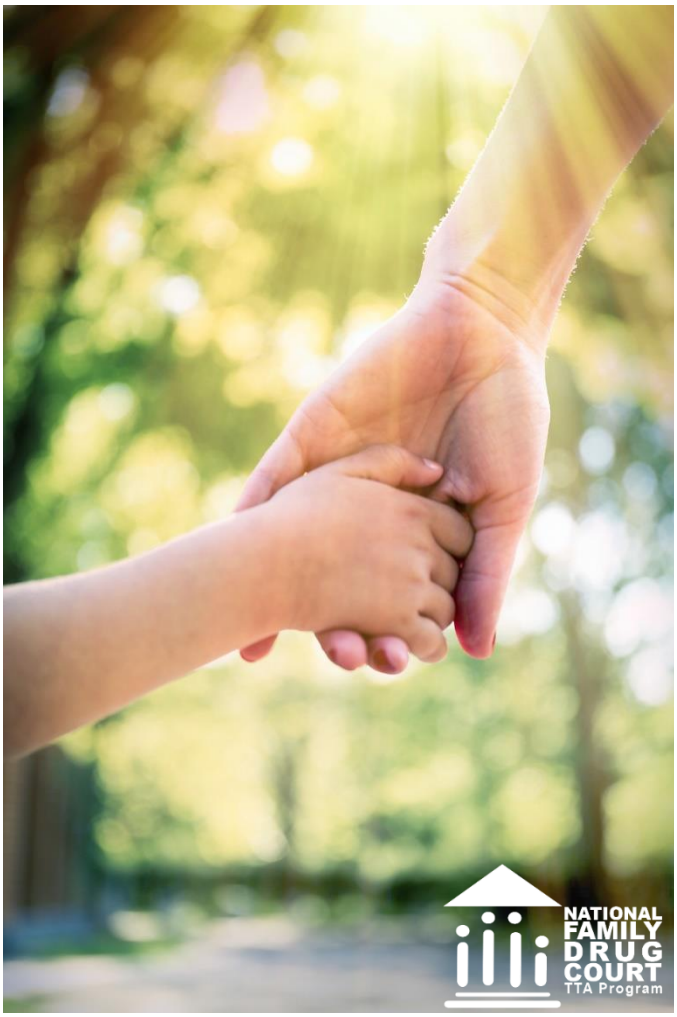



# Matching Service to Need: How Family Drug Courts Identify, Assess and Support Families to Achieve Recovery, Safety, and Permanency

*A Practice Brief presented by*
*Children and Family Futures*
*Lake Forest, California*
*June 2016*

*The National Family Drug Court Training and Technical Assistance Program is supported by Award No. 2013-DC-BX-K002 awarded by the Office of Juvenile Justice and Delinquency Prevention Office of Justice Programs*

## Introduction & Overview

Parental substance use disorders are a prevalent risk factor among families in child welfare services. Mothers with substance use disorders in the US are more than twice as likely to lose custody of their children than non-affected mothers (Suchman, DeCoste, Leigh, & Borelli, 2010) and when children are taken into protective services, mothers affected by substance use disorders are least likely to comply with court orders and most likely to permanently lose custody of their children (Barnard & McKeganey, 2004; Grella, Needell, Shi, & Hser, 2009). For the families who have children placed in protective custody, there is no time to lose in working toward recovery, safe parenting, and family stability as statutory timelines set forth by the Adoption and Safe Families Act (ASFA) (1997) drive decisions about the need for children to have permanency in their caregiving relationships. Thus, timely, effective, and coordinated interventions are critical to achieve treatment and child welfare outcomes.

As an adaptation of the adult criminal drug court model, Family Drug Courts (FDCs) have used the adult drug court experience, literature, and research to guide development and implementation of its model. Through intensive monitoring, high levels of coordination, effective communication, and comprehensive services, FDCs offer a solution to improve outcomes for families affected by parental substance use and child maltreatment. FDCs emerged in the mid-1990s to address inadequate access to treatment for substance use disorders among parents in child welfare and to improve families' outcomes in child welfare services and dependency courts. With over 300 FDCs now in operation across the nation, FDC outcomes have shown significantly higher rates of parents' participation in substance use disorder treatment, longer stays in treatment, higher rates of family reunification, less time for children in foster care, and decreased incidence of repeat maltreatment and return to out-of-home care compared to non-family drug court participants (Marlowe & Carey, 2012).

There is a body of evidence on *what works* with families affected by parental substance use disorders and child maltreatment including those served in FDCs.[1] *Who FDCs work for* and *who FDCs should be serving*, however are questions that remain particularly challenging to the field. Early studies (Boles & Young, 2011; Carey et al. 2010a, 2010b; Worcel et al., 2007) showed that FDCs who served the following types of clients had equivalent or better outcomes:

- Co-occurring mental health problems
- Unemployed
- Less than a high school education
- Criminal history
- Inadequate housing
- Risk for domestic violence
- Methamphetamine, crack cocaine, or alcohol as primary drug or substance

These findings would suggest that FDCs are well poised to serve the most demanding and challenging clients, or as the adult drug court field describes as "high-risk, high-need" individuals. These are families who would otherwise fail to achieve the goals of their treatment and child welfare case plans without intensive supervision, services, and support. Unfortunately, many FDCs struggle in defining their treatment and service population and the process for identifying FDC participants is often unclear or inconsistently applied. Many FDCs also lack the resources or the partnerships to provide the scope of services needed to meet these multiple and complex needs.

The purpose of this brief is to provide needed guidance on who FDCs should be serving, and how participants should be identified, assessed, served and supported. Given the time limits set forth by ASFA, it is critical that each of these processes be conducted in a timely, systematic, and coordinated manner by the entire FDC collaborative so families can achieve safety, permanency, and well-being. Since FDCs are imbedded in the larger service systems, this brief also explores the definitions of *risk and safety* as defined by the child welfare system and *need for treatment* as defined by the substance use disorder treatment field and how these assessments can be used to match families to the appropriate level of services. Throughout the brief, key questions (highlighted in green boxes) are offered for FDC teams and agency partners to consider when identifying, assessing, and referring clients into FDC. These questions point to the critical tasks of sharing information and serve as important reminders that the "team" and the collaborative process are just as important as the selection of a validated tool or evidence-based program.

**Seven (7) Common FDC Ingredients:**

1. System of identifying families
2. Timely access to assessment and treatment services
3. Increased management of recovery services and compliance with treatment
4. Improved family-centered services and parent-child relationships
5. Increased judicial oversight
6. Systematic response for participants – contingency management
7. Collaborative non-adversarial approach grounded in efficient communication across system and court

## Key Concepts and Definitions

### Risk & Safety

Adult drug courts are imbedded in the criminal justice system, and therefore, serve adults as a response to criminogenic risk and substance use disorder treatment needs to reduce recidivism of criminal behavior. Criminogenic risk refers to the prognosis or likelihood that the individual will not succeed in standard supervision and will continue to engage in the criminal behavior without an increased level of supervision and support (Marlowe, 2012a). Criminogenic risk is measured by validated tools such as the *Level of Service Inventory-Revised (LSI-R);*[2] *Correctional Offender Management Profiling for Alternative Sanctions (COMPAS),*[3] *Risk and Needs Triage (RANT)*[4]*; and the Federal Post Conviction Risk Assessment (PCRA)*[5].

[1] These include seven common practices identified by Children and Family Futures (see Box) and capture the key drug court elements of increased judicial monitoring and enhanced substance use recovery support. Although the ability to link any of these specific practice ingredient to a positive or negative outcome in the FDC context remains challenging due to lack of research (Marlowe & Carey 2012), a solid set of recommendations for effective practice and policy can be made. In 2013, CFF published a set of FDC Guidelines to provide further guidance and recommendations for policy and practice based on research or practice-based evidence.

[2] LSI-R - https://ecom.mhs.com/(S(zhkd5d55qlwc3lr2gzqq5w55))/product.aspx?gr=saf&prod=lsi-r&id=overview
[3] COMPAS - http://www.northpointeinc.com/software-suite.aspx
[4] RANT - http://www.trirant.org/
[5] PCRA - http://www.uscourts.gov/FederalCourts/ProbationPretrialServices/Supervision/PCRA.aspx

Family drug courts are imbedded in the larger child welfare system, and therefore respond to child safety and risk factors associated with parents' substance use disorders and treat the entire family unit to achieve safety and permanency outcomes. The concept of ***risk*** in child welfare practice denotes the likelihood that child maltreatment will occur or reoccur in the future if there is no intervention (Lund & Renee, 2009). Levels of risk to the child are generally assessed in a range from low, moderate, or high and guide decisions on whether to open, keep open, or close a child protection case (Child Welfare Information Gateway, 2013a). Typically, children determined to be at low-risk for abuse or neglect are unlikely to have a child welfare case opened (See Group A on Graphic 1). Families that are determined to need some level of child welfare supervision (ranging from informal supervision with the child remaining in-home or a formal court petition for the child's protective placement) are considered either moderate or high-risk, meaning there is a significant likelihood of future child maltreatment by the parent without intervention. The subset of those families where substance use disorder is a contributing factor is the pool from which FDCs identify their candidates. The pathway for families to enter FDCs begins with a safety assessment to determine if factors in the home create an immediate threat to the safety of the child and risk assessment to determine the likelihood of future maltreatment that are conducted by the child welfare' emergency response system. A common child welfare risk assessment tool used in many jurisdictions is the *Structured Decision-Making Tool.*[6]

Whereas criminogenic risk indicators are focused on the adult in the criminal justice system, risk factor indicators for child welfare include *child and family characteristics* that may contribute to a higher risk of further maltreatment such as:

- Having a child under age 5
- Child with special needs (whether due to diagnosed or undiagnosed prenatal exposure or other disabilities)
- Multiple children in the home
- Single parent homes with lower family income or dependency on public assistance
- Issues affecting parenting ability such as inappropriate discipline (Carnochan, et al, 2013; Slack, et. al, 2011, Child Welfare Information Gateway, 2013b).

The inclusion of child and family characteristics in child welfare services (CWS) risk assessments highlights the unique focus of FDCs on the family unit as the primary client. This particular focus on serving families and addressing the parent-child relationship will be highlighted further when discussing the service and treatment needs of families in FDCs.

The concept or dimension of ***safety*** is a key component of CWS assessments and refers to the current conditions within the family that pose an immediate threat of danger to the child. Whereas the concept of child risk denotes whether CWS supervision is necessary, safety refers to placement and whether a child can stay at home or not. Safety is based on the immediate need of a child to be placed in protective custody or remain home if enough protective supports are in place to prevent removal (Lund & Renee, 2009). A child is unsafe when he/she is vulnerable to immediate or impending danger and the caregivers are unable or unwilling to provide protection. A safety assessment involves identifying threats based on the caretaker's behavior and a judgment about the capacity of the caretakers to protect their child. For example, parents who are conducting drug sales out of their home or have a severe substance use disorder that interferes with providing nutrition and shelter for the child placing the child in grave danger. Protective capacities are cognitive, behavioral, and emotional qualities of the caregiver that support child safety (Lund & Renee, 2009, see Box).

Criminal justice system professionals make similar assessments when determining a course of action regarding safety threats to the community as decisions are made on arrest, release, and the degree of the individual's community supervision. These safety assessments should not be confused with criminogenic risk assessments, which again are not necessarily concerned with risk of violence or dangerousness (safety) but rather risk of treatment failure.

[6] SDM - http://www.nccdglobal.org/assessment/sdm-structured-decision-making-systems/child-welfare

## KEEPING KIDS SAFE: CAREGIVER PROTECTIVE CAPACITIES

**Cognitive protective capacity** refers to specific knowledge, understanding and perceptions that contribute to parenting vigilance (i.e. the caregiver plans and articulates a plan to protect the child; the caregiver understands his/her protective role)

**Behavioral protective capacity** refers to specific action, activity and performance that is consistent in parenting vigilance (i.e. the caregiver takes action to correct problems or challenges; the caregiver uses resources necessary to meet the child's basic needs)

**Emotional protective capacities** involves specific feelings, attitudes, identification with the child and motivation that results in parenting vigilance (i.e. the caregiver displays concern for the child and child's experience and is intent on emotionally protecting the child)

*(Source: Appendix B: Protective Capacities Definitions and Examples, Child Safety: A Guide for Judges and Attorneys, Lund & Renee, 2009)*

The safety and protective factor dimensions of a CWS risk assessment may result in parents with a substance use disorder maintaining custody of their children if enough protective factors are in place. In fact, the national trends in child welfare services show a growing population of families in "in-home" services (i.e. the child remains in home with or without court supervision).

Therefore, it is inaccurate to assume that a parent who has a history of a substance use disorder, is currently using alcohol or other illicit drugs, or is participating in medication assisted treatment automatically equates to an unsafe environment for the child necessitating placement in protective custody. Rather, the task is understanding parents' substance use and behavior associated with threats to child's safety. This assessment allows child welfare staff to formulate actions that manage the identified threats in the least intrusive way while assessing the parent(s) role in safety.

### Service and Treatment Needs

The concept of ***need*** for treatment is similar in both the criminal justice and child welfare systems and refers to requiring services to remediate functional impairments through substance use disorder treatment and other services. In child welfare cases, the service priorities are to address parent and family challenges so there is appropriate and adequate care of the child and to remediate conditions that are barriers to ensuring safety of the child and to improve family functioning. The child welfare agency has the ultimate legal responsibility to decide who will be served, what the overall focus of intervention needs to be, and whether the whole family is getting the services they need and making the changes necessary to achieve the outcomes of safety, permanency, and child well-being (Schene, 2005).

Determining the existence of substance use disorders and parents' need for treatment should be a standardized area of assessment for families brought to the attention of child protective services. Ideally, all families entering child welfare services would receive a screening for substance use disorders, and then those that screen positive would receive an expedited assessment using a valid and reliable tool to determine diagnoses, the appropriate level of treatment needed (e.g., residential, intensive outpatient, outpatient), type of treatment (e.g., detoxification or medication assisted treatment for opioid disorders), and the areas of life functioning requiring remediation. Reasonable efforts by CWS (which are overseen by the dependency court) mandate that every family that enters CWS due to parental substance use as sustained in the petition should receive some level of treatment.

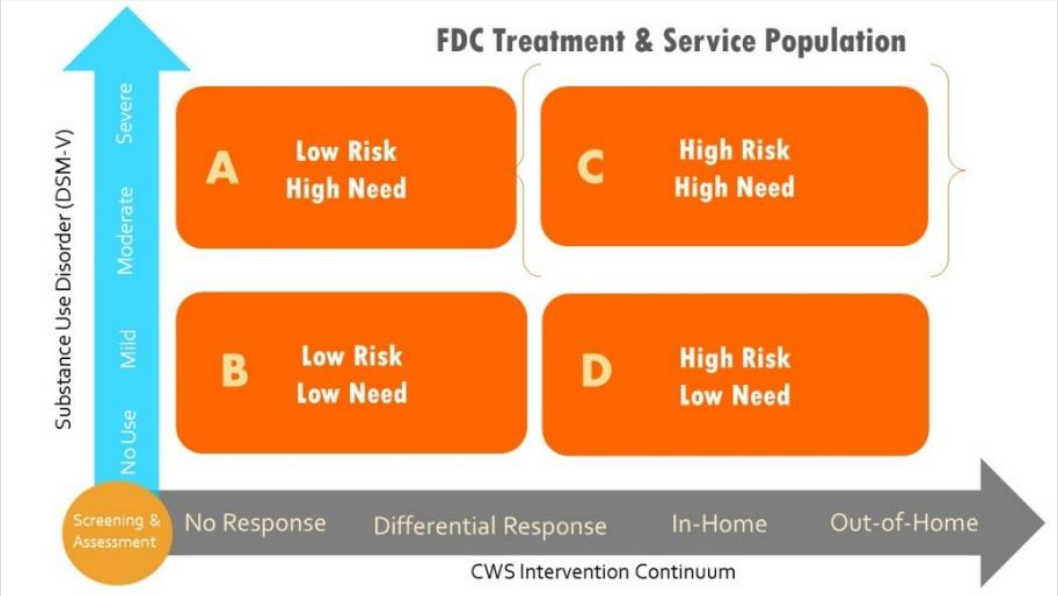
The most common service and treatment needs among individuals in the criminal justice system include substance dependence, major psychiatric disorders, brain injury, and lack of basic employment or daily living skills (Belenko, 2006; Simpson & Knight, 2007). Although child welfare staff would identify similar needs among families, a needs assessment would extend beyond parents and include the needs of each family member to ensure family safety, sufficient protective factors, and stability. For example, assessments should include child-related factors regarding pre- and post-natal exposure to parents' substance use. Trauma-informed assessments for children and parents should also be implemented to investigate trauma histories and symptoms. The focus on family recovery and child well-being should be reflected in the comprehensive treatment needs assessment for the entire family unit.

## PUTTING IT TOGETHER – RECOMMENDATIONS FOR PRACTICE

The determination of who FDCs should be serving is one of the most critical yet difficult decisions facing practitioners and FDC teams. Whereas established research directs adult drug courts to focus their resources on serving adults most likely to reoffend (high-risk) and with the highest criminogenic needs, the research for FDCs and the families they serve is less established. For FDCs to be part of an effective systems response, they must demonstrate a capacity to direct their limited resources to appropriate client populations. The following section offers some practice and research recommendations for FDC practitioners to consider as they seek guidance on whom they shall serve, how should clients be identified, and how they should then be served based on identified needs.

1. **FDCs should serve families that are in need of treatment and increased supervision and support and are at risk of failure of successfully completing the CWS case plan without such intervention.**

**Graphic 1** provides a matrix of four potential treatment and service populations, which are plotted along the vertical axis as Substance Use Disorder (ranging from no use to severe), and the horizontal axis of CWS intervention (ranging from a no response to out-home-placement) continuum. Groups A and B are families who would not be involved with CWS or be referred to Differential Response pathway where voluntary services are offered since the risk to the child is low. Families in Group A have a moderate to severe substance use disorder but do not present with parenting concerns requiring CWS attention or intervention. Families in Group D are involved in the child welfare system but for other reasons outside of parental substance use. If they do have a history, this can be addressed in less intensive services and under traditional court supervision.




Applying the high-risk high-need concept to the FDC context would suggest that there are some families in the child welfare system affected by parental substance use who will not succeed in the traditional dependency system unless they receive an increased level of supervision, support, and accountability. Reflected in Group C, these are families with children who are at risk of future maltreatment and parents who present certain factors and experiences that place them at a higher risk of failing in their case plan under standard court supervision of their treatment regimen. Parents who have a high need for treatment (Groups A and C) should be connected to effective and quality programs and level of care based on the clinical assessment. Families may also need enhanced coordination of additional services for functional impairments such as mental health care, trauma,[7] parenting programs specific for this group of parents, specialized child developmental services for children with effects of their pre- and post-natal exposure of parental substance use as well as concrete service needs such as housing, transportation, child care and income support.

[7] For more information about trauma-informed care, visit: http://www.samhsa.gov/nctic/trauma-interventions

FDCs should take caution that serving high-risk and high-need families does not limit serving only families in which the children have been removed. In fact, FDC outcomes suggest that a range of families regardless of placement status of the child have benefitted from participation in an FDC (Rodi, et al, 2015). These are families with children that may be at moderate-high risk of future maltreatment, but strong protective factors of families are in place to allow the child to remain in the home. Some FDCs have responded to trends in CWS by giving priority access to families where children are determined to remain in home while parents participate in FDC services. These groups are often parents of an infant with pre-natal substance exposure for whom traditional dependency court requirements of six-month reviews and monthly visits by child welfare workers may not be sufficient levels of supervision. Instead, they receive additional supports of the FDC including intensive supervision, access to quality treatment services and increased judicial oversight to ensure treatment success and child safety. Other jurisdictions have established pre-file FDC dockets that are serving intact families that are at risk of entering the child dependency system unless they succeed in their substance use disorder treatment services. The potential costs savings as well as the prevention and intergenerational effects of serving these groups of "in-home" child welfare cases are substantial.

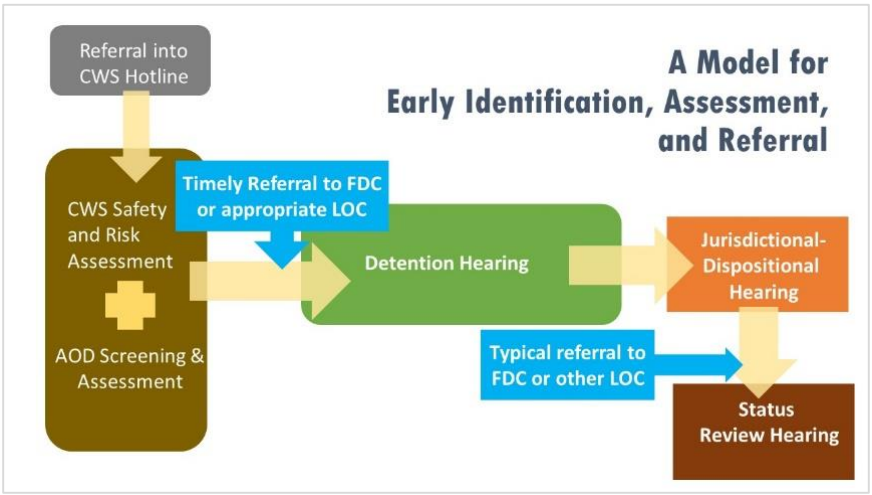
Many FDCs have exclusionary criteria for serious mental health issues, violent felonies, and domestic violence arrests or convictions while others rely on subjective criteria, personal impressions, or perceived client motivation to determine participants' suitability for the FDC program. Studies have shown, however, that parents with extensive criminal histories, inadequate housing, and a greater risk for domestic violence were more likely to complete FDC than those without these risk factors (Carey et al, 2010a, 2010b).

For FDCs to effectively identify their treatment and service population, future research should focus on identifying specific family characteristics predictive of FDC success as well as cost studies to measure cost benefits. That is the further test of the high-risk and high-need principle: *how can inclusion/exclusion criteria be tracked over time to determine which FDC clients receive the greatest benefit in terms of client outcomes and cost savings?*

What are the admission criteria for participation in the FDC? What are the exclusionary criteria? Are the criteria objective and applied in a standardized manner? Is the FDC tracking who is getting screening out of the program and for what reasons?

**2. Effective FDCs should develop joint policies and practice protocols among substance use disorder treatment, child welfare and the court to standardize screening and assessment of substance use disorders and risk to children among families in the child welfare system**

For families involved in child welfare services with parental substance use, an effective response starts with a timely substance use disorder screening and then assessment for those with a positive screen. Under ASFA, parents have limited time to comply with reunification requirements, including attaining and demonstrating recovery from their substance use disorder and safely caring for their children. Given these time mandates, FDCs must ensure that assessments are conducted at the earliest possible point following contact with child protective services, ideally near the time of the first court hearing and prior to the dispositional hearing.



The use of standardized and validated assessments to match clients to the appropriate level of care is far superior and yields significantly better results than relying on professional judgment (Andrews & Bonta, 2010; Babor & Del Boca, 2002; Karno & Longabaugh, 2007; Viera et al., 2009). The best approach is to administer a structured interview that is congruent with the diagnostic criteria in the Diagnostic and Statistical Manual Fifth Edition (DSM-V) (Marlowe, 2012a). The FDC should ensure that staff members who are conducting the clinical assessment are properly trained in the administration of the interview and are well versed in the DSM-V criteria.

Assessments to make these determinations must be timely and integrated with the child welfare case plan so parents receive the appropriate level of services based on their identified risks and need for treatment. Ideally, these assessments should be conducted as early as possible, preferably before the Detention Hearing (See Graphic 2). Some jurisdictions postpone the clinical assessment and referral to the FDC until after the Jurisdictional-Dispositional Hearing. Other jurisdictions do not conduct the clinical assessment until after the client is referred into the FDC. When these scenarios occur, valuable time is lost to demonstrate readiness for reunification and valuable resources are expended on families who may not need this level of intervention.

This underscores the critical need for FDCs to understand how to appropriately assess parental substance use and how it relates to the safety of children and parenting capacity. In most FDCs, the assessments of child risk and safety are conducted by child welfare staff and the clinical assessment for substance use disorder and the need for treatment and type of treatment placement are determined by a substance use disorder treatment professional. Although the use of validated tools is important, the important task of sharing assessment results is also critical so that each parent can be assigned to the appropriate level of both treatment and child welfare supervision.

This level of collaborative practice requires FDCs to ensure cross-training to build interdisciplinary skills and communication protocols for child welfare and substance use disorder treatment systems. A helpful resource entitled *Screening and Assessment for Family Engagement, Retention and Recovery (SAFERR)*[8] developed by the National Center on Substance Abuse and Child Welfare provides further discussion on cross-system collaboration and coordinated system response.

If substance use is a factor, what determines if children are removed or remain in the home? What factors guide worker's decisions? Are these factors consistently applied? Are parents referred for assessment? If yes, how? Always? Is it tracked? How long does it take to get an assessment?

If a parent completes an assessment, with whom is this information shared? How? Are treatment recommendations shared with the CWS worker? What happens if a parent refuses or doesn't show up? With whom is this information shared? Are there strategies to improve engagement?

**3. Ensure that clients are properly matched with the appropriate level of services**

Known as the responsivity principle in the criminal justice system, effectiveness and cost efficiency can be ensured when treatment and support services are appropriately matched to the risk and need profile of participant (Marlowe, 2012b). For instance, some families may need only outpatient treatment, while others will not succeed unless their treatment is paired with intensive monitoring. When clients are referred and placed in the wrong level of treatment or service, valuable time along the ASFA timeline and limited resources are wasted.

Another lesson learned from the adult drug court research is that clients may worsen when matched with the wrong treatment intervention. That is, parents who meet criteria for a severe substance use disorder should not be grouped in treatment programs with parents who do not meet diagnostic criteria or are assessed with a mild substance use disorder (Lowenkamp & Latessa, 2004; McCord, 2003; Petrosino et al., 2000).

Since not every family involved in the CWS due to parental substance use needs the intensive level of FDCs, it is imperative that FDCs be able to identify their program along the continuum of services currently in place in their community. These services may include recovery support or self-help groups, outpatient treatment or day treatment, and residential treatment services. Making appropriate matches involves being aware of the continuum of services available to serve the range of families affected by some level of substance use disorders. Many FDCs are so heavily

[8] https://www.ncsacw.samhsa.gov/files/SAFERR.pdf

focused on their program that they become isolated or unaware of the larger systems and community to which they belong. FDCs practitioners that are systems-focused would also concern themselves with how other families are being served outside of the FDC and what their outcomes are by monitoring available outcomes data collected by funding agencies.

Who decides the level of care needed? What is the basis for this recommendation? How is a referral to FDC made? Who determines who is referred?

What is the average wait time to enter into treatment? What happens while parents are waiting? Who communicates with parents regarding treatment recommendations, level, and availability?

**4. Provide the scope of services needed to address the effects of parental substance use on family relationships – family-based and family-strengthening approaches towards recovery.**

There is emerging evidence to support the importance of providing parent-child and family enhancements in FDCs to meet identified needs of participant families. These enhancements include evidence-based parenting, attachment or relationship-based counseling, early childhood intervention, and trauma-focused services, which are provided through the FDC's collaborative network and partnerships with their community (Rodi, et al, 2015). FDCs that have provided these enhanced services have demonstrated improved safety, permanency, and family well-being outcomes while those who do not provide such services may undermine the long-term success of participating adults by ignoring the needs of their children. Equally important to the type and scope of services offered is information sharing across systems regarding the family's participation and progress.

How is participation and progress in the parent-child EBP shared across the FDC team? With other partners or interested parties? How is progress in the EBP determined and/or measured?

## RESEARCH RECOMMENDATIONS

FDCs were created to improve outcomes of families affected by parental substance use involved in the child welfare system. Empirical evidence shows that through cross-system collaboration, accountability, and support services, FDCs are helping families achieve permanency, stability, and recovery more effectively than standard practices. Yet, differences in program models result in different patterns of outcomes. Further research is needed to fully understand these differences and better serve children and families with complex needs. The following are a set of research recommendations based on the current state of the field:

- *Future research should focus on understanding who benefits from participating in FDCs.* Are FDCs equally effective for a wide range of families, or are FDCs more effective for one group and less effective for another? This entails identifying specific family characteristics predictive of FDC success. By effectively identifying treatment and service populations, FDCs are able to produce cost beneficial outcomes for the greatest number of children and families.
- *Future research should focus on effective methods to screen for families likely to benefit from FDC participation.* Validated screening and assessment tools for FDC referral do not exist because of the lack of research on predictive family characteristics of FDC success. Once treatment and service populations are identified and validated with empirical evidence, research should focus on developing and validating a screening tool for FDC referral.
- *Future research should focus on mechanisms of effects that determine which court, treatment, and child welfare programmatic investments work for which populations.* Are certain FDC components more effective for families with certain characteristics? Research is limited on FDC structure, practices, and mechanisms of effect. While there are many local evaluations of FDCs, variations in the implementation of the model make it difficult to draw conclusions on active ingredients or core components of the model. Future research should focus on better understanding moderating influence of programmatic and non-programmatic characteristics on effectiveness. In other words, by identifying what works for whom with empirical evidence, FDCs will better be able to match the complex needs of families with the appropriate level of service, oversight, and accountability.

Since current FDC funding may be insufficient to support these research and evaluation recommendations, FDCs should consider partnering with local universities, local foundations willing to fund one-time, intensive evaluation, or secure appropriate funds through the Affordable Care Act to build the capacity of information systems that could support intensive evaluations.

## REFERENCES


Andrews, D.A., & Bonta, J. (2010). *The psychology of criminal conduct* (5th ed.). Waltham, MA: Anderson Publishing.

Babor, T., & Del Boca, F. (Vol. Eds.) (2002). *Treatment matching in alcoholism: International research monographs in the addictions.* In G. Edwards (Series Ed.). Cambridge, UK: Cambridge University Press.

Barnard, M., & McKeganey, N. (2004). The impact of parental problem drug use on children: What is the problem and what can be done to help? Addiction, 99(5), 552–559 http://dx.doi.org/10.1111/j.1360-0443.2003.00664.x.

Belenko, S. (2006). Assessing released inmates for substance-based-related service needs. *Crime & Delinquency*, 52: 94-133.

Boles, S., & Young, N. K. (2011). Sacramento County Dependency Drug Court year eight outcome and process evaluation findings. Irvine, CA: Children and Family Futures.

Breshears, E.M., Yeh, S. & Young, N.K. Understanding Substance Abuse and Facilitating Recovery: A Guide for Child Welfare Workers. U.S. Department of Health and Human Services. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004.

Carey, S.M., Sanders, M.B., Waller, M.S., Burrus, S.W.M., & Aborn, J.A. (2010a, June). *Jackson County Community Family Court process, outcome, and cost evaluation: Final Report*. Portland, OR: NPC Research. Available at http://www.npcresearch.com/Files/Jackson_Byrne_0610.pdf.

Carey, S.M., Sanders, M.B., Waller, M.S., Burrus, S.W.M., & Aborn, J.A. (2010b, March). *Marion County Fostering Attachment Treatment Court – Process, outcome and cost evaluation: Final report*. Portland, OR: NPC Research. Available at http://www.npcresearch.com/Files/Marion_Byrne_Final_0610.pdf.

Carnochan, S., Rizik, Baer, D., and Austin, M.J. (2013). Preventing the recurrence of maltreatment. *Journal of Evidence-Based Social Work.* 10(3), pp. 161-178.

Child Welfare Information Gateway. (2013a). How the Child Welfare System Works. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

Child Welfare Information Gateway. (2013b). What is child abuse and neglect? Recognizing the signs and symptoms. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

Grella, C.E., Needell, B., Shi, Y., & Hser, Y. (2009). Do drug treatment services predict reunification outcomes of mothers and their children in child welfare? *Journal of Substance Abuse Treatment, 36,* 278-293. doi: 10.1016/j.jsat.2008.06.010

Karno, M.P., & Longabaugh, R. (2007). Does matching matter? Examining matches and mismatches between patient attributes and therapy techniques in alcoholism treatment. *Addiction,* 102(4), 587-596.

Lowenkamp, C.T., and Latessa, E.J. (2004). Understanding the risk principle: How and why correctional interventions can harm low-risk offenders. *Topics in Community Corrections, 2004.* (Washington, DC: U.S. Department of Justice, National Institute of Corrections), 3-8.

Lund, T.R., and Renee, J. (2009). Child safety: a guide for judges and attorneys. *American Bar Association:* Washington, DC.

Marlowe, D.B. (2012a). Drug Court Practitioner Fact Sheet: Targeting the Right Participants for Adult Drug Courts. National Drug Court Institute: Alexandria, VA.

Marlowe, D.B. (2012b). Drug Court Practitioner Fact Sheet: Alternative Tracks in Adult Drug Courts: Matching Your Program to the Needs of your Clients. National Drug Court Institute: Alexandria, VA.

Marlowe, D. B., & Carey, S. M. (2012) Need to Know: Research Update on Family Drug Courts. National Association of Drug Court Professionals: Alexandria, VA. http://www.nadcp.org/sites/default/files/nadcp/Reseach%20Update%20on%20Family%20Drug%20Courts%20-%20NADCP.pdf

McCord, J. (2003). Cures that harm: Unanticipated outcomes of crime prevention programs. *ANNALS of the American Academy of Political & Social Science,* 587, 16-30.

Petrosino, A., Turpin-Petrosino, C. & Finckenauer, J.O. (2000). Well-meaning programs can have harmful effects! Lessons from experiments such as Scared Straight. *Crime & Delinquency, 46,* 354-379.

Rodi, M.S., Killian, C. M., Breitenbucher, P., Young, N.K., Amatetti, S., Bermejo, R., & Hall, E. (2015). New Approaches for Working with Children and Families Involved in Family Treatment Drug Courts: Findings from the Children Affected by Methamphetamine Program. Child Welfare, 94(4).

Schene, P. (2005). Comprehensive Family Guidelines for Child Welfare. National Child Welfare Resource Center for Family-Centered Practice. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

Simpson, D.D. & Knight K (Eds). (2007). Special Journal Issue: Offender needs and functioning assessments. *Criminal Justice and Behavior,* 34(9).

Slack, K.S., Berger, L.M., DuMont, K., Yang, M., Kim, B., Ehrhard-Dietzel, S., and Holl, J.L. (2011). Risk and protective factors for child neglect during early childhood: A cross-study comparison. *Children and Youth Services Review*. 33(1), pp. 1354-1363

Suchman, N.E., DeCoste, C., Leigh, D., & Borelli, J. (2010b). Reflective functioning in mothers with drug use disorders: Implications for dyadic interactions with infants and toddlers. Attachment & Human Development, 12(6), 567–585 http://dx.doi.org/10.1080/14616734.2010.501988.

Viera, T.A., Skilling, T.A., & Peterson-Badali, M. (2009). Matching court-ordered services with treatment needs: Predicting treatment success with young offenders. *Criminal Justice & Behavior*, 36(4), 385-401.

Worcel, S., Furrer, C., Green, B.L., & Rhodes, B. (2006). Family treatment drug court evaluation final phase I study report. Portland, OR: NPC Research.

Worcel, S. D., Green, B. L., Furrer, C. J., Burrus, S. W. M., Finigan, M. W. (March 2007) Family Treatment Drug Court Evaluation: Final Report NPC Research: Portland, OR.