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SWINBURNE UNIVERSITY OF TECHNOLOGY

the family drug treatment court

an evaluation report

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The CFBS is Australasia's leading centre for excellence in the areas of forensic mental health and forensic behavioural science research teaching and practice development.

A key focus of the CFBS is to transfer academic and clinical excellence into practice in the health, community services and criminal justice sectors.

The CFBS brings together academics, clinicians, researchers and students from a variety of disciplines. The CFBS also works collaboratively with established industry partners including Victoria Police, Corrections Victoria as well as other international experts.

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GLOSSARY

CSO	Custody to Secretary Order
DHHS	Department of Health and Human Services
DRC	Dispute Resolution Conference[1]
FDAC	Family Drug and Alcohol Court (UK)
FDTC	Family Drug Treatment Court
FRO	Family Reunification Order
FPO	Family Preservation Order
IAO	Interim Accommodation Order
PCO	Permanent Care Order
SUD	Substance Use Disorders
CCV	Children's Court of Victoria[2]

Terminology

Clients	Any parent engaged with the FDTC program
Participants	Clients who provided consent for the evaluation of the FDTC and were subsequently interviewed.
First hearing	Date of the first hearing at the Children's Court of Victoria for the current Protective Application
Completion	Date of the final hearing at the Children's Court of Victoria, where a final Court Order was granted.

[1] Also referred to 'conciliation conference'
[2] 'Mainstream court' and 'CCV are used interchangeably in this report

EXECUTIVE SUMMARY

Introduction

Parental drug abuse is not uncommon in families involved with child protection. It becomes increasingly prevalent in cases where children are placed in out of home care. On average, children spend 18 months in out of home care and experience multiple placements per year (Levine, 2012).

In establishing the Family Drug Treatment Court (FDTC), Levine (2012) explains that judges and magistrates typically make an order to address problems experienced by the families. These orders however, are rarely effective as the monitoring process is the responsibility of Child Protection Practitioners (practitioners), who also have high case-loads and are often burnt-out. In these contexts, parents may be less likely to comply with the orders requiring them to undertake treatment for their drug use.

FDTCs were established to reduce maltreatment by treating the underlying drug abuse problem through the collaborative efforts of the court, child protection and welfare agencies as well as other services including drug treatment services. Levine (2012) explains that the FDTC offers a way out of the relentless and damaging cycle:

> *Giving parents more time (without also providing them more systematic support) can result in cases drifting on for years and lack of stability for children – in escalating costs of out of home care and long-term problems for children, families, the child protection system, the courts and the broader community.*

In Australia, the FDTC is located in the Family Division of the Children's Court Complex in Broadmeadows. It is available only to families living in the catchment area of the Northern Region as determined by the Department of Health and Human Services.

The aims of the FDTC are to provide a coordinated response to drug affected parents by creating a safe and stable environment for family reunification and therefore minimising the time children spend in out-of-home-care.

The Evaluation

The purpose of the FDTC evaluation was to determine whether the FDTC is achieving its goals in assisting parents to overcome their drug use issues and create a safe and stable environment for family reunification.

The evaluation was conducted by the Centre for Forensic Behavioural Science (CFBS) at Swinburne University. It commenced upon receipt of all ethical regulatory approvals in September 2017 and was completed within 12 months.

The evaluation was conducted using various methodologies:

1. **Time and motion** was used to compare they type and length of interactions between parties attending the FDTC and the Victorian Children's Court (CCV). Interactions were monitored over four days.
2. **Staff interviews** were undertaken to determine the overall perception of the FDTC
3. **Online staff surveys** were undertaken to determine the levels of satisfaction and dissatisfaction of the FDTC model
4. **Interviews** were used to determine perceptions and experiences of FDTC parents enrolled in the program
5. **Data linkage** was used to determine the efficiency, effectiveness and impact of the FDTC by comparing data to eligible cases from the mainstream CCV. The test cohort comprised all inducted clients in the FDTC and clients were followed up to September 2017. The cohorts could not be matched because information contained in the court databases is significantly different.

Key findings

Since its opening, 149 parents were referred to the FDTC where approximately 2/3 of individuals referred were inducted; rates fluctuated between 3 and 12 per quarter. Of those inducted, almost one in three completed or graduated from the program (29%). The remaining clients were either exited by the Magistrate (51%) or withdrew for other reasons (21%).

There were no differences between age, education, housing or mental health disorders for completing and non-completing FDTC clients. The results indicate that demographics of individuals do not identify those who are more or less likely to complete the program. Whilst the findings speak to the unpredictability associated with abstinence of drugs, the comparison does not measure characteristics or factors, such as readiness to change or attitudes towards the intervention which may indicate success (as indicated by program completion). An improved understanding of this is may be warranted, given the limited resources of the FDTC.

Are characteristics of clients attending the FDTC different from those attending the CCV?

Individual characteristics and demographics between FDTC and CCV clients were not compared because variables contained in the databases[3] were different. One of the main reasons for this was is that the nature of data contained in the DHHS CRIS database is child-focussed whereas data in FDTC BridgeCRM data is parent-focussed.

[3] FDTC (BridgeCRM database), Victorian Children's Court (Lex database) and Department of Health and Human Services, Child Protection (CRIS database)

Comparisons of historical involvement with child protection for FDTC and CCV cases was possible. Results indicated that compared with CCV families, the history of child protection involvement for FDTC families tended to be more extensive for prior protective reports, substantiations and protective applications.

How do the approaches of the FDTC and CCV differ?

The approaches adopted by the FDTC and CCV are fundamentally different as indicated by interactions occurring in the courtroom. The therapeutic context of the FDTC emphasises the Magistrate-client interactions whereas CCV hearings emphasise Magistrate-lawyer interactions.

Direct communication with the Magistrate is highly valued by participants as they are given 'a voice' in the hearings. The integral involvement of FDTC clients provides them with a sense of empowerment and motivation. Participants describe the FDTC program as one based upon honesty and compassion and which provides a context of support rather than of blaming and judging.

In the FDTC, the Magistrate plays a pivotal role. Participants consistently describe the Magistrate in a positive light, characterising her understanding, supportive and respectful. Importantly, the decision-making process is perceived by participants as fair and just, regardless of the outcome. Participants regarded the role of the FDTC as one to increase their knowledge as well as change their behaviour and attitudes about drugs, both of which ultimately improve their chances of having children returned to their care.

Whilst staff acknowledged the supportive environment and valuable work of the FDTC, they also identified the potential for improving the service and expanding the reach of the court. Suggestions included building on collaborative links within the private and public sectors and working on increasing referrals to the FDTC.

An evidence-informed FDTC model

It is advisable that the FDTC develop or adopt and document a model that guides its work. A model rooted in theory and research will assist the court maintain a consistent approach towards working with parents affected by drug abuse. An example of a model that may be incorporated into the FDTC model is proposed by Neger and Prinz (2015) and explains child abuse occurring in the context of drug abuse; it comprises parenting knowledge, emotional regulation and drug abuse as core components. Evidence-based programs with a focus upon parenting knowledge/behaviour and emotional regulation. This will lead to a more consistent approach that will adapt to new circumstances and allow for strengthening over time.

Workplace satisfaction in the FDTC

In terms of employee satisfaction, staff indicated overall good levels of satisfaction with the workplace. Lower levels of satisfaction or higher levels of dissatisfaction were identified for work content, professional development and employee interpersonal relationships. A lack of communication also appears to be an issue for some staff.

What is the efficiency of the FDTC compared with the CCV?

FDTC clients were on average engaged with the FDTC and CCV for 322 days longer compared with clients of the CCV mainstream court. However, the FDTC was slightly more efficient once clients were inducted. As all clients of the FDTC and the CCV were engaged in the mainstream court for considerable periods, results suggest that if the time spent in the mainstream court were minimised for the FDTC clients, the FDTC would be more efficient.

What is the effectiveness of the FDTC compared with the CCV?

FDTC clients who completed or engaged with the program (clients who were not exited by Magistrate and may have left prematurely for reasons beyond their control) were more likely to be reunified with their children compared with those who were exited from the program or in mainstream CCV. Results indicated that:

- FDTC clients were **1.6 – 2.5 times** more likely to be re-unified with their children, compared with mainstream CCV or those exited from the program by the Magistrate.
- FDTC clients **engaged for at least 6 months** with the program had higher likelihood of re-unification compared to the mainstream CCV, regardless of if they had eventually been exited or not.

The indicators used in the current evaluation were broad proxy measures of the reunification outcome and the figures may underestimate the relative effectiveness of the FDTC program. The greater effectiveness of FDTC compared with the mainstream CCV, however is clear, particularly given that clients engaging with the FDTC had a greater child protection involvement compared with those from the mainstream court.

Further detailed research however would determine the extent to which other more nuanced measures of reunification compare, for example, supervised and unsupervised visits.

What is the impact of the FDTC on child protection outcomes compared with the CCV?

Clients involved with the FDTC for at least one session, were less likely to have a substantiated child protection report. For those who had a report, FDTC clients had fewer subsequent reports. Specifically, compared with the FDTC, cases from the CCV were 2.2 times more likely to have a substantiated report during their post-court period.

There was however, no difference between the groups for the time elapsed from final protective order to a new substantiated report. The results indicate that from a child protection perspective, the FDTC appears to impact families beyond the time engaged with the court resulting in a reduction in the number of subsequent reports and substantiations.

Recommendations

Recommendation 1: Given the extensive historical involvement with child protection of FDTC families, efforts should be made to encourage eligible parents to engage at earlier stages within the child protection process. FDTC should be a preferred initiative, particularly during the early stages of the child protection process as it will reduce the length of engagement with the court system and improve living stability of children. This strategy may require increasing the FDTC's visibility to the child protection workforce, court and legal staff by developing seminars or workshops as a means of enhancing familiarisation with court principles.

Recommendation 2: The FDTC may consider focusing on enhancing and expanding the program to include families located in other areas of Melbourne. Co-locating FDTCs in existing CCV complexes would provide an alternative to the mainstream adversarial system. Planning for expansion would require further links be established with private and public agencies and research to identify and map areas of high needs.

Recommendation 3: It is important that the work of the FDTC is theoretically guided to improve consistency beyond the current workforce. This may involve adopting, at its most fundamental level, an approach to understanding parental substance abuse. A documented approach will increase consistency and transparency of decision-making.

Recommendation 4: Given the results of the staff survey, the FDTC may consider identifying potential causes for the findings and aim to improve employee satisfaction and reducing dissatisfaction.

Recommendation 5: Given the positive results, further research should be conducted to explore the expansion of the court. The current study is limited by way of the blunt indicators (court orders) used for re-unification. A detailed study is recommended to provide a more nuanced understanding and therefore a more accurate reflection of parent-child re-unification that is not solely based on court orders. Further, longer-term monitoring of clients may provide an indication of the FDTC's impact on intergenerational transmission of drug abuse and child protection involvement. Other research monitoring of longer-term outcomes of clients including employment status, criminal justice system involvement and mental health service usage may determine the economic benefits of the work undertaken at the FDTC.

REVIEW OF THE LITERATURE

Parental drug abuse

Parental drug abuse is not uncommon. With almost 20% of parents consuming alcohol at risky levels, alcohol is the most commonly abused drug in Australia amongst parents with dependent children. Between 8 and 16% of parents have recently engaged in cannabis use and 5 and 10% in other illicit drug use. Amphetamines, heroin, cocaine, ecstasy and hallucinogens are the most commonly consumed illicit drugs. Almost four of five drug addicted parents consume multiple drugs (AIHW, 2011; Australian Institute of Health and Welfare, 2011; Taylor, Marquis, Coall, & Wilkinson, 2017).

In the United States (US), alcohol and methamphetamines are most commonly indicated in child welfare cases (Green, Rockhill, & Furrer, 2006; Lloyd & Akin, 2014); cocaine, marijuana, and heroin is observed to a lesser extent (Choi & Ryan, 2006). In contrast, parents with dependent children in the United Kingdom (UK) and mainland Europe more commonly engage with alcohol, marijuana, opioid and stimulant use (Basnet, Onyeka, Tihonen, Fohr, & Kauhanen, 2015; European Monitoring Centre for Drugs and Drug Addiction, 2010; Forrester, 2000; Manning, Best, Faulkner, & Titherington, 2009). Australian trends mirror those in the UK. In Australia, over 13% of children aged less than 12 years live with regular parental binge drinking, 2.3% live with at least one daily cannabis user and 0.8% live with an adult who has recently consumed methamphetamines (Dawe et al., 2006).

Parental drug use is not homogenous with different patterns of drug use noted between single and coupled parents and between genders. For example, compared with coupled parents, a greater proportion of single parents use illicit drugs and more frequently engage in binge drinking (Australian Institute of Health and Welfare, 2016). In addition, males are far more likely than females to use any licit or illicit drug, with the exception of pharmaceutical abuse, which is evenly distributed (Australian Institute of Health and Welfare, 2011).

Parental drug abuse impacting on parenting

Parental drug abuse impacts differently upon parenting practices, parenting styles and family functioning. The direct and indirect consequences of drug abuse affect a number of interactive pathways commencing with exposure during pregnancy, environmental exposure post-birth and compromised parenting behaviour. This is further complicated by drug type, amount and rate of consumption (Mayes & Truman, 2002). Parental drug abuse is also associated with a number of risk factors including socioeconomic disadvantage and a parent's history of abuse victimisation (Dawe et al., 2006). Consequently, the complexities associated with drug abuse and how it impacts on parenting does not involve a simple cause-effect relationship.

Parenting is conceptualised in a variety of ways indicating the many ways in which it can be affected by drug use. Whilst alcohol and heroin may depress mood, amphetamine provide feelings of elation. All drugs however are likely to impact on the ability of the parent to respond to a child's needs in at least one way. How this happens and how parenting is impacted will depend upon many factors including the legal, illegal and social contexts in which the drug use takes place. Different challenges may impact differently on individual dyadic relationships[4], broader parenting practices[5] as well as family functioning[6]. Parental drug abuse attests to the complexity and interrelatedness of parenting, family and societal factors as well as the potential for the intergenerational transmission of drug use (Mayes & Truman, 2002).

A conceptual model of parental drug abuse and child abuse

The link between drug abuse and child abuse is complex as indicated in Neger and Prinz's (2015) conceptual model (see Figure 1, next page). The model describes pathways of the influence between parental drug abuse and child abuse and neglect. It highlights the role of deficits in emotional regulation and accumulation of psychosocial stressors as well as a lack of parenting knowledge.

Emotional regulation

> *Emotional regulation ….a process through which individuals modulate their emotions consciously and non-consciously to appropriately respond to environmental demands. Individuals deploy regulatory strategies to modify the magnitude and/or type of their emotional experience or the emotion-eliciting event (Aldao, Nolen-Hoeksema, & Schweizer, 2010:218).*

Modulating arousal or emotional regulation is central to many neuropsychological functions and is genetically and experientially based. Acute or chronic traumatic experiences may result in altering an individual's ability to modulate arousal.

Whilst emotional dysregulation is associated with mental disorders and is incorporated into explanatory models for many mood and personality disorders (Aldao et al., 2010), it is also a core feature of drug abuse. It is associated with negative emotions such as anxiety, stress and depression and drug abuse often serves to self-medicate or avoid

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[4] *Parenting styles* is a broader term that encompasses "behaviours that include aspects of parent-child interaction that communicate emotional attitude but are not goal directed or goal defined" (Darling & Steinberg, 1993:493). These include tone of voice or body language when communicating with the child.

[5] *Parenting practices* are behaviours defined by "specific content and socialization goals" (Darling & Steinberg, 1993:492) involved in parenthood that may include attending school functions, spanking or making time to engage with the child.

[6] *Family functioning* is broader again and encompasses "behaviour of family members as well as member interactions in both expressive and instrumental domains" (Wolock & Magura, 1996:1186). These include dysfunctional boundaries, poor communication skills, high family conflict and role distortion.

emotions resulting effective symptom relief (Kober & Bolling, 2014; Mayes & Truman, 2002; Neger & Prinz, 2015).

Poor parenting from difficulties associated with impulse control and negative emotions should be addressed in drug treatment programs. Learning to manage cravings and long term strategies focused on maintaining abstinence play an important part of many treatment programs (Kober & Bolling, 2014). Emotional regulation also plays an important part in parenting as children often rely on their parents to regulate their emotions until they develop these abilities themselves. When parents do not assist to regulate their child's emotions, they are prone to arousal problems in adulthood (Mayes & Truman, 2002).

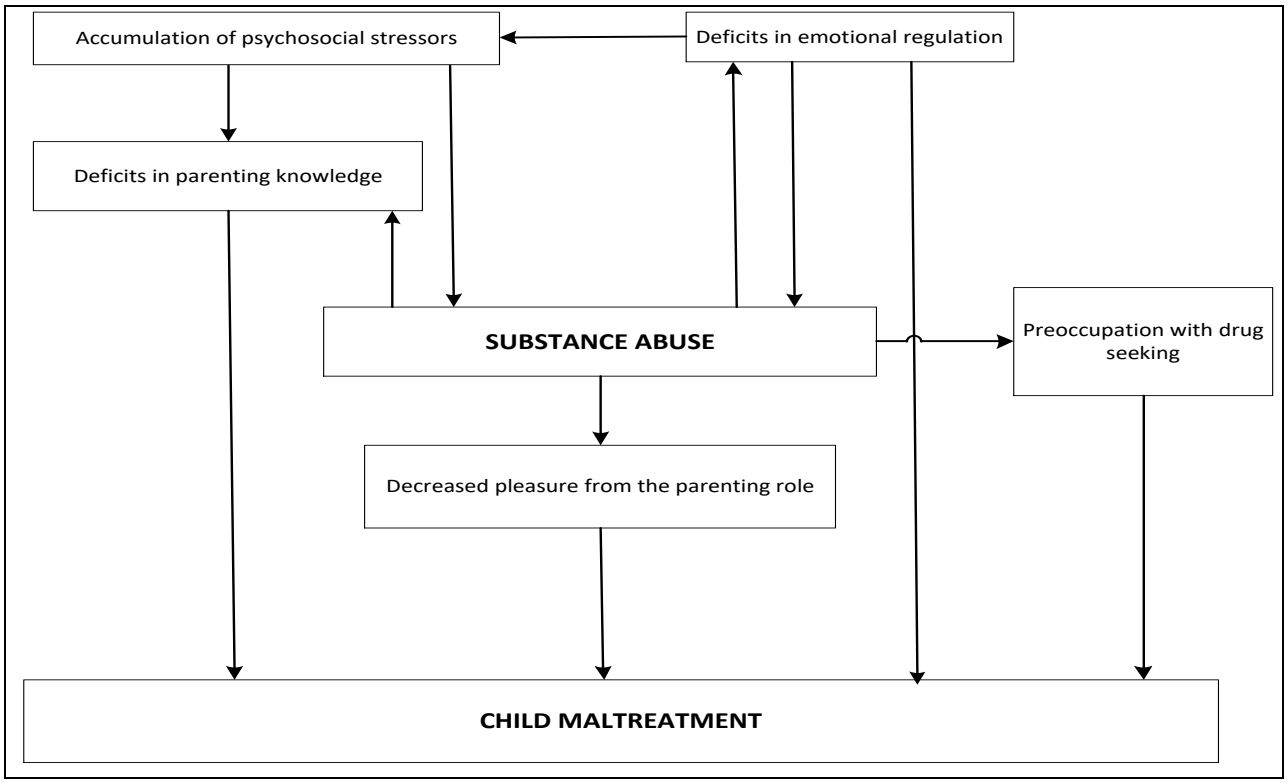


Figure 1.
Conceptual framework connecting drug abuse and child maltreatment
Reproduced from Neger and Prinz (2015).

Parental knowledge

Parental drug abuse may impact on parenting skills, family functioning and general child-rearing practices such as discipline, boundary setting, consistency of care and reliability (Kroll & Taylor, 2001). Parents who abuse drugs often demonstrate low levels of knowledge about child care and development (Velez et al., 2004). Possible reasons for this lack of knowledge may include unique personal histories including sexual, physical

and emotional victimisation, mental illness, stressful and chaotic living conditions, poverty and child characteristics caused by exposure to drugs in-utero.

Parents who have limited knowledge of child development and parenting may have inappropriate expectations of children and attribute malicious intent to a child who does not have the developmental capacity to undertake a task. Parents lacking knowledge may be unable to implement alternative strategies other than harsh and unwarranted discipline (Neger & Prinz, 2015).

Literature suggests that deficits in knowledge are often attributed to cognitive impairment, compromised attention due to drug or withdrawal states and limited access to parenting education resources (Neger & Prinz, 2015).

Parental drug abuse impacting on child outcomes

It is well established that parental drug abuse is associated with poor developmental outcomes for children, a finding that is particularly enhanced for infants exposed to drugs during pregnancy. Frequently, drug exposed newborns are found to experience irritability, disturbances in sleeping and eating, gastrointestinal problems and seizures (Neger & Prinz, 2015).

For children reared in the context of drug abuse, compromised attachment may result from the parent's inability to respond to their child during periods of withdrawal, heavy use and non-use (De Bortoli, Coles, & Dolan, 2014). These children experience many difficulties including being at increased risk of developing speech and language problems, behavioural problems and experience isolation and conflict at school. During adolescence, children exposed to parental drug abuse are at greater risk of developing depression and anxiety and engaging in drug abuse (Barnard & McKeganey, 2004; Biederman, Faraone, Monuteaux, & Feighner, 2000; Bountress & Chassin, 2015; Bromfield, Lamont, Parker, & Horsfall, 2010; Burdzovic & O'Farrell, 2017; Kroll, 2004; Lester et al., 2009).

Parental drug abuse and child removal

Parental drug abuse is significantly associated with child maltreatment (Taylor et al., 2017; Walsh, Macmillan, & Jamieson, 2003) as well as preventable child deaths (Brandon et al., 2011). Inflated rates of drug abuse amongst parents involved with child protective services is well documented. Many of the children require out-of-home placement (Brandon et al., 2011; Canfield, Radcliffe, Marlow, Boreham, & Gilchrist, 2017; De Bortoli, Coles, & Dolan, 2015; Holland, Forrester, Williams, & Copello, 2014).

Between 50 and 80% of children in out-of-home care have at least one drug misusing parent (Besinger, Garland, Litrownik, & Landsverk, 1999; De Bortoli, Coles, & Dolan, 2013) and many children are affected by parents with co-morbid disorders. A pivotal study estimated that between 37% and 53% of people with a drug disorder also have a co-morbid psychiatric condition (Regier et al., 1990).

The impact of parental drug use on parenting is often one of decreased responsivity to the child's basic safety and emotional needs. Drug affected parents have less supervision, more punitive parental discipline and aggression, and fewer positive parent-child interactions (European Monitoring Centre for Drugs and Drug Addiction, 2010; Thomas, 2011). In this context, children frequently have insufficient food available in the home, higher rates of school absenteeism due to less supervision, are more likely to be exposed to family violence and a police presence in the home (Gruenert, 2013). In some circumstances, children take on caregiver duties and other adult responsibilities to manage both the drug using parent, and, or other siblings (Kroll, 2004).

Whilst protecting children from the harmful effects of drug abuse may require their removal from the family home, their re-unification remains of central importance. Whilst foster care is preferable to a child residing with a drug-affected parent, problems associated with the foster care system are well documented; it is under-resourced and the child experiences frequent placement changes which impact on their health and wellbeing (Minty, 1999; Newton, Litrownik, & Landsverk, 2000; Oosterman, Schuengel, Slot, Bullens, & Doreleijers, 2007).

Assisting parents to abstain from drug use and improve their parenting abilities will have many positive effects. There is a reduced reliance upon the State to manage a child's care, less public costs associated with placements and a promotion of re-unification and positive outcomes for children and families (Dore & Doris, 1997; Marlowe & Carey, 2012).

CHILDREN'S COURT OF VICTORIA

The Children's Court of Victoria (CCV) is located at 477 Little Lonsdale Street in Melbourne, Victoria. The CCV is located at other locations in and around Melbourne at Dandenong, Frankston, Heidelberg, Moorabbin Justice Centre, Ringwood, Sunshine, Werribee and the Neighbourhood Justice Centre (Collingwood) and Broadmeadows.

The Family Division of the Children's Court of Victoria has jurisdiction to hear a range of applications and make a variety of orders in relation to the protection and care of any person under the age of 17 years.

Hearings in the Family Division

The adversarial court, the CCV is based upon a progression of hearings as indicated in Figure 2. The adversarial process has its roots in the traditional common law method of presenting cases in a process that requires the parties, rather than the judge, to define the issues. With this approach, the quest for proof underlies the premise of the adversarial system where alleged facts and evidence are tested by putting arguments to the court (Cummins, Scott, & Scales, 2012).

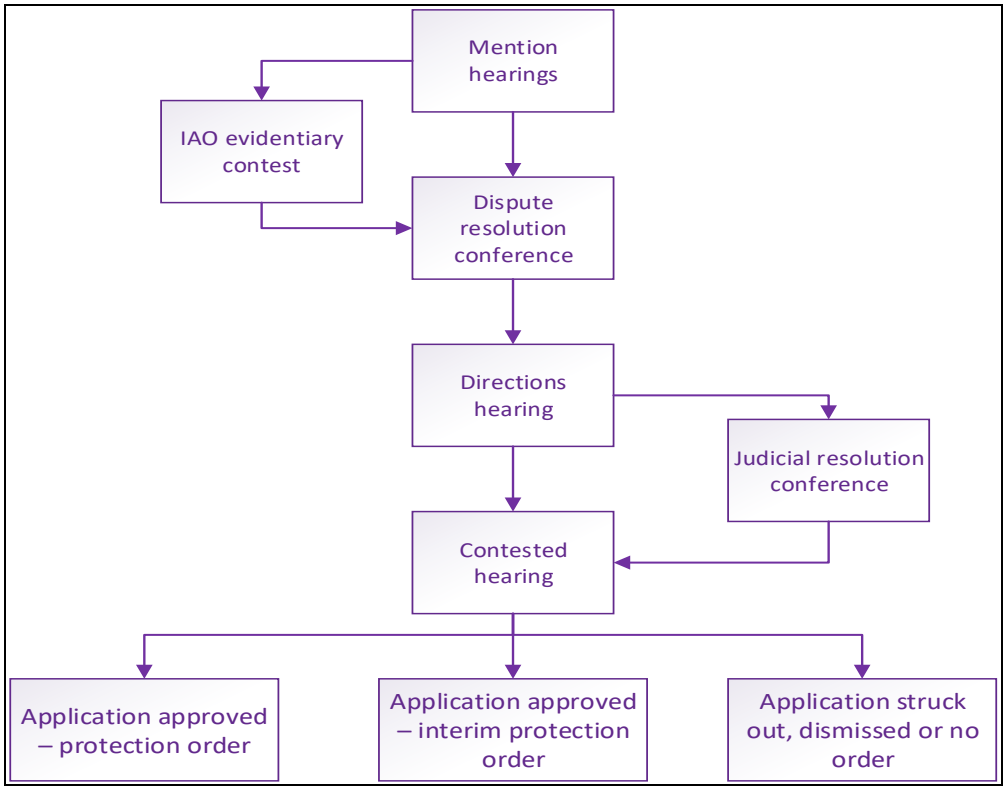


Figure 2
Progression of hearings through the family division of the Children's Court of Victoria
*Extracted from Victorian Law Reform Commission (2010)

At each hearing stage, parties establish their own case rather than seeking common ground to identify a solution that is in the best interests of the child. There are several hearing types in which a case progresses through the court:

Mention hearing is a case management hearing. When the protection applications begin by notice, the first listing is a mention. Cases may be listed for a mention at any time during the court process for reasons such as to assess wither a specific action has been taken.

Interim Accommodation Order (IAO) Evidentiary Contest is required if parties are unable to agree upon where the child should live in the short term. IAO hearings may require submissions from legal representatives.

Conciliation Conference (CC) is the first stage of a contested protection application. This hearing provides the parties with an opportunity to agree on a specific action. Independent convenors chair the conference.

Judicial resolution conference may occur at any time between commencement of a protection application and final orders. The conference is presided over by the President or a magistrate to negotiate settlement between the parties.

Directions hearings are held when a case has failed to resolve before a DRC. It takes place approximately two weeks before the final (contest) hearing and is regarded as a final opportunity for the magistrate or the judge to informally mediate the outcome. If this is unsuccessful, then the mechanics of the case are focused upon, such as arranging for witnesses to appear.

Contest hearings occur when cases fail to resolve by negotiation and may be quite lengthy. Witnesses may be called to give oral evidence, and this is subject to cross-examination (Victorian Law Reform Commission, 2010).

Disadvantages of the adversarial approach, particularly in the Family Division of the CCV, have been highlighted in grey literature. Lengthy periods are spent by professionals waiting to be called as witnesses in court cases impacting upon workload management and resources. Other commonly cited limitations of the adversarial system includes the inequities associated with resource imbalance between parties, lengthy trials, the adversely effected relationships between parents and welfare agencies and the emphasis placed on the confrontational approach, the result of which often aligns with neither party (Cummins et al., 2012; Victorian Law Reform Commission, 2010).

THE FAMILY DRUG TREATMENT COURT

A novel concept

Children's courts and child protective services tend to focus upon parental rights and child custody arrangements (Harrell & Goodman, 1999). Whilst the best interests of the child is always paramount, re-unification is the primary goal for these families (Fernandez & Lee, 2013; Papageorgiou, 2017). The role of mainstream courts is mostly limited to decision-making about the living arrangements of children with limited focus placed upon improving the circumstances associated with parental drug abuse.

In 1994, the first Family Drug Treatment Court (FTDC) was established in the US to create an environment where a child's safety and rights could be protected during a time parents could access mental health, addiction and other support services within the court setting (Choi, 2012; Oliveros & Kaufman, 2011). It was created in response to increasing rates of child maltreatment involving parental drug use as a means of integrating community and legal services for parents who were experiencing a combination of substance use and legal problems (Harrell & Goodman, 1999; Larry & Lawson, 1994).

Figure 3
His Honour Greg Levine established Australia's first pilot program of the FDTC in the Children's Court of Victoria.
*Reproduced from *The Age*

The FDTC offers therapeutic jurisprudence to drug abusing parents involved with child protection. Adapting the work of Richardson (2016) to the context of child protection and parental substance abuse, the elements of the therapeutic approach:

1. promote behavioural change rather than compliance with the child protection system
2. focus on the future rather than apportioning blame and focusing on the past
3. recognise the importance of procedural justice by affirming individuals are competent and equal, provide them with a voice and treat them with dignity and care, and
4. incorporate judicial involvement in proceedings as well as participation of all parties and encourage self-determination and individual choice.

Three models of FDTCs are described in the literature. The first, the parallel model involves two judges where each judge focusses on either child welfare or drug treatment progress. The second, the integrated model involves one family one judge where a single judge oversees the child welfare case and the drug treatment process. The third model, the dual track/two-tiered model, is a hybrid of the two models. The Melbourne model of the FDTC is based upon the integrated model, which is also adopted in London. In this model, social services, health practitioners and Magistrates join forces to systematically target parental drug use to improve social outcomes for children and families (Harrell & Goodman, 1999; National Association of Drug Court Professionals, 2004).

Evaluating Family Drug Courts in the US and UK

Promising results have been indicated in evaluation studies of Family Drug and Alcohol Courts (FDACs) as well as FDTCs.

Across the UK, FDACs operate from 12 courts with this number expected to grow with the first FDAC operating from the Central Family Court between 2008 and 2010 (National Unit FDAC, 2017). Evaluation results indicated higher reunification rates, higher rates of permanency placement, and lower rates of recurrent drug use among families who participated in the FDAC compared with families heard in the mainstream court setting (Harwin, Alrouh, Ryan, & Tunnard, 2014).

In the US, parents engaged in FDTC programs are more likely to complete drug treatment (Ashford, 2004; Bruns, Pullmann, Weathers, Wirschem, & Murphy, 2012; Worcel, Green, Furrer, Burrus, & Finigan, 2008) and abstain from drug use in the shorter and longer-terms (Harwin et al., 2016; Harwin et al., 2014) compared to parents in the mainstream court settings. Children of parents participating in FDTC programs tend to spend less time in foster care (Bruns et al., 2012; van Wormer & Hsieh, 2016) and are more likely to be reunified with their parents, compared with children whose cases are heard by mainstream courts (Ashford, 2004; Gifford, Eldred, Vernerey, & Sloan, 2014; Green, Furrer, Burrus, & Finigan, 2009; Harwin et al., 2016; Harwin et al., 2014; van Wormer & Hsieh, 2016)

UK models share many core components, there are also differences between the courts:

1. The FDAC model in London engaged in more long-term follow-up services post-graduation compared with the US model (Levine, 2012). This is a significant strength of the UK model particularly given reunifications can be particularly fragile (Harwin et al., 2011) and are likely to benefit from sustained support.
2. Parents in the US tend to become involved with FDTCs much earlier whereas involvement with FDACs tends to be a measure of last resort (Levine, 2012). Recommendations to change this have been made, particularly given the poorer and longer term outcomes associated with children living drug using parents (Harwin et al., 2014).
3. Drug abuse programs undertaken by clients of the courts in the US involve inpatient referrals compared with outpatient services in the UK. Outpatient services are preferable as they assist parents with recovery in conditions that provide a more realistic test of the parent's capacity to function in the community (Levine, 2012).

Despite the differences, similar results have been observed with the UK and US models. The initial evaluation of London's FDAC indicated that 40% of parents abstained from drug use compared with 25% of parents in the mainstream court setting (Harwin et al., 2014). As a consequence, 35% of FDAC parents were reunited with their children compared with 19% of parents in the mainstream court setting (Harwin et al., 2014). Children of parents participating in FDTC programs require less foster care, child welfare, and adoption-related costs compared with families in mainstream courts.

In addition to drug-abstinence and re-unification, other benefits to parents completing FDTC programs include increased chances of gaining employment and improved social functioning (Bryan & Havens, 2008). Benefits to both individuals and families extend to government savings in relation to the provision of long-term services. Studies in the US indicated government savings in the order of $5K to $10K for families participating in the FDTC (Brook, Akin, Lloyd, Johnson-Motoyama, & Yan, 2016; Burrus, Mackin, & Finigan, 2011). Similar savings are estimated in the UK (Harwin et al., 2011).

The nature and outcomes observed by FDTCs varies between jurisdictions. Further research is required to determine the factors or specific approaches used by FDTCs that contribute to successful outcomes (Edwards & Ray, 2005; York et al., 2012). This understanding is required to refine services and provide continued support to existing and newly established FDTCs (Doris Duke Charitable Foundation, 2017).

Despite this, overall findings have provided support for expanding the implementation of FDTCs in the US particularly as fewer than 10% of eligible families have the opportunity for their case to be heard in a FDTC (Brook et al., 2016). There are 370 FDTCs in operation in the US (Doris Duke Charitable Foundation, 2017) and nine specialist teams working across 12 courts in 15 local authorities.

Elements influencing successful outcomes

There are a number of elements known to influence successful outcomes in courts.

Parental engagement

Parental engagement is known to play a role in enhancing outcomes in child welfare more generally, as well as contributing to sustainable family reunification within the FDTC setting (Dakof, Cohen, & Duarte, 2009; Kemp, Marcenko, Hoagwood, & Vesneski, 2009). Specifically, providing services to parents that are personally relevant may strengthen their connection to those services, improve engagement and motivate participation (Drabble, Haqun, Kushins, & Cohen, 2016).

The potential for improving outcomes was explored in the FDTC context by providing enhanced services aimed at building parental engagement. A US study compared parents participating in a non-enhanced FDTC service which involved addiction treatment, collaboration with the magistrate and regular drug screens with parents participating in a newly developed enhanced court initiative designed to increase engagement (Dakof et al., 2009). The enhanced component comprised gender-specific needs, family violence, the parent-child attachment relationship, communication skills, and parent's own experiences of being parented themselves (Dakof et al., 2009). Results showed that 72% of the mothers undertaking the engagement-enhancing initiative graduated from the court compared with 38% who received typical FDTC services. In addition, 70% of mothers who undertook the initiative were reunified with their children whereas 40% of mothers participating in the non-enhanced program FDTC services.

More recently, a study observed particularly high rates of engagement and satisfaction among parents who received a mentor parent in conjunction with standard FDTC services (Drabble et al., 2016). Mentors who had successfully graduated from the FDTC program and had reunified with their child(ren) offered currently engaged parents with advice related to their own experiences. Parents reported that their sustained involvement with the court was strongly influenced by having a mentor who had been through the process to share their experiences and hopes. Within child welfare systems more broadly, it has been observed that ensuring culturally-relevant and sensitive processes can enhance parental engagement, as can ensuring that the relevant workers are sensitive to, and validate parent's potential ambivalence towards, the child welfare system (Kemp et al., 2009).

Positive stakeholder perceptions

Perceptions of stakeholders are important in the evaluation process. Beyond parents, the perceptions of court staff, Judges/Magistrates and other social and health care workers involved in FDTCs have been published (Bambrough, Shaw, & Kershaw, 2014; Edwards & Ray, 2005; Harwin et al., 2011) as their views are key for promoting parental recovery from drug abuse and sustainably reunifying families. Stakeholder perceptions are important in

appreciating the work of FDTCs in the hopes that they will continue to grow (Bambrough et al., 2014).

Stakeholders are overwhelmingly positive and perceive FDTCs as superior to mainstream alternative courts for promoting parental recovery from drug abuse and sustainably reunifying families.

In their review of the FDAC in London, Harwin and colleagues (2011) examined the views of case workers and parents involved in court proceedings. Case workers reported valuing the Court's specialised skill and knowledge, its ability to coordinate services, and expressed an appreciation of the judges for being able to engage and motivate parents. Case workers tended to express a preference for the FDAC compared with the mainstream alternative as the FDAC was resourced and less antagonistic towards parents. Parent's perceptions were similarly overall, positive. They reported that they felt heard, unjudged, and appreciated and felt the court was honest and communicated with them. Parents reported enjoying feeling that the judges at the FDAC treated them as "human beings", and they particularly valued the judicial continuity in that they felt their assigned judge became familiar with their case over time. Another study reflected views of several social workers who were instrumental in establishing the court. They indicated that the FDAC was more transparent, progressive, efficient, and humane compared to mainstream court proceedings (Bambrough et al., 2014).

Judges themselves have also been vocal in communicating their perspectives on and appreciating FDTCs (Edwards, 2010; Edwards & Ray, 2005). Judges in the US have indicated that FDTCs are effective because clients are treated with respect and dignity, receive tailored plans, and feel heard in comparison to mainstream courts which are more directive and less collaborative. Judges also report believing that taking the time to develop a relationship with each client, demonstrating an interest in their wellbeing, is one of the most influential motivators for the client to change. Judges have reported receiving comments from clients expressing that they have never felt so cared for, and have urged peers to establish FDTCs in other jurisdictions to promote similar family outcomes more widely (Edwards & Ray, 2005).

Collaboration

Effective collaboration between individuals and agencies has been identified as important for enhancing the effectiveness of FDTCs. It improves the quality of relapse support available to parents, improves the ability of the court to coordinate relevant resources and provide consistent advice to parents (Green, Rockhill, & Burrus, 2008). For parents, collaboration has a therapeutic effect that is important and connects them to a supportive and multi-disciplinary team, a situation that may be considered quite foreign to some parents (Green et al., 2008). Efforts aimed at improving inter-agency collaboration within FDTCs is becoming an area of priority (Kovach, Curiel, York, & Bogard, 2017).

Trauma-focussed FDTCs

An understanding of the context of drug use may assist in recovery processes. Trauma exposed individuals are at a significantly higher risk of becoming drug misusers (Dube, Feletti, Dong, Giles, & Anda, 2003) and parents presenting to FDTCs often have traumatic childhoods (Edwards, 2010). As a result, there has been a growing awareness that services targeting FDTC clients should recognise that traumatic experiences represent events which alter and define lives and may form a central part of identities (Drabble, Jones, & Brown, 2013).

Courts providing processes that incorporate knowledge about trauma and are characterised by empowerment, safety, respect, and collaboration (Drabble et al., 2013) are important in FDTCs. Court personnel trained on the subject of trauma and to identify and address potential triggers such as crowded waiting rooms, behaviour of security personnel, and intimidating court processes (Drabble et al., 2013) improves court services. When court clients feel safer and heard, they are more willing to adhere to the court's directions.

The interest of trauma-informed practice in FDTCs is growing (Powell, Stevens, Lo Dolce, Sinclair, & Swenson-Smith, 2012). FDTC judges are currently recognising the need for tailored court services which take into account traumatic histories (Edwards, 2010).

MELBOURNE FDTC PROGRAM

Australia's first Family Drug Treatment Court (FTDC) is located on the corner of Pearcedale Parade and Dimboola Road in Broadmeadows, Melbourne. It is based within the same complex as the Family Division of the mainstream Victorian Children's Court.

The FDTC was launched in May 2014, operates weekly and hears child protection cases from the northern region of metropolitan Melbourne. The complex is child-friendly with two courtrooms specifically designed for child protection cases. These areas include the Cubby House and an outdoor children's area. The Cubby House is Australia's first safe haven for children who have been removed from their home because they are at risk of abuse (see Figure 4).

Figure 4.
Children's Court Cubby House provides a sanctuary for children. The ceiling is adorned by figured plywood, representing an inverted landscape of hills and cities inspired by their upside down world. The blue carpet represents the sky. *Reproduced from Mihaly Slocombe Architects (http://www.mihalyslocombe.com.au/projects/cubbyhouse/)

Parents engaging with the FDTC program have children involved with child protection as a result of their drug abuse compromising their parenting capacity and the safety and wellbeing of children in their care.

"Concerns raised by submissions included a perception that adversarial court processes prevent effective collaboration occurring between court staff, a child's parents and DHS child protection practitioners to address the child's needs"

(The Vulnerable Children's Inquiry, 2012, p102).

"Changes are also required to some elements of the operation of the Children's Court to reduce the adversarial nature of court processes. These reforms should allow for increased opportunities for collaborative problem solving that would promote the ongoing safety of the child while, at the same time, maintain the critically important link between the child and family"

(The Vulnerable Children's Inquiry, 2012, pxiii).

The aims of the FDTC are to:

- provide a coordinated response to family fragmentation by assisting parents overcome their drug use issues and create a safe and stable environment for family reunification; and,
- minimise the time to achieve permanent, stable and safe placements for children in out-of-home-care.

The program model

The FDTC provides parents with intensive holistic support, and facilitates access to a number of services assist them in overcoming their drug abuse. It draws upon psychological and legal frameworks that focus upon creating a caring and supportive environment as an agent of therapeutic change that targets unique characteristics of clients enabling them to sustain change (Choi, 2012). The court employs a range of staff including a program manager, a clinical practice leader, and clinical case managers. See Figure 5.

Figure 5.
Family Drug Treatment Court.
*Reproduced from Children's Court of Victoria, 2016/17 Annual Report

FDTCs provide case management with respect to alcohol and drug treatment within the management of legal cases. The FDTC does not make formal changes to the existing orders or conditions. If changes to conditions are required, then the matter is listed as a

mention for variation application. The FDTC Magistrate and the FDTC clinical team do not determine case planning decisions on behalf of child protection.

The FDTC adopts a problem-solving, non-adversarial approach that is based upon communication and collaboration between judges, support workers and clients. The FDTC Magistrate plays a pivotal role which enables them to maintain a supportive and highly communicative relationship with clients via frequent meetings.

The FDTC Magistrate holds the ultimate decision-making responsibility with respect to referrals, inductions, phase progressions, phase demotions, any decisions made with respect to Court Orders, deviations and exits. The Magistrate presides over the case from beginning to end and seeks to coordinate decisions and resources to support families.

The Statewide Program Manager holds responsibility for program operations, leadership, management and coordination of the successful implementation of the FDTC program and its clinical service objectives.

The Clinical Practice Leader is responsible for the oversight of and quality assurance processes for the clinical service component of the FDTC program as well as providing supervision and practice guidance to the clinical team and assisting in the coordination of service provision for parents in the program.

The Clinical Case Manager provides assessment and case management to FDTC clients, centred around the development of Family Recovery Plans. Clinical Case Managers work in collaboration with care team members to provide advice to the Magistrate with respect to client's progress towards Family Recovery Plan goals (see below).

The Child Protection Practice Leader is the conduit between the court and Child Protection. They hold responsibility for the collation and provision of Child Protection feedback to Progress Review Hearings, and for representing the views of Child Protection within those hearings. The Child Protection Practice Leader provides advice and support to child protection in the development of Family Recovery plans and is central to the resolution of issues between FDTC and child protection as and when they arise.

By maintaining these approaches and providing clients with the necessary resources, FDTCs seek to assist parents to achieve a sustainable resolution to their drug use problems and aim for long-term family reunification.

Eligibility

To be eligible for referral to the FDC, a prospective participant must:

a) Have a child/children residing out of their care predominantly due to concerns relating to substance use, and the youngest child must be aged under 3 years;

OR

b) Have a child/children OF ANY AGE residing out of their care predominantly due to concerns relating to substance use, where the duration of the out of parental care placement does not exceed 6 months.

Judicial discretion may apply with respect to the making of any referral where the above eligibility criteria are not met.

The prospective client must consent to the referral being made.

The prospective client must be seeking to have their child/children returned to their care.

The child protection case must be case-managed from the Department of Health and Human Services' Preston Office.

Referral process

Referrals to the FDTC may come from any person with an interest in the matter, however, referrals are typically made by child protection practitioners or lawyers representing the parent.

Assessment processes

Parents elect to participate in the FDTC program. Following referral, an assessment process to determine the suitability of the parent is undertaken. Assessment for appropriateness to be inducted into the Family Drug Court focusses on ascertaining:

a) The existence of an alcohol or other drug (AOD) problem experienced by the prospective client;

b) The acknowledgement of that AOD problem by the prospective client as causative with respect to their child/ren not being in their care; and

c) A preparedness by the prospective client to address this issue (i.e. "Treatment Readiness") in accordance with core program requirements, as per Participant Manual- FDTC to provide a copy at the time of assessment.

Induction

The decision to induct a client rests with the FDTC Magistrate and is guided by clinical and child protection advice. At induction, the client and Magistrate sign the FDTC Undertaking. In addition, the client must acknowledge that their AOD use has contributed to their child/ren not being in their care and confirm their understanding of the core program requirements.

Family Recovery Plan

Once the parent has been inducted into the program, a Family Recovery Plan is developed. The plan articulates needs, goals and tasks that chart a client's recovery and progress through the program. The purposes of Family Recovery Plans are to provide:

1. clarity and a sense of purpose for clients;
2. clarity regarding roles and responsibilities of the Clinical Case Manager and other case managers/members of the care team, and;
3. the FDTC Magistrate with a point of reference for discussion in Progress Review Hearings and with respect to decision making around phase progression.

Throughout the program, clients progress through phases which involve attending a range of treatment and case management services, as required. Services accessed by clients may include residential treatment, mental health counselling, drug and alcohol counselling, parenting programs, housing services and drug screen testing.

Family Reunification Planning meetings are scheduled following induction and phase progression. They are attended by the Clinical Case Manager, relevant professionals, support and family members and if relevant, members from Aboriginal Controlled Community Organsations. There are three phases of the FDTC program:

Phase 1, Trust phase requires clients to remain in the phase for a minimum of four weeks and demonstrate their ability and willingness to:

- attend weekly Progress Review Hearings
- participate in the development and review of their Family Recovery Plan.
- remain in regular contact with their clinical case manager
- attend appointments with support agencies
- submit for urinalysis testing three times per week
- submit for random alcohol breath-testing, where required
- attend contact visits with their child/children regularly.

During this phase, clients are expected to:

- attend all FDTC-related appointments on time.
- demonstrate three weeks of clear drug screens
- reflect on what they've achieved throughout the Trust Phase.
- present their reflections to the Magistrate.

Phase 2, Readiness phase involve clients remaining in this phase for a minimum of two months and demonstrate their ability and willingness to continue the requirements of Phase 1 and:

- submit for urinalysis testing twice times per week, or as directed by a member of the FDTC team (instead of three times per week as required for Phase 1)
- participate in the My Kids and Me group.

During this phase, clients are expected to:

- attend all FDTC related appointments, on time
- demonstrate sustained abstinence
- demonstrate a sustained commitment to abstinence
- demonstrate insight into the factors that have driven their drug use
- present their reflections about their Readiness Phase achievements to the Magistrate
- have completed the My Kids and Me program

Phase 3, Family phase As with Phase 2 Family Recovery Planning, the development of the Phase 3 Family Recovery Plan is to occur within one month of phase progression. While it may likely be informed by the Phase 2 Family Recovery Plan review, the focus of a Phase 3 Family Recovery Plan should focus on the maintenance of progress made in prior phases, with goals and tasks associated with the clients's life post-FDTC. Phase 3 Family Recovery Planning review ought to encompass clear exit planning.

Clients are required to:

- attend monthly Progress Review Hearings
- maintain regular communication with their clinical case manager
- attend all other appointments as directed to do so by the FDTC
- submit for urinalysis testing once a week as directed by a member of the FDTC team
- where relevant, submit for random alcohol breath-testing as directed by a member of the FDTC team
- explore vocational interests

During this phase, clients are expected to:

- through drug screen results, demonstrate sustained abstinence from primary drugs of concern
- participate in the development and review of their Family Recovery Plan
- present a reflection describing harmful impact of previous substance use on themself, their family, and their children to the Magistrate
- demonstrate an ongoing commitment to abstinence
- participate in planning for life beyond their participation in the FDTC. This might include exploring vocational interests
- attend regular contact with their child/children if they are not already in their care

Drug screens

Clients are required to regularly submit supervised urine drug screens. The drugs types screened for include sympathomimetic amine class (for example, epinephrine, norepinephrine, dopamine), barbiturates, THC (cannabis), cocaine/metabolic, benzodiazepine class, opiate class, methadone/metabolic, alcohol and GHB.

Parenting program: 'My Kids and Me'

FDTC clients are expected to attend a parenting program. The program is run specifically for the FDTC by the Kids in Focus program at Odyssey House. It is a seven-week program for parents whose children have been placed in care and where re-unification forms part

of the case plan. The program is "not designed to give clients practical parenting help; rather its aim is to give clients an opportunity to reflect on their experiences and give an opportunity to change" (Gibson & Parkinson, 2013:4). Specifically, the psycho-educational program holds workshops focussing on conceptual issues and adopts a highly experiential approach by using metaphors and imagery as means of communicating difficult concepts. Topics covered include "how did I get here?", "looking after yourself", "the legal system" and "what's it like for your kids?".

A limited evaluation of the program indicated small increments in knowledge and confidence at the end of the program, the significance of which was not calculated (Gibson & Parkinson, 2013). The longer-term impact of the program with respect to changes in parenting and subsequent involvement with child protection was not assessed.

Other programs

The range of other opportunities are strongly encouraged but not considered essential to graduation. These include yoga/mindfulness training, a craft group, a cooking group, engagement with a peer mentor, and participation in peer support group.

Program duration and exit

The FDTC is a 12-month program considered to be a sufficiently long period that allows changes to drug abuse patterns to be sustained through treatment (National Association of Drug Court Professionals, 2017).

Family Reunification Orders (FROs) can only be granted by the CCV for up to 12 months during which the child is in out of home care. In extenuating circumstances, this may be extended to 24 months. After the time period has lapsed, the child is likely to be placed on a Care by Secretary Order (CSO) with all parental rights conferred on DHHS (Ward, 2017). Consequently, it is important that the FDTC program functions within the statutory timelines.

There are three potential ways to leave the program:

The first involves the client choosing to exit the program prematurely or is exited by the Magistrate. The procedure involves clients receiving a letter/electronic advice warning of potential exit unless progress is made within a specified time-frame. This usually occurs after a sustained period of non-compliance with core program requirements and/or non-attendance. Should renewed compliance not be achieved, "special mentions" are listed in the mainstream court to discuss issues contributing to the potential exit. In this context, legal representatives are provided with the opportunity to counsel their clients and be formally warned. If these processes do not lead to renewed engagement, the client is exited by the Magistrate.

The second, 'Completion', occurs when a client remains in the program for the full 12 months despite not having completed all core requirements or met all Family Reunification Plan goals.

The third involves clients meeting all goals and criteria for 'Graduation' within 12 months. In this case, FDTC proceedings tend to conclude with graduation ceremonies to celebrate the successful completion of the program by parents (Levine, 2012). In doing so, the ceremony highlights the supportive system used to assist families recover from the effects of parental drug abuse. See Figure 6.

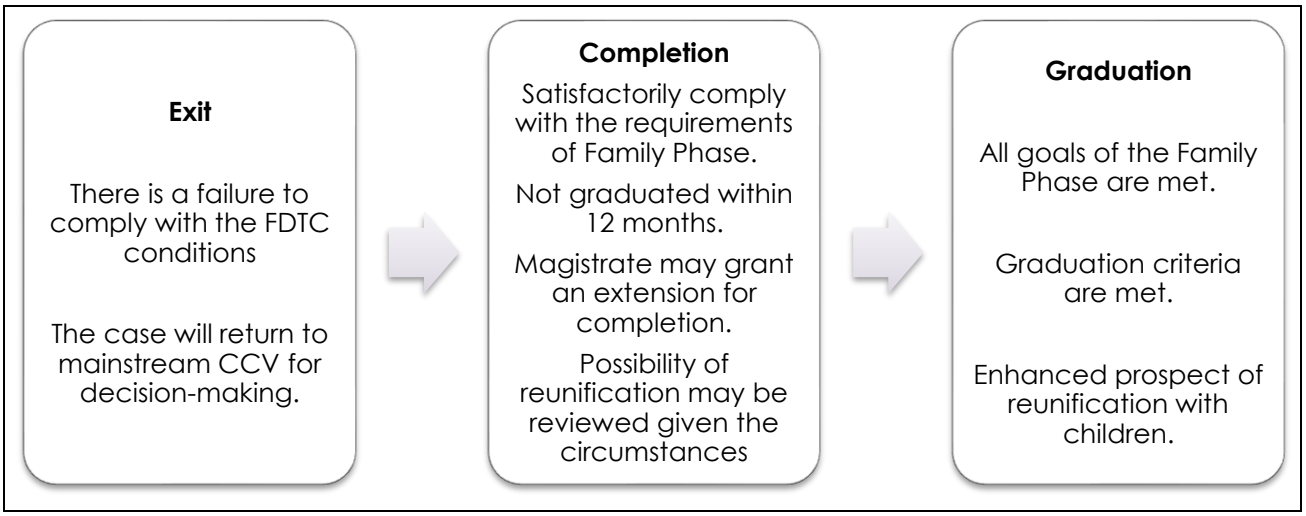


Figure 6.

Program completion.

THE EVALUATION

The FDTC evaluation was conducted by the Centre for Forensic Behavioural Science (CFBS), a research centre within the Faculty of Health, Arts and Design at Swinburne University of Technology

The evaluation project received approvals from:

Department of Justice Research Ethics Committee (JHREC)
Swinburne University Human Research Ethics Committee
3. Centre for Research and Evaluation (Department of Health and Human Services). This process required approval from the Minister to release data for children in out-of-home care

The total funding received for the research was $25,000 inclusive of GST.

Rationale

The FDTC is a novel court established to deliver an alternative option to the mainstream CCV for child protection cases involving parental drug abuse.

A formal evaluation of the FDTC was established to assess whether the aims of the court are being achieved. To date, evaluation research of similar courts has only been conducted in the US and UK. The current study is the first of its kind undertaken in Australia.

In 2016, a Situation Analysis Discussion Paper reviewing the court's operations and processes was released (Health Outcomes International, 2016). The current evaluation builds upon this report.

Evaluation framework

The framework depicted in Figure 7 provides an overview of the components making up the overall FDTC evaluation. The evaluation will focus on:

- comparing interactions occurring during FDTC and CCV hearings as a means of describing differences between the adversarial and non-adversarial approaches
- interviewing staff and clients of the FDTC as a means of qualitatively evaluating the FDTC
- determining the satisfaction of employees as a means of assessing the FDTC model, and
- comparing FDTC and CCV outcomes for efficiency, effectiveness and impact.

Summary of contents:

1. *Rationale*
2. *Evaluation framework*
3. *Overarching research questions*
4. *Evaluation questions and sub-questions*
5. *Methods and materials*

In addition, characteristics of FDTC completers and non-completers will be compared to identify differences between the groups and where possible, compare case characteristics of CCV and FDTC to determine whether specific case types are more likely to be heard before the FDTC court.

The following proxies were used to measure outcomes:

1. **Efficiency** was determined by the time taken to final court order providing for re-unification.
2. **Effectiveness** was determined by the granting of a court order providing for re-unification
3. **Impact** was determined by subsequent reports and substantiations during the follow-up period from final court order to September 2017.

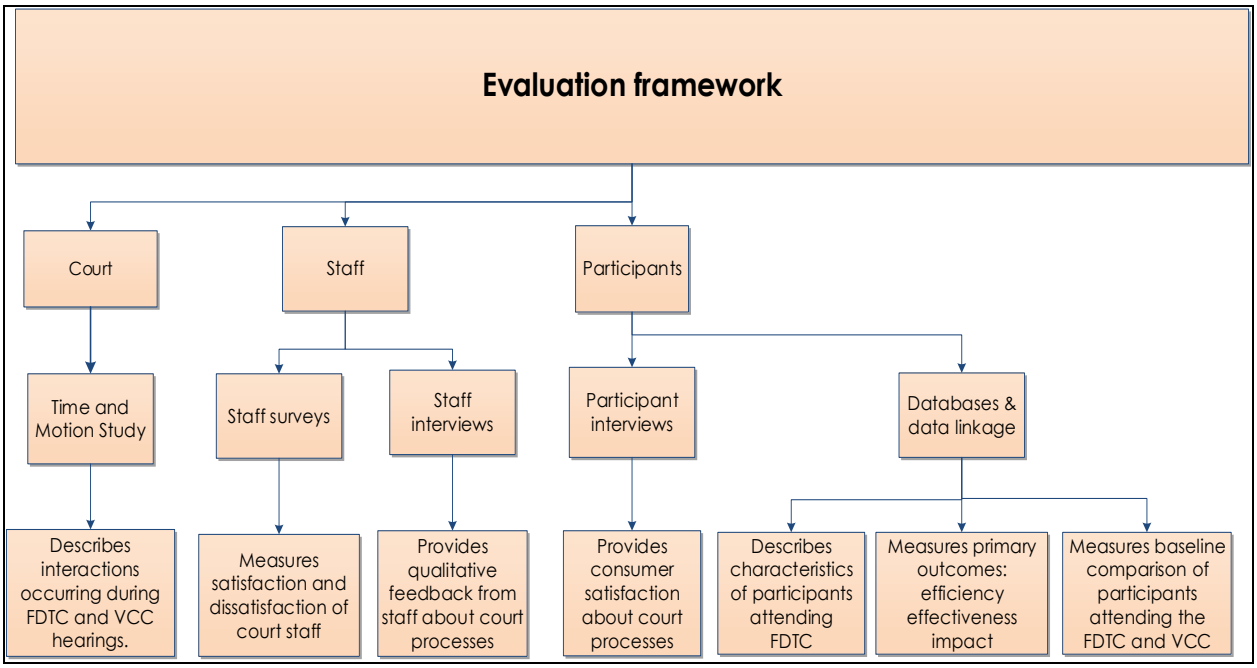


Figure 7.
Evaluation framework comprising stakeholders, methodologies and purposes of analyses

Research design and questions

This research is designed to evaluate the FDTC against its objectives, particularly in relation to the child protection outcomes.

Below, Figure 8 describes the comparison cohort research design used to compare the outcomes of the FDTC and the CCV.

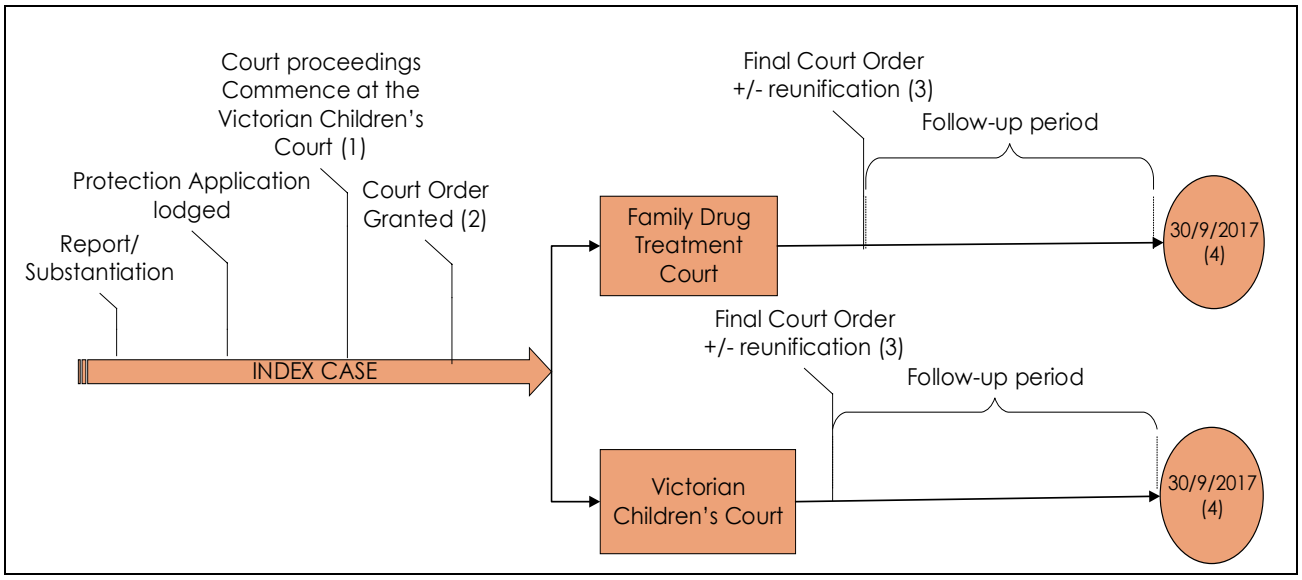


Figure 8.
Research design

Below, Figure 9 details sub-questions that are used to inform the overarching research questions. In determining the primary outcomes (efficiency, effectiveness and impact), data from two groups is compared:

Test group (or the FDTC group) comprises all parents who have been referred to the FDTC. These are referred to as participants of the FDTC.

Control group (or the CCV/mainstream group) comprises a sample of cases identified by Magistrates at the CCV as eligible to participate in the FDTC program. All cases heard before the CCV since May 2014 were identified and included in the analysis.[7]

[7] The CBFS researchers were provided with cases identified by Magistrates as eligible to participate in the FDTC. Due to ethical and logistical considerations, there was no provision for the eligibility to be confirmed.

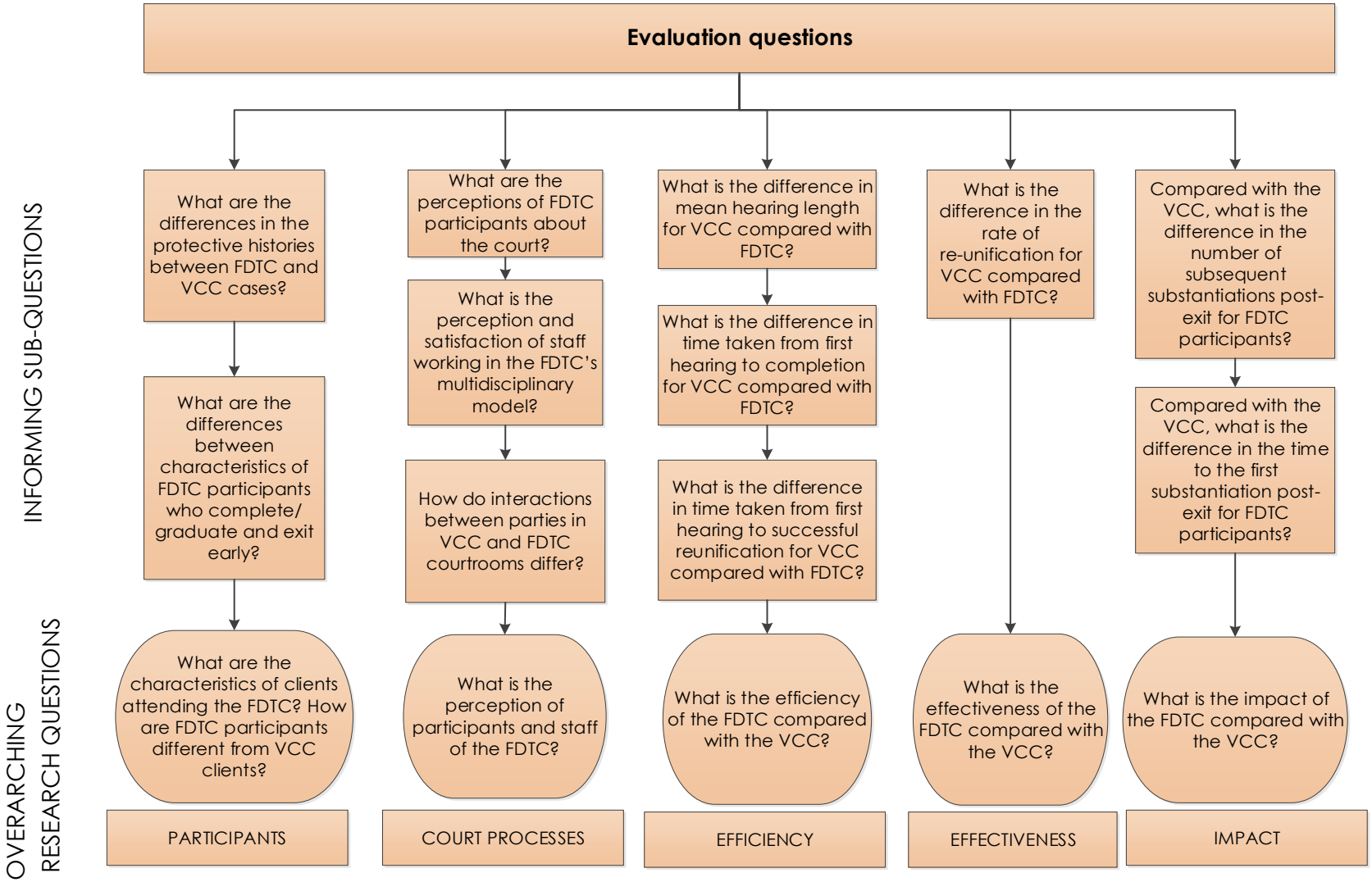


Figure 9

Questions and sub-questions informing the overall evaluation.

Methods and materials

Courtools: Court Employee Satisfaction Measure 9

> *"Knowing how employees perceive the workplace is essential to facilitate organizational development and change, evaluation teamwork and management style, enhance job satisfaction, and thus, improve service to the court's constituents" (National Centre for State Courts, 2005).*

The Court Employee Satisfaction Survey Measure 9 was developed by the National Centre for State Courts (National Centre for State Courts, 2005). It is a 30-item self-administered survey of employee opinions on whether staff have the materials, motivation, direction, sense of mission and commitment to do quality work. Each item is responded to using a five-point Likert scale where the higher the score, the more positive the respondent's view of the court.

Satisfaction and dissatisfaction of staff was measured using the Courtools survey. The survey is based upon Herzberg's two-factor model of job satisfaction. In his theory, he proposed that job satisfaction operates on two independent continua: job satisfaction and job dissatisfaction. Job satisfaction measures intrinsic factors or motivators which include achievement, advancement, the work itself, responsibility and recognition. Job dissatisfaction is determined by measuring external factors or hygiene which include company policy and administration, technical supervision, working conditions, salary and supervision (Maidani, 1991).

In contrast to the traditional continuum, the dual factor model contends that factors leading to job satisfaction are different to those that lead to job dissatisfaction. Ideally, there will be high levels of hygiene and motivating factors to maximize motivation and reduce complaints. For example, dissatisfied staff are likely to raise, amongst other things, factors including company policy, relationships with supervisors, work conditions or salary. Herzberger argues these aspects do not impact on job satisfaction when altered. For staff who are not satisfied, factors raised are more likely to be in relation to recognition or achievement. Whilst this group may not be satisfied, they may not be dissatisfied.

Research by Smith and Shields (2013) empirically examined job satisfaction for social service workers using Herzberg's motivation framework. Their findings indicated that both hygiene and motivation factors were important predictors of job satisfaction. The strongest predictors were 'experiences with supervisors' and 'variety and creativity', indicating the important role of supervisory behaviours and the intellectually interesting work that involves ongoing learning and skill development.

The content of the survey was uploaded to Survey Monkey and the link was distributed to court staff via Court Program Manager. Responses were uploaded into SPSS, analysed and interpreted according to the method described in National Centre for State Courts (2005). Scores greater than 80 are considered high and indicate the court "is doing a

good job". Scores over 70 but less than 80 is considered an average score indicating the court is "doing okay". Scores less than 70 indicate a below average score, indicating the court "needs improvement".

Time and motion

The current study employs a Time and Motion methodology to analyse interactions between judges, lawyers and clients during a hearing. The current study involved all authors of the current report to undertake the observation of FDTC and CCV hearings. Observation involves a continuous method of data collection of interactions between the parties in the court room. The most common method of data collection is paper and pencil form. Categories are provided alongside spaces for recording in the data collection forms. See Attachment 1.

Client-participant interviews

The study included interviews with participants of the FDTC. The consent process was undertaken in a private room located on the FDTC premises to ensure privacy and confidentiality was maintained. Researchers provided participants with verbal information about the study and an opportunity to read the plain language statement before the commencement of the interview. All participants providing consent to be interviewed, signed a consent form which was retained and stored in a secure location at the CFBS.

The interview was guided by nine questions and designed to explore the perception of the FDTC by considering advantages and disadvantages with the program. All responses were transcribed by the researcher during the interview. The question prompting responses were:

1. How did you find out about the Family Drug Treatment Court?
2. Was the program explained to you before you entered it?
3. Have you ever attended the CCV on other lists?
4. This time around, how many hearings did you attend before coming to the FDTC?
5. How long have you been attending the FDTC?
6. What do you like most about the FDT Court?
7. Do you find the Magistrate helpful? Give an example.
8. What do you like least about the FDT Court?
9. Has your view about working with child protection changed during the time you have been at the FDTC? If so, how?
10. How has the court changed your behaviour and/or thinking about drugs? In what way?

11. Do you find the court to be fair in how decisions are made during the time you are in the program? What makes you feel this way?
12. Do you think the result would be different if your case was heard in the normal Children's Court (list) compared with the FDT Court?
13. On a scale from 1 to 10, how do you score the FDT Court overall?

Staff interviews

The study included the views of professional staff working at the FDTC. At the time of the interview, the staff member was advised that the interview was voluntary, no identifying details would be recorded and that they could withdraw at any time during the interview.

The interview was guided by eight questions designed to focus on their view of the FDTC's model, its strengths and weaknesses and whether the court is achieving its aims for families and service delivery partners. The questions prompting responses were:

1. How long have you been working or engaging with the FDTC?
2. Have you worked in other CCVs?
3. From your perspective, what is a significant strength of the FDTC?
4. From your perspective, what is a significant weakness of the FDTC?
5. The primary objective of the FDTC is to support substance abusing parents to provide the best chance of rehabilitation and of being reunited with their children. Do you think that the FDTC has achieved its aims?
6. Do you think the Court has established collaborative links with required agencies to improve outcomes for families attending the court? In your view, what links with services could be improved?
7. How do you think the FDTC model could be improved?
8. Do you think it should be expanded to other regions? If so, why and if not, why not?

Data extraction and linkage

The evaluation comprised a data-linkage component using three sources: BridgeCRM/files (database of the FDTC), Lex (database of the Victorian Children's Court, Family Division) and Client Relationship Information System (CRIS, database for Child Protection, DHHS).

Family Drug Treatment Court (BridgeCRM)

FDTC data for clients was extracted from BridgeCRM. Where there was missing or incomplete information, it was cross-referenced against hard copy files. Extractions from BridgeCRM provided information about parent gender and age, Indigenous status, ethnicity, number of children, whether a partner was also engaged with the FDTC, the

age of the youngest and oldest child at the first hearing, income source, highest level of education, housing status, criminal matters, mental illness, drugs of choice and referrals to service providers.

Victorian Children's Court database (LEX)

The Platypus system (LEX) is a system which comprises the CCV's Family Division case management system for child protection matters. Extraction from LEX provided information about the type and grounds for the Protection Application type, dates of first and last hearing and the orders granted.

Client Relationship Information System (CRIS)

CRIS is a case management system, developed by the DHHS. It is used to create and maintain client (child) records, sort and search case notes as well as generate client plans and reports. Data extractions from CRIS will provide information about reports and substantiations made to child protection during the pre-current and post-current periods as well as whether re-unification occurred.

Statistical analysis

A challenge of the data analysis related to the different person focus for the databases from which data was extracted. Whilst CRIS is a client (or child) focused database, BridgeCRM is a parent focused database. In cases where multiple children were listed in a Protection Application, the oldest child on the application was used to identify the parent. This resulted in one participant and one child per analysis. A further challenge related to the inconsistent variables contained across the databases pertaining to the same case. This precluded cases from being matched for purposes of comparison.

Statistical analyses were carried out using the Statistical Package for Social Sciences (IBM SPSS Statistics), Version 24. Associations between groups (FDTC and CCV) and key categorical variables were examined using Chi-square(χ^2) analyses and reported in numbers and percentages. Multi-way-frequency analysis was used where potential confounds due to difference in the FDTC and CCV samples characteristics were identified. This allowed for the testing of interaction effects and the influence that these differences had on the substantive analyses.

Continuous variables such as durations and counts were compared across groups using t-tests and ANCOVA when potential confounds were identified. All continuous variables met the assumption of equality of variance across the groups. A number of variables demonstrated non-normal distributions: total time engaged with the court process, time to re-unification, post-court reports to child protection, and post-court substantiated reports to child protection. For these variables the median or mode are reported for measures of central tendency and the interquartile range as a measure of variation.

RESULTS - CLIENTS

Client status

Since commencing, 149 individuals were referred to the FDTC to 30 September 2017. Of these, the majority (59.7%) had been inducted into the program and exited. Approximately one third (34.2%) were not inducted and the remaining clients (6.0%) had not yet completed at 30 September 2017. See Figure 10.

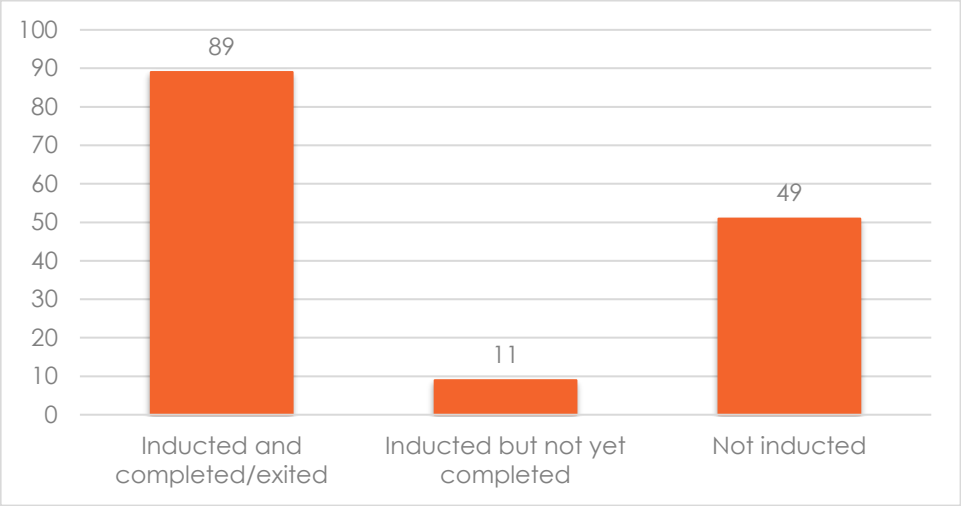


Figure 10.
Client status at 30 September 2017 (n=149).

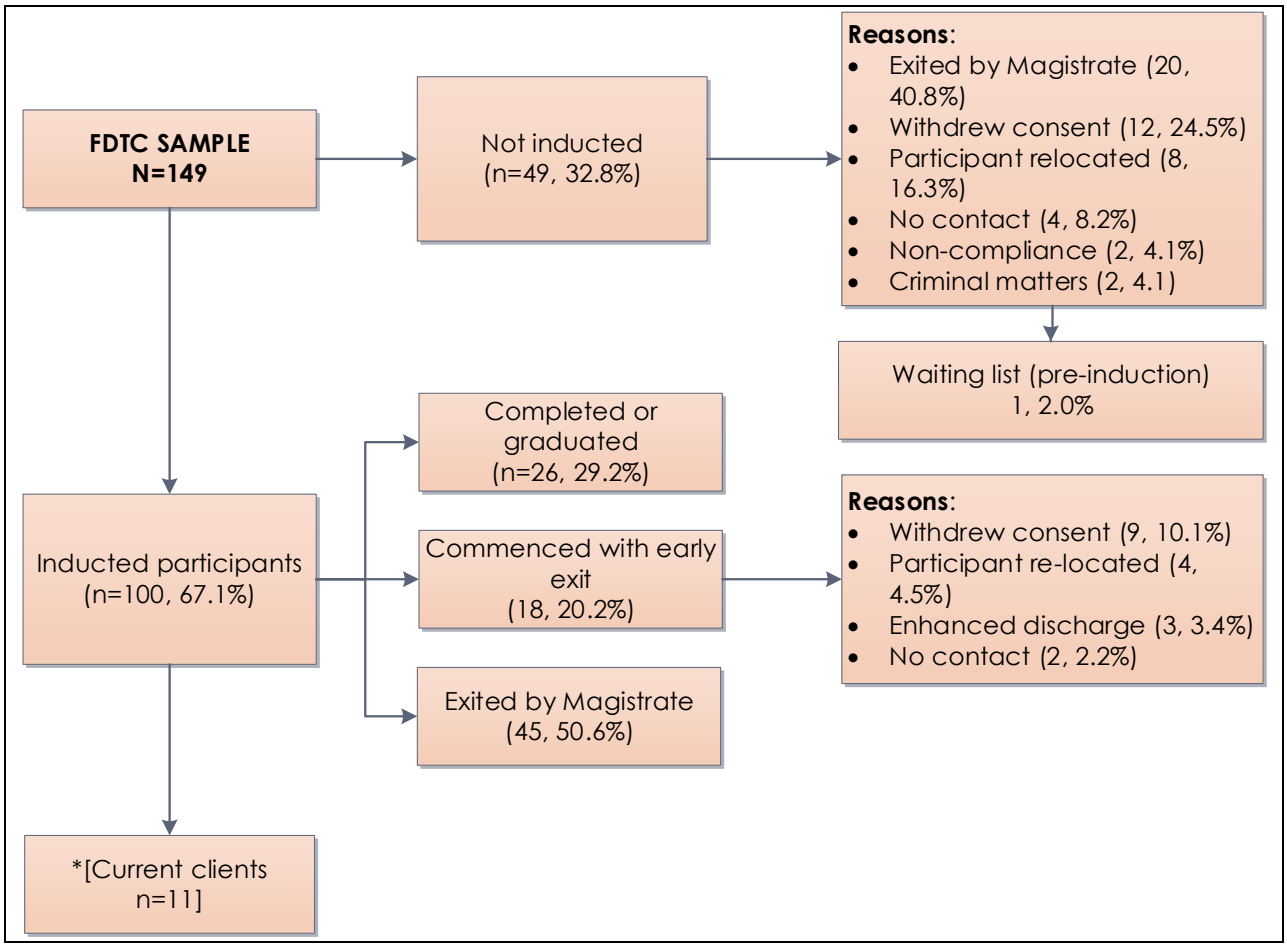
Of those who were inducted (n=98), approximately one in three graduated or completed the program.

Of the clients who were inducted and exited the program, the majority (50.6%) were exited by the Magistrate for reasons relating to a failure to comply with core program conditions such as urinalysis, court attendance or general engagement.

The remaining clients (20.2%) exited the program prematurely for other reasons, as listed in Figure 11. Of those who were not inducted (n=49), almost all clients were exited at the Readiness Phase indicating they had completed the initial assessment phase but were ineligible to proceed with the FDTC program. Most commonly, these clients were exited by the Magistrate or withdrew consent.

Summary of contents:

1. *Pathway of clients coming into contact with the FDTC*
2. *FDTC client characteristics*
3. *Induction rates*
4. *Differences between completers and non-completers inducted into FDTC program*
5. *Comparison of FDTC and CCV protective histories*



*Current clients have been inducted but have not completed and do not form part of the exit data

Figure11.
The status of FDTC clients at September 2017 (n=149)

Phase at exit or completion

Table 1 details the phase of the FDTC during which clients exited the program.

Table 1. Phase at time of exit (n=89)

Phase	All inducted clients (n=89)	Premature exit (n=63)
Referral	1	1
Trust phase	48	48
Readiness phase	19	14
Family phase	21	0

Most commonly, clients exited prematurely from the program during the Trust phase and to a lesser extent, the Readiness phase. Only clients who completed or graduated from the program entered the Family phase.

Induction rates

To 30 September 2017, 1431 appearances by FDTC clients have been documented. Since opening in May 2014, FDTC has heard an average of 8.2 cases every week. Figure 12 indicates a slightly increasing trend with new inductions overall fluctuating between 3 and 11 clients per quarter.

Eighty-nine (89) clients were inducted and exited from the FDTC program. The mean number of appearances per client before the FDTC Magistrate was 16 (SD=9.788, Median=16.0, Range=0-37). Zero appearances are possible in cases where the client did not attend court after induction. The mean number of days engaged with the FDTC was 245 (SD=147.605, Median=251, Range=0-574).

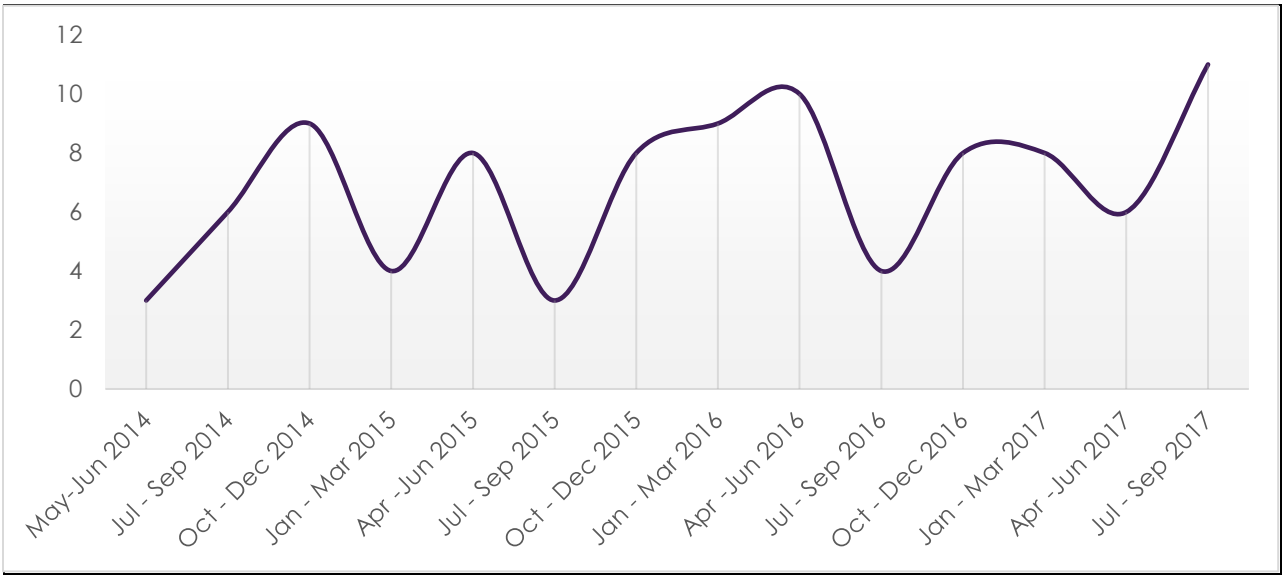


Figure 12.
Induction rates of clients per quarter (May 2014 – September 2017)

Comparison of completers and non-completers

Of those who were inducted into the FDTC (n=98), 75.5% were female (n=74), 16.3% identified as Aboriginal (n=16) and 67.3% identified as being Australian (n=66). The remaining nominated ethnicities included Croatian, English, Filipino, Greek, Italian, Maltese, Middle Eastern, New Zealander, Samoan, Syrian and Turkish (<2.0% each). The ethnicity of five clients was unknown.

Overall, 81 (82.7%) clients consumed amphetamines, 63 (64.3%) cannabis, 26 (26.5%) opioids, 79 (80.6%) tobacco, 36 (36.7%) alcohol, 26 (26.5%) prescription medication and 11 (11.2%) consumed other drugs such as GHB, hallucinogens and cocaine.

Of those who were inducted, one client was employed. The remaining clients received incomes from Centrelink (Disability, Newstart, Parenting payment, Youth Allowance) or other Centrelink payments. The income source of two clients was not known.

Forty clients had, at one time, a partner in the FDTC program however they were no more likely to complete the program if they had a co-enrolled partner ($\chi^2(1) = .008$, p = ns).

Table 2. Comparison of clients and case characteristics by outcome for inducted clients (n=89)

	Completed/ Graduated (n=26)	Premature exit (n=63)	X^2 or *t-test*†	*df*	*p*
		%			
Protection Application			3.254	2	*ns*
By Notice	3.8	12.7			
By Apprehension	23.1	11.1			
By Emergency care	73.1	76.2			
Gender			.053	1	*ns*
Male	23.1	25.4			
Female	76.9	74.6			
Aboriginal or Torres Strait Islander	19.2	17.5	.039	1	*ns*
Mean parental age**	31.75	32.67	-.524†	83	*ns*
Mean number of children*	1.48	1.65	-.729†	86	*ns*
Age of the youngest child***	2.88	2.53	-.483†	81	*ns*
Highest level of education ****			.085	2	*ns*
Post-secondary qualifications	4.3	4.4			
Certificate qualifications	39.1	36.5			
Did not commence VCE	56.5	67.5			
Housing			.159	1	*ns*
Private (owned or renting)	46.2	50.8			
Public, temporary or homeless	53.8	49.2			
IVO*	38.5	27.4	1.050	1	*ns*
Mental health disorders	65.4	79.4	1.933	1	*ns*
Presence of a partner	30.6	39.7	.053	1	*ns*

*missing=1, **missing=4, ***missing=4, ****missing=21, †=t-test

The comparison of characteristics and demographics listed in Table 2 did not identify differences between clients who completed or graduated from the program from those who did not. Whilst these findings speak to the unpredictability associated with abstinence of drugs, the comparison does not measure characteristics or factors, such as readiness to change or attitudes towards the intervention, which may also be

important in increasing success. An improved understanding of this may be warranted given the limited resources of the FDTC.

Mental illness

FDTC clients who were inducted into the program were most commonly diagnosed with anxiety and/or mood disorders. A diagnosis was not documented for 25 clients. See Table 3.

Table 3. Diagnoses of inducted FDTC clients (n=100)

Diagnosis	**n**	**%***
Anxiety Disorders	75	92.6
Mood Disorders	68	84.0
Schizophrenia or other psychotic disorders	13	16.0
Personality Disorders	2	2.5
Attention-Deficit and Disruptive behaviour disorders	1	1.2
Acquired Brain Injury	1	1.2

* Percentages do not add to 100. Clients may have been diagnosed to one or more services.

Referrals

Of those FDTC clients who were inducted, most referrals were made to alcohol and drug services. Fewer clients were referred to mental health services, health care services, general practitioners and housing services. Seven clients were not referred to any services. See Table 4.

Table 4. Service referrals to inducted FDTC clients (n=100)*

Services	**n**	**%**
Alcohol and Drugs	86	86.0
Mental Health	38	38.0
Health Care	25	25.0
General Practitioner	20	20.0
Housing	19	19.0
Family Support	13	13.0
Legal Representation or advice	11	11.0
Counselling	8	8.0
Family Violence Support	7	7.0
Residential Withdrawal/rehabilitation	5	5.0
Employment	3	3.0
CISP	2	2.0
Centrelink	1	1.0

* percentages do not add to 100. Clients may have been referred to one or more services.

Comparison of protective histories

A comparison of the protective histories of the CCV and FDTC samples was conducted for proportions and counts of markers of persistence and severity of protective concerns. Namely, primary grounds for the application that was substantiated, and number of prior reports, substantiations, and protective applications. The proportion of cases in each sample that were closed as of 30th September 2017 was also considered.

These comparisons revealed that the clients engaging with the FDTC were more likely to have had emotional harm as the primary proven abuse compared to the VCC sample. A second comparison revealed that compared with the mainstream court, the FDTC group tended to have a more extensive history of child protection involvement with a higher number of prior protective reports, substantiations, and applications. See Table 5.

To ensure these differences did not confound comparisons, the initial FPO or FRO and application grounds for emotional or physical harm were used as co-variates in the subsequent analyses. Unless otherwise noted, these factors did not influence the differences between the samples.

Table 5. Comparison of case characteristics for CCV and FDTC clients

	FDTC (n=102)	CCV (n=402)	X^2/*t-test*
	%		
Application grounds:			144.49**
Emotional harm	69.6	15.2	
Physical harm	17.6	75.9	
Sexual harm	1.0	0.7	
Neglect	6.9	1.2	
Unknown	4.9	6.9	
Closed 30 September 2017	35.3	45.5	7.13*
	M (SD)		
Historical protective concerns:			
Reports	2.76 (3.3)	1.50 (2.1)	-3.66**
Substantiations	0.54 (0.8)	0.35 (0.6)	*-2.11**
Protective applications	0.30 (0.7)	0.14 (0.3)	*-2.32**

Note: * p < .05, ** p < .001

RESULTS – COURT MODEL & PROCESSES

Court hearings

Of the 17 cases scheduled in CCV courtrooms, 23 cases were heard as additional cases were added to the schedules of sitting Magistrates. In contrast, 24 cases were scheduled to be heard in the FDTC, but 17 cases were heard because clients did not attend. See Figure 13.

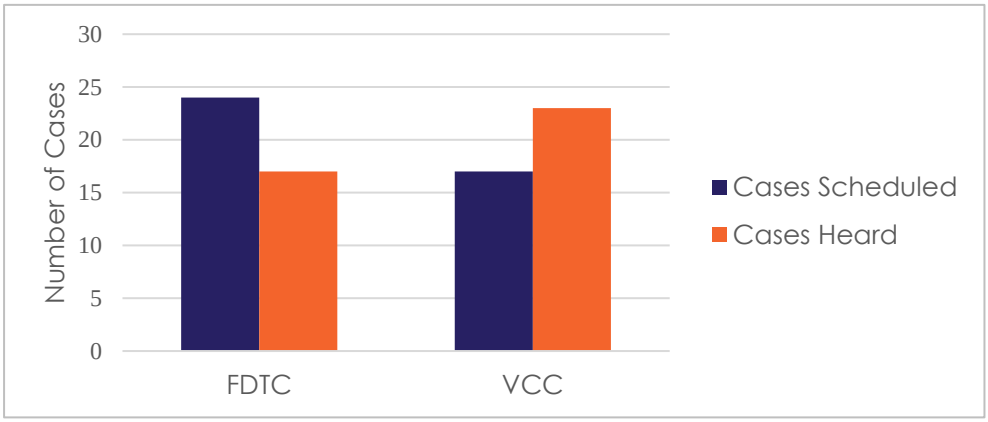


Figure 13
Court attendance by scheduled and heard cases

The mean length of time taken for hearings at the courts indicated no difference ($Mean_{FDTC}$=13.76, SD = 4.96; $Mean_{CCV}$=20.65, SD = 30.54; $t(38)$ = .92, p=*ns)*. Notably, the elevated standard deviation for CCV hearings indicates a greater variance for CCV hearings compared with FDTC hearings. This is not surprising given hearing lengths in the CCV is likely to be a factor of case progression.

Interactions and exchanges during court hearings

Table 6 provides the mean interaction times in CCV and FDTC cases. In the CCV, the main discourse occurs between the Magistrate and the lawyer. The lawyer also interacts with their client as does the Magistrate, but to a much lesser extent. This exchange pattern is characteristic of the adversarial system where the lawyer's role is to represent the interests of their client to the Magistrate.

In contrast, interactions in the FDTC were more evenly distributed between the parties present in the courtroom.

Summary of contents:

Court hearings

Comparing interactions and exchanges in court hearings

Perceptions of FDTC participants

Perceptions of FDTC staff

Multidisciplinary model and employee satisfaction

As the client does not require legal representation in the FDTC model, the main discourse occurs between the Magistrate and the client. The client however, also interacted with court staff and child protection staff.

Patterns of interactions occurring in the courtrooms were found to be very different for CCV and FDTC which reflects differences in the adversarial and non-adversarial approaches.

Table 6. Mean interaction time (in minutes) between key stakeholders.

	FDTC (n=17)	**CCV** (n=23)	
Interactions	*M*(SD)	*M*(SD)	*t(38)*
Judge/Magistrate			
Client	10.71 (2.89)	0.35 (1.11)	*15.75***
Lawyer	-	14.35 (27.52)	
Witness/Professional	0.47 (0.8)	0.13 (0.63)	*1.51*
Child Protection	1.76 (1.15)	0.13 (0.63)	*5.78***
Court Staff	3.65 (2.60)	0.61 (1.2)	*4.96***
Court	0.24 (0.44)	1.35 (1.03)	*4.18***
Lawyer			
Client	-	0.35 (0.78)	
Lawyer	-	0.35 (0.78)	
Witness	-	0.26 (0.86)	
Child Protection	-	1.61 (2.69)	
Court Staff	-	0.17 (0.39)	
Client			
Witness/Professional	0.00 (0.0)	0.00 (0.0)	-
Child Protection	4.41 (2.0)	0.04 (0.21)	*10.44***
Court Staff	2.94 (1.92)	0.00 (0.0)	*7.38***
Total Time	13.76 (4.96)	20.65 (30.54)	

*p<0.05, **<0.01

Perceptions of FDTC participants

Nine clients provided consent to be interviewed. Given there were 11 active clients at the time of the evaluation, the response rate was approximately 82%.

Of the clients interviewed, learning about the FDTC program was mainly through their child protection practitioner (4) or their lawyer (3). The remaining participants were informed by the judge at the CCV or by the drug rehabilitation centre they were attending at the time.

Understanding of the program

Prior to commencing, the program was explained to all participants who were interviewed. When asked, explanations frequently focused on the additional supports available to them and the voluntary nature of the court:

> *"The worker explained that there were three phases, and that if you follow all directions by the court then the chances of things working out with the children would improve" (Client 1).*

> *"My DHS worker said it would be the best thing for me. I was told I would receive things like social support and counselling as part of the process" (Client 2).*

> *"I was told it was based on not being forced, that it was voluntary to do. I was told there were three stages and a one-year commitment. I was told the first stage I would have to test three times per week, the second would* be two tests per fortnight, and then it would decrease again at stage three" (Client 3).

> *"I was told it was a new program that has been used in the US and has now been bought to Australia …." (Client 4).*

> *"… told weekly court, testing, reduced DHS. Less DHS was big appeal" (Client 9).*

Positive program attributes

There were many positive attributes identified by participants in the FDTC program. Mostly, participants described the elements of the therapeutic approach, particularly those associated with procedural justice and fairness. These included the court hearing their voices and offering care and support.

Participants appreciated the ability to be honest:

> *"I like that I can be honest without people getting mad at me" (Client 3).*

> *"Pushing us to be drug free but not in a heavy-handed approach" (Client 6).*

Participants recognised the personal nature of the support offered at the FDTC:

> *"It feels like everyone cares and is trying their best to help" (Client 2).*

> *"No matter what the situation, the case manager is there to help. Even it is it not drug-related, the court is very supportive of your needs. I feel like the court advocated on my behalf, and I loved being able to call my case worker for resources and support. It felt that they were there for you" (Client 7).*

> *"They give support rather than judgement. I'm a recovering drug user, need support, not judging, they don't judge… If you miss screens, they understand and support, not just punish. They know what you are doing, what is happening, because you see them regularly. They know me more, so they know when it is a real fuck up and when it is just life" (Client 9).*

Participants felt empowered and motivated:

> *"This has motivated me for the sake of myself and my son" (Client 3).*

> *"They empowered me and gave me choices" (Client 4).*

Active judicial involvement plays an important part of the therapeutic jurisprudence. Participants had many positive comments about the Magistrate's approach and it forming a central part of the overall positive perception experienced by the participants:

> *"It is easy going, and it is good to sit across from the judge and not feel judged. It feels like the judge is on your level, so it is less intimidating" (Client 1).*

> *"I like how we sit around a table with the judge and have a chance to speak" (Client 2).*

> *"It is nice to have the judge in front of you, it is more helpful" (Client 4).*

> *"They were very supportive and never blamed or judged or put you down" (Client 8).*

Participants described they felt heard by the Magistrate:

> *"The Magistrate is easy going and has compassion and understanding of my circumstances" (Client 1).*

> *"She understands what I'm saying and where I'm coming from" (Client 2).*

Participants frequently described the Magistrate as personable, caring and helpful:

> *"She makes sure plans are followed through, for example that any issues with DHHS are always followed up" (Client 2).*

> *"She's a nice lady. She is not pushy, she is soft and friendly" (Client 4).*

> *"They put effort in and they actually care" (Client 7).*

> *"There was one time when she got together with me and my partner and she helped us strategise how best to help us to get our child back" (Client 7).*

> *"She gives support, guidance, activities, it is helpful. The support is to help you and make you do it. I don't feel nervous anymore coming in, they want to help me get better" (Client 9).*

Negative program attributes

When asked about negative aspects of the program, four of the nine participants stated that there was "nothing" negative about the court. Few participants raised logistical difficulties:

> *"The travel. I spend four hours travel time each day that I go in. It would be good if there were multiple locations for these courts" (Client 1).*

> *"I found it complicated in the beginning in terms of understanding what I needed to be doing. However, I did have the opportunity to have everything explained to me which was good" (Client 4).*

> *"Every collection centre has different times for DHHS urines" (Client 5).*

One participant remained wary of continued child protection involvement:

> *"DHHS is still involved. I feel like DHHS isn't as open minded as the Magistrate. Feel like because there is a person from DHHS in the room that I am being labelled. I don't feel like they treat each person differently. It is good that FDTC takes some of the power out of DHHS hands" (Client 7).*

Decision-making by the FDTC

When asked about the decision-making process in the FDTC, the importance of procedural fairness for the participants, emerged. The fairness in relation to the procedure, rather than the outcome, was a focus of responses:

> *"I feel like I have not had to 'fight' for my rights. My rights have been respected here" (Client 1).*

> *"I have been given a lot of chances and they respect my view here" (Client 2).*

> *"I think it is fair. Nothing they ever say is in a negative way… like the screens… they tell you that it is better to do them even if they are dirty. If you have a dirty screen, they don't get angry at you, they try to help" (Client 7).*

> *"I had a short period of custody and when I served it, they supported me to come back into the program even though I fucked up" (Client 9).*

Changing behaviour and attitudes about drugs

When asked if the FDTC changed their attitude towards drugs, responses of participants focused upon the role drugs in the context of family and self-awareness. Participants felt

they had a greater understanding of drugs and their drug addiction and had an opportunity to reflect upon their attitudes and values.

> *"This court made me realise that I don't need drugs. Cognitive Behavioural Therapy was great, it changed my thinking about drug use completely" (Client 1).*

> *".. [the FDTC] had changed my thinking about drugs a lot. It made me realise that family is most important" (Client 4).*

> *"It has changed my relationship with my partner and that changes my view on drugs. My partner thinks it is all left to be to get [child's name] back. He thinks that he can still do what he wants and associate with people that use drugs. FDTC made me realise that he needs to help as well, it isn't all on me" (Client 7).*

> *"Family relationship courses and nutrition courses helped to change my perspective on myself, I learned I could live without drugs and did not need them" (Client 8).*

In addition, participants improved their understanding of drug use and how it impacts upon their behaviour:

> *"My mental health has improved and I am able to identify triggers and my own feelings" (Client 2).*

> *"When I started, I was smoking a fair bit of ice. Since starting at the court, I'm using every week or two and then I relapse. It's becoming shorter (the days of relapse). This is because of their support" (Client 5).*

> *"The weekly check-in makes me pay more attention. I can see the progress being made. I am focused on my outcome of getting the boys back" (Client 9).*

Impact of the FDTC

Experience with mainstream court appears to have impacted negatively upon the relationship between participants and child protection. For some clients, the perception remains negative:

> *"It hasn't changed – I still don't like DHHS. When [child's name] got taken, they instantly started looking down at me" (Client 7).*

> *Have a better worker now, she is helping, wants me to do well. DHS [sic.] still same though (Client 9).*

For other participants, there seemed to be more middle ground:

"I have learned how to speak to with DHS [sic.] workers" (Client 2).

"I don't like DHS [sic.], however my current DHS worker is the nicest out of the three I have dealt with" (Client 3).

"She [the DHHS caseworker] works well with the family and the school and she's really involved" (Client 5).

"Judges can be quite quick to rule in DHHS's favour especially in the beginning of court proceedings. Since then, I've realised that the courts want to keep families together" (Client 5).

"DHHS were on the same agenda as the FDTC and this was to get kids back with parents. In the mainstream court, it feels like the complete opposite" (Client 6).

Overall, participants felt that their outcome would have been negative if they had attended the mainstream court. Many attributed these outcomes to the fundamentally different approaches adopted by the courts:

"I would probably still be on drugs. In this program I have been abstinent for 8 months. Without this program I would be either on drugs or in jail" (Client 1).

"In a normal court I would not have the chance to talk to the judge about triggers and feelings. I would not have learned as much or taken it as seriously" (Client 2).

"A normal court is more directive and punishing, and less collaborative and would be less motivating for me to abstain. Normal courts are more focused on punishment as opposed to motivating and support" (Client 3).

"There would also have been poorer outcomes for my children" (Client 8).

"I wouldn't get the boys back and would still be waiting for a court date. Nothing would move" (Client 9).

The FDTC was rated 10 out of 10 by almost all participants. One participant suggested more face to face support with the case manager rather than phone calls.

Perceptions of FDTC staff

A number staff were interviewed about their perspectives on the FDTC.

Strengths of the FDTC

Staff readily acknowledged the positive attributes of the court:

"There is a joint benefit. There is requirement to come into the court regularly and engaging with clients is one of the difficulties. My clients are commonly clients of the court and community treatment services. Clients may be more likely to attend for court than they would be treatment services" (Staff 1).

"It is judicially-led, non-judgemental and provides comprehensive service to participants" (Staff 5)

"Effort is made to give the participants every opportunity. But no excuses, it is followed-up whatever the issues of concern are. Provide positive feedback for what doing too. They don't always succeed, though they have the chance, and support to do it" (Staff 3).

"The program here – I work with other services and the attention to detail is high with the FDTC. I can't fault that. It feeds into the strong relationship between the court and other organisations supporting the client" (Staff 2).

"I have worked at Melbourne [CCV mainstream] too, here you see them weekly, get to know them and can work together on progress. At Melbourne, it is like 3 or 6 months between, so many coming through you hardly know them. The intensive work really makes a change" (Staff 4).

Weaknesses of the FDTC

Staff also identified limitations of FDTC.

"One potential weakness is that they don't have an outreach component for the program. I have outreach capacity whereas the court staff don't (or limited capacity) and therefore, I work well in the context/role of the FDTC" (Staff 2).

"Clients struggle with the commitments around testing – no access to a car. Even though I think it's a necessary requirement, clients find this difficult. But it's a voluntary program and it comes down to whether they think they can manage or not" (Staff 1).

"There is a lack of available services, particularly housing. If a participant has nowhere to live, you can't really address their issues. Melbourne and Dandenong Drug Courts have a number of houses available to clients through the Minister of Housing but we don't have access to these" (Staff 5).

"Sometimes it's difficult to get people into Odyssey or Windana… it can take up to months. [The difficulty arises when] we get someone available at one point in time and by the time a place becomes available, something else has happened and [the participant] is not so keen. We are trying to get some beds through private accommodation" (Staff 5).

> *"It would be good to focus on parenting skills, and life skills. Many are good parents when not on drugs, though some really struggle to parent even when clean. I think parenting skills or parent training would really help." (Staff 4)*

FDTC achieving its aims

On a broader level, view was held that the FDTC assists individuals directly and indirectly to reunite with their children and cease drug use:

> *"In terms of the aims, the court makes lives better. I would say … in every single case, even if they exit. The fact they turn up without being forced. We reinstate agency with the person. At no point do we say 'you must' and the doors are shut". (Staff 1).*

> *"I know we need the data, but on the ground, you see really positive change. Many of the parents really make the effort and turn their life around, still a way to go, they get there and you can see how good it is for the kids to have a parent". (Staff 3).*

> *"Yes, I think the court has achieved it's aims. We have had enough parents who have been reunited with their children to say it has been a success for those parents….. we have had some parents who have exited the program and gone on to reunification. I would like to think that these parents may not have been ready in our program but ultimately decided to cease drug use and did it by themselves" (Staff 5).*

Collaborative links

Staff believe collaborating is a core strength of the FDTC.

> *"Services are always welcome to come to court and support services and the team is always welcome to come and update the court. The team is regularly in contact with client services each week" (Staff 1).*

> *"I think in terms of collaborative approach, the court does that really well. You can have a client that has drug and alcohol, mental illness and homelessness. This level of collaboration is high and is two ways" (Staff 2).*

> *"Community involvement and engagement is greatest with the FDTC. We (the FDTC) could be doing more work is engaging with our legal practitioners and child protection litigation office, to increase referrals" (Staff 1).*

> *"Case managers collaborate and therefore, clients avoid telling the story twice. Other staff have a heads up on a current event. Every week, drug and alcohol send updates to the court case manager so they [the court] are on the same page as the client" (Staff 6).*

Improvements

Staff identified some improvements, particularly in relation to identifying participants who are more likely to complete the program and developing further collaborative links:

> *"Intake and assessment is crucial to the success of the program. Clients are assessed thoroughly to identify those with the highest chances of success are moved into the program. The program may not suit everyone. Clients show negative signs before, but no subsequent testing". (Staff 2)*

> *"[Given the] limited numbers and resources, perhaps there could be a psychometric component about motivation?" (Staff 1)*

> *"Potential clients on the waitlist could be asked to screen 3 times per week. If there is no compliance, then the question needs to be asked whether they are suitable for entry in the program". (Staff 6)*

> *"From what I've seen here, if parents are fully committed to the program, they will get their children back. There is no example that I can think of that a problem of the client has not been resolved by the court and its relationship with the client support services" (Staff 1).*

> *"If the program was two years, I think we would have much better outcomes for people …. Because of the permanency requirements … 12 months is what we have been given to work with" (Staff 5).*

> *"We need to make more links with private health providers as a philanthropic exercise for them. There are not enough services to go around" (Staff 5).*

Expansion of the FDTC

Staff were critical of the location requirement to access the program:

> *"In the current model, your catchment area is important where you live [and it shouldn't be]. You should have access to the court wherever you live" (Staff 1).*

> *"Its postcode justice that only people that live in the Preston area can utilise our program. There are so many more people out there with the needs and they just miss out" (Staff 5).*

FDTC employee satisfaction

The Courtools survey was distributed to 12 staff including Magistrates, Court and Child Protection staff as well as staff of the Marram Ngala Ganbu (the Koori Court located in Broadmeadows) who work closely with the FDTC. Of these, 11 staff responded to the

survey yielding a response rate of 92%. There were no missing items. See Table 7 for a summary of results.

Table 7. Results measuring staff satisfaction/dissatisfaction (n=11)

	Item	Mean score
Satisfaction	Overall	76.2
	Achievement	78.9
	Work content	73.5
	Responsibility	76.4
Dissatisfaction	Overall	80.0
	Supervision and relationship with boss	80.0
	Work conditions	77.1
	Interpersonal relations	66.5

Work satisfaction

Work satisfaction is related to the opportunities that promote achievement, recognition, responsibility and interesting work (National Centre for State Courts, 2005). The overall level of staff satisfaction was average (76.2) comprising solid average scores for all components.

For **achievement**, the overall mean score was in the high average range (78.9) indicating staff are mostly aware of what is expected of them, receive timely feedback on how they are doing and are recognized for their accomplishments.

All items for the achievement category consistently scored highly with the exception of 'the court uses my time and talent well' which scored 69.1. For this item, responses were bi-modally distributed with no respondents giving a neutral response. This indicates a group of staff has a low satisfaction level with how their time or talent is used and may benefit from further challenges. See Figure 14.

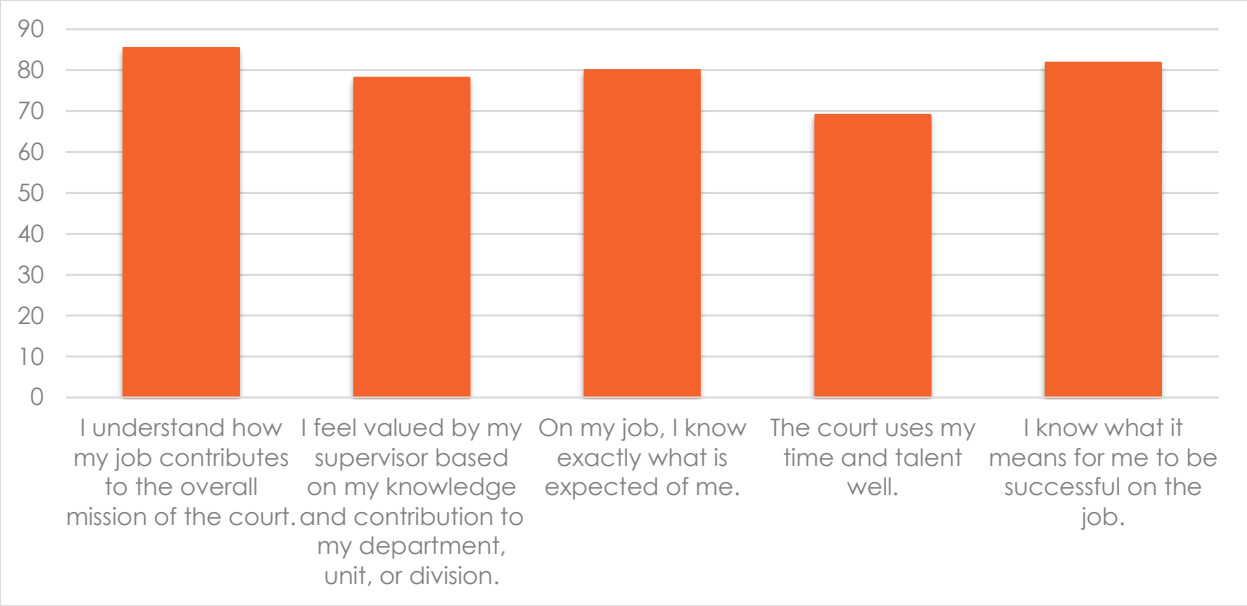


Figure 14
Responses for achievement (%)

For **work content**, the overall mean score was in the average range (73.5) indicating staff were mostly but not always aware that the work they do is important, and that their tasks contribute meaningfully to a common purpose. Work content yielded the lowest score of any of the satisfaction measures. Upon closer inspection of the lower scoring item "I am kept informed about matters that affect me in the workplace" results were bimodally distributed indicating a group felt communication of information is not optimal. No respondent provided a neutral response to this item. Similarly, results for the higher scoring item "the court and its leaders are dedicated to continuous improvement" yielded a binomial distribution indicating a group of staff did not agree with this statement.

The lowest scoring item was "I enjoy coming to work". Responses were positively skewed indicating that whilst a few respondents provided a negative or neutral response, a slight majority of respondents answered this item positively. Amongst other things, Herzberg (1987) found that for employees to be motivated, they must feel personally responsible for the work produced. For some staff, motivation to come to work may be increased by considering new and difficult tasks or assigning specialized tasks to workers who can become experts. See Figure 15.

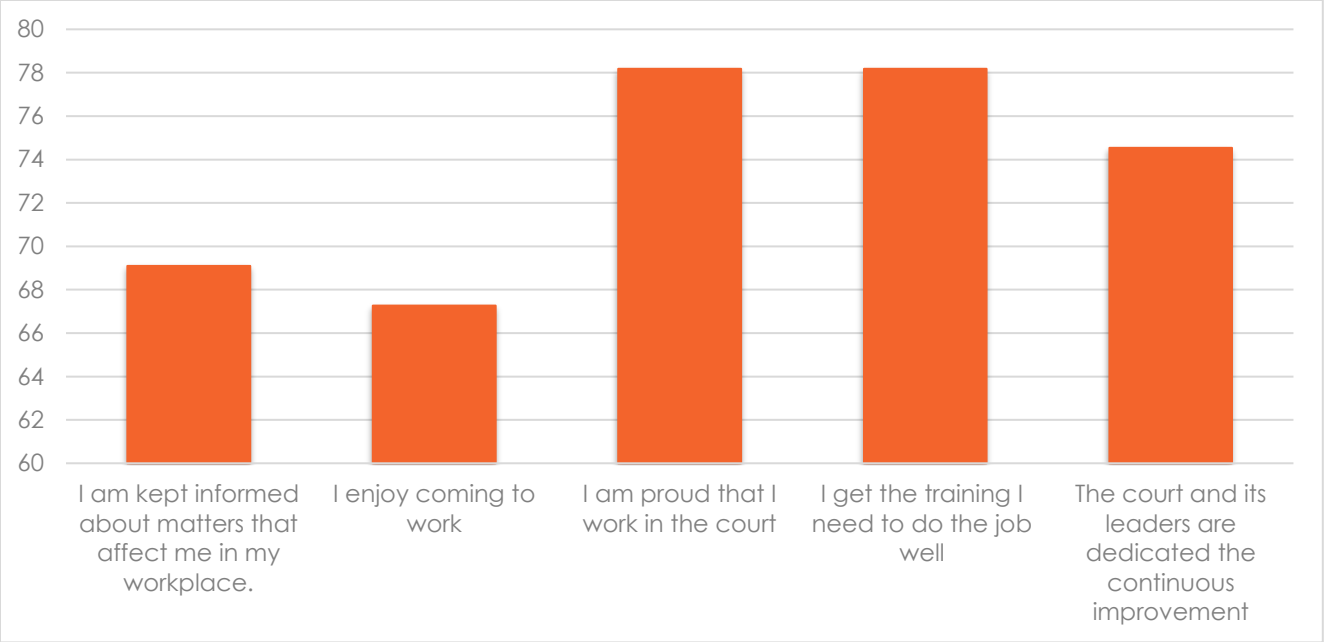


Figure 15.
Responses for work content (%)

For **responsibility**, the mean score was in the average range (76.4) indicating that staff do not consistently feel that they are provided with freedoms and authorities to undertake their work. Increased satisfaction is associated with court supports that encourage staff to grow and develop their skills.

All items scored more than 70 and one item more than 80. The two lowest scoring items in this category were "As I gain experience, I am given responsibility for new and exciting challenges at work" and "I have an opportunity to develop my own special abilities". Whilst responses to the earlier item were positively skewed whereas responses to the second item were bimodal indicating a proportion of staff did not feel their work was sufficiently challenging. See Figure 16.

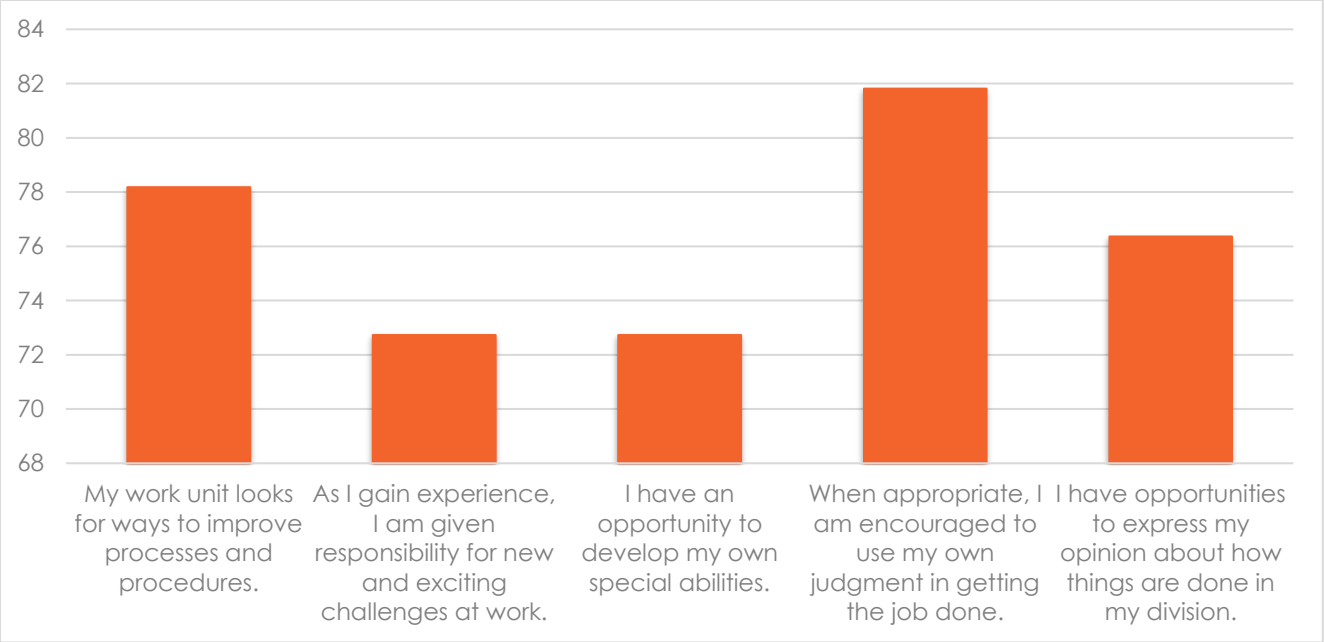


Figure 16.
Responses for responsibility (%)

Work dissatisfaction

Work dissatisfaction is related to policies that are perceived as being unfair, incompetent or unfair supervisors, bad interpersonal relationships, unpleasant working conditions, unfair salaries and job insecurity (National Centre for State Courts, 2005). Higher scores on these scales signify greater work satisfaction. Overall staff satisfaction was good (80.0) comprising very high scores for supervision/relationship with boss and work conditions but this was offset by the lowest scoring subcategory – interpersonal relations.

For **supervision and relationship with boss,** the overall mean score was 80.0 indicating low levels of dissatisfaction associated with supervision, leadership and respectful treatment of employees. All mean responses for items scoring 80 and above were generally and consistently responded to positively.

Only one item "managers and supervisors follow up on employee suggestions for improvements in services and work processes" scored lower because a small number of respondents did not agree with the statement, which lowered the overall score. This finding may be connected with the lower response previously identified related to internal communication. See Figure 17.

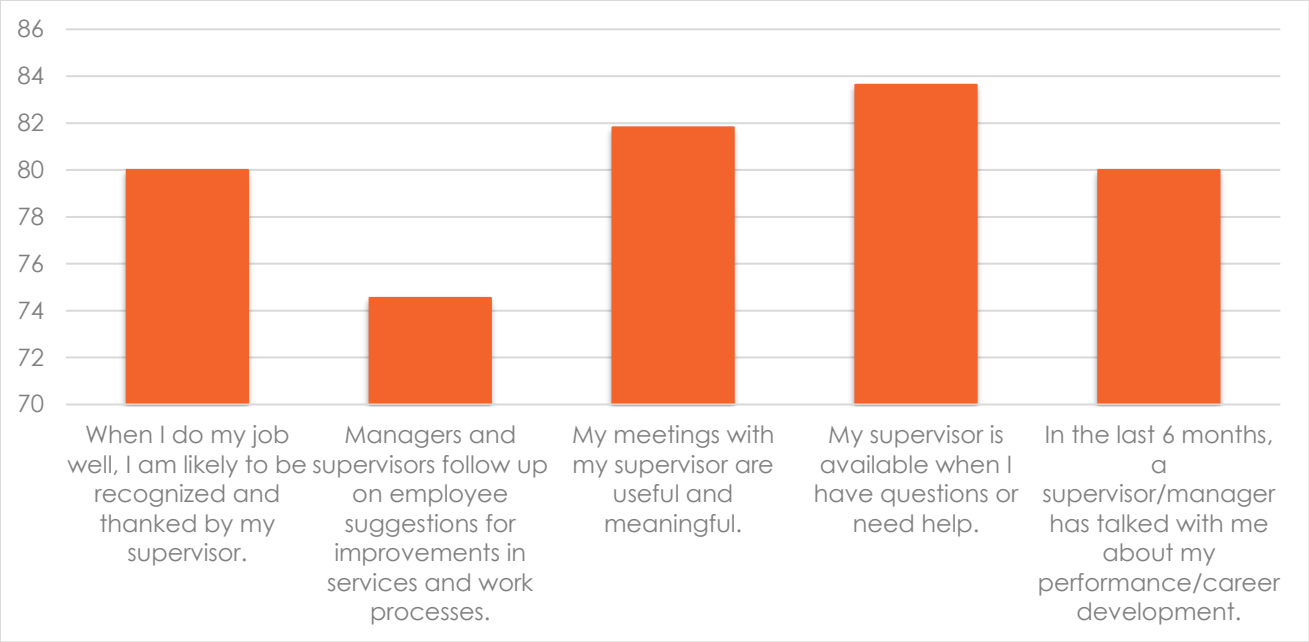


Figure 17.
Responses for supervision and relationship with boss (%)

For **work conditions**, the overall mean score was 77.1 indicating quite low levels of dissatisfaction associated with work spaces, equipment for the work, public-employee interactions and staff ability to complete their work. Mean responses for all items was consistently high with the exception of "I am treated with respect" and "my working conditions and environment enable me to do my job well". For these items, responses were more evenly distributed across the scale, indicating some disagreement with these statements. See Figure 18.

For **interpersonal relations,** the overall mean score was 66.5, indicating significant levels dissatisfaction associated with levels of teamwork in the immediate work group. Interpersonal relations scored the lowest for all sub-categories measured. Two individual items indicated a good score, albeit on the lower end of the scale. Three items scored lower than 70 and one item scored 50.9.

The three lowest scoring items were "the people I work can be relied upon when I need help", "communication within my division is good" and "my co-workers work well together". Given the generally positive responses provided to items in the supervision and relationship with boss sub-category, the current responses may be more about the relationships between colleagues. See Figure 19.

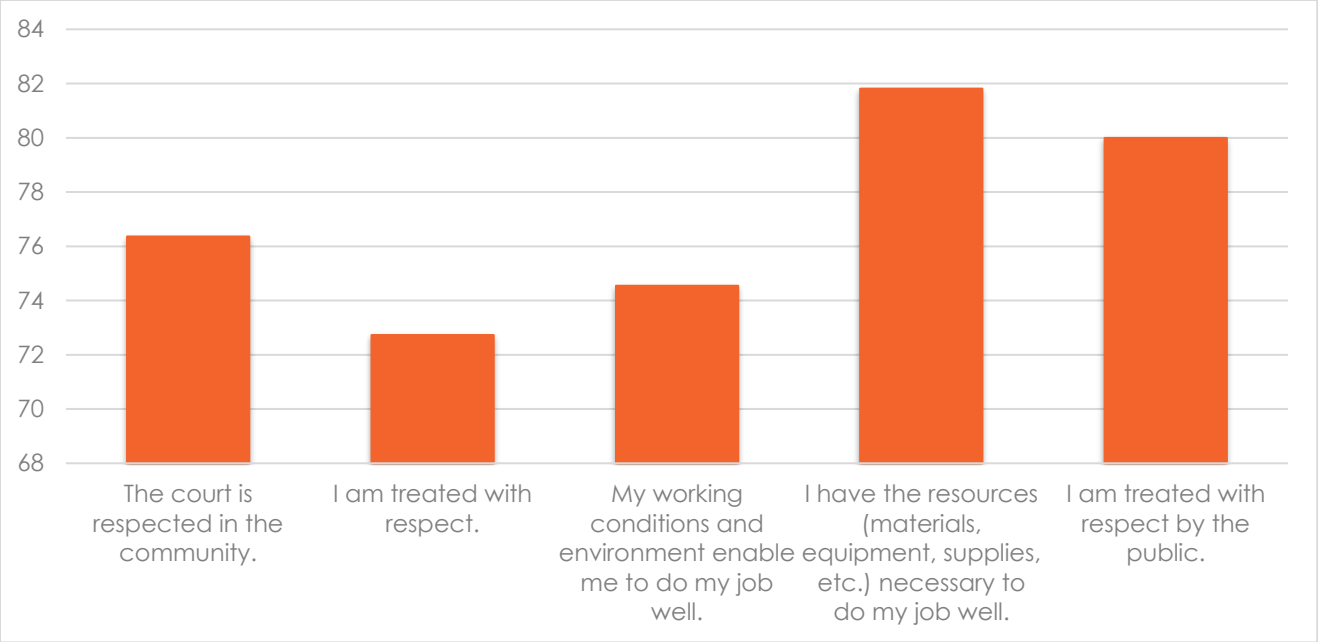


Figure 18.
Responses for work conditions (%)

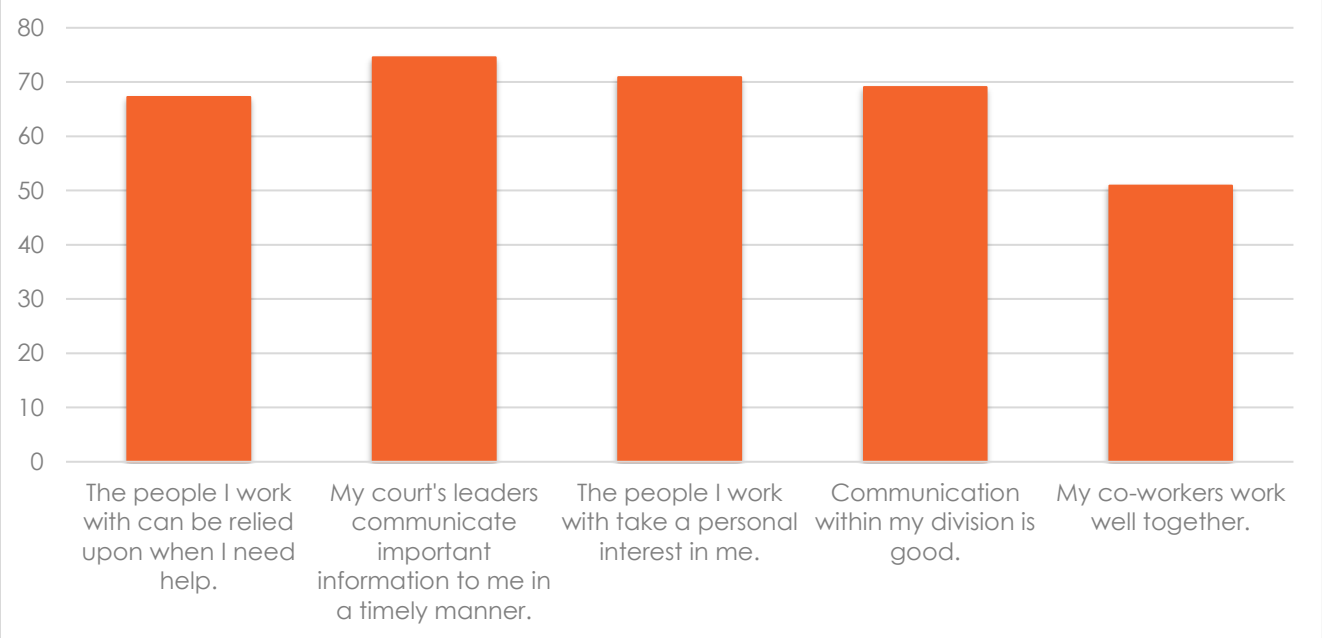


Figure 19.
Responses for interpersonal relations (%)

RESULTS – OUTCOMES

"There are different meanings of success" (FDTC Staff).

Summary of contents:

1. *Efficiency*
2. *Effectiveness*
3. *Long term impact*

Efficiency

Levine (2012) argues that the FDTC involves a shorter-time frame to reunification or permanent placement and in doing so, reduces the period of uncertainty about the child's long-term placement. This was assessed in the current evaluation.

Total days to completion

There were two approaches used in this analysis. The mean number of days between first hearing in the CCV mainstream court to the matter being finalised and orders being made was compared for FDTC participants and clients attending the CCV mainstream court. In this approach, the total number of days for FDTC participants includes the individual's time in the FDTC program as well as hearings in the CCV mainstream court. A second approach involves adjusting the number of days using a pseudo-matching design to account for the days an FDTC participant spent in the CCV mainstream court. This allows for a comparison of efficiency from the point of FDTC-induction. An FDTC participant was included in the analysis if they had attended at least one session with the FDTC.

To ensure fair comparison, total days from the first hearing to final order was assessed between FDTC participants who were exited from the FDTC and those who either completed or had their case closed due to reunification. This analysis found no significant differences in duration ($t(52.59) = -.721$, $p = .47$) for the FDTC group as a whole compared to the CCV mainstream court. Similarly, the average time spent by FDTC and CCV mainstream court only clients in the CCV mainstream courts did not differ ($t(352) = .06$, $p = .95$; FDTC time in CCV mainstream: Median = 283, Range = 143 – 687, IQ Range = 168).

Finding: FDTC participants were engaged with the court, from first hearing to final order, for an average of 322 days longer than individuals engaged with the CCV mainstream alone ($t(98.26) = -5.22$, $p < .001$; FDTC: Median = 658, Range = 388 – 932, IQ Range = 171; CCV: Median = 269, Range = 118 – 1032, IQ Range = 204).

However, when the time that FDTC participants had spent in the CCV mainstream court prior to FDTC induction was accounted for using a pseudo-matching design, the FDTC participants spent on average 55 days less time engaged with the court compared to the CCV mainstream alone ($U = 710.5$, $p < .05$).

Interpretation: The median time spent in the CCV mainstream court by all (FDTC and CCV) participants was 283 days, with greater variation in the FDTC participants, and slightly more efficiency of the FDTC once participants were inducted. The findings suggest that despite the longer engagement overall of the FDTC participants, it is likely that the FDTC is slightly more efficient than the CCV if clients were inducted into the program at an earlier point during the child protection process.

Time taken for successful re-unification

Finding: Of those cases that successfully achieved re-unification, FDTC participants tended to take on average 317 more days to achieve re-unification in total compared to the CCV mainstream court ($F(1, 429) = 8.91$, $p < .01$; FDTC: Median = 695, Range = 226 – 2043, IQ Range = 489; CCV: Median = 378, Range = 43 – 1166, IQ Range = 444). However, once accounting for CCV mainstream court involvement pre-FDTC induction, this difference reversed, with FDTC participants achieving re-unification on average 60 days sooner than CCV mainstream court clients ($U = 689.5$, $p < .05$).

Interpretation summary: As noted above, the greater duration observed in the FDTC cohort consists of both FDTC participation and CCV mainstream court hearings prior and post-FDTC involvement. Indeed, with the findings above, it is likely that the FDTC achieves re-unification with a shorter time, if the period in the CCV mainstream is accounted.

Effectiveness

To assess effectiveness of the FDTC, rates of re-unification was considered as a proxy of effectiveness. The assumption is that re-unification would only be considered by the court if it is safe to do so, and as such reflected some improvement in the parent's capacity to provide care and protection for their child.

Rates of successful re-unification

Given significant differences in the proportion of re-unifications between those participants who were exited from the FDTC and those who completed or were engaged it was decided to compare these two groups separately to the CCV mainstream court ($\chi^2(1) = 15.92$, $p < .001$; FDTC engaged, 67% reunification; FDTC exited, 27% reunification).

Results: Participants engaged with the FDTC where significantly more likely to achieve re-unification (67 per 100) compared to those who were exited from the FDTC (27 per 100) or the CCV mainstream court (43 per 100; $\chi^2(2) = 15.91$, $p < .001$).

Interestingly, there was a positive effect of duration of FDTC program engagement on likelihood of re-unification. This held for both FDTC participants who had been exited from the program and those who had completed or graduated, with 6-12 months of FDTC engagement showing the most efficacy ($\chi^2(2) = 7.30$, $p < .05$).

Table 8: *Proportion of participants re-unified with their children by court and duration of FDTC program engagement.*

	Proportion re-unified			
	Total	0 – 3 mths	3 – 6 mths	6 – 12 mths
CCV mainstream	43.3%			
FDTC exited	27.4%	29.4%	44.3%	66.7%
FDTC engaged	67.5%	44.4%	76.9%	72.2%

Similarly, the number of days engaged with the FDTC program was moderately associated with the likelihood of re-unification (Kendall Tau = .22, $p < .01$).

Interpretation summary: Results indicate that FDTC participants who engage with the program are 1.6 to 2.5 times more likely to be re-unified with their children, compared with mainstream CCV or participants who were exited from the program. Furthermore, even participants who were exited from the FDTC showed higher rates of re-unification if they had been engaged with the FDTC for at least 6 months. It is likely that the FDTC is most effective when participants complete at least 6 months of the FDTC program.

Long-term impact

To assess sustained impact of the FDTC compared to the CCV mainstream court; the number of subsequent reports, rate and number of substantiated reports, and time from final protective order to a substantiation of a report by child protection was compared across the courts.

A comparison of reports and the number, time and rates of substantiations for FDTC participants who exited prematurely with completed or graduated participants revealed no significant differences (reports: $t(47.24) = -1.37$, $p = .18$; number substantiations: $t(70.95) = -.53$, $p = .60$; time to substantiation: $t(3.91) = .90$, $p = .42$; rate of substantiations: : $\chi^2(1) = .31$, $p = .58$). As such, the FDTC group was treated a whole and was compared to the CCV mainstream court sample.

Subsequent reports to child protection

Results: Participants involved with the FDTC, for at least one session or more, tend to have a lower rate of subsequent reports to child protection concerning the safety of their child

who had been re-unified with them (t(221.61) = 3.43, p < .001; FDTC: Mode = 0, Range = 0 – 6; CCV: Mode = 1, Range = 0 – 9).

Similarly, those involved with the CCV mainstream court were more likely to have substantiated reports ($\chi^2(1)$ = 3.54, p < .05; FDTC: 6 per 100; CCV: 13 per 100) and a greater number of substantiated reports (t(298.41) = 2.66, p < .01; FDTC: Mode = 0, Range = 0 – 1; CCV: Mode = 1, Range = 0 – 4).

There was no difference in the time taken from final protective order to a new substantiated report, for those who had a substantiated report, between the FDTC participants and the CCV mainstream court (t(5.90) = -.13, p = .90; FDTC: Mean = 507 days, SD = 296 days; CCV: Mean = 490 days, SD = 251 days).

Interpretation summary: Results indicate that compared with the CCV, FDTC participants were less likely to have a report made to child protection and less likely to have the report substantiated. When the report was made however, there was no difference between FDTC and CCV participants for the time taken to substantiation.

KEY THEMES AND DISCUSSION

Key themes have been identified and briefly discussed in the context of theoretical perspectives. These themes are used to develop recommendations in the report.

Parenting capacity in the context of drug abuse

It is important that the work of the FDTC is theoretically driven. In particular, this may be most useful when thinking about parenting capacity and drug abuse. A model explaining child abuse occurring in the context of drug abuse is proposed by Neger and Prinz (2015), and comprises three components:

1. Parenting knowledge
2. Emotional regulation
3. Drug abuse[8]

Parenting knowledge (and capacity)

Participants of the FDTC program are required to attend a parenting program "My Kids and Me". The challenge for participants of the program lies with children not being in their care at the time of the program. As a result, participants do not have adequate opportunity to practice their parenting roles.

Although "My Kids and Me" allows participants to reflect upon their experiences, it is not designed to provide information about parenting. Given the important role of parenting knowledge in the Neger and Prinz model, participants may benefit from parenting programs that provide a practical understanding of parenting. In her model, Houston (2016) lists the key attributes of parenting as:

1. Key attributes of parenting (comprises parental behaviour, parental belief systems and parental constitution)
2. Problem solving
3. Communication
4. Roles
5. Affective involvement
6. Affective responsiveness
7. Behavioural control

The court may like to consider additional parenting programs that covers a number of these aspects to assist participants understand about some of the expectations of parenting.

[8] Drug abuse leading to abstinence is the focus of the FDTC and discussion is not required for this context

Emotional regulation in the context of parenting

Historical experiences of FDTC participants are important for the treatment of drug use. Emotional regulation has been implicated as a causal risk factor of drug abuse disorders (Kober & Bolling, 2014) and is associated with interpersonal trauma such as violence or child abuse. Unresolved traumatic experiences may impact on attachment and blunt a parent's ability to respond to their child's distress.

Given the very high levels of anxiety and mood disorders in the FDTC sample, the court may like to consider trauma symptomatology and its role in addressing drug use as a part of the overall FDTC program.

Court staff satisfaction

Survey results measuring employee satisfaction indicate that staff do not perceive themselves as contributing meaningfully to a common purpose and there is a suggestion of communication levels lacking between team members. These results should be interpreted within the context of the court's development and strategies should be implemented to improve issues that may be affecting the motivation of court staff.

Therapeutic alliance

The concept of therapeutic alliance generally comprises a collaborative relationship between client and therapist with a strong working alliance and shared tasks and goals (Bordin, 1979). Bordin explains that "the effectiveness of [the] tasks … depends upon the vividness with which the therapist can link the assigned task to the patient's sense of difficulties and his wish to change" (1979:254). The therapeutic alliance process therefore involves active participation by both client and therapist (Lustig, Strauser, Dewaine Rice, & Rucker, 2002).

Reviews of the literature have identified that early therapeutic alliance appears to be a consistent predictor of engagement and retention in drug treatment (Meier, Barrowclough, & Donmall, 2005). The evidence is unclear however whether the alliance impacts on post-treatment outcomes (Connors, Carroll, DiClemente, Longabaugh, & Donovan, 1997; Meier et al., 2005).

In the context of the FDTC, the Magistrate develops a direct relationship with parents through the hearings. She builds an ongoing relationship with the family and encourages parents to turn their lives around. Levine alluded to this when he describes the "power of personalising the professional-client relationship to achieve better compliance" (2012:14).

The results confirmed the important role for the Magistrate in developing the therapeutic alliance. Participants of the evaluation described the Magistrate's approach and her

role as core to their overall positive perception. Participants felt they had a voice and described the Magistrate as caring, personable and helpful.

Authoritative parenting style

In some respects, the approach of the Magistrate mirrors that of the authoritative parent, providing emotional support, high standards and appropriate autonomy. Baumrind describes authoritative parenting as one beyond the issue of authority "to include maturity demands, communication style, (including both effectiveness and directionality), and nurturance (in which a distinction is made between warmth and involvement)" (Darling & Steinberg, 1993:490).

The importance of connecting with the Magistrate is valued by FDTC participants. This is evidenced by the positive comments made by participants describing her as compassionate, understanding, respectful and willing to listen. Furthermore, providing participants with a good understanding of the program and its goals before commencement is effective means of delivering expectations.

Procedural fairness

Interactions described by the participants contributed to positive program attributes particularly as they involved the support of the court and their ability to be honest without being judged. These freedoms provide participants with the ability to feel empowered and motivated. The physical setting of the court and the ability of the judge to be seated at the same level as the participants was clearly valued by many. This may have contributed to a perception of judicial fairness as participants did not feel they were unfairly treated but provided with respect. This led, they believed to a more positive outcome, as parents and for their children.

Successful outcomes

Although the evaluation adopts re-unification as a proxy for success, this should be treated with caution as re-unification may not be in the child's bests interests and foster care is the successful outcome.

Results measuring efficiency indicated that overall, FDTC clients were engaged for longer periods, compared with clients attending CCV only. However, **the FDTC was slightly more efficient once participants were inducted**. Despite the longer engagement overall, of the FDTC participants, it is likely that the FDTC is slightly more efficient than the CCV if clients were inducted into the program at an earlier point during the child protection process.

Results measuring effectiveness indicated that **participants of the FDTC program are 1.6 to 2.5 times more likely to be re-unified with their children**, compared with mainstream CCV or participants who were exited from the program. Furthermore, even participants who were exited from the FDTC showed higher rates of re-unification if they had been

engaged with the FDTC for at least 6 months. It is likely that the FDTC is most effective when participants complete at least 6 months of the FDTC program.

Results measuring impact indicated that compared with the CCV, **FDTC participants were less likely to have a report made to child protection and less likely to have the report substantiated, post-exit.** When the report was made however, there was no difference between FDTC and CCV participants for the time taken to substantiation.

These results are further enhanced by the finding that compared with CCV only clients, the **FDTC group tended to have a more extensive history of child protection involvement** with a higher number of prior protective reports, substantiations, and applications.

Further research

Further research may explore the whether the behavioural change is sustainable and other benefits the FDTC brings to its participants such as employment and community engagement. Longitudinal research could be used to develop an understanding of the impact of FDTC on intergenerational transmission of child protection involvement and drug abuse.

Attachment 1: Time and Motion data collection form

	Case 1	Case 2	Case 3	Case 4
	Time (minutes)	**Time (minutes)**	**Time (minutes)**	**Time (minutes)**
Date				
Location				
Judge interacting with:				
Clients				
Lawyers				
Witnesses/professionals				
Child protection representatives				
Other court staff				
Court				
Lawyers interacting with:				
Clients				
Witnesses/professionals				
Child protection representatives				
Other court staff				
Clients interacting with:				
Witnesses/professionals				
Child protection representatives				
Other court staff				
No of people present				
Total time for case				
No of cases heard				
No of cases scheduled				

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9 June 2017

Professor James R P Ogloff AM
Director, Centre for Forensic Behavioural Sciences
505 Hoddle Street
CLIFTON HILL VIC 3068

Dear Professor Ogloff Jim,

Family Drug Treatment Court Evaluation Study

The purpose of this letter is to express the support of the Children's Court of Victoria for the proposed evaluation of the Family Drug Treatment Court (FDTC) by the Centre for Forensic Behavioural Sciences.

In 2014, in response to the findings of the Protecting Victoria's Vulnerable Children Inquiry, and based on the research conducted by Magistrate Greg Levine through his Churchill Fellowship in 2012, the Children's Court implemented the Family Drug Treatment Court (FDTC) as a three year pilot program in the Family Division of the Court at Broadmeadows. The FDTC aims to improve outcomes for children and families where drug and alcohol abuse is the principal reason for the removal of the child/ren from the care of their parent/s.

The Government recently announced funding to extend the pilot for a further 12 months to allow for further evaluation. I understand the Centre for Forensic Behavioural Sciences will be in a position to undertake the further evaluation of the FDTC in the second half of 2017.

The proposed evaluation will compare measurable outcomes for participants in the FDTC with the outcomes of those matters where drug and alcohol issues have been the focus of the child protection proceedings in the 'mainstream' court process of the Family Division of the Children's Court. Interviews with program participants and staff will provide important qualitative information about the impact of the initiative on children, families and child protection workers whose child protection proceedings are conducted in the FDTC. Evaluation of this kind will provide critical insights into the effectiveness of the FDTC in an Australian setting, noting the only other evaluation of an equivalent court was conducted in the UK.

It is important that initiatives such as the FDTC are the subject of independent, qualitative research and accordingly, the Children's Court fully supports the involvement of the Centre for Forensic Behavioural Sciences in undertaking this critical research.

Yours sincerely

Judge Amanda Chambers
President

REFERENCES

AIHW. (2011). *Drugs in Australia 2010: tobacco, alcohol and other drugs*. Canberra: Australian Institute of Health and Welfare.

Aldao, A., Nolen-Hoeksema, S., & Schweizer, S. (2010). Emotion-regulation strategies across psychopathology: A meta-analytic review. *Clinical Psychology Review, 30*(2), 217-237. doi:https://doi.org/10.1016/j.cpr.2009.11.004

Ashford, J. B. (2004). Treating substance-abusing parents: A study of the Pima County family drug court approach. *Juvenile and Family Court Journal, 55*(4), 27-37.

Australian Institute of Health and Welfare. (2011). *2010 National Drug Strategy Household Survey report*. Canberra.

Australian Institute of Health and Welfare. (2016). *National Strategy Household Survey 2016*. Canberra.

Bambrough, S., Shaw, M., & Kershaw, S. (2014). The family drug and alcohol court service in London: A new way of doing care proceedings. *Journal of Social Work Practice, 28*(3), 357-370.

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

Basnet, S., Onyeka, I. N., Tihonen, J., Fohr, J., & Kauhanen, J. (2015). Characteristics of drug-abusing females with and without children seeking treatment in Helsinki, Finland. *Scandinavian Journal of Public Health, 43*, 221-228.

Besinger, B. A., Garland, A. F., Litrownik, A. J., & Landsverk, J. A. (1999). Caregiver substance abuse among maltreated children placed in out-of-home care. *Child Welfare, 78*(2), 221-240.

Biederman, J., Faraone, S., Monuteaux, M., & Feighner, J. (2000). Patterns of Alcohol and Drug Use in Adolescents Can Be Predicted by Parental Substance Use Disorders. *Pediatrics, 105*(4), 792.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, research & practice, 16*(3), 252.

Bountress, K., & Chassin, L. (2015). Risk for behavior problems in children of parents with substance use disorders. *American Journal of Orthopsychiatry, 85*(3), 275-286.

Brandon, M., Sidebotham, P., Bailey, S., Belderson, P., Hawley, C., Ellis, C., & Megson, M. (2011). *New learning from serious case reviews: a two year report for 2009-2011*. Retrieved from London, United Kingdom:

Bromfield, L. M., Lamont, A., Parker, R., & Horsfall, B. (2010). *Issues for the safety and wellbeing of children in families with multiple and conplex problems: the co-occurence of domestic violence, parental substance misuse, and mental health problems*. Canberra: Australian Institute of Family Studies.

Brook, J., Akin, B. A., Lloyd, M. H., Johnson-Motoyama, M., & Yan, Y. (2016). Family drug treatment courts as competensive service models: Cost considerations. *Juvenile & Family Court Journal, 67*(3), 23-44.

Bruns, E. J., Pullmann, M. D., Weathers, E. S., Wirschem, M. L., & Murphy, J. K. (2012). Effects of a multidisciplinary family treatment drug court on child and family outcomes: Results of a quasi-experimental study. *Child Maltreatment, 17*(3), 218-230.

Bryan, B., & Havens, J. (2008). Key linkages between child welfare and substance abuse treatment: Social functioning improvements and client satisfaction in a family drug treatment court. *Family Court Review, 46*(1), 151-162.

Burdzovic, J. A., & O'Farrell, T. J. (2017). Psychosocial problems in children of women entering substance use disorder treatment: A longitudinal study. *Addictive Behaviors, 65*, 193-197.

Burrus, S. W. M., Mackin, J. R., & Finigan, M. W. (2011). Show me the money: child welfare cost savings of a family drug court. *Juvenile and Family Court Journal, 62*(3), 1-14.

Canfield, M., Radcliffe, P., Marlow, S., Boreham, M., & Gilchrist, G. (2017). Maternal substance use and child protection: a rapid evidence assessment of factors associated with loss of child care. *Child Abuse and Neglect, 70*, 11-27.

Choi, B., & Pak, A. (2007). Multidisciplinarity, interdisciplinarity and transdisciplinarity in health research, services, eduation and policy: 1 Definitions, objectives and evidence of effectiveness. *Clinical and Investigative Medicine, 30*(6), E224 - E232.

Choi, S. (2012). Family drug courts in child welfare. *Child and Adolescent Social Work Journal, 29*(6), 447-461.

Choi, S., & Ryan, J. P. (2006). Completing substance abuse treatment in child welfare: The role of co-occuring problems and primary drug of choice. *Child Maltreatment, 11*(4), 313-325.

Connors, G. J., Carroll, K. M., DiClemente, C. C., Longabaugh, R., & Donovan, D. M. (1997). The therapeutic alliance and its relationship to alcoholism treatment participation and outcome. *Journal of Consulting and Clinical Psychology, 65*(4), 588.

Cummins, P. C., Scott, D. S., & Scales, B. (2012). *Report of the Protecting Victoria's Vulnerable Children Inquiry*. Retrieved from Melbourne, Victoria:

Dakof, G. A., Cohen, J. B., & Duarte, E. (2009). Increasing family reunification for substance-abusing mothers and their children: Comparing two drug court interventions in Miami. *Juvenile & Family Court Journal, 60*(4), 11-23. doi:10.1111/j.1755-6988.2009.01033.x

Darling, N., & Steinberg, L. (1993). Parenting style as context: An integrative model. *Psychological bulletin, 113*(3), 487.

Dawe, S., Frye, S., Best, D., Moss, D., Atkinson, J., Evans, C., . . . Harnett, P. (2006). *Drug use in the family, impacts and implications for children*. Retrieved from Canberra, ACT:

De Bortoli, L., Coles, J., & Dolan, M. (2013). Parental substance misuse and compliance as factors determining child removal: A sample from the Victorian Children's Court in Australia. *Children and Youth Services Review, 35*, 1319-1326.

De Bortoli, L., Coles, J., & Dolan, M. (2014). Linking illicit substance misuse during pregnancy and child abuse: what is the quality of the evidence? *Child & Family Social Work, 19*(2), 136-148. doi:doi:10.1111/cfs.12002

De Bortoli, L., Coles, J., & Dolan, M. (2015). Aboriginal and Torres Strait Islander children in child protection: A sample from the Victorian Children's Court. *Journal of Social Work, 15*(2), 186-206. doi:10.1177/1468017314529511

Dore, M. M., & Doris, J. M. (1997). Preventing child placement in substance-abusing families: Research-informed practice. *Practice Forum, 77*(4), 407-428.

Doris Duke Charitable Foundation. (2017). *National Strategic Plan for Family Drug Courts*.

Drabble, L. A., Haqun, L. L., Kushins, H., & Cohen, E. (2016). Measuring client satisfaction and engagement: The role of a mentor parent program in family drug treatment court. *Juvenile & Family Court Journal, 67*(1), 19-33.

Drabble, L. A., Jones, S., & Brown, V. (2013). Advancing trauma-informed systems change in a family drug treatment court context. *Journal of Social Work Practice in the Addictions, 13*, 91-113. doi:10.1080/1533256X.2012.756341

Dube, S. R., Feletti, V. J., Dong, M., Giles, W. H., & Anda, R. F. (2003). The impact of adverse childhood experiences on health problems: Evidence from four birth cohorts dating back to 1900. *Preventative Medicine, 37*, 268-277.

Edwards, L. P. (2010). Sanctions in family drug treatment courts. *Juvenile & Family Court Journal, 61*(1), 55-62. doi:10.1111/j.1755-6988.2009.01038.x

Edwards, L. P., & Ray, J. A. (2005). Judicial perspectives on family drug treatment courts. *Juvenile & Family Court Journal, 56*(3), 1-27.

European Monitoring Centre for Drugs and Drug Addiction. (2010). *Children's voices: Experiences and perceptions of European children on drug and alcohol issues*. Retrieved from Luxembourg:

Fernandez, E., & Lee, J. (2013). Accomplishing family reunification for children in care: An Australian study. *Children and Youth Services Review, 35*(9), 1374-1384. doi:10.1016/j.childyouth.2013.05.006

Forrester, D. (2000). Parental substance misuse and child protection in a British sample. A survey of children on the child protection register in an inner London district office. *Child Abuse Review, 9*(4), 235-246.

Freiberg, A., Payne, J., Gelb, K., Morgan, A., & Makkai, T. (2016). *Queensland Drug and Sopecialist Courts Review. Final Report*. Queensland Courts.

Gibson, C., & Parkinson, S. (2013). *Evaluation of 'My Kids and Me' Final Report*. Univesity of South Australia and Australian Centre for Child Protection.

Gifford, E. J., Eldred, L. M., Vernerey, A., & Sloan, F. A. (2014). How does family drug treatment court participation affect child welfare outcomes? *Child Abuse and Neglect, 28*, 1659-1670.

Green, B. L., Furrer, C. K. W., S. D, Burrus, S. W. M., & Finigan, M. W. (2009). Building the evidence base for family drug treatment courts: results from recent outcome studies. *Drug Court Review, 6*(2), 52-82.

Green, B. L., Rockhill, A., & Burrus, S. W. M. (2008). The role of interagency collaboration for substance-abusing families involved with child welfare. *Child Welfare, 87*(1).

Green, B. L., Rockhill, A., & Furrer, C. K. (2006). Does substance abuse treatment make a difference for child welfare case outcomes? A statewide longitudinal analysis. *Children and Youth Services Review, 29*, 460-473.

Gruenert, S. (2013). *The case for a Family Drug Treatment Court.* Paper presented at the Victorian Alcohol & Drug Association, Victoria.

Harrell, A., & Goodman, A. (1999). *Review of specialized family drug courts: Key Issues in handling child abuse and neglect cases*. Retrieved from Washington, DC:

Harwin, J., Alrouh, B., Ryan, M., McQuarrie, T., Golding, L., Broadhurst, K., . . . Swift, S. (2016). *After FDAC: outomes 5 years later. Final report.* Retrieved from http://wp.lancs.ac.uk/cfj-fdac/publications/

Harwin, J., Alrouh, B., Ryan, M., & Tunnard, J. (2014). *Changing lifestyles, keeping children safe: An evaluation of the first Family Drug and Alcohol Court (FDAC) in care proceedings.* Retrieved from

Harwin, J., Ryan, J. P., Pokhrel, S., Alrouh, B., Matias, C., & Momenian-Shneider, S. (2011). *The Family Drug and Alcohol Court (FDAC) Evaluation Project Final Report*. Retrieved from London:

Health Outcomes International. (2016). *Court Services Victoria, Evalulation of the Family Drug Treatment Court*. Retrieved from Glynde, SA:

Herzberg, F. (1987). *One more time: How do you motivate employees?* : Harvard Business Review

Holland, S., Forrester, D., Williams, A., & Copello, A. (2014). Parenting and substance misuse: Understanding accounts and realities in child protection contexts. *British Journal of Social Work, 44*, 1491-1507. doi:10.1093/bjsw/bcs197

Houston, S. (2016). Assessing parenting capacity in child protection: towards a knowledge-based model. *Child & Family Social Work, 21*(3), 347-357.

Jessup, R. L. (2007). Interdisciplinary versus multidisciplinary care teams: do we understand the difference? *Aust Health Rev, 31*(3), 330-331.

Kemp, S. P., Marcenko, M. O., Hoagwood, K., & Vesneski, W. (2009). Engaging parents in child welfare services: bridging family needs and child welfare mandates. *Child Welfare, 88*(1).

Kober, H., & Bolling, D. (2014). Emotion regulation in substance use disorders. *Handbook of emotion regulation, 2*, 428-446.

Korner, M. (2010). Interprofessional teamwork in medical rehabilitation: a comparison of multidisciplinary and interdisciplinary team approach. *Clin Rehabil, 24*(8), 745-755. doi:10.1177/0269215510367538

Kovach, J. V., Curiel, V., York, A. F., & Bogard, S. (2017). Enhancing information sharing in family drug courts: A lean six sigma case study. *Juvenile & Family Court Journal, 68*(3), 27-41. doi:10.1111/jfcj.12095

Kroll, B. (2004). Living with an elephant: Growing up with parental substance misuse. *Child and Family Social Work, 9*, 129-140.

Kroll, B., & Taylor, A. (2001). *Parental substance misuse and child welfare*: Jessica Kingsley Publishers.

Larry, B., & Lawson, M. (1994). Barriers to cooperation between domestic-violence and substance-abuse problems. *Families in Society, 75*(5).

Lester, P. E., Weiss, R. E., Rice, E., Comulda, S. W., Lord, L., Alber, S., & Rotheram-Borus, M. (2009). The longitudinal impact of HIV+parent's drug use on their adolescent children. *American Journal of Orthopsychiatry, 79*(1), 51-59.

Levine, G. (2012). *A Study of Family Drug Treatment Courts in the United States and the United Kingdom: Giving parents and children the best chance of reunification*. Retrieved from Acton, ACT:

Lloyd, M. H., & Akin, B. A. (2014). The disparate impact of alcohol, methamphetamine, and other drugs on family reunification. *Children and Youth Services Review, 44*, 72-81.

Lustig, D. C., Strauser, D. R., Dewaine Rice, N., & Rucker, T. F. (2002). The relationship between working alliance and rehabilitation outcomes. *Rehabilitation Counseling Bulletin, 46*(1), 24-32.

Maidani, E. (1991). Comparative study of Herzberg's two factor theory of job satisfaction among public and private sectors. *Public Personnel Management, 20*(4), 441 - 448.

Manning, V., Best, D. W., Faulkner, N., & Titherington, E. (2009). New estimates of the number of children living with substance misusing parents: results from UK national household surveys. *BMC Public Health, 9*.

Marlowe, D. B., & Carey, S. M. (2012). *Research update on Family Drug Courts*. Retrieved from Alexandria, Virginia:

Mayes, L., & Truman, S. (2002). Substance abuse and parenting. In M. Bornstein (Ed.), *Handbook of Parenting* (2nd ed., Vol. 4, pp. 329-360). Mahwah, New Jersey: Lawrence Erlbaum Associates Publishers.

Meier, P. S., Barrowclough, C., & Donmall, M. C. (2005). The role of the therapeutic alliance in the treatment of substance misuse: A critical review of the literature. *Addiction, 100*(3), 304-316.

Minty, B. (1999). Annotation: Outcomes in long-term foster family care. *Journal of Child Psychology and Psychiatry, 40*(7), 991-999.

National Association of Drug Court Professionals. (2004). *Defining drug courts: The key components*. Washington, DC.

National Association of Drug Court Professionals. (2017). What are drug courts?

National Centre for State Courts. (2005). Courtools: Trial Court Performance Measures. In (Vol. Version 2.0).

National Unit FDAC. (2017). Existing Sites. Retrieved from http://fdac.org.uk/locations/existing-sites/

Neger, E. N., & Prinz, R. J. (2015). Interventions to address parenting and parental substance abuse: Conceptual and methodological considerations. *Clinical Psychology Review, 39*, 71-82. doi:https://doi.org/10.1016/j.cpr.2015.04.004

Newton, R. R., Litrownik, A. J., & Landsverk, J. A. (2000). Children and youth in foster care: disentangling the relationship between problem behaviors and number of placements. *Child Abuse and Neglect, 24*(10), 1363-1374. doi:10.1016/S0145-2134(00)00189-7

Oliveros, A., & Kaufman, J. (2011). Addressing substance abuse treatment needs of parents involved with the child welfare system. *Child Welfare, 90*(1), 25-41.

Oosterman, M., Schuengel, C., Slot, N. W., Bullens, R. A. R., & Doreleijers, T. A. H. (2007). Disruptions in foster care: A review and meta-analysis. *Children and Youth Services Review, 29*(1), 53-76. doi:10.1016/j.childyouth.2006.07.003

Papageorgiou, J. (2017). *Guidance on Family Reunification*. Melbourne, Victoria: Department of Human Services.

Powell, C., Stevens, S., Lo Dolce, B., Sinclair, K. O., & Swenson-Smith, C. (2012). Outcomes of a trauma-informed Arizona family drug court. *Journal of Social Work Practice in the Addictions, 12*(3), 219-241. doi:10.1080/1533256X.2012.702624

Regier, D., Farmer, M., Rae, D., Locke, B., Keith, S., Judd, L., & Goodwin, F. (1990). Comorbidity of mental disorders with alcohol and other drug abuse. *Jama, 264*(19), 2511-2518.

Researchgate. (2017). Whats the difference betewen interdisciplinary Interdisciplinary and Multidisciplinary? Retrieved from https://www.researchgate.net/post/Whats_the_difference_between_Interdisciplinarity_and_Multidisciplinarity

Richardson, E. (2016). *Envisioning next generation mental health courts for Australia.* (Unpublished PhD), Monash University, Melbourne,

Sheehan, D., Robertson, L., & Ormond, T. (2007). Comparison of language used and patterns of communication in interprofessional and multidisciplinary teams. *J Interprof Care, 21*(1), 17-30. doi:10.1080/13561820601025336

Smith, D. B., & Shields, J. (2013). Factors related to social service workers' job satisfaction: Revisiting Herzberg's motivation to work. *Administration in Social Work, 37*(2), 189-198.

Taylor, M. F., Marquis, R., Coall, D., & Wilkinson, C. (2017). Substance misuse-related parental child maltreatment. *Journal of Drug Issues, 47*(2), 241-260.

Thomas, C. (2011). *Childhood neglect, neglect and parental substance misuse*. United Kingdom: Child and Family Training.

van Wormer, J., & Hsieh, M. (2016). Healing families: Outcomes from a Family Drug Treatment Court. *Juvenile & Family Court Journal, 67*(2), 49-66.

Velez, M. L., Jansson, L. M., Montoya, I. D., Schweitzer, W., Golden, A., & Svikis, D. (2004). Parenting knowledge among substance abusing women in treatment. *Journal of Substance Abuse Treatment, 27*(3), 215-222. doi:10.1016/j.jsat.2004.07.004

Victorian Law Reform Commission. (2010). *Protection Applications in the Children's Court. Final Report 19*. Retrieved from http://www.lawreform.vic.gov.au/sites/default/files/VLRC_Protection_Applications_in_the_Childrens_Court_Final_Report.pdf

Walsh, C., Macmillan, H. L., & Jamieson, E. (2003). The relationship between parental substance abuse and child maltreatment: findings from the Ontario Health Supplement. *Child Abuse and Neglect, 27*(12), 1409-1425.

Ward, F. (2017). Diminishing powers. *Law Institute Journal, April 2017*.

Wolock, I., & Magura, S. (1996). Parental substance abuse as a predictor of child maltreatment re-reports. *Child Abuse & Neglect, 20*(12), 1183-1193. doi:https://doi.org/10.1016/S0145-2134(96)00114-7

Worcel, S. D., Green, B. L., Furrer, C. K., Burrus, S. W. M., & Finigan, M. W. (2008). Effects of family treatment drug courts on substance abuse and child welfare outcomes. *Child Abuse Review, 17*(1), 427-443.

York, J., Lamis, D. A., Garfinkel, P. W., Bluestein, N. P., Boxx, M., Ellis, A., . . . Donaldson, S. (2012). Family drug treatment courts and social determinants of health. *Family Court Review, 50*(1), 137-149.