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Lessons Learned from a Coalition-Driven Implementation of a Family Treatment Court In a Rural Mid-Atlantic Region County

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Abstract

The multitude of adverse effects of substance use disorders is well-outlined in prevention and treatment literature, including a correlation between child welfare cases and parental drug use. In 2018, a cross-sector network in a rural county in the Mid-Atlantic region of the United States applied action research to address a significant spike in substance-related child welfare cases. The network implemented a Family Treatment Court (FTC), an empirically supported model that has historically demonstrated success in reducing parental substance use and higher rates of family reunification compared to other approaches. Community input and planning guided this project through the iterative process of action research. Lessons learned include (a) maintaining fidelity to inclusion–exclusion criteria, (b) individualizing FTC participant treatment needs, (c) applying sanctions consistently among program participants, (d) offering a support group to participants, and (e) providing a continuum of recovery supports.

Keywords*:* family treatment, substance use, counseling, lessons learned

Leçons tirées d'une mise en œuvre dirigée par une coalition d'un tribunal de traitement familial dans un comté rural de la région du centre de l'Atlantique

Résumé

La multitude d'effets indésirables des troubles liés à l'utilisation de substances est bien décrite dans la littérature sur la prévention et le traitement, y compris une corrélation entre les cas de protection de l'enfance et la consommation de drogues par les parents. En 2018, un réseau intersectoriel dans un comté rural de la région du centre atlantique des États-Unis a appliqué la recherche-action pour faire face à une augmentation importante des cas de protection de l'enfance liés à la toxicomanie. Le réseau a mis en place un tribunal de traitement familial (FTC), un modèle fondé sur des données empiriques qui a historiquement démontré son succès dans la réduction de la consommation de substances par les parents et des taux plus élevés de

réunification familiale par rapport à d'autres approches. Les commentaires et la planification de la communauté ont guidé ce projet tout au long du processus itératif de recherche-action. Les leçons apprises comprennent : le maintien de la fidélité aux critères d'inclusion/d'exclusion, l'individualisation des besoins de traitement des participants au FTC, l'application cohérente de sanctions parmi les participants au programme, l'offre d'un groupe de soutien aux participants et la fourniture d'un continuum de soutien au rétablissement.

Mots-clés : traitement familial, toxicomanie, counseling, leçons apprises

1.0 Introduction

Addiction prevention and treatment literature have delineated the negative consequences of substance use disorders. Some of the deleterious effects of substance use on an individual level may include (a) relationship strife, (b) unstable housing, (c) physical problems, (d) economic hardship, and (e) legal involvement (Bruns et al., 2012). On a community level, substance use can strain the child welfare system, with up to 80% of all child welfare cases involving parental substance use (Freisthler et al., 2021). Furthermore, drug and alcohol use may result in an increased burden on criminal justice and behavioral healthcare systems. Jails often house individuals in need of treatment, and many treatment staff experience challenges in providing effective treatment for individuals with a substance use disorder (Surratt et al., 2018). Rural communities face unique challenges as access to care is cited as the top identified rural health priority during the past decade (Bolin et al., 2015). Mental health and substance use disorders were also included in the top five priority areas. Unfortunately, substance use treatment for rural residents is often difficult to access due to transportation barriers, a limited number of providers, and a lack of providers with specialty treatment expertise (Coughlin et al., 2019).

One solution to address substance-related child welfare cases and functional impairments caused by addiction in rural communities is Family Treatment Court (FTC). FTC is a model with demonstrated efficacy in treatment completion and reunification (Cosden & Koch, 2015; Fessinger et al., 2020; Gifford et al., 2014). Research suggests that parents involved in FTC were significantly more likely to engage and remain in treatment when compared to their non-FTC counterparts. Moreover, their children spent less time placed out of the home and were more likely to return to parental care (Bruns et al., 2012).

In 2018, a coalition of mental health and substance use community agencies in a Mid-Atlantic rural county in the United States examined local substance use data and observed the surge in substance use in the community, particularly with opiates and methamphetamines (Smith Ramey & Randall, 2020). For example, the county had the highest rates of drug overdose deaths and emergency department drug overdose visits among the adjacent counties (Virginia Department of Health [VDH], n.d.). Community partners also noted a spike in substance-related child protective services cases. The Department of Social Services' senior management reported a 23% increase in child welfare cases compared to the previous year. According to Department of Social Services senior management, ninety percent of the child welfare cases in this community were linked to parental substance use. The network of community partners collectively agreed that current approaches to

addressing substance use disorders were insufficient to meet the community's needs (Smith Ramey & Randall, 2020).

The purpose of this article is to present a case study on the development and implementation of an FTC in a rural county in the United States Mid-Atlantic Region. The community-based effort was conceptualized, developed, and established by a coalition of stakeholders that included court services, community behavioral health providers, the health department, and the department of social services. The cross-sector coalition was consistent with the participatory traditions of action research, an iterative person-centered research paradigm that has been historically applied to addressing social problems (Altrichter et al., 2002). Action research's iterative spirals (i.e., planning, acting, observing, and reflecting) apply to intractable multigenerational social issues such as substance use (Kemmis & McTaggart, 1988). An action research framework enabled the cross-sector coalition to use current publicly available and organizationally bound data in planning and establishing the FTC pilot, systematically collecting data related to FTC, and informing decisions on improving the FTC development and implementation.

1.1 Brief Literature Review

FTC is one of many specialty dockets, including Adult Drug Court, Juvenile Drug Court, and Mental Health Court. These specialty dockets are also referred to as problem-solving courts. These courts offer an alternative to the punitive role of the judicial system by coupling the accountability of court oversight with evidence-based treatment using a multidisciplinary team approach (Marlowe Carey, 2012). FTC is a civil court with cases referred through a child welfare agency. The goal of FTC is family preservation and wellness. Individuals may be referred to an FTC program through a child welfare agency when they have a substantiated case of child abuse or neglect related to parental substance use. Two important concepts of an FTC are therapeutic jurisprudence (i.e., therapeutically applying the law) and procedural justice (i.e., the idea of fairness in the processes that resolve disputes) (Fessinger et al., 2020). Heideman et al. (2016) found that parents who believed they had a voice in their court proceedings felt more positive about the judicial interactions, underscoring the importance of strong judicial leadership in an FTC program.

FTCs have a demonstrated history of efficacy in the areas of child welfare and reunification. Parental completion of an FTC program is associated with reduced lengths of stay in the child welfare system (Gifford et al., 2014). Children whose parents completed an FTC program were more likely to be reunified with their parents and less likely to leave the child welfare system through adoption or a kinship placement when compared to parents who enrolled in an FTC but did not complete the program (Gifford et al., 2014). Fessinger et al. (2020) found that procedural justice is associated with better outcomes for parents enrolled in FTC. A mediation analysis suggested that FTC parents believed the court proceedings were fairer and participated more consistently than parents who were not involved in an FTC (Fessinger et al., 2020). As a result, these parents reunified with their children more often than non-FTC parents involved in the child welfare system. Two factors identified as best predictors for successful FTC outcomes by Child and McIntyre (2015) were parent participation in support group meetings and negative tests for substance use. These findings underscore the importance of a combination of both formal clinical interventions and community support engagement activities.

Research supports longer-term sustainable outcomes in the FTC model informed by several key considerations in FTC programming. For example, one study found that alcohol and drug use remained low six months post entry into FTC (Powell et al., 2012). Significant decreases were also documented in mental health problems. Relatedly, housing stability and employment increased for FTC participants (Powell et al., 2012). Other factors associated with the successful completion of FTC were drug screening and the therapeutic relationship between the client and counselor (Marlowe & Carey, 2012). Frequent urine drug screening is associated with treatment retention and an increased likelihood of treatment completion. Furthermore, FTC participants who reported a positive relationship with their counselor were more likely to complete drug court. Logsdon et al. (2021) found that overall engagement and positive relationships with all FTC team members (e.g., the judge, the child welfare workers, the case manager) were associated with higher completion rates of FTC across time.

2.0 Action Research Conceptual Model

Action research is defined as a community-based, action science and learning approach often used to improve practice in healthcare settings (Lingard et al., 2008). Kemmis and McTaggart (1988) proposed a model of action research entitled the action research spiral. Their model consists of process cycles for organizations or coalitions, including (a) planning for a change; (b) acting and observing the process and consequences of the change; (c) reflecting on these processes and consequences; (d) replanning, acting and observing; and (e) reflecting. The model allows for flexibility and overlap of stages. In addition, initial plans may become outdated as new information is gathered through learning experiences. Thus, the action research spiral follows an iterative approach, allowing for growth and new learning throughout the cycle of change. This action research spiral guided the cross-sector network through the review of local drug overdose data, the development and implementation of the FTC pilot, including program revisions, expansion of the pilot, lessons learned, and future directions of FTC.

2.1 Local Drug Overdose Data

2.1.1 Planning for a change. The impetus for the community network's action research project developed out of the rise in drug overdoses in the region coupled with the increase in substance-related child welfare cases. More specifically, the community network wanted to improve practice through the process of action, evaluation, and critical reflection. Consistent with Kemmis and McTaggert's (1988) action research approach, the network began to plan for a change. The first step was a review of the Department of Health opioid overdose data highlighting a marked increase in overdose deaths for all drugs, including opiates and methamphetamines, from 2018 (1,486 deaths) to 2020 (2,297 deaths) (VDH, 2020). In 2018, the rural county had the highest number of Emergency Department overdose visits in the catchment area at 19.9 per 100,000 compared to adjacent counties (4.2 per 100,000; VDH, 2020). The network focused on a common purpose (i.e., reducing overdose deaths and improving family wellness) and creating knowledge through action (i.e., the development of an FTC pilot).

2.2 FTC Pilot

2.2.1 Acting and observing the consequences of the change. Drawing from the research (Kemmis & McTaggert, 1988), the network chose to take an action step in their project, cultivated through the strong ties and relationships among community partners. In 2018, the community network formed an ad hoc committee to develop and implement an FTC pilot in response to the local drug overdose data (Smith Ramey & Randall, 2020). By starting FTC as a pilot with five participants in 2018, revisions were made to programming as identified by the FTC operations team, coupled with participant feedback. Ad hoc network members formed the FTC operations team, comprised of the domestic and relations presiding judge, department of social services family services workers, the court-appointed advocate, and substance use–mental health treatment providers. Part of the role of the operations team was to establish protocols for FTC, including the preparation of an FTC manual, codification of the eligibility criteria, the establishment of the induction process, and the development of the phases of treatment. In addition, the operations teams sought guidance from the state Supreme Court, the Center for Children and Family Futures and National Association of Drug Court Professionals (2019) on Family Treatment Court Best Practice Standards. These standards include (a) organization and structure; (b) the role of the judge; (c) ensuring equity and inclusion; (d) early identification, screening, and assessment; (e) high-quality and timely substance use disorder treatment; (f) comprehensive case management and support for families; (g) therapeutic responses to behavior; and (h) monitoring and evaluation. The team focused on implementation and measurement of the standards through consultation with the state Supreme Court specialty docket coordinator and site visits to other treatment courts. The team also tracked graduation and completion rates for the participants involved in the pilot. These early steps toward observing the consequences of change led to the addition of an external evaluator to measure program fidelity once federal grant funding was awarded.

2.3 Revision to the FTC Pilot

2.3.1 Reflecting on processes and replanning. About a year after the pilot implementation, network members reflected on successes and challenges, which allowed for replanning, consistent with the action research spiral (Kemmis and McTaggert, 1988). As a result, revisions were made to the FTC processes. One example of a revision to FTC based on information accrued from the pilot was the addition of a peer recovery specialist to the treatment team. Often participants were approached to be a part of FTC and they declined, or they agreed to participate and dropped out of FTC at the first signs of adversity. The network theorized that a peer recovery specialist may assist with initiation, engagement, and retention for participants in FTC. The initial FTC pilot did not include a peer recovery specialist as part of the team. A peer recovery specialist is an individual with lived substance use experience who serves as a role model and supports individuals with a substance use disorder and assists them with linkage to pro-recovery activities in the community (Jones et al., 2020). Peer recovery specialists mentor participants and provide education and recovery support. Research suggests peer recovery specialists are associated with improved recovery outcomes (Bassuk et al., 2016). Peers play a vital role in the ongoing recovery treatment, aftercare, and support functions. These roles may include one-on-one coaching and role-modeling with clients, co-facilitating support groups, and linkage to pro-recovery peers (Jones et al., 2020). In addition, the peer recovery specialist also assisted FTC participants with

transportation to required appointments and meetings while facilitating the delivery of peer support services. Transportation to meetings, appointments, and court was a significant barrier for FTC participants elucidated through the initial FTC pilot.

2.4 FTC Pilot Graduations and Capacity Expansion

2.4.1 Acting, observing. The action research spiral (Kemmis & McTaggert, 1988) denotes action and observation, with a goal of enhancing knowledge through taking specific action and reflecting upon these processes. Procedural changes associated with participant graduation included applying rewards to FTC participants (e.g., gift cards, praise from the judge) in the early phases of FTC and offering participants a choice of treatment options to support participant agency. These steps were operationalized through the graduation of FTC pilot participants and reflection and interpretation from the FTC participants and operations team. On March 11, 2020, the FTC celebrated its first graduate. The FTC marked another graduate in April 2020 and three additional graduates in June and July 2020. Observations from the initial FTC graduates included a reduction in participant substance use and reunification with their children. Data on participant graduation, program attendance, and drug screening results were collected by the child welfare agency and reported to the state Supreme Court database. As a result of the successful graduations and family reunification of the pilot participants, the cross-sector network targeted funding to expand the capacity of FTC to serve additional families. To sustain and increase the capacity of FTC, in February 2020, the treatment agency applied for federal funding to provide external support to FTC for the next five years. In June 2020, the agency was awarded a two-million-dollar federal grant to expand capacity from five individuals served to 100 individuals and families over 5 years (Smith Ramey & Randall, 2020). This funding allowed additional positions to be added for the full-time dedicated support of FTC, including a therapist, case manager, peer recovery specialist, and family service specialist. All positions receiving federal funding were trained in evidence-based modalities as part of FTC programming.

2.4.2 FTC Programming. FTC uses evidence-based substance use treatment, Community Reinforcement Approach ([CRA]; Meyers & Godley, 2001). Multiple studies have shown that CRA decreases substance use and increases healthy and positive non-using behaviors and activities (Hunt & Azrin, 1973; Meyers & Godley, 2001). In addition, CRA's fidelity is monitored closely because drug courts implemented with fidelity to an evidence-based practice have superior outcomes compared to drug courts that are not adherent to an evidence-based treatment model (Cheesman et al., 2016).

FTC exemplifies effective partnership across the child welfare agency, the treatment provider, the health department, and court services. The child welfare agency refers cases to FTC after substance-related abuse or neglect is substantiated. The community behavioral health agency leads the treatment arm of the team by providing mental health and substance use counseling, medication management (e.g., medication assisted treatment for substance use), case management, and recovery support. The health department contributes a peer recovery specialist who models pro-social behavior and assists with treatment initiation and retention with FTC participants. Furthermore, the juvenile and domestic relations judge oversees FTC's weekly docket. A multidisciplinary approach is an identified best practice and key component of an FTC (Marlowe & Carey, 2012).

The current FTC is predicated on using best practices with demonstrated efficacy. These practices include random drug screening, weekly contact with FTC participants, rewards and sanctions, and the delivery of evidence-based substance use treatment. These practices have been associated with increased treatment compliance and the completion of FTC (Sieger & Haswell, 2020). A participant's average length of stay in FTC is 12 months. Drug court protocol is divided into five phases. Each phase designates the frequency of court appearances, treatment services, social services visits, drug–alcohol screens, and employment seeking expectations. Phases one, three, four, and five are 60 days, and phase two is 90 days. Drug screening is provided biweekly in the first two phases and weekly in phases three and four.

Treatment service level needs are determined through the American Society of Addiction Medicine (ASAM), a validated dimensional assessment and placement tool incorporating individual preferences and needs. The ASAM Criteria is used to determine an appropriate level of treatment intensity for an individual with a substance use disorder or co-occurring substance use and mental health disorder (Mee-Lee & Gastfriend, 2008). The ASAM assessment serves as a mechanism for prioritizing court resources and services for clients with the highest treatment needs. FTC goals include: (a) maintaining abstinence; (b) improving quality of life through long-term sobriety; (c) increasing knowledge of the disease and understanding of the recovery process; (d) gainful employment; (e) safe, drug-free housing; (f) identifying relapse triggers; and (g) developing positive coping strategies to deal with triggers. Distal goals include improving family and social relationships, gaining life skills to enhance recovery, and identifying and participating in pro-social, drug-free activities to integrate into positive community supports.

2.5 FTC Lessons Learned

2.5.1 Reflecting. Reflection is a critical component in action research and the conceptual model proposed by Kemmis and McTaggart (1988). Reflection allows a deeper level of enhanced understanding of the phenomenon being studied. In this case, substance-related child welfare cases and drug overdoses were the overall targets of review. As a result of the FTC pilot and subsequent capacity extension, several lessons have been learned since the FTC pilot in 2018 with the initial five participants. The subsequent capacity expansion in 2020 provided additional opportunities for programmatic improvement. Generalized lessons learned for other rural communities and networks considering the development of an FTC include the following: (a) maintaining fidelity to inclusion–exclusion criteria, (b) individualizing FTC participant treatment needs, (c) applying sanctions consistently across program participants, (d) offering a support group to participants, and (e) offering a continuum of recovery support.

2.5.2 Ensure adherence to inclusion–exclusion criteria. The FTC operations team found that maximizing the conditions necessary for a successful outcome in FTC involved fidelity to the inclusion and exclusion criteria. Early in the implementation the focus was growing the program and the inclusion criteria was viewed broadly in determining admissions. Through participant drop outs, the team recognized that a broad net was not conducive to successful graduation rates for participants. While research suggests equal outcomes for participants in FTC regardless of drug of choice (Cheesman et al., 2016), other predictors are associated with more favorable outcomes. Some factors associated with positive outcomes in FTC are high-risk individuals with a moderate or severe substance use disorder, less than a high school

education, co-occurring mental health issues, inadequate housing, a criminal history, and domestic violence. Individuals with these characteristics were more likely to complete FTC (Marlowe & Carey, 2012). The FTC operations team developed written inclusion and exclusion criteria to guide a review of every potential referral to FTC. Examples of exclusion criteria include individuals who are acutely suicidal, homicidal, or those individuals who do not have a substance use disorder. While it may be tempting to enroll a client with high needs who may benefit from the program, FTC has learned that adherence to the inclusion criteria supports improved outcomes. In addition, fewer dropouts of the program occur when there is adherence to the inclusion and exclusion criteria. Other communities considering implementing an FTC may benefit from establishing and adhering to the inclusion and exclusion criteria anchored in the literature (Marlowe & Carey, 2012) to increase the likelihood of successful outcomes for participants.

2.5.3 Tailor treatment needs. In the beginning of the program, the team developed a structured treatment manual for every participant. While structure was helpful to mold a treatment approach, flexibility and tailoring the needs of each participant was necessary to support participant outcomes. A rigid approach to treatment did not support participant engagement in the treatment process and implicitly sent an adversarial rather than therapeutic message. Treatment interventions need to address each individual's specific triggers and consequences for use to assist the participants in replacing their drug use with pro-social behavior (Meyers & Godley, 2001). A one-size-fits-all approach does not work for all FTC participants. While all participants share the commonality of involvement in the child welfare system, each individual and family system is unique. Additionally, the antecedents and consequences of an FTC participant's substance use differ across participants. Some families may require an emphasis on parenting skills, while other families may require a focus on job-finding skills. The FTC operations team developed a process for early identification and assessment to address the unique needs of parents and children to develop an individualized plan of care (Lloyd, 2015). Other localities considering the development of an FTC may benefit from developing a treatment plan of care that is uniquely matched to each participant's needs and goals.

2.5.4 Consistent application of rewards and sanctions. FTC participants attend court together as a group and see their peers receive sanctions and rewards as the judge takes turns reviewing each participant’s progress. The participants noticed when sanctions and rewards were not applied consistently. This led to perceptions of favoritism among the team. Therefore, the team took a purposeful approach to apply consistent rewards and sanctions to participants. The FTC multidisciplinary team applies the drug court best practice of implementing rewards and sanctions to FTC participants (Marlowe & Carey, 2012). Some examples of rewards are gift cards, commemorative coins, and praise from the judge. Limited jail time and community service hours may be used as sanctions for problematic behavior. The FTC participants may view the program as not fair and just if they see sanctions are applied at will rather than through a systematic process. This potential discord may undermine the group cohesion that forms during the FTC phased treatment process. Participants in the latter stages of the program are often mentors or supports for those participants in earlier stages. Ensuring consistency for rewards and sanctions supports a cohesive team-building process and is consistent with the FTC tenet of procedural justice (Fessinger et al., 2020; Heideman et al., 2016). Other networks considering developing an FTC may benefit from ensuring that their protocols for implementing sanctions and rewards are consistent across all FTC participants.

2.5.5 Support group for participants. Early in the FTC program, participants were not offered a support group as part of the overall array of FTC programming. The team felt that it was important for participants to have an avenue where they could connect with their peers in a safe and confidential manner. A factor identified as the best predictor for successful FTC outcomes was parent participation in support group meetings (Child & McIntyre, 2015). Following the pilot in 2018 and subsequent expansion in 2020 through federal funding, the community behavioral health agency developed an FTC support group for participants and their significant others. The group was facilitated by treatment staff, with peer recovery specialists providing support and transportation. In addition, childcare was provided to the children of the participants. The purpose of the group was twofold. First, the group offered a safe space for participants to voice feedback and share their own experiences in the FTC program. Second, the group did not include social services or judicial staff. This allowed participants to feel comfortable sharing their feedback and developing healthy relationships with other FTC participants. Participants enjoyed having a venue where they could spend time with their peers and develop healthy connections. Other organizations considering developing an FTC may benefit from including a support group for FTC participants to foster mentorships, peer support, and a pro-recovery environment.

2.5.6 Offer a continuum of recovery supports. Because many FTC participants had transportation barriers there were challenges with attendance at appointments provided at different locations in the locality (e.g., treatment sessions, support meetings, psychiatric appointments). Pederson et al. (2016) found that the treatment preference of homeless young adults includes a 'one-stop shop' of service offerings where they can access mental health, substance use, and medical services. In line with the research, FTC participants have stated a preference for this 'one-stop-shop' approach to treatment and recovery supports. Medication-assisted treatment, peer recovery support, medication management, case management, intensive outpatient programs, and outpatient counseling are all a part of the continuum of treatment and recovery supports available to FTC participants. Initially, the FTC program used several providers to deliver the abovementioned services. However, transportation served to be a challenge in the rural county, with many participants required to travel up to several hours a week to attend appointments at multiple locations. As a result, the main service provider expanded services to include medication-assisted treatment, peer recovery, medication management, case management, intensive outpatient programs, and outpatient counseling in one centralized location. Other organizations considering implementing an FTC may benefit from offering a variety of recovery-oriented supports and services to decrease potential participant stress from using multiple providers at different locations.

3.0 Conclusion

This case study outlined the development and implementation of an FTC that began out of a need to address the significant increase in child welfare cases driven by parental substance use and poor treatment outcomes. The cross-sector network identified FTC as an evidence-based model to improve family wellness and functioning through action research. The network followed the FTC best practice literature to develop protocols, including rewards and sanctions and therapeutic jurisprudence, and supported program sustainability through obtaining federal funding. Several key lessons to support the sustainability of FTC included a support group for participants, flexibility to revise staffing patterns driven by client needs

(e.g., the addition of a Peer Recovery Specialist), and provision of an array of recovery support options for FTC participants.

A limitation of this case study is its generalizability, as other communities and collaborative networks may have different facilitators and barriers toward the development and implementation of an FTC (e.g., poor collaboration among organizations, lack of consensus toward community goals). However, overall, other agencies and networks considering implementing an FTC may learn from this community network's strategies and collaborative framework to address parental substance use and child welfare cases.

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