

Child Advocacy Program
Art of Social Change:
Child Welfare, Education, & Juvenile Justice

Professor Elizabeth Bartholet
Lecturer on Law Jessica Budnitz

ASSIGNMENT PACKET for Session #5
October 10, 2013

Substance Abuse and Child Maltreatment:
The Family Drug Court Model

Jeri B. Cohen, Circuit Judge, Juvenile Division, 11th Judicial Circuit,
Miami, FL

James Dwyer, Arthur B. Hanson Professor of Law,
William & Mary Law School

Response Panelist:

Ivana Culic, MD, Interim Medical Director, Special Care Nursery, Beverly
Hospital; Attending Neonatologist, Children's Hospital Boston;
Instructor in Pediatrics, Harvard Medical School

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Assignment

Speaker Biographies

Session Description

Readings:

Pages *

Elizabeth Bartholet

- Bartholet, *Nobody's Children* NC 67-81,
207-32

Jeri B. Cohen

- Cohen, et al., *Dependency Drug Court: An Intensive Intervention for Traumatized Mothers and Young Children*, in *Clinical Work with Traumatized Young Children* edited by Joy D. Osofsky (2011) 1-15
- P. Hora, *Family Dependency Treatment Courts in the United States*, International Society for Prevention of Child Abuse and Neglect (ISPCAN) Sept. 3-6, 2006, York, UK 16-18
- D. Marlowe and S. Carey, *Research Update on Family Drug Courts*, National Association of Drug Court Professionals, May 2012 19-29

James Dwyer

- J. Dwyer, *Family Drug Court Skepticism*, 2013 30-44

* NC refers to Nobody's Children pages: all other page numbers refer to this Assignment Packet

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Speaker Biographies

Judge Jeri B. Cohen is currently a circuit judge in the Eleventh Judicial Circuit Dependency and Criminal Drug Court Divisions. She received her Bachelor of Arts degree at Boston University, her Master of Arts degree at Harvard University, and her Juris Doctorate at Georgetown Law. Before being elected to the bench in 1992, Judge Cohen was a trial attorney with the Office of the General Counsel, Securities Exchange Commission in Washington, D.C., and an Assistant State Attorney under Janet Reno. While Judge Cohen has presided in several divisions of the County and Circuit Courts, her primary assignment has been in the Dependency Division of the Juvenile Court. Judge Cohen is recognized as a national expert on issues relating to child welfare, substance abuse and mental health. She is responsible for creating one of the first dependency drug courts in the country for parents who lose custody of their children because of addiction. She has worked on a national level with the Department of Justice and the National Drug Court Institute, to develop curricula and train dependency drug courts across the country. She has taught at statewide and national conferences and judicial colleges, and published numerous articles on family drug courts and child welfare. Her drug court was an original mentor court for The Center for Substance Abuse Treatment. She received a four year National Institute of Drug and Alcohol grant along with The University of Miami School of Epidemiology to study motivational casework in family drug court. This study was one of the first randomized court-based studies in the country. Judge Cohen is the chair of the Community-Based Care Alliance in Miami-Dade County tasked with overseeing the privatized child welfare system for the Eleventh Judicial Circuit. She is the past chair of the Statewide Court Improvement Project responsible for bringing state dependency courts into compliance with federal child welfare requirements. She served in this capacity for four years, setting up the statewide Model Court program for Florida. During her tenure, she oversaw the development of the statewide Dependency Court Benchbook that integrated law with behavioral health. She was a senior judicial fellow for the National Association of Drug Court Professionals, sat on the Governor's Commission for Substance Abuse and Mental Health, and currently serves on the Executive Committee of the South Florida Behavioral Health Network, the entity managing mental health and substance abuse services for Miami-Dade County. Judge Cohen has received numerous awards, including the Community Service Award from the South Florida Jewish Federation and the statewide Child Advocate of the Year award from the Guardian Ad Litem program.

Professor James Dwyer has taught Family Law and Youth Law at William & Mary since 2000, and at the University of Wyoming and Chicago-Kent law schools previously. He has written four books and numerous articles on the rights of children and the rights of biological and legal parents in connection with children's schooling, medical care,

parentage, custody, protection from maltreatment, and adoption. His family law textbook was released in 2012. Professor Dwyer's major current projects are a book critiquing liberal policy responses to parental and community dysfunction and a book developing a general theory of children's rights and national responsibilities with respect to children's international migration.

Ivana Culic, MD is the Associate Director of the Special Care Nursery at Beverly Hospital as well as a staff neonatologist at Children's Hospital in Boston. Born and raised in Croatia, Dr. Culic attended the University of Zagreb Medical School where she completed her post-graduate studies. As valedictorian of her medical school class, she was offered a postdoctoral fellowship in Molecular Biology at Boston University. She then spent two years working to better understand the molecular base of adult onset illnesses. Following the time she dedicated to the basic science, Dr. Culic turned her interest towards clinical medicine. She completed her Pediatric Residency and Fellowship in Neonatal-Perinatal Medicine at Tufts University, (Floating Hospital for Children) in Boston. Following graduation from Tufts, Dr. Culic began her career as a neonatologist, working at both Children's Hospital Boston and Beverly Hospital. She is board certified in pediatrics and in neonatal perinatal medicine. In addition to her clinical practice, she is an Instructor of Pediatrics at Harvard Medical School. Dr. Culic is married, has three children and currently resides on the North Shore.

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Session Description

Any genuine effort to reform the child welfare system must address parental substance abuse. Between 70-90% of parents responsible for child abuse and neglect have a serious substance abuse problem, involving either illegal drugs or alcohol, frequently both.

Traditional court models for dealing with children and substance abusing parents in the child welfare system arguably have failed. As an alternative to the adversarial court model, family drug treatment courts have been created, offering a dual promise. First, these courts aim to provide drug-abusing parents priority access to treatment and other support so they can rehabilitate and thereby keep custody of their children. Second, these courts aim to provide children the nurturing parenting they deserve by moving them to foster and adoptive parents, if their birth parents fail at recovery in a reasonable time period. Are these courts fulfilling their promise? Some argue that the courts primarily focus on family preservation at the expense of child well-being, permitting children to return to homes with substance abusing parents with limited parenting capacity or allowing children to languish in foster care, rather than freeing them up for adoption in a timely manner.

Judge Jeri Cohen will describe the innovative family treatment court she founded and runs in Florida. Her court is admired as among the most successful in the country. She will discuss: why and how she created the court, how she defines its success, the strengths and limitations of her court model, possibilities for replication, and more generally how to create systems change.

With a Ph.D. in Philosophy as well as a J.D., Professor James Dwyer has written extensively on children's issues, arguing for a more child-centric legal regime. In his provocative work, he challenges fundamental legal premises, including the legal presumption that biological parents will provide the best care for their children. He argues that in some cases, parental rights should be terminated at birth when a parent has already demonstrated s/he is grossly unfit. Risk factors at the time of birth, such as evidence of parental substance abuse or mental illness, should be considered when making determinations about appropriate interventions, especially during critical developmental periods like infancy.

Dr. Ivana Culic will respond to Cohen and Dwyer's remarks. Culic, a neonatologist with extensive experience treating drug-affected infants, will describe the short and long-term developmental risks these newborns face.

CHAPTER 13



Dependency Drug Court

An Intensive Intervention for Traumatized Mothers and Young Children

**Jeri B. Cohen
Gayle A. Dakof
Eliette Duarte**

Trauma is no stranger to the women and children involved in dependency drug courts (DDCs). Young children of addicted mothers are at high risk of physical and emotional neglect (Erickson & Tonigan, 2008); often they witness or are victims of family violence (Magura & Laudet, 1996; Walsh, MacMillan, & Jamieson, 2003), and they are likely to receive neglectful and punitive parenting (Hein & Miele, 2003). The research is unequivocal: Infants and toddlers exposed to trauma display significant behavioral and emotional problems (e.g., Maughan & Cicchetti, 2002; Osofsky, 1995), and are at high risk for poor developmental outcomes throughout childhood and adolescence (Osofsky, 2004; Windom, 2000). Moreover, the mothers of these young children are themselves often trauma victims (Banyard, Williams, & Siegal, 2003). Many were neglected and abused as children, and as adults have suffered the exigencies of poverty, violence, and despair (Gara, Allen, Herzog, & Woolfolk, 2000).

The problems associated with child maltreatment and maternal substance abuse constitute a public health concern of the utmost importance (Magura & Laudet, 1996). It is estimated that as many as 80% of children involved in the child welfare system have a drug-dependent parent (Barth, Courtney, Duerr, Berrick, & Albert, 1994; Curtis & McCullough, 1993; Locke & Newcomb, 2004). Although there are interventions for adult substance use, interventions for infants and toddlers exposed to traumatic circumstances, and interventions designed to improve parenting practices of mothers involved in the child welfare system (e.g., Casanueva, Martin, Runyan, Barth, & Bradley, 2008; Suchman, Pajulo, DeCoste, & Mayes, 2006), these services are often not coordinated, integrative, or holistic. In many dependency courts, service providers for the parents and service providers for the children rarely, if ever, communicate or approach the case with a coordinated case plan that seeks a symbiosis between the services. By offering intensive and integrated multidisciplinary services aimed at addressing the dual problems of child maltreatment and maternal addiction, DDC offers a unique and distinct approach to handling child abuse and neglect cases involving addicted, frequently dual-diagnosis parents. DDCs, adapted from the adult drug court model, were established to serve “the best interests of the child” by helping parents “become emotionally, financially, and personally self-sufficient and to develop parenting and coping skills adequate for serving as an effective parent on a day-to-day basis” (Office of Justice Programs, 1998, p. 5). DDCs address parental addiction, mental health, and trauma, as well as child safety and permanency (Edwards & Ray, 2005; Green, Furrer, Worcel, Burrus, & Finigan, 2009), and, as such, offer a unique opportunity to change the lives of children—to break the intergenerational cycle of substance abuse, poor mental health, and violence—and to prevent future trauma exposure for mother and child.

Although research on DDC is limited, a small number of studies indicate that drug court has promise (Boles, Young, Moore, & DiPirro-Beard, 2007; Dakof, Cohen, & Duarte, 2009; Dakof et al., in press; Green, Furrer, Worcel, Burrus, & Finigan, 2007, 2009; Haack, Alemi, Nemes, & Cohen, 2004; Worcel, Furrer, Green, Burrus, & Finigan, 2008). Most DDCs share key elements, including a nonadversarial relationship among the participating partners, comprehensive assessment of service needs, frequent court hearings and drug testing, intensive judicial supervision, enrollment in substance abuse treatment programs designed to improve parenting practices and other necessary services, and the administration of judicial rewards and sanctions. In order to graduate from DDCs, participants must have successfully completed substance abuse treatment, remain compliant with mental health services, have a specified period of continuous abstinence, show evidence of a safe and stable living situation, spend a substantial period of time adequately performing the parental

role, and have a life plan initiated and in place (e.g., employment, education, vocational training).

DDCs frequently include drug court counselors, who refer clients to substance abuse treatment and other court-ordered services, develop a recovery service plan, and monitor and report clients' ongoing progress to the court (Edwards & Ray, 2005). Although there are numerous components to DDCs, the contributions of the drug court judge and counselors to the effectiveness of drug court are undeniable (Dakof et al., 2009; Edwards & Ray, 2005; National Association of Drug Court Professionals [NADCP], 1997).

MIAMI-DADE DEPENDENCY DRUG COURT

The State of Florida 11th Circuit Judicial Juvenile Court in Miami, Florida, established a DDC in 1999. In order to be eligible for DDC, parents must be (1) 18 years or older, (2) with at least one child adjudicated dependent; (3) have a diagnosis of substance abuse or dependence, (4) have a potential for family reunification; and (5) after consultation with their attorney, voluntarily enroll in drug court.

The DDC is a 12- to 15-month program organized into four phases. Progression through the phases is related to the mother's level of substance abuse treatment and compliance with court orders. An assessment of the mother (using the Addiction Severity Index, as well as other structured instruments) is conducted immediately upon acceptance into drug court, and placement in appropriate substance abuse treatment is commenced, in many instances, even before the arraignment of the case. Whenever possible, children are kept with their parents in maternal or family addiction programs. When this is not possible, visitations occur frequently in order to maintain mother-child bonding. Thus, with very young children, visitation may occur three times per week. Parents are drug-tested (urine screens) at each court hearing and in their substance abuse treatment programs. These programs are required to report progress or lack thereof to the court. During the first month of drug court, mothers attend weekly drug court hearings. Thereafter, if reports to the court indicate that the mother is progressing well, court hearings are reduced to twice monthly. During Phase 2 of the program, which lasts approximately 3 months, clients continue to attend twice-monthly hearings. In Phase 3, which lasts another 3 months, the frequency of hearings is reduced to once per month. In the final Phase 4, which extends to graduation from drug court, clients attend hearings every 6–12 weeks.

This multiphase process includes a collaborative team approach that involves attorneys, drug court counselors, child welfare workers, treatment

providers, parent educators, and other social and health care service providers, as needed. Drug court counselors have contact with their clients, either in-person or on the phone, on a weekly basis through Phase 2, reducing to biweekly in Phase 3, and monthly in Phase 4. Counselors are available more frequently on an as-needed basis. The caseload for drug court counselors is between 10 and 15 active cases. All cases have both dedicated child welfare workers and drug court counselors. Along with the attorneys, the drug court counselors, child welfare caseworkers, and treatment providers meet weekly to staff the case.

ENGAGING MOMS PROGRAM FOR DEPENDENCY DRUG COURT COUNSELORS

Counselors in the Miami–Dade DDC have been implementing the Engaging Moms Program (EMP) for over 5 years. This program is based on the theory and method of multidimensional family therapy (Liddle, Dakof, & Diamond, 1991). EMP was designed to help mothers succeed in drug court by complying with all court orders, such as attending and benefiting from substance abuse treatment, parenting intervention programs, and other services ordered by the court (e.g., domestic violence counseling, psychiatric care). EMP counselors do whatever it takes to facilitate recovery and stability, and enhance a mother’s capacity to parent her children. EMP has shown considerable promise in the DDC context (Dakof et al., 2009, in press), specifically by increasing the likelihood of positive child welfare and parent outcomes when compared to standard drug court case management. EMP has been shown to reduce the number of parental rights terminations, placement in the foster care system, and overall risk for child abuse; and to improve the mother’s mental and physical health status.

EMP counselors focus on six core areas of change: (1) mother’s motivation and commitment to succeed in drug court and to change her life; (2) the emotional attachment between the mother and her children; (3) relationships between the mother and her family of origin; (4) parenting skills; (5) the mother’s romantic relationships; and (6) coping and problem-solving skills. Mothers achieve change by participating in a series of integrated individual and family sessions with the drug court counselors (e.g., individual sessions with mother, individual sessions with family/partner, family and couple sessions).

EMP is organized in three stages: Stage 1, Alliance and Motivation; Stage 2, Behavioral Change; and Stage 3, Launch to an Independent Life.

In Stage 1, the counselor focuses on two goals: (1) building a strong therapeutic alliance with the mother and her family, and (2) enhancing mother and family motivation to participate in drug court and to change

their behavior. EMP counselors provide support to both the mother and her family. They empower and validate; highlight strengths and competencies; build confidence in the program; and are very compassionate, loving, and nurturing. To enhance motivation, the EMP counselor highlights the pain, guilt, and shame that the mother and her family have experienced, and the high stakes involved (e.g., losing a child to the child welfare system), while simultaneously creating positive expectations and hope.

Stage 2 focuses on behavioral change in both the mother and her family/spouse focusing especially on drug use, parenting, and romantic relationships. EMP has several goals for this stage. First, counselors enhance the emotional attachment between the mother and her children by working individually with the mother to help her explore her maternal role. Mother and children sessions designed to enhance the mother's commitment to her children are also provided. Equally important is enhancement of the attachment between the mother and her family of origin and/or spouse. This is accomplished by helping the family restrain from negativity and offer instrumental and emotional support to the mother. Considerable attention is devoted to repairing the mother's relationship with her family, which frequently has been damaged by past hurts, betrayals, and resentments. Romantic relationships, typically with men, have often been a source of pain and distress for many of the mothers involved in the child welfare system. Hence, the EMP program addresses these relationships by helping the mother conduct a relationship life review, including examination of tensions between having a romantic relationship and being a mother. The counselors help the mother examine the choices she has made, and continues to make, in terms of romantic relationships, and teach her how to make better decisions for herself and her children. EMP counselors also help the mother address slips, mistakes, setbacks, and relapses in a nonpunitive and therapeutic manner (i.e., forward looking). Finally, in Stage 2, the EMP counselor facilitates the mother's relationship with court personnel (judge, child welfare workers, and attorneys) and treatment or other service providers. The EMP counselor conducts "shuttle diplomacy" between the mother and service providers to prevent and resolve problems, and helps the mother take full advantage of the services provided to her. With respect to the court, the drug court counselors facilitate therapeutic jurisprudence in the courtroom by preparing mothers for court appearances and advocating for the mother in front of the judge and at weekly drug court case reviews.

In the final launching phase (Stage 3), the EMP counselor helps the mother prepare for an independent life by developing a practical and workable routine for everyday life; addressing how the mother will balance self-care, children, and work; outlining a plan to address common emergencies with children and families; and addressing how the mother will deal with potential problems, mistakes, slips, and relapses.

THE WORK OF THE DEPENDENCY COURT JUDGE

Being an effective DDC judge requires considerable knowledge, skill, and experience. Obviously, the role of the DDC judge is key because he or she not only makes all the final decisions concerning graduation or discharge, child placement, and whether or not to terminate parental rights (TPR) but also establishes the tone and direction of the court, holds drug court counselors and key drug court partners (attorneys, treatment and other service providers, child welfare caseworkers) to high standards, resolves differences among partners, and functions as a role model. If the judge is well-organized and efficient, then the partners will be well-organized and efficient; and if the judge works to a high standard of excellence, then so will the partners. Finally, if the judge is highly involved in the daily functioning and workings of the drug court, clearly articulates the mission and values of the dependency drug court, and embraces a leadership style that is both collaborative and firm, then drug court counselors, partnering agencies and institutions, and even the DDC mothers will have an opportunity to function at an extremely high level of competence and cooperation.

Drug court is a collaborative effort among the various professionals and stakeholders involved in child welfare; this includes not only the judge but also the attorneys (defense and state); child advocates, such as the guardian *ad litem*, child welfare caseworkers, substance abuse treatment providers, parenting intervention providers, other service providers (e.g., child psychologists and psychiatrists), day care agencies, and schools; physicians; and, of course, the DDC counselors. Sometimes the sheer number of professionals involved can be overwhelming and counterproductive (i.e., “Too many cooks spoil the brew”), but the needs of the mothers and young children involved in DDC are vast, and it is frequently necessary to have a large number of professionals involved in the life of a single family. Without strong judicial leadership there would be chaos, inefficiency, and ineffectiveness.

The judge not only establishes the direction of the court, convenes the necessary stakeholders, monitors progress or the lack thereof, and demands respect for due process but also functions as an inspirational leader. Given the natural conflict between the long tradition of an adversarial legal system and the nonadversarial nature of drug court, a strong judicial leader is necessary to speak for the mission of drug court and to create an environment where mutual trust is nurtured. Each partner is essential to drug court, and the judge, of course, must rely on all the stakeholders. Thus, the DDC judge first needs to convene a highly competent and dedicated group of partners and stakeholders, then to respect each member’s expertise and turf in the context of very strong judicial leadership.

Given the complex nature of DDC, the judge’s training as an attorney is not sufficient. The judge in this setting needs to develop considerable com-

petency in the fields of substance abuse and early child development, mental health and trauma, parenting practices, and family functioning (Lederman & Osofsky, 2008). This seems like a tall order, but it is our experience that the more the judge knows about these areas, the better he or she is able to determine which services and types of care are necessary. The judge will also be better able to monitor the delivery of services and use his or her position to demand higher quality services for mothers and young children, and to negotiate with the providers for enhanced services.

Dependency courts generally, and DDCs in particular, have a distinctly comprehensive perspective on young children involved in the child welfare system. The DDC focuses not only on the immediate family but also the extended family and anyone else who comes into contact with the child. The ultimate goal is to break the intergenerational cycle of substance abuse, untreated mental illness, domestic violence, and child neglect and abuse. The most effective DDC judges are widely read on child development, addiction, and trauma; they seek out educational opportunities and demand excellence in every aspect of their court, including the implementation of evidence-based practices (Lederman, Gomez-Kaifer, Katz, Thomlison, & Maze, 2009). With knowledge comes judicial leadership and innovation.

Clearly, DDC is a cooperative and collaborative effort, and it is the judge's responsibility to ensure that all the parties involved in the court work as a team. Achieving a truly cooperative and nonadversarial drug court is not an easy task, and it does not happen without strong and consistent teamwork. Many actions can be taken to inspire and maintain teamwork. First, all partners need to be aware of what other partners on the team are doing. Second, the judge cannot be biased and should show respect toward all partners. Third, all parties should be encouraged to attend monthly drug court meetings and weekly staffings designed to facilitate staff dedication to the court and its mission, and to solicit a discussion of problems and solutions.

Key ingredients of an effective DDC involve strong judicial leadership based on (1) knowledge about drug court, legal issues, child development and maternal addiction; (2) a clear and consistent mission; (3) competent partners who embrace evidence-based practices; (4) the creation of an atmosphere of respect and teamwork; (5) and a demand for excellence. It is the drug court judge who is responsible for integrating all the disparate parts of DDC into a comprehensive and integrated whole, ultimately leading it to its success or failure.

CASE ILLUSTRATION

What follows is an illustration of how DDC can produce positive developmental outcomes for young children involved in the child welfare system.

In this illustration we focus on how the judge and drug court counselors facilitate improvement in the young child through adequate assessment and placement in appropriate interventions, and improved parenting practices. It is important to recognize that since the mission of DDC is to sustain the mother's recovery from drug use and improve her overall functioning, as well as to improve parenting practices and child functioning, this illustration is necessarily partial. We do not delineate how the judge and drug court counselor help the mother (1) develop better coping, problem-solving, and communication skills; (2) sustain her sobriety; (3) improve her relationships with her family of origin and romantic partners; and (4) develop a life plan to balance her own individual needs with the demands of being a parent.

Our focus is on 2-year-old Reggie, exposed before birth to cocaine and benzodiazepines, and his 38-year-old mother Brianna. Prior to Reggie's birth, Brianna had her parental rights terminated on four children because she repeatedly failed to complete substance abuse treatment and demonstrate sufficient skills and capacity to parent her young children adequately. It was alleged in the dependency petition that Reggie frequently accompanied his mother while she was under the influence of drugs and engaged in prostitution. Child welfare records revealed that Brianna had five prior abuse reports concerning Reggie; the whereabouts of Reggie's father were unknown; and Brianna did not have family members who were willing to assist her. A level of care (LOC) assessment to determine psychosocial, medical, and developmental functioning revealed that Brianna had been using drugs for 29 years; dropped out of high school in the 10th grade; and was exposed to multiple traumas, including sexual abuse and domestic violence. She was diagnosed with major depression.

With respect to Reggie, the petition stated that he had severe developmental delays, specifically that he "is retarded and does not speak." Multiple sources reported that he did not respond to his name, speak or make sounds, follow directions, feed himself, or make eye contact. He banged his head repeatedly and generally failed to interact with others. Indeed, a teacher at the day care center described Reggie as "being in his own world." Psychological tests revealed that he had pervasive developmental delays, particularly in communication, fine motor skills, and problem-solving, personal, and social skills. The only domain in which he was not delayed was gross motor skills. While Reggie was medically stable, he did suffer from asthma requiring a nebulizer.

Child welfare workers who observed a visitation between mother and son reported that Brianna was overintrusive and smothering, and Reggie was detached and rejecting: "Reggie's mother swept him off his feet when he first arrived, hugging and kissing him. She did not let go of him for several minutes, and he had his head turned away from her the entire time. Reggie did not reciprocate the affection, and his body became stiff while his mother

was hugging him. ... She was hyperverbal and remained in close proximity to Reggie's face. ... Reggie allowed his mother to hold him but did not return affection."

In dependency court, in contrast to DDC, this case would have gone to expedited termination of parental rights. Indeed, the mother had failed to complete prior substance abuse programs; was unemployed, with a low educational level; engaged in prostitution; and had little family support. She had lost four other children and appeared incapable of using good judgment and/or learning from past mistakes and experiences. Most significantly, it was thought that the severity of Reggie's developmental delays were, at least in part, attributable to extensive maternal neglect. Although a high percentage of children ages 0–3 come into the dependency court system with significant developmental delays in at least one domain, few come into the system with pervasive delays such as Reggie's. Given the facts of the case, the drug court judge was skeptical about the mother's ability to make significant progress within the Adoption and Safe Family Act time lines, and believed the prognosis for the mother's recovery to be extremely poor given any amount of time. However, instead of simply rejecting Brianna and Reggie from drug court, the judge decided to give Brianna and Reggie a chance. The judge made this decision on the basis of several factors: (1) the possibility that Reggie's assessment was not adequate, (2) the fact that Brianna was already enrolled in residential substance abuse treatment, and (3) Brianna's age. She was 38 years old, and in the court's experience, older women do better in treatment; they seem ready to change.

The judge immediately ordered a comprehensive neurological evaluation of the child, along with occupational, speech, and play therapy. The court was anxious to ascertain whether the delays were the result of severe neglect or an organic syndrome on the autism spectrum. Indeed, several assessors voiced the opinion that the child might be autistic. Nonetheless, the judge was willing to wait for the neurological examination before making a final decision regarding expedited TPR.

While waiting for the results of the neurological examination, mother and child were enrolled in drug court. The initial goal for the DDC counselor and judge was to retain the mother in treatment and ensure that she benefited from the program by enhancing her motivation to complete treatment; noticing and providing praise for all her accomplishments no matter how small; highlighting what she had to lose and gain from treatment; strengthening her self-examination, coping, problem-solving, emotion regulation, and communication skills; and addressing barriers to success, including her relationships with men. The judge requested weekly status reports from the drug court counselor, child welfare worker, and treatment provider. Frequent court hearings were held not only to praise the mother but also place high expectations on her (e.g., a sustained recovery, improvement

in parenting skills, a stable living situation). The drug court counselor, as is prescribed in EMP Stage 1, focused on developing a strong therapeutic alliance with the mother (“I am behind you 150%”); preventing and solving problems that frequently arise in residential substance abuse programs, such as conflict among the residents and dissatisfaction with the facility and counselors; and advocating for the mother in court. The DDC counselor helped Brianna recognize that Reggie might be her last chance to be a mother, and that doing well with him offered her a chance to redeem herself and reduce the guilt she felt as a result of losing four previous children to the child welfare system.

Although Brianna was diagnosed with major depression, other symptoms were observed during the weekly court appearances and individual sessions with the drug court counselor, including disorganized thoughts, pressured speech, and odd mannerisms. It is important to recognize here that only through close contact by both the judge and the drug court counselor with the mother were these other behaviors observed. The drug court team began to question the accuracy of the original diagnosis, and the judge ordered a second evaluation.

Both mother and child were provided with a case plan. Unfortunately, but not unusual in the child welfare system in the United States, the psychiatric reevaluation for the mother and the neurological evaluation for her son were completed 4 months after the original court order. Given that Brianna’s initial psychiatric evaluation did not appropriately diagnose her, the court lost valuable time in ordering appropriate services. Without the support of her drug court counselors, she would never have been able to remain in treatment and sober while waiting for professionals to diagnose her. As part of her case plan, Brianna was required to (1) remain in her substance abuse treatment program, (2) participate in frequent Narcotics Anonymous meetings with a sponsor, (3) obtain appropriate mental health care, (4) provide thrice-weekly drug tests, (5) participate in weekly EMP sessions with the DDC counselor and weekly court hearings in front of the DDC judge, and (6) complete a comprehensive, evidence-based parenting program.

Although Brianna was complying with her case plan, progress was slow, and she, like most people who are attempting a major life change, was ambivalent about her desire to change, and at times felt discouraged and hopeless that she would succeed in drug court. Normally, the EMP drug court counselor would reach out to any family members (mothers, fathers, sisters) living in the community and facilitate rapprochement with the mother and her family. In this case, because no family members in South Florida were willing to engage with Brianna at that time, the drug court counselor resurrected Brianna’s relationship with her deceased mother. The counselor helped Brianna realize the importance of her relationship with her mother (hence, how important she was to Reggie), how proud Brianna’s

mother would be of her efforts to be a good parent to Reggie, and how it was possible to get off drugs and have a good life, since her mother, too, had been an addict but was able to reach and maintain sobriety. Moreover, the drug court counselor highlighted Brianna's strengths and accomplishments, such as remaining in treatment, participating in visits with her son, as well as what she had to gain by all this hard work: having a relationship with her son and being an important part of his life and development ("He needs you. You need him."). The counselor never forgot to emphasize how much she believed in Brianna, and that she had her full support and would do whatever it took to help Brianna get what she wanted (to be a full-time parent to Reggie). The counselor praised every small accomplishment and gradually Brianna improved her parenting practices. Visitations became more satisfying for both mother and child, Brianna felt extremely proud of herself, and Reggie was more responsive to her.

The case plan called for Reggie to receive a neurological exam, as well as a comprehensive array of services, including occupational, speech, and play therapy. The results of the neurological examination and review of medical records on both mother and child revealed no organic abnormality. The mother smoked and drank "mildly" during pregnancy, and tested positive for cocaine at Reggie's birth. The neurologist found Reggie to be "extremely overactive and distractible, with no specific language." Significantly, however, after nearly 5 months in foster care, he was able to respond to his name, repeat some words, and follow simple directions. He mimicked applause and could place objects in their proper receptacles. His fine motor skills appeared normal with small objects, and he attempted to dress himself and put on his socks. The neurologist reviewed all historical documents available on Reggie and determined that his social interaction had greatly improved. He was now interacting with his peers, smiling, and making good eye contact. In fact, he was found to be affectionate with people rather than object-oriented. Reggie was diagnosed with pervasive developmental disorder but not autism.

Despite the recommendations from the neurology report, it was difficult to get the appropriate wraparound services in place for Reggie. Even with the involvement of dedicated and committed drug court counselors and child welfare workers, the drug court judge was forced to intervene from the bench on numerous occasions in order to obtain the vital services. In addition, Reggie was moved twice before he was placed with an appropriate and loving foster mother, who was willing to work with the biological mother. Finally Reggie was placed in a suitable and high-quality program, where he has flourished. Additionally, he received other needed services, such as dental care, immunizations, well-child checkups, and an ear, nose, and throat (ENT) audiology examination. Genetic testing was also undertaken to rule out any genetic abnormality. When Reggie turned 36 months

old, an Individual Educational Staffing was performed in order to plan for his educational future in the public school system.

After receiving the neurologist's report and hearing a verbal opinion from the neurologist that the child's delays were the result of neglect, the judge was inclined to move toward TPR. The mother was staying sober, but her mental health was deteriorating and her presentation in court was volatile, in that she presented with anxiety, pressured speech, and a somewhat fragmented thought process. The drug court counselor advocated strongly against TPR. In collaboration with the mother's defense attorney, the drug court counselor rallied support among the professionals involved in drug court, including treatment providers, the guardian *ad litem*, the child's day care provider, the foster mother, and the child welfare caseworker and attorney. Led by the drug court counselor, this group appealed to the judge to allow the family to remain in drug court at least until the mother received appropriate mental health care. After considering the testimony from all these interested parties, the judge decided to give the mother a three-month case plan.

As the judge and drug court counselor suspected, the mother's second psychiatric evaluation resulted in a diagnosis of bipolar II disorder. Brianna was placed on medication for this disorder, and a few months later her functioning had improved tremendously. It was evident during the court hearings that her thought process had become coherent and goal-oriented, and her speech had an even quality to it. Moreover, she had completed the first part of the parenting program, started dyadic therapy, successfully completed residential substance abuse treatment, and moved first to a halfway house, then to her own apartment, and was employed. She was actively attending outpatient treatment. After leaving her residential program, Brianna continued to attend outpatient substance abuse treatment; provide urine samples three times per week; and attend individual counseling, dyadic therapy, and daily meetings. Brianna found a sponsor and became actively involved in working the 12-step program. She continued to call and meet with her drug court counselor and to attend all court hearings on a bimonthly basis.

It is important to recognize that the court ordered Brianna to have not only regular supervised visits with Reggie but also to accompany him to most of his medical appointments and all therapy sessions, and to maintain regular and close contact with the foster parent, the day care program, and any other professionals working with Reggie. It is worth noting that many foster care systems isolate the parent from the child and his or her treatment and treatment providers while the child is in care, even when a reunification case plan exists. For obvious reasons, in a case such as this, reunification would have been impossible without the mother actively participating in the child's treatment and interacting with the professionals. Especially with young children, courts should encourage parents to attend all appoint-

ments for their children and interact frequently with the foster parents. This provides the court with a window into the parents' parenting skills, builds efficacy in the parent/child relationship and allows the parents to model the foster parents' parenting techniques.

Brianna completed an evidence-based parenting program, and reports to the court from the parenting program that compared pre- and posttreatment observational visits between Brianna and Reggie indicated tremendous growth of both mother and child in their relationship. Whereas at the pretreatment parenting observation Reggie was aggressive and sought distance from his mother, at the posttreatment observation he physically sought his mother out and wanted to be close to her. Brianna encouraged Reggie in a child-friendly tone, and laughed and interacted with him in a calm and relaxed manner, without being verbally or physically intrusive. While Reggie showed much affection toward his mother, at times he hit her and became aggressive. When she told him not to hit Mommy, he immediately relented and caressed her face. Play was reciprocal and Brianna was able to follow her child's lead. Reggie was permitted to explore at his own pace, and Brianna assisted him in transitioning from one activity to the other.

As is evident, Brianna was engaged in numerous services and her obligations were many. This can wear anybody down. The drug court counselor worked with Brianna to sustain her motivation, advocate for her in the courtroom, reduce or rearrange some of the service demands, and assist her in benefiting from the interventions she received. For example, the drug court counselor discussed the benefits of these services with Brianna, and how those services were designed to assist her in realizing her stated goals (being an involved and good parent to Reggie). The drug court counselor worked on diminishing Brianna's frustration toward required/recommended service and service providers.

Reggie's and Brianna's functioning continued to improve. Parenting program counselors, Reggie's occupational therapist, child welfare workers, and the foster mother all had nothing but praise for Brianna. It was reported she was better able to regulate emotions and behaviors, and this was contributing to Reggie's ability to regulate his behavior. Indeed, the occupational therapist described her as nurturing, appropriate, consistent, reliable, and loving. The parenting program dyadic therapist reported, "Brianna and Reggie's relationship continues to evolve from an insecure relationship to a healthy, secure attachment. The mother has been able to provide amazing consistency with her visitation with her son in child care and with the parent-child psychotherapy. . . . Reggie has made drastic changes in his interactions with his mother, laughing with her and molding his body into hers when he plays with her. . . . The transformation has been amazing." The foster mother, who became a preadoptive placement for Reggie, reported that she was "so proud" of Brianna and was willing and pleased to

communicate with her and assist her. The drug court counselor advocated for increased independence for the mother, and the drug court team recommended daytime unsupervised visits and one overnight, which the judge granted. Ultimately, the mother and child were fully reunified. Today, Reggie lives with his mother Brianna, who provides a stable and loving family environment.

CONCLUDING REMARKS

Drug abuse and mental health comorbidity among women with children is a serious social and public health problem that not only impairs the mother but also places her children at risk of abuse, neglect, and numerous social, health, and behavioral problems (Brady, Back, & Greenfield, 2009). Moreover, mothers involved in the child welfare system who have substance abuse problems are more likely than non-drug-using child welfare-involved mothers to have their parental rights terminated (Marcenko, Kemp, & Larson, 2000). Thus, there is increasing urgency to develop new ways of working with substance-abusing parents involved in the child welfare system (Kerwin, 2005; Maluccio & Ainsworth, 2003; Marsh & Cao, 2005; Young, Gardner, & Dennis, 1998). Judicial and child welfare systems throughout the nation have turned to drug courts as a setting where parents can acquire the tools needed to turn their lives around and become productive, drug-free members of society (Tauber & Snavely, 1999). The Miami-Dade DDC embraces a model in which the drug court judge and counselors are the key change agents within the DDC content: The drug court counselor is the leader and coordinator of individual cases, and the drug court judge is the leader of the court as a whole. This collaboration is the foundation and scaffolding that facilitates building a successful DDC. The DDC judge and counselors collaborate to create an effective multidisciplinary intervention designed to ameliorate maternal addiction and child maltreatment with (1) a therapeutic jurisprudence vision of the mission of DDC; (2) clearly delineated and therapeutic roles; (3) strong leadership; and (4) implementation of evidence-based interventions both within and outside of drug court, thus achieving the promise of the judicial-mental health partnership proposed by Lederman and Osofsky (2008) “to establish more effective interventions when a child comes into care and is adjudicated dependent . . . it is crucial that we begin to develop and implement interventions that will make a difference for these families especially those that will interrupt the intergenerational cycles of abuse and neglect” (pp. 44–45).

DDC generally, and perhaps the Miami-Dade DDC model in particular, appears to be a promising intervention not only to ameliorate the trauma associated with maternal addiction and child maltreatment but also

to produce better child welfare outcomes (Dakof et al., 2009, in press). This, we hope, will help to reduce the risk of young children of addicted mothers for ongoing exposure to chronic trauma, especially physical and emotional neglect. We believe that DDC offers a unique opportunity to integrate and coordinate high-quality service delivery to young children and addicted mothers involved in the child welfare system and, hence, finally to provide the kind of services necessary to change the lives of families who come in contact with the child welfare system. Judicial leadership, with its demand for accountability and excellence coupled with the implementation of evidence-based drug court counseling (e.g., EMP), evidence-based parenting interventions, and substance abuse and trauma treatment seem to be the best hope to prevent poor developmental outcomes for young children of addicted mothers and to begin to change the life trajectory for both mother and child (Lederman et al., 2009).

ACKNOWLEDGMENTS

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Family Dependency Treatment Courts in the United States

Hon. Peggy Fulton Hora¹

Judge of the Superior Court (Ret.)

International Society for Prevention of Child Abuse and Neglect (ISPCAN)

September 3-6, 2006

York, UK

AOD, Co-Morbidity and Child Maltreatment

Out of three million reports made in the United States each year², almost one million cases of child abuse and neglect are filed and substantiated.³ Over one quarter of a million children are removed from their homes as a result of child abuse investigations or assessments.⁴ The number of children in out-of-home placements has doubled in the last two decades.⁵ The cost of maintaining the U.S. child welfare system is at least \$10 billion.⁶ It is consistently estimated that alcohol and other drug abuse is a factor in 80% of child maltreatment cases⁷ with alcohol being the abused substance almost 90% of the time.⁸ "There is no safe haven for these abused and neglected children of drug- and alcohol-abusing parents. They are the most vulnerable and endangered individuals in America."⁹

Co-occurring factors such as a serious mental illness and other mental health issues further complicate these cases. Almost 12% of mothers in the U.S. have serious mental illness (SMI)¹⁰ and 3.2% have SMI plus substance abuse problems.¹¹ In one program serving vulnerable children, 95% of the parents had a co-occurring disorder.¹² Maltreatment is perpetrated by a parent 78% of the time.¹³ Ninety percent of the parents whose children were abused or neglected are female.¹⁴ Traditionally, little substantive help was given parents whose substance abuse and other mental health problems caused them to lose their families. Children were spending years in foster care and few parents were able to reunite with their offspring. Although not all children who are exposed to drugs *in utero* or in their homes experience difficulties, half of the children in foster care in the U.S. show developmental delays, four to five times the rate found in the general population.¹⁵

Adoption and Safe Families Act (ASFA)¹⁶

Different countries take a variety of approaches to this issue. The United States Congress passed ASFA in 1997. It has very specific time lines for reunification of a family after a judicial determination to take jurisdiction over the child and remove him or her from the home. Along with these time constraints, there is a presumption favoring reunification of the family over termination of parental rights while simultaneously planning for "permanency placement" should reunification efforts concurrently. This means that while parents are working on reunification the court should also be making sure that an alternate permanent placement is identified. Sadly, even if a child is available for adoption after termination of parental rights, only 1:4 of the 126,000 children awaiting adoption are welcomed into new families.¹⁷ One half million children wallow in foster

care going from home to home and then, when they “age out,” they are turned out into the street at the age of 18 with no parental guidance into adulthood.¹⁸

In order to promote permanency planning, a stated goal of the legislation, courts must finalize permanent placement no later than 12 months after a child enters foster care. Additionally, if a child has been out of the home for 15 of the previous 22 months, the court is mandated to begin termination of parental rights proceedings. For parents in need of substance abuse and other mental health treatment, these timelines have been virtually impossible to meet considering the length of waiting lists for publicly-funded treatment among other factors. Moreover, it is not uncommon in traditional court settings to have the first case review six months after the original order. Should there be lack of compliance in any way, the parent(s) have only six more months to perform perfectly in order to regain custody of their children. Not surprisingly, few parents have been able to meet this challenge.

Family Dependency Treatment Courts (FDTC)

The first problem-solving court to address child dependency issues started in Reno NV in 1995. These types of courts are not mere replicas of the adult drug treatment court (DTC) model but rather a blend of DTCs with the best practices of dependency courts under the confines of ASFA. At the end of 2005, there were 198 FDTCs operational and an additional 188 were in the planning stages.¹⁹ The standard that is employed as mandated by statute is “best interests of the child.” FCTCs, like other collaborative courts, use a partnership model that includes the court, child protective services and service providers for the parents, children and families. The twin goals of FDTCs are protection of the child and family reunification by promoting parental abstinence through support, treatment and access to needed services. The interdisciplinary team develops a service and treatment plan, determines its pace and order of delivery and jointly reports to the court all the while avoiding inconsistent or conflicting requirements which are all too common in traditional dependency case processing. More than parents’ substance abuse is reviewed by the FDTC team: domestic violence, parenting skills, mental and physical health, pending criminal charges, housing, child care and employment or education may also be factors that need coordination and access to services.

As in other problem-solving courts, judicial leadership is key and case reviews are as frequent as weekly. The judge focuses the team on treatment, recovery and supportive services and requires accountability from the parents and the organizational stakeholders. In the U.S., judicial officers have a powerful fiscal weapon they can bring to bear on service providers who are not making “reasonable efforts” at reunification. If judges make such findings, agencies may not receive federal funding.

If, at the end of 12 months, parents are making good progress and an end is in sight for reunification of the child with the family of origin, the plan may be extended for six more months giving parents a total of 18 months to engage in treatment and move towards a mature recovery. Can parents make such significant progress? Absolutely--with immediate entry into appropriate treatment, coordinated services and with court

supervision by a FDTC. The best hope for abused and neglected children is the treatment and recovery of their parents.²⁰

Evaluations

Data from a federal cross-site study show parents participating in FCTCs are more likely to be reunified with their children and less likely to have terminations of parental rights. Case processing time appears to also be shorter thus reducing stays in foster care. Families in these courts were more likely to enter substance abuse treatment, more likely to stay in treatment and more likely to complete treatment than were parents in traditional dependency courts. The parents also had significantly less recidivism for both criminal and child protective services cases.²¹ These outcomes are remarkable considering the fact that these parents, on average, had not graduated from high school, were receiving public assistance and 40% were single parents.²² Similar results – faster reunification, early entry into and successful completion of treatment, reduced recidivism, fewer behavioral problems for the children – have also been seen in a four site study completed in 2004.²³

One specific program, The Engaging Moms Dependency Drug Court (EMDDC) in Miami, came about because the traditional child welfare system was not working in Florida and 87% of mothers giving birth to a substance-exposed newborn (SEN) had multiple SEN deliveries.²⁴ Using a FCTC model, and using Intensive Case Management (ICM) as a comparison group, the Engaging Moms program has shown impressive results. About 80% of children were reunified with their families using the EMDDC program compared to 57% of those in ICM.²⁵ Moreover, negative urine test results stayed steady at 33% at 6, 12 and 18 months in ICM compared with 100% of the EMDDC program participants.²⁶

Another program, Specialized Treatment and Recovery Services (STARS), in Sacramento CA shows similar remarkable results using a FCTC model. Of the 70-90% of cases rooted in substance abuse, more than 50% involved the synthetic stimulant methamphetamine. The reunification rate prior to the STARS program was a dismal 18-20%. That means 4:5 parents who lost their children to foster care never got them back. Now using the intensified treatment and support services model of STARS, almost 45% of parents and children are reunified. Of particular significance is the fact that parental use of methamphetamine was not a negative predictor of reunification. Only parents using marijuana were reunited at greater rates than meth-using parents. Heroin users and alcohol abusers were the most likely to lose their children.²⁷

Conclusion

FCTCs are part of a larger U.S. movement toward problem-solving courts. This approach has been endorsed by the Conference of Chief Justices and is recognized as a “best practices” model.²⁸ The power of the court coupled with immediate placement into appropriate treatment and provision of support services is the best way to serve children who are being abused and neglected.



Research Update on Family Drug Courts

By Douglas B. Marlowe, J.D., Ph.D. and Shannon M. Carey, Ph.D.

May 2012

Between 60% and 80% of substantiated child abuse and neglect cases involve substance abuse by a custodial parent or guardian (Young et al., 2007). Continued substance abuse by a custodial parent is associated with longer out-of-home placements for dependent children and higher rates of child revictimization and terminations of parental rights (TPR) (Brook & McDonald, 2009; Connell et al., 2007; Smith et al., 2007). Parents who complete substance abuse treatment are significantly more likely to be reunified with their children, and their children spend considerably fewer days in out-of-home foster care (Green et al., 2007; Smith, 2003). Unfortunately, more than 60% of parents in dependency cases do not comply adequately with substance abuse treatment conditions and more than 80% fail to complete treatment (Oliveros & Kaufman, 2011; Rittner & Dozier, 2000; U.S. Government Accountability Office, 1998).

Family Drug Courts (FDCs)¹ were created to address the poor outcomes derived from traditional family reunification programs for substance-abusing parents. The first FDC was established in 1995 in Reno, Nevada; now well over 300 programs operate throughout the United States (Huddleston & Marlowe, 2011). These specialized civil dockets were adapted from the adult criminal Drug Court model (adult Drug Courts) (Wheeler & Fox, 2006). As in adult Drug Courts, substance abuse

treatment and case management services form the core of the intervention; however, FDCs emphasize coordinating these functions with those of child protective services. In addition, participants must attend frequent status hearings in court during which the judge reviews their progress and may administer gradually escalating sanctions for infractions and rewards for accomplishments. Unlike adult Drug Courts, where the ultimate incentive for the participant

¹ These programs are variously referred to as Family Drug Treatment Courts, Family Treatment Drug Courts, Family Dependency Treatment Courts, and Family Treatment Courts.

might be the avoidance of a criminal record or incarceration, in FDC the principal incentive for the participant is family reunification, and a potential consequence of failure may be TPR or long-term foster care for the dependent children.²

Continued substance abuse by a custodial parent is associated with longer out-of-home placements for dependent children and higher rates of child revictimization and terminations of parental rights.

The child welfare system also reaps benefits from FDCs. Dependency courts are required by statute to make reasonable efforts towards family reunification and to reach permanency decisions within a specified time period of approximately twelve to eighteen months.³ By allowing for more efficient case processing and providing a wider range of needed treatment services, FDCs assist the courts to meet these statutory obligations.

FDC is among the most effective programs for improving substance abuse treatment initiation and completion in child welfare populations.

Effectiveness

A number of methodologically sound impact evaluations have been completed within the past several years, revealing significantly better outcomes in FDC as compared to traditional family reunification services (Green et al., 2009; Marlowe, 2011). A recent review of the research literature concluded that FDC is among the most effective programs for improving substance abuse treatment initiation and completion in child welfare populations (Oliveros & Kaufman, 2011).

Table 1 (see end of article) summarizes outcome evaluations that had acceptable methodological rigor. Where multiple studies were conducted on the same program, the most recent or comprehensive evaluation is presented. These evaluations included comparison samples of parents or guardians in dependency proceedings who were identified as having a substance abuse problem and who would have been eligible for FDC but did not participate. The participants for the contemporary comparison samples were recruited during the same time period as for the FDC and were typically drawn from adjacent counties or had been placed on a wait list because of insufficient slots in the FDC program. Participants for the historical comparison samples were recruited from the same jurisdictions as the FDC participants during an earlier period before the FDC was established. In most of the evaluations, the researchers matched the FDC and comparison groups on variables, such as parental substance abuse history and child welfare history, that were significantly correlated with outcomes or statistically controlled for differences on these variables in the outcome analyses (See Table 1).

Treatment completion rates were 20 to 30 percentage points higher for the FDC participants than for the comparison participants.

The parents or guardians in FDC programs were more likely than the comparison participants to complete substance abuse treatment in all but one of the evaluations and these differences were statistically significant in all but two of the evaluations. In most instances, treatment completion rates were 20 to 30 percentage points higher for the FDC participants than for the comparison participants. Although not reported in the table, parents in the FDCs were also significantly more likely to enroll in substance abuse

² Some FDCs apply a hybrid model that consolidates criminal and civil dependency cases for individuals charged with a drug offense who also have children in the dependency system.

³ Adoption and Safe Families Act of 1997, P.L. 105-89.

RESEARCH UPDATE ON FAMILY DRUG COURTS

treatment, entered treatment sooner, and remained in treatment longer than the comparison parents in most of the evaluations. As was noted earlier, dependency courts are required to make reasonable efforts towards family reunification and achieve permanency within a specified time. Increasing parental entry into and engagement with treatment directly furthers these statutory goals.

Family reunification rates were higher for the FDCs in all but one of the evaluations and were significantly higher in all but three of the evaluations. In most instances, family reunification rates were approximately 20 to 40 percentage points higher for the FDC programs than for the comparison groups. The relatively few instances in which the differences were not statistically significant were typically attributable to insufficient sample sizes.

Family reunification rates were approximately 20 to 40 percentage points higher for the FDC programs than for the comparison groups.

The children of the FDC participants also spent significantly less time in out-of-home placements in the majority of the evaluations, typically averaging fewer months in foster care. Approximately half of the evaluations examined new dependency petitions or reentries to the child welfare system following family reunification; however, those that did typically tracked the samples for only a relatively brief period of twelve months post-reunification. Because returns to child protective services usually occur after a few years, new dependency petitions during the first twelve months were infrequent in most conditions and did not differ appreciably between the FDC and comparison groups. One noteworthy exception is the evaluation of the Sacramento Dependency Drug Court, which examined child welfare outcomes after sixty months. That study reported a lower rate of new substantiated allegations of child maltreatment for the FDC participants (17% vs. 23%); however, differences in reentry rates to foster care were small (21% vs. 24%) (Boles & Young, 2011).

The children of the FDC participants also spent significantly less time in out-of-home placements in the majority of the evaluations, typically averaging fewer months in foster care.

Two evaluations (Carey et al., 2010a, 2010b) also tracked and examined new criminal arrests. Both studies reported substantially lower arrest rates for the FDC participants as compared to the comparison groups (40% vs. 63% and 54% vs. 67%, respectively). These findings are important because although FDC proceedings are civil in nature, participants frequently have concurrent involvement with the criminal justice system. Reducing criminal recidivism might, therefore, be an important value-added benefit of FDC programs.

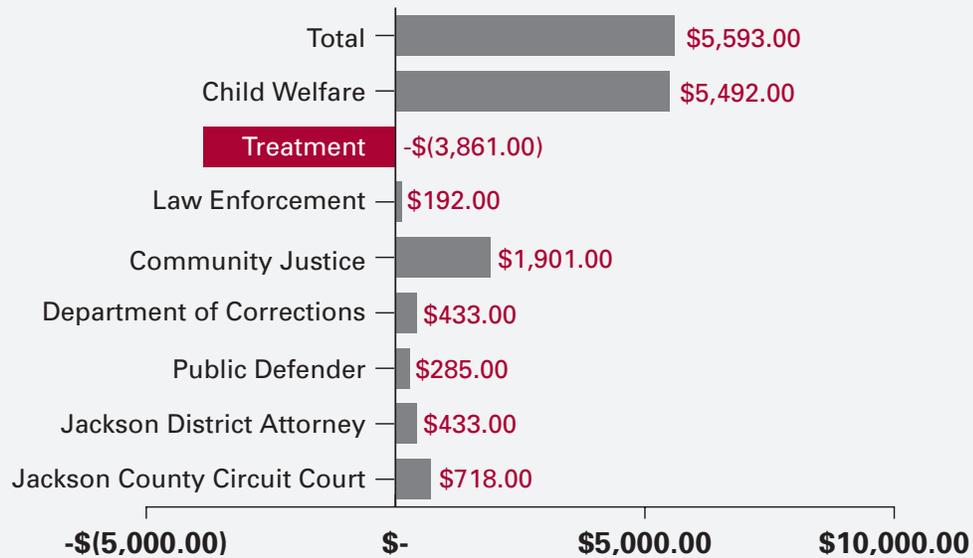
Cost-Effectiveness

Several evaluations reported cost savings for FDC resulting from a reduced reliance on out-of-home child placements. Estimated savings from the reduced use of foster care were approximately \$10,000 per child in Maine (Zeller et al., 2007), \$15,000 in Montana (Roche, 2005), \$13,000 in Oregon (Carey et al., 2010b), and £4,000 (\$6,420) in London (Harwin et al., 2011).

Several evaluations reported cost savings for FDC resulting from a reduced reliance on out-of-home child placements.

Three evaluations included cost-effectiveness analyses that took into account a wider range of up-front expenditures and financial benefits of the programs and yielded estimates of the average net cost savings per family (Burrus et al., 2008; Carey et al., 2010a, 2010b). These studies employed a cost-to-taxpayer approach that treated participants' interactions with publicly funded agencies as transactions in which public resources were consumed and societal costs incurred. *Program costs* were those associated with providing services to participants. For example, when parents or guardians appear in court for status hearings or are tested for drugs, resources such as judge time, defense attorney time, court facilities,

Figure 1. Average Cost Savings Per Participant Realized by each Agency in the Jackson County Community Family Court. Adapted with permission from Carey and colleagues. (2010a).



and urine test cups are consumed. *Outcome costs* were those associated with participants' subsequent interactions with outside agencies, such as the child welfare system and criminal justice system. *Cost savings* were determined by calculating the program and outcome costs for the FDC and contrasting those figures with comparison group costs.

Program costs for the FDCs ranged from approximately \$7,000 to \$14,000 per family.

The program costs for the FDCs ranged from approximately \$7,000 to \$14,000 per family, depending on the range and intensity of services that were offered. The majority of the program costs were attributable to substance abuse treatment. Not surprisingly, programs that provided services for both the dependent children and their parents had the highest treatment costs.

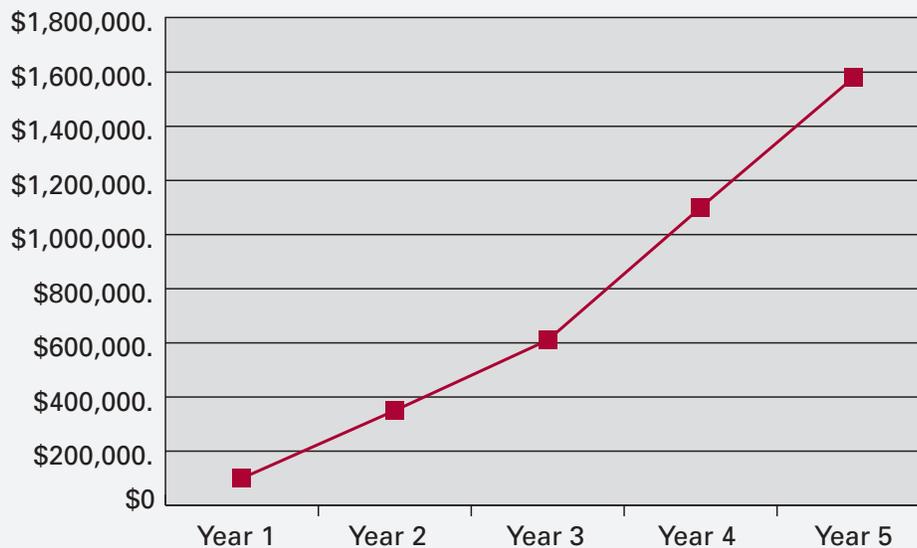
Outcome costs were substantially lower in all three studies for the FDC participants than for the comparison groups. This was primarily due to the decreased use of child welfare resources by the children (e.g., less time in foster care) and decreased use of criminal justice resources by the parents (e.g., fewer rearrests and less time in jail or on probation). Taking into account both the investment costs of the programs and the value of the outcomes that were produced, the average net cost savings from the FDCs ranged from approximately \$5,000 to \$13,000 per family.

The average net cost savings from the FDCs ranged from approximately \$5,000 to \$13,000 per family.

Figure 1 presents detailed cost information from one of the evaluations performed in Jackson County, Oregon. Nearly every agency involved in the FDC realized some cost savings, although the magnitude of the savings varied considerably.

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Figure 2. Total Cost Savings Over Five Years for the Marion County Fostering Attachment Treatment Court. Adapted with permission from Carey and colleagues. (2010b).



The child welfare system realized the largest cost savings as a result of reduced use of foster care. Community corrections followed in cost savings as a result of parents spending less time on probation or in jail. Notably, the treatment program was the only agency that did not reap net dollar benefits. This was because the parents in the FDC program participated significantly more in treatment than did the non-FDC participants. As was intended, the FDC significantly increased parents' use of substance abuse treatment services and as a result decreased their use of other publicly funded services, such as those of child welfare, community corrections, and the courts.

The child welfare system realized the largest cost savings as a result of reduced use of foster care.

Importantly, the total cost savings that may accrue to a community from a FDC accumulate as participants maintain improvements over time and more participants enter the program. Figure 2 depicts the total cost savings

that accrued from a FDC in Marion County, OR, over a five-year period (Carey et al. 2010b). The total taxpayer cost savings increased approximately ten fold over the five years.

The total taxpayer cost savings increased approximately ten fold over the five years.

Target Population

In the criminal context, adult Drug Courts have been found to be equivalently effective for participants regardless of their primary drug of choice, associated mental health problems, or criminal history (Carey et al., 2012; Zweig et al., 2012). In fact, evidence suggests adult Drug Courts are more effective for participants who are high risk and seriously addicted to drugs or alcohol (Marlowe, 2009). Similar findings are emerging for FDC programs. A four-site national study of FDCs (Worcel et al., 2007) found that few participant characteristics predicted better outcomes, suggesting the programs

tended to be equally effective for a wide range of participants. In fact, marginally better outcomes ($p = .08$) were reported for mothers with co-occurring mental health problems and other demographic risk factors, such as being unemployed or having less than a high school education. Other studies similarly found 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). Treatment success rates in FDCs also do not appear to be influenced by parents' primary drug of abuse, including methamphetamine, crack cocaine, or alcohol (Boles & Young, 2011). This suggests that, as with adult Drug Courts, the effects of FDC appear to be equivalent or greater for individuals presenting with more serious histories.

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

Best Practices

In the criminal court context, a good deal of research has identified the best practices within adult Drug Courts that are associated with better outcomes (Carey et al., 2012; Zweig et al., 2012). Although research in FDCs is just beginning to catch up to this level of sophistication, comparable findings are beginning to emerge suggesting that many lessons learned about best practices in adult Drug Courts are also applicable to FDCs.

Time to Treatment Entry. The sooner parents or guardians entered substance abuse treatment, the less time their children spent in foster care and the more likely they were to be reunified with their families (Green et al., 2007).

Many lessons learned about best practices in adult Drug Courts are also applicable to FDCs.

Frequency of Counseling Sessions. Participants who met more frequently with their counselors (typically weekly for at least the first phase of the program) remained in treatment significantly longer and were more likely to complete treatment (Worcel et al., 2007).

The sooner parents or guardians entered substance abuse treatment, the less time their children spent in foster care and the more likely they were to be reunified with their families.

Length of Time in Treatment. The more days parents or guardians attended substance abuse treatment, the more likely they were to be reunified with their children (Green et al., 2007). One evaluation in Montana reported that, particularly for parents who were abusing methamphetamine, attending at least fifteen months of substance abuse treatment increased the likelihood of success by 63% (Roche, 2005).

Completion of Treatment. A consistent finding across multiple sites is that completion of substance abuse treatment is associated with significantly fewer days in foster care for dependent children and a greater likelihood of family reunification (Green et al., 2007; Worcel et al., 2007). A statewide study in Maine found that parents who completed substance abuse treatment were five times more likely to be reunified with their children (Zeller et al, 2007).

The more days parents or guardians attended substance abuse treatment, the more likely they were to be reunified with their children.

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Family Treatment Model. Contrary to many beliefs, most family-based treatments are *not* evidence-based. The only family interventions that have shown consistent evidence of success are those 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). Examples of counseling packages that incorporate these principles include multisystemic therapy and multidimensional family therapy. Both of these treatments, with some modifications, have been shown in controlled experiments to significantly improve outcomes in FDC (Dakof et al., 2009; Dakof et al., 2010), Juvenile Drug Court (Henggeler et al., 2006; Schaeffer et al., 2010), and the child welfare system (Oliveros & Kaufman, 2011; Swenson et al., 2009). These studies demonstrate that FDCs should apply manualized, structured, evidence-based family treatments and offer outreach services, where needed, in participants' homes or communities of origin.

Parents who completed substance abuse treatment were five times more likely to be reunified with their children.

Relationship with Counselor. Participants who reported a more positive therapeutic relationship with their counselors were more likely to complete treatment (Worcel et al., 2007).

FDCs should apply manualized, structured, evidence-based family treatments and offer outreach services, where needed, in participants' homes or communities of origin.

Relationship with Judge. Participants in FDC focus groups indicate they perceived their interactions with the judge to be especially critical to their success in the program. Specifically, being treated with respect by the judge and

being empowered by the judge to engage actively in their own recovery were believed to produce greater achievements (Somervell et al. 2005; Worcel et al., 2007). More research is needed to establish whether these perceptions are, in fact, associated with better outcomes in FDC; however, comparable studies in adult Drug Courts confirmed that a participant's positive perceptions of the judge were a predictor of significantly greater reductions in substance abuse and crime (Zweig et al., 2012). It seems reasonable to anticipate that similar findings may emerge in FDC as well.

Participants in FDC focus groups indicate they perceived their interactions with the judge to be especially critical to their success.

Drug Testing. Participants who were subjected to more frequent urine drug screens remained in treatment longer and were more likely to complete treatment (Worcel et al., 2007).

Parenting Classes. Adult Drug Courts that provided parenting classes had 65% greater reductions in criminal recidivism and 52% greater cost savings than Drug Courts that did not provide parenting classes (Carey et al., 2012). Although these analyses were conducted in the criminal court system as opposed to in FDCs, they often included parents who were involved in collateral dependency proceedings.

At least a dozen methodologically defensible evaluations conducted in eight U.S. states and London by independent scientific teams offer convincing evidence that FDCs produce clinically meaningful benefits and better outcomes than traditional family reunification services for substance-abusing parents.

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Table 1. Summary of Methodologically Acceptable Evaluations of Family Drug Courts

Citation	Location(s)	Research Design	Sample Sizes (N's) ^a	Follow-Up Interval	Guardian Treatment Completion
Ashford (2004)	Pima County, AZ	Contemporary non-matched comparison	FDTC: 33; Comparison: 45	12 mos. post-entry	48% vs. 31%
Boles & Young (2011)	Sacramento, CA	Historical non-matched comparison	FDTC: 4,858; Comparison: 173	12 to 60 mos. post-entry	66% vs. 57% ^b
Bruns et al. (2011)	King County, WA	Contemporary matched comparison	FDTC: 76; Comparison: 182	12 to 42 mos. post-entry	62% vs. 29% ^{**}
Burrus et al. (2008)	Baltimore, MD	Historical matched comparison	FDTC: 200; Comparison: 200	16 mos. post-petition	64% vs. 36% ^{**}
Carey et al. (2010a)	Jackson County, OR	Contemporary and historical matched comparison	FDTC: 329; Comparison: 340	12 to 48 mos. post-entry	73% vs. 44% ^{***}
Carey et al. (2010b)	Marion County, OR	Contemporary and historical matched comparison	FDTC: 39; Comparison: 49	12 to 24 mos. post-entry	59% vs. 33% [*]
Harwin et al. (2011)	London, England	Contemporary non-matched comparison	FDTC: 55; Comparison: 31	6 to 12 mos. post-entry	N.R.
Worcel et al. (2007)	Santa Clara, CA	Contemporary matched comparison	FDTC: 100; Comparison: 370	24 mos. post-entry	69% vs. 32% ^{***}
"	Suffolk, NY	Contemporary matched comparison	FDTC: 117; Comparison: 239	24 mos. post-entry	61% vs. 32% ^{***}
"	Washoe, NV	Contemporary matched comparison	FDTC: 84; Comparison: 127	24 mos. post-entry	62% vs. 37% ^{**}
"	San Diego, CA	Contemporary matched comparison	FDTC: 438 ^d ; Comparison: 388	24 mos. post-entry	31% vs. 40%
Zeller et al. (2007)	Belfast, Augusta & Lewiston, ME	Contemporary and historical non-matched comparisons	FDTC: 49; Comparisons: 38 & 55	12 mos. post-exit	55% vs. 23% [*] & 34%

^ap < .05; ^{**}p < .01; ^{***}p < .001; †p-value not reported. TPR = Termination of parental rights. CPS = Child protective services. N.R. = not reported.

^bN's may reflect multiple children per family and in some instances multiple guardians per family. N's may be smaller in some comparisons due to missing or incomplete data.

^cIncludes participants who left treatment before completion but made satisfactory progress.

^dReflects new substantiated allegations of child maltreatment but not necessarily new petition or reentry to foster care.

^eIncludes 334 participants who received court-ordered case management and recovery support services outside of the traditional FDTC context.

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Child Time in Out-of-Home Ccare	Family Reunification	TPR	New CPS Petition After Reunification	Guardian Criminal Arrests	Avg. Cost Savings Per Family
N.R.	52% vs. 30%	N.R.	N.R.	N.R.	N.R.
352 vs. 369 days	45% vs. 27%***	N.R.	17% vs. 23%† ^c	N.R.	N.R.
481 vs. 689 days***	41% vs. 24%***	N.R.	N.R.	N.R.	N.R.
252 vs. 346 days**	70% vs. 45%**	N.R.	N.R.	N.R.	\$5,022
307 vs. 407 days*	51% vs. 45%*	13% vs. 20%*	N.R.	40% vs. 63%**	\$5,593
211 vs. 383 days**	80% vs. 40%**	8% vs. 35%**	N.R.	54% vs. 67%†	\$13,104
153 vs. 348 days†	39% vs. 21%†	N.R.	N.R.	N.R.	N.R.
437 vs. 504 days**	76% vs. 44%***	11% vs. 34%	2% vs. 6%	N.R.	N.R.
312 vs. 310 days	57% vs. 55%	8% vs. 11%	5% vs. 0%*	N.R.	N.R.
301 vs. 466 days***	91% vs. 45%***	3% vs. 34%**	2% vs. 2%	N.R.	N.R.
477 vs. 477 days	56% vs. 45%*	24% vs. 28%	7% vs. 9%	N.R.	N.R.
589 vs. 688 & 647 days	21% vs. 25% & 28%	27% vs. 29% & 31%	7% vs. 7% & 9%	N.R.	N.R.

(Continued from page 7)

Clearly, more research is needed to identify other best practices and evidence-based practices that can optimize their effectiveness and cost-effectiveness in FDCs.⁴ If the history of adult Drug Courts is any indication, research on FDCs is likely to pick up pace as the programs increase in numbers across the country and scientists take notice of the promising results.

Conclusion

In the short span of approximately seven years, FDC has emerged as one of the most promising models for improving treatment retention and family reunification rates in the child welfare system (*cf.* Green et al., 2009; Oliveros & Kaufman, 2011). At least a dozen methodologically defensible evaluations conducted in eight U.S. states and London by independent scientific teams offer convincing evidence that FDCs produce clinically meaningful benefits and better outcomes than traditional family reunification services for substance-abusing parents. These positive benefits do not appear to be limited to low-severity or uncomplicated cases and indeed may be larger for parents presenting with more serious clinical histories and other negative risk factors for failure in standard treatment programs. Finally, evaluators are beginning to uncover the specific practices within FDCs that can optimize their outcomes and cost-benefits for taxpayers.

These promising findings clearly justify additional efforts to expand and enhance FDC programs. Ignoring the positive results and continuing to invest public dollars in programs that have not been tested or that have been discredited is unjustifiable. Research is clear that FDC programs outperform the traditional child welfare and dependency court systems in terms of protecting vulnerable children and rehabilitating and reuniting dysfunctional families. The most rational and humane course of action to protect dependent children is to build upon the firm foundation of success that is emerging from FDC.

⁴ Evidence-based practices that have been identified in substance abuse treatment programs and child welfare settings other than FDC can be found at <http://www.oasas.ny.gov/prevention/nrepp.cfm> and <http://www.cebc4cw.org/topic/substance-abuse-treatment-adult/>.

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NADCP

**National Association of
Drug Court Professionals**

About NADCP

It takes innovation, teamwork and strong judicial leadership to achieve success when addressing drug-using offenders in a community. That's why since 1994 the National Association of Drug Court Professionals (NADCP) has worked tirelessly at the national, state and local level to create and enhance Drug Courts, which use a combination of accountability and treatment to compel and support drug-using offenders to change their lives.

Now an international movement, Drug Courts are the shining example of what works in the justice system. Today, there are over 2,500 Drug Courts operating in the U.S., and another thirteen countries have implemented the model. Drug Courts are widely applied to adult criminal cases, juvenile delinquency and truancy cases, and family court cases involving parents at risk of losing custody of their children due to substance abuse.

Drug Court improves communities by successfully getting offenders clean and sober and stopping drug-related crime, reuniting broken families, intervening with juveniles before they embark on a debilitating life of addiction and crime, and reducing impaired driving.

In the 20 years since the first Drug Court was founded in Miami/Dade County, Florida, more research has been published on the effects of Drug Courts than on virtually all other criminal justice programs combined. The scientific community has put Drug Courts under a microscope and concluded that Drug Courts significantly reduce drug abuse and crime and do so at far less expense than any other justice strategy.

Such success has empowered NADCP to champion new generations of the Drug Court model. These include Veterans Treatment Courts, Reentry Courts, and Mental Health Courts, among others. Veterans Treatment Courts, for example, link critical services and provide the structure needed for veterans who are involved in the justice system due to substance abuse or mental illness to resume life after combat. Reentry Courts assist individuals leaving our nation's jails and prisons to succeed on probation or parole and avoid a recurrence of drug abuse and crime. And Mental Health Courts monitor those with mental illness who find their way into the justice system, many times only because of their illness.

Today, the award-winning NADCP is the premier national membership, training, and advocacy organization for the Drug Court model, representing over 27,000 multi-disciplinary justice professionals and community leaders. NADCP hosts the largest annual training conference on drugs and crime in the nation and provides 130 training and technical assistance events each year through its professional service branches, the **National Drug Court Institute**, the **National Center for DWI Courts** and **Justice for Vets: The National Veterans Treatment Court Clearinghouse**. NADCP publishes numerous scholastic and practitioner publications critical to the growth and fidelity of the Drug Court model and works tirelessly in the media, on Capitol Hill, and in state legislatures to improve the response of the American justice system to substance-abusing and mentally ill offenders through policy, legislation, and appropriations.

Family Drug Court Skepticism

James Dwyer

I am not an expert on family drug courts (FDCs). I've read some of the literature on their philosophy and results, and I have observed one a couple of times, but there is much I do not know about their operations. I therefore characterize my perspective on them, as an advocate for children, as skeptical rather than critical.

Why have any concerns? There is an obvious rationale for the existence of FDCs – namely, that specializing translates into expertise and efficiency. Judges whose entire docket consists of cases involving substance abusers are likely to digest a great amount of medical and social science information on substance abuse and substance abusers, to acquire greater experience that enables them to predict addicts' behavior and to know what incentives have the best chance of changing behaviors, and to establish an effective multi-disciplinary team to provide wrap-around services to parents struggling with this disease. And, in fact, I have little (but still some) concern about their use in cases involving older children who have an established, positive relationship with the struggling parents; in those cases, it is usually best for the child that the state make substantial efforts to rehabilitate parents, even if it will take a couple of years to know whether the parents can succeed. As such, the better able courts are to pursue the objective of rehabilitation, the more likely is a good outcome for those older children. Some of the concerns expressed below still exist in cases involving older children, but I will focus my attention on cases involving newborns and infants.

Cases involving babies predominate in family drug courts. A study of three FDCs in large cities found that in 63% of the courts' cases the child at issue was not even born yet.¹ Most of these parents have older children as well, though; overall, three quarters of cases before those FDCs involved two or more children.² A fourth of the parents had previously had rights terminated as to one or more other children,³ so the courts could have terminated rights as to the newborn immediately if they found that in the child's best interests.

As a general matter, child protection laws and procedures do not differentiate between babies and older children. That is a tragic mistake. Newborns differ from, for example, a ten-year old, in at least three important ways that necessitate a very different approach: 1) Newborns are not yet attached to birth parents. 2) Newborns have the attachment period ahead of them, the critical time being 7 to 24 months. 3) Newborns are readily adoptable, even if suffering from in utero drug or alcohol exposure. In short, newborns have much less to lose and much more to gain from the state's terminating the rights of birth parents immediately or soon after birth. The cost-benefit analysis for them is far different than it is for a ten year-old.

My first concern about FDCs is that the formal policies governing them, reflecting the prevailing substantive legal framework and child protection practices, also do not differentiate between newborns and older children. Drug courts appear to operate on the same assumption that in all cases parents should have the maximum time permitted by law to become rehabilitated and capable of assuming full custody of their children. For example, reports on FDC effectiveness treat as unqualified success any child's return to mother from foster care by the crucial 15 month mark,⁴ but anyone who thinks it good for a baby to have caregiver and home environment changed at 15 months cannot have a very good understanding of child development. So the first skeptical question I would have for a proponent of drug family courts is this: Is it the case that *in practice* the many players involved in child protection cases, and in particular the judge, *do* treat newborns differently, even though the substantive and procedural legal rules do not tell them to do so,

¹ Haack, Alemi, Nemes, and Cohen, Experience with Family Drug Courts in Three Cities, 25 Substance Abuse 17, 20 (2005).

² Id. at 21.

³ Id.

⁴ See, e.g., Gayle A. Dakof, Judge Jeri B. Cohen, and Eliette Duarte, *Increasing Family Reunification for Substance-Abusing Mothers and Their Children: Comparing Two Drug Court Interventions in Miami*, 60 Juvenile and Family Court Journal 11, 18-19 (2009).

in recognition of the very different cost-benefit analysis for newborns – for example, by applying a much shorter rehabilitation timeline and by ensuring concurrent planning? If they do not act differently with newborns, then I have to believe they are grievously disserving most of the children that come before them.

A second cause for concern is statements I see of family drug courts' goals. According to one source, the Office of Justice Programs, which has overseen the birth and development of FDCs, has "identified the goals of FDC as to help the parent to become emotionally, financially, and personally self-sufficient and to develop parenting and coping skills adequate for serving as an effective parent on a day-to-day basis."⁵ The same source says that family drug courts represent the judiciary's response to ASFA timelines and "an attempt to recognize and accommodate the chronic relapsing nature of substance abuse and the co-morbid conditions that accompany it."⁶ Another source states that "[f]amily/dependency drug courts were established to assist courts and child welfare agencies in their efforts to help parents overcome their drug dependency so they can provide a healthy and safe environment for their children and avoid losing their parental rights."⁷ That all sounds good: fix people, improve parenting, prevent suffering. The problem is that such statements are entirely adult-focused.⁸ They mention children, but only through the lens of helping spare adults from suffering loss of a relationship they value (or are assumed to value) and who apparently should get special accommodation because their disease makes it especially difficult for them to rehabilitate within ASFA timelines. It is, in fact, a common complaint by feminist legal scholars that it is too difficult for drug-addicted mothers to get themselves and their lives in order within ASFA's 15/22 time frame.

The problem with this way of thinking should be obvious, yet I find myself repeatedly having to point it out to people. The singular and fundamental justification for judges having the power to dictate where and with whom a child will live is that the child cannot make that decision for herself or himself. We competent adults are absolutely entitled to decide ourselves with whom, among available other persons, we will live and share family life. It is an extraordinary thing for state actors to make such decisions for anyone. Thus, a competent adult who suffers abuse from an intimate partner, or who discovers that an intimate partner has a drug addiction and therefore is likely to be unfit as a partner, is legally entitled to exit the relationship based on nothing more than her conclusion that that is in her best interests. There is no question in such cases of whether a court could order such an adult to live in some form of limbo while all the queen's horses and all the queen's women try to rehabilitate the partner, and then order the adult to return to the partner if he progresses to the satisfaction of the judge. Children's inability to make and act on a decision to exit a relationship, based on their own best-interests, means that someone else must make a decision for them, but it in no way justifies someone making that decision based on something other than the children's best interests, such as the happiness and sympathetic appearance of the other person in the relationship. This parent-focused mentality infusing FDC advocacy is patently illicit and likely to harm children, because it is undeniable that holding children in limbo while the state tries to rehabilitate parents is in a substantial percentage of cases – in particular, cases involving newborns -- *not* the best thing for the children. So my second skeptical question for drug court proponents is this: Can you *demonstrate* that, despite such uncodified mission statements, all of the actors involved in family drug court proceedings actually give lexical priority to doing whatever is in the best interests of every child?

We might also ask by what legal authority judges arrogate to themselves the power to define the goals of a child protection proceeding or to transform a child protection proceeding into a parent-rehabilitation

⁵ Id. at 19.

⁶ Id. at 18-19.

⁷ Dakof, Cohen, and Duarte, *supra* note 4 at 13. See also *id.* at 12 (stating that drug courts "with their emphasis on recovery and personal transformation in lieu of punishment, embody the principles of therapeutic jurisprudence").

⁸ See also Haack et al., *supra* note 1 at 19 (stating that the parent is "the party" before the court); Oetjen, Cohen, Tribble and Suthahar, *Development of the Miami-Dade County Dependency Drug Court, Technical Assistance Brief, Permanency Planning for Children Department, National Council of Juvenile and Family Court Judges* (2003), at 3 (stating that "parents are the 'clients'" in FDCs).

proceeding. If a state's legislature has declared that the primary or controlling aim of legal proceedings arising from parental unfitness is to serve the welfare of children,⁹ how can the Office of Justice Programs or any individual judge presume to say the goal is something else? If specialized domestic violence judges got together and declared that henceforth the goal of domestic violence proceedings would be to keep couples together, the public would surely demand to know the source of their power to define the aims of those proceedings. It is so easy for governmental actors to get away with extraordinary things when the only persons prejudiced thereby are children.

A third concern, related to the second, is that FDC judges will come to identify and sympathize so strongly with parents that, regardless of what the legal rules are, they will tip heavily in their decision making toward protecting parents' interests. This must compromise not only the child-protecting function of the court system but also the child-protecting functions of CPS, GALs, and private service providers, all of whom are substantially under the thumb of judges. This concern first arose for me when I observed an FDC in Richmond, VA. The judge had developed a close relationship with the mothers that came before her, to the point that she was coming down off the bench in most hearings to embrace the mother. Can you imagine a judge today doing that with a man who abuses his wife because of his alcoholism, giving him a high five when he improves, hugging him in consolation when he falls back on the bottle and the judge must, with great reluctance, impose stern measures? If that did routinely occur, would it raise any concerns for advocates for domestic violence victims?

FDC judges even characterize themselves as coaches to parents, and their court proceedings as non-adversarial.¹⁰ Coaches are people who are on your side no matter what, who give both guidance and encouragement, who become even quasi-parents to players. Can you imagine a domestic violence court in which the judges viewed themselves as coaches for batterers? What is the likelihood in that "therapeutic" milieu of the FDC that a judge can apply the legal rules as the legislature intended or in a manner that ensures children's interests come first? FDC judges appear to have taken over a role that CPS case workers have traditionally carried out – namely, meeting regularly with parents found to have maltreated or posed a risk to children, to see how they are doing and to give them recommendations and support, and coordinating all the services parents need to complete their rehabilitation. And this same concern has arisen with CPS workers; in fact, it has been documented – that is, that CPS caseworkers identify with parents more so than with children. I have many times heard CPS directors use the phrase "our parents," but never the phrase "our children." I imagine FDC judges speak in the same way of "our parents."

The reasons why many CPS workers and directors appear to be parent protectors as much or more so than child protectors are not difficult to intuit. They see the parents far more often than they see the children. They have been trained to fix people, not to decide when someone is unfixable. The director of CPS in Allegheny County, Pennsylvania reminds his workers daily that every TPR represents a failure on their part. CPS case workers are adults themselves, and most of them are also parents, whereas their own childhood is a distant and vague memory and they likely never suffered maltreatment themselves. Like any humans, they want to avoid pain, and it must be quite painful to look at a person and say you are going to end their relationship with a child. If the child is an infant, caseworkers do not need to face the child at all. If the child is older, it is probably usually more painful to tell such a child that he will never go "home" again than it is to say "you will have to stay in foster care a while longer, because mom needs more time." And underneath all of these interactions is the pervasive and strong, even if rarely explicit, belief in this society that parents own their children.

⁹ See, e.g., Florida Statutes 39.001 ("(1) The purposes of this chapter are: (a) To provide for the care, safety, and protection of children in an environment that fosters healthy social, emotional, intellectual, and physical development; to ensure secure and safe custody; to promote the health and well-being of all children under the state's care; and to prevent the occurrence of child abuse, neglect, and abandonment. ... (b) 1. The health and safety of the children served shall be of paramount concern.").

¹⁰ E.g., Oetjen et al., *supra* note 8 at 6 (stating that the judge aims to establish a "rehabilitative relationship" and "consciously therapeutic rapport" with parents), 8 (stating that the FDC favors a "non-adversarial approach.").

Undoubtedly all or most of these same pro-parent pressures also influence FDC judges. The main possible exception is professional training, but undoubtedly the judges drawn to these courts have a relatively social-worky personality and some distaste for legalistic decision making.¹¹ So an additional question I would pose for proponents of FDCs is how often do FDC judges decide to terminate parental rights before the ASFA timeline forces them to do so when parents are still seeking return of their children? Stated another way: Do FDC judges generally wait for the legal deadlines or parental indifference to make the TPR decision for them, rather than pulling the plug as soon as the cost-benefit analysis for the child dictates doing so? And a final, related set of questions is: Why is it necessary for courts to take over this traditional caseworker function? If a judge is needed to oversee parental compliance with a treatment program, why not a drug court that substitutes for a criminal court rather than a court that substitutes for the juvenile court? And who, now, if anyone, in cases involving child maltreatment or endangerment stemming from parental substance abuse, serves as an independent and objective evaluator of children's best interests? And if there is anyone doing that, do they have any power in the legal process?

None of the foregoing is meant to suggest that the state response to parental unfitness should be punitive. The vast majority of these parents were once the battered or uncared for children whose parents the state was trying to rehabilitate. Their unfitness as parents was foreordained. They are damaged and sick, not evil. It is an illogical evasion to suggest that anyone opposed to the parent-focused, therapeutic approach of FDCs must have a judgmental personality and punitive aim.¹² People I know who think CPS and courts need to be more aggressive in shifting babies from unfit birth parents to adoptive parents never speak in terms of parental deservingness or blameworthiness. They say simply that the state is justified, perhaps morally compelled, to spare today's children from the same fate their parents experienced. Part of the problem with the thought process of those who think parents should have every last chance to turn their lives around and reclaim their children is that *they* think in terms of deservingness and blame. They are unwilling to support TPR until they are prepared to say that the parent deserves it, that the parent is to blame, perhaps because the parent has not tried hard enough or has given up. So as long as a parent continues to make significant effort, they want to keep supporting the parent. Again the contrast with common reactions to partner abuse is illuminating; no one argues that wife-batterers deserve every last chance to reform themselves before the state may end the marital relationship, and no one accuses domestic violence victims who seek to exit the relationship with the abuser of having a judgmental personality and unsympathetic, punitive aim, even if they file for divorce immediately after the first incident of violence.

Until I hear reassuring answers to the questions I've posed from objective and knowledgeable observers of FDCs, I am opposed to transfer of substance-abuse-related maltreatment or endangerment cases involving babies from normal juvenile courts to FDCs. What should be done with newborns when the likely custodian has a substance abuse problem (or a history of child maltreatment or violent crime, or is incarcerated) is an assessment of the prospects for that parent to become an adequate and permanent custodian for the child within six months.¹³ That assessment would take into account mental health diagnosis (some mental illnesses are much harder to treat than others), drug of choice (some are more addictive and dangerous than others),¹⁴ maltreatment history, previous rehab efforts, prior TPRs, criminal history, positive opportunities (e.g., for employment and better housing),¹⁵ family support,¹⁶ and additional stressors (e.g., other children in foster care, chronic victimization by partners, co-residence with other substance abusers).¹⁷

¹¹ Cf. Haack et al., *supra* note 1 (“The distinction between judicial activity and substance abuse treatment blurs...”).

¹² Cf. Dice, Claussen, Katz and Cohen, *Parenting in Dependency Drug Court*, 55 *Juvenile and Family Court Journal* 1, 1, (2004) (asserting, without supporting citation, that the non-FDC court process for responding to child maltreatment and endangerment is punitive).

¹³ See “Structured Decision Making,” Child Welfare Information Gateway, at <https://www.childwelfare.gov/systemwide/assessment/approaches/decision.cfm>

¹⁴ Cocaine appears still to be the most common. See Dakof, Cohen, and Duarte, *supra* note 4, at 18.

¹⁵ Most FDC parents are high school dropouts living on welfare. *Id.*

¹⁶ Most FDC parents have no partner to assist with parenting. *Id.*

¹⁷ Cf. Haack et al., *supra* note 1, at 21 (stating that 80% of FDC cases involve an allegation of domestic violence).

If the prognosis is too poor for it to be a sensible gamble for the child, the state should terminate the child's legal tie to that birth parent immediately and effect an adoptive placement. If there is substantial chance for reform by six months, then the state should place the newborn in a pre-adoptive foster home and engage in concurrent planning. Then, at the six month mark, the state's options should be limited to a) placement in the birth parent's custody, if that is safe and likely to be permanent, b) minor time extension if there is good cause from a child-centered perspective, or c) TPR. Sadly, a six month timeline would likely mean most serious drug users lose their legal tie to their offspring right after the child is born; drug rehabilitation in general has a very low success rate, and it is rare for someone to get it under control permanently within six months.¹⁸ But children's timeline cannot tolerate extension of impermanence into the crucial attachment period; they need good and permanent caregivers to be in place before it begins. In other words, what the child welfare system needs to develop is a triage response to substance abuse among parents of newborns, using research-based protocols to identify the most hopeful cases and concentrate resources on them, while quickly seeking alternative caregivers for children in the other cases.

Below is an excerpt from one of my articles that reinforces, elaborates, and provides support for some of the points above. The few footnotes I left in appear as endnotes.

**THE CHILD PROTECTION PRETENSE: STATES' CONTINUED CONSIGNMENT OF
NEWBORN BABIES TO UNFIT PARENTS, 93 Minn. L. Rev. 407 (2009)**

James G. Dwyer

* * *

I. STATE CREATION OF PARENT-CHILD RELATIONSHIPS

The state creates the legal parent-child relationship, and in doing so confers on certain adults powers, rights, and responsibilities with respect to certain children. The legal relationship ensures an opportunity for a social relationship. The state currently assigns children initially to adults for upbringing purposes almost exclusively on the basis of biological parentage. There is no basis in the parentage laws of any state for excluding some adults from parentage of a child on the grounds that they are not minimally qualified to serve as parents or are at very high risk of committing serious child maltreatment. Even maliciously killing a child today does not legally disqualify one from being named the legal parent of another offspring tomorrow. ... By way of comparison, it is inconceivable that any adult would similarly choose a spouse without giving any consideration to that person's history in intimate relationships and, in particular, any history of partner abuse that person might have, or any substance abuse problem that suggests unfitness as a spouse. Likewise, it is inconceivable that the state would approve any applicant for adoption of a child who has a history of severe child maltreatment or a substance abuse problem. The fact that parentage law today completely disregards such disqualifying history or characteristics is difficult to explain on any grounds other than an exaggerated notion of the importance of being raised by one's biological parents and/or a morally untenable notion of parental ownership of biological offspring.

¹⁸ See, e.g., Hui Huang and Joseph P. Ryan, Trying to come home: Substance exposed infants, mothers, and family reunification, 33 Children and Youth Services Review 322 (2011), at § 3.2 (reporting results of study showing that giving substance abusing mothers both residential drug treatment and transitional services in the community raised the rate of reunification by the child's eighteenth month to just nine percent); Oliveros et al, Addressing Substance Abuse Treatment Needs of Parents Involved with the Child Welfare System, 90 Child Welfare 25, 30 (2011) (describing research finding "recovery coaches" increase reunification rates only from 13% to 18%); id. at 33-34 (summarizing studies showing that FDCs increase reunification rates substantially but with average stay in foster care still over a year, and that FDCs also double the rate of renewed maltreatment and return to foster care); S. Budde and A. Harden, "Substance exposed infants in Illinois (1998-2001): Trends in Caseloads, Placement, and Subsequent Maltreatment, Chapin Hall Center for Children, Chicago, IL (2003) (finding that in Illinois only 14% of substance exposed infants achieved reunification within 7 years).

II. WHY IT IS CRUCIAL TO GET IT RIGHT AT BIRTH

A. Newborns' Developmental Needs

B. Why Newborns Are Different

Child-protection law fails to differentiate among children by age, instead taking a “one rule fits all ages” approach. Correspondingly, many scholars writing about the child-protection system write as if all children are affected in the same ways by it, regardless of age. Yet several things clearly differentiate newborn children from older children who come to CPS attention. First, the first year of life is the most important developmentally. Second, children are readily adoptable immediately after birth, but their chances for adoption diminish steadily from that point on, especially if they incur maltreatment or spend a substantial period of time in foster care. Third, newborn children have no established relationship with birth parents to maintain.

This last fact, in particular, is typically overlooked by those who advocate for family “reunification” efforts in all cases. For example, Dorothy Roberts, a prominent critic of the child-protective system, writes:

Think for a moment what it means to rip children from their parents and their siblings to be placed in the care of strangers. Removing children from their homes is perhaps the most severe government intrusion into the lives of citizens. It is also one of the most terrifying experiences a child can have.

What Roberts describes is simply not applicable to children taken into state custody at birth or within the first few months of life. Those children are not attached to their birth parents and experience no terror in the absence of their birth parents. In light of newborns’ preattachment reality, it is a misnomer to characterize efforts at rehabilitating unfit birth parents of newborns as “reunification,” and it is incorrect to characterize taking a newborn into CPS custody as disruption of a family relationship. The question from a CPS perspective in the case of a newborn is whether the state will try to create a minimally adequate relationship in the first instance between a child and birth or will instead immediately create a permanent relationship for the child with some other adults who are already well prepared to be nurturing caregivers. If the state chooses the former path, establishing and maintaining for a substantial period a legal relationship with unfit birth parents, it actually sets up the children for the terrifying experience Roberts describes, given the high probability of maltreatment in the birth parents' custody and the substantial possibility of ultimate adoption by someone other than the foster parents (resulting in severance of any relationship the baby has with the foster parents) in cases where birth parents are incapable of taking custody at the child's birth. Sensible policy and proper respect for newborns’ needs and moral rights should lead agencies to try to identify the newborns whose parents have the poorest prognosis and to take the latter path with those babies--that is, immediate placement with adoptive parents. CPS agencies generally do not have sufficient funding to provide substantial services to all the parents they now attempt to rehabilitate, so the resources are spread thinly over all rather than concentrated on parents who have a reasonable chance of becoming capable of adequate care giving.

The most common response to acknowledgement of the limited resources for reforming dysfunctional parents is to argue that the only policy change needed is to devote massively more public resources to the child-protective system and to services for unfit parents, and that terminating parental rights is unfair so long as the state does not provide parents with effective services. There are two problems with this response. First, even the best, most resource-intensive parent-rehabilitation programs, with all the facilities and services and encouragement experts typically recommend, have very little success with dysfunctional parents. [FN95] For example, a five-year demonstration project in Cook County, Illinois that provided 1500 randomly selected parents with a comprehensive needs assessment, entry into treatment programs within twenty-four hours of assessment, and a “Recovery Coach” to coordinate their services, monitor their progress, advocate on their behalf, and give them encouragement succeeded in

securing the recommended services very quickly for the vast majority of parents in the program, but raised the rate at which social workers thought it "safe" to return a child to parent custody only from 11.6% to 15.5%. Most parents whose children need to be taken into state custody have dysfunctions so deep, stemming from damage they themselves incurred as children, that they are not going to overcome them even in a couple of years, [FN97] and newborns cannot wait more than six months or so for a permanent and nurturing caregiver.

Second, even if a massively greater investment in parental rehabilitation would lead to a timely transformation of enough unfit parents to make waiting for their birth parents a good bet for at-risk newborns, until that investment is made the children now being born to unfit parents should have their needs addressed based on what is actually available, not what would be available in a perfect world. If the current foster care system is a failure, as some maintain, then we should be quite uncomfortable about placing children in it, especially newborn babies, while we make unpromising efforts to effect dramatic changes in deeply dysfunctional birth parents.

Importantly, even where there is a good chance of eventual birth-parent custody, it makes much less sense for a newborn than for an older child to wait for that to occur. It is a mistake simplistically to assume that placement with the legal parents, following a court determination that that would be safe, is always or even usually the best outcome for children who enter the foster care system. In most cases in which "reunification" does occur today, the placement with birth parents occurs only after a year or more of rehabilitative efforts, and roughly half occur only after two or more years. [FN98] A year is simply too long for a newborn to wait for a biological parent to become capable of custody, and transferring custody to a birth parent after a year is likely to entail a detrimental disruption of an attachment to the initial caregiver if the child was placed with foster parents. Moreover, reunification does not mean that a child will then have even a decent upbringing; a substantial percentage of children whom the state transfers from foster care to birth-parent custody end up in the child protective system again, after another maltreatment report, [FN99] meaning that the child has multiple damaging disruptions during the crucial first years of life. Further, many of those who do remain in the parents' home thereafter will have only a marginal existence, suffering maltreatment that goes undetected or receiving parental care that is just above the local CPS agency's threshold for intervention.

Placing babies born to criminals in a holding pattern while birth parents serve jail terms is also very detrimental to the children, because of the impact on attachment and on a child's sense of identity. Even after release, incarcerated parents are generally not able for some time to establish a home for and take care of a child, so the child's wait for permanency is likely to extend well beyond the expected release date, which is itself likely to be years down the developmental road if the parents have committed felonies. In addition, most incarcerated mothers suffer from a host of personal problems--in particular, drug addiction, alcoholism, mental illness, and lack of education--that will continue to plague them after release, and accordingly they are quite likely to return to prison after being "reunited" with the babies to whom they gave birth while in prison.

III. FEDERAL LAWS PUSHING STATES TO BE PROACTIVE

IV. WHY THE POTENTIAL IS UNREALIZED

The federal oversight agency, the Children's Bureau at the Department of Health and Human Services, gathers little information on state practices in implementing ASFA and KCASFA, and most states do not collect this information from their local CPS agencies. Evidence from non-HHS sources is limited but suggests that local agencies still almost never seek TPR until after they spend considerable time trying to rehabilitate parents, so long as parents are present and resist termination. For example, a GAO survey of four states found that only 102 of 14,489 children entering foster care were "fast-tracked" for adoption, [FNI27] and that only one percent of children adopted from foster care

are under age one. That tiny fraction of cases in which adoption occurs soon after birth might well comprise solely cases in which birth parents acquiesce to TPR. This Part explains why states still almost never place children born to unfit parents in adoptive homes until after the children have been damaged by maltreatment and/or prolonged foster care.

A. High-Risk Parents Do Not Come to the State's Attention

B. CPS and Courts Lack Authority to Intervene Prior to Maltreatment

Even if a child born to high-risk parents comes to CPS attention, there is no clear federal mandate that states take action to prevent maltreatment of that child. In all states, the law does require local CPS agencies to conduct an assessment or investigation of a child's situation when it receives a report of parental conduct that would meet the state's definition of abuse, neglect, or endangerment, and does permit CPS workers to take custody of a child where the report is substantiated and the child would otherwise suffer harm. In most states, however, nothing in the circumstances of a newborn child prior to placement in the birth parents' home could meet those definitions, absent a very generous and nontraditional interpretation of statutory language. Standards for intervention historically were drafted with only a reactive focus, an assumption that the state should get involved with respect to a given child only after a parent has maltreated that child, has overtly threatened to harm the child, or has put that child in a dangerous situation, and historically the prevailing understanding of child maltreatment was limited to conduct toward a child after birth. ...

KCASFA ostensibly creates an exception to the general rule, limited to newborns who happen to be tested for drug exposure and who test positive. It requires that local CPS agencies have "procedures for the immediate screening, risk and safety assessment, and prompt investigation of such reports" and "a plan of safe care" for any baby reported to have a positive toxicology screening. In practice, however, there is widespread evasion of this federal directive. States have generally complied with KCAFSA to the extent of requiring medical professionals to report drug exposure, requiring local CPS agencies to respond to any such report by conducting an initial assessment or investigation, authorizing CPS to file a petition in juvenile court for a removal order or other protective order, and authorizing courts to order a removal of the child and placement in foster care. However, most states' statutes do not require CPS to file a petition of any sort with a court when they verify the drug exposure of a baby; they merely permit CPS to do so. [FN149] As discussed further below, there is a strong cultural bias among CPS workers against intervention on the basis of pre-natal harm, so giving them the authority but not a mandate to bring a baby's situation before a judge for review is likely insufficient to ensure safety for such babies. Moreover, the law in most states also does not require courts to react to a CPS petition if filed; the law similarly just permits judges to issue an order in response if they so choose, and many judges are also predisposed not to take any coercive action against a woman based on her conduct during pregnancy. In short, there are three institutions that all must act if the newborn child of a drug addict is to receive protection--a medical facility, a local CPS agency, and a court, and each of them is legally free not to act if sympathy for the birth mother makes them averse to acting.

In addition, at least one state, Virginia, has created an enormous loophole in what limited directive there is with respect to implementation of the investigation and "plan of safety" mandate, an exception to the KCAFSA -mandated provisions that in fact precludes local CPS agencies from acting in many cases even if they are alarmed by the baby's situation and want to act. Virginia's Department of Social Services, with some supportive signaling from the General Assembly, has issued regulations instructing local CPS agencies to "invalidate" newborn toxicology reports if "(i) the mother of the infant sought substance abuse counseling or treatment during her pregnancy prior to the infant's birth and (ii) there is no evidence of child abuse and/or neglect by the mother after the infant's birth." Thus, CPS must invalidate a report of a drug-exposed baby and walk away from the situation if the mother received any counseling or treatment during pregnancy or even if she did not receive any counseling or treatment, so long as she attempted to receive one or the other and so long as the baby has not yet been maltreated

when CPS interviews the mother. DSS regulations define counseling and treatment in a quite broad way, such that it “includes, but is not limited to, education about the impact of alcohol, controlled substances and other drugs on the fetus and on the maternal relationship; education about relapse prevention to recognize personal and environmental cues which may trigger a return to the use of alcohol or other drugs.” Such education might be quite minimal and might make little impression on a drug addict. Indeed, the positive toxicology test at birth will almost always mean that whatever counseling or treatment a birth mother did receive was ineffective. This major exception to the state rule purportedly implementing KCAFSA makes irrelevant whether any counseling or treatment was effective in getting the mother to stop her substance abuse. Yet her inability to stop at such a time when she should be most highly motivated to stop--that is, when she knows she is poisoning her unborn child--suggests that she will be unable to get her addiction under control anytime soon after the child is born, and this in turn suggests that the baby is at high risk of abuse or neglect. But Virginia makes such risk irrelevant.

Further, for a child protection agency to do anything more than offer services to a parent, in most states there would have to be a “founded” report of abuse or neglect, and in most states drug exposure in utero does not satisfy the statutory definition of abuse or neglect, because child protection laws only apply to children after birth. Pennsylvania law, for example, authorizes only provision of services to the child in response to in utero drug exposure. Courts in some states might have authority to issue temporary emergency orders based solely on the commencement of an investigation of a drug-exposed baby's situation, but continued state involvement requires a CPS allegation of abuse or neglect, which CPS cannot make without a founded report of conduct that falls within the state's definition of abuse or neglect. A handful of states do treat in utero exposure to controlled substances as abuse or neglect and authorize CPS protective action on that basis.

C. CPS Agencies Resist TPR Without Rehabilitative Efforts

I. Social Worker Identification with Parents

In nearly every case, social workers who remove children from parental custody place the child in foster care and commence a program of rehabilitative efforts with the parents, so long as CPS can locate the parents and the parents do not flatly refuse to make any effort to change. No matter how horrible birth parents' child maltreatment history is, and with little regard for the age of the child and the extent of the child's relationship with the birth parent, social workers almost never seek immediate TPR and adoption. [FN163] Why is this the case?

First, the law authorizing CPS agencies to seek TPR conventionally has been permissive, not mandatory, so the decision to petition has been entirely discretionary. ASFA contained a provision requiring states to make petitioning for TPR without reasonable efforts mandatory for CPS agencies in certain cases--that is, those in which the parent previously committed a violent felony against another child. But that is narrower even than the category of reunification bypass situations explicitly authorized by ASFA, leaving out cases in which parents had prior TPRs or aggravated circumstances.

Such a mandate would be superfluous if all CPS agencies were inclined to pursue TPR without first undertaking a plan of parent rehabilitation whenever doing so would be best for a child, but they generally are not. It is contrary to historical practice, the practice dominant when most social workers of today were trained, and the practice encouraged by the “reasonable efforts” command of AACWA. It is also contrary to the social work mentality; social workers are not trained to determine when efforts to rehabilitate parents would be futile, and they are not trained to determine when adoption would be better for a child than attempting to make it possible for the child safely to live with birth parents. [FN168] They are trained to help people overcome problems, and so TPR represents failure for them. An observer of ASFA's passage predicted social worker resistance to its aims:

State agencies already have a proven record of undermining the Child Welfare Act because of their unyielding, one-sided belief in reunification [I]n 1997 Congress learned that states still

sometimes sent children back into households that no amount of family preservation could help. Numerous studies confirm that social workers and judges often strain mightily to avoid severing a child's bonds to her parents, even when doing so would ultimately benefit a child.... [FN169]

This prediction of social worker resistance to ASFA is borne out by a recent survey of CPS staff in California. Attempting to discover why CPS workers in that state rarely employ the state's extensive reunification bypass law, Berrick et al. found that many social workers expressed "ambivalence about its use due to philosophical perspectives on the social work profession." A representative comment by a social worker was: "It doesn't fit with the social work ethic. We are social workers. We do this work because we think people can change." In my own conversations with numerous CPS agency directors and social workers in Virginia, I heard the same perspective voiced. One local agency official told me emphatically that her agency would never petition for TPR without reasonable efforts, because "we don't give up on parents," and "you never know when someone might change."

Part and parcel of this perspective is an adult-centered orientation among many--though certainly not all--CPS social workers. In conversation, it becomes clear they view their "clients" as the dysfunctional parents, not the maltreated children. When I give presentations to CPS social workers and directors and I raise this concern, there are always a couple who approach me afterwards and, in hushed tones, say something to the effect of "it is so true; CPS is all about helping parents and giving them every last chance, not about doing what is best for the children." In addition, their understanding of child development, and of the permanent and severe damage that attachment failure and maltreatment in infancy can cause, is generally quite limited. Perhaps in part because of this limited knowledge (and in part because of their focus on parents' supposed rights), social workers have viewed their aim for newborns and other children as just ensuring safety, not ensuring an adequate environment for a child's healthy development.[FN175]. By way of contrast, when adults choose partners they certainly consider much more than whether a potential partner would threaten their physical safety.

Moreover, there are practical reasons why CPS agencies are reluctant to forego rehabilitation efforts and seek TPR immediately upon removal of a child. Parents might be more likely to litigate and appeal a TPR decision when CPS elects to forego rehabilitation, and if they do so they are likely to find a receptive audience in many judges, who are also adult-centered and comfortable with the conventional approach of giving dysfunctional biological parents every last chance to change. Because of the time and expense that litigation at trial and appellate levels entail, many social workers and attorneys conclude that it is more efficient to make the rehabilitative effort and then petition. In many agencies, there are also cumbersome administrative procedures for approving bypass recommendations, which further deter social workers from seeking them. And even if an immediate TPR would save them time and resources in the long-run, over-burdened social workers are likely to take the "foster care and rehabilitation" route because it is familiar to them and it entails less effort in the short-term. [FNI80]

2. Babies Lost in Relative Care

Even if children are removed at or soon after birth from the custody of birth parents who are manifestly unfit, they might quickly fall off the CPS radar screen if a court places them with relatives. Placement with relatives is generally an alternative to state assumption of custody and not a state-supervised foster care arrangement. In some states, a child must be in CPS custody in order for CPS to petition for TPR, so placement with relatives results in extended impermanence. In fact, placing a child with relatives allows CPS to avoid the mandatory TPR-filing requirement of ASFA for cases in which parents were previously convicted of violent felonies against another child. Placement with relatives generally results in little or no state oversight of a child's situation. CPS agencies have great discretion as to what placement they request a court to order and most operate with a strong bias toward relative placement.

Studies find that children whom CPS places with kin rather than non-kin foster parents on average have poorer outcomes. This is likely in part because they tend to receive fewer services than do children in non-relative foster care despite having similar needs, but it is no doubt also in part because the

dysfunction manifested by the parents runs through much of the extended family and much of the birth parents' community. As Elizabeth Bartholet explains:

[W]e should be willing to face up to the fact that child maltreatment is only rarely aberrational. It ordinarily grows out of a family and community context. Keeping the child in that same context will often serve the child no better than keeping him or her with the maltreating parent.

In fact, in many cases, relatives simply give the child over to the birth parents, without CPS authorization or awareness, so that kin care effectively amounts to return to parents, even though the parental conditions that originally necessitated removal still exist.

With older children, there is more reason to risk possible adverse outcomes from placement with relatives. Once a child has developed relationships with birth parents, extended family members, and others in the birth parents' community, the child has an interest in continuity of interpersonal connections and environment that counts in favor of placement with relatives. With newborn children, however, that interest in continuity is absent; there is only an interest in later developing family ties to biological parents and relatives. In addition, because older children are less likely than newborns to be adopted, placement with relatives might give older children a better chance than they would have in non-relative foster care, should their birth parents never regain custody, of completing childhood in an environment where they feel like they are part of a "real" family. That reason for relative placement also does not apply to newborns.

... [T]he law in most states does not in fact require that CPS ever give priority to relatives at any stage of a child protective intervention. Rather, it only requires that case workers investigate whether there are relatives who are willing and able to take custody and then choose the placement that is best for the child, after considering both relatives and non-relatives. The problem is that many social workers interpret the requirement of considering or giving a presumption to relatives as a mandate to place a child with a relative unless none are willing and minimally qualified, and they operate under a "keep the child with the family" ideology that draws no distinction among children based on age, that overlooks the several ways in which a newborn child's situation differs from that of an older child.

D. Grounds for TPR Without Rehabilitation Efforts Are Too Narrow

State statutory provisions authorizing TPR are confined to specific circumstances, not allowing for TPR whenever that would simply be best for the child. Importantly, ASFA did not explicitly preclude inclusion of other bases for TPR without reasonable efforts... However, many states have interpreted the background requirement of reasonable efforts to reunify that AACWA imposed as precluding what ASFA does not explicitly authorize. Accordingly, most states have very limited and narrow grounds for TPR without rehabilitative efforts and therefore for seeking a good, permanent home immediately after birth for a child born to manifestly unfit parents. Congress was somewhat clearer with ASFA that states were free to add more circumstances than those which ASFA mentioned under the heading of "aggravated circumstances" toward the child in question, [FN205] yet most states have limited aggravated circumstances to just those which the federal law lists, which focus on egregious post-birth conduct by parents toward the child now at issue. ...

One very important set of circumstance ASFA does not directly address are those involving parental dysfunction that has not previously resulted in a TPR or criminal conviction. While there is widespread recognition that hardcore drug addicts, severely mentally ill people, and profoundly mentally disabled persons are generally unable to hold jobs that would support a family, to manage a household or finances, or otherwise to exercise control over their own lives, current child protection law in most states does not reflect the reality that such people are also generally incapable of caring adequately for a baby and are extremely unlikely to become capable of doing so within six months of being offered rehabilitation services. Moreover, in the case of maternal drug or alcohol abuse, a child who has been damaged neurologically by in utero exposure to drugs or alcohol might need not merely an adequate parent or

even an average parent for his or her healthy development, but actually an exceptionally good parent or two, to provide the extra care the baby needs to remediate that early damage. If a set of exceptional potential parents is available to adopt a drug-exposed newborn, that is most likely to be a much better choice for the baby than being suspended in foster or kin care while CPS makes unpromising efforts to make drug-addicted, mentally ill, or mentally disabled birth parents minimally adequate.

ASFA also leaves out from the “no reasonable efforts” grounds incarceration. Several states’ statutes nevertheless treat incarceration per se as an aggravated circumstance or as an independent basis for TPR, in recognition of the fact that being separated from a child by incarceration straightforwardly precludes a birth parent from caring for the child. [FN207] ... [Contrariwise,] at least two states treat incarceration as an *excuse* for not taking care of a child. [FN209]

In addition, limiting the “maltreatment of another child” basis for reunification bypass to violent felony convictions and prior TPRs leaves out situations where a birth parent has abused or neglected other children and has been unable to recover custody of them despite rehabilitative efforts CPS has already made, but as to whom there has not yet been a criminal prosecution or TPR. The parent, who is not presently fit to have custody of any children, now is faced with the challenge of becoming capable of caring not only for the older children but also for a newborn baby. The prognosis for that parent becoming a consistent, nurturing caregiver for the newborn child in time for the child successfully to develop a healthy bond and secure attachment is extremely poor. [FN210] ... Child welfare experts have stated ... that “when parents of a child entering care have already lost multiple children to the system and made no subsequent change to their lifestyle, providing another 12 months of services seems unlikely to effect change in the parent, while unduly burdening the child with extended stays in foster care.” [FN212] Several states already have TPR provisions that look more broadly at a parent’s child maltreatment history, rather than only prior terminations or felony convictions, but most do not. [FN213]

E. Courts Refuse TPR Absent Extensive Rehabilitative Efforts

While courts currently grant most petitions for TPR, the rate of approval for TPR petitions is much lower in cases in which parents have not walked away from the scene and have not been given substantial time and services, even though the latter set of cases typically involves the most clearly unfit parents, as to whom social workers believe there is little chance of success. [FN214] A GAO survey of ASFA implementation revealed parent-protective judicial attitudes at work. It also found evidence that such attitudes operate especially strongly in the case of babies whom CPS takes into custody at birth based on maltreatment of other children. Because the parents have not yet hurt the new baby, judges believe they “should be given an opportunity to demonstrate their ability to care for this child.” More generally, many judges simply are “not supportive of ASFA's goals.” Judges’ reluctance might stem in part from adhering to a traditional view that biological parents own their offspring and from identifying more strongly with parents who appear before them than with the babies in question, who typically do not appear before them. [FN219] It likely stems in part also from judges’ limited knowledge of child development and, in particular, of the crucial developmental importance of the first year of life. [FN220]

In sum, proactive and preventive intervention to spare newborn children of unfit birth parents from permanently and seriously damaging early experiences remains exceedingly rare under current law and practices. Despite Congress's best intentions, the nation's child protective systems remain reactive and parent-focused.

V. REMEDIES

To complete the reforms Congress intended ASFA and KSAFSA to effect, further legislation is needed to a) expand the category of persons deemed presumptively unfit to raise children, b) identify at birth the biological offspring of such persons, and c) push CPS agencies and courts to take the actions necessary to prevent maltreatment of those children. The last will require, with birth parents who cannot quickly be made adequate caregivers, creating expeditiously an alternative family for the children.

A. More Expansive Grounds for TPR Without Reasonable Efforts

In thinking about expanding the “no reasonable efforts” TPR grounds, one should bear in mind that, prior to ordering TPR, courts must always find, by clear and convincing evidence, both that parents have engaged in certain behavior or have certain problems and that TPR would be in the child’s best interests. The best-interests assessment looks beyond the parental conduct or characteristic that is the “fault” predicate for TPR, to see whether other factors suggest it is best for the child to gamble on parental rehabilitation despite the parent’s history or problems. Courts take into account whether CPS has made efforts in the past to rehabilitate the parents; how responsive parents have been to such efforts; the availability of an alternative permanent placement; whether the other biological parent (rather than adoptive parents) would have custody of the child following termination; and many other things.

To address the clearest and most common circumstances in which newborns would likely have a much better life by being placed immediately in families with adults other than their birth parents, Congress should require states also to authorize TPR without reasonable efforts when birth parents have severe substance abuse or mental capacity problems, are incarcerated, or have substantial maltreatment histories that have not yet resulted in a TPR or criminal conviction. Iowa law authorizes immediate TPR when a “parent has a severe, chronic substance abuse problem” and “the parent’s prognosis indicates that the child will not be able to be returned to the custody of the parent within a reasonable period of time considering the child’s age and need for a permanent home.”.

In Virginia, I proposed legislation to address incarceration and multiple children in state custody... Objections I received ... include those typically leveled against CPS interventions generally--namely, that they trample the natural rights of biological parents and that they have a disparate impact on poor and minority-race parents and communities. The proposition that some adults are morally entitled to be in a family relationship with certain children independently of that being good for the children is just as untenable as would be a claim by one adult that he is morally entitled to enter into a marriage with another adult regardless of any decision on her part that she wants that for herself. In any event, the expanded “no reasonable efforts” grounds for TPR proposed here would effect little change in birth parents’ relationships with newborn children, because they would operate in cases where parents are highly likely to lose custody of their children anyway and ultimately to lose parental rights. Arguably, unfit birth parents would in many cases be better off, would suffer less, if the state effected a TPR immediately after birth, rather than pushing the birth parents for a year or more to do something they are incapable of doing, repeatedly denying their requests for custody, explicitly or implicitly condemning them for not transforming themselves, with the TPR threat hanging always over their heads.

Complaints about child protective systems having a disparate impact are also unpersuasive. If current interventions are generally appropriate, then there is no basis for alleging harm to poor or minority populations. Indeed, from a child-centered rather than adult-centered perspective, there is a relative advantaging of persons in low-income families or of minority race, insofar as children of poor parents or of minority race are disproportionately receiving state assistance in avoiding maltreatment and death. Second, available empirical evidence shows that CPS workers are generally not reacting to poverty per se or to families’ race or culture, but rather are reacting to real threats to children’s well being. Moreover, studies of attitudes toward CPS intervention have found no difference between social workers and members of lower-income and minority-race communities in their views of what parental conduct warrants CPS involvement.

Underlying the disparate impact criticism is an understandable basic sense of unfairness, that certain groups of adults have the misfortune of losing custody of offspring piled on top of many other misfortunes in their lives. Such sympathy, though, however admirable, cannot justifiably lead to sacrificing the welfare of today’s newborn children and consigning them to the same lives of misfortune. For the state to force newborn babies into family relationships with grossly unfit parents because

taking away “their” children would add insult to the injury of poverty and inadequate public assistance treats the children as mere instruments for the gratification of others and is a condemnable abuse of state power. [FN234]

An additional objection that might be couched in child-centered terms is that some parents eventually overcome their addictions, psychological problems, criminality, and other causes of absence or maltreatment. What is relevant from a child welfare perspective, however, is not whether there is *any chance* that a birth parent can ever overcome his or her problems, but rather *how likely* it is that the birth parent can overcome his or her problems in time to avoid the substantial and lasting damage to the newborn child that is likely to arise either from maltreatment and failure of attachment or from the delays and disruptions that foster care typically entails. With the types of circumstances and conditions identified above as potential additional bases for TPR without rehabilitation efforts, the prospects for quickly overcoming parental problems are extremely poor. Many critics of ASFA’s 15-22 rule in fact base their criticism on the reality that treatment for substance abuse is typically very lengthy, and unlikely to succeed within the time ASFA allows for rehabilitation efforts, and that imprisoned parents cannot be expected to become good caregivers right after release from prison. With older children, that fact might counsel in favor of relaxing the 15 to 22 provision (though that rule already contains a “best-interests exception” that states now use more often than not). Conversely, with newborns, it counsels in favor of immediate TPR and adoption.

Others argue that a lengthy foster care period, while CPS agencies undertake rehabilitative efforts, does not harm children, because most adopted children are adopted by their foster parents. However, the fact that most children adopted from the child protective system are adopted by foster parents does not mean that children remain in the home that was their initial post-removal placement. It simply means that adoptive parents typically serve as foster parents first. The foster parents who adopt might be the second, third, or sixth set of foster parents with whom the child lived. [FN241] In addition, even when a child’s first placement is with caretakers who will adopt, life is not the same emotionally and psychologically for a child’s new family before and after the court decisions creating legal protection for their relationship. Adoptive parents report high levels of anxiety while waiting for the legal process to run its course, and foster parents report a certain level of detachment from children, to protect both themselves and the children emotionally, in case the state ultimately removes the child from the foster home and places him or her with the birth parents. ...

One way partially to address these concerns is to establish a regular practice of “concurrent planning” with respect to newborns taken into state custody. At present, however, concurrent planning rarely occurs. [FN249] In part this is because CPS case workers do not understand it, do not have time to do it, expect strong resistance from judges and parents’ attorneys, or are opposed to the practice because it seems--to them and/or to the parents--to compromise their commitment to working with the parents on rehabilitation. [FN250] It is also in part because there is a substantial shortage of potential adoptive parents willing to participate. [FN251]. Even when social workers are inclined and able to engage in concurrent planning, TPR might be preferable, especially with newborns. If the ultimate outcome in a given concurrent planning case is placement in the custody of birth parents, the baby’s attachment to the foster-adopt parents, which is likely to resemble normal child attachment to parents, is severed. This severing is detrimental to the child and might not be outweighed by the benefit of being raised by a biological parent. The birth parent or parents are likely to be marginal caregivers even after being deemed legally minimally capable of assuming custody, and, in a substantial percentage of cases, birth parents will lose custody again, resulting in further disruption and trauma for the child. A judge in New York State laments: “Judges have seen repeatedly the re-entry of children into foster care based on relapse by the biological parents and the positive toxicology of subsequently born siblings. Whenever a child born with a positive toxicology is returned to the parents, the judge prays that the child is safe.”

B. Identify At Birth Children at High Risk of Maltreatment

C. Compel CPS and Courts to Act Expeditiously

... [T]o deal with CPS resistance to pre-maltreatment action, state statutes should be amended so that if the CPS investigation reveals that a newborn child would be at substantial risk of maltreatment in parental custody, CPS must petition for custody of the child, to trigger a court review of the baby's situation. ...

A further necessary reform is to require that CPS, when it assumes custody of a newborn child, seek a pre-adoptive foster care placement. Following any removal, CPS would assess the likelihood of parents' being capable of assuming custody within six months of the birth, using well-established instruments for conducting such assessments. [FN264] The maximum time allowed birth parents to become capable of caring for a child should be much shorter in the case of a newborn. [FN265] If the prognosis for birth parent custody within six months is poor, CPS should immediately petition for TPR unless it has strong reason to believe some other disposition would better serve the child's interests. Even when immediate TPR is not the disposition and instead CPS endeavors to rehabilitate the birth parents, CPS should immediately begin the agency process for approval of an adoption--that is, engage in concurrent planning, unless it is clear that the condition currently making custody with birth parents unsafe is likely to end soon. Every effort should be made to avoid multiple foster care placements for infants.

Moreover, there should be a presumption *against* placement of a removed newborn child with relatives, in virtue of the tendency of dysfunction to run throughout families and in light of the fact that newborns have no existing ties to biological relatives to preserve. There are also the dangers that relatives will feign interest in adopting in order to keep a child near the birth parents and that, even if they do adopt, they might give birth parents more access to the child than is beneficial for the child, because of sympathy for or fear of the parents.

Lastly, a separate dispositional provision applicable only to newborn children could *require* the court having jurisdiction of any children removed at birth because of substantial maltreatment risk to render whatever disposition is in a child's best interests, including immediate TPR if the prognosis for parental rehabilitation is very poor, taking especially into account newborns' pressing need for permanency. An additional or alternative means of pushing judges to order TPR without rehabilitative efforts when that is best for a child would be to establish a statutory presumption in favor of TPR when the parental-conduct predicate for a fast-track TPR is satisfied, shifting the burden to the parents to show TPR would not be in the child's best interests. [FN268]

Additional training of social workers and judges regarding the crucial importance of permanency for newborns, with instruction as to attachment, bonding, and brain development, might also go some way toward changing their inclinations in a child-centered direction. Alternatively, CPS agencies might need to employ persons who are not social workers but who are instead trained to conduct investigations, to make prognoses of parental rehabilitation, and to make best-interest decisions for newborns, and to give those employees authority to decide which disposition the agency will seek. Agencies might limit social workers' function to overseeing parental rehabilitation efforts after prognosis specialists and courts have decided that that will be the goal. Ensuring appointment of a GAL in all cases in which a newborn at risk is identified and training at least some GALs in the special needs of newborns and the proposed special legal provisions for newborns could help to expedite permanency for these children. Authorizing foster parents, prospective adoptive parents, and GALs to petition for TPR might be a further desirable remedy for CPS's reluctance to petition.

[FN95]. See CAPTA: Successes and Failures at Preventing Child Abuse and Neglect: Hearing Before the Subcomm. on Select Education of the Comm. on Education and the Workforce, 107th Cong. 70 (2002) [hereinafter CAPTA] (statement of Richard Gelles) (“[A]s yet, there is no empirical evidence to support the effectiveness of child welfare services in general or the newer, more innovative intensive family preservation services.” (emphasis removed)); Smith & Fong, *supra*