



THE WINSTON CHURCHILL MEMORIAL TRUST OF AUSTRALIA

Report by GREGORY LEVINE, 2011 Churchill Fellow

A Study of Family Drug Treatment Courts in the
United States and the United Kingdom

Giving parents and children the best chance of reunification

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Signed: Gregory Levine

Dated: July 9, 2012

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1. Introduction

Parental substance abuse is a significant problem in a high proportion of cases that come before Children's Courts in Australia. As a result, many children are removed from their parents' care, often permanently. The goal of family reunification – which is widely recognised to be in the best interests of the child, both in principle and in legislation – is rarely achieved in these cases.

Family Drug Treatment Courts (FDTCs) were created to address the poor outcomes from traditional family reunification programs for substance-abusing parents. There are now over 300 programs throughout the United States (Huddleston and Marlowe, 2011) and since 2008, one program in the UK, in the Inner London Family Proceedings Court. A variety of names are used to identify these courts (eg Family Drug Treatment Court, Drug Dependency Court, Family Dependency Treatment Court, Family Treatment Court, Family Drug and Alcohol Court), but the term FAMILY DRUG TREATMENT COURT (FDTC) will be used in this report to designate the proposed Australian model.

No such court exists in Australia. This Churchill Fellowship allowed me to study FDTCs in the US and UK in order to establish the first Pilot in Australia. FDTCs are a highly attractive alternative, given their non-adversarial, problem-solving approach, a central role for the Judge/Magistrate in monitoring and motivating parents and the collaborative, multidisciplinary mode of managing rehabilitation and reunification. Currently there is no operational or first-hand knowledge in Australia about how to establish and run these courts. Thus the aim of this study was to examine the function, operation, resourcing and multidisciplinary practices and strategies of the FDTC.

I was awarded this Churchill Fellowship as a Magistrate with over twenty years experience, including five years as Head of the Children's Court, and a long term commitment to developing non-adversarial, therapeutic processes for social justice outcomes. This Churchill research has strengthened my determination to develop a new court that better serves the children of families struggling with substance abuse in Australia. I travelled with my wife Emeritus Professor Barbara Kamler, a professor of education, who took an active and enthusiastic interest in all aspects of the project. Over the two months of our travels, she not only visited all the sites with me, but adopted a co-researcher role in the meetings, interviews, data collection and literature reviewing. The study is therefore a collaborative effort and the 'we' of this report refers both to me and Professor Kamler. I am deeply grateful for her engagement, insight and support in the conduct of the study and the writing of the report.

I would like to thank the Churchill Trust for providing me with the invaluable opportunity to carry out this study of FDTCs. We were overwhelmed by the generosity of all those professionals we met in the United States and United Kingdom, who connected us to resources and openly discussed their programs, approaches, analyses and evaluations. We thank them all. Their commitment to the children and families in their programs was inspiring and has fortified our intention to establish the first FDTC in Australia.

2. Executive Summary

A Study of Family Drug Treatment Courts in the United States and the United Kingdom

By Gregory Levine, Magistrate, Children's Court of Victoria

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Parental substance abuse is a serious social problem that requires urgent attention. Increasing numbers of children in Victoria are being removed from their parents' care, often permanently. The goal of family reunification – which is recognised to be in the best interests of the child – is rarely achieved through traditional court processes. This Churchill Fellowship provided the opportunity to conduct an in-depth study of Family Drug Treatment Courts in the US and UK, the most effective intervention a court is capable of providing to substance abusing parents and their children. The aim was to develop sufficient in-depth understanding of their processes and procedures to set up the first FDTC in Australia.

The FDTC is not a court in the traditional sense. It is designed as a specialist problem-solving court with a skilled Team of multidisciplinary professionals attached to the court. I visited 6 exemplary FDTCs in the US and 1 in the UK and met with Judges, FDTC Teams, residential and outpatient treatment clinicians, administrators, child and adolescent psychiatrists, lawyers, academic researchers and specialists who provide training and evaluations of FDTCs.

Highlights included: attending court hearings and observing the Judges and FDTC teams working successfully in a very different non-adversarial court process; seeing the positive outcomes for parents in graduating and achieving reunification with their children; meeting with senior personnel of the National Association of Drug Court Professionals, The Justice Programs Office at American University and the Centre for Court Innovation who provided expertise and inspiration for the processes of establishing an FDTC in Australia; visiting The Linda Ray Intervention Center, Miami, and its outstanding approach to helping children 0-3, severely affected by parental substance abuse, reach their developmental potential; meeting with the London FDAC Team, led by Judge Nick Crichton, to engage with a new court model recently established on the US model but adapted for the UK context.

The major lesson from this research is that Family Drug Treatment Courts offer a proven structure and set of processes for interrupting the intergenerational harm caused by substance abuse and for giving parents the very best chance to rehabilitate and be reunited with their children. FDTCs impact positively on the lives of children by shortening the time lines to achieve permanency planning. They save money, particularly through the reduced use of foster care. They improve the way Children's Courts engage with families because the judicial officer maintains control of cases through a docket system, develops a direct relationship with parents through frequent hearings and works closely with a strong multidisciplinary Team who provide carefully coordinated case management and intensely monitored treatment services for both parents and children. This collaborative team approach is far more successful than the traditional court process in achieving reunification of families. Given the substantial numbers of child protection cases each year in Children's Courts where parental substance abuse is the dominant issue, there is a compelling argument for the establishment of FDTCs in Australia.

My central recommendation is that the first Australian FDTC be established in Melbourne as a pilot program over a three-year period. I will meet with senior members in the government, non- government and university sectors to form a Steering Group consisting of highly qualified experts in child protection, substance abuse treatment, mental health, justice and the legal profession. Its key role will be to champion the formation of the FDTC within the Children's Court of Victoria; to seek out funding and the provision of necessary treatment and rehabilitation resources; to develop a model for its approach, procedures, multidisciplinary Team membership and evaluation. Information about the FDTC will be widely disseminated at conferences, seminars, communication with professional organisations and likely user groups. If the pilot is as successful as the courts observed in the US and UK, I anticipate that it will be entrenched in legislation as an integral part of the Family Division of the Children's Court of Victoria.

3. The Churchill Program: March-April 2012

This Churchill study was realised through a comprehensive program of visits to 6 Family Drug Treatment Courts in the United States (San Jose, California; Stockton, California; Omaha, Nebraska; Miami, Florida; Washington DC; New York City) and 1 in London (the only court set up outside the United States). The aim was to develop in-depth understanding of the innovations of Family Drug Treatment Courts and sufficient methodological and operational knowledge to set up a similar court in Australia.

From	To	Place	Institution/Organisation
4 March	9 March	Santa Clara County, San Joaquin County, California	<ol style="list-style-type: none"> (1) Santa Clara Superior Court, Judge Susan R Bernardini [sbernardini@scscourts.org] (2) Judge Len Edwards, Centre for Families, Children and the Courts, San Francisco [Leonard.Edwards@jud.ca.gov] (3) Deborah Dohse, Drug Court Coordinator [ddohse@scscourt.org] (4) Judge Stephen Manley, Superior Court of California [smanley@scscourt.org] (5) Judge Jose Alva, San Joaquin Superior Court, [jalva@courts.san-joaquin.ca.us] (6) Judge Peggy Hora, Superior Court of California [judgehora@judgehora.com]. Retired. (7) Parisi House on the Hill, Debbie Miranda, Executive Officer [dmiranda@parisihoth.org] Terrie Miller, Clinical Manager [tmiller@parisihoth.org] (8) SCC Department of Alcohol and Drug Rehabilitation Services, Mark Stanford, PhD [Mark.Stanford@hhs.sccgov.org] (9) Allen Korenstein, Dependency Advocacy Centre [akorenstein@sccdac.org]
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From	To	Place	Institution/Organisation
			<p>(3) FDTC Staffing Team (Katie King, FDTC Coordinator; Archie Scott & Kendra Jones, Case workers; Jennie Cole Mossman, Centre for Children, Families & the Law, University of Nebraska; Paulette Merrell County Attorney; Janice Walker, State Court Administrator; Claudia McKnight, Public Defender; Heartland Family Services; Guardian ad litem; Lawyers)</p> <p>(4) Heartland Family Services, Barb Jessing [bjessing@heartlandfamilyservice.org]</p> <p>(5) Family Works, Heather Bird, Director [hbird@heartlandfamilyservice.org]</p> <p>(6) Project Harmony, Colleen Roth, Operations Director [acarnes@projectharmony.com]</p>
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24 March	25 March	Puerto Rico	Professor David Wexler, Director, International Network on Therapeutic Jurisprudence [davidbwexler@yahoo.com]
26 March	30 March	Washington DC, Alexandria, VA, Upper Marlboro, MD	<p>(1) Superior Court of the District of Columbia, Judge Pamela Gray [S.Pamela.Gray@dcsc.gov]</p> <p>(2) Estrellita Hicks FTC Coordinator [estrellita.hicks@dcsc.gov]</p> <p>(3) West Huddleston, CEO, National Association of Drug Court Professionals [whuddleston@nadcp.org]</p> <p>(4) Meghan Wheeler, Independent Consultant, National Drug Court Institute (NDCI) [mwheeler@ndci.org]</p>

From	To	Place	Institution/Organisation
			<p>(5) Professor Caroline Cooper, Director Justice Programs Office, School of Public Affairs, American University [ccooper@american.edu]</p> <p>(6) Earl Hightower, Hightower Intervention Services [earlh@hightowerintervention.com]</p> <p>(7) Nellie Vasquez-Rowland, President, Safe Haven Foundation [Neli@Asafehaven.com]</p> <p>(8) Second Genesis, Thomas Barrett CEO [Thomas.Barrett@secondgenesis.org]</p>
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We were guided throughout this project by the expertise of Judge Len Edwards, a pioneer in the Dependency Drug Treatment Court in California. He was instrumental in assisting with the itinerary and identifying key locations and contacts. At each site we visited, we took a multi-focal approach.

- (a) Firstly, we visited the Court: closely observing court proceedings, team planning meetings and administrative processes, talking with Judges, Program Coordinators and members of the Multidisciplinary Teams who are the heart of the treatment and rehabilitation of parents.
- (b) Secondly, we visited residential rehabilitation treatment centers and outpatient services used by the court and there we met with administrators, clinicians, education officers and mothers who were in treatment.
- (c) Thirdly, we met with academic researchers and specialists from affiliated universities, including child psychologists/psychiatrists, drug and alcohol, legal and social work academics and those directly involved in training staff to run the courts and evaluate the success of the programs.
- (d) Fourthly, we gained access to a wide array of written court documents and handbooks and the most recent research studies and evaluation reports on the Family Drug Treatment Courts.

Given the breadth and depth of our Churchill investigation, we regard this work as a feasibility study for developing a Pilot FDTC in Victoria, Australia. In sum, the data collected comprises:

- (1) Direct observations of 8 judges in 7 family drug treatment courts
- (2) Informal interviews with 11 FDTC Judges, past and present; 3 Judges from the criminal drug court and other problem-solving courts; and 6 FDTC Program Coordinators
- (3) Attendance at 6 FDTC multidisciplinary team meetings, including consultation with coordinators, case workers, mental health workers/psychiatrists, domestic violence workers, drug and alcohol specialists, clinical nurses, housing experts, lawyers and guardians ad litem
- (4) Visits to 6 residential drug treatment facilities (the preferred treatment option in the US)
- (5) Visits to 3 outpatient drug treatment facilities, 2 in the UK (the preferred treatment option) and 1 in the US; and 2 child development and child advocacy centers
- (6) Interviews with 8 academic researchers who track and evaluate the progress of the FDTCs and/or have expertise in problem solving courts; 3 experts on drug court policy and program development
- (7) Meetings with 5 lawyers who specialise in representing drug court clients
- (8) Meetings with 4 CEOs of non-profit organisations that provide services for substance abuse recovery programs
- (9) Full day meeting at the National Association of Drug Court Professionals, Washington DC, the national organisation for FDTCs in the United States. Consultation with West Huddleston, CEO, NADCP and full day in-service with Meghan Wheeler, Chief Training Coordinator/ Consultant re training required to set up FDTCs
- (10) Collection/Analysis of FDTC program documents, handbooks and manuals; review of quantitative and qualitative research conducted on FDTCs in the US and FDAC in the UK from 2007 to 2012.

4. What is the social problem that Family Drug Treatment Courts address?

Parental substance abuse is a serious social problem that requires urgent attention, world-wide. In England and Wales substance abuse is a significant factor in up to two thirds of care proceedings (Harwin et al, 2011). In the United States, it is estimated that between 60 and 80 percent of substantiated cases of child abuse and neglect cases involve substance abuse by a custodial parent or guardian (Young et al, 2007).

While there are no available statistics in Australia on this trend, anecdotally the pattern is similarly high. The absence of such figures – the fact that they have not yet been collected – is a significant gap. We do know that the families involved in child protection cases are characterised by one or more intersecting problems: drug or alcohol abuse, family violence, poverty, lack of education, inadequate housing, intellectual disability or mental illness (Victorian Law Reform Commission, 2010). While we cannot tabulate the percentage of Australian neglect and abuse cases involving parental substance abuse, we do know the problem is real and the consequences for the children and families concerned, devastating.

Once children are removed from their families care and protection proceedings commence, the likelihood of reunification is low. In Victoria, during 2010-11 approximately 3000 children and young people were placed in accommodation away from their family home, and on average stayed in care for 18 months, some in 3 or 4 placements in a single year. Over the past decade, the number of Victorian children and young people in out-of-home care has increased by 44 per cent, bringing the total number in care to 5,700 by June 2011. (Cummins et al, 2012: xxvi). Australia-wide, the number of children in out-of-home care has risen every year over the last 10 years, with 35,895 estimated in out-of-home care as of 30 June, 2011 (Lamont, 2011). Many of those children will carry the emotional and psychological impact of family separation into their adolescence and adulthood.

The long-term impact of out-of-home care is costly: emotionally, psychologically and financially. Recurrent expenditure on child protection and out-of-home care services was approximately \$2.5 billion across Australia in 2009-10. Nationally, out-of-home care services accounted for the majority (64.9% or \$1.7 billion) of this expenditure (Steering Committee for the Review of Government Service Provision, 2011). A study by the Social Policy Research Centre found that the cost of caring for children in foster care is, on average, 52% higher than the costs of caring for other children not in care (McHugh, 2002). But the psycho-social costs to the child are equally high. Adequate foster care is in short supply and many children in out-of-home-care experience multiple placement changes (Delfabbro, King, & Barber, 2010; Rubin, O'Reilly, Luan, & Localio, 2007). Such placement instability and lack of certainty about returning to the birth family has adverse effects on children, including emotional difficulties, behaviour problems and poor academic performance (Lamont, 2011).

To date, the traditional court process for dealing with parental substance abuse has had little success in improving poor outcomes for children and parents. Typically, a Judge or Magistrate makes orders to address multiple problems: requiring parents to attend drug treatment programs, do regular drug testing, attend parenting and anger management courses, attend relationship or domestic violence counselling and get assistance to find suitable accommodation. But these orders are rarely effective because there is no adequate follow-up process.

There are few adequate systems in place to ensure court orders are followed through – and hence to help parents rehabilitate and reunify with their children. Once orders are made, the court's responsibility ends there; the Judge or Magistrate has no further contact with the family or

knowledge of the outcomes. Further, there is no effective coordination of the multiple agencies parents need to access. The only person in the current system who is responsible for ensuring court orders are followed is the allocated social worker. But a number of reviews across Australia have highlighted ongoing crises in child protection services, high case-loads, poor training and supervision, burnout, and high turnover of child protection workers (Stevens & Higgins, 2002; Office of the Victorian Ombudsman, 2010). Such problems can lead to drug addicted parents not receiving the intensive monitoring they require; and may result in cases being unallocated, thus extending the time children remain in out-of-home care.

Here then is the problem in a nutshell. Increasingly, families in Australia are plagued by problems of parental substance abuse. Children are being removed from these families. Court orders are being made to facilitate parental rehabilitation and recovery, but these are not effectively carried out or coordinated. In the absence of adequate monitoring and support, parents are less likely to comply with or complete substance abuse treatment. One of the regular criticisms made of the Children's Court in Victoria is that it allows parents too many opportunities to prove they can rehabilitate. Giving parents more time (without also providing more systematic support) can result in cases drifting on for years and lack of stability for children – in escalating costs of out-of-home care and long-term problems for children, families, the child protection system, the courts and the broader community.

What the Family Drug Court offers is a way out of this relentless and damaging cycle- a proven structure and set of processes for interrupting the intergenerational harm caused by substance abuse and for giving parents the very best chance to achieve rehabilitation and to be reunited with their children. The remainder of this report demonstrates the way out by describing the features and principles of these courts, how they operate, their strategies for enhancing substance abuse treatment, rehabilitation and child safety, and evaluations of their effectiveness and cost benefits.

5. What are the key features of the Family Drug Treatment Court?

The Family Drug Treatment Court is not a court in the traditional sense. It is designed as a specialist problem-solving court with a team of multidisciplinary professionals attached to it. Its central goal is to protect children and to reunite families by providing substance-abusing parents with support, treatment, and comprehensive access to services for the whole family (Wheeler and Fox, 2006:3).

This problem-solving, multidisciplinary approach is consistent with the ongoing commitment of the Children's Court of Victoria to the initiation of problem-solving approaches, the development of specialist lists, and encouraging measures to improve collaborative practice (Children's Court of Victoria Submission to the Protecting Victoria's Vulnerable Children Inquiry, 2011). Significantly, it also supports findings from the recent Cummins Inquiry (Report of the Protecting Victoria's Vulnerable Children Inquiry, 2012). That report strongly recommends a less adversarial model for hearings in the Children's Court; new specialist and docketing listings, with one judicial officer seeing cases through from commencement to end; and increased cooperation between all agencies involved in child protection.

These reforms should allow for increased opportunities for collaborative problem-solving that would promote the ongoing safety of the child while, at the same time, maintain the critically important link between the child and the family (Cummins et al, 2012: xliii)

Six key features define the FDTC and distinguish it from traditional court proceedings.

5.1 A problem solving rather than adversarial approach to decision making

In a problem-solving approach to working with families, the judicial officer uses the authority of the court to monitor parents and encourage their recovery and reunification with their children. A comprehensive analysis of the issues are made in collaboration with all the agencies who bring their particular expertise to the development of a process and a solution for the family. In more traditional adversarial proceedings, parties have a particular position which they strive to have accepted by the court; decisions are based on the quality of evidence and evaluation of witnesses and legal argument. A move away from this model reduces conflict and dispute; all parties are focused on working to achieve a particular goal - the same goal - thus enhancing the chances of family reunification.

5.2 Court-based multidisciplinary Team approach to case management

A specialist team is attached to the court which coordinates many agencies (child protection, drug and alcohol, mental health, housing, etc) to work with substance abusing parents and their children. This ensures comprehensive case planning and a coordinated approach to the initiation and completion of substance abuse treatment. Using a multi-skilled team means a broader range of expertise can be accessed; it provides consistency in reporting back to the court and allows regular adjustments to be made to case plans for children and parents to ensure programs are working appropriately. Ongoing cross training among team members is seen to be essential to this multidisciplinary approach as it facilitates working together to reduce institutional or programmatic barriers to better serve families (Wheeler and Fox, 2006:3).

5.3 Judicial continuity though using a docket system

The judicial officer maintains control of cases to ensure consistency, familiarity and continuity for parents, lawyers and the team. While the docket system is universally used in the US in all courts, and has been introduced in the UK Family Drug and Alcohol Court, it will need to be introduced into the Australian court. (The only exception is one program operating in the Family Court of Australia). This constitutes a new role for the Judge/Magistrate in building an ongoing relationship with the family and encouraging parents to turn their lives around. Regular and frequent interactions with parents during court hearings facilitate a comprehensive understanding of the issues and a potentially more efficient use of judicial time. Being treated with respect by the Judge and empowered to actively engage in their own recovery is cited by some parents as being critical to their success in the program (Marlow and Carey, 2012).

5.4 Quicker child-focused time lines regarding family reunification or permanent placement outside the home

Compared to the current system, time lines are tighter for determining whether there can be reunification of the children with their parents. If the parents are not successful in the treatment program, then earlier resolution of long-term permanency planning occurs. 12 months is the usual timeline for decision making in both the US and the UK and all effort is made to keep the child's need for early resolution as the primary focus. Timelines are court-based and court-controlled rather than left to the case worker; progress is intensely monitored by the team against time constraints that are kept to the forefront of parent's rehabilitation. In the current system in Australia, by contrast, cases may not come to court more than once every 12 months and there is no regulated system of progression. The net result in the FDTC is a more rapid process for reunification or permanent placement outside the home and critically, a reduction in that period of uncertainty about a child's long-term placement.

5.5 Closely monitored rehabilitation to keep parents focused on recovery and improved parenting

Treatment and intervention is not only more rapid, it is better coordinated as a multidisciplinary approach enhances communication and action between agencies. Strategies for treatment are regularly reviewed by the team, where the focus is never just about parents getting clean and drug-free, but also addresses underlying and compounding issues of addiction, such as domestic violence, mental and physical health, housing, child care and education that impact on their capacity to parent. It is widely accepted that addiction affects not only the parents, but their children, who are at high risk of emotional and physical neglect, psychological problems and poor developmental outcomes (Dice et al, 2004). The explicit focus in FDTCs on improving the parent-child relationship is thus a significant innovation that can work to mitigate the damage experienced by these children.

5.6 More frequent court reviews to foster compliance and connection

FDTC participants appear before the Judge and the Team on a weekly, biweekly or monthly basis, depending on their treatment progress. Contact decreases gradually as parents become engaged in treatment and restructure their lives. This frequency of contact and ongoing review of progress is a critical motivator for parents to comply with treatment and case planning. It also fosters strong

relationships and connection. Experiences in other disciplines (eg doctor-patient, teacher-student, social work-client) confirm the power of personalising the professional-client relationship to achieve better compliance and learning outcomes. (Edwards and Ray, 2005:26). Frequent hearings also permit the court to hold service providers accountable for services promised to FDTC parents.

6. How does the Family Drug Treatment Court differ from the Criminal Drug Court?

The Family Drug Treatment Court was adapted from the Criminal Drug Court model. It can be understood as an extension of that model for cases involving child abuse and neglect. There are, however, significant differences because FDTCs must treat parental addiction and recovery as well as address child safety and permanency. There are currently 10 Criminal Drug Courts in Australia but no Family Drug Treatment Courts.

6.1 Similarities in principles: Ten Key components

The first Criminal Drug Court began operating in 1989 in Miami, Florida. Since that time, the drug court model program has been adopted in 50 states (plus the District of Columbia, Guam and Puerto Rico) as well as in over 20 countries outside the United States (BJA Drug Court Technical Assistance Project, 2012).

In Australia, Criminal Drug Courts currently operate in 5 states: New South Wales (1), Queensland (5), South Australia (1), Victoria (1) and Western Australia (2). Although their formation, process and procedures differ across jurisdictions, their main aim is to divert drug users from incarceration into treatment programs for their addiction. (http://www.aic.gov.au/criminal_justice_system/courts/specialist/drugcourts.aspx, accessed May 2012)

Criminal Drug Courts have experienced tremendous growth since their beginnings almost 23 years ago, with over 1400 now operating in the US and approximately 75 in the planning stages. FDTCs have also grown rapidly since the first court began in 1993; over 300 are now located in 37 states, plus the District of Columbia, and another 21 are in the planning stages (BJA Drug Court Technical Assistance Project, 2012).

Family Drug Treatment Courts draw on best practice from the adult criminal drug court model and adhere to its ten key components. Adherence to the following ten principles is seen to be critical to ensuring fidelity to the model and promoting parental recovery through a coordinated team approach.

THE TEN KEY COMPONENTS of the Criminal Drug Court Model

1. Drug Courts integrate alcohol and other drug treatment services with justice system case processing
2. Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights
3. Eligible participants are identified early and promptly placed in the drug court program
4. Drug courts provide access to a continuum of alcohol, drug and other related treatment and rehabilitation services
5. Abstinence is monitored by frequent alcohol and other drug testing
6. A coordinated strategy governs drug court responses to participants' compliance
7. Ongoing judicial interaction with each drug court participant is essential
8. Monitoring and evaluation measure the achievement of program goals and gauge effectiveness
9. Continuing interdisciplinary education promotes effective drug court planning, implementation and operations
10. Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court effectiveness. (Bureau of Justice Assistance and National Association of Drug Court Professionals, 2004).

6.2 Differences in focus, structure and purpose

Despite this common set of principles, there are significant differences between the two types of court. FDTCs differ in the focus, structure, purpose and scope of their activity because the best interests of the child must also be served (Wheeler and Fox, 2006). While FDTCs provide every necessary service to parents, they must also address and prioritise the needs of children and the family. Key differences can be summarized as follows:

- **program incentives**

In the Criminal Drug Court the principle incentive is to avoid a criminal record or incarceration. In the FDTC the key incentive is family reunification. Parents who succeed know they will have their children returned. Those who fail will face termination of their parental rights and/or long-term foster care for their children.

- **scope of services**

The Criminal Drug Court provides coordinated substance abuse treatment and closely monitored case management services for participants. In the FDTC there is the additional need to coordinate protective services for children with adult services and address all factors that impede family reunification. Thus FDTC partners include 1) the court; 2) child protection services and; 3) a wide array of drug treatment and other service providers for parents, children and families

- **measure of success**

To 'graduate' from the Criminal Drug Court participants must follow court orders and stay clean and sober for a sufficient period of time. In the FDTC being 'drug free' is not the only measure of success. Parents also need to demonstrate effective parenting skills, the capacity to provide income, safe housing and a home free of violence for their children in a relatively short period of time.

- **response to non-compliance**

In the Criminal Drug Court, jail is used as a tool to support treatment when participants are chronically non-compliant or ultimately fail the program. The Family Drug Treatment Court is not a criminal court. The focus of intervention is safeguarding the child, not punishing the parent. FDTCs rarely use jail to punish parents; they develop other responses to non-compliance that are designed to change behavior.

- **gender differences in participants**

Most Criminal Drug Court participants are male while women comprise more than 85% of the participants in FDTCs. Nationally as of 2001, 87% of FDTC graduates in the US were women and 13% were men (Cooper, 2001). This gender difference has significant treatment implications, with most FDTCs structuring services to meet women's specific needs, such as dealing with low self esteem and depression, childhood trauma, domestic violence, co-occurring health disorders as well as taking a comprehensive approach to treating the mother-child relationship and including children, especially infants, in treatment. (Edwards and Ray, 2005:5)

In sum, this dual focus in FDTCs on the parent's recovery from drug and alcohol abuse and the child's need for protection and a safe home differentiates the Family Drug Treatment Court from the Adult Criminal Drug Court. Families bring complex problems and abstinence from drugs is only part of the story. The FDTC therefore provides every possible service to facilitate healthy child-parent relationships and improved parenting. Ultimately, however, decisions about timelines for safe permanency are child-focused and sensitive to children's developmental needs. When parents cannot address the issues that interfere with ability to care protectively, permanent plans are made to place children in out-of-home care.

It should be noted that in the United States, the FDTC must adhere to strict timelines established by the passage of the Adoption and Safe Families Act 1997. Courts are required to expedite permanency hearings and determine a child's permanent placement 12 months after the child enters foster care. This time frame places great pressure on all participants in the child protection system and particularly the Judge to move the process along and conclude the permanency process in the one year time frame (Edwards and Ray, 2005:5). A Termination of Parental Rights (TPR) proceedings is initiated if the child has been in foster care 15 of the most recent 22 months.

In Victoria, Section 319, Children Youth and Families Act 2005 provides that the Children's Court may make a permanent care order if the child's parents have not had care of the child for a period of at least 6 months, or for periods that total at least 6 of the last 12 months. The court must be satisfied that the parent is unable or unwilling to care for the child or it is not in the child's best interest to be in the care of the parent. Despite these tight timelines, very few permanent care proceedings occur this quickly. The emphasis is on continuing to work with parents and maintaining reunification as the goal, even when that goal is probably unrealistic, because the timelines are not mandatory. Our observation in both the US and UK courts confirm that adhering to tighter child-sensitive timelines is more likely to produce results which are in the child's best interests.

7. What does the research say?

A body of research on Family Drug Treatment Courts confirms that the FDTC is among the most effective programs for improving substance abuse treatment initiation and completion in child welfare populations (Oliveros & Kaufman, 2011). Since the first court opened in 1993, the results have been highly positive for parental recovery, family reunification and financial benefits to government.

The continuing success of the FDTC has been fostered by strong governmental support in the United States. On May 10, 2012 the US House of Representatives approved \$45 million for the Drug Court Discretionary Grant Program, an increase of \$14 million over the previous year. Democrat Stephen Lynch who proposed the amendment to increase funding said: 'Addiction does not discriminate as it shatters lives, breaks up families, and costs hundreds of billions of dollars annually...Drug courts work. Drug courts save money. They reduce crime...Most importantly, drug courts help restore and preserve families.' [<http://forum.adeincorp.com/viewtopic.php?f=21&p=1186>, accessed 10.6.12]

7.1 FDTC effectiveness: parental recovery and family reunification

The most recent Research Update on Family Drug Courts (Marlowe and Carey, 2012) pulls together results from a number of methodologically rigorous impact evaluations completed within the last few years. In a nutshell, the results show:

- parents in Family Drug Courts are twice as likely to go to treatment and complete it. In most instances treatment completion rates were 20 to 30 percent higher for the FDTC participants than for the comparison participants.
- children of Family Drug Court participants spend significantly less time in out-of-home placements, such as foster care.
- family re-unification rates were 20 to 40 percent higher for Family Drug Court participants than for comparison groups. (Marlow and Carey, 2012:2-3)

Detailed results from one of the evaluations performed in Jackson County, Oregon, from January 1, 2001 – July 31, 2008, illustrate the trend (Carey et al, 2010). Compared to child welfare-involved parents who experienced traditional family court processes, CFC (Community Family Court) parents:

- spent nearly twice as long in treatment and were almost twice as likely to complete treatment;
- had their children spend 257 fewer days in foster care (104 fewer per child) in the 4 years after drug court entry;
- were re-unified with their children more often and significantly sooner;
- had significantly fewer terminations of parental rights (TPRs);
- were re-arrested nearly half as often for any charge, and;
- had 33% fewer arrests with drug charges over time.

Overall, these results show the program was successful in reducing drug usage, reducing time in foster care and increasing child and public safety.

7.2 FDTC cost benefits: reduced foster care placements

Recent evaluations also highlight the ways in which FDTCs save money for government. The studies employ a cost-to-taxpayer approach, which treat family interactions with publicly funded agencies as transactions in which public resources were consumed and societal costs incurred. Three kinds of costs were calculated: Program costs (providing services to participants); Outcome costs (subsequent interactions with outside agencies such as child welfare and criminal justice); and Cost savings (calculating program and outcome costs against comparison group costs) (Marlowe and Carey, 2012: 3-4).

Program costs for the FDTCs ranged from approximately \$7,000 to \$14,000 per family, depending on the range and intensity of services offered. Outcome costs were significantly lower for FDTC participants than the comparison groups because of the decreased use of child welfare services. Importantly, cost savings accrued because of the reduced reliance on out-of-home foster care placements. The average net cost savings for the FDTCs ranged from approximately \$5,000 to \$13,000 per family. [Marlowe and Carey, 2012:4].

Results from the Jackson County, Oregon evaluation can illustrate how these cost benefits were realised. The program investment cost was \$12,147 (including treatment) per CFC participant. The cost due to recidivism, treatment and foster care usage over 4 years from program entry was \$29,694 per CFC participant compared to \$35,287 per comparison individual, resulting in a savings of \$5,593 per participant (regardless of whether they graduated) The majority of the cost in outcomes for CFC participants was due to foster care (\$15,000).

In sum the program had:

- a criminal justice, treatment and child welfare system cost savings of \$5,593 per participant over 4 years.
- a 106% return on its investment over a five-year period. That is, as participants maintain sobriety over time and more enter the program, total cost savings increased approximately ten fold over five years (Carey et al, 2010: 66).

7.3 Evaluation of FDAC, London: program effectiveness and cost benefits

Positive results are also reported from the Family Drug and Alcohol Court following the evaluation of its first years of operation, from 2008-2012 (Harwin et al, 2011).

Program Effectiveness

- FDAC parents were more successful in controlling their substance misuse (48% compared to 39% in the comparison group)
- FDAC parents had a higher rate of family reunification (39% compared to 21% in the comparison group). When parents could not control their substance misuse, it took on average 7 weeks less for children to be placed in permanent care, than in the comparison group.

- FDAC parents accessed substance misuse services sooner and were more successful at staying in treatment

Cost Benefits

- The average cost of the FDAC team per family was £8740 over the life of a case. This cost is offset by savings to local authorities from more children staying with their families.
- Further reduction in costs came from: (a) shorter care placements (£4,000 per child less); (b) shorter court hearings (saving £682 per family); fewer contested cases; (c) work done by experts in ordinary cases carried out by specialist team (saving £1,200 per case)

Overall, these results show a clear benefit to FDTC participants and to society in interrupting the cycle of intergenerational substance abuse and child neglect. There are tangible benefits to the taxpayer as well in terms of criminal justice, treatment, and child welfare-related costs in using the FDTC process over traditional models of court processing. Significantly, it is the reduced use of foster care that results in the largest cost savings. Given the escalating rise in foster care costs in Australia, such a result creates a strong economic impetus for adopting the FDTC model in Australia.

8. How do Family Drug Treatment Courts operate? Practices and innovations

Family Drug Treatment Courts provide a structured, therapeutic approach to assist parents to live a drug-free life and achieve family reunification within specified time frames. We observed a number of in-common and pioneering practices across the courts we visited to operationalise a collaborative problem-solving approach to monitoring, treatment and family rehabilitation.

8.1 A dedicated and well-trained FDTC team

While the exact composition of the FDTC team differed from court to court, it always included a Court Coordinator, an essential position for facilitating the good coordination, collaboration and communication between a wide array of multidisciplinary professionals and the court. Teams also include dedicated case workers for adults and children and dedicated drug addiction specialists. This continuity of personnel was essential to foster relationships of trust with parents and ensure effective communication within the court, particularly as the team liaised with a wide array of other professionals (eg early intervention specialists, mental health and substance abuse providers, trauma and domestic violence counsellors, school specialists, vocational and child psychologists, housing specialists etc.)

The Miami DDC engaged in concerted negotiations (National Council of Juvenile and Family Court Judges, 2003) with social services to obtain three dedicated protective caseworkers to develop and manage all aspects of the case plans, while additional funding from state legislatures and national grants was sought to fund 5 specialist positions for the team. The London FDAC team, funded by a £1.5 million grant over three years, consisted of 6 full-time and some part-time positions, including a Court Coordinator, an Administrator, 2 child and family social workers, a substance misuse specialist, a clinical nurse and a child and adolescent psychiatrist.

8.2 Eligibility criteria for participation

Participation in FDTC is voluntary for parents in neglect and abuse cases where allegations involve substance abuse. Eligibility criteria are as inclusive as possible to reach out to challenging populations. In fact, some courts 'choose the most difficult cases that will require the most intensive services and monitoring, including those cases where the mother has given birth to several drug or alcohol- exposed babies.' (National Council of Juvenile and Family Court Judges, 2003:9). This is in line with research that suggests the FDTC has equivalent or greater effects for individuals with more serious histories and multiple risk factors, such as mental health problems, domestic violence, inadequate housing (Marlowe and Carey, 2012) All courts, however, do develop some exclusion criteria, including: not accepting parents accused of sexual or severe physical abuse, with a severe criminal history or with severe mental health issues that are not well controlled – as these make rehabilitation within the allocated time period, unlikely.

8.3 Assessment process

All parents are assessed at the beginning of the program to determine eligibility and the nature of their addiction and life history problems. A court-referred substance abuse treatment program is then developed by the Team. Most of US courts we visited administer a two-hour psycho-social assessment at the first court appearance. Parents are then sent to residential treatment facilities almost immediately and the further specifics of treatment are worked out there, in ongoing

communication with the FDTC team. In London, a more extensive day-long assessment procedure was implemented. A detailed treatment plan was then devised by the FDAC Team, to which parents must agree at their second court hearing, with outpatient rather than residential services the preferred mode of treatment.

8.4 On-site court drug testing

Drug testing is a central component of the court's monitoring function in order to track recovery and detect relapses. FDTCs use frequent, random and observed drug testing. On-site urine testing is conducted at all US courts on the day a parent appears in court; results are available to the judicial officer before the hearing. In London FDAC, saliva swabs were taken before court, as these were seen to be more reliable than urine screens. They are also more expensive and had to be sent out for analysis, thus no results were available until the day after the parent appeared; hair strand tests were also used.

8.5 Phased structure of the program

The length of the FDTC program is usually one year and commences with the parent's voluntary agreement to participate. Most courts have four- five phases and intensive monitoring of parents through these phases, during which time parents appear before the court on a regular basis, often weekly at the start. The phases are structured around incremental goals, expectations and requirements and the use of graduated incentives to effect behaviour change.

Expectations for phase advancement are made clear to parents upon admission to the program. For example, the 0-3 Program in Omaha designates 5 phases: Phase 1 Choice: 45 days, parents come to court every week; Phase 2 Challenge: 60 days, parents come every 2 weeks; Phase 3 Commitment: 90 days, parents come every 3 weeks; Phase 4 Commencement: 90 days, parents appear every 4 weeks; Phase 5 Change: 90 days.

The structure in the London FDAC is less prescribed, but organised around 4 court milestones over 12 months (Entry to the court; Agreement to IPM treatment plan; Case Management Conferences (CMC) often 3-4 months into the process; Final Issues Resolution Hearing (IRH); there are also two key phases of treatment progression: 1) getting clean and addressing issues behind addiction; 2) changing parenting behaviours to provide a safe home for children.

8.6 Team meetings before each court appearance

One of the key forums for ensuring FDTC team collaboration and communication is the team meeting or "staffing" held immediately prior to court case reviews. These team meetings appear are critical to the success of the court; when attendance is sporadic or communication channels poor, court interactions with parents suffer. The Court Coordinator ensures all reports (drug screens, health provider updates, residential or outpatient reports etc) are up to date and distributed at least one day before the meeting. FDTC team members then discuss the progress of each family's case, suggest modifications and/or formulate future plans or responses. Staffing sessions are generally attended by the Court Coordinator, case managers, treatment staff and other service providers and often lawyers. In some courts the Judge attends (eg San Jose, London), at others (eg Omaha, Miami, New York, Washington) the Judge does not, due either to a busy schedule of other hearings or because it is believed this fosters judicial objectivity and better interactions in court.

8.7 The use of sanctions and rewards

FDTCs understand that substance abuse treatment is a complex process and that some relapse is inevitable. Motivational responses to parents are typically strength-based and use a predictable system of rewards for achieving milestones and developing skills that support reunification, recovery, and a stable lifestyle. Sometimes a graded system of rewards are applied, such as decreased court appearances and urinalysis, increased unsupervised visitation with children, phase advancement for compliance and ultimately reunification with children. In some courts we observed clapping for parents and eternal markers of achievement, such as entertainment vouchers, children's books and toys. Sanctions are also applied for non-compliance (eg missed hearings, counselling session or drug tests), through increased urine screens, community service hours, phase demotion, or essays reflecting on noncompliance or termination of parental rights. However, it has been argued (Edwards, 2010) that punishments are neither necessary or appropriate given the ultimate sanction- permanent loss of their children and a limited time to demonstrate they can parent safely.

8.8 Graduation ceremonies

At all courts we observed graduation ceremonies to mark FDTC participants successfully completing the program and being reunited with their children. These were very joyful events attended by the whole family and friends to celebrate the accomplishments of the parent. In the Omaha FDTC, the term Commencement is used to highlight the beginning of a new phase. Most courts developed their own rituals (some elaborate, others simple), including the presentation of a certificate by the Judge and congratulatory speeches from FDTC team members and/or other successful parent graduates. As not all participants graduate, success is also measured by early resolution of the issues and achieving permanency for children.

8.9 Parents as mentors

Many FDTCs encourage graduating parents to be mentors and sponsors for other parents entering the program. Successful parents are highly motivational for other mothers still struggling with addiction and drug-related family crises. The capacity to develop mentoring appears to be resource-dependent. The Mentor Moms Program operates throughout Santa Clara County, California and is highly successful in encouraging new clients to engage in and persevere with substance abuse treatment (Edwards and Ray, 2005). In London, it was found that effective parent mentoring required support and training from a dedicated team member. When resources were tight, mentoring was put on the back burner, but is currently being reinvigorated by a part-time position.

8.10 Data collection for good case management and evaluation

Evaluation is critical to FDTC program success. All the courts we observed had a designated clerk or administrator to devise and oversee systems to track the entry, progress and outcomes of participation in FDTC. Such data enables a court to understand and plan for the extent of parental substance abuse in their community. Many US courts applied for external grants and/or forged relationships with local universities to do evaluative as well as therapeutic work. In London, the Nuffield Foundation funded researchers from Brunel University to conduct the FDAC Feasibility Study and Evaluation Project. The Miami DDC had close research ties with the University of

Miami, Department of Epidemiology and the Linda Ray Intervention Center, which provides intensive early intervention for children. The Omaha FDTC collaborated with the University of Nebraska via Project Safe Start Nebraska, a federally funded project that provides assessment and dyadic psychotherapy for parents and their children

8.11 Quality partnerships for parenting

Interventions designed to improve parenting practices are central to the rehabilitation of parents in FDTCs. There is, however, concern in the US about the quality of parenting classes offered and the absence of evidence-based approaches in some locations. A recent NADCP evaluation of best practice (Marlowe and Carey, 2012) favours family interventions that: ‘(a) provide outreach to participants in their homes or community, (b) teach parents or guardians to be more consistent and effective supervisors of their children, and (c) enhance positive communication skills among family members (Child Welfare Information Gateway, 2012; Fixsen et al, 2010; Liddle, 2004, cited in Marlowe and Carey, 2012:10.) At the London FDAC, we observed a number of innovative strategies to engage parents beyond the usual ‘skills’ classes, eg through Video Interaction Guidance; Social Behaviour Networking Theory; Family Group Conferencing; Motivational Interviewing.

8.12 Facilitating FDTC set up, operation and cross training

Setting up an effective multidisciplinary Team requires planning and training. When there is no previous history of collaboration, new ways of working between agencies in child protection, substance abuse and justice are required. All the courts we observed developed processes to eliminate duplication of effort and to facilitate communication and knowledge of each other’s expertise, resources and practices. Often memoranda of understanding (MOUs) were developed regarding roles, responsibilities, and authority among the agencies. In the US invaluable technical assistance for setting up a new court, making decisions about court operation and cross training teams is available at the state and national level.

For example, we visited the National Association of Drug Court Professionals (NADCP), which has a critically important role as the national membership, training and advocacy organisation for the Drug Court model. It hosts an annual conference, sponsors ongoing research and evaluation, and provides numerous training events for FDTCs through its professional service branch, the National Drug Court Institute (NDCI). We also engaged with multiple resources and impressive levels of expertise offered by the Center for Court Innovation, New York City; and by the Justice Programs Office at American University, Washington DC, which offers evaluation and training services to courts engaged in judicial improvement efforts.

8.13 Collaborative approaches to advocacy

All parties in the FDTC have legal representation, with lawyers appearing for parents, children and social welfare agencies, as in traditional court proceedings. However, the problem-solving mission of the court necessitates a changed and more collaborative role for lawyers. They become involved in assisting clients to understand and persevere with the FDTC process, rather than engaging in an adversarial win/lose procedure. They work with the Team; ensuring parents understand their commitment to treatment and rehabilitation and supporting them through possible relapse, reunification and/or other permanency planning. In the courts we observed, the Guardian ad Litem played a significant role in advocating for the child, particularly in discussions of when/

how a parent's rehabilitation progress justified reunification. Many attorneys we met said they were initially cautious about the benefits of FDTC, but with time urged their clients to join as the considerable benefits offered by this new court structure emerged.

8.14 Intervening early

The Omaha FDTC (established in May 2005) was the only court we visited that was designed as a ZERO to THREE Court, to assist families with at least one infant or toddler under the age of three at the time their case was filed. This deliberate focus on the earliest years recognises that young children are the fastest growing population in the child welfare system; that the rate of child abuse is highest amongst children younger than three; and that young children are more vulnerable because they remain in care longer and are at greater risk of abuse while in care (Katz, Lederman & Osofsky, 2011:xx). The Omaha Court argues that 1 in 5 foster care placements are infants; once in care, they remain twice as long as older children; babies under age 1 make up 25% of the children in the child welfare system and; 76% of child abuse fatalities occur to children under age 4 (Johnson, 2007). It is believed that FDTC interventions can impact on the developmental delays and/or serious psychological damage experienced by young children in substance abusing families, if these occur early enough.

8.15 Co-parenting by birth parents and foster parents

The Miami DDC was the only court we visited which promoted the concept of co-parenting. Foster parents were invited to come to court for the regular hearings which substance abusing parents attend. The Judge encourages a partnership right from the beginning, despite some initial reluctance by foster parents, as this is seen to enhance empathy and benefit all parties. When children see everyone getting on, it decreases conflicts of loyalty and smooths transitions to and from visitations. It allows the foster parent to model good parenting behaviours and facilitates an ongoing connection, either in the case of adoption or of family reunification, when foster parents may act as respite carers for birth parents.

9. How does the Family Drug and Alcohol Court in the UK differ from the Family Drug Treatment Courts in the US?

It was invaluable to study the Family Drug Treatment Courts in the United States where there is a longer tradition of these courts and almost 20 years experience and compare these with the Family Drug and Alcohol Court in London, which only began in 2008. Clearly, there were many similarities in principle and operation: judicial continuity, regular judicial oversight of the cases and frequent court hearings with parents, a strong multidisciplinary team, carefully coordinated case management and intensely monitored treatment services for both parents and children. However, the judicial docket system is not universally used in the UK and had to be introduced into this specialist problem solving court, just as it will need to be in Australia.

In 2006, a Steering Group was set up in the UK, at the initiation of Judge Nick Crichton, and a Feasibility Study (Ryan et al, 2006) conducted which provided strong evidence of the need for such a court in England. It found the FDTC to be a sound model - intensive, closely managed intervention, offering parents a real incentive to tackle their problems but tough on those who cannot stay the course. And its structure and processes were seen to be an innovative solution to the growing problem of parental substance abuse in the UK. It recommended that a three-year pilot be set up at the Wells Street Inner London Family Proceedings Court, to be evaluated on whether outcomes for children and parents improve.

As judicial continuity was seen to be essential, two specialist judges were assigned to oversee all reviews of parental substance abuse, with cases listed on one day per week (Monday), and judges sitting alternate weeks. The timescales of the court process were tightened (to 12 months) to reduce the risk of cases drifting. Having a specialist Team attached to the court increased the court's confidence in making decisions, without the need for reports from a wide range of external experts, thus potentially reducing the cost of proceedings. Further, a multidisciplinary approach was seen to address a number of ongoing problems, including: a lack of training for social workers on substance abuse issues and how to deal with parental denial or resistance; poor communication between different professionals and tensions created by differences in ideologies, practices and objectives; a fragmentation of services, making it hard for professionals to coordinate their work and for parents to find their way around the system (Ryan et al, 2006).

Below we list some of the differences we observed during our time at court and with the FDAC team and researchers.

9.1 Naming of the court

While all courts in the United States work with parents who misuse both drugs and alcohol, and parents attend both AA (Alcoholics Anonymous) and NA (Narcotics Anonymous) for their long-term recovery, none of these courts use alcohol in their name. Drugs is the preferred generic term. By contrast, the London court is called the Family Drug and Alcohol Court to call attention to both substances and because alcohol is seen to be an equal if not greater problem in cases of child protection where children have been removed (Harwin et al, 2006). FDAC also uses the term substance MISUSE, while the US courts more commonly talk of about substance ABUSE. Misuse is perhaps a slightly less judgmental term in relation to dysfunctional parental behaviour, and is more suggestive of substance addiction as an illness.

9.2 Cases come later to court

One of the greatest problems faced by FDAC is being treated as ‘a court of last hope’ for family reunification. Proceedings come to FDAC later than in the US. Cases are often held onto by local authorities (child protection agencies) who have a high threshold for what constitutes significant harm. Authorities also have to pay substantial court fees to commence proceedings. Both factors appear to influence the lower success rate of family reunification in the UK. Two key recommendations from the first FDAC Evaluation address this problem: ‘Bringing cases to court earlier’ and ‘provision of a pre-birth assessment and intervention service’ in order to improve outcomes and to ‘produce savings in the long term if outcomes are improved’ (Harwin et al, 2011: 4).

9.3 Residential drug treatment used sparingly

In developing treatment plans, parents are most often referred to outpatient services and facilities, such as the highly recommended Core Trust. It is believed that a better test of capacity to parent occurs in the community (through outpatient services), rather than when parents are residing in a more secure and safe residential environment with every support. Most US courts, by contrast, use residential treatment as their first port of call and beds appear to be readily available.

9.4 Less overt use of sanctions and rewards

Both FDTs and FDAC use affirmation and strength-based approaches to parental achievement in the program. The FDAC court, however, creates a less emotional space, with less overt use of rewards and sanctions; this may be due to cultural differences. Thus there are no farewell letters to children or essays or community service as sanctions for non-compliance; no toys, gift vouchers, or clapping as rewards for positive recovery achievements. Nevertheless, the UK court is a respectful, caring, warm and verbally encouraging place. The team provides parents with a diary when they sign up to FDAC as a welcome and to teach them to organise appointments and daily routines. Our observations in the US suggest that external rewards worked best when they were directed to enhancing parenting (eg through gifting story books for reading to children).

9.5 Use of non-lawyer reviews

In the US, lawyers always appear when the parent comes to court. In FDAC, families meet the Judge and Team on a number of occasions without legal representation. This is due to funding restrictions (legal aid will only pay for 4 appearances) and the belief that parents will speak more directly and openly to the judge in this less formal setting. Minutes of these meetings are always sent to lawyers so they are kept fully informed. There are four key court events when lawyers must appear with the parent: 1. First hearing and entry to the court; 2. Second hearing when parents sign the FDAC agreement to their treatment plan 3. Case Management Conferences (CMC), often 3-4 months into the process 4. Issues Resolution Hearing (IRH) at the end, to resolve placement of the child.

9.6 Treatment model less intensely connected to AA and NA

In the US, regular attendance at AA or NA meetings and finding a sponsor is an essential requirement of treatment to ensure abstinence for parents during the program and after. Four meetings per week are usually required by the FDTC and a stamped sheet indicating attendance is brought to the court for verification. In the UK, AA attendance is a suggested course of action, but it is not discussed as intensively in the court (eg the challenge of finding a reliable sponsor) and is not 'required' as part of treatment.

9.7 Supervision orders made 12 months after graduation

Ongoing supervision orders are made in the UK so that the case can continue to be monitored after graduation. This allows local authority workers to be involved with the family for up to 12 months, so if there are problems they can bring the case back to court. In the US, many professionals spoke about the need for post engagement with families, but there appeared to be few established procedures. The FDAC Evaluation recommended 'the provision of a short-term aftercare service' 'to help parents sustain their recovery and continue to parent effectively once proceedings end. Research shows that reunifications when parents have misused substances are particularly fragile' (Harwin et al, 2011:4).

10. What do the parents say? Stories of recovery

We met many courageous women, confronting their demons and successfully rehabilitating because the infrastructure of the court and its related agencies helped them recover. FDTc parents are empowered to be involved in decision-making and are acknowledged for their accomplishments. They must also face their problems and accept the consequences for non-compliance. When they do go off track, however, FDTcs continue to believe in them, giving them every chance within a limited time frame to reunify with their children. The outcomes are always uncertain, reunification is never a given and the journey is rarely smooth and untroubled, as the following two stories illustrate.

Both narratives come from our experiences at the Miami Dade County Drug Dependency Court, as it was here that we had the most extended conversations and direct interactions with mothers in the program. It is often easy in submitting formal reports of this kind to lose the humanity, pain and inspiration involved in the experience being reported. We hope these stories capture a sense of the drama, intensity and bravery involved in parents' engagement with FDTcs – and its effects on us as observers.

10.1 On the use of sanctions for mothers who reuse

The Miami Dade County Drug Dependency Court is a vital and creative family drug court. Judge Jeri Cohen is dynamic, tough, resourceful, working with a team of case workers, child advocates, lawyers, substance abuse and mental health counselors, to help drug addicted mothers get rehabilitated and reunited with their children. But the time lines are short and this is continually emphasized to parents.

We witness one mother, Erica (pseudonym) who is clearly struggling with her addiction. Her two sons were removed six months earlier. Erica has been inconsistent in her commitment to the program and she has just used again. While doing some house cleaning, she found a bottle of alcohol, stared at it all day, then finally drank it and tested positive. The clock is ticking for her, at 9 months the Judge will need to see a consistent period of sobriety so she is confident that reunification is a real option for this family. Erica looks terrible, her hair is askew, dark circles under her eyes, hands shaking. She has been given the toughest sanction of the court: to write a goodbye letter to her children. She is holding the letter in her hand. The Judge asks her to read it aloud to the court. She turns to her lawyer and begs her to read it for her. The lawyer says she can't. The judge needs the mother to understand what it will be like to lose her children if she uses again.

Erica sobs her way through the reading. She apologizes to her sons, age 4 and 6, for being weak, for forsaking them. She promises she will always love them. She will always be their mother, she asks them to forgive her. As observers, we are tense with her pain, teary. But the power of this public sanction is visible and has effects. Soon after the reading, the Judge talks with Erica about what happened, the trigger, how to deal with the temptation next time, who to call, how to get help. She is compassionate but tough. She says: 'You see how it feels, Erica. You don't want to do it. You don't want to lose them. Fold the letter and put it in your purse. And the next time this happens read the letter and then call your sponsor. We don't want you to lose your children and we are here to help you get them back. You understand?' Moments later Erica leaves the court with her lawyer. The next case is called.

10.2 On relapse and the fragility of the journey to recovery

The Jefferson Reaves House (JRH) is a residential drug treatment facility affiliated with the Miami Drug Dependency Court. The Director of Clinical Services, Mr Assan Nijie, creates an embracing atmosphere for the 34 mothers and 6 babies in care at the time. JRH provides transport to the court, conducts random drug tests on site and encourages mothers who want to reunify to stay for 6 months. The aim is to get clean and independent, however, finding employment and housing for the women is their greatest challenge, as it is for all the programs we visited.

Mr Nijie introduced us to Jenny (pseudonym), a mother and past client, now employed by Jefferson Reaves House in the accounting department. Jenny was a bright, articulate woman, well groomed. It was difficult to imagine her on the street as she spoke candidly about the many times she failed to get clean. She was a serial rehabilitator: she would go off drugs, get clean, go home, only to be lured back by her mother, who was also using.

In 2006 Jenny had already lost 3 children and was 5 months pregnant before she realised it. She met a man, got married and had a child called Madison; 6 weeks later she was pregnant again, with Nicole. With no independent housing, the family went to live with her mother, also a drug user, and soon Jenny started using again. The father got custody of Nicole and Madison, Jenny went into residential rehabilitation at The Village, but she could not cope when she learned her husband went off with another woman. She went back on crack and her girls went into foster care. But on one of her access visits, she left the children in the car to do crack. They were taken from her. Within 3 weeks she lost her children, her job, car, home and was spending \$5000/week on crack cocaine.

In 2008 things changed when she entered the Miami Drug Dependency Drug Court, although she remembers being so out of it, she could not stay awake for the interview. She was sent to Reaves House, where she made steady progress and was able to have Nicole and Madison live there with her. When she graduated she got a good job, but the firm went bankrupt. Soon after, she became pregnant with twins. Her new partner brought his six year old into the relationship and she brought Madison and Nicole as well as the twins– five children in all. But she stayed sober and set up a construction company: her partner was the builder, she did the administration. She also went back to studying accountancy and eventually was offered an internship by Reaves House, where she now works full time. Jenny is still studying, tutors students at her house on Sundays, attends AA meetings and maintains her sobriety. She radiates her extraordinary achievement and is a joy to speak to. She proudly shows us photos of her five kids and is optimistic about her future. We are too, she is inspiring, but we appreciate the thin line between success and failure, the fragility of it all and the enormous effort required to maintain equilibrium.

11. Conclusions

This Churchill Fellowship has allowed me, in collaboration with Professor Kamler, to conduct an in-depth study of Family Drug Treatment Courts as they operate in the United States and the United Kingdom. These courts are a significant innovation on the traditional adversarial approach to dealing with parental substance abuse, currently used in Australia. Evaluations in the US and UK show that FDTCs reduce costs to courts and social services and significantly improve outcomes for parents and for children. FDTCs have a proven history and a set of processes that work.

We are not only inspired by the proactive and positive possibilities offered by this new court structure. We argue that establishing an FDTC in Australia is of the highest priority.

We propose that a pilot be set up within the Children's Court of Victoria, utilising my long experience and established networks and the knowledge gained from this research.

There is every reason to believe this innovative, problem-solving court will have an equally positive impact on the lives of substance abusing parents and their children in Australia as we witnessed in the US and UK.

11.1 The benefits of FDTCs

This report has highlighted the numerous strengths of FDTCs. Creating the first Family Drug Treatment Court in Australia will have multiple benefits to children, substance abusing parents, drug addiction, social service and legal professionals and to government. Key benefits can be summarised as follows.

- **FDTCs shorten the time to achieve permanency planning for children**

Tight, child-focused timelines impact positively on the lives of children, who may already suffer from physical and emotional neglect and social isolation, resulting in a host of behavioural and educational problems. Intensified drug treatment and monitoring of parent's rehabilitation results in greater success and a more rapid process of reunification with their children. If parents do not succeed, there is a timely reduction in uncertainty about a child's long-term placement outside the home. This earlier resolution enables a better outcome in terms of stability and attention to children's developmental needs.

- **FDTCs save money**

The evaluation studies of FDTCs are highly positive for parental recovery, family reunification and cost savings to government. Significantly, it is the reduced use of foster care that results in the largest cost benefits. With the escalating cost of foster care in Australia, such savings are significant. Savings are also achieved in the less easily quantified costs of long-term parental substance abuse, including family dysfunction and continuing to be reliant on social welfare as well as the increased likelihood of children themselves becoming substance abusers.

- **FDTCs improve the way Children's Courts engage with families**

FDTCs offer the most effective preventative intervention a court is capable of providing to substance abusing parents. Because the judicial officer maintains control of cases through a docket system, this ensures consistency, familiarity and continuity for parents, lawyers and the Team. Having a multidisciplinary specialist Team attached to the court ensures comprehensive case planning and a coordinated approach to the initiation and completion of substance abuse treatment. More frequent court reviews before the Judge and the Team fosters compliance and connection for parents - thus enhancing the chances of rehabilitation and family reunification.

- **FDTCs provide a collaborative approach to parental substance abuse**

FDTCs are effective because they use the multidisciplinary skills of a Team of experts to work with substance abusing parents and their children. This requires a concerted, collaborative effort among the various components of the justice, child protection and public health treatment sectors. A multidisciplinary approach enhances treatment effectiveness and communication between agencies and with the court. It fosters a more sustained approach to the underlying and compounding issues of addiction, such as domestic violence, mental and physical health, inadequate housing, child care and educational issues that impact on the capacity to parent. This leads to better case management and a coordinated approach to the multiple factors that interfere with family reunification.

- **FDTCs offer the best chance of family reunification**

FDTCs have the potential to reduce the number of children in out-of-home care, who carry the emotional and psychological impact of family separation into their adolescence and adulthood. They provide a radical intervention to an ongoing crisis: a high rate of parental substance abuse, an increasing number of children being removed from families and a low success rate in family reunification. Recovery from substance abuse is never a given. Rehabilitation is a fragile process intertwined with a host of accompanying problems. But FDTCs offer hope, more hope than traditional proceedings.

They increase the chances of reunification because they offer comprehensive support, treatment and access to services and close attention to the needs of the whole family.

11.2 The changes required

To set up and implement the FDTC in Australia will require a number of changes to current approaches for dealing with substance abusing parents. This will involve changes in ways of working for the judiciary, social work, drug addiction and legal professionals. In broad terms, the FDCT requires a more collaborative, intensely monitored and less fragmented approach to working with parents and children than currently operates. This process would be managed through the courts with a Judge/Magistrate closely involved from the start and all the support services provided through the intermediary of the court. A comprehensive analysis of the problems and issues can then be made in collaboration with all the agencies and professionals, who bring their particular expertise to develop a process and a solution for the family.

The changes required will affect a number of institutions and professions in Australia, including:

- **The Judiciary**

A docket system of hearing cases will need to be introduced so that one Magistrate or Judge maintains involvement in the case from the time it reaches court until the final resolution for permanency planning. This will require a change to listing procedures in the Children's Court as well a new role for the Judge/Magistrate in building an ongoing relationship with the family through more frequent court hearings. A designated Clerk will need to be identified/appointed as responsible for overseeing a system to track the entry, progress and outcomes of participation in FDTC; and for assisting the Judge/Magistrate administer the complex and graduated calendar of hearings when parents appear weekly, bi weekly or monthly, depending on their progress through different phases of the program.

- **Department of Human Services**

The formation of a strong FDTC would require the Department of Human Services to provide experienced social workers to form part of the multidisciplinary Team. This would reduce isolation, removing sole responsibility for case management from the individual social worker to the Team. The expertise of the social worker would assist in the development of a holistic approach to supporting families affected by substance abuse, and a coordinated approach to providing services for adults and children.

- **Substance abuse specialists**

The FDTC provides a more prominent role for substance abuse specialists. They will no longer just be witnesses to proceedings who provide expert opinion, but will become an integral part of the Team - actively involved in case management processes and working with the families. They play a significant role in improving everyone's knowledge about the dynamics of addiction and recovery and provide expertise in developing appropriate treatment plans and services.

- **Legal professionals**

The problem-solving approach of the FDTC necessitates a more collaborative, less adversarial role for lawyers. They assist clients to understand and persevere with the FDTC process and work with the Team, often attending team meetings. Lawyers ensure that parents understand their obligation to commit to treatment; and advocate for them through possible relapse, reunification and/or other permanency planning. There is a significant role for Independent Children's Lawyer in advocating for children's best interests throughout process. The Department of Human Services would also be represented by lawyers to provide advice to social workers and assistance to the court during hearings.

11.3 The challenges ahead

There are numerous challenges to be addressed in developing the first Family Drug Treatment Court in Australia. The UK experience indicates that none of these are insurmountable.

- **The need for resourcing**

Starting the FDTC in Australia will require discussions and negotiations with government and non-government agencies to provide start up funding for a pilot program. In the US, the continuing success of FDTCs has been supported by a strong history of federal government funding as well as grants from state and local authorities. In the UK, the FDAC pilot was made possible through a grant of £1.5 million jointly funded by the Department of Education, the Ministry of Justice, the Home Office, the Department of Health and three pilot authorities (Camden, Islington, Westminster).

Funding is essential to ensure a continuity of personnel in the FDTC multidisciplinary Team, which in turn fosters relationships of trust with parents and ensures effective communication within and outside the court. Essential positions include a Court Coordinator, to facilitate collaboration and communication between a wide array of multidisciplinary professionals; a dedicated Clerk or administrator to track the entry, progress and outcomes for FDTC participants and manage timelines for permanency planning; several dedicated social workers and substance abuse clinicians with expertise in children and families work, a child psychiatrist and lawyers dedicated to the court. There will need to be a dedicated courtroom and team meeting rooms, preferably away from the general body of the Children's Court.

- **Creating new operational procedures**

To set up the FDTC, multiple decisions need to be made about creating a new system of operating, including: how substance abusing parents are identified, assessed, invited to participate, given case plans for rehabilitation and improved parenting, monitored during treatment, given sanctions and encouragement as appropriate during the family drug court process. Discussions need to address how to adapt the US and UK models to the Australian context and what the makeup of the multidisciplinary Team will be and how the team will work.

- **Developing new alliance across disciplines**

Setting up an effective FDTC multidisciplinary Team will require planning and training. If there is no previous history of collaboration, new ways of working between agencies in child protection, substance abuse and justice will need to be developed. Memoranda of understanding (MOUs) can be useful in this regard to delineate roles, responsibilities, and authority among the agencies and to reduce institutional or programmatic barriers to serving families. Ongoing cross training among team members can also play a critical role in facilitating communication and knowledge of each other's expertise, resources and practices. In Washington D.C., we had preliminary discussions with the NADCP about developing a proposal for a joint training initiative to facilitate FDTC planning and implementation in Australia.

- **Mapping available resources in the community**

No FDTC can be successful unless it has adequate treatment services for substance abusing parents and their children. A resourceful FDTC Team uses its own expertise in substance abuse and child protection, but also accesses additional support in relation to housing, domestic violence, mental health and improving the parent-child relationship. It is therefore critical to conduct an

initial mapping of the services that might be accessed to ensure an integrated holistic approach. In Melbourne, for example there are multiple agencies who provide interventions for parental substance abuse and for children exposed to traumatic circumstances. A critical first step is to identify the scope and quality of services available and the willingness of agencies to work collaboratively with the FDTC to foster long term recovery and family reunification.

12. Recommendations

This report has outlined the strong social, therapeutic and economic reasons for adopting the FDTC model in Australia. If outcomes are improved for substance abusing parents and their children in the same way that occurs in the US and UK, everyone benefits. Evaluations suggest we can anticipate a significant increase in the numbers of children being reunited with their families and the related benefits this has to the community. Cost benefits are also likely for government and the agencies responsible for the care of children who have been separated from their families.

There are 4 key recommendations that arise from this research.

12.1 to establish an Australian FDTC in Melbourne, Victoria as a 3 year pilot

The central recommendation is that the first Family Drug Treatment Court in Australia be established in the Children's Court of Victoria and that this is to operate as a pilot program over a three year period. As was the case in creating FDAC, London, three years will be needed to allow time for the court to be set up and run long enough for all involved to gain sufficient experience and to enable a reasonable time frame for evaluation. If the pilot is successful, it is anticipated that the FDTC will be recognised through legislation as an integral part of the Family Division of the Children's Court of Victoria.

12.2 to form a Steering Group to guide planning and development

To move from the intention to create a FDTC to the reality will require a collaborative approach. I intend to take a leadership role in contacting and convening the critical participants who might be part of a Steering Group – reaching out to experts in justice, social work, child protection, the substance abuse treatment community, mental health, children's services, legal practitioners and university academics in social work, substance abuse and law. The key role the Group will be to champion the formation of the court and make strategic decisions about its approach, procedures, resourcing and multidisciplinary Team membership.

12.3 to develop a program of research and evaluation

We have already noted the absence of any information in Australia on the number of cases in Children's Courts involving substance abuse, or the number of families reunited with their children, and over what time period. Interestingly, the same lack of data was faced by the FDAC team in London before they began their pilot. While there is clearly a strong case for implementing this Australian FDTC initiative, documenting its processes from the outset and evaluating its outcomes will be critical to establish its value and effectiveness. It will be important to begin conversations with academics to source research funding for that purpose.

12.4 to disseminate information about the Australian FDTC

As the Family Drug Treatment Court is a new initiative for Australia and is not widely known about, it is critical to engage a broad audience in discussions about its structure, innovation and benefits. I intend to advocate for the benefits of an Australian FDTC in a wide variety of community and government forums, at the state and national level. I will communicate the findings of this

Churchill Fellowship research to multiple professional groups and agencies who might be involved in developing a new collaborative team-based approach to dealing with parental substance abuse. Discussions have already commenced within the court, with the Department of Human Services and Monash and Melbourne Universities.

We have also planned a more formal set of conference presentations and papers in Victoria, nationally and internationally, including the following:

- Levine, G. 'Family Drug Treatment Courts'. Presentation made to the 18th Biennial Conference of the Association of Australian Magistrates in collaboration with the Victorian Magistrates Conference: Doing justice locally and globally. July 25-28, Melbourne.
- Levine, G. and Kamler, B. 'Developing a model for Family Drug Treatment Courts in Australia.' Presentation to the Child Protection Legal Forum: Holistic approaches in the Child Protection Legal System. October 18, 2012, Melbourne.
- The highlight of this event will be the opportunity to interact with Judge Nick Crichton, who provided the pivotal leadership in starting FDAC, London at the Wells Street Inner London Family Proceedings Court. As it is anticipated a core Steering Group will be formed by October, we have invited Judge Crichton to meet with the Steering Group on October 19 to guide discussion about the operational and strategic decisions needed to move forward the establishment of the FDCT in Melbourne.
- Levine, G. and Kamler, B. 'The case for a Family Drug Treatment Court in Australia: Putting children first'. Paper to be presented to the 6th World Congress on Family Law and Children's Rights, 17-20 March 2012, Sydney.
- This Congress provides an opportunity to extend conversations outside Victoria as it brings together government officials, family law practitioners, jurists, advocates, policing and protection agencies, medical practitioners, politicians and other organisations with a common interest in the active protection of children.
- Levine, G. and Kamler, B. 'The challenges of setting up the first Family Drug Treatment Court in Australia: creating a collaborative and therapeutic environment in cases involving parental substance abuse.' Paper to be presented to the 31st Congress of the International Academy of Law and Mental Health, Therapeutic Jurisprudence strand. July 14-19, 2013, Amsterdam, Netherlands.
- This Congress presents the opportunity to discuss our work in an international forum, where participants bring expertise in family drug courts, mental health and therapeutic jurisprudence.

Given the success of FDTs in the US and UK in both protecting children and reuniting families, we are committed to implementing such a court in Australia. They have a proven record of improving outcomes for substance abusing parents and their vulnerable children. They offer the best opportunity now available of breaking the destructive cycle of high numbers of children being removed from families.

We thank the Churchill Trust for supporting this first critical step in acquiring first-hand, operational knowledge about the Family Drug Treatment Court. This is in the best interests of children and the broader Australian community.

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