant Behavior

The FTC administers equitable responses using principles of procedural fairness that are therapeutic, meaningful, and relevant to the children, parents, and family members affected by the response. The FTC regularly monitors its responses to participant behavior to ensure that they are equivalent in similar situations across groups.

E. Team Training

The FTC provides training to its operational team and partners to ensure that culturally relevant services and supports are implemented for children, parents, and families to achieve stable recovery, reunification, and positive child welfare case closure.

Rationale and Key Considerations

A. Equitable FTC Admission Practices

Rationale

In June 2010, the board of directors of the National Association of Drug Court Professionals (NADCP) passed a unanimous resolution directing drug courts to examine whether policies, procedures, or services have resulted in or contributed to disproportionality or disparities among racial, ethnic, or other minority populations and, if so, to undertake reasonable corrective measures to eliminate them *(1)*. This resolution places an affirmative obligation on FTCs to continuously assess whether

- there is proportional access for all demographic groups in the child welfare population and equitable admission to the FTC program;
- participants receive equitable needs-based treatment and services; and
- participants have an equal opportunity to succeed.

The resolution instructs drug courts to implement evidence-based assessment tools and clinical interventions that are valid and reliable for use with participants, and calls for team members to participate in training that can help them identify and address implicit bias and develop cultural competence to effectively intervene with all individuals who are part of the FTC's target population *(2)*.

There is a substantial body of research that documents the over-representation of Black and American Indian/Alaska Native (AI/AN) families in the child welfare *(3–6)* and criminal justice systems *(7,8)*. Institutional racism has produced significant inequities in these populations in the United States *(9,10)*. Institutional racism, also referred to as structural racism, is variously defined but generally references the ways in which institutional policies and practices create different outcomes for different racial groups. In particular, the effect is to create advantages for Whites and disadvantages for people from groups classified as people of color *(11,12)*. As a result of these disadvantages, people of color are more likely to be poor, live in neighborhoods with higher crime rates and lower access to healthful resources (e.g, grocery stores and parks), and experience reduced access to medical care *(13,14)*. Each of these factors places the households of people of color at greater risk of overidentification by law enforcement, school personnel, and medical professionals *(8,15,16)*.

In the child welfare case process, disproportionality may result from various decision points in the process including reporting, investigation, substantiation, foster care placement, access to services, and case closure *(3,6,17–19)*. In July 2017, the U.S. Census Bureau estimated that 22.6% of the U.S. population was under age 18. Of this percentage, 51% were White, 14% were African American, 25% were Latino/a (of any race), 4% reported two or more races, and 1% were AI/AN *(20)*. The Adoption and Foster Care Analysis Reporting System (AFCARS) collects and reports child welfare data from all U.S. states and territories. The 2017 AFCARS report revealed disproportionality in the foster care rate across all races. Although White children made up slightly more than half the total U.S. population of children (51%), only 44% of children in foster care were White. Black children constituted just 14% of children in the U.S., but they made up 23% of all children in foster care, almost twice their proportional rate. Likewise, children of two or more races and AI/AN children were placed in foster care at roughly twice the rate of their percentages in the overall population. Rates of disproportionality by race differ across years and geographic location; however, children and

families of color are consistently disproportionately represented in child welfare *(6)*.

Although disproportionality is well documented in the child welfare setting, few studies focus on these issues in FTCs. One study that explored enrollment differences among racial and ethnic minority children in FTCs showed that White children were over-represented, whereas Hispanic, Black, Asian and Pacific Islander, and multiracial children were under-represented *(21)*.

Some studies and surveys indicate that racial and ethnic minorities are under-represented in all types of treatment courts for numerous reasons including both programmatic and historical or systemic. While programmatic barriers might affect admission of any potential participant, studies of disproportionality in treatment courts have found these barriers to be of particular significance for racial and ethnic minorities. Programmatic barriers include unnecessarily restrictive eligibility criteria *(22,23)*, participation requirements that are difficult to meet without personal transportation *(24)*, and unavailability of culturally and linguistically appropriate treatment or other services *(25)*. While programmatic barriers are a significant contributor to lower treatment court enrollment rates among under-represented groups, individuals in these populations also refuse to participate at higher rates *(26–29)*.

Referred and eligible participants for treatment courts cite a variety of reasons for refusing an offer of admission. During a focus group with potential adult drug court participants who identified as African American, the potential participants reported that the messages they heard during orientation demonstrated a lack of caring and too much attention to rules rather than individual needs *(29)*. Certain populations, including people of color, immigrants, LGBTQ, and members of minority religions, may have experienced mistreatment or abuses by the legal and treatment systems, resulting in significant distrust of these systems *(30–33)*. Treatment courts, while intended to be highly supportive, place greater accountability on participants than "business as usual" within the child welfare and dependency court processes. It is common for potential FTC participants to refuse admission, fearing that increased scrutiny by the FTC will put their family at greater risk than trying to work through the regular child welfare process. Populations that already distrust the legal and treatment systems are much less likely to voluntarily agree to place themselves or their family at even greater exposure to these systems *(34–36)*.

Key Considerations

Collection and analysis of data are critical to determining whether the FTC is enrolling a population of participants representative of and proportional to both the community at large and the community's child welfare population that has substance use and mental health treatment needs *(2,37)*. If there are discrepancies between the child welfare population and the population served by the FTC, the FTC investigates why and seeks to remedy the discrepancies *(2,38)*.

There are opportunities to either reduce or exacerbate disproportionality at every stage of the child welfare case *(39)*. The use of universal screening instruments ensures that all families that come to the attention of the child welfare system are screened for SUDs and referred for further assessment and treatment if the screening tool suggests the parent may have an SUD *(See Standard 4)*. Likewise, if the FTC has clear and simple eligibility criteria such as "an active child welfare case and assessed SUD," the parents or guardians are referred to the FTC *(38)*. These kinds of universal procedures help to address issues of both explicit and implicit bias *(2)*.

> *Collection and analysis of data are critical to determining whether the FTC is enrolling a population of participants representative of and proportional to both the community at large and the community's child welfare population that has substance use and mental health treatment needs.*

The FTC also investigates why individuals from certain populations are less likely to agree to participate. The FTC and its partners develop outreach strategies (e.g., Motivational Interviewing, co-location of staff, parent mentors, recovery support specialists) to increase referrals and admission of parents from under-represented communities by addressing concerns and describing the benefit of FTC participation *(2,40)*.

B. Equitable FTC Retention Rates and Child Welfare Outcomes

Rationale

Disparities are inequitable differences in the services received or outcomes experienced by race, gender, or other characteristic *(41)*. Disparities can occur between participants of different races, ethnicities, or genders but may also be related to family composition, age, language preference, or other characteristics. The Administration for Children and Families recommends that child welfare agencies examine disproportionality and disparities at each decision point to identify areas for potential improvement *(6)*. FTCs seek equitable FTC retention rates, discharge rates, and child welfare outcomes.

As noted previously, children of color are disproportionately identified for child welfare intervention and placed in foster care. Children of racial and ethnic minorities are more likely than White children to experience lengthy stays in out-of-home care without a clear plan for permanency, be placed in group care, and have poor educational, social, behavioral, and other outcomes *(42)*. In 2017 AFCARS report, AI/AN children (512 days) and Native Hawaiian or other Pacific Islander children (463 days) had the longest median lengths of stay in foster care, followed by Black children (450 days) and White children (439 days). The median length of stay in foster care was lowest for Asian children, at 421 days *(43)*. Further, the proportion of White children placed in family settings, including relative and nonrelative foster homes, pre-adoptive homes, and trial home visits increased by 6% between 2007 and 2017, while children of color had smaller improvements ranging from 1% to 5% *(44)*. Black and Latino/a children were also less likely than White children to receive in-home family services, Black and AI/AN children were less likely to be reunified, and Black children were less likely to be adopted *(42)*. Numerous studies have found a link between disparate child welfare outcomes and the co-occurrence of poverty and racial and ethnic minority status *(3,17,42)*.

The limited research on the intersection of race and child welfare outcomes in the FTC context has shown promising results. The evaluation of the King County Family Treatment Court (KCFTC) in Washington State explored the intersection of race and FTC participation as factors contributing to parent recovery and child permanency outcomes. The study examined the differences in outcomes between KCFTC participants and a comparison group of nonparticipants *(45)*. Analyses of differences by race and ethnicity indicated that families of color in the KCFTC entered treatment sooner than those in the comparison group and at a rate equivalent to that of White families in the KCFTC *(45)*. Further, children of color in the KCFTC were more likely to be returned home (i.e., to have their dependency case dismissed, be reunified, or have a trial home visit) than children of color in the comparison group and had return rates comparable to those of White children in KCFTC.

Another study of FTCs examined length of stay in out-of-home care and reunification with a parent or caregiver within 12 months. It found that similar percentages of White, Black, AI/AN, and Latino/a children who experienced reunification with a parent or caregiver did so within 12 months *(21)*. However, median length of stay in out-of-home care varied by race and ethnicity. Black and multiracial children had significantly longer median lengths of stay than White children.

Cultural Humility

Practice experience and research have demonstrated that disparities can be reduced or even eliminated when staff and programs actively seek to engage each participant and family in ways that meet their particular needs and recognize their strengths *(46,47)*. These practices, which encompass family-centered practice and cultural humility, honor family members as experts in their own lives *(47,48)*. Cultural humility recognizes that no one is an expert in another's culture and that each individual and each family are unique within their culture *(49–51)*.

These approaches call on the FTC team to work with the participant, child(ren), and family support system, asking them to describe what they experience as barriers and what they consider areas of strengths. A good assessment process, use of child and family teams and/or family group decision making to develop a single, comprehensive case plan, and provision of culturally relevant intervention services (e.g., SUD and mental health treatment, parenting programs, employment supports) are all effective ways to reduce disparate outcomes *(46)*.

Gender

In addition to examining patterns of disproportionality and disparity by race, FTCs should look at interim and outcome data for participants of different genders. FTCs are more likely to admit and successfully engage female participants *(52,53)*; this is, in part, reflective of their higher likelihood to be named as the respondent parent and have a case plan of reunification. But fathers are frequently under-represented in FTCs for a variety of reasons *(54)*. In some cases, there may be more than one father involved or the father figure (also sometimes referred to as the social father, stepfather, or adoptive father) *(55)* may not be the biological father at the time a child welfare case is substantiated *(56)*. Men confront a variety of social barriers related to parenting and substance use or mental health recovery that often complicate their engagement with the FTC *(57,58)*. Men may also be discounted for their active parenting role or may be seen as a potential abuser of the mother or child(ren) *(54,56,57,59,60)*. Positive stereotypes of men as fathers focus on their role as the protector of the family, provider of household income, and role model for the children. Men involved in child welfare cases with substance use disorders or co-occurring disorders face a stigma related to their failure to protect the family and the effects of their substance use disorders or co-occurring disorders on themselves and the family *(61,62)*.

The FTC and child welfare partners actively seek to identify and engage with fathers as early as possible; they make the fathers feel welcome in the FTC process and important to the well-being of the children and family *(62,63)*. A review of foster care files found that when fathers are actively involved in the child welfare case, children are more likely to be reunified with parents or to be placed with relatives instead of nonrelatives *(64)*. In another study specifically examining the involvement of Black fathers in permanency planning, children were reunited with birth families more often and had shorter stays in foster care when fathers were involved *(65)*.

Family Culture

Every participant and his or her family bring to the FTC a perspective acquired through their experiences and culture. Culture encompasses the family, community, and historical processes that have shaped individual and family role expectations, family structure, and beliefs about treatment, parenting, and the courts *(66)*. To successfully engage, retain, and discharge participants and families, the FTC and its partners endeavor to understand and find the areas of strength within the cultural context of each participant and family *(46,67)*.

Family-centered and culturally relevant case management and interventions begin with high-quality assessments of strengths and needs *(See Standard 4)*. These assessments seek to identify areas of individual, family, and community strengths and resources that can be used to support the parent, child(ren), and family during active involvement in the FTC and that can continue to provide support upon discharge. It is common for case plans to identify the

areas of need; however, it is the areas of capacity and resources that provide hope and a sense of future needed to sustain the participant through the work and challenges involved in successful case closure.

> *To successfully engage, retain, and discharge participants and families, the FTC and its partners endeavor to understand and find the areas of strength within the cultural context of each participant and family.*

Child and family teams, family group conferencing, and family group decision making engage children, parents, and extended family in case planning and decision making. These structured and professionally facilitated processes empower participants and family members to define their family, their needs, their hopes, and their strengths *(68,69)*. In a study of White, Black, and Latino/a families whose children were taken into foster care, families that participated in family group conferencing reported feeling more satisfied with the process, relatives felt more empowered, children reported feeling less anxious (particularly when they were placed in a kinship home), and Black and Latino/a children were more likely to be reunified *(70)*.

In a study examining why Black participants have tended to graduate from drug court at lower rates than Whites, Black participants in a focus group stated that the treatment they received was irrelevant to their needs. In particular, they believed their case plans did not address more pressing concerns such as unemployment, low education, and mental health symptoms *(71)*.

ASFA and ICWA

The rights and well-being of children, parents, and families with substantiated child welfare cases are protected by state, federal, and tribal laws. Two federal laws, the Adoption and Safe Families Act (ASFA) (Public Law 105-89) and the Indian Child Welfare Act (ICWA) (25 USC § 1901-1963), include provisions intended to strengthen the family's rights and protect cultural values. ASFA, enacted in 1997, establishes a set of time frames intended to reduce the child's time to permanency and addresses "reasonable efforts" *(72)*. The legislation also requires that states seek adoptive or other permanent placements with "fit and willing" relatives and gives placement preferences to adult relatives when they meet state child protection standards. ICWA is a direct response to state and federal policies that disproportionately removed AI/AN children from their families and tribe with the effect of diminishing the "unique values of Indian culture" (25 U.S. C. 1902). Both laws serve to hold the child welfare agency, courts, and affected family members accountable for meeting the needs of the children and family, with a goal of increasing successful reunification or finding the best alternative for the children, one that is focused on maintaining family and cultural connections.

ASFA calls for the provision of "reasonable efforts" to prevent removal of a child and to finalize the permanency plan. Although each state defines reasonable efforts within its own legal code, most reference efforts that provide accessible and culturally appropriate services intended to improve a family's capacity to provide a safe and stable home *(73,74)*. The FTC serves as a key resource to ensure that reasonable efforts are made to preserve families and avoid the trauma of removal by working with their child welfare and family partners as part of the safety plan. Further, if removal is required, the FTC is a critical partner in making sure that children, parents, and familiy members receive all the services needed to safely restore the family and that the services address not just the needs but also the strengths and wishes of the family.

ICWA, on the other hand, requires all state courts to use "active efforts" to provide remedial services and rehabilitative programs designed to prevent the breakup of AI/AN families (25 USC § 1912[d]). Federal regulations define active efforts to include

helping parents obtain housing, financial resources, transportation, effective mental health and substance use disorder treatment, peer support, and other community resources. In addition to providing services, the FTC also seeks out and engages the child's tribe to provide support services (25 CFR § 23.2). The Act requires agencies seeking a foster or pre-adoptive home for an AI/AN child to give preference to the child's extended family or a home that has been licensed, approved, or otherwise specified by the child's tribe.

The FTC therefore establishes relationships with nearby tribes to develop shared processes for supporting and finding the most suitable placements for tribally enrolled or eligible children.

Families We Choose

In the population it serves, an FTC recognizes the different meanings of "family" and the different roles of family members. While all families have their own definition of who is part of the family, individuals known variously as "fictive kin," "voluntary kin," and "families we choose" may be particularly important members for African American *(75–77)* and LGBTQ persons *(77)*. These individuals are unrelated by blood or marriage but regard one another as family and are important members of informal networks for many families. When seeking supports for families, the FTC team and child welfare staff (in particular) seek out these kin to learn if a member of this extended family network could serve as a part of the family's safety plan or as a placement for the children.

While LGBTQ legal rights have shifted significantly in recent years, family composition and legal relationships remain complex. A unique challenge for LGBTQ participants and families is that they might have insufficient legal documentation to demonstrate their relationships to their partners and children. Child welfare interventions could separate these families, especially if the parents are not married to each other. Limited access to advocacy and other supports can further isolate members of the LGBTQ community. The Child Welfare League of America has issued a position statement in support of same-sex parenting, affirming that "lesbian, gay, and bisexual parents are as well suited to raise children as their heterosexual counterparts" *(78)*.

Key Considerations

When considering how to improve FTC retention and child welfare outcomes in ways that reduce and ultimately eliminate disparities, several strategies have been found to be effective *(71,79,80)*. These strategies are grounded in

- increasing family voice and being family-centered in the development of case plans and selection of services;
- seeking to create work and treatment spaces that are reflective of the members of the target population community; and
- engaging and developing services and supports that meet the needs of the target population.

These approaches are honored throughout the entirety of the case, from identification of a family in need through development of a case plan and engagement with services to the final closure of the case.

Family Voice and Family-Centered

There are many ways the FTC can amplify family voice and be more family-centered when working with families that are involved in the child welfare system and have a parent with an SUD or co-occurring disorder.

- Engage respectfully with families and follow the practices of cultural humility.
- Ask family members to identify needs, strengths, and resource "family" members (individuals who may not be related by blood or marriage).
- Use practices such as child and family team and family group decision making to develop a case plan that is reflective of the family's needs, strengths, and resources while ensuring the safety of the children.
- Use tools such as exit interviews or surveys and participant focus groups to determine which policies and practices of the FTC are viewed by children, parents, and families as family-centered and honoring family voice and which are not.

Engaged Provider Approach

There are many strategies that FTC can use to increase engagement when working with families:

- Employ facilitators, clinicians, and recovery support specialists of the same gender, racial and ethnic background, or other important characteristics as participants.
- Provide services that are accessible (location), available (times), and in languages spoken by the target population to reduce the barriers encountered by FTC participants.
- Conduct walk-throughs of intake and service provision processes. What do participants see, experience, and sense when they engage with the various providers and required processes of the FTC? Do people of different genders, races, and ethnicities see themselves in the posters and forms provided? Do they feel safe and welcome?

Services and Supports Reflective of Target Population Needs

There are many strategies that FTC can use to provide recovery and reunification services and supports for families involved in the child welfare system.

- Write case plans to reflect the particular strengths, needs, and resources of each child, parent, and family (case plans should appear substantially different for each family).
- Reassess case plans and FTC expectations regularly and alter them as needed to meet the particular needs of each child, parent, and family.
- Address all four of the Substance Abuse and Mental Health Services Administration's (SAMHSA) dimensions of recovery (health, home, purpose, and community) when developing case plans *(See Standard 6)*.
- As needed to prevent removal, achieve reunification, or ensure successful permanency, look at the courts' interpretations of legislative language on reasonable efforts when addressing access to supportive services.

C. Equitable Treatment

Rationale

Disparities associated with treatment outcomes can be reduced or eliminated when the treatment delivered is culturally appropriate and when clinicians are trained to deliver the intervention with fidelity and cultural respect *(81,82)*. Culturally sensitive attitudes and respect for clients' cultural backgrounds are strong predictors of positive SUD treatment outcomes for participants from racial and ethnic minority groups and significantly increase retention rates *(83)* (*See Standard 6*).

A study of 142 treatment courts serving more than 20,000 participants identified a range of policies and procedures associated with better outcomes and smaller disparities for members of different racial, ethnic, and gender groups *(84)*. Treatment courts that provided family counseling had significantly smaller disparities in completion rates for White and Black participants, and treatment courts that included community members on the advisory committee significantly decreased racial disparities *(84)*.

Having all FTC participants engage with an evidence-based parenting education intervention that includes opportunities for parents and children to learn and practice skills together is critical to developing parent and child competences and enhancing parent and child attachment. When selecting a parenting intervention, it is also critical that the program be effective for children, parents, and families that the FTC serves. Even an evidence-based parenting program is only effective with certain ages of children, and not all curricula have been tested and found effective with different racial and ethnic populations *(85)* *(See Standard 6)*.

While FTC participants have been found to carry some of the highest trauma burdens of any treatment court population *(86–88)*, people of color and members of marginalized communities such as African Americans and AI/ANs often contend with historical trauma in addition to direct trauma *(33,89–92)*. Historical trauma places these populations at greater risk for health disparities because of toxic stress from accumulated disadvantage as well as genetic and epigenetic risk factors *(93–100)*. Treatment courts that employ trauma-informed and trauma-responsive strategies have higher engagement, retention, and successful completion rates *(86)*.

The FTC addresses the effects of policies that may endanger AI/AN family ties and recognizes the communities' experiences of ongoing discrimination *(101)*. Tribal healing to wellness courts can serve as a resource to other FTCs that include a subpopulation of AI/AN families. These courts frequently incorporate a wide range of cultural, traditional, and/or community values, practices, and activities in their phased treatment plan requirements. For example, a cultural advisor may be consulted or even serve on the team. Wellness courts frequently utilize restorative justice–related activities that seek to repair broken relationships, such as peacemaking, talking circles, or mediation; participation in spiritual or community activities, such as ceremonies, competitions, feasts, games, or the Native American Church; or seeking the advice and/or mentorship of knowledge holders and elders *(102)*.

Disparities associated with treatment outcomes can be reduced or eliminated when the treatment delivered is culturally appropriate and when clinicians are trained to deliver the intervention with fidelity and cultural respect.

Key Considerations

National and international organizations recognize the importance of assessing and treating individuals in the context of their cultural identity. The American Psychological Association and the American Counseling Association have professional policy and practice guidelines specifically addressing the needs of participants from historically marginalized communities, including guidance on serving LGBTQ populations *(103–107)*. The Cultural Formulation Interview, included in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders, helps professionals collect and organize culturally relevant clinical information for use during diagnostic and clinical case planning *(108)*.

Different cultures approach treatment, self-efficacy, and personal interactions differently *(109)*. Certain cultures, including men of most racial and ethnic backgrounds, have been conditioned to be strong, not cry, and not share intimate details of their lives and feelings *(62)*. This culture conflicts with the treatment culture expected by most providers. Many African Americans and Asians have been conditioned not to admit mental health symptoms and may be reluctant to fully disclose *(110,111)*. Some cultures admire assertive behavior while others consider such behavior disrespectful. Team members strive to engage respectfully with individuals and families and not to make assumptions about culture.

The use of language can be an important sign of respect. For participants who do not speak English fluently, the FTC provides written or audiovisual materials in the participant's primary language; it also ensures that the translated materials are culturally appropriate for the intended audience and that the participants understand the message as intended. Likewise, program materials and spaces where participants engage with the FTC and its partners display diverse images that are inclusive of the range of FTC participants and families.

D. Equitable Responses to Participant Behavior

Rationale

To achieve the goals of stable recovery of and healthy parenting by participants, the FTC team must respond effectively to participant behavior *(See Standard 7)*. Treatment courts monitor and address any real or perceived belief that racial or ethnic minority participants are sanctioned more severely or incentivized less favorably than nonminority participants for similar infractions. A study conducted by the National Association of Criminal Defense Lawyers argued that racial and ethnic minority participants receive more severe sanctions than their majority peers *(112)*, and minority participants in at least one focus group reported feeling more likely than other participants to be ridiculed or laughed at during drug court sessions in response to violations *(113)*. Despite these concerns, most research suggests that drug and other problem-solving courts administer sanctions evenhandedly to participants from different racial and ethnic groups and that differences are attributable to the specifics of each case, not to race or ethnicity *(114–118)*. Adherence to the principles of procedural fairness is among the most effective ways the FTC team guards against real and perceived differences in responses to participant behavior *(119,120)*. Procedural fairness involves treating participants with respect and dignity, allowing participants to explain their

> *"Adherence to the principles of procedural fairness is among the most effective ways the FTC team guards against real and perceived differences in responses to participant behavior.*

perspectives, and seeking to avoid disparate treatment of participants who are otherwise equitable (similar behavior and time in the program) *(121,122)*.

Many historically marginalized groups have a history of interpersonal and intergenerational trauma. Environmental factors (e.g., early exposure to trauma) can contribute to both substance use and mental health disorders *(123)*. These known and unknown trauma histories may increase the likelihood of behavior that is not conducive to stable recovery and healthy parenting behavior *(124,125)*. When an individual manifests such behavior, the FTC team responds to the behavior while recognizing the effects of the individual's trauma history.

Key Considerations

Treatment courts successfully intervene in the chronic diseases of substance use and mental health disorders through a combination of highly effective treatment and the accountability and support provided through case management and therapeutic responses to behavior. The FTC develops policies and procedures that guide the team to effectively and equitably respond to participant behavior *(See Standard 7)*.

Team behavior that supports the engagement and success of historically marginalized and other underserved populations also supports the engagement and success of the overall child welfare population. Respectful engagement with participants, team members, and community partners is the norm. Disrespectful, rude, or demeaning language and behavior are never acceptable. Procedural fairness, including providing opportunities for the participant to explain his or her side, is important in all cases but may be even more critical for a participant who is part of a minority population *(See Standard 7)*. It is essential that child welfare workers, clinicians, attorneys, and judicial officers recognize that they are in positions of power. This power differential may be amplified among people of color and other marginalized populations.

Policies that support equitable response to behavior include written guidelines that establish the expectations for behavior within each phase and a range of incentives and sanctions that may be employed in response to either compliance or noncompliance. These guidelines are developed with the FTC team and published in the policy and procedure manual and the participant handbook. Although treating each positive drug test or missed appointment the same way might seem fair, the team instead employs a policy of flexible certainty. Flexible certainty allows the team to respond to behavior in a way that considers each person's situation and needs and that supports positive behavior change.

Procedures that support equitable response to behavior include the following:

- Establishing FTC team norms for pre-court staffing discussions;
- Assigning the role of ombudsmen on a rotating basis to monitor FTC team behavior;
- Reviewing a data dashboard during regular meetings to facilitate analysis of program operations and participant progress;
- Adopting feedback processes such as exit surveys and focus groups to ask current and former participants about their experiences; and
- Evaluating program outcomes including analysis focused on the experiences and outcomes of underserved populations.

Establishing norms for pre-court discussion and assigning an ombudsman are two ways that the FTC team develops and maintains procedures that are focused on respectful, problem-solving discussions and are mindful of explicit and implicit bias. Bias, either for or against an individual or particular population, can influence the way in which an individual's case is discussed and behavior responses are decided. Established norms help the team focus on facts rather than rumor, opinion, or history. An ombudsman monitors team discussions and provides feedback on whether the team is devolving into biased behavior or decision making.

Regular review of a data dashboard, collection and review of exit survey and focus group data, and formal program evaluations provide critical feedback loops to the FTC on how policies and procedures affect participant engagement. The FTC uses these tools to specifically investigate the experiences of historically marginalized and other underserved groups and seek ways to support increased engagement and improve outcomes.

E. Team Training

Rationale

Training for the operational team and the FTC's many partners is one of the most critical and effective interventions for ensuring equity and inclusion. Team training has been found effective in reducing bias in decision-making processes in child welfare, treatment, and the courts *(2,49,126–128)*.

Individuals and families with substantiated child welfare cases and who have substance use disorders or co-occurring disorders face some of the highest levels of stigma and prejudice of any population *(129–131)*. Stigma is defined as "an attribute that links a person to an undesirable stereotype, leading other people to reduce the bearer from a whole and usual person to a tainted, discounted one," while prejudice is defined as "an aversive or hostile attitude toward a person who belongs to a group, simply because he belongs to that group, and is therefore presumed to have the objectionable qualities ascribed to the group" *(132)*. The target population for an FTC is frequently the target of prejudice: often poor and members of a minority community (race, ethnicity, sexual orientation, language, religion). Simultaneously, their substance use disorder or co-occurring disorder (both highly stigmatized health conditions) has contributed significantly to the neglect and/or abuse of their children (one of the most stigmatized community offenses). The stereotypes associated with poverty, substance use, mental illness, and child welfare must be confronted and deconstructed for the FTC to effectively engage with and support children, parents, and families *(133)*.

Training can enhance a professional's understanding of the role of implicit bias, the importance of diversity, and the need to determine a client's cultural background and influences *(126,127,134)*. Effective cultural sensitivity

> *One of the most important predictors of positive outcomes for racial and ethnic minority participants is a culturally sensitive attitude in frontline staff and their supervisors.*

curricula focus, in part, on identifying and examining the often implicit or unconscious biases that staff members might have about their clients *(128,135)*. To produce positive outcomes, staff and service providers must understand the cultural context of the children, parents, and families being served and must also have a willingness and the skill to work within this context.

Implicit bias has been found to have a consistently negative effect on judicial decision making in criminal courts *(35,135–138)*. However, training judicial and other court officers to recognize implicit bias and act to counteract it has produced measurable improvements in case processes and outcomes *(128,135,136)*.

One of the most important predictors of positive outcomes for racial and ethnic minority participants in SUD treatment is a culturally sensitive attitude in front-line staff and their supervisors *(126,139)*. In an agency, managers establish the tone and expectations for all staff. When managers value diversity and respect their clients' cultural backgrounds, clients remain significantly longer in treatment and these programs deliver services more efficiently *(25)*.

Increasingly, research and practice suggest the effectiveness of training practitioners and supervisors in cultural humility rather than focusing strictly on cultural sensitivity or cultural competence *(49–51)*. Cultural humility teaches that a person cannot become an expert in another's culture and that not all groups are culturally homogenous. Cultural humility focuses on teaching practitioners to be open, to be self-aware of their own biases and positionality, and to seek ways to reduce power differentials.

Key Considerations

When individuals are selected to serve as FTC operational team members, it is critical that each considers his or her own prejudices and beliefs about substance use and mental health recovery, parenting, the roles of fathers and mothers, and individuals from minority populations. Implicit bias either against or for a particular group is a normal human trait *(128,135)*. However, if the work calls for engagement with parents whose substance use disorders or co-occurring disorders have contributed to the neglect or abuse of their children, it is imperative that each team member, professional, and paraprofessional believe that an individual can achieve stable recovery to successfully parent. Likewise, implicit biases associated with a person's skin color, where they live, who they love, or where they are from must not interfere with the opportunities that individuals and families are given to participate in the FTC and the treatment and other services associated with the case plan.

Ongoing interagency training at all levels is essential to ensure cultural awareness and responsiveness. Training helps team members identify and examine their implicit or unconscious biases and teach strategies to reduce disproportionality and disparities. The training addresses the history and ongoing effects of institutional racism and historical trauma that produced inequities and disparities. Leadership training addresses ways to identify and implement data-informed solutions, maintain accountability to historically marginalized communities and other underserved groups, and understand the role of organizational gatekeeping in perpetuating inequities.

Training topics include the following:

- Trauma-informed and trauma-responsive approaches and treatment;
- Cultural humility (curiosity and openness to other cultures, values, and beliefs);
- Role of culture and personal experience in behavior (e.g., touches, gestures, eye contact);
- Gender-responsive approaches;
- LGBTQ community issues;
- Understanding of institutional/structural racism and its role in creating White privilege;
- Effect of different learning styles, language preference, and cognition on an individual's capacity to engage in education and therapy; and
- Understanding of implicit bias, including how to recognize personal bias and counteract its effects.

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4. Early Identification, Screening, and Assessment

The process of early identification, screening, and assessment provides the greatest opportunity to fully meet the comprehensive needs of children, parents, and families affected by substance use disorders (SUDs) that come to the attention of the child welfare system. Family treatment court (FTC) team members and partner agencies screen and assess all referred families using objective eligibility and exclusion criteria based on the best available evidence indicating which families can be served safely and effectively in the FTC. Team members use validated assessment tools and procedures to promptly refer children, parents, and families to the appropriate services and levels of care. They conduct ongoing validated assessments of children, parents, and families while also addressing barriers to recovery and reunification throughout the case. Service referrals match identified needs and connect children, parents, and family members to evidence-based interventions, promising programs, and trauma-informed, culturally responsive, and family-centered practices. FTC team members take on varying roles for this process to occur in a timely and efficient manner.

Provisions

A. Target Population, Objective Eligibility, and Exclusion Criteria

The FTC serves children, parents, and families involved in the child welfare system when substance use of a parent/caregiver is a contributing factor. It targets families that require the intensity of services, increased support and monitoring, and routine judicial oversight necessary for the parent to comply with the child welfare case plan, complete SUD treatment, and safely reunify with and provide a safe, stable, and permanent placement for his or her child(ren). The FTC defines its target population using objective eligibility and exclusion criteria, specified in writing and communicated to all referral sources. It does not make eligibility determinations based on subjective criteria.

B. Standardized and Systematic Referral, Screening, and Assessment Process

Families entering the child welfare system are promptly, systematically, and universally screened and referred to the FTC as early as possible in the child welfare case. The FTC has an agreed-upon process for referring, screening, and assessing all parents, children, and families. Any source can refer a potential participant to the FTC for screening and assessment, and all referral sources are trained in when it is appropriate to refer their clients.

C. Use of Valid and Reliable Screening and Assessment for Parents and Families

Valid and reliable instruments are used to screen and assess parents and families referred to the FTC. Screening indicates the possible presence of a condition or disorder (i.e., SUD, co-occurring mental health disorder), whereas an assessment identifies the effects, severity, and consequences of that condition to determine the appropriate intervention and level of care recommendation. Screening and assessment tools provide information on FTC eligibility, appropriate treatment, complementary services, case planning, and monitoring for children, parents, and family members.

D. Use of Valid, Reliable, and Developmentally Appropriate Screening and Assessment for Children

Children of FTC participants receive timely and comprehensive screening and assessments using validated and developmentally appropriate instruments, as well as prompt referrals to appropriate evidence-based services. The operational team assesses, or refers for assessment, children of FTC participants within a standardized time frame and monitors the receipt of services. Age-appropriate, validated instruments are used to identify issues

that need to be addressed, such as health, behavioral, and psychosocial problems; poor parent-child attachment; prenatal substance exposure; child maltreatment; and trauma. Child assessments reoccur at developmentally appropriate intervals, service plans are modified to reflect changes in each child's needs, and FTC team members are made aware of relevant information based on agreed-upon information-sharing protocols.

E. Identification and Resolution of Barriers to Recovery and Reunification

The operational team systematically monitors and helps resolve identified community-based barriers that hinder children, parents, and families in obtaining needed services or making timely progress toward case plan goals. The FTC team, in collaboration with the family, promptly identifies barriers to treatment completion and reunification and develops solutions. Participants are not referred for unneeded services; when services are needed, evidence-based options are always favored over ones without an evidence base *(See Standard 6).*

Rationale and Key Considerations

A. Target Population, Objective Eligibility, and Exclusion Criteria

Rationale

FTC targets families that require the intensity of services, increased support and monitoring, and routine judicial oversight necessary for them to comply with their child welfare case plans, complete SUD treatment, safely reunify, and provide a safe, stable, and permanent placement for their children.

Treatment courts that use standardized risk and needs assessment tools to determine eligibility have significantly better outcomes, including significantly higher treatment completion and reunification rates, than courts that do not use such tools *(1,2)*. Adult drug court research indicates that the population of offenders with the greatest need for the drug court model are "high-risk/high-need." These are individuals likely to engage in the same pattern of criminal behavior or fail in a less intensive rehabilitative or supervision disposition (high-risk) and diagnosed with a severe SUD (high-need) *(3)*. Similarly, studies of family treatment courts showed equivalent or better outcomes for the most difficult and demanding cases *(4–7)*. However, using the term "high-risk/high-need" to describe the family treatment court target population can be problematic. The risk/need designation in FTCs differs from adult drug courts in several areas of practice:

1. First and foremost, FTCs must meet the mandates of the child welfare agency and dependency court to ensure the safety and well-being of and permanency for children through treatment of the entire family *(8)*. FTCs assess for safety, risk, need, and protective factors for children, parents, and families throughout the child welfare case; the assessment is not restricted to the parent with the SUD.

2. Child welfare risk and prognostic risk are distinctly different. Child welfare risk assesses the likelihood that child maltreatment will occur or reoccur in the future *(9)*, whereas prognostic risk assesses the likelihood that an individual will continue to engage in criminal behavior *(10)*. Using the general term "risk" in both instances is not a viable option; therefore, clarification must be made when discussing risk in the context of the FTC. FTCs consider assessing for prognostic risk to identify the risk of a parent's failure to complete SUD treatment, failure to comply with the child welfare case plan, and future criminal involvement. Further review is needed to determine if existing child welfare safety, risk, and needs assessment tools capture risk factors needed to determine prognostic risk.

3. Some FTC participants have no pending, current, or past criminal charges, others may have limited involvement with the criminal justice system, and still others may have extensive involvement in the criminal justice system. A structured prognositc risk assessment informs the FTC team if there is a need to separate those who assess as a high prognostic risk from those who assess as a low or low/moderate prognositc risk into different treatment groups or residential settings *(11)*. Unlike in adult drug courts, lack of sufficient prognostic risk (i.e., low-risk) does not exclude families from an FTC. However, accurately assessing prognostic risk is necessary for the FTC to assign the appropriate level of monitoring, support, and case management services and to avoid

mixing high- and low- prognostic risk participants in treatment and housing.

Because of the many complexities, research has not yet clearly prescribed a target population for FTC families based on either child welfare risk or criminogenic risk. The research that has emerged points to the critical importance of conducting structured, validated, and reliable risk assessments of the child, parent, and family so that child welfare can formulate a fitting response for the safety, well-being, and permanency needs of the child and determine the appropriate level of support, monitoring, and case management services for parents to comply with the case plan *(12,13)*.

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Consequently, FTCs present a unique context for defining both risk and need. Families involved in child welfare are at risk of two possible distinct adverse outcomes — a child could experience repeat maltreatment or a parent could fail to complete SUD treatment and to comply with case plan requirements.

Although these outcomes are different, existing child welfare literature indicates that predict one outcome predict the other. Moreover, the judicial interventions that can reduce the likelihood of these outcomes are the same: greater monitoring, consistent engagement, and judicial oversight *(12,14–19)*.

Parents of children at greater risk of child maltreatment require increased monitoring, consistent engagement strategies, and judicial oversight to prevent child maltreatment reoccurrence and SUD treatment failure. The FTC uses risk assessment measures to identify families that require the intensity of services, increased support and monitoring, and judicial oversight necessary for the parent to comply with his or her child welfare case plan, complete SUD treatment, and safely reunify with the child.

Research has shown that families in the child welfare system with the following risk factors are more likely to fail to complete treatment, fail to comply with case plan requirements, and fail to reunify with their children: younger parents, younger children, children with special needs, children with prenatal exposure to substances, earlier parental SUD onset, family violence, parental criminal justice system involvement, lack of social support, parental history of trauma, previous SUD treatment failure, and previous child welfare involvement *(20–26)*.

Research has also shown that families in the child welfare system include the following need factors: SUD severity, parental use of certain substances of abuse (e.g., heroin, methamphetamines), co-occurring mental health disorders, socioeconomic issues (e.g., lack of housing, education, or employment), deficits in parent-child attachment and parenting skills, parental stress, lack of employment skills, and lack of daily living skills *(20–25,27,28)*.

The presence of an SUD is both a risk and a need factor for children, parents, and families with child welfare involvement. For this reason, many FTCs assess eligibility solely by determining whether the potential participant has an SUD *(29,30)*. No evidence suggests that this practice interferes with FTC effectiveness.

Use of subjective criteria has the potential to exclude families from FTCs for reasons that have not proved valid or meaningful in the course of the court experience. Removing subjective eligibility restrictions and applying evidence-based selection criteria significantly increase the effectiveness and cost-efficiencies of drug courts by allowing them to serve their target population *(31,32)*. Using objective criteria allows for a perception of fairness among participants and team members. Integrated processes of continuous quality improvement, including ongoing

reviews of eligibility and exclusion criteria, are central to effective FTCs *(2,33)*.

Some FTCs exclude participants with a serious criminal history *(33–36)*. However, several studies have found that parents with extensive criminal histories, domestic violence, and inadequate housing are more likely to complete treatment than parents without those factors *(5,6)*. Participants with high criminogenic risk are as likely to be successfully discharged from FTCs as long as they receive appropriate levels of services, monitoring, and judicial oversight *(7,27,30)*.

Key Considerations

The FTC does not screen potential participants based on subjective impressions of the individual's motivation to change, readiness for treatment, prior child welfare permanency decisions, or dependency court case dispositions. The FTC does not use voting or personal impressions to determine a participant's admission into the FTC.

The governance structure reviews the FTC's eligibility and exclusion criteria, referral data, and program participation data annually to ensure equitable inclusion of all families who meet the eligibility criteria. Based on findings from this review, the FTC adjusts the eligibility and exclusion criteria and communicates them to all partner organizations and potential referral sources.

The FTC collects data on its participants to assess adherence to the eligibility and exclusion criteria. For example, review of data can determine whether the FTC screens and refers families from underserved populations (e.g., people of color, men, LGBTQ, English nonproficient) and whether these families have the same outcomes as other families *(37)*. FTC team members identify and address barriers or increase foundational supports to ensure equitable opportunities to fully engage in FTC.

B. Standardized and Systematic Referral, Screening, and Assessment Process

Rationale

Prompt identification and referral of eligible families to the FTC is critical *(38,39)*. Federal mandates limit the time that parents have to comply with reunification requirements *(8)*. Early identification, screening, and assessment of services is particularly important for parents with SUDs to demonstrate the ability to safely care for and provide a permanent stable home for their children within Adoption and Safe Families Act (ASFA) time lines. Ideally, screening and referral to the FTC occur in conjunction with the child welfare investigation and initial case planning process, and prior to the dispositional hearing *(39)*. Ongoing assessments using a decision-making model grounded in research has proven effective in developing responses based on risk, need, safety, strengths, and protective factors present at various points in the child welfare case *(40)*. Effective communication and collaboration between referral sources and the FTC are imperative in ensuring that the FTC serves as many eligible children, parents, and families as early as possible in the child welfare case. A memorandum of understanding (MOU) defines responsibilities with the partnerships to ensure that the assessment results are promptly communicated to the multidisciplinary FTC team *(39,41)*.

Parents with child welfare system involvement are more likely to receive a prompt SUD assessment and referral to treatment if the child welfare agency engages in universal screening using a validated SUD screening tool and if there is an MOU between treatment providers and child welfare to guarantee priority access to assessment and treatment *(41)*. The FTC develops MOUs with the child welfare agency to ensure that all partners use a standardized, universal screening tool to quickly refer families for an FTC eligibility assessment.

Rapid entry into SUD treatment is one of the most consistent predictors of increased time spent in treatment as well as increased likelihood of treatment completion and reunification with children *(2,7,33,36,38,42)*.

The most commonly used placement criteria are those of the American Society of Addiction Medicine (ASAM). These criteria include six dimensions: withdrawal, acute intoxication, and overdose risks; medical conditions; co-occurring psychiatric or emotional disorders; readiness for change; potential for return to use or continuing use; and recovery and living environment. A holistic, biopsychosocial assessment that captures information from across all six ASAM dimensions will present the SUD treatment provider with the necessary information to determine treatment, service planning, and level of care placement. Individuals who receive the indicated level of care according to the ASAM Patient Placement Criteria have significantly higher treatment completion rates and fewer returns to use than patients who receive a lower level of care than that indicated by ASAM, such as outpatient treatment when the ASAM criteria indicate a need for residential treatment *(43–48)*. Results are significantly better when the FTC assigns parents with SUDs to a level of care that is based on a standardized assessment of their treatment needs as opposed to relying on professional judgment or discretion *(49–52)*. Participants from racial and ethnic minority groups were more likely than nonminority participants to receive a lower level of care than is warranted by their assessment results *(53,54)*.

> *Early identification, screening, and assessment of services is particularly important for parents with SUDs to demonstrate the ability to safely care for and provide a permanent stable home for their children within Adoption and Safe Families Act (ASFA) time lines.*

A randomized controlled trial of families involved in the child welfare system because of parental SUDs found that matched services significantly increased the likelihood of reunification *(22)*. These findings have been replicated in FTCs *(21,55,56)*.

Parents with an SUD and child welfare system involvement are vulnerable to overtreatment. Dependency courts order parents with SUDs to participate in twice as many services as parents without SUDs, resulting in many unnecessary services *(57)*. Parents with co-occurring SUDs and mental health disorders are even more likely to receive unnecessary services while not receiving services that are needed. Younger parents are already at higher risk of FTC noncompletion, so the FTC is careful to avoid placing younger participants in residential SUD treatment they do not need *(58)*. If the operational team cannot articulate a sound rationale (i.e., recent findings from a validated assessment) for requiring a participant to receive a given service, the team reconsiders that service *(See Standards 5 and 6)*.

Requiring participants to receive unneeded services wastes time and resources and can worsen outcomes by placing excessive demands on participants and reducing the time available to engage in more productive or needed activities *(59)*. Referring participants to more services or more intensive services than they require is also associated with poorer outcomes. Individuals who receive a higher level of care (e.g., inpatient treatment) than indicated by the ASAM criteria have equivalent or worse outcomes than individuals receiving the indicated level of care, and the higher level of care is rarely cost-effective *(47)*. In several studies of adults with criminal justice system involvement, those with SUDs who received residential treatment when a lower level of care would have sufficed had significantly higher rates of treatment failure and criminal recidivism than those with similar needs assigned to outpatient treatment *(60–62)*. The negative impact of receiving an excessive level of care appears to be most pronounced on adults younger than 25 years, perhaps because they are more vulnerable to antisocial peer influences *(63–67)*.

Some FTCs provide the same level of care initially to all participants or routinely taper the level of care as participants move through the program phases. This approach is contrary to best

practice because the ASAM Patient Placement Criteria stipulate that initial and subsequent placements be based on individual multidimensional assessments *(68)*.

Key Considerations

The FTC screens and further assesses, or refers for assessment, participants at the time of FTC entry using validated tools to identify needs, such as those related to trauma, mental health disorders, housing, employment, income, education, domestic or intimate partner violence, parenting and family skills, and criminal justice involvement. Child welfare case plans respond to the identified concerns and match evidence-based service referrals to identified needs *(39)*. The FTC repeats these assessments at regular intervals and modifies case plans to reflect changes in level of need.

For pregnant women, the FTC provides SUD treatment that addresses their full range of needs (e.g., health and nutrition, HIV testing and early intervention, mental health screening, preparation for parenting, economic needs) and the potential long-term effects on their lives. Interventions likely to result in a short-term, temporary interruption in substance use are inadequate to ensure the health and well-being of the woman and her child *(69,70)*.

In working with child welfare families, the FTC may not know whether a family is military connected, either on active duty or veteran status. The identification of veterans and provision of culturally responsive services that address family needs enhances engagement and retention with this population *(71)*.

While it may never be too late to accept a family into the FTC, it may be unrealistic for the parent to benefit fully from the FTC services and supports if the child has been removed and only a few months remains before termination of parental rights is considered under ASFA. For this reason, FTC should never be the option of last resort.

C. Use of Valid and Reliable Screening and Assessment for Parents and Families

Rationale

Research on risk and safety in child welfare programs indicates that standardized assessment tools paired with sound professional judgment are significantly more reliable and valid than professional judgment alone in predicting successful reunification and matching clients to appropriate treatment and case management services in child welfare programs *(72,73)*. Professional judgment is most appropriately applied to selecting assessment instruments and linking assessment findings to case services.

A clinical assessment tool to evaluate the diagnostic symptoms of an SUD and any mental health disorders is used to determine the appropriate treatment intervention, level of care, and complementary services. Selecting an appropriate assessment tool to validly diagnose a substance use or mental health disorder is critical to ensure the FTC is serving the intended population. SUD screening tools are insufficient for establishing FTC eligibility because they do not accurately distinguish a severe SUD from a less severe SUD *(74,75)*.

The literature recommends several standardized risk and need decision-making tools that have been well validated in child welfare populations. The Structured Decision-Making Risk Assessment tool

estimates the likelihood of future harm to a child based on actuarial data *(72)*. A review of 85 family assessment instruments *(76)* identified six other comprehensive, validated tools that address multiple domains of risks and strengths: the North Carolina Family Assessment Scale *(77)*, Strengths and Stressors Tracking Device *(78)*, Family Assessment Form *(79)*, Family Assessment Checklist *(80)*, Ackerman-Schoendorf Scales for Parent Evaluation of Custody *(81)*, and Darlington Family Assessment System *(82)*. Previous research points to FTC-specific validity of at least one of these instruments. One study used the North Carolina Family Assessment Scale to show that family functioning improved as a result of FTC participation *(34,83)*.

> *Selecting an appropriate assessment tool to validly diagnose a substance use or mental health disorder is critical to ensure the FTC is serving the intended population.*

Several assessments of parent and family strengths and needs have been validated in populations with child welfare involvement. The Addiction Severity Index *(84)* is a publicly available biopsychosocial assessment tool validated in FTCs to determine the extent of SUD severity; it includes medical, employment, alcohol, drug, legal, family, and psychiatric domains *(34)*. The Global Appraisal of Individual Needs (GAIN) is another comprehensive, evidence-based biopsychosocial assessment instrument designed to help researchers and clinicians obtain information for diagnosis, placement, treatment planning, and outcome monitoring *(85)*. FTC studies have used GAIN, which measures participant service needs across the following domains: background and treatment arrangements, substance use, physical health, risk behaviors, mental health, environment, legal, and vocation *(86)*.

Key Considerations

The FTC uses risk assessment tools supported by empirical evidence showing that the tool predicts repeated maltreatment, future SUD treatment failure, lack of cooperation with FTC expectations, and the intensity of monitoring required to accomplish child welfare case plan goals equally well in all populations, including underserved groups represented in the local child welfare population. Assessment administrators are trained and proficient in administering the assessment tools and interpreting the results. Coordination and collaboration between partner agencies is critical to ensuring that participants are not being assessed multiple times with the same or similar assessments by different providers.

Adjustments to the level of care made by a treatment provider are based on each participant's response to treatment and not the FTC's programmatic phase structure *(See Standard 7)*. Participants do not receive punitive responses if they fail to respond to a level of care that is substantially below or above their assessed treatment needs.

D. Use of Valid, Reliable, and Developmentally Appropriate Screening and Assessment for Children

Rationale

The FTC promptly screens, or refers for screening, the children of participants for a wide array of developmental delays, and social, emotional, and behavioral problems using validated assessment tools appropriate for each child's chronological age *(34)*. Comparing a child's chronological age with his or her developmental age enables the operational team and children's service providers to identify deficits, delays, and service needs.

The children are assessed using multidimensional, validated, and age-appropriate tools administered by a trained clinician at each developmental milestone, regardless of the duration of the family's FTC involvement. The effects of exposure to parental SUD may manifest in various ways that can affect physical health, attachment, psychopathology, behavior, social and motor skills, and cognitive and learning ability *(87)*. Moreover, symptoms can present differently depending on a child's age. For example, an infant with prenatal exposure to substances may exhibit the typical physical health symptoms of neonatal abstinence syndrome, whereas older youth might present with oppositional behavioral issues and externalizing disorders.

Several multidimensional, developmentally appropriate, and evidence-based child assessment tools are available. Research conducted in FTCs has shown that the third edition of the Ages and Stages questionnaire is effective in identifying changes in the functioning of children ages 1 month to 5.5 years, and the Child Behavior Checklist is similarly effective for children and adolescents ages 6 to 18 years *(34,88,89)*.

Key Considerations

According to Part C of the Individuals with Disabilities Education Act, children younger than 3 years with prenatal exposure to substances or who have experienced maltreatment are eligible for early intervention services. Children of parents in the FTC who might be eligible for such services require prompt referrals for clinical assessment. Older children are also screened for their own substance use and mental health issues because these problems are particularly common in children of parents with an SUD. Parents of school-age children benefit from support and mentoring to advocate for their children's needs in school. Educational assessments determine if children are eligible to receive special education services through an Individualized Education Program.

E. Identification and Resolution of Barriers to Recovery and Reunification

Rationale

Families with parental SUDs face threats to successful reunification beyond their SUDs. Identifying their comprehensive needs apart from SUD treatment using validated assessment instruments and addressing these needs with appropriate services are critical to successful outcomes. Mothers with SUDs in treatment programs that provide high levels of education, employment, and family services are reunified with

their children significantly more quickly than mothers in programs that provide less access to these services *(23)*. In addition, posttreatment substance use rates are lower when participants receive educational, housing, and income support services in treatment *(90)*. FTC participants rated addressing the distinct needs of children, parents, and families as among the court's most important goals *(91)*.

Key Considerations

Professionals often misjudge the inability to access needed services as a barometer of participant motivation. Systematic monitoring of service delivery, paired with the careful monitoring of barriers, increases the operational team's awareness of the challenges FTC participants and their children and families face in accessing services. FTC team member can help parents, children, and families overcome these barriers.

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5. Timely, High-Quality, and Appropriate Substance Use Disorder Treatment

Substance use disorder (SUD) treatment is provided to meet the individual and unique substance-related clinical and supportive needs of persons with SUDs. For participants in family treatment court (FTC), it is important that the SUD treatment agency or clinician provide services in the context of the participants' family relationships, particularly the parent-child dyad, and understand the importance of and responsibility for ensuring child safety within the Adoption and Safe Families Act time line for child permanency. A treatment provider's continuum of services includes early identification, screening, and brief intervention; comprehensive standardized assessment; stabilization; appropriate, manualized, evidence-based treatment including medications if warranted; ongoing communication with the FTC team; and continuing care. The parent, child, and family treatment plan is based on individualized and assessed needs and strengths and is provided in a timely manner including concurrent treatment of mental health and physical health.

Provisions

A. Timely Access to Appropriate Treatment

The FTC has protocols and practices to ensure that participants have timely access to the appropriate level of care in a treatment program (e.g., residential, intensive outpatient, outpatient) to address their assessed SUD and affected areas of life functioning (e.g., social and family relationships, legal consequences). Participants receive an SUD assessment and begin treatment as soon as possible after becoming involved with the child welfare agency. The FTC tracks the time between the case opening and treatment entry to monitor timely access as a routine process measure.

B. Treatment Matches Assessed Needs

FTC participants receive treatment that appropriate for their current needs based on a valid and reliable clinical assessment instrument conducted by a qualified treatment provider. Adjustments in SUD treatment—including changes in level of care, therapeutic and clinical services, and recovery supports—are based on ongoing formal reassessments of participants' clinical needs.

C. Comprehensive Continuum of Care

Participants have access to a continuum of SUD treatment that may include medication management in each level of care: outpatient treatment, intensive outpatient treatment, partial hospitalization, residential or inpatient treatment, and medically managed intensive inpatient services (i.e., medical detoxification or medical stabilization onto psychiatric or other SUD medications). Each participant's level of care is determined by the initial assessment and ongoing reassessments to meet his or her unique needs. Each participant's treatment dosage and duration are sufficient to achieve and sustain recovery. Once acute SUD treatment services are no longer required, participants engage in continuing care to maintain stable health and recovery. This includes clinical and recovery management services to help participants prevent return to use, build and engage in social and recovery support networks, and access additional treatment and services as needed.

D. Integrated Treatment of Co-Occurring Substance Use and Mental Health Disorders

The FTC provides participants who have co-occurring substance use and mental health disorders with integrated treatment that addresses both disorders concurrently and in a coordinated manner.

E. Family-Centered Treatment

Participants receive comprehensive family-centered SUD treatment designed to engage individuals in the recovery process and to meet their needs as well as those of their children and family members. The treatment plan addresses the effects of the participants' SUD on each family member according to their level of need and builds upon their strengths to improve individual and family recovery and functioning. FTC participants have access to residential SUD treatment that allows their children to reside with them when it is in the best interests of the children.

F. Gender-Responsive Treatment

FTC treatment providers create a safe and supportive environment for participants of all genders. Treatment providers receive ongoing training and clinical supervision to ensure that treatment modalities, staffing, and environments meet the needs of all FTC participants (e.g., gender-specific groups, provision of child care, medical and nutritional interventions).

G. Treatment for Pregnant Women

The FTC has a protocol and practices for identifying the unique needs of pregnant participants and provides treatment and other services to meet these women's needs, including integrated prenatal, perinatal, and postnatal medical care as well as SUD interventions. The FTC evaluates pregnant women with opioid and other SUDs for medication-assisted treatment (MAT) and provides or coordinates delivery of this treatment when clinically indicated.

H. Culturally Responsive Treatment

The services and practices of FTC treatment providers are respectful of and responsive to the cultural and linguistic needs of FTC participants. Operations, services, and staff at the clinical, programmatic, and administrative levels demonstrate an understanding of participants' attitudes, backgrounds, religious beliefs, experiences, social relationships, values, and other factors that shape FTC participants' cultural orientations.

I. Evidence-Based Manualized Treatment

Participants receive appropriate evidence-based, manualized treatments that research shows can achieve the desired outcomes for participants' clinical needs and circumstances. Treatment agencies that partner with the FTC provide these treatments with fidelity to the model. Treatment providers are trained, certified (when applicable), and clinically supervised to ensure continuing fidelity to the model.

J. Medication-Assisted Treatment

FTC participants receive MAT for SUDs based on an objective determination by a qualified medical provider that MAT is medically indicated. The FTC does not exclude individuals who are prescribed or considering MAT from entering, remaining in, or completing the FTC program and does not prevent or prohibit the use of MAT by participants when this treatment is clinically indicated. FTCs do not mandate MAT as a prerequisite for program participation even if medications are recommended by a physician or other treatment provider.

K. Alcohol and Other Drug Testing Protocols

The FTC uses a standardized drug testing protocol to monitor participants' use of illicit and licit substances throughout their FTC participation. The FTC ensures that participants are tested randomly a minimum of two times per week (whether by the FTC or its partners), which is usually frequent enough to detect any substance use quickly and reliably. The FTC's drug testing protocol specifies the frequency, scheduling, randomization procedures, observation, duration, and breadth of testing. The protocol also outlines processes for confirmation, notification, and dissemination of test results.

L. Treatment Provider Qualifications

The FTC's treatment providers are licensed, certified, or accredited as determined by each state's standards. These providers are experienced in and knowledgeable about working with families involved with the child welfare system and the courts. Treatment providers are appropriately trained and supervised to ensure fidelity to evidence-based treatment models. Treatment providers receive continuing education and clinical supervision to ensure adoption of best practices in the treatment of SUD, mental health, and related disorders.

Rationale and Key Considerations

A. Timely Access to Appropriate Treatment

Rationale

Readily available treatment is one of the research-based principles of effective SUD treatment identified by the National Institute on Drug Abuse *(1)*. Moreover, timely access to comprehensive SUD treatment is one of five goals set by the U.S. Department of Health and Human Services in its report to Congress *(2)*. Families in the child welfare system affected by SUDs need high-quality SUD treatment that is provided promptly in conjunction with active engagement, retention, monitoring, and continuing care strategies to achieve successful long-term recovery.

Timely access to treatment—meaning that the participant waits only a brief time between SUD assessment and treatment engagement—is critical for treatment engagement and success *(3–5)*. Long wait times to enter SUD treatment are associated with pretreatment attrition and a reduced likelihood of completing subsequent treatment sessions *(6–9)*. Common language and a standardized measure that defines timely access to treatment in quantitative terms do not currently exist for the SUD treatment field in general or for families in the child welfare system or in FTCs specifically. The Healthcare Effectiveness Data and Information Set (HEDIS), for example, measures the percentage of individuals who initiate treatment within 14 days of an SUD diagnosis *(10)*.

A statewide longitudinal study found that the sooner mothers with child welfare involvement entered SUD treatment after their children's placement in out-of-home care, the more likely they were to reunify with those children *(11)*. Similarly, participants in an FTC that provided immediate, intensive SUD treatment had significantly more reunifications, their children had fewer placements in longer-term foster care, and their children spent less time in non-kinship foster care than families not in the FTC. These FTC participants, who also received regular judicial monitoring, team support, and comprehensive case management, entered treatment 35% sooner after their date of petition and were almost twice as likely to complete treatment *(12)*.

The more than 65 cross-system collaboratives funded in the first round of the federal Regional Partnership Grant Program and the Children Affected by Methamphetamine Program showed that timely access to SUD treatment was associated with positive outcomes for families affected by SUDs and involved with the child welfare and court systems *(13)*.

Key Considerations

FTC team members effectively collaborate, communicate, and share information across systems to ensure participants are assessed, referred, and successfully linked to SUD treatment in a timely manner. Research suggests that faster access to treatment is associated with an increased likelihood of treatment retention *(11)*. The longer an individual remains in treatment, the more likely she or he is to complete the treatment episode, and completion of a treatment episode is associated with a higher likelihood of successful reunification and child welfare case closure *(11)*. Given this research, the FTC establishes a goal for "timely" treatment initiation, tracks and review data associated with this goal, and makes adjustments to practice to continue to reduce time to treatment initiation. For instance, FTCs work toward ensuring that parents are referred to treatment within 24 to 72 hours of identification of need and begin treatment within 7 days.

> *FTC team members effectively collaborate, communicate, and share information across systems to ensure participants are assessed, referred, and successfully linked to SUD treatment in a timely manner.*

Strategies to improve timely access to treatment may include co-locating SUD treatment staff within child welfare or the courts to reduce time to assessment and immediately link FTC participants to treatment. Dedicated SUD treatment liaisons who actively participate in staffing and attend court sessions also increase access and reduce time to treatment engagement *(14)*. When a complete assessment of needs or the recommended treatment level of care is not immediately available (e.g., waiting for residential bed availability), the FTC works with its community partners to involve the parent and other caregivers in some other treatment-focused activities to maintain engagement.

A cross-site study of 13 agencies participating in the Network for the Improvement of Addiction Treatment (NIATx) process showed that improvements such as simplified intake procedures and assessment processes, expanded hours of operation, elimination of redundant paperwork, on-demand scheduling and next-day admissions, cross-training, and enhanced telephone responsiveness resulted in significant declines of 37% in days to treatment entry and 33% in days between assessment and first treatment *(15)*. One of the participating agencies reported that increasing staff availability to provide clients with immediate assessments, establishing a clinician pool to handle client overflow, and providing same-day admission to intensive outpatient treatment reduced the time from first contact to first treatment session from 4.1 to 1.3 days (68%), reduced client no-shows, and increased continuation in treatment and transfers across levels of care *(16)*.

B. Treatment Matching Assessed Needs

Rationale

Treatment outcomes are significantly better when individuals with SUDs receive care based on a standardized, objective assessment of their treatment needs *(17–19)* *(See Standard 4)*. The assessment will determine two different recommendations. The first, generated through the American Society of Addiction Medicine (ASAM) Patient Placement Criteria 2-R, indicates what level of care or how much structure and support an individual will likely need to attain stable recovery. The second is generated by the structured interview and assessment of clinical needs that indicates what kinds of treatment the individual requires, such as individual versus group, trauma treatment, MAT, or relapse prevention.

Individuals who receive the level of care indicated by the ASAM Patient Placement Criteria have significantly higher treatment completion rates and fewer returns to substance use than those who receive a level of care lower than clinically needed *(20–23)*. Providing individuals with a lower level of care than recommended can produce poorer outcomes, and overtreatment does not produce better outcomes than the recommended level of treatment *(22)*. Furthermore, ASAM identifies "adult special populations," which include parents and pregnant mothers, who should be considered for specially designed residential substance-related or co-occurring disorders treatment that they attend with their children *(24)*. Interviews with parents who were involved with the child welfare system and had an SUD emphasized the importance of timely access to treatment and related services customized to meet their particular individual and family needs *(25)*.

Individual and family therapeutic needs are reassessed throughout the participant's time in the FTC as treatment needs change or new needs emerge in the course of treatment *(1)*. The principle of continuous assessment applies particularly to a return to substance use, which often indicates a need for additional or otherwise modified treatment for an individual with an SUD *(26)*.

Key Considerations

The treatment provider and the FTC participant jointly determine the appropriate level of SUD treatment. Other members of the FTC operational team, particularly child welfare caseworkers, who have pertinent information about the family's strengths and needs, share that input with the treatment provider to help the provider make the most informed decision. Standardized assessment results drive the treatment provider's recommendations. The ASAM criteria for addictive, substance-related, and co-occurring conditions are the most widely used and comprehensive guidelines for treatment level of care placement *(27)*.

In addition to assessing for level and type of treatment, the FTC assesses the participant's current stage of change related to the key requirements of FTC participation. Formally identified as the Transtheoretical Model of Change (Stages of Change), it describes the process of change through a cycle of six stages, uniquely based upon the individual's experiences and decision-making process to change behavior. The Stages of Change proceed, although not always in a cyclical manner, from pre-contemplation, to contemplation, to preparation, to action, and then to maintenance *(28)*. Assessing for stage of change is important because if the FTC approaches the participant with a case plan requirement for which she or he is unprepared, the participant is likely to respond with resistance. The FTC uses techniques such as Motivational Interviewing to reduce this resistance and help the participant move through the process *(29)*. Individuals will likely express differing levels of commitment to change or ambivalence about the various aspects of their lives, including their relationships with their children and family members as well as with their recovery.

The treatment provider and other members of the FTC engage in a process of ongoing assessment of the participant's treatment and other needs and of his or her stage of change regarding particular aspects of the case plan. When FTC participants continue or return to use after treatment entry, the FTC treatment provider, in collaboration with other members of the FTC operational team, conducts a comprehensive assessment and makes therapeutic treatment adjustments to meet the participant's needs *(See Standard 7)*.

Ensuring that all FTC participants receive the appropriate treatment within the continuum of care has been and will likely continue to be a major challenge for FTCs in most jurisdictions, particularly rural communities. Increasingly, FTCs are relying on telemedicine, online peer support, and similar innovations to improve access to needed care *(30)*.

C. Comprehensive Continuum of Care

Rationale

The National Institute on Drug Abuse states that "research has shown unequivocally that positive outcomes are contingent on adequate treatment length" *(1)*. There is no predetermined adequate duration of treatment because individuals progress through SUD treatment at various rates depending on the type and severity of their clinical needs as well as their support system *(1)*. In general, the longer an individual is engaged in a continuum of care with SUD treatment professionals, the better the sustained recovery outcomes are for that person and his or her children and family *(1,31)*.

Treatment and recovery outcomes are significantly better in drug courts offering a continuum of care for SUDs that includes residential treatment and recovery housing in addition to outpatient treatment *(32–34)*. For participants in adult drug courts, the most positive effects of SUD treatment come from involvement in treatment for 6 to at least 12 but as long as 20 months;

treatment lasting less than 3 months generally does not positively affect recidivism rates or substance use *(35,36)*. Other population studies of women (including pregnant and parenting) and men found strong associations between length of stay in SUD treatment of 6 to 12 months or more and positive posttreatment outcomes, such as no substance use, improved social functioning, reduced arrest rates, and increased employment rates *(31,37–41)*.

Because SUDs are a chronic disease, individuals in recovery sometimes return to use. Nearly two-thirds (64%) of those admitted to SUD treatment in 2015 had been in treatment at least once before *(42)*. In one study of pregnant and parenting women in residential treatment, 84% reported prior treatment before their current episode *(37)*. An individual's vulnerability to return to use remains high for at least 3 to 6 months after treatment completion, and about 40% to 60% of individuals who complete treatment return to use after a year *(43,44)*. Therefore, after an FTC participant completes a course of intensive treatment, the FTC or the treatment provider continues to monitor the participant and ensure that he or she receives continuing care for at least 3 to 6 months, but preferably 12 months or longer *(1,45–47)*. A review of 20 controlled studies found that continuing care lasting a minimum of 12 months was more likely to produce positive outcomes *(48)*.

Continuing care approaches appear to be most effective if they include active outreach efforts to bring treatment to the individual and are delivered by trained counselors, nurses, or case managers *(46,47)*. A 4-year evaluation of quarterly recovery management checkups that included assessments, Motivational Interviewing, and linkages to treatment reentry for individuals with chronic SUDs found that ongoing monitoring and early reintervention were associated with reduced time to treatment readmission (if needed), receipt of more treatment, reductions in substance use and related problems, and increased abstinence *(49)*.

Key Considerations

Participants enter treatment at the appropriate level for their needs based on a standardized assessment *(See Standard 4)* and receive increased or decreased treatment intensity over time as needed *(45)*. Treatment in each level on the continuum of care has individualized, clinical components (e.g., behavioral therapies, medications, recovery supports) shown to be effective in reducing substance use and improving health and functioning *(50)*. The FTC includes treatment providers on the team capable of offering multiple levels of care to treat participants who need to change levels of care.

Many FTC jurisdictions face challenges in providing participants with the appropriate SUD continuum of care as well as sufficient dosage and duration. These challenges result from continued changes in the health care system, including the shift away from residential to nonresidential treatment *(51)*. Private insurance and Medicaid managed care often do not support payment of SUD treatment for the 6 up to 20 months commonly needed to address complex treatment needs. The FTC discusses and resolves how to continue care in the event a third-party payer discontinues treatment earlier than recommended. For example, the FTC can expand peer-led parent and alumni support groups or build in additional one-on-one time between a peer or recovery support specialist and a participant.

The FTC participant receives continuing care after the initial intensive SUD treatment once he or she has achieved stable recovery and most or all his or her treatment goals, and is ready for sustainable, recovery-focused self-care *(52)*. This care begins, as appropriate, before the participant is discharged from the FTC. The objectives, duration, format, and components of continuing care are individualized for a given FTC participant, take into

account available community resources, and are documented in a discharge plan *(45)*. Continuing care includes routine assessments and treatments customized to the individual's needs and preferences. The treatment provider systematically monitors the individual's clinical status and risk of return to use and adjusts the treatment intensity as needed *(53)*.

The main goal of continuing care is to sustain the recovery progress achieved in the initial phase of treatment and prevent a return to use and repeat involvement in the child welfare system and the courts. When developing the continuing care plan, the FTC seeks out and connects the participant, children, and family members to community-based and natural supports. These can and should include a recovery support community, ongoing healthy parenting supports, and a medical home. The recovery support community may be a traditional AA/NA group or other group such as Rational Recovery, or could include regular involvement in a faith community or moving meditation such as tai chi or yoga. Parenting and family supports may be found through the school system, faith community, or ongoing parent group that has grown out of parenting classes. The FTC connects all family members to a medical home, prior to discharge, that can provide continuing monitoring and support for the parent's and children's physical and mental health.

Although continuing care is essential for all FTC participants, it is particularly important for those with other long-term psychiatric, social, or medical challenges who might have more severe clinical needs and face more significant challenges in their long-term recovery.

D. Integrated Treatment of Co-Occurring Substance Use and Mental Health Disorders

Rationale

Up to 60% of people with SUDs have other mental health disorders, such as anxiety disorder, depression, or bipolar disorder *(1)*. SUDs and mental health disorders exacerbate each other, and the symptoms of one can hinder the treatment and recovery process of the other *(54)*. Untreated co-occurring mental health disorders can also interfere significantly with an individual's ability to participate successfully in drug court or SUD treatment *(54–58)*.

Family, genetic, and environmental factors (e.g., early exposure to trauma) can contribute to both SUDs and mental illness *(54)*. People with co-occurring SUDs and mental health disorders are best served by integrated treatment from the same clinicians in the same setting or by treatment from collaborating SUD and mental health programs *(1,59,60)*. Treating both illnesses simultaneously in an integrated manner is generally the best approach, including for FTC participants *(5,61–65)*.

Integrated treatment for individuals with co-occurring SUDs and mental health disorders is more effective than nonintegrated treatment and has positive effects on treatment retention, substance use, psychiatric symptoms, hospitalization rates, arrest rates, housing status, functional status, and quality of life *(59,62,66-72)*. In one study, drug court participants who received psychiatric medications for psychological or emotional problems, in addition to their SUD treatment, were seven times more likely to graduate than participants with psychiatric symptoms who did not receive psychiatric medications *(55)*.

> *Integrated treatment for individuals with co-occurring SUDs and mental health disorders is more effective than nonintegrated treatment and has positive effects on treatment retention, substance use, psychiatric symptoms, hospitalization rates, arrest rates, housing status, functional status, and quality of life.*

Key Considerations

Common mental health disorders include but are not limited to depression, anxiety, attention-deficit/hyperactivity disorder. Participants may also have major mental illnesses such as schizophrenia or bipolar disorder. These disorders can make daily activities difficult and impair a person's ability to work, interact with family, relate to others, and fulfill other major life functions. The medical providers and other community treatment providers on the FTC team connect participants to comprehensive, integrated substance use and mental health disorder treatment that includes appropriate prescribing and monitoring of psychiatric medications *(5,65,73)*. When fully integrated treatment delivered by the same treatment agency and team is not possible, the FTC team ensures regular collaboration and care coordination among the various care providers.

Clinicians working with FTC participants with co-occurring mental health disorders provide individualized treatment planning and pharmacotherapy tailored to each participant's needs. Psychotropic medications (e.g., antidepressants, antianxiety agents, mood stabilizers, stimulants, antipsychotics) can be important in treating many mental health disorders. The clinician and the FTC participant jointly plan treatment.

The FTC does not exclude people solely because they have a co-occurring mental health disorder, developmental disability, or cognitive disability (e.g. associated with fetal alcohol spectrum disorder or traumatic brain injury). Because functioning and symptom severity vary in individuals with co-occurring disorders, the FTC operational team determines the degree to which each individual's condition could affect her or his FTC participation. A psychiatric evaluation by a qualified clinician who can recommend whether to admit the individual based on the FTC's capabilities, activities, and requirements can usually make this determination. The FTC operational team determines those adaptations necessary to meet the needs of a participant based upon the levels of functioning participants need to meet the FTC's requirements for a positive outcome *(73)*. In addition, the FTC team identifies and addresses the personal (e.g., stigma, personal beliefs about treatment providers) and structural barriers (e.g., service availability, insurance coverage, provider training) that individuals with co-occurring disorders face *(74)*.

E. Family-Centered Treatment

Rationale

About three-quarters of women who enter SUD treatment are mothers of children younger than 18 years old *(75)*. Additionally, half to two-thirds of men seeking SUD treatment are the biological fathers of at least one child, and 20% to 30% live with or have custody of their child *(76,77)*. Some studies, however, have shown that fewer than one-quarter of parents with SUDs in the child welfare system complete SUD treatment *(78–81)*.

Lack of child care, the need to balance competing demands of parenting and working toward recovery, and difficulty managing the disparate requirements of SUD treatment and child welfare case plans are major barriers to parents seeking and completing SUD treatment *(79,82)*. Children often provide the motivation that parents with SUDs need to seek treatment. However, parents commonly identify their parenting responsibilities as one of the major reasons for not enrolling in residential SUD treatment because, in large part, they fear losing custody of their children, are concerned about the length of time treatment will separate them from their family, fear losing their housing, or are worried about the cost of child care while they are in treatment *(83–87)*.

A treatment plan includes considerations of the complex demands of parenting. Parental SUDs can

disrupt family attachment, relationships, rituals, roles, routines, communications, social life, and finances *(88–94)*. Parents with SUDs who are in the child welfare system say that comprehensive treatment programs are most effective when they offer families community-based services and supports *(See Standard 6)* to help them build protective factors that include social connections, concrete supports (e.g., housing, food, financial assistance), children's social and emotional competence, and knowledge of parenting and child development *(25)*.

Family-centered treatment programs that address the multiple needs of children, parents, and family members are a promising prevention and treatment approach that results in improved outcomes, including the following *(80,95–104)*:

- Increased treatment retention rates and reduced substance use rates;
- Decreased risk of child abuse;
- Increased rates of reunification and positive permanency outcomes;
- Reduced rates of infants with prenatal substance exposure;
- Improved psychosocial and family functioning for children, parents, and family members;
- Improved parent mental health, physical health, and employment;
- Reductions in depression and parental stress;
- Improved parenting attitudes;
- Enhanced parental bonding with children; and
- Improved child developmental and behavioral outcomes.

Residential treatment programs that allow children to accompany a parent in treatment are more successful in engaging and retaining these parents in treatment *(97)*. Postpartum women and parents with SUDs are more likely to enter residential treatment, remain in treatment, complete treatment, and remain substance free longer if their children can stay with them than parents who are separated from their children in residential treatment *(102,105–112)*. Residential treatment programs for mothers with their children have positive parent and child outcomes, such as enhanced parent-child bonding, improved interactive and reciprocal communication, and maternal sensitivity to the child's needs *(106,107,109,113–118)*. Moreover, inpatient stays for parents with their children also provide a venue for the FTC team to assess parenting skills and parent-child attachment and to provide intensive parenting interventions, developmentally appropriate services for children, and family therapy *(114,119)*.

Key Considerations

To become more family-centered, the FTC adopts a broad definition of family to include all individuals whom the child and parent define as "family." These may include blood relatives such as grandparents, parents, and siblings as well nonblood relatives such as "cousins," friends, and others who are considered family. While this is critical for all families, this broader, relational definition may be particularly important in the context of certain cultural groups and in light of family trauma histories *(120–122)*. Common principles for a family-centered treatment approach include the following *(83,123)*:

- Provide SUD treatment, clinical support services, and community support services for participants, children, and families;
- Address the effects of the parent's SUD on every member of the family identified by the parent;
- Be dynamic because families are dynamic;

- Build on family strengths to improve family management, family member well-being, and family functioning;
- Improve family relationships so that family members provide emotional and practical support to parents to support recovery and parenting;
- Coordinate across different systems to meet complex family needs;
- Be gender and culturally responsive;
- Utilize an array of professionals in an environment of mutual respect and shared training;
- Prioritize the safety of all family members (including and especially the children).

Treatment providers can integrate family-centered approaches into all treatment modalities, including outpatient, intensive outpatient, and residential care. Provider approaches to family-centered treatment, however, may differ along the following continuum from least to most comprehensive actions *(75,124)*:

- Ask about family members, discuss family dynamics, and offer some family groups that focus only on the parent's recovery and not that of the family;
- Support individuals in their parenting roles and recognize the importance of involving the family as part of treatment;
- Provide parents and their children with clinical treatment and support services, including parenting and family-strengthening programs;
- Address the needs of other immediate family members, such as spouses and partners, as well as parents and grandparents (particularly if they are participating in care for the children);
- Treat the family as a whole by engaging all family members involved with services and creating a coordinated and integrated family treatment plan for each family.

FTCs in some jurisdictions, particularly rural areas and those with limited resources, might encounter challenges in connecting their participants to family-centered, residential treatment programs because such programs are in short supply and are not available in all communities. For example, only 2.6% of treatment facilities surveyed in 2016 had residential beds for participants' children, and just 6.4% provided child care *(125)*. Even when children are accepted into residential treatment, these programs often impose age restrictions and limit the number of children a parent may bring to treatment *(83)*.

In the absence of family-centered treatment resources in their communities, the FTC operational team can use an approach that prioritizes family-centered assessment and case planning *(126)*. The Family First Prevention Services Act of 2018 gives states and tribes an opportunity to increase services for families by providing Title IV-E reimbursement for up to 12 months for a child placed with a parent in a licensed SUD residential family-based treatment facility.

F. Gender-Responsive Treatment

Rationale

A large body of research has established that gender affects both the development of SUDs and the treatment and recovery processes. For example, men and women have different reasons for initiating substance use, health and social effects of use, pathways to treatment, motivations for entering treatment, consequences if they do not enter treatment, and treatment and recovery needs *(1,56,127,128)*. Women who enter treatment for an SUD typically present with more severe medical, behavioral, psychological, and social problems than men entering treatment *(129)*. Studies have shown that LGBTQ populations have a higher risk for substance use and mental health disorders *(130)* often associated with higher rates of trauma exposure *(131)*.

Gender differences also extend to co-occurring mental health disorders. For example, men are twice as likely as women to develop SUDs over their lifetime, but women are 2 to 3 times more likely to have major depression and anxiety disorders (including posttraumatic stress disorder), and women tend to have greater rates of comorbidity with substance use *(75,83,132–135)*. Although depression often precedes alcohol use disorders in women, the order is reversed in men *(136)*. The many women entering SUD treatment with co-occurring mental health disorders and a history of trauma further highlight the need for gender-responsive clinical strategies and treatment *(1,83,137)*. Trans-men, trans-women, and gender-nonconforming individuals also require treatment interventions that specifically recognize and address their particular health needs, high rates of community stigma, victimization, and trauma exposure *(131,138,139)*.

Although most individuals with SUDs face barriers to engaging and staying in treatment, women are more likely than men to face certain barriers, including the following *(127,136,140)*:

- Stigma associated with substance use (particularly for pregnant women);
- Fear of reprisal from significant others and family members;
- Fear of not being able to care for or losing custody of their children;
- Lack of basic supports, such as child care and transportation;
- Lack of money or insurance to pay for treatment;
- Lack of culturally responsive services;
- Wait lists for treatment;
- Lack of gender-specific treatment and treatment for pregnant women;
- Competing requirements of the child welfare and other systems in which the parent is involved; and
- Pessimism about the need for and effectiveness of treatment.

A 2016 national survey found that 46% of treatment facilities provided treatment programs or groups specially tailored to women, and only 21% provided such services for pregnant women *(125)*.

Gender-responsive treatment that addresses the biological, social, and environmental differences between women and men as well as their needs, characteristics, and co-occurring disorders results in better outcomes. Women who receive gender-specific treatment interventions (e.g., therapeutic child care, prenatal care, parenting training, women-only programs, education on topics related to motherhood) have higher rates of treatment retention, better substance use and mental health outcomes, reductions in criminal behavior and incarceration, improved physical health and birth outcomes, higher rates of family reunification, and increased

employment *(32,56,97,107,112,136,141–148)*. This is despite the likelihood that these women tend to have more severe treatment needs than those who receive care in mixed-gender programs *(56,97,107,146)*.

Targeting father-specific issues as part of treatment may improve outcomes for fathers with SUDs. Several promising treatments that focus on fathering for men in SUD treatment have been developed and others are being evaluated *(149,150)*. Positive treatment outcomes for both women and men are associated with longer time in treatment. Treatment retention rates appear to vary by the unique characteristics (e.g., levels of psychological functioning or psychiatric symptoms, socioeconomic status, social support) of each gender *(56)*.

Key Considerations

Treatment providers need to be aware of and address the circumstances and particular strengths and needs of each gender (including transgender and gender-nonconforming populations) in regard to their substance use, its effects, and pathways to treatment to facilitate increased treatment engagement and retention. Ideally, gender-responsive clinical therapeutic approaches, practices, and curricula are provided to all FTC participants.

G. Treatment for Pregnant Women

Rationale

FTCs may serve pregnant women in three ways. A woman may become pregnant while in the FTC; she may be pregnant at the time that she is referred to the FTC; or, she may be referred to the FTC as part of her Plan of Safe Care *(See Standard 6, Provision J)* following delivery of an infant with neonatal abstinence syndrome.

Pregnancy is a critical time in the life of the woman and the fetus. Use of licit and illicit mood altering substances during pregnancy can be particularly stressful but it can also serve as a potential point of intervention *(151)*. When medical and other professionals approach the woman with a focus of seeking to help her maintain a healthy pregnancy and delivery, this period can serve to engage and stabilize her and her family in treatment *(152–154)*. The delivery of a healthy child is a strong motivator for many women, their partners, and other family members to make significant changes.

As the FTC and its community-based partners approach the woman and her family, it is important to recognize her particular vulnerabilities *(151,155)*. Pregnant women with SUDs are more likely than women with SUDs who are not pregnant to be young, have a low income, and have a history of trauma. They are also more likely to have co-occurring mental health disorders and hepatitis B and C *(155)*. This intersectionality of risk and needs places the woman, her fetus, and any other children at greater vulnerability *(156–158)*. One study of pregnant or parenting women who received residential SUD treatment indicated that 49% had serious mental health problems, 77% had experienced abuse, 50% had criminal justice involvement, and 60% had physical health problems *(113)*. Another study found that 45% of more than 700 pregnant women attending a perinatal SUD treatment program had been exposed to physical, sexual, or emotional abuse during the current pregnancy. Their reported rates of physical violence were two to five times higher than those for pregnant women in the general population *(159)*.

Alcohol and other substance use during pregnancy can increase the risk of miscarriage; premature birth; and delivery of infants with low birth weight, small size for gestational age, fetal alcohol syndrome, fetal alcohol spectrum disorders, or neonatal abstinence syndrome

(75,152). Prenatal substance use is also associated with other adverse health and developmental outcomes in infancy and increases the likelihood of being reported to child protective services *(88,154,160,161)*. Pregnant women with SUDs are more likely to receive delayed prenatal care, which can further increase the risk of poor maternal and infant outcomes *(162,163)*. Given the dangers associated with substance use during pregnancy and the complex needs of pregnant women with SUDs, early identification, timely access to treatment, comprehensive case management, and integrated care for these women by the FTC team are essential *(83,164)*.

FTCs partner with obstetricians, gynecologists, and birthing hospitals and are aware of how these institutions identify substance use, support pregnant and parenting mothers, and generate Plans of Safe Care. These partnerships empower the FTC to more fully assist pregnant participants and advocate for evidence-based practices in their communities. Participants in a Centers for Disease Control and Prevention expert meeting recommended universal substance use screening during pregnancy to identify the appropriate response based on the substance use pattern *(165)*. Participants suggested that the screening, brief intervention, referral, and treatment approach could reduce substance use in pregnancy and should be integrated into prenatal care *(163)*. Evidence-based brief SUD screening tools that have been validated in adults, including pregnant women, with court involvement include the Hudson Index of Alcohol and Drug Involvement, UNCOPE (Used, Neglected, Cut Down, Objected, Preoccupied, Emotional Discomfort), Drug Abuse Screening Test, and Michigan Alcoholism Screening Test *(166–169)*.

Interventions that help pregnant women stop or reduce their substance use as early in their pregnancy as possible can improve pregnancy, neonatal, and child outcomes *(75,170,171)*. Many women are reluctant to admit substance use when pregnant and to seek help for their substance use and mental health disorders because they fear criminal prosecution, child welfare involvement, and stigma *(151,172,173)*. Using early screening, responding with an empathic and problem-solving approach, and focusing on increasing the woman's own self-efficacy are all effective strategies to engage the woman, her partner, and her family in treatment interventions *(151,174–176)*.

Connecting pregnant and substance-using participants to timely and adequate prenatal care can help prevent or mitigate negative pregnancy outcomes *(153,174,177)*. The infants of mothers who received comprehensive and individualized SUD treatment along with prenatal care had significantly better outcomes (higher mean birth weight, fewer neonatal intensive care unit admissions, fewer positive toxicology screening results at birth, shorter hospitalizations, and a lower risk of low birth weight, very low birth weight, and prematurity) than infants whose mothers entered treatment after delivery *(178)*. In addition, when women received integrated SUD treatment that also provided services to their children, they were significantly more likely to attend more prenatal visits and to deliver at term than women in nonintegrated treatment programs *(115)*.

Integrated prenatal SUD treatment programs can promote positive outcomes if they have the following key elements *(164)*:

- Are family-centered and trauma informed;
- Offer integrated services including screening, assessment, treatment, and referral;
- Do not stigmatize the women;
- Address unmet social and primary physical needs (e.g. housing, nutrition);
- Are multidisciplinary; and
- Initiate policy change at the state level in addition to intervening at the family level.

Research has established the value of evidence-based SUD treatment, including medications, for pregnant

women with SUDs *(1)*. For pregnant women with an opioid use disorder, buprenorphine and methadone maintenance are the physician-recommended standard of care and are safe and effective for maintaining maternal abstinence and retention in prenatal care, produce positive birth outcomes, and can be safely used during breastfeeding *(162,179)*. Compared with methadone, buprenorphine has been associated with shorter treatment duration, less medication needed to treat neonatal abstinence syndrome (NAS) symptoms, and shorter hospitalizations for neonates *(180)*.

Return to substance use after stopping increases the woman's risk of death from overdose and exposes the fetus to additional stress and risk from unmonitored doses and other maternal factors related to active substance use *(181,182)*. Because of these risks and the fact that infants born with NAS can be treated effectively, the Substance Abuse and Mental Health Services Administration (SAMHSA) recommends MAT for most pregnant women with opioid use disorders rather than withdrawal or abstinence *(181)*.

For pregnant women with co-occurring mental health disorders, leaving such disorders untreated or stopping medications for these disorders can threaten the health of the woman and the fetus *(75,183,184)*. Withdrawal from pharmacotherapy during pregnancy should be avoided whenever possible, even if this withdrawal is medically supervised, because it is associated with a high rate of return to substance use, putting both the pregnant woman and the fetus at risk for adverse outcomes *(181)*.

Key Considerations

In addition to the treatment barriers that all women face, pregnant women face unique barriers that prevent them from seeking and participating in treatment, including challenges in receiving support and advocacy from their care providers, who frequently have biases against this population *(185)*. Sometimes, substance use during pregnancy can be prosecuted in some jurisdictions, which makes pregnant women with SUDs fearful of being arrested and intensifies the stigma they face when seeking treatment and their fear of losing custody of their children *(186,187)*.

The FTC operational team are mindful that pregnant women with SUDs have priority admission status for SUD services in programs funded by the federal Substance Abuse Prevention and Treatment Block Grant. If a provider cannot admit a pregnant woman who seeks or is referred for treatment and would benefit from treatment, within 48 hours the provider must offer interim services, such as crisis intervention, counseling on the potential effects of substance use on the fetus, referral to prenatal care, or HIV and tuberculosis screening and counseling *(75)*. It is imperative that the FTC treatment providers and child welfare partners develop policies or processes that facilitate high-priority treatment access for all pregnant participants.

For FTC participants who are pregnant and have co-occurring mental health disorders, treatment decisions are based on each woman's needs and circumstances. Treatment decisions are also based on the benefits of psychotropic medication use during pregnancy compared with the risks of these medications to the developing fetus *(188)*. Because risks vary by medication and the stage of pregnancy when the medication is taken, the FTC team ensures that pregnant women with co-occurring mental health disorders are connected to medical professionals who can closely monitor them throughout their pregnancy and after delivery *(183)*.

All women are at risk of postpartum depression (PPD). However, women recovering from SUDs are at higher risk for PPD and are carefully monitored by therapists and the FTC team, including through continued drug testing while in the FTC *(See Provision K, Alcohol and Other Drug Testing Protocols)* *(189)*.

H. Culturally Responsive Treatment

Rationale

Current demographic trends, such as the increasing proportion in the U.S. population of racial and ethnic minorities, nontraditional family structures, and households that speak a language other than English at home, requires the need for SUD treatment that is respectful of and responsive to diverse cultures, languages, health literacy levels, and other communication needs *(190–192)*. Diversity exists both between and within cultural groups *(193,194)* and, therefore, families with similar backgrounds can differ in numerous ways *(195,196)*.

According to the Diagnostic and Statistical Manual of Mental Disorders, fifth edition, cultural meanings, habits, and traditions can contribute to the stigma or recovery and support associated with an individual's experience. Culture can also be a supportive factor in recovery and influence an individual's acceptance or rejection of an SUD diagnosis and his or her adherence to the treatment plan *(197)*.

Studies show that among individuals with substance use and mental health disorders, members of racial, ethnic, and other minority groups (e.g., LGBTQ) are less likely than their white-majority, heteronormative counterparts to receive appropriate diagnoses, enter treatment, remain in and complete treatment, receive adequate care, and report satisfaction with treatment *(3,74,138,198–200)*.

Providing culturally and linguistically appropriate services is increasingly recognized as a key strategy for eliminating disparities in health and health care *(201–204)*. Culturally responsive services based on provider knowledge of the stressors, needs, and strengths of each participant group can improve participant-provider relationships, encourage participant engagement, and improve treatment retention *(195,205)*. SUD treatment programs with culturally competent practices and policies, such as those that match providers with clients based on their cultural and linguistic backgrounds, have shown higher retention rates for African American and Latino/a clients *(203,206,207)*. The cultural sensitivity of staff—especially managers and supervisors—and their personal involvement in the community has been associated with greater access to treatment, shorter wait times, and greater treatment retention for African American and Latino/a clients *(203,206,208)*. In addition, Spanish-language translations of treatment materials have been associated with a higher likelihood of treatment completion for Latinos/as *(209)*. Studies also show that the incorporation of traditional healing practices and culture-based interventions (e.g., sweat lodge ceremony) into SUD treatment can enhance the health and well-being of indigenous populations *(210,211)*.

Key Considerations

Culturally responsive service delivery is the process of providing effective services within the consumer's cultural context. Whenever possible, the FTC assigns staff to participants based on shared racial, ethnic, or cultural backgrounds *(206)*. To provide culturally responsive SUD treatment, the FTC treatment providers and other operational team members must recognize and overcome any implicit biases that might adversely affect their decisions about participant treatment *(212)*.

Effective culturally responsive treatment addresses differences among culturally diverse groups in risk factors, patterns, rates, and adverse effects of substance use as well as perspectives, expectations, and beliefs affecting treatment engagement and retention. The FTC operational team receives training on how to provide culturally

> *To provide culturally responsive SUD treatment, the FTC treatment providers and other operational team members must recognize and overcome any implicit biases that might adversely affect their decisions about participant treatment.*

responsive services *(See Standards 1 and 3)* to help reduce disparities and improve treatment quality and effectiveness. This cross-cultural training increases the team's understanding of how barriers to treatment differ among racial and ethnic groups *(198,213,214)*. Moreover, it is delivered by community leaders who work with the diverse populations receiving SUD treatment through the FTC *(206)*. The FTC operational team also refers to resources that address substance use and treatment patterns, beliefs and attitudes about treatment, prevalence of co-occurring mental health disorders, and treatment issues and considerations for major racial and ethnic groups in the United States, including African Americans; Asian Americans; Native Hawaiians and other Pacific Islanders; Hispanics and Latinos/as; Native Americans; and Whites such as SAMHSA's *Treatment Improvement Protocol (TIP) Series Number 59, Improving Cultural Competence (195)*.

Ideally, the culturally responsive treatments provided by the FTC were developed, tested, and validated in the populations that the FTC serves. However, many treatments have not yet been adequately studied in groups from different cultures. The FTC might therefore need to adapt treatment practices or supplement with a curriculum or other practices to better serve its target populations if their values, cultures, beliefs, and needs were not represented in the original research participants. Modifications to an intervention for these reasons can sometimes be made in consultation with the intervention's developers. The FTC also strives to obtain and incorporate the feedback of participants on revisions to make practices more culturally appropriate and relevant *(213)*. The FTC documents its modifications, their outcomes, and their effects on program fidelity to enhance knowledge about best practices for culturally responsive treatment. Moreover, the FTC and its treatment providers maintain and regularly review data that enable the team to identify and respond to any differences in program processes and treatment outcomes (e.g., timely access, retention, completion) among participants based on their racial and ethnic backgrounds.

I. Evidence-Based Manualized Treatment

Rationale

FTC treatment providers utilize "manualized" treatment; in order to ensure consistency in outcomes, developers of treatment protocols create a manual that directs clinicians' practice. The Institute of Medicine states that evidence-based practice is the integration of best research evidence with clinical expertise and the treatment consumer's values *(215)*. SUD treatment that has undergone a rigorous process to establish its effectiveness improves treatment outcomes, facilitates consistency in practice, establishes accountability of treatment providers, increases cost-effectiveness of treatment, and improves the overall quality of treatment *(216)*. A 2006 study by the Washington State Institute for Public Policy found that the average evidence-based SUD and mental health treatment can achieve roughly a 15% to 22% reduction in the incidence or severity of SUDs and mental health disorders and that such treatment can also achieve approximately $3.77 in benefits per dollar of treatment cost *(217)*.

> *Funding for SUD treatment demands that programs use evidence-based treatment to improve quality, access to care, allocation of resources, and client safety. Such evidence-based SUD treatment must be implemented with fidelity to the model.*

The SUD treatment field, as well as the larger health care system, has experienced a growing number of federal and statewide initiatives to require or prioritize evidence-based SUD treatment implementation

and delivery *(216,218–221)*. At the federal level, for example, states must report their use of evidence-based programs and strategies as part of the National Outcomes Measurement System within their Substance Abuse Prevention and Treatment Block Grant application. States participating in the Certified Community Behavioral Health Clinics demonstration program must incorporate a minimum set of evidence-based practices *(222)*. The Centers for Medicare and Medicaid Services reimburses for several evidence-based practices, including integrated SUD and mental health treatment. In addition, Title VII of the 21st Century Cures Act enacted in 2016 calls for SUD and mental health treatment to keep pace with science and promotes the importance of evidence-based treatment and practices.

Several states have passed laws to prioritize evidence-based programs, including requiring the use of such programs, providing incentives for their use, and dedicating funding to them, as well as requiring agencies to inventory existing programs and prohibiting funding of programs shown to be ineffective *(219)*. For example, Oregon's law, which served as a precedent for similar efforts in other states, currently requires that 75% of its publicly financed SUD and mental health treatment be evidence based *(220)*. A study of state strategies and policies to promote evidence-based SUD treatment found that nearly two-thirds (64%) of Single State Agencies for SUD treatment used evidence-based treatment as a criterion in their provider contracts, 55% had regulations or accreditation policies that supported the use of evidence-based treatment, and 51% tied state funding to the use of evidence-based treatment *(223)*. A follow-up study found that statewide implementation of evidence-based psychosocial interventions and MAT increased significantly over 3 years *(224)*.

The demand by providers, funders, purchasers, and regulators of SUD treatment that programs use evidence-based treatment to improve treatment quality, access to care, allocation of resources, and client safety will only increase *(221)*. Importantly, however, such evidence-based SUD treatment must be implemented with fidelity, meaning that an intervention is delivered as intended by the program developers and in line with the program model. Fidelity is critical to successful application of interventions proved effective in clinical trials to real-life settings and is associated with better treatment outcomes *(225-228)*.

Key Considerations

The ultimate effectiveness of the FTC is influenced heavily by the quality of the SUD treatment it provides. Several sets of criteria exist for designating an intervention as evidence based, but their standards of evidence quantity and quality vary. While there is currently no consensus in the addiction treatment field on precisely which standards to use to define and identify evidence-based SUD treatment, there is agreement that criteria are necessary *(216)*. Various federal agencies and research and professional groups have developed lists, databases, and standards of evidence-based treatment for SUDs. These resources include Agency for Healthcare Research and Quality's National Guideline Clearinghouse, American Psychological Association's Society of Clinical Psychology, California Evidence-Based Clearinghouse for Child Welfare, Early Intervention Foundation, Iowa Consortium for Substance Abuse Research and Evaluation, Oregon Health Systems Division's approved list of evidenced-based practices, SAMHSA's Co-Occurring Disorder Center for Excellence, SAMHSA's Evidence-Based Practices Resource Center, and the University of Washington Alcohol and Drug Abuse Institute *(216,221,229)*.

Although inclusion or evidentiary criteria may differ among these sources, some key criteria for high-quality, evidence-based manualized treatment include the following *(230,231)*:

- The intervention was studied in at least two randomized clinical trials or quasi-experimental studies and was found to be effective for the target population when implemented with fidelity. The research results were published in peer-reviewed journals.
- The intervention was studied in more than one setting and in samples with different types of patients, and the findings yielded consistent results.
- The intervention resulted in positive outcomes related to treatment goals and objectives for the individuals receiving the service.
- The intervention is standardized (there is a written manual or similar guidance document) and sufficiently operationalized for staff use so that it can be replicated.
- A fidelity measure for the intervention exists or could be developed from available information, allowing practitioners to verify that they are implementing the intervention in a way that is consistent with the evaluated protocol.
- The intervention is feasible and can be applied in the FTC's region.
- Training in the intervention's implementation is available.

The use of manualized treatment, although recommended as best practice, presents a variety of implementation challenges. While delivering treatment services, the clinician must also take into consideration the motivation, insight, and skills of the client enrolled in treatment. In many instances, the implementation of a manualized intervention in a group setting involves clients in various stages of change and stages of engagement in the recovery process. Clinicians are in the difficult position of ensuring material is relevant and individualized to meet the unique needs of each client in attendance. When possible, the clinician can be creative, allow for some flexibility, and determine how modifications can be made to the curricula to meet the needs of clients, while maintaining fidelity to the intervention. If available, the clinician should reach out to the developer to gain insight on adjustments to ensure the individualized delivery of treatment services of the intervention maintains fidelity to the research base of the model.

Many FTC teams—particularly those in large, urban jurisdictions—include multiple SUD treatment providers, which can make monitoring the provision of high-quality, evidence-based treatment with fidelity difficult. FTC team members (as appropriate) conduct regular site visits to treatment facilities serving FTC participants to observe and discuss the treatment provided and the fidelity monitoring processes used *(5,232)*. Such visits aim not to disrupt the effective delivery of treatment services. To protect patients' confidentiality rights, observation of patients not in the FTC can occur only with the patients' written consent. Because observers without treatment expertise may have limited ability to assess the quality of services delivered, these observers are permitted only to observe the setting in which treatment is delivered, review treatment manuals and patient records, and interview staff and patients.

J. Medication-Assisted Treatment

Rationale

Medication-assisted treatment (MAT), also increasingly known as medication for addiction treatment or medication in addition to treatment *(233)*, is an evidence-based, holistic approach that combines medications with counseling and behavioral therapies *(1)*. Methadone and buprenorphine have

been successfully prescribed for opioid use disorders for more than three decades *(1,234,235)*. More recently, extended-release naltrexone was added as a highly effective medication for the treatment of opioid use disorders *(236–238)*. Acamprosate, disulfiram (also known as antabuse), and naltrexone have been found effective in the treatment of alcohol use disorder *(239,240)*. While there are medications to treat marijuana, amphetamine, and cocaine use disorders under consideration at the time of this writing, the FDA has not approved any for those disorders *(50)*. As part of a comprehensive SUD treatment program, MAT can increase retention in treatment and reduce rates of substance use, return to use, overdose deaths, criminal activity and arrests, HIV transmission and risk behavior, and pregnancy-related complications *(241–244)*. The effectiveness and benefits of MAT for pregnant women with opioid use disorders is discussed in Provision G, Treatment for Pregnant Women.

Together with a range of clinical and supportive services, MAT can help parents achieve stability and focus on other aspects of their recovery, such as obtaining employment or housing or enhancing their parenting skills *(50,245–247)*. Moreover, a study showed that parents with opioid use disorders who were involved with child welfare and received MAT had a significantly higher chance of retaining custody of their children than those who did not receive MAT. With each additional month of MAT, parents were 10% more likely to retain custody, and a year of MAT increased the likelihood of retaining custody by 120% *(248)*.

Key Considerations

Only appropriately qualified health care professionals decide whether FTC participants need medication, how to provide the medication in the context of other clinical services, and the conditions in which each participant reduces or stops taking the medication *(50)*. For all FTC participants, but especially those who are pregnant or planning to become pregnant, careful discussion and informed consent are needed when selecting MAT *(235)*. Therefore, unlike other interventions (e.g., group therapy), MAT is not coerced or mandated even when recommended by a treatment provider or prescribed by a physician. All participants must be well informed and allowed to decide if they want medications to be a part of their addiction treatment. While MAT cannot be coerced, participants who choose to receive MAT can be required to comply with its protocol until and unless they appropriately notify their provider and the program of their intent to discontinue.

> *As the knowledge base in the field continues to expand, the FTC and its partners must ensure that all operational team members are educated about the role of MAT in treating the chronic health condition of substance use disorder. All providers on the team must also be familiar with their current legal, ethical, and programmatic responsibilities to provide MAT to FTC participants.*

Psychosocial supports, such as counseling and case management, are delivered in conjunction with medications *(27,181)*. To adhere to these guidelines, the medical and other treatment providers on the FTC team collaborate and communicate with one another to monitor participants' receipt of MAT. These providers review FTC participants' treatment progress and ensure that they receive comprehensive, coordinated treatment planning.

Availability of MAT for parents who have SUDs and child welfare system involvement has been limited *(249–251)*. A national study released in 2018 and conducted by the Assistant Secretary for Planning and Evaluation with the U.S. Department of Health and Human Services found that across the country when MAT was available, it was frequently delivered in ways that were not consistent with clinical practice guidelines *(249)*. For example, MAT was often delivered without counseling or recovery supports and some child welfare staff and judges

were hesitant to reunify children with parents who were stabilized on methadone or buprenorphine. Examining treatment admissions for pregnant women with opioid use disorders, another study found that about two-thirds of these women did not receive MAT, despite it being the standard of care for this population *(252)*. Inconsistent use and availability of MAT also exists in adult drug courts due to team members' and community partners' uncertainty about its benefits and a lack of familiarity and comfort with its use *(253)*.

Although access to SUD and mental health treatment, including access to MAT, has improved in some communities, lack of clinician knowledge about the various forms of MAT and MAT's high cost remain significant barriers to access *(251)*. The costs of long-term maintenance on medications such as buprenorphine and extended-release naltrexone remain a particular barrier for families served in the FTC *(74,251)*.

As the knowledge base in the field continues to expand, the FTC and its partners must ensure that all operational team members are educated about the role of MAT in treating the chronic health condition of substance use disorder *(248,254)*. All providers on the team must also be familiar with their current legal, ethical, and programmatic responsibilities to provide MAT to FTC participants. The FTC policy and procedure manual and the participant handbook address the use of MAT and other prescription medicines while participating in the FTC *(255,256)*. FTCs establish communication expectations with MAT providers and other clinicians who treat and prescribe medications for FTC participants. These communication protocols include the exchange of release of information forms and the establishment and monitoring of safe prescribing procedures. These procedures help ensure that medication is not being misused, underutilized, or diverted and include such activities as monitoring ingestion, providing limited quantities, counting pills, and monitoring active drug levels in urine or blood samples. Reputable treatment providers should seek to establish safe prescribing procedures and open communication with the FTC team.

K. Alcohol and Other Drug Testing Protocols

Rationale

Valid, reliable, random, and frequent drug testing is an important component of FTC interventions *(257)*. Drug testing serves as one diagnostic tool that can identify new use by the participant, prompting intervention with appropriate treatment adjustments, services, and supports *(258,259)*. Conversely, it helps to identify participants who are not using, thereby providing opportunities for positive reinforcement and giving the participant an objective measure of his or her successful abstinence. Drug testing also creates an opportunity for participants to be honest and to tell a member of the FTC team that she or he used alcohol or other drugs and that a drug test will be positive for that substance. When administered randomly, drug testing can also act as a deterrent to alcohol and other drug use. One evaluation of an FTC reported a 50% decrease in positive tests when the program increased its random, observed testing to twice weekly *(260)*. Twice weekly testing is usually frequent enough to detect any substance use quickly and reliably, since the metabolites of most drugs of abuse are detectable in urine for approximately 2 to 4 days *(257)*.

There is currently insufficient research within child welfare populations to make a clear recommendation for drug testing protocols outside those established within the adult drug court best practices. However, a practice-based consensus guide is available describing key considerations in child welfare settings *(261)*. The nature of SUDs as a chronic, relapsing disease suggests maintaining close monitoring to enhance and support abstinence until long-term recovery is attained. Each FTC needs to establish its protocol for drug testing type, frequency, collection

site and staff, payment source, and communication strategy based on local conditions and context. Research on best practices in adult drug courts identifies several critical factors to be addressed in drug court drug testing policy *(257,262)*. The following criteria help to ensure reliable drug testing results:

- Participants are tested for alcohol and other commonly used drugs of abuse.
- Participants are tested, on average, twice weekly.
- The FTC ensures a process to achieve random testing of all participants.
- Drug testing occurs throughout FTC participation.
- Urine collection is witnessed by staff trained to monitor for drug testing and who are the same gender as the participant.
- The FTC utilizes procedures to ensure valid specimens that are not adulterated or substituted.
- The FTC receives rapid results: negative results within 1 day, and confirmation of positive results within 2 days.
- The participant manual and FTC participation agreement clearly state policies and procedures for drug testing.
- Drug testing is conducted in a trauma-informed and respectful manner in clean facilities where the collection and testing will not be interrupted.

Drug testing is just one of many tools FTC teams use to assess a participant's engagement and progress in treatment and recovery *(258,263)*. The participant, the participant's family support system, and the FTC team members are also critical sources for understanding what the participant needs to successfully engage in treatment and achieve stable recovery. A single positive or negative drug test alone is insufficient to make any assessment of an individual's treatment needs.

Due in part to the rise in opioid use, states have developed protocols and guidelines providing direction to obstetrician-gynecologists and to birthing hospitals and other health care centers to identify pregnant women who may be using substances as well as infants who were prenatally substance exposed *(264)*. Drug testing is often a secondary screening method used in addition to interviews with the women and other sources as well as other clinical tests *(151,265)*.

Key Considerations

Drug tests alone are not sufficient to determine whether a parent has an SUD, is able to parent safely, is under the influence of a substance, or is in recovery. Importantly, drug testing also cannot substantiate allegations of child abuse or neglect *(262)*. Clinical and other professional expertise is needed to answer these questions. Random, frequent, observed, and valid drug testing can be accomplished in a variety of ways; it is not important which FTC team member or partner agency conducts the testing, only that the testing meets the criteria listed above. The FTC's treatment partners conduct alcohol and other drug testing as a standard part of their treatment protocol. Drug test results are incorporated into the FTC's review of participant progress whenever best practices for drug testing are followed.

"Drug tests alone are not sufficient to determine whether a parent has an SUD, is able to parent safely, is under the influence of a substance, or is in recovery. Importantly, drug testing also cannot substantiate allegations of child abuse or neglect. Clinical and other professional expertise is needed to answer these questions.

Drug testing specimen types all have particular strengths and weaknesses *(263)*. At the present time, urine is the specimen of choice for abstinence monitoring in FTC programs. Other specimen types such as sweat, hair, or oral fluids may also be used when indicated. Alternative testing for alcohol can be accomplished using

breathalyzer devices or transdermal monitoring. Alternative specimens are recommended when best practices for urine drug testing cannot be met (i.e., a same gender staff person is not available or bathroom facilities do not support respectful and safe testing). These alternative specimens may also be a reasonable accommodation for participants whose trauma histories make observed, urine drug testing contraindicated. Presumptively positive drug test results obtained from initial screening tests are confirmed by gas chromatography–mass spectrometry (GC/MS) or liquid chromatography–mass spectrometry (LC/MS-MS) when a participant denies use.

Drug testing continues throughout participation in the FTC. While it is expected that participants will develop a variety of skills to support healthy recovery during their time in the FTC, it is not uncommon for treatment court participants to experience a return to use in any portion of the program including late in their time in the program and during times of case plan transition. FTCs continue a random drug testing protocol to support therapeutic goals throughout the participant's time in the FTC; this may include other testing methods as indicated by individual needs.

FTC operational team members and community partners always treat participants respectfully and avoid using pejorative terms such as "dirty" to describe a participant who has tested positive for a prohibited substance use. Instead, the FTC uses the proper terms describing the drug test sample as "positive" or "negative" for a particular drug. Individuals with SUDs experience stigma in many forms, and FTC team members are cognizant of the messaging and language they use.

L. Treatment Provider Qualifications

Rationale

Training SUD treatment providers to implement evidence-based practices with fidelity is essential for delivering these treatments properly and optimizing participant outcomes *(216,218,266)*. Education and licensure of substance use and mental health treatment providers (e.g., certified addiction counselor, certified addiction professional, licensed substance abuse treatment practitioner) are important, since these are associated with more positive attitudes toward and a higher likelihood of implementing evidence-based practices *(267–271)*. A large-scale study also found that clinically certified professionals significantly outperformed noncertified staff members in administering standardized clinical SUD assessments *(272)*.

Government licensing and accreditation rules for SUD and mental health treatment providers can influence the breadth of treatment options offered to participants *(273)*. A national study of outpatient treatment facilities found that some sources of accreditation or licensing had positive associations with treatment comprehensiveness (e.g., percentages of participants receiving physical examinations, mental health care, and employment counseling; average number of individual therapy sessions) and the percentage of participants receiving written aftercare plans *(274)*.

Key Considerations

Licensure and accreditation often serve as proxy indicators of SUD treatment quality and delivery of evidence-based treatment with fidelity *(274)*. Given the range of and variations in licensing and accrediting treatment

programs, the FTC operational team does not rely solely on this information when referring FTC participants to a treatment provider. Moreover, an appropriately licensed provider may not have adequate knowledge and experience to treat FTC participants or their families effectively. Variations in types of providers, qualifications, and capabilities can affect the dissemination and implementation of evidence-based treatment practices *(275)*.

Caseloads must be small enough to let FTC clinicians adequately assess participant needs and deliver timely, appropriate, and effective substance use treatment and related services. Derived from expert consensus, the recommended staff-to-participant ratios for SUD treatment clinicians are no more than 50 to 1 if they deliver clinical case management, 40 to 1 for individual therapy or counseling, and 30 to 1 for delivering both services *(257)*. A staff-to-participant ratio ranging from 8 to 1 to 15 to 1 is recommended for intensive outpatient treatment groups *(276)*.

Each state regulates SUD treatment programs and treatment counselors through licensure and certification processes guided by state statutes and regulations. State licensing requirements for SUD treatment facilities vary by state and type of program. In most states, the Single State Agency (SSA) in charge of SUD treatment and prevention regulates SUD treatment programs *(277)*. Multidisciplinary team members are familiar with the state and national requirements for agencies and SUD treatment providers.

In addition to licensing, some SUD treatment facilities and programs are accredited by national accreditation organizations, such as the Commission on Accreditation of Rehabilitation Facilities and the Joint Commission (previously known as JCAHO). State quality assurance requirements for SUD treatment facilities and programs are diverse and typically focus on processes rather than outcomes *(278)*.

Currently, no well-defined, consistent, and regulated national standards stipulate who can provide SUD treatment in the United States. Government agencies or nongovernmental organizations affiliated with national credentialing bodies have primary responsibility for certifying and regulating individual counselors in most states *(277)*. The level of education among SUD treatment counselors varies greatly. Recent data showed that while 57% of counseling staff had a graduate degree, the majority (60%) of those individuals were not certified in addiction treatment *(279)*. Differing degrees of training and competence of individual SUD treatment clinicians add further challenges to the provision of evidence-based treatment, particularly because evidence-based manualized treatments are typically delivered and validated in the research context by highly trained and educated clinicians *(216)*.

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6. Comprehensive Case Management, Services, and Supports for Families

Family treatment court (FTC) ensures that children, parents, and family members receive comprehensive services that meet their assessed needs and promotes sustained family safety, permanency, recovery, and well-being. In addition to high-quality substance use and co-occurring mental health disorder treatment, the FTC's family-centered service array includes other clinical treatment and related clinical and community support services. These services are trauma responsive, include family members as active participants, and are grounded in cross-systems collaboration and evidence-based or evidence-informed practices implemented with fidelity.

Provisions

A. Intensive Case Management and Coordinated Case Planning

The FTC operational team provides participants with intensive supportive case management, including coordinating the services that children, parents, and family members receive across service systems. It uses the results of reliable and valid needs assessments to develop a coordinated case plan (or a set of case plans) and systematically monitors the plan to ensure that children, parents, and family members are linked to and receive services to meet their needs.

B. Family Involvement in Case Planning

Children, parents, and family members (as appropriate) are active partners in identifying their needs and strengths, and making decisions about their family's treatment and case plan, setting goals, and achieving desired outcomes. The FTC operational team's approach to family involvement is family-centered, culturally responsive, and strengths-based.

C. Recovery Supports

The FTC connects participants with recovery supports that promote treatment engagement and retention, and sustained recovery. It links the participants with professionally trained and, in some cases, certified recovery specialists (also known as recovery coaches), or with peer support specialists (also known as peer mentors). These professionals have knowledge based on their lived experience of substance use disorders (SUDs) and recovery plus formal training to assist others with their recovery. Specialists begin providing recovery support prior to or soon after the participant enters the FTC, and they continue delivering these services throughout the child welfare case process and after FTC discharge. The FTC team also actively works with participants to build a community-based recovery support network to help the participants maintain long-term recovery. FTCs include community-based support groups in the array of services and supports they offer to meet participants' individual needs. FTCs do not require participants to attend any specific peer support group but rather provide a range of options.

D. High-Quality Parenting Time (Visitation)

FTC participants and their children engage in high-quality, well-resourced, face-to-face parenting time (visitation) when the child is in out-of-home placement. These sessions have a therapeutic focus and are frequent enough to establish, maintain, and strengthen the parent-

child relationship while protecting the child's safety, addressing the child's developmental and physical needs, and working to achieve sustained permanency. When needed, trained individuals facilitate supervised parenting time as parents work to achieve unsupervised parenting time. The FTC does not use parenting time as an incentive or sanction for participant behavior.

E. Parenting and Family-Strengthening Programs

Participants receive evidenced-based, culturally appropriate parenting or family-strengthening programs designed for families affected by parental SUDs and co-occurring additional risk factors. The FTC team matches interventions to the needs of each child and the parent, and to the relationships within the family. All interventions include a parent-child interaction component (in which parents and children attend sessions together). Providers of these services deliver the programs with fidelity to ensure that intended outcomes are most likely to be achieved.

F. Reunification and Related Supports

When a child has been placed in out-of-home care, participants and their family members receive reunification services and related supports to promote sustained engagement in complementary services, connect with community resources, help build healthy support networks, and support sustained family stability and safety in preparation for reunification and for post-reunification.

G. Trauma-Specific Services for Children and Parents

Participants and their children receive evidence-based or evidence-informed, trauma-specific, clinical interventions to treat their trauma-related symptoms and disorders identified by trauma screening and assessment and to facilitate recovery, healing, and resilience. Trained professionals provide needed trauma-specific medical, physiological, psychological, and psychosocial therapies with fidelity to ensure that intended outcomes are most likely to be achieved.

H. Services to Meet Children's Individual Needs

Children of participants are connected to a continuum of high-quality prevention, intervention, and treatment services to meet their physical, cognitive, social, emotional, behavioral, developmental, therapeutic, and educational needs identified by a comprehensive assessment, ideally through a medical home (i.e., a comprehensive team-based approach for primary health care and nonmedical service delivery) for the family. Services and supports for children and adolescents are age and developmentally appropriate. The FTC operational

team matches the services to the child's identified needs and monitors providers so that services are delivered with fidelity. Parents are encouraged and supported to participate in the services for the child, even when the child is in out-of-home placement.

I. Complementary Services to Support Parents and Family Members

Participants and their families receive the comprehensive range of complementary support services they need to promote engagement and retention in SUD treatment and for sustained recovery and permanency. These ancillary and critical services (e.g., child care, employment, educational, domestic violence, legal, transportation, food, clothing, housing, medical and dental care) are chosen to meet the individual needs of participants and their family members identified by formal assessment. A parent's involvement with these services is not used as a barrier to reunification. Close attention is paid to ensure that services are culturally and linguistically responsive.

J. Early Intervention Services for Infants and Children Affected by Prenatal Substance Exposure

Infants and children under the age of 3 who are prenatally substance exposed are connected to early screening and assessment through federal and state entitlements under Part C of the Individuals with Disabilities Education Act. The early screening and assessment determine the need for intervention services that address the infant or child's developmental, physical, social and emotional, physical health, and safety needs. Available services after assessment may vary from state to state.

K. Substance Use Prevention and Intervention for Children and Adolescents

Children of participants have access to evidence-based SUD prevention and early intervention services that are culturally, developmentally, and age appropriate, and are designed to enhance protective factors and reduce risk factors. The FTC operational team ensures that these services are delivered with fidelity to increase the likelihood that the intended outcomes are achieved.

Rationale and Key Considerations

A. Intensive Case Management and Coordinated Case Planning

Rationale

FTC children, parents, and family members have multiple, complex needs and are involved with numerous services, providers, and agencies. Typical FTC case plans include a myriad of services and supports—for example, SUD treatment; child welfare services; mental health and trauma services; parenting training or education; medical, dental, and vision-related services; employment, educational, and vocational services; and other community supports such as housing and domestic violence services. Managing and coordinating the multiple requirements and many appointments can be challenging for parents, making case management support crucial. One study found that, on average, parents with SUDs in the child welfare system had approximately nine weekly service event requirements in their reunification case plans compared with approximately five for parents without SUDs in the child welfare system *(1)*. Often, services are fragmented and uncoordinated, requiring participants to engage with many agencies and individuals to fulfill their court, child welfare, and SUD treatment case plan requirements, a responsibility that can be overwhelming and burdensome *(2)*.

FTC participants need intensive and clinically based case management to meet their extensive service needs and to access and coordinate service delivery across systems *(3)*. Intensive case management differs from traditional models of case management in its small caseloads and high frequency and intensity of contact between participants and case managers.

Meta-analyses and systematic reviews of randomized controlled trials have found that intensive case management improves outcomes compared with treatment as usual for individuals with SUDs. Intensive case management improves linkages with SUD treatment, health care, dental care, and other related ancillary services; increases retention in SUD treatment and ancillary services; reduces substance use; increases treatment satisfaction; and improves overall functioning in areas such as employment, housing stability, legal issues, and family problems (e.g., conflicts with family members) *(3–5)*. In adult drug courts, participants who met with a clinical case manager more than once a week engaged in fewer criminal acts and less substance use than participants who had one or fewer contacts per week with a case manager *(6)*.

> *FTC participants need intensive and clinically based case management to meet their extensive service needs and to access and coordinate service delivery across systems.*

Several studies document the effectiveness of intensive case management for families in the child welfare system and affected by SUDs. One residential co-occurring substance use and mental health treatment program for women and their children involved with the child welfare system found that enhancing its existing program with integrated case management (as well as an evidence-based parenting program) resulted in reduced mental health symptoms, reduced substance use, and longer treatment retention. Nearly all women who participated in the enhanced program reunified with their children, in part because the integrated case conferences enabled dependency court and child welfare staff to learn about the woman's progress in recovery and family support that would continue after discharge *(7)*. Another study of families involved

in the child welfare system with parental SUDs found that families receiving intensive case management provided by a recovery coach used SUD treatment at a significantly higher rate and were more likely to achieve stable family reunification than families who did not receive such services *(8,9)*.

Research also points to the effectiveness of case management in improving outcomes for other vulnerable populations of women with children. For example, the Parent-Child Assistance Program, an intensive case management model for high-risk pregnant and parenting mothers with SUDs and their children, uses a multidisciplinary team-based approach to provide comprehensive, coordinated services. This model has demonstrated positive outcomes, including increased abstinence, stable and permanent housing, decreased subsequent pregnancies and incarcerations, and greater treatment and mental health services needs met *(10)*. Among parenting women with SUDs who received welfare assistance, long-term intensive case management was associated with significantly higher rates of SUD treatment initiation, engagement, and retention and increased abstinence and employment rates compared with the standard practice of screen and refer *(11–13)*. Furthermore, a nine-state case study found that case management and care coordination were critical to providing high-quality, cost-effective, and age- and developmentally appropriate therapeutic services for children whose parents were in SUD treatment *(14)*.

Data from the National Survey of Child and Adolescent Well-Being indicated that higher levels of interagency service coordination and communication between child welfare agencies and mental health service providers were significantly associated with greater use of mental health services and improved mental health outcomes in children and adolescents *(15)*. In addition, research indicates that wraparound care (also referred to as family-centered intensive case management) produces positive behavioral, functioning, and related outcomes for children and youth *(16–18)*.

Key Considerations

Case Management Models and Functions

Case management is a coordinated approach to the delivery of supports and services to meet the needs of children, parents, and family members. These services and supports include SUD treatment as well as physical and dental health, mental health, social, and other services that participants need to meet their specific challenges and achieve their stated case plan goals. Case management models for adults vary, but four common approaches include brokerage or generalist, strengths-based, wraparound or Assertive Community Treatment, and clinical or rehabilitation *(19,20)*. These four models, which are not mutually exclusive and may complement one another, are briefly described below.

- ***Brokerage/generalist***. This least intensive model of case management involves assessing participants and referring or linking them to indicated services. A brokerage or generalist approach can be thought of as traditional case management in contrast to intensive case management, since it is provided on an ad hoc, as-needed basis, and interaction between the case manager and individual is limited. This approach is not recommended for FTC participants because of their high levels of needs.
- ***Strengths-based***. A strengths-based philosophy can be applied to any case management model. This approach leverages participants' natural resources (e.g., informal rather than institutional support networks) and provides assertive outreach to encourage individuals to actively set their treatment goals and select treatment options.
- ***Wraparound/Assertive Community Treatment (ACT)***. This multidisciplinary, team-based, collaborative planning model is the most intensive form of case management and is designed for individuals, such as

FTC participants, who need services from multiple service providers and systems. The model was developed to meet the needs of children and adults with severe mental health needs but has been adapted for use with high-needs individuals with substance use and mental health disorders. Participants have around-the-\ clock access to a highly integrated team of professionals who work together to deliver a wide range of services. Caseloads are small, approximately 8 to 10 individuals per staff member.

- ***Clinical/rehabilitation***. The case manager provides the clinical and therapeutic treatment along with case management functions in an integrated fashion. This may be a particularly appropriate or useful approach in FTCs where participants are in intensive SUD treatment or where SUD treatment providers are skilled in case management and able to assume this responsibility *(19)*.

Each FTC team must decide which model(s) (or adaptation of a model) best meet the needs of its target population, program, and community *(19)*. The availability of community-based services and supports, the local environment in which the FTC operates, the organizational structure of the court or FTC partner agencies, and other systems-related issues or barriers may affect the overall success of case management and which model is best in a given situation *(3,5,20)*.

All case management models for adults with SUDs encompass the core functions described below *(20)*. This guidance for case management of participants can be extrapolated to participants' children and family members.

- ***Assessing*** the participant's needs, wants, priorities, strengths, challenges, and resources;

- ***Planning*** for how the participant's needs can be met (i.e., a plan of action that outlines the participant's goals, strategies to achieve each goal, who is responsible for carrying out each strategy, and a time frame for completing each goal);

- ***Linking*** to increase the participant's access to and receipt of comprehensive treatment and support services to meet his or her identified needs and goals;

- ***Monitoring*** the participant's involvement and progress with services and resources; coordinating services through regular communication and information sharing with the team; and reassessing and adjusting the case plan and services as needed; and

- ***Advocating*** on behalf of the participant to make sure he or she obtains needed services and resources (i.e., educating, communicating, and negotiating with service providers to remove barriers to treatment and services and to ensure that treatment and services are appropriate for the individual).

A single individual or a team of individuals may carry out these case management core functions. Typically, case managers have a professional background in SUD treatment, mental health care, or social work. In some FTCs, recovery coaches or public health nurses serve as case managers or care coordinators *(8,9,21)*. Regardless of their profession, these "boundary spanners" are skilled at facilitating interactions among agencies *(20)*.

In most FTCs, multiple team members may perform certain case management functions, and the team may include a family navigator who assists in facilitating case management for children, parents, and family members. Ideally, the FTC designates a primary case manager responsible for the overall service coordination and case

management process. This designated person ensures open communication and information sharing among team members so the recipient's full range of services throughout the continuum of care are met *(19)*.

In short, effective case management is the glue that binds together the components of the comprehensive FTC program, standardizes the FTC process, and explicitly documents the participant's progress throughout his or her participation in the FTC program and involvement in the child welfare system *(19)*.

The Coordinated Case Plan

An essential and distinct aspect of case management is the development of a coordinated case plan in which the sequence and timing of services are realistic and achievable, and effectively balance a participant's immediate needs with his or her long-term goals. In some cases, having one plan is not possible and therefore coordination of multiple plans is the goal. The coordinated case plan (or plans) is individualized, family driven, culturally competent, and community and strengths-based. It is also family-focused, meaning it addresses family functioning, with special attention paid to coordinating children's and adolescent services with those of the parents.

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The FTC operational team develops the coordinated case plan in conjunction with the participant, his or her support system, and the children (if developmentally appropriate), and all members of the team update it. This ensures that the participant has an investment in and understands the plan. Development of a single, coordinated case plan reveals potential areas of multiple and potentially conflicting requirements from different systems; resolving such conflicts keeps the participant from becoming overwhelmed. Clear communication, cross-systems information and data sharing, and shared decision making are all critical aspects of the care coordination process.

B. Family Involvement in Case Planning

Rationale

Engaging parents and their families throughout treatment and case planning enhances the FTC operational team's capacity to support families and improve parent, child, and family outcomes. In some instances, this may include family members who are providing kinship placement. Parental and family engagement is central to successful child welfare practice *(22,23)*.

Frequent contacts between caseworkers, along with group decision-making processes for parents and families, are effective ways to improve child welfare outcomes, such as higher rates of reunification and lower rates of reentry into foster care *(24–29)*. These interactions also increase placement stability *(30,31)* and lead to more timely permanency decisions *(30,32)*. Family involvement and family group decision-making processes also increase family engagement in case plans. This engagement can enhance the family's commitment to achieving case objectives as well as relationships between the family and service providers and the fit between the family's needs and services. The engagement also increases compliance with treatment and service requirements *(28,33)*. It is important for someone from the parent's legal representation team (i.e., attorney) to be engaged in case planning to provide additional support.

Key Considerations

Family can be broadly defined by participants and their children often to include individuals who are not blood related but with whom there is a supportive relationship. There are also opportunities for parents to rebuild severed relationships with family members who had distanced themselves *(34)*. Effective family engagement by the FTC operational team, particularly child welfare caseworkers, requires establishing open and honest communication with parents and families, requesting family participation and feedback, and providing instruction and reinforcement for families to successfully complete mutually agreed-on case plan activities *(28)*.

The FTC can use the following measurable quality standards to help assess its family involvement efforts *(35)*. These standards call on programs to do the following:

- Encourage families to participate in program planning, development, and implementation so that activities and services respond to the needs and interests of the families;
- Be accessible and welcoming to families;
- Conduct outreach to families and sustain constructive relationships with them; and
- Model family-centered approach with staff members and in administrative practices by taking the needs of staff and their families into consideration.

Effective case management relies on comprehensive service matching for all family members. An important example is how the needs of military-connected families are addressed in the FTC. What affects one member of a military-connected family likely affects them all. The initial tasks involve being knowledgeable about the needs of and services available to these families and connecting them with the appropriate services. The needs of these families are significant. Child maltreatment rates have doubled among military families since the beginning of the conflicts in Iraq and Afghanistan, rising from a rate below that of civilians in peacetime to a rate 22% higher than civilians in wartime. This may be due in part to multiple deployments; a 2014 study found that 36% of service members had been deployed more than once, a figure that has likely risen in subsequent years. Increases in domestic violence and child maltreatment rates were also related to the rates of trauma and other mental health problems among active duty service members; these rates increased with each successive deployment *(36)*.

C. Recovery Supports

Rationale

For families involved in the child welfare system, SUD treatment retention and completion are strongly correlated with reunification *(37,38)*. Completion of 90 or more days in SUD treatment approximately doubles the likelihood of reunification *(39)*. Parents who do not make progress in SUD treatment and parenting training are more likely to have their parental rights terminated *(40)*. However, one study indicated that approximately 60% of parents in child abuse and neglect cases did not comply adequately with SUD treatment attendance conditions *(41)*. Other studies found that approximately three-quarters or more of parents did not complete treatment *(39,42–44)*. Thus, services to support early treatment engagement, retention, and completion are a critical complement to clinical SUD treatment.

> *For families involved in the child welfare system, SUD treatment retention and completion are strongly correlated with reunification. Completion of 90 or more days in SUD treatment approximately doubles the likelihood of reunification.*

Recovery Specialists and Peer Support Specialists

A proven engagement and retention strategy is the use of trained and sometimes certified recovery specialists (sometimes referred to as recovery coaches or substance abuse specialists) or trained peer support specialists (sometimes referred to as peer mentors). The Centers for Medicare and Medicaid Services designated qualified peer support providers as an evidence-based model of care and a Medicaid-billable service under specific conditions *(45)*. Recovery and peer support specialists work with parents, child welfare caseworkers, treatment agencies, and other members of the FTC team to remove barriers to SUD treatment, engage parents in treatment, and provide ongoing support to parents and families during their involvement in the FTC and child welfare system.

The positive outcomes associated with recovery and peer support specialists for individuals with SUDs include reductions in the rates of substance use, return to use, criminal justice involvement, emergency service use, and rehospitalization. In addition, individuals with SUDs who receive recovery and peer support often experience improvements in treatment retention, relationships with treatment providers, housing stability, access to social supports, and satisfaction with treatment *(46)*.

Recovery and peer support specialists also affect positive outcomes for parents with SUDs. In two regions of Illinois, a recovery coach program for parents with SUDs and child welfare system involvement produced the highest reunification rates when it engaged families within 1 month of the temporary custody hearing *(47)*. More broadly, studies of parents enrolled in an FTC or other drug court involved with the child welfare system, and who worked with a certified or trained recovery or peer support specialist found the following results *(47–56)*:

- More timely or rapid treatment entry and greater engagement in treatment;
- Longer stays in treatment and higher treatment completion rates;
- Reduced substance use and higher recovery rates;
- Reduced child maltreatment recurrence rates;
- Increased reunification and foster care case closure rates;
- Fewer days for children in out-of-home care and fewer foster care reentries;
- Reduced risk of youth delinquency after reunification;
- Fewer subsequent births of infants with prenatal substance exposure;
- Elimination of racial disparities in reunification;
- Cost savings for child welfare agencies; and
- Increased employment and decreased arrests and incarcerations.

Peer and Mutual Self-Help Groups

Peer and mutual self-help groups are another effective recovery support for individuals with SUDs and a key component of a participant's community-based recovery support network and continuing care. These groups augment but do not replace either peer or recovery support specialist connections or formal, clinical SUD treatment. These self-help groups, in which people in recovery (or seeking recovery) come together to share knowledge, experiences, hope, and coping and recovery maintenance strategies, have been found to produce positive outcomes that can include the following *(57–61)*:

- Increased treatment engagement and retention;
- Improved relationships with treatment providers and social supports;
- Increased satisfaction with treatment;
- Higher rates of abstinence and reduced rates of return to substance use;
- Improved psychosocial functioning; and
- Greater levels of self-efficacy.

FTCs provide linkage to a range of peer and mutual self-help groups rather than requiring participation in any specific group. Federal courts have ruled that 12-step programs including Alcoholics Anonymous and Narcotics Anonymous are deity based and therefore mandatory attendance requirements by courts violate the First Amendment *(62–66)*.

Key Considerations

While recovery specialists and peer support specialists share common goals and may have overlapping roles and responsibilities, there are some important distinctions between the two. Recovery specialists are professionals with formal training or and sometimes certifications related to SUD treatment and recovery. They may provide SUD consultation, assessment, drug testing, and case management services to participants, and they often act as formal liaisons to increase communication and coordination among court, child welfare, SUD treatment and other systems *(67)*. Recovery specialists may, but are not required to, have their own life experience with recovery. A defining attribute of peer support specialists, however, is their lived experience with recovery and often with the child welfare system as well. Peer support specialists are also trained but not necessarily certified. Because not all organizations define and distinguish recovery specialists and peer support specialists in this way, the FTC clarifies roles and qualifications with providers who utilize either kind of specialist and ensure their training includes components specific to working with families in child welfare.

> *In working to increase participant engagement and retention, recovery and peer support specialists ensure that the services they offer are recovery oriented, person-centered, voluntary, relationship focused, and trauma informed.*

Currently, there is not a nationally recognized recovery or peer specialist certification. Rather, individual states have their own unique training and certification requirements. Funding mechanisms for these types of recovery support programs may also differ *(68,69)*. In addition to state training or certification requirements, the FTC provides recovery and peer specialists with orientation and ongoing training and education specific to the unique needs of families who are involved with the child welfare system *(67)*.

In working to increase participant engagement and retention, recovery and peer support specialists ensure that the services they offer are recovery oriented, person-centered, voluntary, relationship focused, and trauma informed *(70)*. To increase treatment connections, these specialists are encouraged to conduct orientation with new FTC participants and actively link them to treatment and recovery activities. These specialists also reach out to participants who do not keep their initial SUD treatment appointments or who drop out of treatment. The FTC continues to provide recovery supports throughout the treatment and reunification process and, after FTC discharge, facilitates continuation of these supports to build a foundation for participants' long-term recovery *(71)*. While the FTC, SUD treatment agency, or other partners can employ recovery and peer support specialists, some FTCs report that placing these specialists on site at the court or in the child welfare office is effective for early engagement *(67)*. Practitioners stress the importance of creating an environment of respect for recovery and peer support specialists to ensure they are accepted as equal partners on the FTC team.

Self-help groups are a readily accessible, community-based resource that participants can use before, during, and after formal clinical treatment. FTC team members are familiar with various approaches (e.g., 12-step, SMART recovery) so they can connect a participant with a group whose structure, format, and philosophy best meets that individual's needs. For example, a number of 12-step programs have women-only groups that female participants may find more welcoming and supportive than mixed-gender groups *(58)*. Other participants may prefer the social-cognitive strategies of groups such as SMART recovery or LifeRing Secular Recovery to the religious or spiritual nature of 12-step programs. Additionally, young adults often find self-help groups designed for their age group to be a more supportive alternative.

D. High-Quality Parenting Time (Visitation)

Rationale

A secure and stable parent-child attachment forms the foundation for children's healthy social, emotional, and cognitive development *(72–75)*. The younger the child and the longer the period of uncertainty and separation from the primary caregiver, the greater the risk of harm to the child's health, development, and well-being *(76,77)*. Infants and toddlers who do not develop secure attachments experience high levels of stress, which can affect brain development and cause long-term harm *(78)*. Young children with unhealthy attachments have a much greater risk of delinquency, substance use, and depression later in life *(76,79)*.

High-quality parenting and family time is important for sustaining the parent-child connection, nurturing parent-child attachment, reducing children's anxiety and feelings of abandonment, reunifying families, and achieving permanency *(79–81)*. The Child and Family Services Reviews conducted in all states found a significant association between visits with parents and siblings and both permanency and well-being outcomes *(82)*. Furthermore, fathers play an invaluable role in a child's successful development, a role that correlates with such benefits for their children as improved cognitive outcomes, self-esteem, and educational performance *(83)*. Fathers' involvement in parenting is associated with more reunifications and fewer adoptions, substantially lower likelihood of later maltreatment allegations, and more rapid exits from foster care for children *(84)*.

Regular, frequent parenting and family time is associated with several positive outcomes for children, including the following *(25,28,81,85–92)*:

- Increased likelihood of reunification;
- Less time spent in out-of-home care;
- Lower likelihood of foster care reentry;
- Fewer placement moves;
- Better adjustment to foster care placement;
- Improved emotional and psychological well-being; and
- Stronger attachments, resulting in fewer behavioral problems and externalizing problems, lower levels of depression, and less likelihood of psychiatric medication use and developmental delays.

Parenting and family time gives parents opportunities to learn and practice parenting skills and allows trained caseworkers to observe and assess family progress *(26)*. Parents have noted that supervised contact through joint or structured activities to build parenting capacity is supportive and helpful, and this contact gives them incentives to attend contact visits *(85)*. Furthermore, regular parenting time increases parent engagement in case plan tasks *(92)*.

The Child Welfare Act of 1980 requires family visits as an essential component of family preservation efforts for children in out-of-home care. In addition, the Fostering Connections to Success and Increasing Adoptions Act of 2008 requires siblings who are not placed together to have frequent visitation or other ongoing interactions with each other, unless such interactions threaten their safety or well-being. Approximately two-thirds of children in foster care have a sibling also in care, and many of these siblings either are not placed together initially or become separated over time *(93)*. Federal laws do not include details on the nature and frequency of visits. States, therefore, develop their own regulations and policies regarding these visits, but these vary substantially in their requirements and levels of detail *(94)*.

For many children, sibling relationships promote resilience *(95)*. For example, a young child's secure attachment to an older sibling can diminish the impact of adverse experiences, such as parental SUD, mental illness, or loss *(96–98)*. For children in out-of-home placement, sibling relationships provide the support, nurturing, and continuity that parents might not deliver. Being with siblings promotes a sense of safety and well-being, and separation can trigger grief and anxiety *(93,99–101)*. Sibling contact not only helps children deal with the immediate trauma of placement,

but it also provides continued support during their time in care and as they approach adulthood *(102)*. Strong and consistent sibling relationships among youth in foster care are associated with increased and quicker reunification *(103)*.

Key Considerations

> *Preventing removal (and thus the need for visitation) through in-home services and supports is optimal whenever possible. Therefore, when children and their parents are separated, it is important to provide parenting time as often as can safely occur.*

Preventing removal (and thus the need for visitation) through in-home services and supports is optimal whenever possible. Therefore, when children and their parents are separated, it is important to provide parenting time as often as can safely occur. When a child is removed from the home, the first visit occurs within 48 hours of that placement *(92,104)*. Research to date has not indicated the optimal and exact frequency and duration of visits between parents and children or between siblings. General guidelines on the frequency and length of visits based on clinical judgment and parent-child attachment research are provided below *(92,94)*.

Recommended Frequency and Duration of Parenting and Family Time (Visitation) **(92, 94)**

Age Range	Frequency of Visits with Parents	Frequency of Visits with Siblings	Duration of Each Visit*
0 to 12 months	*Daily if possible or 3-5 times per week*	*One or more times per week*	*At least 60 minutes*
12 to 24 months	*Daily if possible or 2-4 times per week*	*One or more times per week*	*60 to 90 minutes*
2 to 5 years	*Daily if possible or 2-4 times per week*	*One or more times per week*	*1 to 2 hours*
6 to 12 years	*At least 1-3 times per week*	*One or more times per week*	*1 to 3 hours*
13 to 18 years	*At least 1-2 times per week*	*One or more times per week*	*1 to 3 hours*

**For all age groups, session duration increases after each successful visit.*

Although the guidelines in the table above are helpful, the FTC operational team considers each child and family's situation and determines the appropriate frequency, number, duration, and types of parenting and family visits *(85,105)*. Factors that the FTC considers in developing a visitation plan for each family include the reason for the child's removal, risk of further abuse, likelihood of reunification, length of time the child has been in care, child's developmental age, child's special needs (e.g., behavioral, medical, educational), need for supervision, the other parent's involvement, cultural context, parent's special needs (e.g., domestic violence, mental illness), parent's progress in SUD treatment and his or her case plan, and requirements of the recovery and reunification process *(79,85,92,105–108)*. Outings that are away from an office and allow parents to engage in their children's appointments and activities such as meals, homework, baths, reading, and playing games are ideal.

The FTC operational team members are trained to understand the potential effects of parental substance use on the dynamics of parenting and family time and the skills needed to address challenges with the family visitation plan *(85)*. These challenges might include the parent's return to substance use, resulting in inconsistent parenting time attendance, lack of ongoing communication with the child, the child's perception that the parent is not well, and the parent's weakened sense of empowerment in his or her parenting role.

To enhance parenting time, improve positive parenting, and facilitate reunification, the FTC can leverage foster parents *(26,79,104,109)*. Co-parenting (also known as shared parenting) by birth parents and foster parents or other substitute caregivers is a child welfare best practice, particularly given the Adoption and Safe Families Act's requirement to simultaneously explore a secondary permanency goal of adoption if the primary goal of reunification cannot be achieved *(110)*. To be effective, shared parenting requires a good collaborative relationship and open, ongoing communication among birth parents, substitute caregivers, and child welfare workers *(110)*. The FTC operational team establishes a protocol for safe co-parenting by biological family and foster or kin members, so that all entities understand what co-parenting means and how it will be implemented safely during a child's out-of-home placement *(104)*. Visitation requiring supervision can consider family members and friends who are well vetted, trained, and informed to ensure the safety and well-being of the child. The importance of providing orientation, communication, and support for all substitute caregivers and visitation supervisors is critical.

E. Parenting and Family-Strengthening Programs

Rationale

Nurturance, attachment, and knowledge about positive parenting practices and child development contribute to positive social and emotional well-being in children and decrease the risk of child maltreatment *(111,112)*. Conversely, parental ambivalence about their parenting role and lack of parenting skills and social support are linked to higher rates of children's reentry into out-of-home care *(28)*.

Effective parenting programs that improve parent-child relationships and family functioning have the following components in common *(113)*:

- Are structured and have a curriculum informed by principles of social learning and attachment theories;
- Include both children and parents and feature relationship-enhancing strategies;
- Engage in a strong and productive therapeutic relationship with the parent;
- Demonstrate skills to be learned, incorporate role-playing during sessions, and require behaviorally specific homework between sessions to apply new skills to the home situation;
- Include psychoeducation about child development and mental health;
- Monitor both the parent's and child's progress;
- Include methods to maintain parent engagement in the group;
- Focus on increasing positive behavior of parents and children with praise and other rewards;
- Require frequent behavioral practice for parents and children together during each session;
- Are delivered by appropriately trained and skilled facilitators or group leaders who receive supervision;
- Offer the prescribed number of sessions shown to maximize participant outcomes; and,
- Deliver these components with fidelity monitoring and active supervision.

A systematic review of parenting programs provided in SUD treatment found that positive results often correlated with the duration of parenting interventions *(114)*. Additionally, parenting interventions that help successfully engage and retain parents in services treat parents as partners with providers,

tailor interventions to the needs of both parents and children, integrate services, and collaborate care across agencies, are culturally responsive, provide peer support and trauma-informed services, and include fathers *(115)*.

Many studies have shown that certain evidence-based parenting and family-strengthening programs in child welfare, residential and outpatient SUD treatment programs, and FTCs have positive outcomes, including the following *(7,28,43,114–129)*:

- Reduced rates of substance use, mental health symptoms, and risky behaviors in parents;
- Increased parental SUD treatment retention;
- Improved parent-child interactions, including increased parent involvement with the children, positive parenting, parental supervision of children, parental confidence, parenting efficacy, maternal sensitivity, and parent-child bonding;
- Reduced parental stress associated with childrearing;
- Lower rates of coercive and punitive discipline practices;
- Reduced risk of child abuse potential;
- Lower repeat child maltreatment rates;
- Increased reunification rates and reduced reentries into foster care and days in out-of-home care;
- Greater cost-effectiveness because of reduced time to reunification;
- Enhancements in children's self-esteem, psychological adjustment, and social skills;
- Reductions in children's behavioral and mental health problems,internalizing behaviors, and risk of antisocial behavior, running away, and teen pregnancy; and
- Improved family bonding and relationships, enhanced family cohesion and communication, and reduced family conflict.

Key Considerations

The FTC operational team matches parenting and family-strengthening interventions with family members' needs, backgrounds, circumstances, and goals, and takes into account the community context to ensure the right fit. The structure and approach of a given parenting program can influence the ability of a parent with an SUD to engage in services effectively. For example, because experiences of trauma are common in FTC participants and these experiences can influence parenting, FTC participants often need a parenting program that includes a trauma component *(See Provision G)*. Early entry into a parenting program may also be part of an overall set of strategies to increase parent engagement.

> *The FTC operational team matches parenting and family-strengthening interventions with family members' needs, backgrounds, circumstances, and goals, and takes into account the community context to ensure the right fit.*

The FTC operational team determines the recovery stage at which parents can participate with their children in a meaningful way and retain and apply acquired skills and knowledge *(130)*. Research suggests that parents can be enrolled concurrently in SUD treatment and parenting interventions as long as the parenting intervention provides instruction on fundamental psychological coping strategies (e.g., developing emotional regulation mechanisms) before teaching parenting techniques *(43)*.

F. Reunification and Related Supports

Rationale

Helping families achieve and maintain reunification, is a primary aim of not just the child welfare system, but also the court, SUD treatment providers, and other partners. Reunification is a time of readjustment for families, and the resulting stress can make it difficult for families to maintain safety and stability, especially when they have many other needs *(131)*. In addition to dealing with SUD and recovery issues, the FTC operational team considers the demands of parenting and family on participants. A qualitative study of women completing court-ordered SUD treatment who were reunified with their families found that participants were concerned about their ability to ask for assistance, reconnect with their children, and cope with the stress of parenting and maintaining their recovery *(132)*. Unmet or continuing needs for services at the time of reunification can increase reentry rates into out-of-home care *(28)*. Post-reunification services, which connect families to community resources and enhance parents' ability to address their children's needs, enhance participant engagement in services; reduce the risk of harm to children, repeat maltreatment, and reentry into foster care; and increase the likelihood of sustained permanency *(28,115)*.

In parent partner programs, parents who have successfully overcome the issues that led to their child welfare involvement serve as peer mentors and provide guidance, support, and education to other parents currently involved in the child welfare system. These programs increase service engagement and produce positive outcomes, including increased compliance with case plans and visitation, more frequent presence at court hearings, reduced parental stress, higher reunification rates, and decreased likelihood of the child's subsequent removal from the home and reentry into foster care *(133–136)*. For example, the Parents for Partners program, which educates parents about the dependency system, has been found to reduce parents' anxiety and other negative feelings about the child welfare process *(137)*.

Key Considerations

No evidence is currently available on the exact duration of post-reunification services, but practitioners note the importance of transitional support for parents once reunification has occurred. Some experts recommend providing these services to families for at least a year *(138,139)*. Flexible, braided funding (i.e., funding from multiple streams) designated for post-reunification services is an identified strategy for effective implementation and is most effective when there are clear eligibility requirements for these services *(28)*.

Common elements of parent support programs include psychoeducational child development and parenting skills approaches, a mutual support process, professional or paraprofessional group facilitation, and parent participation in group decision making *(136)*. Some FTCs now offer recovery groups (sometimes referred to as reunification support groups) that focus on child welfare and safety issues. These groups typically begin during unsupervised or overnight visitations and continue until 3 months after reunification. A treatment provider and recovery support specialist from the FTC operational team lead these groups, which support parents throughout the reunification process. Group participants receive guidance and encouragement, and they have opportunities to discuss parenting concerns without fear of repercussions.

Foster parents can serve as an important reunification resource and support for birth families by communicating positively with birth parents, actively participating in reunification efforts, supporting children through transitions, and providing emotional support to children *(110)*. Shared Family Care program and the Parent Collaboration Model are two examples of how foster or resource families can support reunification *(140)*. In Shared Family Care, parent(s) and children are placed together in the home of a host family that is trained to mentor and support the

parents as they develop the skills and supports necessary to care for their children independently. The Parent Collaboration Model includes a stronger than typical relationship between the foster parent and birth parent as well as more frequent contact and visitation.

G. Trauma-Specific Services for Children and Parents

Rationale

Children

Children who are exposed to substance use in the home are 5 times more likely than other children to have experienced a traumatic event and to have a stress response to that event *(141)*. Among children in the child welfare system (and therefore among children with parents participating in an FTC), trauma exposure is almost universal. In a nationally representative study of children involved in child welfare services, more than half of the children had experienced four or more adverse childhood experiences by the time of contact with the child welfare agency, and only 1% had had no adverse childhood experiences *(142)*. Another national study found that more than 70% of children in the child welfare system had experienced complex trauma, defined as chronic or repeated and typically early-onset exposure to two or more instances of sexual, physical, or emotional abuse; domestic violence; neglect; severe caregiver impairment; or school or community violence *(143)*. Children in the child welfare system with complex trauma have greater mental health needs and difficulties in functioning that extend beyond typical posttraumatic stress disorder (PTSD) reactions, and thus they have more extensive service needs *(144)*.

Children also experience trauma when they are removed from their home, placed in substitute care, or have multiple foster care placements. Nearly one-third of foster care alumni reported being retraumatized while in foster care *(145)*. Children can be further retraumatized when they return to the care of their biological parents after developing attachments to one or more foster families *(146)*.

These adverse childhood experiences and chronic stressful events can result in negative short- and long-term outcomes, including traumatic stress reactions, PTSD, disruptions in development, SUDs, depression and other mental health conditions, poor physical health, and educational challenges *(141,147,148)*. The risk of negative outcomes increases with the number of adverse childhood experiences *(148,149)*.

In children and adolescents, receipt of needed trauma-specific services is associated with a decrease in cognitive, behavioral, emotional, and interpersonal problems. These services also increase school attendance and reduce other school problems

> *Family-based trauma interventions that address the needs of both children and parents are associated with enhanced parent-child relationships and interactions, improved attachment, and reduced regulatory problems, parental stress, child abuse potential, and likelihood of referral to child welfare services.*

(147,150,151). Family-based trauma interventions that address the needs of both children and parents are associated with enhanced parent-child relationships and interactions, improved attachment, and reduced regulatory problems, parental stress, child abuse potential, and likelihood of referral to child welfare services *(152–157)*.

Parents

Most parents with SUDs in the child welfare system have a history of traumatic experiences, and between 30% and more than 90% of women in SUD treatment have a history of physical and sexual abuse, depending on the definition of abuse and the population of focus *(158)*. More than 80% of female adult drug court participants were found to have experienced a serious traumatic event in their lifetime, more than half were in need of trauma-related services, and more than one-third met diagnostic criteria for PTSD *(159–161)*. One study found that the majority of female participants in one drug court felt they did not receive adequate treatment for their trauma issues *(162)*. Rates of trauma exposure in

men seeking treatment for SUDs have been found to range from 42% to 95% *(163)*.

Exposure to trauma can adversely affect areas of function critical to successful FTC participation. For example, parents' traumatic experiences often lead to limited physical or emotional availability to children, diminished capacity to empathize with their children, difficulties with parent-child attachment, increased risk of child maltreatment, and decreased satisfaction with parenting *(155,164–169)*. Substance use and mental health disorders are more difficult to treat when trauma-related symptoms and disorders are not detected early and treated effectively *(170)*. One multisite study found that integrated, trauma-informed models of SUD and mental health treatment for women were more effective and did not cost more than treatment that was not trauma informed *(171)*.

Evidence-based and evidence-informed trauma-specific interventions for children and families have been developed for a variety of settings and use a range of approaches whose safety and effectiveness are supported by robust evidence *(172)*. Several trauma-specific treatments for men with SUDs show promise in clinical practice but have not been tested in clinical trials *(169)*.

Trauma-specific interventions for parents in child welfare, SUD treatment, and adult drug court settings are associated with the following positive outcomes *(152,154,157–160,173,174)*:

- Improved treatment retention;
- Increased rates of successful drug court discharge;
- Decreased likelihood of jail sanctions;
- Reduced prevalence of SUDs and mental health disorders, such as anxiety, depression, and PTSD;
- Increased rates of employment, educational enrollment, and housing stability;
- Greater likelihood of reunification;
- Increases in positive parenting practices (e.g., support and positive enforcement of child behavior) and parent-child interactions; and
- Reduced caregiver stress and child abuse potential.

Key Considerations

Trauma-specific services address the effects of traumatic experiences on children, parents, and family members. The FTC matches appropriate interventions to parents and children, in gender-specific settings where possible. For example, parents with identified SUDs and co-occurring mental health and trauma disorders receive integrated treatment that addresses their trauma-related symptoms concurrently with their SUDs and mental health disorders *(170)*. Practitioners have noted that how a parent is addressed in court hearings by the judge and others has an effect on their overall engagement, and therefore trauma-informed skills that promote respectful interaction by all FTC team members and the use of non-stigmatizing language about parents can contribute to a trauma-responsive experience.

Children's trauma-related symptoms vary by developmental stage, culture, and family environment. It is essential for the FTC operational team to understand these variations so it can provide the appropriate trauma-specific services *(172,175)*. The importance of connecting parents back to cultural understandings of parenting serves to reconnect parents with aspects of their culture that may have been lost.

H. Services to Meet Children's Individual Needs

Rationale

Children affected by parental SUDs, mental health disorders, and involvement in the child welfare system are at risk of behavioral, social, emotional, developmental, and other challenges *(176–180)*. Very young children often experience grief and loss from being removed from their homes as well as emotional and psychological challenges as they adjust to foster care placement *(75,76,181,182)*. Among all children entering out-of-home care, parental substance use was a contributing factor in 18.0% of these cases in 2000 increasing to 39.3% in 2017; among children less than 1 year, that number increased from 13.4% in 2000 to 18.6% in 2017 *(183)*. Federal regulations requiring referral of infants and young children (0 to 3 years old) with substantiated maltreatment to early intervention is an opportunity for the FTC team to strengthen its service provision to this particularly vulnerable group.

Studies suggest that up to 80% of all children in the child welfare system exhibit serious behavioral or mental health problems, and children in foster care have rates of behavioral, developmental, and mental health problems 2 to 4 times higher than those of children in the general population *(26,115,184–186)*. Yet most children in foster care have unmet service needs. For example, one-half to three-quarters of these children have unmet mental health, developmental, or behavioral needs; more than three-quarters have unmet routine health care needs; approximately 42% have unmet special education needs; and one-half have unmet developmental or behavioral needs *(187–191)*. Unmet medical, mental health, and behavioral health needs in children are associated with higher rates of unstable foster care placements, increased risk of repeat maltreatment, and higher rates of reentry into out-of-home care *(28,187,192)*.

Children's social and emotional competence is a protective factor that has been found to contribute to positive social and emotional well-being and a lower risk of child maltreatment *(111,112)*. Empirically supported, appropriate, timely, and often long-term interventions (e.g., 6 to 12 months) reduce behavioral difficulties, improve cognitive and developmental functioning, strengthen attachments, and increase academic achievement *(78,116,193,194)*. In the absence of appropriate intervention services, children experiencing neglect or abuse remain at increased risk of poor outcomes and problems that continue through adolescence and into adulthood *(78)*. Young children with unhealthy attachments were found to be at greater risk of delinquency, substance use, and depression later in life *(76,79)*. High-quality mental health, behavioral, and developmental services for children has been found to reduce repeat maltreatment, prevent children's removal from the home, increase rates of reunification, sustain permanency, reduce rates of children's reentry into care, and improve child and family well-being *(28,153,195–199)*. Moreover, increasing funding for direct services for the children of FTC participants is cost-effective *(200)*. Well designed early childhood interventions have generated a return of $1.80 to $17.07 for each dollar spent *(194)*.

> *Moreover, increasing funding for direct services for the children of FTC participants is cost-effective. Well-designed early childhood interventions have generated a return of $1.80 to $17.07 for each dollar spent.*

Key Considerations

Meeting the complex needs of children involved in the child welfare system and the courts because of parental SUDs requires the engagement of professionals that extend beyond the courts, child welfare system, and SUD treatment agency to include public health, dental care, maternal and child health, early intervention, education, Medicaid, and other community-based service agencies as well as pediatricians. The FTC operational team coordinates services for the children of participants with services for the parents to support the healing of their relationship while keeping the child's safety paramount.

Children can receive services in a variety of settings (e.g., at home, in the foster home, in an early childhood education classroom, and in other types of centers). The FTC team can also offer these services as part of certain parenting and family-strengthening programs *(See Provision E)*. Regardless of the setting, interventions that ensure positive well-being outcomes for children and youth do the following *(116,194)*:

- Reduce socially and physically toxic conditions in the home and family environment that adversely affect a child's health, development, and well-being;
- Teach, promote, and reinforce executive functions, such as self-regulation, and positive interactions and relationships with others;
- Limit opportunities for problem development;
- Promote the pragmatic pursuit of prosocial values;
- Use well-trained caregivers; and
- Have small child-to-staff ratios.

I. Complementary Services to Support Parents and Family Members

Rationale

The FTC provides a comprehensive array of clinical and community services and supports in conjunction with high-quality SUD treatment to help participants achieve and sustain recovery and maintain family safety, stability, and well-being *(201–205)*. Primary health care includes dental care for parents, children and family members.

The FTC operational team matches comprehensive services to the needs of the participant, children, and family to produce positive outcomes *(1,24,196,201,206,207)*. Services that do not meet an identified need can burden and further overwhelm parents who are already dealing with many complex issues and various court, child welfare, and SUD treatment case plan requirements. One study found that approximately 35% of parents seeking reunification with their children were ordered to receive treatment services for problems they did not have, according to their assessments *(1)*. Such inefficiencies can hinder efforts to improve family functioning and lead to longer stays in foster care for children.

Parents with SUDs often have complex health and social needs that, left unaddressed, may affect their ability to participate in and complete SUD treatment, child welfare, and FTC case plan requirements. For example, women in SUD treatment have 2 to 4 times the rate of partner violence as women in comparable community samples *(208)*. Substance use has long been linked to HIV infection and transmission because use can impair an individual's judgment and lead to risky sexual behavior *(209)*. As part of the comprehensive assessment process, the FTC team tests participants (or refers participants to local testing providers) for HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases, and links participants to treatment when necessary *(71)*.

Economic resource hardships related to food insecurity, housing (e.g., difficulty paying rent, homelessness), utilities (difficulty paying for utilities or having utilities shut off), and financial assistance (e.g., receiving public benefits or monetary assistance from family members) are identified risk factors associated with increased child maltreatment and child welfare system involvement *(24,210–214)*. The Fourth National Incidence Study of Child Abuse and Neglect found that children in low socioeconomic status households were more than 5 times likelier to experience child abuse or neglect than other children, and children whose parents were unemployed had child neglect rates 2 to 3 times greater than children with employed parents *(215)*. Moreover, a recent study assessed the effects of 4 socioeconomic status risk factors (single parent, yearly income of less than $15,000,

unemployment, and severe housing issues) on family reunification among mothers with SUDs in child welfare. Mothers with three or four risk factors were much less likely (39.1% and 49.3%) to reunify than mothers with one risk factor, and their children spent longer time in foster care *(216)*.

Housing problems are common in families involved in the child welfare system and those with co-occurring substance use and mental health disorders *(217,218)*. Those transitioning out of residential SUD treatment might have particular difficulty securing safe and affordable housing, and many parents lack the resources to find housing on their own *(219)*. The lack of stable and safe housing is a risk factor for entry into foster care and delays in reunification with children *(220)*.

Providing families involved in the child welfare system with housing-related services reduces repeat child maltreatment and the risk of placement in foster, kinship, or other substitute care while facilitating reunification and rapid child welfare case closure *(217,221,222)*. In a large longitudinal study, rates of separations from children, intimate partner violence, substance use problems, psychological distress of the household head, and food insecurity were lower in families that received high-priority access to a long-term housing subsidy than in families that received usual care (no additional referrals) *(223)*. The children of families with long-term housing subsidies also had fewer school or child care absences and fewer behavior problems *(221)*. Helping participants meet housing, food, medical care, employment, and other basic needs increases family stability, enhances child development, increases likelihood of reunification, and reduces rates of child maltreatment and removals from the home *(1,24,28,39,111,112,201,224,225)*. When a range of services in addition to SUD treatment is available, the number of months that participants remain in treatment and the number of counseling sessions that participants receive increase *(204)*.

Key Considerations

The FTC case plan does not replace the child welfare case plan or the treatment plan but rather is coordinated, supporting the key elements of all plans. The complementary services and supports outlined in all case plans are consistent, avoiding duplication and unnecessary services.

In providing specialized employment or vocational services to help participants obtain and keep a job, the FTC operational team members work together to prevent conflicts between these services and a participant's many other obligations, which include mandatory attendance at court hearings, treatment groups, and parenting programs. The team also provides related services, such as child care or transportation that a participant needs to meet employment requirements. Employment or vocational supports appropriate to the participant's needs, abilities, and circumstances are integrated into the overall case plan, initiated at the appropriate time, evaluated, and adjusted as needed.

Housing interventions for families with child welfare involvement vary in scope and intensity based on need, ranging from an acute requirement for short-term housing to longer-term solutions to address chronic homelessness with multiple co-occurring problems. Housing services include rapid rehousing as well as transitional and supportive housing *(217)*.

The affordable housing crisis is well documented *(226)*. Historically, child welfare agencies, courts, and treatment providers have viewed housing as a potential reward following treatment plan success and a demonstration of "readiness for housing." Child welfare and treatment agencies typically do not feature housing as a major element of their programs, relying on outside referrals to housing agencies as a potential resource. Without affordable housing as a foundation for recovery, the chances increase that participants will cycle through a variety of costly treatment, institutional, homeless, and justice environments without positive impact on the family or community at large. When child welfare participates in community collaborations it can contribute to the prevention of family

and youth homelessness. Child welfare and affordable housing agencies can work together to reduce the effects of homelessness *(227)*. In January 2017, the Children's Bureau issued an Information Memorandum providing guidelines for a child welfare response to the growing recognition of housing needs, including the following:

- Actively consider and prioritize the role of safe, stable, and affordable housing in child welfare outcomes;
- Link child welfare administrative data to other available data to understand and document the housing needs of families and youth;
- Attend and participate in homelessness response sector's Continuum of Care (CoC) program meetings;
- Meet the public housing authorities in the community;
- Partner with housing providers including landlords; and
- Use case management as a method to leverage housing resources and support services.

CoC has incorporated a model of coordinated entry into its system; it includes an assessment of housing needs and allocation of resources to persons prioritized by the system, under an umbrella of collaboration and resource sharing. Strategic partnerships with entities such as CoC and new financing opportunities open up avenues to expand a community's capacity to serve families with child welfare, behavioral health, and housing challenges.

Supportive housing integrates a housing subsidy with wraparound services. This evidence-based intensive intervention uses affordable, stable housing as a platform to engage high-need individuals and families in support services. Some supportive housing providers have leveraged the foundation of a stable home wrapped in multidisciplinary services with family treatment courts and the use of recovery coaches and peer mentors. Studies show that providing families with permanent affordable housing and support services can prevent or end a family's involvement with child welfare *(228)*.

> *"Families housed early, at the front end of involvement, are afforded equitable opportunities to remain together safely, fully engage in treatment and services, and maintain a home in which to receive services and practice critical skill development and parenting time.*

Families housed early, at the front end of involvement, are afforded equitable opportunities to remain together safely, fully engage in treatment and services, and maintain a home in which to receive services and practice critical skill development and parenting time. Even when residential treatment is most appropriate, the security offered by having a home to return to following a temporary absence for treatment removes many barriers and offers hope and motivation for the future.

J. Early Intervention Services for Infants and Children Affected by Prenatal Substance Exposure

Rationale

Each year in the United States, hundreds of thousands of infants are exposed prenatally to substances (based on rates of past-month drug use among pregnant women) *(229)*. Nationally, the number of pregnant women with opioid use disorders at delivery more than quadrupled between 1999 and 2014 *(230)*. The lifelong consequences of prenatal substance exposure include impairments in growth, behavior, cognition, executive functioning, language, and achievement *(179,231,232)*. Ongoing parental substance use and an unhealthy home environment also adversely affect infant and child development.

There a number of pharmacological and nonpharmacological interventions that can improve outcomes for parents and infants. Medication-

assisted treatment (MAT) is an effective intervention, for opioid use disorder, resulting in healthy outcomes for mother and infant *(233)*. Nonpharmacological interventions such as rooming-in (i.e., having the newborn and mother in the same room following birth) are recommended to assist infants experiencing symptoms from prenatal substance exposure; rooming-in specifically has become the standard of care and is associated with a reduced need for medication *(233)*.

The short- and long-term effects of prenatal substance exposure depend on such factors as the frequency, timing, and types of substances used; co-occurring environmental and family deficiencies; social determinants of health; and extent of prenatal care *(146,231,234,235)*. The American Academy of Pediatrics recommends that doctors observe opioid-exposed infants for 3 to 7 days after birth before discharging them and conduct early follow-up with families after discharge. These infants are at greater risk of admission to the neonatal intensive care unit, birth complications, a longer hospital stay, and pharmacologic treatment *(236)*.

Early identification, appropriate developmental interventions, and a nurturing home environment improve the long-term well-being and cognitive, developmental, behavioral, and health outcomes of infants affected by prenatal substance exposure *(234,237–241)*. An intensive early intervention program for children younger than 3 years with developmental delays and prenatal cocaine exposure has resulted in significant gains in every developmental domain (personal-social, communication, motor, and cognition), significantly lower rates of special education placements, improved parent-child relationships, and no repeat child maltreatment or dependency petition filings *(237,242,243)*.

Early identification of prenatal exposure through prenatal screening and assessment is a critical factor for improving outcomes for infants over the long term *(233)*. Delayed or incorrect diagnoses and the lack of appropriate interventions can increase the incidence of mental health or behavioral problems and the need for special education services *(244,245)*. In fact, the pre-pregnancy and prenatal periods are considered the first two points of intervention that can lead to reduced potential harm to infants with prenatal substance exposure *(246,247)*. Both are opportunities to provide supports and services for children, parents, and family members.

However, a child's postnatal environment—particularly a stable and nurturing home—is equally important for the child's developmental, behavioral, and educational outcomes *(241,244,245)*. The strong influence of a healthy postnatal environment supports the need for comprehensive, family-centered care that includes high-quality SUD treatment, parenting and family-strengthening programs, and many of the other services and supports described in this standard.

The Comprehensive Addiction and Recovery Act (CARA) of 2016 amended sections of the Child Abuse Prevention and Treatment Act (CAPTA) specific to prenatal substance exposure. Among the changes is the requirement that Plans of Safe Care address the treatment needs of affected caregivers or family members in addition to the needs of the infant. A successful strategy for collaborative work to implement these changes include involving key local and state agencies and partners beyond child welfare, the courts, and SUD treatment—for example, primary health care, pediatricians, and home visiting and public health agencies *(248)*. FTCs serve families who may be covered by the CARA amendments to CAPTA and therefore are part of the process for developing the required Plans of Safe Care.

Key Considerations

To effectively serve participants, the FTC works with state and local partners to implement the CAPTA requirements to develop Plans of Safe Care for infants who are affected by substance use, experience withdrawal symptoms, or have fetal alcohol spectrum disorders; the needs of their affected families or caregivers are addressed as well. A Plan of Safe Care is a collaborative, family-centered case plan that brings together various assessments, case plans, and service providers to ensure the short-term safety and long-term well-being of the infant. There is a need for collaboration among multiple agencies and organizations to support the effective development and implementation of Plans of Safe Care *(246)*. The FTC is uniquely positioned to implement the Plan of Safe Care requirements because of its emphasis on collaborative practice and improving outcomes for families involved in the child welfare system and affected by SUDs.

> *The FTC is uniquely positioned to implement the Plan of Safe Care requirements because of its emphasis on collaborative practice and improving outcomes for families involved in the child welfare system and affected by SUDs.*

The FTC operational team members need a solid understanding of all applicable legislation to determine their approach to developing and implementing the Plan of Safe Care. A statewide survey found that 92% of social services professionals (social work, child welfare, and early intervention professionals), 82% of children's health care providers (physicians and obstetric, neonatal, and pediatric nurses), and 71% of juvenile court personnel (attorneys and judges) were unaware of federal mandates related to referrals and service provision for infants and toddlers with prenatal substance exposure *(249,250)*.

The FTC partners with multiple agencies and disciplines (e.g., obstetricians and gynecologists, pediatricians, neonatologists) to coordinate health, development, treatment, housing, and other services and supports needed for the infant, caregiver, and family *(235)*.

K. Substance Use Prevention and Intervention for Children and Adolescents

Rationale

Children of parents with SUDs are at greater risk of developing their own SUDs than other children, and they are also more likely to initiate drinking at an earlier age and escalate their drinking more quickly to an SUD *(179,251–254)*. Several long-term studies have shown that universal substance use prevention and early intervention programs reduce risky behavior, promote protective factors, increase access to school- and community-based resources, and prevent the development of many social and health problems *(255)*. The benefits of these programs continue into adolescence, young adulthood, and even adulthood. These services can, for example, improve personal, social, and familial functioning; enhance academic and career achievement; and reduce involvement with the juvenile justice system and mental health services *(240)*. According to the National Institute on Drug Abuse's evidence-based principles of substance use prevention in the early years of a child's life (ages 0 to 8 years), intervening early in childhood can alter the life-course trajectory in a positive direction; increase protective factors and reduce risk factors; have positive long-term effects; affect a wide array of behaviors; and have a positive effect on children's health and well-being *(256)*.

In the general population, research shows family-based interventions are the most effective prevention and treatment approaches for adolescent substance use and negative developmental outcomes *(254)*. Among children of parents with SUDs, family-based programs also are most effective at producing positive outcomes, particularly programs that last longer than 10 weeks and involve parenting training, and children's and family skills training components *(257,258)*.

Key Considerations

The FTC operational team works with its community partners to connect children of participants to substance use prevention programs with the following hallmarks of effective programs *(256,259)*:

- Aim to enhance protective factors and reverse or reduce risk factors;
- Address all forms of substance use alone or in combination, the type of substance use problem in the local community, modifiable risk factors, and risks specific to the population;
- Create programs that are long-term and implement repeated interventions of sufficient dosage;
- Strengthen identified protective factors;
- Intervene as early as infancy (such as reducing risk factors, promoting positive self-regulation);
- Employ interactive techniques and varied teaching methods, such as peer discussion groups and parent role-playing;
- Enhance family bonding and positive relationships (family-based programs);
- Target improving academic and social-emotional learning to address risk factors (programs for elementary school children);
- Aim to increase academic and social competencies for middle or junior high and high school students;
- Retain core elements of the original research-based intervention if adapted to meet a community's needs, community norms, or differing cultural requirements;
- Evaluate outcomes; and
- Use well-trained staff to deliver programs.

Substance use prevention programs for children and adolescents have been found to be more effective when they combine two or more programs, such as family-based and school-based programs *(240)*.

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7. Therapeutic Responses to Behavior

The family treatment court (FTC) operational team applies therapeutic responses (e.g., child safety interventions, treatment adjustments, complementary service modifications, incentives, sanctions) to improve parent, child, and family functioning; ensure children's safety, permanency, and well-being; support participant behavior change; and promote participant accountability. The FTC recognizes the biopsychosocial and behavioral complexities of supporting participants through behavior change to achieve sustainable recovery, stable reunification, and resolution of the child welfare case. When responding to participant behavior, the FTC team considers the cause of the behavior as well as the effect of the therapeutic response on the participant, the participant's children and family, and the participant's engagement in treatment and supportive services.

Provisions

A. Child and Family Focus

The FTC team's responses support and promote improved parenting, healthy parent-child relationships, and family functioning. Responses to behavior do not have a detrimental effect on participants or their children or families and do not to interfere with dependency court hearings or requirements. The FTC team never uses parenting or family time as an incentive or sanction. Decisions about parenting and family time are based on the children's best interests, including safety, well-being and, permanency.

B. Treatment Adjustments

Adjustments in the type of treatment, level of care, and dosage are based on the clinical needs of the participant's substance use and mental, physical, social, and emotional health. When a participant does not meet treatment expectations, child welfare case plan goals, or FTC phase expectations, the clinical treatment professionals in consultation with members of the FTC team reassess the individual to determine if a treatment adjustment is needed. Adjustments to treatment are not used as an incentive or a sanction.

C. Complementary Service Modifications

FTC participants often require services and supports beyond those associated directly with treatment. Structural barriers (e.g., lack of transportation, housing, income) and individual barriers (e.g., learning disabilities, health disabilities) may affect the individual's capacity to achieve stable recovery and successful closure of the child welfare case and may contribute to behaviors that are inconsistent with these goals. If the FTC determines that inconsistent or noncompliant behavior is due to an unavoidable barrier, it responds by providing additional supports and services.

D. FTC Phases

The FTC phases support behavior change and completion of child welfare and treatment case plans. Advancement is based on achievement of realistic, clearly defined behavioral objectives or milestones associated with sustained recovery, stable reunification, and safety, well-being, and permanency for children. The policy and procedure manual and the participant handbook (*See Standard 1*) clearly indicate the criteria for advancement through the phases that each participant must complete for successful discharge from the FTC. The FTC does not demote participants to earlier phases.

E. Incentives and Sanctions to Promote Engagement

The FTC develops a range of incentives and sanctions of varying magnitudes that it employs throughout the participant's time in the FTC. The operational team administers incentives and sanctions with the goals of enhancing participant engagement; encouraging behaviors that support sustained recovery, healthy family relationships, and long-term reunification; and holding participants accountable for expectations established by the FTC.

F. Equitable Responses

The consequences for an individual participant are equivalent to those received by other participants who engage in comparable conduct in similar circumstances and with similar expectations. The responses that participants receive do not differ by gender, race, ethnicity, nationality, socioeconomic status, or sexual orientation. The FTC operational team considers all of the relevant factors for each participant when recommending a response to the judge that will be delivered in court. Team members must always be able to articulate the reason a particular response was recommended and ordered for a given participant.

G. Certainty

The operational team reliably detects and responds consistently to all participant behaviors. The FTC has protocols in place to monitor participant behavior and confirm compliance and noncompliance, including attendance at and participation in court, treatment, and child welfare case plan activities. The FTC ensures that appropriate interventions, services, and supports are offered in a timely manner.

H. Advance Notice

The FTC notifies participants, in advance, of the behaviors required for successful participation. The participant handbook and the policy and procedure manual identify a broad range of responses to compliance or noncompliance with the FTC's expectations and orders.

I. Timely Response Delivery

The FTC responds to compliant or noncompliant behavior as soon as possible after the behavior, following FTC policies and procedures to minimize the time from event to response. The FTC adheres to legal and ethical communication protocols and communicates at least once a week about participant behavior.

J. Opportunity for Participants to Be Heard

The FTC gives all participants an opportunity to express their perspectives on their behavior, disagreements about facts, and other relevant issues. A participant may ask his or her attorney or defense representative to assist in addressing concerns or questions.

K. Professional Demeanor

The FTC operational team's interactions with the participant, children, family, and other members of the participant's support system are respectful and professional. Shaming, anger, ridicule, and foul or abusive language are never appropriate or effective for producing positive behavior change.

L. Child Safety Interventions

The child welfare agency and the dependency court are responsible for the protection of children's safety and well-being, and determine the appropriate child safety interventions. Changes in placement and parenting time are made based on safety, well-being, and permanency indicators. Case plan and child welfare safety intervention decisions incorporate the expert knowledge of FTC operational team members and other service providers. Time with children is never used as an incentive or a sanction.

M. Use of Addictive or Intoxicating Substances

The FTC team responds to the use of nonmedically-indicated intoxicating or addictive substances, including alcohol, cannabis (marijuana), and prescription medications, regardless of the substance's licit or illicit status. Medical experts determine whether a prescription for an addictive or intoxicating medication is medically indicated and whether nonaddictive, nonintoxicating, and medically safe alternatives are available.

N. FTC Discharge Decisions

The FTC has agreed-upon criteria in its policies and procedures manual and participant handbook for successful, unsuccessful, and neutral discharges of participants. The discharge criteria provide a framework for the FTC team to determine the appropriate discharge for each participant.

Rationale and Key Considerations

A. Child and Family Focus

Rationale

When developing responses to behavior, FTC operational team members reinforce the child-parent family relationship. FTCs that offered Celebrating Families! and Engaging Moms, which are family-focused interventions during which parents and children attend together, improved parenting capacity, increased participants' understanding of their substance use disorder (SUD), and had fewer new maltreatment allegations *(1–3)*.

FTCs that provide parenting and children's services have better child welfare and treatment outcomes than those that provide services targeted only to parental SUD recovery *(4–6)*. For a more thorough discussion of family-centered treatment see Standard 6.

Key Considerations

All FTC responses to behavior aim to improve child, parent, and family safety, well-being, and permanency by reinforcing behaviors consistent with recovery, reunification, and resolution of the child welfare case, and extinguishing behaviors that are inconsistent with these goals.

Incentives for positive participant behaviors include family activities and services that support the needs of the children and other family members. Examples include certificates to purchase gifts for the children, opportunities to take the children on family-friendly outings, and books and toys that help participants engage in positive parenting. Asking parents what they would like as incentives and letting them make age-appropriate choices empowers them to engage with the process of recovery and reunification and reinforces their understanding of child development.

All FTC responses to behavior aim to improve child, parent, and family safety, well-being, and permanency by reinforcing behaviors consistent with recovery, reunification, and resolution of the child welfare case, and extinguishing behaviors that are inconsistent with these goals.

Delivery of sanctions always takes into account the children's safety and well-being. If the children are living with the parent participating in the FTC, the team considers how imposing a sanction will affect the children and their relationship with that parent.

The FTC operational team is aware of and able to respond to the dependency case requirements. If the FTC and dependency court proceedings are separate, the FTC, with the appropriate releases of information, shares case details and requirements with the dependency court, and vice versa. FTC team members and the dependency court staff carefully consider the participant's overall progress toward stable recovery, family well-being, and reunification when making decisions. If the participant has different attorneys or social workers in the FTC and dependency courts, with the appropriate releases of information, these individuals communicate with each other and make sure that expectations are consistent.

B. Treatment Adjustments

Rationale

The FTC works with parents in child welfare cases who have substance use or co-occurring disorders that are chronic, biopsychosocial diseases that can result in conduct (e.g., continued or return to use, missed appointments) inconsistent with stable recovery, reunification, and family well-being *(7,8)*. FTC participants are also more likely than other individuals involved in dependency or criminal court proceedings to have experienced significant and sustained trauma *(9–12)*.

Psychiatric disorders and trauma can be masked by substance use, and periods of abstinence can result in the emergence of symptoms not detected in previous assessments *(13)*. Sometimes, a participant may not be able to engage in a group setting and requires individual therapy sessions or a gender-specific treatment group *(14)*. When determining how to respond to participant behavior that is inconsistent with stable recovery and reunification, the FTC team considers whether to reassess the participant for a possible treatment adjustment, even if a sanction of some kind might also be warranted *(15)*.

Key Considerations

> *Before implementing a sanction, the FTC team considers whether the behavior might be a manifestation of trauma experienced by the participant and whether the sanction might cause further harm. Subsequently, the team works collaboratively to identify the most appropriate course of action to both respond to the observed behavior and develop a plan to address the therapeutic needs of the participant.*

The FTC's expectations for participant behavior must reflect the recovery trajectory of someone diagnosed with a moderate to severe SUD. The recovery pathway for each individual is unique and influenced by a variety of biopsychosocial factors. These individuals frequently experience co-occurring mental and physical health diseases as well as educational and employment barriers that complicate their recovery *(16)*. Before implementing a sanction, the FTC team considers whether the behavior might be a manifestation of trauma experienced by the participant and whether the sanction might cause further harm *(17)*. Subsequently, the team works collaboratively to identify the most appropriate course of action to both respond to the observed behavior and develop a plan to address the therapeutic needs of the participant. Behaviors inconsistent with the expectations of the FTC phase and case plan could indicate that the participant needs a treatment adjustment to meet severe, complex, or changing needs. Imposing sanctions for substance use early in treatment is contraindicated *(15)*. Only trained clinicians can make decisions about changes in treatment levels and use of medications to treat medical conditions *(18)*.

C. Complementary Service Modifications

Rationale

Behaviors that do not reflect sustainable recovery and healthy family relationships might be due to structural barriers (e.g., lack of reliable transportation, lack of safe and substance-free housing) or individual barriers (e.g., low literacy, cognitive impairment) rather than intentional noncompliance *(9,16)*. The FTC operational team makes sure that participants understand how to comply with and are fully capable of meeting a requirement before sanctioning them for noncompliance. In deciding whether to impose a

sanction and which sanction is most appropriate, the team considers whether the noncompliance was due to a barrier that the participant could not control. An example of such barriers is the lack of transportation that prevents a participant from arriving at treatment appointments on time. Another might be a cognitive impairment that affects sequencing, making the planning involved in getting to an appointment extremely challenging for the participant *(19)*.

Key Considerations

The FTC team always considers the underlying cause of each behavior and responds in a manner that will help the participant, children, and family members achieve well-being. Key to this is attending to the Substance Abuse and Mental Health Administration's (SAMHSA's) four dimensions of recovery: health, home, purpose, and community *(20)*. When formulating a response to participant behavior, the team considers how stability or lack of stability in these four dimensions affects a participant's engagement and success in the FTC. When participants successfully address any of the elements within these areas (e.g., employment, education), the FTC team recognizes and celebrates the achievement. The team makes sure that the participant and family have successfully addressed all four dimensions prior to discharge *(21)*.

The comprehensive assessment of needs of the children, parent, and family members continues throughout the participant's time in the FTC. Periods of transition, such as a phase advancement, serve as a useful interval to revisit the case management and service plans, set goals associated with the next phase, and identify benchmarks related to sustained recovery and stable reunificaton and permanency. If an FTC participant is not fully engaging in opportunities to parent his or her children, the team considers whether additional treatment, services, or parenting support is required *(22,23)*. The team closely attends to transitions, which are a time of significant vulnerability and risk for relapse *(24,25)*.

D. FTC Phases

Rationale

A structured phase system, defined behavioral benchmarks within each phase, and criteria for phase advancement provide the organization and structure that participants need to meet FTC requirements. In FTCs, phases help the court to structure expectations in relation to the Adoption and Safe Families Act (ASFA) time to permanency requirements or other comparable dependency time lines. In cases where the children have been removed, the phases support the participant in accomplishing key tasks that are required prior to return of the children and case closure.

As participants accomplish the goals and tasks of each phase, they become better equipped to make healthy choices regarding the use of illicit drugs and alcohol, engage in productive activities, take on parenting responsibilities, and work to achieve their treatment and child welfare case plan goals *(26)*.

Research on adult drug courts has documented reduced recidivism and increased cost savings when these courts use a clearly defined phase structure and have concrete behavioral requirements for advancement from one phase to the next *(27–29)*.

Key Considerations

The FTC constructs a broad framework that allows for flexibility and modification based upon the unique circumstances of each family entering the FTC. An FTC phase structure is beneficial for both the participant

and the FTC team. Phases provide participants with a visual blueprint of court, child welfare, treatment, and other related service expectations that are contained within the requisite plans established. Phases allow FTC team members the ability to comprehend the requirements of families through the lens of all systems. FTC team members work collaboratively and systematically to set reasonable expectations and identify those associated behavioral change indicators a parent must accomplish throughout the FTC process. Additionally, the phases are a constant reminder of the complex and, at times, competing expectations required to achieve stable recovery, safe reunification, and permanency within mandatory time lines.

The FTC does not predetermine the exact amount of time a participant will spend in each phase. Rather, the FTC identifies a reasonable amount of time in each phase that an individual with a severe SUD may need during the life of the child welfare case to achieve safe and stable recovery and reunification. A phase system allows the participant and team members to establish behavioral goals, specifically identifying the tasks associated with the steps it will take to accomplish those goals (e.g., good physical health, parenting competence, family security, housing, employment, transportation, stable recovery).

FTCs identify behaviors as proximal or distal for FTC participants and, together with the participant, develop a road map for achieving stable recovery, long-term reunification, and closure of the child welfare case *(30)*. Proximal behaviors are currently within the participant's capacity to accomplish, and distal behaviors require additional time, with the assistance of ongoing treatment and services, to gain the skill, knowledge, and experience, to accomplish *(26)*.

FTCs focus on the establishment and accomplishment of defined behavioral indicators (i.e., milestones or benchmarks) related to reunification and recovery. It is important to recognize that time spent in a particular phase often has little to do with demonstrable skills. FTC phases are not based on SUD treatment levels of care, the status of a child's placement in or out of the home, or visitation level of supervision. It does not matter what an FTC calls the behavioral indicators (milestones or benchmarks, or road map for recovery and reunification) as long as the following key concepts are included:

- Sequence phase requirements, case plan, and treatment plan expectations so that the participant does not become overwhelmed;
- Establish reasonable expectations for what someone in early versus later recovery is intellectually, cognitively, and physically able to do;
- Establish measurable behavior indicators and other achievements associated with dependency case milestones, such as unsupervised visits, overnight visits, trial home placement, and reunification; and
- Establish measurable behavioral indicators and other achievements associated with recovery milestones, such as achieving 30 days of abstinence, obtaining a sponsor, making changes in associations, and other life choices that promote a recovery lifestyle.

Phase promotion creates a sense of accomplishment and progress, and is predicated on achievement of realistic and defined behavioral objectives related to recovery, reunification, and closure of the child welfare case. When children are removed from parental custody, the FTC phase structure then aligns with ASFA time lines *(30)*. In particular, the FTC structures the phases so that children can be safely reunified with parents as soon as possible, no more than 18 months from the time of removal or after 15 of 22 months of out-of-home placement. Phase advancement is not based on the duration of FTC participation, treatment level of care, treatment phase, placement of the child, or parenting and family time (i.e., level of supervision, visitation plan).

The following structure provides recommendations for the development of FTC phases.

1. The first phase focuses on acute stabilization, orientation, and engagement. The ongoing assessment of the children's, parent's, and family members' risk, need, and protective factors provides the requisite information for the development of a comprehensive case plan. This phase focuses on fundamental activities to address the acute physical and mental health of children, parents, and family. Family and parenting activities ensure the developmental needs of the child are being met based on assessment and services provided to the family. This generally brief phase allows the participant the opportunity to experience a positive and successful orientation that further supports and encourages engagement and continued adherence to FTC expectations.
2. The second phase focuses on the clinical stabilization of the participant's substance use, mental health, and physical disorders, and addresses the acute and chronic needs of the children and family members. Ongoing services to meet the physical, developmental, social, and emotional needs of children are critical at this time. Engagement in family and parenting activities continue to be prioritized to ensure that the developmental needs of the child are being met. Activities that more fully engage participants in acquiring the tools to support recovery and reunification are key during this phase. Acknowledgment of the problems associated with their SUDs and consideration of change allow participants to begin to internalize their motivation for recovery.
3. The third phase focuses on prosocial habilitation in which the participant is assessed for motivation, insight, and skill to engage in activities that demonstrate his or her ability to recognize and respond to the safety and well-being of the children and other family members. Participants engage in activities that indicate they are making positive choices that support a recovery lifestyle. Reasonable and necessary treatments and services (e.g., parenting interventions, housing and employment assistance) prepare the participant, children, and family for stable reunification. Family and parenting activities continue to ensure that the developmental needs of the child are being met based on assessment and services provided to the family. During this phase, the FTC team reassesses the needs of the participant, children, and family for continued delivery of treatment and other supports.
4. The fourth phase focuses on adaptive habilitation in which the participant begins to improve his or her life and that of the children and family members through the development and enhancement of job skills, life skills, vocational educational goals, and financial stability. Even if participants have jobs, this phase help them identify vocational and educational goals to improve their future and overall well-being. It provides the opportunity for children, parents, and families to develop solid recovery and reunification supports. Engagement in family and parenting activities continue to ensure that the developmental needs of the child are being met. During this phase, the FTC operational team continues to assess risk factors and identify protective factors to determine what is needed to build a solid foundation for stable recovery and reunification.
5. In the fifth and final phase, which focuses on maintenance of recovery and reunification supports, the participant demonstrates the ability to increase his or her network of support to ensure long-term recovery and stable reunification. The focus of this phase is transition planning for child welfare case closure. Participants engage in activities that ensure children's safety, well-being, and permanency. Parents and children transition from the formal supports of the FTC to the support of family, friends, and the community. Participants must be self-motivated to maintain a prosocial lifestyle and have the insight to foresee their children's needs and their own related to safe and stable recovery, reunification, and permanency. They recognize the challenges and resources to meet these needs as obstacles arise.

The five-phase approach above provides recommendations regardless of the status of a child's placement in or out of the home. It is proposed that the five phases are set over a 12-month period, recognizing the potential modification of the goals in each phase and flexibility for the FTC to extend the time a participant spends in each phase based on assessed need, advancement based on behavioral indicators, developmental needs of the child, stable recovery of the parent, and child welfare mandated time lines to permanency.

Reducing the formal FTC interventions of treatment or monitoring before the participant's SUD and other treatment needs have stabilized increases the risk of return to use or other behavioral setbacks. Return to use soon after a phase promotion is often a sign that services were reduced too abruptly. The FTC does not demote a participant to an earlier phase for noncompliance with the court and case plan expectations, because doing so can exacerbate the "abstinence violation effect" *(31)*. This effect occurs when individuals with SUDs lapse after an extended abstinence period and conclude, wrongly, that they have accomplished nothing in treatment and will never succeed in recovery. This counterproductive all-or-nothing thinking could increase their risk of return to use or withdrawal from treatment and the FTC *(31–33)*. The FTC counteracts the abstinence violation effect by stabilizing the participant and helping him or her to learn from the experience. Instead of demotion for noncompliance, the FTC operational team develops a plan for addressing behavioral concerns and provides additional structure and supports that move the participant forward. These services might reflect the expectations of an earlier phase, such as increasing the number of court appearances and case manager contacts, until the participant can successfully meet the expectations of the more advanced phase.

E. Incentives and Sanctions to Promote Engagement

Rationale

Incentives and sanctions are used as a key engagement strategy to support behavior change *(34)*, thereby helping participants achieve sustainable recovery and healthy families *(35,36)*. The application of sanctions and incentives to change behavior is based on the principles of operant conditioning *(37)*.

> *Understanding the participant's motivations and stage of change with respect to his or her substance use and other changes needed to achieve stable recovery and child permanency are also critical to successful participant engagement.*

Responding to participant behaviors effectively can be challenging *(26)*. The FTC employs incentives and sanctions of varying magnitudes to increase the engagement of participants in their case plans, SUD and mental health treatment, and positive parenting *(34)*. The FTC does not seek to punish participants *(38,39)*. Magnitude, meaning the size or extent of something, is used to describe the overall perceived value or severity of an incentive or a sanction *(26)*. In considering the relative magnitude of a response, the FTC operational team considers what the individual participant values *(38,40)*.

Imposing too many high magnitude sanctions can lead to ceiling effects, meaning that the FTC team will have fewer options available to gain the participant's attention and engagement with her or his case plan *(34)*. However, the opposite action can also be problematic; imposing frequent, low magnitude sanctions can lead to habituation and make participants less responsive to sanctions *(41)*. An example of sanctioning that can lead to habituation is giving the participant an hour of community service every time she or he is late for treatment, court, or other responsibility. In contrast, applying a high magnitude sanction for failing to meet goals that are within the participant's ability underscores the importance of while preventing habituation *(26)*.

The FTC might impose a restriction or take away a privilege that is meaningful to that participant. For instance, a participant who is capable of getting to appointments on time but does not prioritize these activities, might be required to stay for all FTC review hearings instead of being able to leave court after her or his review *(40)*. Imposing sanctions too often or too severely for the behavior exhibited can generate behaviors consistent with learned helplessness (a sense of powerlessness, arising from a persistent failure to succeed) and undermine the FTC's ability to support positive behavior change *(42)*.

Numerous studies suggest that reinforcement of positive behaviors and use of incentives for desired behaviors are just as effective as, or even more effective than, sanctions *(15,35,38,43)*. One study demonstrated that participants were less likely to use drugs when the judge and drug court team responded to participant behavior with positive comments and treatment adjustments. In contrast, negative comments by the judge and team were associated with an increase in positive drug test results *(44)*. Incentives (e.g., praise, certificates of accomplishment, gift certificates) help the FTC team members and participants focus on desired behaviors rather than undesired ones *(35,40,45)*.

Responses to behavioral expectations must not only reflect compliance with expectations but also take into consideration a participant's capacity to perform at that standard of behavior *(46,47)*. Understanding the participant's motivations and stage of change *(See Standard 5)* with respect to his or her substance use and other changes needed to achieve stable recovery and child permanency are also critical to successful participant engagement *(48)*. Motivational Interviewing coupled with realistic case planning is often more effective than sanctions or incentives at eliciting behavior changes *(48)*.

Although the FTC team must reliably detect and respond to all target behaviors (e.g., abstinence, appropriate participation in parenting time, active participation in treatment and parenting programs) *(26)*, outcomes are significantly better when the team has a reasonable degree of discretion to modify the consequence in light of the facts of the situation *(27,49,50)*. This approach is consistent with legal and ethical requirements that drug court judges exercise independent discretion when resolving factual controversies and imposing consequences (*See Standard 2*).

The use of jail sanctions in FTCs is controversial. Unless public safety is a concern, incarceration should be viewed with caution. Jail sanctions in adult drug courts produce diminishing returns after approximately 3 to 5 days *(27,51,52)*. Drug courts that impose jail time lasting more than 2 weeks are 2.5 times less effective at reducing crime and 45% less cost-effective than those that do not use jail or impose only brief sentences *(27)*. A recently released Bureau of Justice Statistics report warns that even brief jail stays, while not cost-effective or successful in reducing crime, increase the likelihood of death by suicide. The report found that 41% of jail deaths occur within the first week of a person's jail stay, and a further review of the data found that 26% of all jail suicides occur in the first 3 days *(53)*. A variety of studies have found that, because of a jailed person's loss of tolerance to a drug, incarceration places substance users at greater risk of overdose and overdose death if they return to use after release *(54)*.

Some dependency courts do use jail sanctions through the mechanism of contempt for noncompliance with the court-ordered case plan. Studies have found that jail sanctions do not encourage drug court participants to engage in treatment and that these sanctions can lead to additional trauma for the participant *(39)*. Jail or incarceration also interferes with the participant's ability to meet visitation and dependency court requirements *(6,39)*.

If an FTC does use jail as a sanction, it must strictly adhere to all due process requirements. The California

Supreme Court ruled in *In re Nolan W.* that a jail sanction for failure to comply with a dependency court order when parental rights have been permanently terminated is inappropriate and excessive *(39)*.

Key Considerations

Incentives and sanctions promote participant engagement in FTC requirements, treatment expectations, prosocial behaviors, parenting responsibilities, and recovery and reunification activities. Such responses are used to increase compliance and motivation. The FTC develops a range of incentives and sanctions from which to select the most appropriate response for each participant's behavior. However, FTCs do not develop or apply rigid sets of incentives and sanctions for given types of behavior (e.g., 2 hours of community service for the first positive drug test, 5 hours of community service for the second positive drug test). Although imposing sanctions for substance use early in treatment is contraindicated *(15)*, the FTC team must reliably detect continued use, acknowledge that the substance use occurred, reinforce the expectation to abstain from substance use, administer a treatment response based on ongoing assessment, and determine if additional case management supports are needed *(26)*.

Behavioral expectations can be proximal or distal and are individualized to each participant. Phase requirements are developed to reflect proximal behavior expectations within a phase, recognizing the need for flexibility because individuals progress differently based on their unique strengths, challenges, and engagement in their recovery and reunification plan. The FTC team continually assesses participant capacity, motivation for change, and needs, to effectively respond to participant behavior using incentives and sanctions.

The FTC may decide to administer higher magnitude sanctions for infractions of rules that are within an individual's capacity (proximal goals), such as being truthful or attending court, case management, or counseling sessions. Conversely, the FTC administers low to moderate incentives, such as praise or recognition, for compliance with proximal goals.

For distal goals, such as abstaining from substance use or obtaining employment, the incentive is of greater magnitude because this type of goal is much more difficult for participants to achieve. In contrast, the sanction for failing to achieve a distal goal is of lower magnitude initially and increases if the behavior continues.

Incentives and sanctions should be meaningful to the participant, and the FTC operational team must assess their effect on the children. Incentives and sanctions support individual and family well-being and are focused on recovery and reunification. A low magnitude incentive might be praise from the judge, a card recognizing an accomplishment, or an opportunity to draw a reward from the fishbowl. A high magnitude incentive might be tickets to an event that the participant can attend with his or her children or a high value gift card. A low magnitude sanction might be a reprimand from the judge while a higher magnitude sanction might be requiring the participant to engage in a highly structured and accountable schedule that provides little opportunity for the participant to engage in drug-seeking and drug-using behaviors.

The use of jail as a sanction in FTC is complex and controversial. Jail sanctions are most often ordered for failure to appear at an FTC hearing or for contempt of a court order *(39)*. This type of sanction is almost always inappropriate and counterproductive in an FTC context. Time spent in jail is not a treatment level of care, it rarely meets the participant's treatment needs (e.g., continuation of medication-assisted therapy or counseling), and it interrupts parenting time with the children.

F. Equitable Responses

Rationale

Participants are most likely to react favorably to a sanction if they believe that the procedures to determine that judgment or select that sanction were fair *(55,56)*. Outcomes are best when participants have a reasonable opportunity to explain their side of the circumstances, are treated in an equivalent manner to similar people in similar circumstances, and are treated with respect and dignity throughout the process *(57)*.

Key Considerations

Because the FTC operational team balances individual circumstances, child well-being, and the therapeutic needs of each participant and family member when assigning consequences to a behavior, participants might not perceive these consequences as fair. Every team member must be able to articulate why the team imposed a particular consequence for one participant and a different consequence for another. For example, responses to positive drug test results might be different for a participant who admits his or her substance use and reengages in behaviors consistent with recovery than for one who lies about the substance use or acts in ways inconsistent with recovery. The FTC judge engages directly with the participant to explain clearly why the team has responded to his or her behavior in a particular way.

> *The FTC team maintains records of the incentives and sanctions imposed for each participant. The team examines these data to ensure that the responses to behaviors were consistent and fair, both for individuals and across all participants.*

The FTC team maintains records of the incentives and sanctions imposed for each participant. The team examines these data to ensure that the responses to behaviors were consistent and fair, both for individuals and across all participants.

G. Certainty

Rationale

The FTC team must reliably detect and accurately determine whether the participant is complying with all child welfare, court, and treatment expectations *(46,58,59)*. If the FTC does not reliably detect noncompliance with FTC rules, the participant could receive sanctions and rewards inconsistently, which is likely to result in continued noncompliance *(26,43)*.

Key Considerations

Participants must understand what the FTC expects them to do and the range of potential consequences for adherence or nonadherence to these expectations. The FTC team must accurately detect all compliant and noncompliant behaviors and communicate the information collected to the participant. For example, if participants learn that the team neither learns about nor responds to their use of substances, then the substance use is reinforced rather than extinguished.

H. Advance Notice

Rationale

Studies of adult learning and psychology have demonstrated the importance of empowering individuals by giving them clearly defined expectations *(60)*. When the FTC establishes realistic and clear expectations for behaviors, it increases a participant's sense of perceived control and can strengthen his or her motivation to perform the behavior *(61)*. Failure to specify the desired behaviors and the consequences of noncompliance can result in learned helplessness, meaning that the drug court participant might become aggressive, withdrawn, or despondent *(26)*.

Research has shown that when adult drug courts issue written guidelines on incentives and sanctions to participants and team members, and when the team follows those guidelines consistently, participants are more likely to comply with expectations and to be successfully discharged *(28,50,62,63)*. Meta-analyses have shown that voucher-based positive reinforcement programs increase compliance with program rules when policies and procedures are communicated clearly and in advance to participants and treatment program staff members *(64,65)*. Adult drug courts are most effective at changing participant behavior when they clearly describe to participants the expectations for earning positive reinforcement and how rewards will be administered *(40,66)*. Frequently reminding participants about their responsibilities and the consequences of successful or unsuccessful discharge also increases the likelihood that participants will continue to participate in the drug court *(50,67)*.

Key Considerations

The FTC clearly documents what participants need to accomplish to close their child welfare cases successfully. This information appears in a participant handbook that is distributed to participants and members of their support systems. Neither the FTC's expectations nor the range of possible responses to adherence or noncompliance should surprise an FTC participant.

The FTC also prepares participants for the possibility that, despite following the expectations of the FTC, they may not be reunified with their children. Even when the FTC judge oversees both the dependency case and the FTC reviews, complexities related to the participant or children, or both, may make a decision for other permanent placement "in the best interest of the child." When different judges oversee the dependency case and the FTC reviews, the two courts must ensure that information flows between them to reduce the likelihood that a participant is surprised by the judgment in either court.

I. Timely Response Delivery

Rationale

A basic principle of behavior modification is that responses to both positive or beneficial and negative or harmful behaviors are significantly more effective when they are delivered as soon as possible after the behavior *(68)*. Timely response delivery reduces the likelihood that intervening events will affect the participant's perception of and response to the consequence *(69)*.

Key Considerations

FTC team members communicate with each other about participant behaviors and/or critical changes in the individual or family case plan in a timely manner. The FTC's policies and procedures manual includes legal communication protocols and procedures that empower particular team members to respond to specific circumstances outside of court hearings. These procedures also outline the role of each team member when a serious concern arises and how to respond in a timely manner, including scheduling the participant to attend the next FTC hearing so that the team can respond with a therapeutic intervention and/or sanction.

A swift response sometimes requires the team to make decisions outside of staffing, but even in these situations, the response reflects team member input. In particular, the participant's parent attorney is notified of both the behavior and the potential FTC response, because as these could influence the dependency case. The team uses additional safeguards to ensure that all team members are aware of the behavior that triggered the response, what the response was, why the response was selected, and who will inform the participant of the response. The team determines in advance, as much as possible, which behaviors and responses must be managed during regularly scheduled staffing and court review hearings.

J. Opportunity for Participants to Be Heard

Rationale

When courts adhere to elements of procedural fairness by giving individuals an opportunity to explain their side, to be treated with respect and dignity throughout the process, and to be treated in an equivalent manner to similar people in similar circumstances, individuals are less likely to engage in noncompliant or illegal behavior and more likely to reduce drug use *(55–57,70)*. In contrast, when participants believe that judges are arbitrary or do not give them an opportunity to explain their side of a controversy, participants are less likely to cooperate with orders and more likely to continue to engage in substance use and other noncompliant behaviors *(71–74)*.

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Key Considerations

Many of the dependency court and child welfare processes can feel disempowering to participants. Giving participants an opportunity to share their thoughts and ask questions enhances participant engagement with the FTC and reinforces positive interpersonal communications. Although an opportunity to be heard is always important, it is essential when the FTC's response might result in the participant's loss of liberty. Further, in any situation where loss of liberty is possible, the participant must be provided access to his or her attorney.

The FTC team strives to accurately identify participant behaviors and uses this information during pre-court staffing to determine an individualized response to that behavior. The judge engages in a conversation with the participant to encourage active and open communication. Sometimes, the participant will raise a concern or share information that is new to the team and that could alter the team's decision regarding imposition of an effective response to behavior. In these cases, the judge is encouraged to either hold a brief bench conference with team members or recess court to discuss the implications of this new information on the response being delivered.

K. Professional Demeanor

Rationale

Much of the research on interactions between drug court personnel and participants has focused on interactions between judges and participants. The Multisite Adult Drug Court Evaluation (MADCE) study found that outcomes were significantly better when participants perceived the judge as fair and independent observers rated the judge's interactions with the participants as respectful, fair, consistent, and predictable *(74)*. Stigmatizing, hostile, shaming, and trauma-inducing comments from the drug court judge are associated with reduced compliance and increased likelihood of recidivism *(72,73)*. The FTC seeks to operate in a trauma-informed and trauma-responsive manner at all times.

Key Considerations

All FTC operational team members must treat participants and their families and others in their support system with respect and dignity. It is never acceptable for a team member to act in a demeaning or disrespectful manner toward a participant or member of that participant's support system. Doing so is also counterproductive because one of the FTC team's roles is to model desirable behavior. It is important for the team to receive training in trauma-informed practice, which can provide insight into why participants behave in manners that are inconsistent with standard behavioral norms and offer strategies for de-escalating and reengaging with these participants. The FTC team closes the courtroom or meets with a participant in the pre-court staffing room when particularly sensitive topics need to be addressed by the participant and the whole team (as opposed to being discussed in a one-on-one treatment or case management meeting). Team members are cognizant of and take into account the traumatizing or retraumatizing effects of sensitive topics when deciding which topics will be addressed in open court, which will be addressed in a private meeting with entire team, and which should be addressed in a one on-one meeting with a team member such as the parent attorney, treatment provider, or case manager.

L. Child Safety Interventions

Rationale

Child welfare workers are responsible for ensuring child safety and may not delegate that responsibility *(75)*. Child welfare workers and judges must base their decisions regarding visitation and custody on safety criteria. Restrictions on visitation are justified by considerations such as volatility of safety threats, how difficult a threat may be to manage, or whether a child's functioning deteriorates after a visit. Custody and placement are also safety decisions that require knowledge, understanding, and evidence of threats present in the home, and parental protective capacity to manage those threats *(76,77)*.

Key Considerations

The FTC operational team always bases visitation and reunification decisions on the safety and well-being of the children. Even if a parent is noncompliant with key aspects of the case plan, the participant's time with his

> *Even if a parent is noncompliant with key aspects of the case plan, the FTC does not reduce the participant's time with his or her children if the children are safe. A child's time with his or her parent is a right of that child and a priority for the FTC team.*

or her children is not reduced if the children are safe. A child's time with his or her parent is a right of that child and a priority for the FTC team.

Visitation decisions are never an incentive or a sanction; however, cancelling, reducing, or delaying visitation and reunification may feel like a sanction to the participant. The operational team must help the participant understand that these decisions are based on the safety and well-being of the child.

M. Use of Addictive or Intoxicating Substances

Rationale

Permitting the continued use of licit addictive or intoxicating substances is contrary to evidence-based practices in SUD treatment and interferes with the achievement of FTC goals *(78–82)*. Ingestion of alcohol and cannabis may precipitate the return to use of other drugs, lead to further criminal activity, increase the likelihood that participants will be discharged unsuccessfully from drug court, and reduce the efficacy of incentives and sanctions used in drug courts to improve participants' behaviors *(83–91)*.

Prescriptions for medications with addictive properties from general medical practitioners for patients with SUDs increase the risks of morbidity, mortality, and illegal medication diversion *(92–95)*. It is important to note that properly prescribed and managed medication-assisted treatment (MAT) is not to be misinterpreted by either the FTC team or the participant and his or her family members as misuse of drugs. For a more thorough discussion of MAT see Standard 5.

Key Considerations

The FTC, child welfare case plan, and treatment plan establish an expectation that the participant will become and remain abstinent from all addictive and intoxicating substances unless contraindicated by the participant's physician. The FTC's policies and procedures manual and participant handbook clearly indicate the court's reliance on the expertise of a medical professional to determine a participant's use of a prescription for an addictive or intoxicating substance. The participant handbook and FTC team members provide guidance to participants about how to talk with their doctors and other medical professionals about their substance use and other co-occurring disorders that may affect their care.

The FTC has a prescription drug and physician policy that is detailed in the policies and procedures manual and participant handbook. The policy includes protocols to communicate with treating physicians as part of the team's approach to supporting participant recovery. It may include recovery supports such as documentation for the participant to provide to a treating physician identifying him or her as someone in recovery and asking that the physician consider alternative therapies to those that could trigger a relapse.

N. FTC Discharge Decisions

Rationale

The stakes in a dependency court judgment—the potential permanent loss of parental rights—are very high *(39)*. Given both these high stakes and the potential outcomes of successful discharge from an FTC, effectively engaging and maintaining participants in SUD treatment and providing support services for participants as well as their children and families are critical.

Key Considerations

Successful discharge means that the participant has accomplished significant goals and reconnected with family and community members. When possible and appropriate, reunification occurs before successful discharge. The FTC team supports and celebrates those with successful discharges, regardless of the resolution of their dependency case, as well as those with unsuccessful FTC discharges who nevertheless met the terms of their child welfare case plan and were reunified with their children.

A participant receives a neutral discharge when the FTC team determines that he or she is no longer capable of participating or available to participate in the FTC for reasons beyond that individual's control because of one of the following reasons:

- The participant is no longer a party to the dependency case or the dependency court no longer has jurisdiction over that participant.
- The participant is incapable of participating in the FTC because of a health or cognitive condition other than an SUD.
- The FTC cannot provide the treatment or interventions necessary for the participant's recovery.

Participants do not receive an unsuccessful discharge for continued substance use if they otherwise comply with their treatment and child welfare case plan. Instead, they receive a neutral discharge if, after efforts by the team to secure appropriate treatment were made, adequate treatment was unavailable to meet their clinical needs. The FTC exhausts all options available in its attempt to support the participant, child, and family's needs as a response to meeting "reasonable efforts." A participant is unsuccessfully discharged from the FTC when he or she is repeatedly unwilling to adhere to the FTC's expectations or repeatedly engages in behavior that is inconsistent with the mission, goals, and objectives of the FTC despite reasonable efforts made to ensure his or her success.

When the FTC judge is different from the dependency court judge, the FTC communicates the discharge decision to the dependency court in a manner that is consistent with the communication protocols established in advance between the two courts. After successful, neutral, or unsuccessful discharge from the FTC, members of the operational team actively connect the participant to treatment and other support resources. These active connections to services, often called a "warm handoff," ensure that participants, children, and family members are engaged in services prior to discharge, not simply referred. Ongoing supports may include alumni and parent support groups, continued support from the FTC case manager and peer support personnel, and other community recovery supports.

Custody and child welfare case decisions are complex and are based on the needs and well-being of the children in light of the capacities and circumstances of their parents. Behaviors that led to successful, neutral, or unsuccessful discharge from the FTC influence but do not determine the final custody decision. Sometimes timely permanency for the child takes precedence when a participant needs more time to achieve stable recovery. There are also cases in which children have significant needs that their parents are not able to adequately meet.

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8. Monitoring and Evaluation

The family treatment court (FTC) collects and reviews data to monitor participant progress, engage in a process of continuous quality improvement, monitor adherence to best practice standards, and evaluate outcomes using scientifically reliable and valid procedures. The FTC establishes performance measures for shared accountability across systems, encourages data quality, and fosters the exchange of data and evaluation results with multiple stakeholders. The FTC uses this information to improve policies and practices in addition to monitoring the strengths and limitations of various service components. Evaluation results and data are also critical components of effective stakeholder outreach and sustainability, helping the FTC "tell its story" of success and needs.

Provisions

A. Maintain Data Electronically

The FTC uses an electronic database to store information about the services provided to children, parents, and family members and to monitor participants' performance in the FTC. The FTC team records information about participant demographic characteristics; dependency court actions and processes; child welfare indicators; substance use disorder (SUD) and mental health treatment; other parent or caregiver, child, family, and parenting needs and services; recovery and reunification support; criminal justice involvement; and children, parent, and family well-being. To the extent possible, data related to the long-term outcomes of child and family well-being following participation in the FTC are also collected.

B. Engage in a Process of Continuous Quality Improvement

The FTC promotes practices and supports an environment in which all partners collaborate to continuously improve processes and outcomes. Data entry occurs within 48 hours of each activity or event and is routinely monitored for quality assurance. Data summaries give the FTC operational team real-time information on participant, process, and outcome measures from which the FTC can engage in continuous quality improvement. Data summaries are also provided to the steering committee and oversight committee to assist in policy setting and sustainability efforts. The FTC engages in an annual evaluation of its policies, procedures, and outcomes and develops an action plan to address challenges, incorporate best practices, and improve outcomes.

C. Evaluate Adherence to Best Practice

The FTC adheres to best practice standards as defined by research on FTCs and in the related areas of child welfare; dependency court; the treatment court model; SUD and mental health treatment; children's developmental service and related health, educational, and social services for children, parents, and family well-being. The FTC uses a standardized approach to monitor provider outcomes and services as well as the quality of support programs, including their fidelity to evidence-based programs and practices.

D. Use Rigorous Evaluation Methods

The FTC ensures evaluations are conducted using the most rigorous methodology available that is both feasible and appropriate to address the pertinent evaluation questions. Whenever feasible, comparison groups are used to increase the credibility of the evaluation results and interpretation of findings.

Rationale and Key Considerations

A. Maintain Data Electronically

Rationale

As treatment courts have expanded, states have increasingly recognized the value of providing or supporting the use of electronic database systems into which treatment court team members can record data and from which they can extract meaningful reports *(1–3)*. Federal funders also support the use of electronic databases and require that all grantees collect data on treatment court interventions and outcomes *(4,5)*.

Electronic database systems facilitate accurate and timely information sharing, effective responses to behavior, continuous quality improvement activities, and evaluation *(1–3,6,7)*. Adult drug courts that enter standardized information about their services and outcomes into an electronic management information system (MIS) with the capacity to generate automated summary reports, such as a participant-specific pre-court staffing document, demonstrated higher rates of cost savings (about 65% more) compared to courts that do not use an electronic database to support treatment court operations *(6,7)*.

Each local FTC develops its own theory of change, logic model, outcome measures, instrumentation, and data collection methods that best fit its local context, policy environment, feasibility, and funding requirements. Data collected include demographics of children, parents, and family members; services referred and received; behavior responses; service referral, admission, and termination outcomes; and child welfare/dependency court orders as well as case-specific and long-term outcomes.

Poor data entry is a significant threat to FTC operations and outcomes. After 48 hours, errors in data entry increase significantly. After 1 week, the risks stemming from data inaccuracies outweigh the benefits that can be obtained by efforts to fill in gaps from faulty memory *(8)*. Entering data later makes it difficult for the operational team to deliver appropriate services because team members lack timely information on participants' current needs as well as previous services received.

The FTC has a pre-court staffing report that empowers the team to view a compressed record of the participant, child, and family activities and progress while in the FTC. FTCs work with MIS vendors and partner agencies to obtain meaningful data reports that enable frontline staff and supervisors to monitor data quality and program operations *(1,3)*. This pre-court report enables team members to efficiently discuss each family and make informed decisions about responses to participant behavior *(See Standard 7)*.

The FTC selects a set of critical data indicators (sometimes referred to as a data dashboard) that help the operational team and steering committee members monitor critical FTC operations such as referrals, admissions, completions, and terminations *(1,3)*. Reviewing data on a monthly basis helps reveal trends in these critical process measures, thereby empowering the FTC to make changes to policies and procedures. Viewing these indicators by key demographics such as gender, race/ethnicity, and age can also provide critical information about the ways that FTC policies and procedures are affecting different demographic populations.

> *Each local FTC develops its own theory of change, logic model, outcome measures, instrumentation, and data collection methods that best fit its local context, policy environment, feasibility, and funding requirements.*

Key Considerations

The "perfect" FTC database would be a secure system that auto-populated data fields from linked electronic systems already in use by child welfare, treatment, courts, and other critical partners. Each agency would maintain its own data system and no one would need to enter the same data into more than one data system. As no such utopian database exists, FTC practitioners most often cobble together data from multiple electronic and paper records to generate pre-court staffing reports and FTC in-program reports, and to conduct more complex evaluations. More than one MIS may be needed to collect and report on different types of information and data to be used by the team and other stakeholders. The need to access data from more than one data source highlights the critical importance of data sharing agreements with key stakeholder agencies such as child welfare, dependency court, and treatment agencies.

Key data resources are now available from multiple public and private organizations. They include those promulgated by the states and by federal agencies including Administration for Children and Families, Centers for Disease Control and Prevention, National Institute on Drug Abuse, Office of Juvenile Justice and Delinquency Prevention, and Substance Abuse and Mental Health Services Administration, as well as those recommended by national training and technical assistance institutions including American University, Center for Court Innovation, Children and Family Futures, National Association of Drug Court Professionals, National Center for State Courts, National Center on Substance Abuse and Child Welfare, National Council on Juvenile and Family Court Judges, National Drug Court Institute, and others.

When the FTC uses an electronic data system designed for managing treatment court data, it should produce a meaningful pre-court report for each participant and family that serves several critical purposes. Each participant's pre-court report is a snapshot of data entry and data quality for that particular participant and family. It is generally easy for FTC operational team members to notice missing data (e.g., drug test results, services attendance) and to recognize errors in data entry when discussing case progress in the pre-court staffing.

Data entry is often reported to be one of the least pleasant tasks for a social worker, treatment provider, or other social services provider. It is tempting to avoid data when faced with competing and often more critical tasks such as counseling, ensuring a client has a place to sleep, or creating an opportunity for a family to spend time together. Despite these pressing issues, the best time to record information about services provided and events is during or immediately after they are delivered or occur. For example, multidisciplinary team members should enter attendance information into the MIS at the time of court hearings and treatment sessions (real-time recording). Because team members are typically responsible for dozens of participants, and each participant has multiple obligations in the FTC, team members might have difficulty recalling events days or weeks later, and trying to do so is likely to introduce errors into the data entered.

B. Engage in a Process of Continuous Quality Improvement

Rationale

Continuous quality improvement (CQI), sometimes called performance and quality improvement (PQI), refers to an intentional process of using data to improve outcomes *(9,10)*. These efforts involve active use of a theory-based management system that examines processes and outcomes toward long-term, shared success *(11)*. This work uses a client-centered philosophy and a systematic approach to collect staff and client feedback in addition to data on standard services and processes *(12)*.

Continuous self-monitoring and rapid-cycle testing (a process that is used to test process modifications on a small scale, measuring change in a particular outcome captured prior to the change and then again afterward in an effort to make improvements in processes and outcomes) are critical for improving outcomes and increasing adoption of best practices in the health care and criminal justice systems *(13–16)*. These strategies are particularly important for complex, community-based interventions, such as treatment court, that require cross-agency collaboration and interdisciplinary communication among multiple service agencies *(17–19)*.

One aspect of continual self-monitoring examines data related to referrals, admissions, and exits. After the FTC screens and deems prospective participants eligible, it tracks whether these prospective participants actually enter, and if they successfully complete the FTC. Drop-off analysis examines if or when FTC participants drop out of the admissions process and active participation in the FTC and can be used to identify opportunities to create new or modify existing processes to better engage parents and family members *(1)*. This monitoring could yield information on the types of intervention or outreach strategies that could reduce refusal rates and increase access to and early engagement in the FTC. Because FTC participation is based primarily on the parent's voluntary decision, the FTC can monitor these decisions and examine the factors (including race, ethnicity, and other demographic characteristics) that contribute to refusal or acceptance of an enrollment invitation. Particular attention is paid to the decisions of traditionally underserved populations, including fathers; veterans; LGBTQ; those with a mental, physical, or intellectual disability; English non proficient; and populations that may hold a historic distrust of the court and other systems involved in the FTC.

Disproportionality and disparities (*See Standard 3*) are a significant concern in child welfare and criminal justice populations *(20–22)*. The FTC reviews referral, admission, and completion data to examine whether the parents, children, and families served by the FTC reflect the community's high-needs child welfare population. In particular, the admissions and successful completion population reflect the age, gender, race, ethnicity, language preference, and family structure of the families with substantiated child welfare cases who have substance use or co-occurring disorders. This information will help the FTC determine whether it is serving the target population and where improvements are needed.

Finally, while the FTC monitors quantitative data—numbers referred, admitted, and successfully or unsuccessfully completed, and the time it takes each case to move through these processes—the FTC also collects and reviews qualitative data. Interviews or surveys with referred, admitted, and discharged participants (regardless of whether the discharge was successful, unsuccessful, or neutral) can explore issues such as participant perceptions to understand why certain groups (e.g., fathers, people of color, younger parents) might be more or less inclined to enroll in and engage with the FTC.

Key Considerations

If embraced, CQI can be the payoff to maintaining accurate and timely data. Often social service providers are hesitant to engage with data, concerned that they will not be able to understand it or that it is less interesting than direct service work. However, if the data system enables FTC partners to assemble meaningful data reports, engaging in CQI can be as meaningful and rewarding as direct service work, reinforcing team and stakeholder investment in evidence-based and recommended practices. Actively engaging in CQI empowers frontline staff, middle managers, and executives to examine processes and outcomes, develop theories about

> *Actively engaging in CQI empowers frontline staff, middle managers, and executives to examine processes and outcomes, develop theories about particular results, generate potential improvements, review the results of the new actions, and begin again.*

particular results, generate potential improvements, review the results of the new actions, and begin again. Within substance use and mental health disorder treatment, the NIATx model of rapid-cycle improvement, also called PDSA (plan-do-study-act), is a commonly used approach to improve outcomes while increasing staff job satisfaction and retention *(13,23,24)*.

The process of CQI requires consistent, coordinated communication and information sharing among the multidisciplinary team and FTC partners *(See Standard 1)*. Barriers to data sharing across agencies are discussed among the steering committee and resolved. FTCs leverage their data to be more effective in sharing their story and making the case for future funding opportunities. In addition to supporting sustainability, these efforts help move FTCs closer to the scale needed to serve all families who may benefit from this intervention.

C. Evaluate Adherence to Best Practices

Rationale

Adherence to research-based best practices is often poor in social services, criminal justice, and SUD treatment programs *(25–27)*. Even when agencies and programs adopt evidence-based practices, ensuring continuing fidelity to the model(s) is a significant and ongoing challenge *(28,29)*. Without continuous data collection and at least annual review of agency and staff adherence to best practices, the quality and quantity of the services provided can decline precipitously *(30,31)*. Like many complex service organizations, drug courts are highly susceptible to "drift," meaning that the program drifts away from fidelity to the model and outcomes for children, parents, and family members deteriorate over time *(31,32)*.

In general, the FTC engages in a structured evaluation on an annual basis as well as implementing such an evaluation during periods of significant transitions involving changes in major policies or key personnel *(33)*. These reviews can be achieved by engaging in an annual, structured self-evaluation during which the FTC examines key data and compares current practices to the FTC's policies and procedures and memoranda of understanding (MOU) *(1)*. The FTC may also decide to engage in a more formal process evaluation, which is often conducted by an independent evaluator. A process evaluation compares current practice to best practice standards and/or the FTC's own policies and procedures to identify where practice has drifted or shifted to accommodate a change (e.g., staffing or policy change). The report provides FTC stakeholders with critical information from which the operational team, steering committee, and oversight committee members can make changes to practice as well as update policies and procedures and MOUs to reflect their shared intentions.

Key Considerations

Ensuring fidelity to the FTC model empowers the collaborative to share data and success stories with the local community, improve child welfare and treatment outcomes, and increase cost-effectiveness. The effectiveness of FTCs is sustained through ongoing attention to the evaluation, review, and modification of FTC policies, procedures, and outcomes. Many states now have certification procedures for treatment courts. Partner agencies, particularly treatment providers, also engage in regular fidelity reviews of the delivery of evidence-based interventions. Whenever available to an FTC and its partners, these processes are pursued as they provide an opportunity for the FTC to reflect on its practice—to celebrate what the FTC is doing well and to develop action plans to address

what should be improved. Management strategies such as PQI and CQI enhance the FTC's adoption of best practices and can prevent drift. Each of these management strategies emphasizes continual self-monitoring and rapid-cycle testing (i.e., NIATx PDSA). When using one of these processes, the FTC collects real-time information about its operations and outcomes, disseminates that information to the multidisciplinary team on a routine basis, and implements and evaluates remedial action plans when indicated *(31)*.

Engaging in a SWOT (strengths, weaknesses, opportunities, and threats) or SCOT (strengths, challenges, opportunities, and threats) analysis provides an opportunity for the FTC operational team, steering committee, and other critical partners to review data about operations, identify areas of internal and external strengths and challenges, consider opportunities, and develop a shared action plan. Studies have not determined how often the FTC should engage in this kind of formal, team-driven evaluation of practice; however, successful organizations typically perform this type of activity at least once a year *(7,15,16)*.

Staff turnover rates often contribute to drift in the quality of services provided *(31)*. Turnover of key staff positions is high in many adult drug courts within a 5-year period *(31)*. The highest staff turnover rates, often exceeding 50%, are for child welfare workers *(34)* and SUD and mental health treatment providers *(26,31,35)*. As a result, annual review of program data and engagement in program improvement activities are even more critical for FTCs and other treatment courts.

D. Use of Rigorous Evaluation Methods

Rationale

Evaluation in Social Service Organizations

FTCs operate across multiple systems and within numerous agencies to meet the complex needs of children, parents, and family members *(1,36)*. Many of these organizations have neither the ability nor the interest to engage in evaluation activities involving random assignment to different treatment or service conditions that significantly disrupt or place undue burdens on staff. Similarly, there are cultural reasons why organizations may be less interested in participating in an evaluation that involves control groups. Random assignment may also raise ethical concerns or introduce bias associated with service provider preferences. It is important for evaluators, in recognizing potential problems, to work with the various system and program administrators to jointly develop an evaluation plan that is rigorous and operates within scientific standards while also accommodating the challenges of social service and treatment delivery *(37–40)*. One of the most important issues to consider when choosing to engage in an evaluation is whether the report will provide recommendations that the FTC can use to enhance its adherence to best practices and improve its outcomes. As a community-based collaborative intervention, the FTC should involve partner agencies in the formation of research questions and methods to access data. Finally, the FTC should negotiate in advance who will own the data once collected and the report once completed, whether the study will be published, and options for the FTC and partner agencies to address and discrepancies or concerns about the approach and conclusions.

Despite the caveats discussed above, rigorous program evaluations have the potential to significantly improve FTC operations. In studies of the 10 Key Components of adult drug courts, jurisdictions that hired an independent evaluator and implemented at least some of the evaluator's recommendations were twice as cost-effective and almost twice as effective at reducing crime as those that did not engage an independent evaluator *(6,7)*.

Use of an Independent Evaluator

It was once considered essential to hire an independent evaluator to conduct a high-quality, evaluation of a program. However, it is now common for large agencies, municipalities, and states to employ qualified staff to maintain data, provide reports to staff and partners, and engage in sufficiently rigorous program evaluations *(37)*. In hiring an independent evaluator, a program can benefit from the confidentiality afforded to participants, team members, and other stakeholders when sharing frank opinions about operations and staff that could be key to identifying effective and ineffective program elements *(41)*.

Methods to Assess Program Impact

The central task of program evaluation is to generate a valid description of the intervention's performance that enables comparison *(37)*. Comparison can be between one group that has received the intervention and another that has not or comparison can be made using a series of pre and post measures that measure a particular attribute prior to an intervention and again after the intervention. Each of these methods has particular advantages and disadvantages.

The "gold standard" in evaluation of an intervention is the use of random assignment to conditions *(42)*. In theory, this should produce a comparison group that is unbiased, meaning that the individuals in the group are not systematically different from the FTC participants beyond the fact that they did not participate in the FTC. Comparing what happened to FTC participants to what would most likely have happened if they had not entered the FTC is known as testing the counterfactual hypothesis *(42)*.

It is generally not possible for social service programs to use random assignment to conditions, for all the reasons noted on the previous page *(40)*. Instead, most social service program evaluators use quasi-experimental techniques that involve constructing a comparison group *(37,40,42)*. Current FTC evaluations often use two types of comparison groups. A historical comparison group usually consists of subjects in the same system prior to the FTC intervention or a contemporary comparison group typically consisting of individuals on the waiting list, opting out of the FTC program, or from a jurisdiction that does not have an FTC *(43)*. Lack of adequate equivalence between the intervention and these types of comparison groups is a major concern.

To make valid comparisons, the FTC participants and the comparison group members must share similar risk prior to and during the intervention. This means that the subjects in the two groups must have similar demographic, social, economic, health and behavioral health, and case characteristics that are likely to lead the individual to the same probability of engaging in substance use, child maltreatment, crime, and other behaviors measured in the evaluation *(42,44)*. There are numerous methods that can be used to improve the validity of a comparison group in a quasi-experimental design, but most of these are complex and require training and experience in statistical matching techniques *(42,45)*.

> *One of the most important issues to consider when choosing to engage in an evaluation is whether the report will provide recommendations that the FTC can use to enhance its adherence to best practices and improve its outcomes. As a community-based collaborative intervention, the FTC involves partner agencies in the formation of research questions and methods to access data.*

Another commonly used method to examine the impact of an intervention analyzes change over time in measurable behaviors or within other markers. This technique captures changes in skills, reported symptoms, physical health, and more by assessing a characteristic before and after a particular intervention. A local program can use this technique to identify change but cannot unequivocally attribute the changes to a particular intervention without the help of advanced statistical techniques that seek to

control for factors outside the direct intervention that may be affecting the outcome *(42)*.

Use of Intent to Treat Analyses

The FTC examines outcomes for everyone who participates for any amount of time instead of evaluating outcomes only for those who are successfully discharged *(8,41,46–48)*. Intent to treat (ITT) analysis includes data for all individuals who participate in the FTC regardless of the discharge outcome (successful, unsuccessful, or neutral) *(49)*. A parent or family that receives any amount of services from the FTC is likely to receive some benefit and should therefore be included regardless of the final outcome of that family's participation. Inclusion of in-program and outcome data for all participants will produce a more conservative estimate of the treatment effect (i.e., FTC participation), but the results will be empirically defensible.

Use of Mixed Methods

Most social service policies and program evaluations benefit from the use of mixed methods—the use of both qualitative and quantitative approaches *(37,40,42)*. Qualitative methods include surveys, interviews, and focus groups with staff, stakeholders, and participants; structured observation of program activities (e.g., process and dynamics of pre-court staffing, court reviews, various service interventions); and review of written materials *(37,40)*. Quantitative methods use program data such as intervention participation and outcomes; time to and time in treatment; and outcomes associated with the broader FTC intervention (e.g., FTC discharge status, child welfare case status) to determine the correlations and effects of various program components) *(42)*. While each approach highlights different data and provides unique insights, the use of both qualitative and quantitative methods can generate a more complete and nuanced understanding of FTC operations and outcomes *(37,40,42)*.

While each approach highlights different data and provides unique insights, the use of both qualitative and quantitative methods can generate a more complete and nuanced understanding of FTC operations and outcomes.

Key Considerations

Challenges of Evaluation

FTC evaluations are likely to be substantially more complex than adult drug court evaluations because they involve more provider systems and include key child, parent, and family outcomes. To conduct a rigorous and meaningful evaluation, the evaluator may need to develop a dataset using data from different electronic data systems and administrative datasets.

Critical to any program evaluation is the establishment of baseline data. Baseline data provides important context to establish target goals and measure the impact of FTC interventions. In FTCs, the baseline data include the jurisdiction's child welfare, court, and treatment system administrative data when available. State and local data may be unavailable for a variety of reasons (e.g., inconsistent data entry, lack of administrative permissions, lack of trust among partners). It important for the FTC to attempt to obtain this data and to document the barriers. The FTC oversight committee and/or state level stakeholders may need to work toward resolution of these barriers.

One of the most significant challenges the evaluator may need to overcome is accessing participant- and family-specific data across providers and data systems. These systems often use different identifiers, making the process of ensuring an exact match across systems difficult without collecting identifiers across systems. Even if the logistics of matching cases can be overcome, it may be difficult to obtain permission to access participant- and family-specific data. Due to these challenges, outcome evaluations are often conducted by organizations and individuals with advanced training in social science research.

Use of an Independent Evaluator

If the FTC lacks resources to hire an independent evaluator, it can contact local colleges or universities to identify students who might be interested in evaluating the FTC as part of a thesis, dissertation, or capstone project. Because such projects require close supervision by senior academic faculty, the FTC can benefit from high-level research expertise at minimal or no cost. Moreover, these students are likely to be highly motivated to complete the evaluation successfully because doing so is important for their academic degree and standing.

The FTC chooses an evaluator who understands child welfare and treatment systems and related data. If the FTC hires an adult drug court evaluator, for example, this individual might be unprepared for the additional complexity of obtaining, working with, and interpreting child welfare data. The evaluator must also understand the SUD treatment, dependency court, and child welfare systems as well as the cross-system processes and outcomes that affect FTC outcomes. Finally, the evaluator should be familiar with the literature on FTC best practices, be able to compare FTC practices with established performance benchmarks, and have the ability to identify strategies to improve the FTC's operations and outcomes.

To choose competent evaluators, the FTC requests recommendations from other FTCs and national organizations that are familiar with FTC operations and research. When selecting an evaluator, the FTC reviews prior evaluation reports, especially those involving FTCs or other problem-solving courts, written by each evaluator being considered. If prior evaluations did not follow the best practices for evaluation provided here, the FTC considers selecting another evaluator who has demonstrated expertise in applying best practices related to FTC program evaluations.

Use of Comparison Groups

Selection of a valid comparison group will be one of the most difficult tasks in designing a rigorous evaluation of an FTC. Few jurisdictions will be interested in engaging in a random assignment to condition—one family receives services through the FTC (treatment) and the other is assigned to "business as usual" (comparison or control). Even if a jurisdiction were interested in engaging in this type of evaluation, families would have to agree to receive services as assigned.

A particular challenge to an evaluation using random assignment to conditions is that treatment courts change practice across systems within a community. A judge trained in therapeutic jurisprudence to preside over a treatment court uses those same skills and education about the effects of substance use, mental health disorders, and trauma when presiding over the regular docket. A child welfare case worker or supervisor, once exposed to FTC practices, is likely to ask different questions or make different decisions about case plans and service referrals on a non-FTC case.

This is a strength of introducing the cross-agency training and systems response promoted by treatment court practice, but it makes finding a valid, in-jurisdiction comparison group unlikely.

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Conclusion

The family treatment court (FTC) field must continue to operate as a learning network. FTCs have prospered and moved forward in practices that support improved outcomes for children, parents, and family members who are involved in child welfare and are affected by substance use disorders (SUDs) or co-occurring disorders. Professionals in the field must remain open to enhancements in daily operations, respond to inevitable barriers and continue to ask hard questions. All FTC federal, state, tribal, and local partners have the opportunity to learn from and share within this network and thus improve practice in FTCs and across the broader child welfare, court, treatment, and social service systems.

The Family Treatment Court Best Practice Standards (FTC Standards) have been developed to meet three broad goals: (1) to guide the daily operations of FTCs; (2) to support federal and state decisions

regarding resource development and priorities; and, (3) to improve outcomes for children, parents, and families affected by SUDs or co-occurring disorders and involved in the child welfare system.

The FTC Standards are intended to be broad enough to encompass FTCs of different sizes and models in diverse communities. Yet to be useful, they are specific enough to guide long-term strategic goals as well as daily operational decisions of the FTC. The FTC Standards reflect a deep body of experience in the practical realties of launching and operating FTCs, augmented with feedback from an extraordinary group of advisers and peer and public reviewers. To fully embrace the standards, FTCs must engage with the lessons from practice experience and embrace what can be learned from further research and implementation. With adoption of these practices, communities demonstrate their commitment to improve child safety and increase child, parent, and family well-being.

The application of these standards presents further opportunities and challenges. State-level systems may wish to develop their own criteria for monitoring compliance with the FTC Standards. Academic institutions could devise checklists or other methods to determine areas of strong implementation and areas for growth. National and state training organizations may wish to design curricula that emphasize the skills and competencies required to implement the standards with fidelity. Various forms of certification could be considered, including offering incentives for voluntary compliance and stronger conformance with the standards, in addition to other means of encouraging consistency with the standards.

While these standards are based on existing research in the areas of child welfare practice, treatment operations, and collaborative courts, further research will expand and enhance our understanding of the effectiveness and impact of each standard. Ideally, future research will isolate the effects of each component, more rigorously test a whole intervention as described in the FTC Standards, and further refine our understanding of how to best match FTC service arrays with the needs and characteristics of children, parents, and family members, including developing models to predict which families are best served by FTCs. Ultimately, cost-benefit analyses that go beyond initial cost data are needed to document the savings and offsets to child welfare systems and other agencies whose budgets may be affected by children removed to out-of-home care or affected by abuse, neglect, SUDs, or trauma.

Ultimately, the value and usefulness of these standards will be measured by their effects on the court, child welfare, treatment, and social service systems and in improvements in the lives of the children and families served by FTCs. Together, we can all foresee improved collaboration and enhanced practice across and within these systems; anticipate reductions in social, economic, and emotional costs related to prenatal substance exposure, child abuse and neglect, and juvenile delinquency; look forward to children who will grow up in healthy families with loving, competent, and healthy parents; children who will not enter juvenile justice but will complete school, contribute to their communities, and raise healthy families into adulthood.

Children grow up in safe and stable families with nurturing, capable, and healthy parents.