

PREDICTORS OF SUCCESSFUL COMPLETION OF FAMILY TREATMENT DRUG
COURT PROGRAMS: AN ARCHIVAL INVESTIGATION

By

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To my Mom and Dad, with love

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Abstract of Dissertation Presented to the Graduate School
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Substance abuse greatly impact our nation's children and the child welfare and protective service systems as many parents who abuse substances neglect or abuse their children as a result of their addiction. Family Treatment Drug Courts (FTDC) were developed to provide support for individuals in accessing and engaging in treatment. However, little is known about the factors associated with positive treatment outcomes from FTDC programs. This study examined six possible factors associated with successful completion of a FTDC program: (1) drug of choice, (2) frequency of drug use (3) prior treatment history, (4) criminal status, (5) social support, and (6) prior Child Protective Service involvement.

By means of an archival analysis of data from existing client records, a sample of 186 FTDC participants was developed. The total study consisted of 88.1% females and 11.9% males. Age was found to significantly differentiate successful from unsuccessful completers as the majority of participants who successfully completed treatment were either thirty-seven years of age or older or between 31-36 years old. The racial/ethnic composition of the study sample was, for the most part, either African-American (N=88, 47.6%) or Caucasian (N=92, 49.7%).

Results of the hierarchical logistic regression analyses revealed that drug of choice, extent of prior treatment, and source of social support were significant predictors of successful treatment outcome. Unsuccessful completers were significantly more likely than successful completers to identify marijuana as their drug of choice and unsuccessful completers were significantly more likely than successful completers to report no prior treatment history. In addition, successful completers reported that they received social support from friends/family/spouse/partner significantly more than did unsuccessful completers.

Based on our findings more research is needed that examines characteristics associated with successful completion of FTDC programs. In addition, research focused on perceptions of the effectiveness of treatment components is needed and the role of motivation on successful completion. Recommendations were also made regarding the need for further research examining gender differences in referral to FTDC programs, influence of co-occurring disorders on successful outcomes, and the impact of FTDC programs on future involvement of participants in the child welfare system.

CHAPTER 1 INTRODUCTION

Alcohol and drug abuse is a pervasive problem in today's society affecting individuals, families, and communities. Research, both past and present, have explored both the advantages and disadvantages of traditional substance abuse treatment programs to improve treatment effectiveness and lower the prevalence of addiction. There is now an abundance of literature assessing the effectiveness of voluntary treatment programs, yet few studies have examined the impact of court-ordered treatment programs such as drug courts (Rempel, 2001). It was once believed that treatment participants admitted voluntarily were more motivated, and thus more likely to have better treatment outcomes than coerced or court-mandated participants (Belenko, 2002). However, there is now some evidence that court-mandated participants are just as likely to have favorable outcomes (Belenko, 2002).

Substance abuse literature has consistently shown that the longer a participant spends in treatment the greater their chances for a favorable treatment outcome (Peters & Murrin, 1998, Lawental et al, 1996, Trone & Young, 1996) with some indicating ninety days of treatment as the minimum for successful treatment outcomes (Brown, 1997; Hubbard et al. 1989). Drug courts have been found to increase retention rates and reduce substance abuse compared with other treatment programs (Peters, Haas, & Murrin, 1999). However, there are varying rates of successful completion among program participants which may be due to differences in participants' characteristics. Drug court participants often vary in criminal status, drug use history, and involvement with social service agencies. An examination of these variables may help determine which clients are more likely not to successfully complete treatment and which can be therapeutically engaged to the point of successful completion. It is unlikely that all program participants will have successful outcomes using the same treatment model or program

design. As Rempel noted: “with the recent explosion of drug courts, it is important for research to identify key characteristics associated with retention among court-mandated populations and to develop effective policies to assist those facing a high risk of drop out” (Rempel, 2001, p. 89). This study will explore the retention rates of participants in a Family Treatment Drug Court program to determine which client characteristics affect retention rates and at what point do clients drop out of treatment. Identification of these factors could facilitate participant retention through the improvement of program structure and design. Participants with characteristics which have been identified as contributing factors to dropping out of treatment could be offered treatment services unique to their needs at the onset of treatment to increase participant retention.

Scope of the Problem

Family Treatment Drug Courts (FTDCs) have undergone limited empirical scrutiny in the substance abuse treatment literature. As of April 2006, there were 183 Family Treatment Drug Courts (FTDC) operating in 43 states in the United States and over 100 programs in development. One of the primary goals of Family Treatment Drug Courts is to support families to access, remain in, and successfully complete substance abuse treatment services. Derived from Adult Drug Courts, which are designed to stop the abuse of alcohol and other drugs and related criminal activity, FTDC participants are involved with substance abuse treatment services due to non-criminal issues related to child maltreatment. However, “unlike Adult Drug Courts, successful treatment does not necessarily guarantee ultimate success in the FTDC context, and the relationship between participants’ engagement in treatment and other services, treatment success, and family reunification remains an important unanswered question” (Worcel, Green, Furrer, Burrus, & Finigan, 2007, p. 18).

In a national evaluation of Family Treatment Drug Courts (FTDCs) conducted by Northwest Professional Consortium, Inc. (NPC) and funded by the Department of Health and

Human Services' Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment, researchers examined whether court, child welfare, and treatment outcomes differed for families served through FTDCs as compared to families who received traditional child welfare services. Designed to answer the question whether drug courts worked, and how and for whom they worked, the study focused on four FTDCs located in California (San Diego and Santa Clara Counties), Nevada (Washoe County), and New York (Suffolk County) chosen due to estimates of adequate sample size and availability of data. The study included the collection of administrative data from court, child welfare, and treatment data sources on a total of 802 FTDC and 1,167 comparison cases.

The researchers examined differences between drug court cases and comparison cases in child welfare outcomes (such as family reunification and length of time to reunification) as well as in treatment outcomes (such as time spent in treatment and treatment completion) to answer whether drug courts worked (Worcel, et al., 2007). They also looked at participant psychosocial characteristics, their drug court experiences, and how both related to outcomes for participants (Worcel, et. al., 2007). Results from this study show evidence of the effectiveness of the FTDC program model on treatment and child welfare outcomes associated with statistically and practically significant results, with 55%-60% increases in the length of stay in treatment services for participants, 40%-54% increases in the rates of treatment completion for participants, 14-36% reductions in the number of days spent in out-of-home placements for children of participants, and 42%-50% increases in the percentage of children reunified with their parents (Worcel, et. al., 2007). To confirm these results that FTDCs are effective with substance abusing clients, more research is needed. More specifically, research examining the factors that influence drug

treatment court success can improve the design and treatment programs and subsequent client outcomes (Butzin, Saum, & Scarpitti, 2002 p. 1616).

Copeland & Wayne (1992), examined predictors of treatment drop-out for female substance abuse clients. Using a retrospective design, they looked at the characteristics of 160 women who left treatment less than five days after their admission and compared them with 160 women who remained in treatment longer than five days to answer two questions: “In what ways do women who drop-out of treatment differ in terms of socio-demographic characteristics, sexual orientation, and the number of dependent children?” and “ Do the groups differ in terms of drug use , treatment history and psycho-social issues such as a history of sexual abuse?” (Copeland & Wayne, 2001, p. 884). None of the participants were under legal sanction to participate in treatment. The researchers found that women less than 25 years of age were significantly more likely to drop out of treatment than were women older than 25 years of age; married women were more likely to drop out of treatment than to complete; women who were employed were five times as likely to complete than to drop-out of treatment; women who reported heroin, amphetamines and tranquilizers as their drug of choice were more likely to drop-out than users of alcohol and/or other drugs; women who were in their first substance dependence treatment were more than twice as likely to complete than drop-out; and that women with a history of participating in a extensive number of hours of (80+) support groups (AA/NA) prior to treatment admission were more likely to complete than drop-out of treatment (Copeland & Wayne, 1992).

According to the 2005 National Survey on Drug Use and Health, an estimated 22.2 million persons aged 12 or older were classified with substance dependence or abuse with only 3.9 million (1.6 percent of the population) receiving some form of treatment. More troubling is the

fact that Americans make up 4 percent of the world's population, yet, consume 65 percent of the world's illegal drugs (Gahlinger, 2004). In addition, one in four Americans will have an alcohol or drug disorder at some point in their lifetime (OAS, SAMHSA, 2005). Billions of dollars have been spent combating the problem of addiction; however, despite the costs, services are relatively scarce and often ineffective (Califano, 2007). According to the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) only 17 percent of those in need of treatment receive it (OAS, SAMHSA, 2002). Furthermore, available treatment programs have low success rates as few individuals are able to break free of their addiction to alcohol and drugs on the first treatment attempt (Califano, 2007).

The devastating impact of substance abuse and addiction is greatly exemplified in our nation's child welfare and protective service systems. Many parents who abuse substances neglect or abuse their children as a result of their addiction. Thus it is common for clients in substance abuse treatment to have some involvement with child protective systems (Howard, 2004). In a survey by the National Center on Child Abuse Prevention Research, 85% of states reported substance abuse as one of the two major problems exhibited by families in which maltreatment of a child or children was suspected (Child Welfare League of America, 2007).

About three million cases of child abuse are reported each year in the United States, and three out of four involve alcohol-and drug-abusing parents (Child Welfare Information Gateway. Retrieved September 26, 2007). Approximately 45 States, the District of Columbia, and Guam currently have laws within their child protection statutes that address the issue of substance abuse by parents. Two main areas of concern are (1) the harm caused by prenatal drug exposure and (2) the harm caused to children of any age by exposure to illegal drug activity in the home (Child Welfare Information Gateway. Retrieved August 5, 2007). Furthermore, the U.S. Department of

Health and Human Services estimates that over 900,000 children were victims of parental neglect or abuse (DHHS, 2004) and that parental substance abuse is a significant contributor to child maltreatment in between 40-75% of all child welfare cases (Magura & Laudet, 1996; National Center on Addiction and Substance Abuse, 1999). Moreover, children whose parents abuse substances stay in foster care longer and have the lowest probability of successfully reunifying with their parents (Green, Rockhill, & Furrer, 2006; Gregoire & Shultz, 2001).

The increase of child welfare cases, resulting from substance abusing and addicted parents, has greatly overwhelmed protective service systems. There are nearly 250,000 child advocates, caseworkers, and judges employed in our nation's one thousand state, local, and private child welfare agencies and twelve hundred family courts (Califano, 2007). The workers are charged with the duty of dealing with substance abuse in the child welfare system. However, the majority of child welfare systems lack effective substance abuse screening and assessment tools, child welfare workers/caseworkers and judges trained in substance abuse, access to appropriate treatment and ancillary services, or adoption/foster care agencies with the capacity to help children of substance abusing parents (CASA, 1999). On September 30, 2003, nearly half a million children lived apart from their families in out-of-home care, (Child Welfare League of America, 2006) due to investigations of abuse and neglect.

Professionals involved with the child welfare system often find themselves inundated with the multitude of child abuse and neglect cases plaguing the protective service systems. Some family court judges hear as many as fifty cases in a single day, for which they must assess the circumstances and credibility of the child, parent(s), caseworker, law enforcement officer, and any other witnesses in approximately ten minutes (Califano, 2007). Social workers and caseworkers may also find that they are limited in the services they are to provide to families;

such as in-home services (Sedlak & Broadhurst, 1996). This may result in a smaller proportion of families receiving important services needed for family stability. In addition, some child welfare professionals are only able to investigate a third of their cases (Sedlak & Broadhurst, 1996).

A 2003 General Accounting Office (GAO) report documented that staff shortages, high caseloads, high worker turnover and low salaries impinge on the delivery of services to achieve safety, permanence, and well-being for children (Child Welfare League of America, 2007). These child welfare/ foster care workers have caseloads of 24-31 clients, when the CWLA recommends that a child protective services caseworker responsible for the initial assessment/investigation have no more than 12 active cases per month and that a foster care caseworker have a caseload of 12-15 children per month (Child Welfare League of America, 2007).

The taxing effect of substance abuse and addiction on the child welfare system has resulted in countless incidences nationwide of failure of child protective services to adequately and appropriately secure the safety of children. One such case occurring in the State of Florida involved a child, Rilya Wilson. Born September 26, 1996 to a homeless, allegedly crack-addicted mother, Rilya Wilson became a ward of the State of Florida soon after her birth, at her mother's insistence and with a court order of placement. The Department of Children & Families awarded custody of Rilya to a family friend of the mother but in April 2000, a Miami-Dade juvenile judge awarded custody of Rilya to her great aunt and grandmother. Both caregivers later reported that in January 2001 a woman from DCF took Rilya from their home for testing and that they had not seen her since that time. A criminal investigation into her disappearance, uncovered negligence on the part of DCF who had not checked on Rilya in months. In fact, Rilya had been

missing 15 months and DCF waited six days following this discovery to file a report with the local police department.

Incidences such as this prompted the Florida Legislature to mandate that the child welfare system undergo reorganization and move towards community-based care. Instead of DCF running the system statewide, under community-based care, the system within each DCF district is locally run by institutions within the community. This has led to more collaboration among community agencies and has fostered a team-like working relationship between child protective services and substance abuse treatment agencies. Operation at this level also assists in improved coordination of service delivery to parents and children.

The interconnectedness of substance abuse and child abuse/neglect requires that systems collaborate to take on the bewildering problem of addiction. However, there are challenges to such collaborations stemming from the varying perspectives of agencies and agency personnel (SAMSHA, 2004). The substance abuse treatment community often views the alcohol and drug abuse of parents, who abuse or neglect their children, as having a progressive, incurable disease that can be treated (SAMSHA, 2004). However, Child Protective Service workers, much like society as a whole, perceive these parents as having made irresponsible choices resulting in the endangerment of their children (SAMHSA, 2004). Further complicating interagency collaboration, is the difference in the client served. Child Protective Service agencies seek to ensure the safety of the child (ren), while substance abuse treatment workers focus on treating the addicted parent (SAMSHA, 2004).

In addition, the staff of each agency operates within particular constraints. Staff in Child Protective Service agencies have defined time lines (usually 18 months) in which they must work in order to prevent children from remaining in out of home placements for long periods of time

(SAMHSA, 2004). This often does not coincide with the treatment expectations of substance abuse agencies who view recovery as a long term process, involving multiple relapses on the part of the parent (McLellan, Lewis, O'Brien, & Kleber, 2000). Furthermore, just as Child Protective Service workers find themselves burdened by burgeoning caseloads so too do most substance abuse treatment programs who have waiting lists for parents being referred for treatment services (SAMSHA, 2004).

Statement of the Problem

Substance abusing parents may be greatly hindered in their ability to provide safe and nurturing homes for their children (US Department of Health and Human Services, 1999); and increased stressors such as loss of employment, poverty, and/or illness only serve to exacerbate the problem. Substance abusers are more likely to change jobs regularly, to be unemployed for long periods of time, and to suffer injuries on the job (Cook & Schlenger, 2004; Alleyne, Stuart, & Copes, 1991). This increases the financial strain of the family which may in turn result in further drug and alcohol abuse.

Most child welfare cases involve the mother and treatment for these women goes beyond substance abuse treatment (Califano, 2007). Many of these women need mental health care, employment, and parenting training (Behnke, Eyler, Woods, Wobie, & Conlon, 1997) and these services are often unavailable when the mother is amenable to participating in treatment and accepting services (Califano, 2007). Approximately 67% of parents with children in the child welfare system require substance abuse treatment, yet child welfare agencies are able to provide treatment to only 31% of these parents (Child Welfare League of America, 2006).

Studies show that the majority of children affected by parental substance abuse remain in the custody of their parents (Feig, 1998). However, there has been a growing movement to remove more children from their biological parents (Califano, 2007) due to the severity of their

addiction and underutilization of treatment services. This has prompted CPS agencies to work harder in connecting parents with substance abuse treatment providers with the realization that 75% percent of the mothers who received comprehensive substance abuse treatment had physical custody of one or more children six months after discharge from treatment, compared with only 54% of mothers who had custody of any of their children shortly before entering treatment. (Child Welfare League of America, 2006). Furthermore, children whose families do not receive appropriate treatment for alcohol and other drug abuse are more likely to end up in foster care, remain in foster care longer, and reenter foster care once they have returned home, than are children whose families do receive treatment (Child Welfare League of America, 2006).

This phenomenon, (parents without custody of their child(ren) has resulted in legislation to expedite adoption laws and requirements. As a result, many have courts established more rigid time lines for family reunification. Family Treatment Drug Courts (FTDCs) were developed to answer the call of these initiatives. Modeled after Adult Drug Courts, which arose from the need to combat the problem of jail/prison overcrowding due to arrests of individuals with substance abuse problems, FTDCs were designed to provide alcohol and drug treatment; wrap-around services supporting substance abuse treatment, assessment, case management; and program coordination to assist substance abusing parents in reunifying with their child (ren) in a timely fashion. The passage of the 1997 Adoption and Safe Families Act expanded the role of family courts by: (1) establishing a judicial role in decisions about whether and what reunification services are required, (2) requiring earlier and more comprehensive permanency hearings than previously required (these hearings must be held within 12 months of initial placement, instead of the prior 18-month requirement), (3) setting deadlines for filing

termination of parental rights petitions, and (4) establishing rights of foster and adoptive parents to receive notice of, and appear in, juvenile and family court proceedings (Hardin, 1998).

Substance abuse treatment programs have developed various programs over the years to combat the problem of addiction in society. And although formal treatment programs share multiple commonalities in regards to treatment modalities and approaches, treatment by no means is homogeneous. Individuals participate in similar formal treatment programs may still have different outcomes. This recognition has resulted in the establishment of alternative treatment programs, such as Family Treatment Drug Courts, to address the growing problem of addiction.

Need for the Study

A major health concern in treating all substance abuse clients is the high rate of recidivism with relapse rates ranging from 25% to 50% of those admitted for treatment (Hartwell, 1998). Because Family Treatment Drug Courts are a relatively new initiative, there has not been a sufficient period of time to document their results. Studies have consistently examined and documented the relationship between retention and effectiveness of drug treatment (Rapp, Sigel, Li, Saha, 1998; Deleon, Melnick, Kressel, 1997; Erickson, Stevens, McKnight, & Figueredo, 1995) and have found that longer treatment duration may result in more favorable recovery outcomes following treatment completion. However, unsuccessful completion from treatment programs have become more the rule than the exception in most drug treatment programs (Califano, 2007) indicating that the majority of individuals admitted to treatment programs, such as FTDCs, do not remain in treatment for a sufficient period of time to receive maximum benefit.

It is essential to determine which client factors may contribute to successful versus unsuccessful completion from Family Treatment Drug Courts. Such information could be used to alter program design and enhance the overall impact of these programs. This information

could also be helpful in deciding on admission criteria for participation in FTDCs. Participants identified at entry to have characteristics that place them at risk for unsuccessful completion may need to receive a different level of care or receive additional services at the onset of treatment admission to decrease their risk of unsuccessful completion. This information could also be useful in designing program structure for each stage of treatment so that they are more conducive to the individual needs to the participant.

Purpose of the Study

Substance abuse treatment providers are increasingly held accountable for demonstrating specific outcomes. Programs must be prepared to demonstrate their effectiveness using objectively verifiable outcome measures (SAMHSA, 2004). Data analyzing the effectiveness of such programs will provide a valuable opportunity to streamline programs and improve services. If treatment providers are able to pinpoint at admission which program participants are susceptible to unsuccessful discharge, as well as when during the course of their treatment they are most susceptible, providers may be able to redesign participants' treatment, the nature of their services and improve outcomes.

The relationship between certain demographic and person-centered variables of Family Treatment Drug Court participants and successful program completion is under examination. The study seeks to discern which client characteristics may result in unsuccessful completion and at what stage of the participant's treatment. This study will examine the retention rate of participants and collect demographic information (i.e., age, gender, race, and education) to determine if there are differences in participant retention rates over the course of participation in the FTDC program. More specifically, the study will examine the relationship among participant retention in treatment and their reported drug of choice, frequency of use, criminal status at admission, social support, and prior Child Protective Services (CPS) involvement. In addition,

relationships among number of positive drug screens or relapses of the FTDC participants and their continued involvement in treatment will also be examined.

Theoretical Framework

The theoretical framework for this study is informed by the Transtheoretical model developed by Prochaska and DiClemente (1992). Knowledge of the substance abusing person's motivational state and the factors leading to it can help guide the development of more effective interventions. Motivation and readiness are viewed by clinicians as critical factors in understanding why substance abusers seek or stay in recovery oriented treatment.

A challenge for many individuals dealing with alcohol and drug abuse is the inconsistency that often exists within them regarding their readiness to change. Individuals may continue to abuse alcohol and drugs despite experiencing negative consequences (i.e., jail, unemployment, illness). Researchers have found that this inconsistency is natural and should be expected, as formal substance abuse treatment programs stress that relapse is part of the recovery process.

Miller and Rollnick (2002) found that substance abusers often recognize the risks, costs, and harm involved in their behavior. However, these individuals are often in a state of ambivalence regarding the need to change. According to the authors, this state of ambivalence is a natural phase of the change process. But, the problem may persist and intensify if individuals become stuck in ambivalence (Miller & Rollnick, 2002). For example, while regaining custody of one's child is a powerful incentive for many parents, those addicted to drugs like crack cocaine, methamphetamine, and alcohol may often be more driven to get high or drink than to recover their children (Califano, 2007).

The Transtheoretical theory portrays the sequence of changes individuals progress through as they initiate and maintain behavior change. They derived 10 distinct processes individuals experience while recovering from alcohol and drug abuse that occur within five stages.

According to the model, as individuals replace high-risk behaviors, such as substance abuse, with healthier alternatives they move through five “stages of change”: precontemplation, contemplation, preparation, action, and maintenance (Abellas & McLellan, 1993). The first stage, *precontemplation*, is the state of unawareness of the problem or a need to change (Miller & Rollnick, 1991). Individuals who present in this stage have no intention to change the behavior. As awareness of the problem increases, the individual enters a state of ambivalence or *contemplation*, in which the individual begins to assess the problem behavior (Miller & Rollnick, 1991). The individual begins to consider change but has not made a firm commitment. As they begin to weigh the pros and cons of the behavior, the individual begins to see the necessity of change and enters the *preparation* stage of change. Following this transition, the individual moves into an *action* stage in which efforts are made to change the behavior. If these efforts are successful, the individual moves into the *maintenance* stage which involves relapse prevention (Marlatt & Gordon, 1985).

An individual’s motivation to make change and participate in substance abuse treatment may influence the probability of them remaining in treatment for a long enough period of time to benefit from exposure to the therapeutic process (Gossop, Stewart, & Marsden 2007) and increase the likelihood of positive treatment outcomes. The Transtheoretical model, in clinical settings, emphasizes the need for different types of treatment and suggests that different interventions are required at the varying stages of change (Miller & Rollnick, 1991) to promote continued participation and treatment compliance. Treatment compliance can be described as following the instructions and requirements of the treatment, such as; attending a certain amount of treatment sessions, abstinence from drugs/alcohol, submission to urine screens, and attendance of support groups (Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous)

(Diclemente & Scott, 1997). These are all observable and measurable events used to determine if the individual has been exposed to the appropriate “dose” of treatment believed to be necessary for change (Diclemente & Scott, 1997). Dose of treatment has been associated with compliance as researchers have found that retention and completion of treatment yields better outcomes (Stark, 1992; Anglin & Hser, 1992).

Strategies and interventions used to promote change differ significantly across the stages (Diclemente & Scott, 1997). Therefore, it is important to match the treatment with the individual’s stage of change. “Stage-based matching of interventions offers a dynamic, process-oriented approach for developing appropriate treatment expectations and shared mutual goals on the part of the therapist and the client” ((Diclemente & Scott, p. 146). “The ideal is sequencing and shifting treatment goals as the client progresses through the process of change” (Diclemente & Scott, p. 147). The Family Treatment Drug Court under study has used the Transtheoretical model and treatment matching in the design and structure of their program. The program is structured into four distinct phases of interventions designed to mirror the type of intervention required for each stage of change of the model.

For example, individuals coming into substance abuse treatment are often in early stages of the Transtheoretical model, a time associated with high dropout rates in treatment programs (particularly outpatient) (Wickizer, Maynard, Atherly, Frederick, Koepsell, Krupski, & Start, 1994; Emrick, Tonigan, Montgomery, & Little, 1993). It is in the stage of *pre-contemplation* that individuals show marked unawareness of a problem and one is exposed to concepts, such as denial. As a result, interventions in early stages of the change process must address the lack of motivation for change, ambivalence about change, and lack of a clear problem focus (Diclemente & Scott, 1997). Conscious-raising interventions, such as confrontations, observations, and

interpretations, have been found to assist individuals in gaining awareness of their problem and from moving from *pre-contemplation* to *contemplation* (Norcross & Goldfried, 2005).

Phase I of the Family Treatment Drug Court requires participants to report to court weekly and attend treatment sessions four days a week (3 hour sessions) where they participate in more educational groups, such as the Disease Model of Addiction and pharmacology. This is intended to move the participant out of a state of unawareness of their substance abuse problem and into *contemplation*. Participants are also required to attend a minimum of 2 support group meetings each week, such as AA (Alcoholics Anonymous) and/or NA (Narcotics Anonymous) to continue to increase their exposure to the therapeutic process of treatment, increase observation of others suffering from the disease of addiction, and foster retention. As participants begin to make the shift to awareness they are required to obtain and begin work with an AA or NA sponsor, the final requirement of Phase I.

Participants in Phase II of the program have reached *preparation*, via their acknowledgement and acceptance of their need to change. “Movement from *pre-contemplation* to *contemplation*, and movement through the *contemplation* stage, involves increased use of cognitive, affective, and evaluative processes of change (Norcross & Goldfried, pg. 150). Participants at this stage are perceived as having more motivation and readiness for behavior change. As a result, interventions become more self-evaluative. An intervention used at this Phase of the program includes writing one’s autobiography which includes milestones, life events, and patterns of drug use. Participants are asked to reflect on their history and process patterns of thinking, feeling, and behaving. Participants moving through *contemplation*, in to Phase II of the Family Treatment Drug Court program, have also attained a required period of abstinence (60 days minimum) and are monitored less frequently. Participants are required to

report to court bi-weekly and treatment session attendance decreases to three days a week. Participants continue to attend educational groups but also begin more therapy groups. In addition, participants are encouraged to develop sober support systems outside of treatment which requires them to continue work with their sponsor and increase support group meeting attendance to 3 meetings each week.

“*Preparation* indicates a readiness to change in the near future and acquisition of valuable lessons from past change attempts and failures” (Norcross & Goldfried, pg. 150). It is important at this point for individuals to begin to set goals and an “action plan” for the future (cite). Interventions, at this stage in the Family Treatment Drug Court involve relapse prevention planning and are designed to assist participants with self-regulation to continue behavior change. Participants attend groups on relapse prevention and are required to develop their own relapse prevention plan. Prevention planning will continue throughout the duration of their participation in the program.

As participants continue to make change, reaching *action*, they are moved to Phase III of the program. “During the *action* stage, it is important that clients act from a sense of self-liberation” (Norcross & Goldfried, pg. 150). Participants are assisted in developing the belief that they have the “autonomy” to change and in fostering a sense of self-efficacy (Norcross & Goldfried, 2005). Monitoring of participants decreases further to attending treatment to two days a week, while support group attendance increases to four days a week. Participants continue to cognitive, affective, and behavioral capacity to cope with external circumstances which may contribute to their substance abuse. Participants work more closely with their sponsor, continue to meet case plan tasks of the CPS agency, and take part in interventions which involve training in behavioral processes. Participants typically continue in *action* through Phase IV of the

program to *maintenance* where relapse prevention interventions are intensified. Participants in Phase IV attend treatment sessions once a week, continue to work with their sponsor, and attend support group meetings 5 times a week.

“Relapse and recycling are an integral part of the process of change” (Diclemente & Scott, p. 147), therefore, participants may move through the stages in a cyclical pattern throughout their participation in treatment. It is not uncommon for Family Treatment Drug Court participants to move back to previous phases of the program as relapses and/or treatment non-compliance occurs. Some participants may repeat a phase of the program multiple times and for a longer duration than others. Furthermore, participants who struggled (i.e. multiple relapses) in early phases of the program may be recommended to remain in Phase IV of the program for a longer period of time to assess their ability to maintain their current stage of change before they are successfully discharged from the program. Due to the evolving nature of “stage of change”, patterns of regression will not be under examination. The participant’s phase of treatment at the time of program discharge will be included in the data for the study.

Hypotheses

By means of an archival analysis of the clinical records of participants of a Family Treatment Drug Court program this study will examine variables related to successful completion from treatment. These variables are (1) participant’s drug of choice, (2) participants frequency of drug use (3) participant’s prior treatment history, (4) participant’s criminal status, (5) participant’s social support, (6) participant’s prior Child Protective Service involvement, and (7) successful completion rate.

The following (seven) hypotheses will be tested in this study:

Ho1: There is no contribution to the prediction of successful completion of Dependency Drug Court of participant’s drug of choice, frequency of drug use, treatment history, criminal status, sources of social support, and involvement with Child Protective Services.

Ho2: There is no relationship between successful completion of Dependency Drug Court and participant's drug of choice.

Ho3: There is no relationship between successful completion of Dependency Drug Court and participant's frequency of drug use.

Ho4: There is no relationship between successful completion of Dependency Drug Court and participant's treatment history prior to program admission.

Ho5: There is no relationship between successful completion of Dependency Drug Court and criminal status of the participant at time of program admission.

Ho6: There is no relationship between successful completion of Dependency Drug Court and sources of social support among participants at time of program admission.

Ho7: There is no relationship between successful completion of Dependency Drug Court and participant's prior involvement with Child Protective Services.

Definition of Terms

- **Arraignment.** At this hearing, the parent or legal custodian admits, denies, or consents to the findings alleged in the dependency petition. If the parent admits or consents, a disposition hearing must be held within fifteen (15) days of the arraignment. If the parent or legal custodian denies the allegation, then a disposition hearing must occur within thirty (30) days of the arraignment.
- **Case plan.** A case plan is a written document that explains the reasons why the child is considered in need of protection, the goal of the ongoing intervention, and the outcomes and actions required to achieve the goal. The plan will detail: (1) the steps the client must take and the terms and conditions he/she must meet to retain or regain custody of the child (ren), (2) a timetable for accomplishment of each step, term, and condition, and (3) a list of resources the CPS agency will make available to the parent.
- **Child protective investigator.** Receives, screens, evaluates, and investigates referrals/complaints relative to alleged child abuse and/or neglect and alleged institutional

abuse and/or neglect; to take the necessary measures to ensure the protection of children; and to do related work as required.

- **Child protective service involvement.** The number of prior open child protective service cases prior to entry into the drug court program.
- **Criminal status.** The individuals self-report of current and previous involvement with the criminal justice system, such as no history of criminal involvement, not under legal supervision but at least one previous criminal charge, and currently under legal supervision.
- **Disposition order.** Dispositional orders may vary. A child may be placed in foster care until completion of the first permanency hearing which will be stated in the dispositional order. Some dispositional orders may place the child in foster care granting the agency authority to parole or discharge the child to the parent at some later point and in some cases a dispositional order may release a child to a parent. For noncompliant respondents, dispositional orders will likely place the children in foster care.
- **Drug court.** A process by which substance abusers entering the court system are placed into treatment and proactively monitored by the judge and a team of justice-system professionals; it employs effective drug testing and graduated sanctions and incentives.
- **Drug of choice.** Self reported drug most preferred or most used by an individual.
- **Family treatment drug court assessment.** Evaluation designed to assist individuals in determining to what degree a client has a substance abuse problem, and what treatment, if any, would be clinically appropriate. The assessment may consist of assessment testing using nationally validated screening tools, (Substance Abuse Subtle Screening Inventory, SASSI-3, DSM-IV and the American Society of Addiction Medicine Diagnostic Criteria

for Substance Abuse and Dependence). Information in a number of areas is gathered; including family background, social history, legal history, medical history, mental health history and substance use history and patterns. The evaluation also assesses client responses and reactions.

- **Frequency of use.** The self-reported pattern of drug/alcohol use of drug court participants.
- **Pre-court staffing.** Meeting held prior to the FTDC hearing involving the Judge, CPS workers, substance abuse provider, court administrator, CWLS attorney, Guardian Ad Litem representative in which progress of the program participants is discussed.
- **Referral (packet).** A referral (packet) includes a copy of the most recent Abuse Hotline Information System Report bringing the client to the court's attention, copies of prior investigation reports, a copy of the dependency emergency shelter petition if removal of child occurred, an initial assessment completed by the assigned CPS service worker, a mediation agreement if applicable, a draft or finalized case plan, and any other legal, department, or agency information relevant to the client's treatment.
- **Reunification (permanency).** Reunification of the child with the parents which must be reached within twelve (12) months.
- **Shelter hearing.** A hearing held within 24 hours of a child's removal from their home, excluding weekends and holidays to determine placement of the child because a parent, custodian, or guardian is unavailable to take immediate custody of the child.
- **Social support.** The support an individual receives from family, friends, spouse/partner, and institutions (i.e., employment, church, support groups).

- **Substance abuse.** Long-term, pathological use of alcohol or drugs, characterized by daily intoxication, inability to reduce consumption, and impairment in social or occupational functioning; broadly, alcohol or drug addiction.
- **Successful completion.** Criteria for successful completion include: (1) remaining clean and sober, (2) fulfilling all drug testing requirements, (3) attending all required AA/NA meetings, treatment sessions, and court sessions, (4) employment or working on educational/vocational plan, and (5) completing all of the goals of the drug treatment plan.
- **Termination of parental rights.** The complete severance by court order of the legal relationship, with all its rights and responsibilities, between child and his/her parent or parents so that the child is free for adoption.
- **Treatment history.** The self-reported frequency and type of substance abuse treatment received by an individual prior to entry into the drug court program (outpatient, intensive outpatient, and/or inpatient treatment).
- **Treatment stage.** The current placement of the participant in the drug court program's stages of program completion (Phases I, II, III, and IV).

Overview of Remainder of Study

The remainder of this study consists of four chapters. Chapter 2 provides a review of related literature. Chapter 3 contains a description of the procedures for the study; including methodology and research design. The results of the study will be presented in Chapter 4. Chapter 5 will include a discussion of the results, conclusions, implications, limitations, and recommendations for further research.

CHAPTER 2 LITERATURE REVIEW

This literature review will examine the existing body of knowledge related to drug court programs, more specifically Family Treatment Drug Courts. First a brief overview of traditional substance abuse components will be provided, followed by a discussion of the development of Adult Drug Courts and Family Treatment Drug Courts. A full description of the program components of the Family Treatment Drug Court program under study will also be provided, followed by a discussion of the variables included in the study: (1) drug of choice, (2) frequency of drug use (3) prior treatment history, (4) criminal status, (5) social support, and (6) prior CPS involvement.

There are various treatment models used to address alcohol and drug abuse but the most widely emulated approach to substance abuse treatment is the Minnesota Model developed by the Hazelden Foundation, which is an abstinence-oriented, multi-professional approach based on the principles of Alcoholics Anonymous (AA). The Hazelden Foundation is a national nonprofit organization founded in 1949 that provides addiction treatment for alcohol and other forms of drug abuse.

Substance abuse treatment is administered in a variety of ways including outpatient, inpatient and detoxification settings. Drug court programs may incorporate any number of these treatment settings in the rehabilitation of its participants. Intensive outpatient programs are usually held for 3-4 days each week for 2-4 hours each day, while outpatient treatment entails less frequent contact (1-2 days a week and shorter 1-2 hours per session). Inpatient or residential programs vary in length; however, typical programs are 28 days or less. They involve 24-hour supervision, a total immersion in treatment, and are highly structured. Detoxification programs are inpatient settings in which clients are monitored by medical staff as they withdraw from

drugs and alcohol. They may or may not be provided medication to assist with withdrawal symptoms. However, the past few years have seen a major shift to outpatient detoxification, organized outpatient treatment programs (both evening and day), office care, and referral to Twelve-Step self-help treatment (Alterman, McClellan, O'Brien, August, Snider, Droba, Cornish, Hall, Raphaelson, & Schrade, 1994).

Treatment encompasses individual therapy, group therapy, family therapy, support groups (such as Alcoholics Anonymous and Narcotics Anonymous), and medication. Group therapy constitutes the most commonly applied modality for the treatment of alcoholism and other substance abuse (Golden, Khantzian, & McAuliffe, 1994). In fact, group therapy is frequently regarded as the psychotherapeutic treatment choice for addicted individuals (Matano & Yalom, 1991).

Adult Drug Courts

Circuit Court Judge Herbert Klein is credited with establishing the first drug court program in Miami's Dade County in an effort to divert nonviolent offenders to mandatory and intensive treatment programs which would address substance abuse issues (Belenko, 2002; Cooper, 2000). The necessity of this program arose in response to a growing problem with crack cocaine in the late 1980s resulting in jail overcrowding (Report on Florida Drug Courts, 2004) and in response to the high rate of recidivism among substance abuse individuals (Fulton Hora, 2002). Prior to the development of drug court, criminal courts would sentence drug offenders to jail for short periods of time in an attempt to manage the growing number of inmates. However, this alternative did little to resolve the problem of drug abuse among offenders and prevent the "revolving door" of drug abuse offenders returning to jail (Report on Florida Drug Courts, 2004).

After enlisting the help of key figures such as State Attorney General Janet Reno, Public Defender Bennett Brummer, and other community leaders, a team approach emerged to address

offender recovery aimed at "habilitation/rehabilitation" through intensive court monitoring. Drug courts offered court-supervised treatment to low-level drug offenders and first-time drug offenders as a means to reduce the number of incarcerated individuals with substance abuse disorders, while others target habitual offenders (Pearce, 1999). These specialized courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety.

This newly developed Drug Court program, following a diversion model of treatment, worked with defendants at the pre-sentence stage of the judicial process and included periodic drug testing, ongoing judicial supervision, sanctions and incentives, and close monitoring. The majority of Drug Court programs today follow this same method wherein, if defendants complete the program requirements, criminal charges against them are dismissed (Belenko, 2005). Drug courts also can be held post-sentence, wherein drug court program graduates receive reduced probation sentences or avoid incarceration (Belenko, 2005).

As of 2002, a total of 1,238 drug courts were operational or in the planning stages of development within all 50 states; including the District of Columbia, Puerto Rico, and Guam (Cooper, 2000). Tribal Courts were also developed among Native American communities and currently there are 14 states which contain Native American Tribal Courts (Cooper, 2000). Based largely on the U.S. model, drug courts have also been developed in Australia, Canada, and Great Britain and are in the planning stages in Brazil and several other countries (Turner et al., 2002).

One of the most positive aspects of drug courts is that they serve a large population of individuals who may not have had an opportunity or access to treatment services due to unique circumstances and socio-cultural experiences. One review of drug courts found, for example, that

25 percent of participants were female, 48 percent were racial minorities, 74 percent had prior felony convictions, 49 percent were unemployed at the time of arrest, 76 percent had undergone prior failed drug treatment, 20 percent had attempted suicide, and between 15 percent and 56 percent reported past sexual or physical abuse (Belenko, 2002). Drug courts provide access to an array of community treatment and support services that may not otherwise be available to their participants. A survey of drug court treatment found that the vast majority of drug courts offered participants outpatient treatment, access to Alcoholics Anonymous and Narcotics Anonymous support groups, mental health treatment, relapse prevention, educational and vocational training, and residential services (Peyton & Grossweiler, 2000).

Family Treatment Drug Courts

The success of Adult Drug Courts served as the impetus for the development of Family Treatment Drug Courts (FTDC) to address child abuse and neglect cases resulting from substance abuse by parents. FTDCs are specialized programs designed to help bring parents and their children back together. These programs are designed to serve individuals who have been charged with child neglect and in which alcohol and/or substance abuse allegations have been made. The goals are to help these participants recover from alcohol or substance abuse and to work toward reuniting parents with their children.

Research findings suggest that interventions aimed at ending substance abuse and addiction cycles, child abuse and neglect, and child maltreatment are more successful when they are family centered (Magura & Laudet, 1996). According to Margura & Laudet (1996), services which are critical for the substance abusing parent include: (1) access to physical necessities, such as food, housing, and transportation, (2) medical care, (3) counseling on substance abuse prevention, (4) training on parenting and child development, (5) social services, social support, psychological assessment, and mental health care, (6) family planning services, (7) family

therapy and health education, (8) life skills training in such areas as financial management, assertiveness training, stress management, coping skills, home management, anger management, conflict resolution, and communication skills, (9) educational and vocational assessment and counseling, and (10) planned, continuing care after program completion. Given the widespread need of services for such parents, a team approach is often essential when child protective service agencies are involved (Howard, 2004).

A *Family Treatment Drug Court* (FTDC) is defined as a drug court that deals with cases involving parental rights, in which an adult is the party litigant, which come before the court through either the criminal or civil process, and which arise out of the substance abuse of a parent and deal with custody and visitation disputes; abuse, neglect, and dependency matters; petitions to terminate parental rights; guardianship proceedings; or other laws, restriction, or limitation of parental rights (Cooper & Bartlett, 1998).

The proportion of child abuse and neglect cases involving substance abuse has grown significantly in recent years (Goodman & Harrell, 1999). FTDCs are designed to handle the needs of this population. The Family Treatment Drug Court's case management unit has the ability to quickly identify and link addicted parents charged with neglect to appropriate drug treatment programs. FTDC monitors compliance, responds to progress and/or problems through graduated sanctions/rewards, establishes cooperation and communication among agencies involved in the reunification process, assures all information is up-to-date and comprehensive and ultimately seeks to speed the entire court process, enabling the children to return more swiftly to recovered parents or achieve other permanent homes. Proponents of Family Drug Courts hope that the authority of the courts can be used to increase the effectiveness of child welfare agencies by expanding access to alcohol and drug treatment, increasing pressure on

parents to address their substance abuse problems, and coordinating the multiple social services needed to stabilize many of these families (p. 2, Goodman & Harrell, 1999).

The first FTDC began in 1994 in Reno, Nevada (U.S. Department of Justice, 2004). A 2004 publication by the National Drug Court Institute and Center for Substance Abuse Treatment chronicles the gathering of four Family Treatment Drug Courts from across the country (Kansas City, Missouri; Reno, Nevada; San Diego, California; and Suffolk County, New York) in 1999 in which practitioners discussed their implementation and experiences with FTDCs. Participants of this 2-day focus group “explored the pros and cons of various approaches to the development and operation of FTDCs, formulated a mission and overall goals for the court, and took the first steps toward devising a national strategy for advancing the FTDC concept” (U.S. Department of Justice, 2004; p. 4). At the time of this focus group there were 10 FTDCs in operation around the country, with approximately 10 more in the planning stage (U.S. department of Justice, 2004).

Participants of this focus group identified several key characteristics shared by the FTDCs; which included (U.S. Department of Justice, p.12 , 2004):

- An integrated focus on the permanency, safety, and welfare of abused and neglected children with the needs of the parents.
- Intervening early to involve parents in developmentally appropriate, comprehensive services with increased judicial supervision.
- Adoption of a holistic approach to strengthening family functioning.
- Individualized case planning based on comprehensive assessment.
- Ensuring legal rights, advocacy, and confidentiality for parents and children.
- Scheduling regular staffings and judicial court reviews.
- Implementing a system of graduated sanctions and incentives.

- Operation within the mandates the Adoption and Safe Families Act (ASFA) of 1997 and the Indian Child Welfare Act of 1979.
- Reliance on judicial leadership for both planning and implementing the court.
- Making a commitment to measuring program outcomes.
- Planning for program sustainability.
- Striving to work as a collaborative, non adversarial team supported by cross training.

Family Treatment Drug Court Process

Each state has a child protective services (CPS) system to investigate reports of child abuse, neglect, and maltreatment to determine whether the child in question is at risk. After an abuse report has been made, the CPS agency initiates a comprehensive assessment of the child's safety and well-being in the family. This assessment may include interviews with the child, the parents, and other family members; visits to the home to evaluate the environment and family dynamics; contacts with schools and other service providers who are or have been involved with the family; and testing to assess the child's health and development (Kropenske & Howard, 1994). If the CPS agency determines that the child is, or is at risk of being, neglected or abused, they may initiate family preservation services (see Figure 1.1).

Parents may go through multiple hearings while involved with CPS, and although Family Treatment Drug Court processes vary widely according to state and jurisdiction, there are generally seven different types of hearings in child welfare (Badeau, retrieved October, 7, 2007) summarized as follows:

Permanency Hearing: To determine whether the child should be placed in emergency, temporary out-of-home care.

Adjudicatory Hearing: To determine if abuse or neglect did, in fact, occur.

Dispositional Hearing: To determine where the child in foster care will live, who will have custody of the child, and what conditions will be placed on the agency and parents.

Periodic Reviews: To review progress under the child's case plan. (These reviews must occur at least every six months).

Permanency Hearing: To approve a clear, definitive permanency plan for the child. (The hearing must occur within 12 months of the child's initial placement.)

Termination of Parental Rights Hearing: To determine whether the parent(s)' rights should be terminated. With some exceptions, federal law requires states to initiate this proceeding for any child who has been in foster care for 15 of the last 22 months.

Adoption of Guardianship Hearing: To make the child legally part of another family, either through adoption or by establishing legal guardianship.

If it is determined that the child is not safe in the home, the CPS agency has the authority to remove the child and place them in an alternative living situation, such as foster care or with a relative. In 1996 few children were removed from their homes and placed in foster care, representing only 16 percent of CPS cases (U.S. Department of Health & Human Services, 1999); however, the increase of pervasiveness and severity of substances today has resulted in an increase in foster care placements. In a 2005 National Association of Counties survey, 40% of child welfare officials reported increases in the number of children placed in foster care due to parental methamphetamine use in the past year (National Association of Counties, 2005). In addition, data indicates that abused and neglected children from substance abusing families are more likely to be placed in foster care and are more likely to remain there longer than are maltreated children from non-substance abusing families (U.S. Department of Health & Human Services, 1999).

Program Structure (Adapted from the Policies and Procedures Manual (2006) for the Dependency Drug Court in the Eighth Judicial Circuit, Alachua County, Florida)

The Family Treatment Drug Court, known as the Dependency Drug Court (DDC) Program in Alachua County, is a partnership between the Judicial Circuit Court, the Department of Children and Families (DCF), Partnership for Strong Families, Child Welfare Legal Services,

defense attorneys, Guardian Ad Litem, and treatment providers. Participation in the DDC program is court ordered, and the average length of treatment in the program is 10-12 months. The goal of the DDC program is to provide immediate treatment and support to parents to assist them in maintaining abstinence from alcohol/drugs and to assume, as soon as possible, total responsibility for parenting their children.

Judicial Role

The Dependency Drug Court Judge is responsible for the supervision and management of the DDC program. The Judge establishes a rehabilitative relationship with the parents, with the goal of providing a supportive and therapeutic environment for all of the participants. The Judge chairs the pre-court case status conference held prior to each session of Dependency Drug Court to review the progress of the parents.

Each week, the Judge reviews with the parent, their progress in meeting objectives outlined in their treatment plan/case plan. The Judge provides praise for parents who are in compliance with case plan goals, as well as, encouragement and consequences/sanctions to motivate parents who are not in compliance. To encourage compliance, the Judge may use both positive and negative incentives and may assume the role of task master, mentor, or confidante.

Drug Court Coordinator

The Drug Court Coordinator provides the link between the Court, attorneys, Department of Children & Families, parents, and the treatment provider. Responsibilities include; (1) Attendance at Shelter Hearings and provision of assistance in the referral process, (2) meeting with parents and attorneys to provide them with information regarding DDC, (3) preparing all of the paperwork including the Order to Participate in the DDC and providing them to the Judge and attorneys, (4) attending staffings, (5) attending weekly DDC hearings, (6) advising the DDC

Judge and other Drug Court Team members of any issues and concerns regarding the Program, and (7) providing training to Judges, attorneys, and agencies of the DDC program.

Guardian Ad Litem

The Guardian Ad Litem's responsibilities are to: (1) attend weekly DDC pre-court staffings, (2) attend weekly DDC hearings, (3) provide relevant information regarding the children's progress to the DDC team, and (4) assist the DDC program by contacting the DDC Coordinator if in the course of his/her duties the Case Coordinator has reason to believe that a parent may be an appropriate candidate for a DDC assessment.

Department of Children & Family Attorney

The attorney for the Department of Children & Families (DCF) represents DCF in DDC cases throughout the legal process. This representation includes helping to identify cases that meet the criteria for DDC; ensuring that there is a corresponding legal dependency case with a case plan goal of reunification; negotiating with legal counsel for the prospective DDC client; and ensuring all necessary legal documents are properly executed and forwarded to the DDC coordinator.

Once a case is accepted into the DDC program and a court order is signed ordering the client into DDC, the DCF attorney continues to represent DCF in all court proceedings including arraignments, disposition and adoption of the case plan and subsequent judicial review hearings. The DCF attorney participates in the weekly pre-court case status conferences with the judge, prepares all court orders for the Court's consideration and attends the weekly DDC court hearings. If a DDC client is non-compliant with the terms and conditions of the DDC program and the team recommends discharging the client from the program, the DCF attorney prepares an order for the court's consideration discharging the client and, when appropriate, files a

termination of parental rights petition or a case plan reflecting some other permanency goal for the children of the DDC client.

Family Care Counselor for Department of Children & Family

The Family Care Counselor (FCC) identifies and assesses the client's needs, family's needs and the needs of the minors placed in the care of DCF due to abuse or neglect by caretakers, with the ultimate goal of permanency. The FCC is responsible for compiling the referral packet information need for the treatment provider to complete the DDC assessment on a prospective DDC program client. The FCC is also responsible for evaluation, coordinating, and ensuring necessary services are provided to the parent. These recommendations are compiled in the parent's case plan, or service plan, and may cover housing, day care, transportation, clothing, food stamps, parenting training, individual or group counseling (including substance abuse treatment), and teaching the parent basic household skills (Howard, 2004). In addition, the FCC will ensure that the DDC team is updated on the client's progress in addressing case plan tasks, and providing any information that would assist the treatment provider in providing treatment services to the parent.

Substance Abuse and Mental Health (SAMH) Liaison:

The SAMH liaison is responsible for maintaining the DDC program budget, and providing a weekly report on the cost incurred. The SAMH Liaison is also responsible for maintaining information on all substance abuse referrals made to SAMH providers. If residential services are required for the program participant, the SAMH Liaison is responsible for providing the financial impact of admitting a client who requires residential services at the weekly case status conference.

In addition, the SAMH Liaison is responsible for ensuring all agency partners are aware of the established outcomes for the DDC Program and reporting quarterly on the documented performance. The SAMH Liaison will also review, with the DDC team, strategies for improving performance when warranted.

Substance Abuse Clinician

The treatment provider's staff is responsible for providing direct clinical services to participants in the DDC program through individual, group and family therapy sessions. The clinician will provide an assessment, treatment plan, referral services and documentation of the DDC parent's progress. The clinician is responsible for explaining program expectations, rules, confidentiality, client rights, and phase requirements to DDC parents. In addition, he/she is responsible for obtaining the parent's signature on the agreement to participate in the DDC program.

The clinician provides progress reports to the Judge and DDC team for all parents participating in the program at weekly staff hearings. Reports will include; (1) progress made towards treatment goals, (2) barriers to treatment for clients, (3) specific issues that need to be addressed that might assist with or impede phase changes, (4) compliance and attendance, (5) results of drug testing and breathalyzer, (6) non-compliance with submitting to drug testing and/or breathalyzer testing, (7) compliance with attending 12 Step meetings, obtaining a sponsor and meeting with their sponsor, (8) recommendations for sanctions for non-compliance issues that might enhance the clinical progress, (9) referrals for needed Case Management services, (10) referrals for other professional services (Domestic Violence, Anger Management, Mental Health, etc.), (11) feedback on referrals to the DCF Liaison, Family Care Counselor, and DDC Coordinator, and (12) information on referrals and outcome measures.

Eligibility Criteria for Dependency Drug Court Clients

Below are the criteria considered when a prospective program participant is referred to the Dependency Drug Court program:

- Parent/Guardian must have a child removed and sheltered due to concerns about the parent's/guardian's alcohol and/or substance abuse.
- Parent/Guardian must have a child adjudicated dependent and be in jeopardy of having parental rights terminated as a result of the parent's/guardian's inability to stop using alcohol and/or drugs.

Referral Process

The Dependency Drug Court coordinator is responsible for attending all dependency shelter hearings, to identify prospective DDC program clients. If the shelter petition is granted, the parent(s) are ordered to complete a Dependency Drug Court Assessment immediately following the hearing. Prospective DDC program clients may also be identified by the Child Protective Investigator, Child Welfare Legal Services Attorney, Guardian Ad Litem, Defense Attorney, and Treatment provider staff working with a DCF client. Once identified, the referral source is responsible for forwarding all relevant client information to the Department of Children and Families.

Variables under Study

Drug of Choice and Frequency

Primary drug of choice is defined as the self-reported drug most preferred or most used by an individual. Researchers often look at this variable because type and frequency of drug use are important factors related to treatment retention and outcome. Some researchers have found significant differences in treatment success rates of clients based on type of drug used and

frequency of use. Schiff and Terry (1997) conducted a study of Florida Drug Treatment Court participants in which they limited eligibility to participate in the study to offenders arrested for drug-related offenses involving cocaine. According to Schiff and Terry (1997) crack cocaine use was found to be significantly and negatively related to completion of the drug treatment court program. They suggest that because crack cocaine is highly addictive, the use of this particular drug was an important factor in preventing offenders from successful completion (Schiff & Terry, 1997).

A drug treatment court study conducted in Delaware also looked at completion and non-completion of participants and found crack cocaine to be a predictor of treatment failure when compared to non crack cocaine-using participants (Saum, Scarpitti, & Robbins, 2001). Peters, Haas, and Murrin (1999) also found that clients who reported cocaine as their drug of choice graduated at a lower rate than those who reported alcohol or marijuana as their primary drug. Furthermore, research indicates that multiple substance use increases the likelihood of unsuccessful completion (Logan, Williams, Leukefeld, & Minton, 2000). In this study, the relationship between drug(s) of choice and rate of successful completion will be examined for Family Treatment Drug Court participants. Frequency of use will also be examined to determine whether frequency of use prior to admission has an effect of participant retention and completion of treatment.

Prior Treatment

It is not uncommon for an individual to go through multiple treatment episodes in the course of their history of drug and/or alcohol abuse due to the relapsing nature of addiction. As a result, multiple treatment admissions are often viewed by treatment professionals as a common occurrence of recovery rather than failed efforts to maintain sobriety (Longshore & Prendergast, 1997). Clients may exhibit different treatment outcomes over the course of their drug history and

prior treatment experiences may affect their current participation in treatment, which in turn, may influence treatment outcomes (Longshore & Prendergast, 1997).

Substance abuse treatment is oriented to the process of recovery from addiction, based upon a model of addiction as a chronic, relapsing disorder (McLellan, Lewis, O'Brien, 2000), which is sometimes referred to as an "addiction career" (Hser, Anglin, Grella, Longshore, Prendergast, 1997). Therefore, clients may go through multiple treatment episodes before they are able to successfully recover from addiction, and may require long-term treatment/intervention. Periodic relapses into substance use as well as multiple treatment episodes are viewed as predictable aspects of the recovery process and constitute a "treatment career" (Hser, Anglin, Grella, Longshore, Prendergast, 1997). This study will explore the relationship between the amount of prior treatment or "treatment career" and successful completion of the Family Treatment Drug Court program.

Criminal Status

Research indicates that an individual does not usually begin substance abuse treatment until they are immersed in a lifestyle of drug use and criminal activity (Stephens, 1991). Growing prison populations in the U.S. are largely due to drug-related crime and drug abuse. Yet, relatively few inmates receive treatment and existing interventions tend to be short-term or non-clinical (Belenko & Peugh, 2005). In 1997 a survey was conducted on inmates in state correctional facilities, a nationally representative sample of 14,285 inmates from 275 state prisons, in an effort to estimate their level of treatment need. The framework drawn on to estimate this level of need was derived from the American Society of Addiction Medicine Patient Placement Criteria and other assessment tools measuring drug use severity, drug-related behavioral consequences, and other social and health problems (Belenko & Peugh, 2005). The results of the survey indicated that one-third of the male and one-half of the female inmate

population needed residential substance abuse treatment, while half of the male and one-third of the female inmate population may have needed either no treatment or short-term treatment interventions (Belenko & Peugh, 2005).

Drug courts were established as an answer to the problem of the increase in the number of inmates charged with drug-related crimes. Research conducted on drug court programs show favorable outcomes for participants with criminal backgrounds. Some researchers have found that drug use and criminal activity are reduced for drug court participants while they are receiving treatment services (Belenko, 1999, 2001) and that retention rates for drug courts are higher than other treatment programs with criminal offenders (U.S. General Accounting Office, 1997). However, many evaluation studies of drug court effectiveness compare offenders who complete drug court with offenders who do not and find that “successes succeed and failures fail” (Goldkamp, White, & Robinson, p. 32, 2001). This study seeks to compare program participants with criminal histories with those who do not have criminal histories to determine the relationship with successful completion of the Family Treatment Drug Court program.

Social Support

Do participants with high levels of social support at treatment onset differ in their treatment outcomes from those with low levels of social support? Dobkin, De Civita, Paraherakis, & Gill (2001) examined the impact of functional support on treatment outcomes for substance abuse program participants. Social support was measured at intake and treatment outcomes were assessed 6 months later. Using regression analyses, and controlling for the effects of days in treatment prior to testing the independent and interactive effects of social support and stress on outcomes, higher levels of perceived functional support were shown to play a role in reducing the severity of alcohol use indicating that there is an association between social support and the tendency for patients to stay in treatment resulting in higher rates of treatment

completion (Dobkin, De Civita, Paraherakis, & Gill, 2001). This data confirms previous research findings (Huselid, Self, & Gutierrez, 1991; Westreich, Heitner, Cooper, Galanter, & Gued, 1997) which suggests that little or no social support at intake may be predictive of poor treatment retention and poorer treatment outcomes.

Research reveals that family relationships and other social institutions play an important role in treatment initiation for men (Grella & Joshi, 1999); such institutions may include an employer or the criminal justice system. However, family relationships do not play as pivotal a role for women with more women being referred to treatment programs by social workers or caseworkers (Grella & Joshi, 1999). Research has shown that the involvement of significant others in a patient's treatment program improves adherence to the treatment program (Galanter, 1993). Therefore, more research is needed to determine whether clients with little or no social support at the onset of treatment fare worse in Family Treatment Drug Court participation than those with higher levels of social support.

CPS Involvement

There is more awareness of the connection between substance abuse and child abuse/neglect prompting more coordination of services ([U.S. Department of Health and Human Services, 1999](#); [Young, Gardner, & Dennis, 1998](#)). Child Protection Services (CPS) work to link substance abusing parents to treatment services quickly to assist in improving treatment outcomes of participants and eventual reunification with children. Yet, there are conflicting perspectives regarding the impact Child Protective Service involvement has on treatment completion of participants.

Some researchers suggest that women involved with CPS, including those who are pregnant, are more likely to have unsatisfactory discharges from treatment than those who are not involved with CPS ([Hohman, Shillington, & Baxter, 2003](#); [Shillington et al., 2002](#)). Research

conducted by Kelly, Blacksin, & Mason (2001), found that a greater presence of Child Protection Services involvement reduced the likelihood of completion of substance abuse treatment. The study consisted of pregnant English-speaking women presenting for prenatal treatment at Cook County Hospital between 1992 and 1995, who admitted to abuse of heroin, cocaine, and alcohol. Women who agreed to participate in the study were randomly placed into two types of prenatal care programs: 1) treatment in the prenatal clinic at Cook County Hospital and referral for substance abuse treatment at a community agency, or 2) prenatal care, substance abuse treatment, and case management in the New Start program (Kelly, Blacksin, & Mason, 2001). There were 165 women randomly placed in the New Start program who were divided into two research samples, (1) completers (15 women) who met the criteria for completion of the treatment program (i.e., no relapse for one year, regular attendance at program activities for at least one year, and initiation of a personal development plan), and (2) non-completers (19) women randomly selected from the women who participated in the program for at least three months, but who did not complete the steps required for completion by the program's criteria (Kelly, Blacksin, & Mason, 2001). Data was obtained from the treatment records collected over the course of the participant's treatment. Completers had significantly less involvement with the state's child protective services (CPS) than did non-completers (27%, $n = 4$ vs. 74%, $n = 14$). (Involvement with CPS means that women either had their children removed from their care or were mandated to treatment as a result of an investigation). Gregoire & Schultz (2001) also found a low rate of treatment completion (less than one-quarter) among parents referred to substance abuse treatment from child welfare, and that treatment non-completion was strongly associated with continued substance abuse and eventual loss of parental rights.

These studies reported that the likelihood of women completing substance abuse treatment was reduced once their children have been taken away (Kelly, Blacksinn, & Mason, 2001) which is in direct opposition to other research findings that report that CPS involvement is often a motivator for treatment completion (Wald, 1991). Although some women will participate actively in treatment to regain custody of their children, others deteriorate when their children are removed from their custody and use drugs more heavily to cope with the loss (Kearney, Murphy, & Rosenbaum, 1994). Although all of the study participants have some involvement with CPS, the relationship between multiple CPS involvement episodes on participant's treatment completion will be examined.

Successful Completion

Family treatment drug court programs vary in size and duration; however, all have distinct markers of stage completion built into the program. Research has shown that longer participation in treatment increases the chance of favorable treatment outcomes (Peters & Murrin, 1998), therefore, participants who complete more stages in FTDCs may be more likely successfully complete the program. The drug court program under study has four stages of treatment completion divided into phases, which all program participants must reach before successfully completing and graduating from the program. The program is designed to reflect therapeutic engagement and the internal motivation of program participants. Treatment intensity is highest at the onset of the program as many clients present in the pre-contemplation and contemplation of the Transtheoretical model (1992) and are believed to require more assistance. In Phase I participants are required to attend treatment sessions (each session is three hours in length) four days a week, two AA/NA meetings a week, and court once a week.

Participants are moved through the program stages as they meet treatment objectives and begin to display more treatment readiness/motivation indicated in the preparation and action

stages of change of the Transtheoretical model (1992). Phase II requires treatment attendance three days a week, three AA/NA meetings a week, and bi-monthly court attendance. Phase III requires treatment attendance two days a week, four AA/NA meetings a week, and bi-monthly court appearances. Phase IV requires treatment attendance once a week, five AA/NA meetings a week, and bi-monthly court attendance. All participants are required to obtain a 12-step sponsor by the end of the first phase of the program and meet regularly with him/her each week. Once the participant has completed Phase IV of the program that are classified as a successful completer. This study will explore the relationship between the variables under study and successful completion of the Family Treatment Drug Court program.

Summary

The literature reviewed in this chapter indicates that Adult Drug Courts, which were developed in response to jail overcrowding, were effective in increasing substance abuse treatment retention of drug offenders and reducing both criminal and substance abuse recidivism rates. Family treatment drug courts were adopted from the adult drug court model to address the increase in child abuse and neglect cases resulting from substance abuse by parents. The goal is to help parents abstain from drugs/alcohol and reunite with their children.

FTDCs have been shown to work and are most effective when they are family centered and incorporate a variety of services (i.e., housing, transportation, parenting classes, and social services). However, there are problems with the existing structure of the program which may impact participant completion rates. For example, Child Protection Service workers often have large caseloads which make it difficult to see that parents are receiving needed services, there are deadlines imposed by the courts which place restrictions on the amount of time participants have to complete treatment objectives, and there may be certain participant characteristics that impact successful completion rates.

This study will look at six variables and their relation to successful completion of a family treatment drug court program. These variables include: (1) participant's drug of choice, (2) participants frequency of drug use (3) participant's prior treatment history, (4) participant's criminal status, (5) participant's social support, and (6) participant's prior Child Protective Service involvement. Determining which participant characteristics affect successful completion would assist in improving program design.

CHAPTER 3 METHODOLOGY

This study is an archival analysis of the records of participants of the Alachua County Family Treatment Drug Court or “Dependency Drug Court Program” in Gainesville, Florida. This study examined six factors associated with successful and unsuccessful completion by participants in the Family Treatment Drug Court program under study: (1) participant’s drug of choice, (2) participants frequency of drug use (3) participant’s prior treatment history, (4) participant’s criminal status, (5) participant’s social support, and (6) participant’s prior Child Protective Service involvement.

Population and Sample

The Dependency Drug Court (DDC) program in Alachua County began on January 19, 2001. Designed as an intensive outpatient substance abuse treatment program, utilizing detox and in-patient treatment services as needed, it incorporates comprehensive family services and court supervision and is approximately 10-12 months in duration. Alachua County’s Dependency Drug Court program is funded by state dollars with a static population of 18 participants. The state appropriates \$112,000 per year as a recurring annualized budget to fund the DDC program in Alachua County. Program size has been adjusted as the need for services has grown. In such cases, alternative sources of funding are sought for additional program participants.

Participants are also responsible for completing all phases of the DDC program and all case plan goals given to them by the Child Protective Service agency in conjunction with participants’ substance abuse treatment; these may include classes in parenting, anger management, and/or domestic violence prevention. Parenting and anger management classes are

provided at Meridian Behavioral Healthcare, the treatment agency. Parents are also referred to other agencies within the community to fulfill other case plan tasks.

Participants are randomly drug tested throughout their participation in the program and must achieve definitive periods of abstinence (3 months abstinence) before unsupervised visitation and reunification with their children is granted. Each client is drug tested using a randomized telephone system. Participants are required to call each day Monday-Sunday by 9:00 a.m. They are greeted with a message announcing the “DDC Color(s) of the Day” and must present for drug testing by 9:00 p.m. The participant must present for urine screen testing when their color is named on the day of the message. If they do not come in for testing, this is judged as a positive screen and as being non-compliant with the treatment program.

Prior to each Dependency Drug Court hearing, the DDC team meets with the Judge or presiding Magistrate to review the progress of each program participant. The Judge will discuss the participant’s progress during court and may either reward participants who are compliant with treatment or impose sanctions for those who are non-compliant. Rewards may include praise, advancement in program phase, a decrease in court appearance, recognition certificates, gifts, increased visitation with children, and reunification with children. DDC participants may be reunified with their children within 90 days of program admission if they meet the following criteria: (1) The overall risk has been reduced as a result of the client’s demonstration of compliance with the DDC program, (2) The participant has complied with all aspects of the drug court program for a period of 90 days, including attendance and participation in all scheduled treatment sessions, (3) The participant has maintained abstinence for a minimum period of 90 days if treated through an outpatient program or a period of 30 days following discharge if treated in an in-patient program, (4) The participant has maintained safe/stable housing for a

period of 90 days, and (5) The participant has maintained a sufficient income to provide for the needs of their child(ren) for a period of 90 days. DDC sanctions may include verbal reprimand from the bench, increased intensity of treatment, community service hours, suspension of visitation with child(ren) or reduction from supervised visits to unsupervised visits, unsuccessful discharge/termination from the DDC program, and/or recommendation to file a petition for termination of parental rights.

Participants graduate or successfully complete the Dependency Drug Court program when they have completed all treatment phases of the program, have maintained abstinence from drugs/alcohol for a period of no less than 180 days, completed any and all DDC sanctions, and developed a plan for ongoing recovery and relapse prevention. Determination if the participant has reached final attainment of these objectives is decided upon by the DDC team, who will conclude if the participant successfully or unsuccessfully completes the program.

The sample for this study was obtained from the clinical records of participants of the Dependency Drug Court program in the 8th Judicial Circuit in Alachua County, FL. The records of participants include the Child Protection Services case plan and shelter petition that discusses the circumstances which resulted in the participant's referral to treatment, as well as, case plan goals to be completed for reunification. The case plan/shelter petition also provides information on any history of participant involvement with CPS. In addition, the clinical records provide information on the participants' demographic information (age, gender, ethnicity, education level, and employment status), medical/health history, family history, mental health history, criminal history, and substance abuse history. Clinical records also include documentation on participant's progress in treatment towards completing goals and objectives and all records

include an account of the participant's status at discharge (successful completion versus unsuccessful completion).

The sample will consist of $n = 225$ participants who were admitted and discharged from the DDC program between January 19, 2001 and January 1, 2008. Although it is estimated that nearly 400 individuals were referred and evaluated for the DDC program during this time, inclusion in the study requires that the participant met diagnostic criteria for participation in the program and agreed to participate at the time of evaluation. Participants must be discharged (successfully or unsuccessfully) from the DDC program to be included; therefore, all clients currently participating in the program will be excluded. The sample consists of 27 (12%) male participants and 198 (88%) females. The average age of participants is between 30-35, single, and unemployed at the time of entry. About one half are white and one half are African-American.

Measurement

The predictor variables in the study are: participant's drug of choice, frequency of use, prior treatment history, criminal status, social support, and prior CPS involvement. The criterion variable is successful completion of Dependency Drug Court. Three clinicians from the selected agency were chosen to review the coding scheme for assessing the level of social support and stages of change demonstrated by the participants. All three clinicians worked in substance abuse treatment programs for five or more years. The first clinician was a residential substance abuse treatment provider and the second and third worked as outpatient substance abuse treatment providers. The following sections describe how each variable was assessed.

Criminal Status. This measure refers to the participant's criminal status at the time they were admitted to the Dependency Drug Court program. A four point rating scale was used to measure criminal status: no history of criminal involvement = 0, participant not under legal

supervision at the time of admission but at least one previous criminal charge = 1, participant under legal supervision at the time of admission = 2, participant under legal supervision at the time of admission and concurrently admitted to Adult Drug Court program = 3. This study assessed the relationship between criminal status of the participant and successful completion of Dependency Drug Court.

Drug of Choice. This measure refers to the parent's drug of choice at the time they were admitted to the Dependency Drug Court program one month prior to admission. A five point rating scale was used indicating dependence on 1 = cocaine, 2 = alcohol, 3 = marijuana, 4 = opiates, and 5 = heroin. Dependence is defined as having met DSM-IV criteria for lifetime dependence. Dependence is defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by one (or more) of the following, occurring within a 12-month period: (1) Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (such as repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; or neglect of children or household), (2) Recurrent substance use in situations in which it is physically hazardous (such as driving an automobile or operating a machine when impaired by substance use), (3) Recurrent substance-related legal problems (such as arrests for substance related disorderly conduct), and (4) Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (for example, arguments with spouse about consequences of intoxication and physical fights). This study set out to clarify the relationship between drug of choice and successful completion of Dependency Drug Court.

Frequency of Drug Use. A five point rating scale was used to assess the frequency of use with 1 = No past month use, 2 = 1 to 3 times in past month, 3 = 1 to 2 times per week, 4 = 3 to 6 times per week, and 5 = Daily use. This study set out to clarify the relationship between frequency of use and successful completion of Dependency Drug Court.

Prior CPS involvement. This four point scale measured prior Child Protective Service involvement of the participant at the time of admission into the Dependency Drug Court program. All parents who had have had one prior open case with the Department of Children & Families (whether the case was closed or not) was coded as 1, 2 prior cases was coded as 2, 3 prior cases was coded as 3, and termination of parental rights was coded as 4. This study set out to clarify the relationship between prior CPS involvement and completion of Dependency Drug Court.

Prior treatment history. This measure refers to the treatment history of the participant at the time of admission into the Dependency Drug Court program. Participants number of prior treatment involvements and level of treatment care was rated on a six point scale regarding the treatment they have participated in. Participants who received treatment once for a drug or alcohol problem (whether they successfully completed treatment or not) in a traditional outpatient program (once a week for 3 months of treatment minimum) will be coded as 1, intensive outpatient treatment (3-5 days a week for 3 months of treatment minimum) will be coded as 2, residential treatment (28 days minimum) will be coded as 3. More than one outpatient treatment admission (outpatient or intensive outpatient) will be coded as 4 and more than one residential admission will be coded as 5. No prior treatment history will be coded as 0. This study set out to clarify the relationship between prior treatment history and completion of Dependency Drug Court.

Social support. This variable refers to the sources of social support that the parent received from friends, family, spouses/partner, and other members of the family as reported in their bio-psychosocial evaluation. Social support was also indicated by recovery peer group support, such as Alcoholic Anonymous groups and Narcotics Anonymous groups. In addition, support from other institutions was considered as a level of support (such as employer, case manager, counselor, etc). Social support was assessed in terms of five categories developed by the researcher and reviewed by the panel of three clinicians. The categories were coded from 1 to 5. Having no social support system was coded as 1, in serious conflict with and/or having been pressured to receive treatment by one's support system was coded as 2, support from friends/family, spouse/partner was coded as 3, support from support groups was coded as 4, support from other institutions was coded as 5. This study set out to clarify the relationship between social support of the participant and completion of Dependency Drug Court.

Successful Completion. This variable is operationally defined as the completion of a program participant due to attainment of objectives and compliance with program rules. For the purposes of this study, participant's completion status (i.e. successful completion or unsuccessful completion) was assigned according to the status at the end of their participation in the Dependency Drug Court program. There are four phases in the DDC program participants must complete. Phase I is the most intensive phase of the program which requires attendance of treatment sessions four days a week (three hours in length) , two AA/NA meetings a week, and weekly court appearances. Participants must also obtain a 12-step sponsor during Phase I prior to moving to Phase II. Phase II requires treatment attendance three days a week, three AA/NA meetings a week, work with a 12-step sponsor, and bi-monthly court attendance. Phase III requires treatment attendance two days a week, four AA/NA meetings a week, work with a 12-

step sponsor, and bi-monthly court appearances. Phase IV requires treatment attendance once a week, five AA/NA meetings a week, work with a 12-step sponsor, and bi-monthly court attendance. Date on stage of treatment completion was collected to examine in which phase program participants were discharged if they unsuccessfully completed the program. This data was coded using a five point scale ranging from 1 and 4. Phase I was coded as 1, phase II was coded as 2, phase III was coded as 3, phase IV was coded as 4. Participants who successfully completed the program were coded as 5.

Null Hypotheses

The following (seven) hypotheses will be tested in this study:

Ho1: There is no contribution to the prediction of successful completion of Dependency Drug Court of participant's drug of choice, frequency of drug use, treatment history, criminal status, sources of social support, and involvement with Child Protective Services.

Ho2: There is no relationship between successful completion of Dependency Drug Court and participant's drug of choice.

Ho3: There is no relationship between successful completion of Dependency Drug Court and participant's frequency of drug use.

Ho4: There is no relationship between successful completion of Dependency Drug Court and participant's treatment history prior to program admission.

Ho5: There is no relationship between successful completion of Dependency Drug Court and criminal status of the participant at time of program admission.

Ho6: There is no relationship between successful completion of Dependency Drug Court and sources of social support among participants at time of program admission.

Ho7: There is no relationship between successful completion of Dependency Drug Court and participant's prior involvement with Child Protective Services.

Data Collection

Meridian Behavioral Healthcare, Inc provided permission for the investigator to collect data from the clinical records of past participants of the Alachua County Dependency Drug Court

program. A list of participants admitted to the DDC program from January 19, 2001 to January 1, 2008 was obtained from the agency's medical manager computer program. This list was then compared to a list of participants currently active in the DDC program and duplicate names were removed from the list of study participants. However any participants that were currently admitted to the DDC program, with prior participation, who were discharged from the program were included. The list of study participants was then sent to the agency's medical records department who pulled the clinical records of the participants for examination.

Two investigators, the primary investigator and a treatment clinician, were used to review and code data from the clinical records in the medical record department. The treatment clinician was a substance abuse treatment provider for the agency under study. She had over five years experience working with an intensive outpatient substance abuse program and familiarity with Family Treatment Drug Court programs, having worked with this population for approximately two years. The clinician was provided with the policies and procedures manual for the Dependency Drug Court program and training which consisted of a review of Dependency Drug Court program rules/objectives, admission criteria, discharge criteria, and program design. The clinician was then provided with a guide for coding criteria agreed upon by the expert panel for each variable in the study. The investigators then followed the coding criteria set by the panel to record the data. If there was a disagreement among the investigators regarding the coding of a variable, that participant was excluded from the data.

An application to the Institutional Review Board (IRB) was submitted requesting an exempt status since the study involved the collection of existing data. Data was also recorded so that no program participants could be identified.

Data Analytic Procedures

The hypotheses for this study were tested using Hierarchical Logistic Regression procedures performed by the statistical program Statistical Package for the Social Sciences (SPSS). The following sets of predictors were used in the hierarchical logistic regression model: person-centered factors (drug of choice, frequency of drug use, treatment history, criminal status, social support, and prior CPS involvement). Alpha (α) was set at 0.05. Demographic information (age, gender, ethnicity, and educational level) while in the DDC program was collected to examine any correlations with successful completion.

CHAPTER 4 RESULTS

The purpose of this study was to examine the relationships between participants' successful or unsuccessful completion of a Family Treatment Drug Court program and their reported drug of choice, frequency of use, criminal status at the time of admission, type of social support, and their prior involvement with Child Protective Services (CPS). In addition, demographic information (age, gender, race, and education) was also collected to determine if there were demographic differences between successful and unsuccessful participants. Data were analyzed using hierarchical logistic regression to examine the relationship of these variables to successful or unsuccessful completion. In this chapter, a description of the study sample is presented, followed by the results for each research question, and a summary of the findings.

Description of the Sample

The participants for this study were drawn from Dependency Drug Court (DDC) participants of the 8th Judicial Circuit Court in Gainesville, Florida discharged between January 1, 2001 and January 1, 2008. After gaining Institutional Review Board (IRB) approval, a list of participants admitted to the DDC program during the time frame was generated using the medical manager computer system of the participating agency. The 225 names on the list were reviewed to determine if any of the participants were currently active in the DDC program. Ten participants who were active clients were deleted from the list. The remaining list of 215 DDC participants was then examined for duplicate names. Seventeen duplicates were deleted resulting in a sample of 198 participants. This list of 198 study participants was then sent to the agency's medical records department and their clinical records were requested. In the course of reviewing the files, it was discovered that 12 participants had been admitted to the DDC program

in error as they had either been referred and/or participated in other treatment programs within the agency. Eliminating these 12 participants resulted in a total sample of 186 participants for the study.

Age

Descriptive information was collected from each of the participant's clinical record and the data are presented in Table 4-1. In Table 4-1 you will see information on gender, age, and ethnicity for the total sample and for the two subgroups of successful and unsuccessful completers. There were 163 females (88.1%) and 22 males (11.9%) in the study sample. Participants ranged in age between 18-25 (N=49, 26.5%), 26-30 years of age (N=46, 24.9%), 31-36 years of age (N=44, 23.8%), and 37+ years of age (N=46, 24.9%). For the most part, the racial/ethnic composition of the study sample was either African-American (N=88, 47.6%) or Caucasian (N=92, 49.7%). Only two Hispanics (1.1%), two mixed ethnic (1.1%), and one American Indian (.5%) were in the sample, and none of the participants identified themselves as Asian-American.

While clients were evenly distributed across categories of age, there were marked differences in age between members of the successful and unsuccessful group. As depicted in Table 4-1, for successful completers, more participants (N=13, 28.3%) were 37+, followed by participants between 31-36 (N=11, 25.0%) years of age, participants between 26-30 (N=5, 10.9%) years of age, and participants between 18-25 (N=5, 10.2%). For unsuccessful completers, more participants (N=44) were between 18-25 years of age, followed by participants between 26-30 (N=41) years of age, participants 31-36 (N=33) years of age, and participants 37+ (N=33).

Table 4-1. Gender, Age, & Ethnicity

Gender	Successful		Total
	No	Yes	
	N (%)	N (%)	N (%)
Female	130 (81.6)	33 (18.4)	163 (88.1)
Male	21 (95.5)	1 (4.5)	22 (11.9)

Age	Successful		Total
	No	Yes	
	N (%)	N (%)	N (%)
18-25	44 (89.8)	5 (10.2)	50 (26.5)
26-30	41 (89.1)	5 (10.9)	46 (24.9)
31-36	33 (75.0)	11 (25.0)	44 (23.8)
37+	33 (71.7)	13 (28.3)	46 (24.9)

Ethnicity	Successful		Total
	No	Yes	
	N (%)	N (%)	N (%)
Caucasian	72 (78.3)	20 (21.7)	92 (49.7)
Persons of Color	79 (84.9)	14 (15.1)	93 (50.3)

* African-American, mixed ethnic, and American Indian categories were combined into persons of color.

Education Level

As depicted in Table 4-2, ninety-six (51.4%) of the total sample reported having less than a high school diploma, fifty-four (29.2%) reported having a high school diploma, 26 (14.1%) reported having some college, seven (3.8%) reported having an Associate’s Degree, and three (1.6%) reported having a Bachelor’s Degree. There were no participants who had earned graduate degrees (Master’s or Doctorate). The highest number of successful completers were participants with some college or a college degree (N=8, 23.5%) followed by participants with

high school diplomas (N=10, 29.4%) and participants with less than a high school diploma (N=16, 47.1%).

Table 4-2. Education.

Education	Successful		Total
	No	Yes	
	N (%)	N (%)	N (%)
Less than high school diploma	79 (83.2)	16 (16.8)	96 (51.4)
High school diploma	44 (81.5)	10 (18.5)	54 (29.2)
Some college and college degree	28 (77.8)	8 (22.2)	36 (19.5)

*Some college, Associate degree, and Bachelor’s degree were combined into some college and college degree.

Stage of Treatment

Stage of treatment was the dependent variable in this study. There are four phases in the DDC program participants must complete. Phase I of the program requires participants to attend treatment sessions four days a week (each session is three hours in length), two AA/NA meetings a week, and weekly court appearances. Participants are also required to obtain a 12-step sponsor during Phase I and maintain weekly contact with them prior to moving to Phase II. Phase II requires treatment attendance three days a week, three AA/NA meetings a week, work with a 12-step sponsor, and bi-monthly court attendance. Phase III requires treatment attendance two days a week, four AA/NA meetings a week, work with a 12-step sponsor, and bi-monthly court appearances. Phase IV requires treatment attendance once a week, five AA/NA meetings a week, work with 12-step sponsor, and bi-monthly court attendance.

Participants who were discharged in Phase I, Phase II, Phase III, and Phase IV were considered unsuccessful completers. Participants may be discharged from the Dependency Drug Court program if they fail to meet the treatment objectives of the program, fail to comply with

any sanctions imposed by the DDC team, and if they drop out from the DDC program.

Participants who successfully completed Phase IV of the Dependency Drug Court program were judged to be successful completers. The majority of participants, 121 (65.4%), were discharged in Phase I of the program within the first 60 days of treatment. There were 16 (8.6%) who were discharged in Phase II, 7 (3.8%) who were discharged in Phase III, and 7 (3.8%) who were discharged in Phase IV. Only 34 (18.4%) participants successfully completed all phases of the Dependency Drug Court program.

Criminal Status

Participant's criminal status was classified into 1 of 4 categories: no history of criminal involvement, not under legal supervision at admission, under supervision at admission, and legal supervision at admission and concurrently participating in an Adult Drug Court program. Within the total sample, 45 (24.3%) had no past and/or current criminal justice involvement, 86 (46.5%) were not under legal supervision at admission, 49 (26.5%) were under legal supervision at admission, and 5 (2.7%) were under legal supervision and concurrently participating in an Adult Drug Court program.

A Chi Square test was not able to be conducted to test the significance of the following differences as there were cells less than five. However, among the successful completers, 9 (20.0%) had no history of criminal involvement, 14 (16.3%) were not under legal supervision at the time of admission but had at least one previous criminal charge, 9 (18.4%) were under legal supervision at the time of admission, and 2 (5.9%) were under legal supervision at the time of admission and concurrently admitted to the ADC program. Among the unsuccessful completers, 36 (23.8%) had no history of criminal involvement, 72 (47.7%) were not under legal supervision at the time of admission but had at least one previous criminal change, 40 (26.5%)

were under legal supervision at the time of admission, and 3 (2.0%) were under legal supervision at the time of admission and concurrently admitted to the ADC program.

Table 4-3. Criminal Status

Criminal Status	Unsuccessful	Successful	Total
	N (%)	N (%)	N (%)
No history of criminal involvement	36 (23.8)	9 (26.5)	45 (24.3)
Not under legal supervision at admission	72 (47.7)	14 (41.2)	86 (46.5)
Under legal supervision at admission	40 (26.5)	9 (26.5)	49 (26.5)
Legal supervision at admission and currently	3 (2.0)	2 (5.9)	5 (2.7)

Drug of Choice

Participant's drug of choice was classified into 1 of 5 categories: cocaine, alcohol, marijuana, opiates, and heroin. Participants could indicate more than one drug of choice and they would be coded as yes within each of the five categories. Within the total sample, 131 (70.8%) reported cocaine as their drug of choice, 90 (48.6%) reported alcohol as their drug of choice, 90 (48.6%) reported marijuana as their drug of choice, 12 (6.5%) reported opiates as their drug of choice, and 1 (0.5%) reported heroin as their drug of choice.

A Chi Square test was not able to be conducted to test the significance of the following differences as there were cells less than five. However, among the successful completers, 23 (67.6%) reported cocaine as their drug of choice, 18 (52.9%) reported alcohol as their drug of choice, 12 (35.3%) reported marijuana as their drug of choice, 1 (2.9%) reported opiates as their drug of choice, and 0 (0.0%) reported heroin as their drug of choice. Among the unsuccessful

completers, 108 (71.5%) reported cocaine as their drug of choice, 72 (47.7%) reported alcohol as their drug of choice, 78 (51.7%) reported marijuana as their drug of choice, 11 (7.3%) reported opiates as their drug of choice, and 1 (0.7%) reported heroin as their drug of choice.

Table 4-4. Drug of Choice

Drug of Choice	Unsuccessful	Successful	Total
	N (%)	N (%)	N (%)
Cocaine	108 (71.5)	23 (67.6)	131 (70.8)
Alcohol	72 (47.7)	18 (52.9)	90 (48.6)
Marijuana	78 (51.7)	12 (35.3)	90 (48.6)
Opiates	11 (7.3)	1 (2.9)	12 (6.5)
Heroin	1 (0.7)	0 (0.0)	1 (0.5)

Drug of Choice: Single Drug use versus Multiple Drug Use

Participants were separated into two groups, DC1= those who reported a single substance as their drug of choice and DC2= those who reported multiple substances as their drug of choice. Within the total sample, 70 (37.8%) reported a single substance as their drug of choice and 115 (62.2%) reported multiple substances as their drug of choice.

Among the successful completers, 16 (47.1%) reported a single substance as their drug of choice and 18 (52.9%) reported multiple substances as their drug of choice. Among the unsuccessful completers, 54 (35.8%) reported a single substance as their drug of choice and 97 (64.2%) reported multiple substances as their drug of choice.

There were no statistically significant Chi Square differences between successful and unsuccessful completers for participants who reported a single substance as their drug of choice

versus participants who reported multiple substances as their drug of choice, (X^2 (1) 1.506, $p = 0.220$).

Table 4-5. Drug of Choice (Single Drug Use versus Multiple Drug Use)

	Unsuccessful	Successful	Total
DC Group	N (%)	N (%)	N (%)
1	54 (35.8)	16 (47.1)	70 (37.8)
2	97 (64.2)	18 (52.9)	115 (62.2)

*DC 1 = single drug use

*DC 2 = multiple drug use

Frequency of Use

Participant's frequency of use was classified into 1 of 5 categories: no past month use, 1 to 3 times in past month, 1 to 2 times per week, 3 to 6 times per week, and daily use. Within the total sample, 42 (22.7%) reported no past month use, 28 (15.1%) reported use 1 to 3 times in the past month, 28 (15.1%) reported use 1 to 2 times per week, 15 (8.1%) reported use 3 to 6 times per week, and 69 (37.3%) reported daily use.

A Chi Square test was not able to be conducted to test the significance of the following differences as there were cells less than five. However, among the successful completers, 12 (35.3%) reported no past month use, 5 (14.7%) reported use 1 to 3 times in the past month, 7 (20.6%) reported use 1 to 2 times per week, 1 (2.9%) reported use 3 to 6 times per week, and 9 (26.5%) reported daily use. Among the unsuccessful completers, 30 (19.9%) reported no past month use, 23 (15.2%) reported use 1 to 3 times in the past month, 21 (13.9%) reported use 1 to 2 times per week, 14 (9.3%) reported use 3 to 6 times per week, and 60 (39.7%) reported daily use. There were marked differences between successful and unsuccessful completers who reported higher frequencies of use and participants who reported lower frequencies of use. Only

29.4% of participants successfully completed who reported use 3 to 6 times per week and daily use, compared with 70.6% of successful completers among participants who reported use 1 to 2 times per week or less.

Table 4-6. Frequency of Use

Frequency of use	Unsuccessful	Successful	Total
	N (%)	N (%)	N (%)
No past month use	30 (19.9)	12 (35.3)	42 (22.7)
1 to 3 times in past month	23 (15.2)	5 (14.7)	28 (15.1)
1 to 2 times per week	21 (13.9)	7 (20.6)	28 (15.1)
3 to 6 times per week	14 (9.3)	1 (2.9)	15 (8.1)
Daily use	60 (39.7)	9 (26.5)	69 (37.3)

CPS Involvement

Participant’s CPS involvement was classified into 1 of 4 categories: one prior open case, two prior open cases, three prior open cases, and termination of parental rights. One prior open case denotes at least one prior open investigation by child protective services before admission to the Dependency Drug Court program. Within the total sample, 132 (71.4%) reported one prior open case, 17 (9.2%) reported two prior open cases, 28 (15.1%) reported three prior open cases, and 8 (4.3%) reported past termination of parental rights.

Among the successful completers, 26 (76.5%) reported one prior open case, 5 (14.7%) reported two prior open cases, 1 (2.9%) reported three prior open cases, and 2 (5.9%) reported past termination of parental rights. Among the unsuccessful completers, 106 (70.2%) reported

one prior open case, 12 (7.9%) reported two prior open cases, 27 (17.9%) reported three prior open cases, and 6 (4.0%) reported past termination of parental rights.

There were no statistically significant Chi Square between successful and unsuccessful completers in terms of their prior CPS involvement of the following three categories: one prior open case with the Department of Children & Families ($X^2 (1) 0.534, p = 0.465$), two prior open cases ($X^2 (1) 1.519, p = 0.218$), and termination of parental rights ($X^2 (1) 0.244, p = 0.621$). Significant differences were found between successful and unsuccessful participants in the frequency with which they reported three prior open cases ($X^2 (1) 4.822, p = 0.028$). However this may not be a valid analysis as there were cells with counts of five or less.

Table 4-7. Prior CPS Involvement

Prior CPS Involvement	Unsuccessful N (%)	Successful N (%)	Total N (%)
One prior open case	106 (70.2)	26 (76.5)	132 (71.4)
Two prior open cases	12 (7.9)	5 (14.7)	17 (9.2)
Three prior open cases	27 (17.9)	1 (2.9)	28 (15.1)
Termination of parental rights	6 (4.0)	2 (5.9)	8 (4.3)

Prior Treatment

Participant's prior treatment status was classified into 1 of 6 categories: no prior treatment history, one treatment admission in traditional outpatient program, one treatment admission in intensive outpatient program, one treatment admission in residential program, more than one outpatient (traditional or intensive) admission, and more than one residential admission. Within the total sample, 95 (51.4%) reported no prior treatment history, 38 (20.5%) reported one prior

treatment admission in traditional outpatient, 14 (7.6%) reported one prior treatment admission in intensive outpatient, 31 (16.8%) reported one prior treatment admission in residential, 12 (6.5%) reported more than one outpatient admission, and 15 (8.1%) more than one residential admission.

A Chi Square test was not able to be conducted to test the significance of the following differences as there were cells less than five. However, among the successful completers, 14 (41.2%) reported no prior treatment history, 9 (26.5%) reported one prior treatment admission in traditional outpatient, 4 (11.8%) reported one prior treatment admission in intensive outpatient, 9 (26.5%) reported one prior treatment admission in residential, 3 (8.8%) reported more than one outpatient admission, and 3 (8.8%) more than one residential admission. Among the unsuccessful completers, 81 (53.6%) reported no prior treatment history, 29 (19.2%) reported one prior treatment admission in traditional outpatient, 10 (6.6%) reported one prior treatment admission in intensive outpatient, 22 (14.6%) reported one prior treatment admission in residential, 9 (6.0%) reported more than one outpatient admission, and 12 (7.9%) more than one residential admission.

Table 4-8. Prior Treatment History

Prior Treatment History	Unsuccessful N (%)	Successful N (%)	Total N (%)
No prior treatment history	81 (53.6)	14 (41.2)	95 (51.4)
One treatment admission in traditional outpatient	29 (19.2)	9 (26.5)	38 (20.5)
One treatment admission in intensive outpatient	10 (6.6)	4 (11.8)	14 (7.6)
One treatment admission in residential	22 (14.6)	9 (26.5)	31 (16.8)
More than one outpatient admission	9 (6.0)	3 (8.8)	12 (6.5)
More than one residential admission	12 (7.9)	3 (8.8)	15 (8.1)

Social Support

Participant's source of social support was classified into 1 of 5 categories: no social support system, in serious conflict with and/or having been pressured to receive treatment by one's support system, friends/family/spouse/partner, support groups (AA/NA), and other institutions. Within the total sample, 60 (32.4%) reported no social support system, 34 (18.3%) reported that they were in serious conflict with and/or had been pressured to receive treatment by their support system, 64 (34.6%) reported receiving support from friends/family/spouse/partner, 4 (2.2%) reported receiving support from support groups (AA/NA), and 19 (10.3%) reported receiving support from other institutions.

Among the successful completers, 2 (5.9%) reported no social support system, 0 (0.0%) reported that they were in serious conflict with and/or had been pressured to receive treatment by their support system, 31 (91.2%) reported receiving support from friends/family/spouse/partner, 3 (8.8%) reported receiving support from support groups (AA/NA), and 9 (26.5%) reported receiving support from other institutions. Among the unsuccessful completers, 58 (38.4%) reported no social support system, 56 (37.1%) reported that they were in serious conflict with and/or had been pressured to receive treatment by their support system, 33 (21.9%) reported receiving support from friends/family/spouse/partner, 1 (0.7%) reported receiving support from support groups (AA/NA), and 10 (6.6%) reported receiving support from other institutions.

Significant differences were found for sources of Social Support; however Chi Square findings may be invalid as there were cells with counts of less than five. Chi Square results were as follows: having no social support system ($X^2 (1) 13.399, p = <.001$), in serious conflict with and/or having been pressured to receive treatment by one's support system ($X^2 (1) 18.083, p = <.001$), support from friends/family, spouse/partner ($X^2 (1) 58.940, p = <.000$), support from support groups (AA/NA) ($X^2 (1) 8.738, p = 0.003$), and support from other institutions (i.e. employer) ($X^2 (1) 11.863, p = 0.001$).

Table 4-9. Social Support

Social Support	Unsuccessful	Successful	Total
	N (%)	N (%)	N (%)
No social support system	58 (38.4)	2 (5.9)	60 (32.4)
In serious conflict with and/or having been pressured to receive treatment by one's support system	56 (37.1)	0 (0.0)	34 (18.3)
Friends/family/spouse/ partner	33 (21.9)	31 (91.2)	64 (34.6)
Support groups (AA/NA)	1 (0.7)	3 (8.8)	4 (2.2)
Other institutions	10 (6.6)	9 (26.5)	19 (10.3)

A post hoc analysis was conducted on year of admission of the participants following discovery that there was a dramatic change in admission criteria in 2004. From 2001-2003 participants who were found clinically appropriate for the Dependency Drug Court program were required to request admission before they were accepted into the program; however, beginning in 2004, all clients found clinically appropriate for the program were recommended for participation. A Chi Square test was not able to be conducted to test the significance of the following differences as there were cells less than five. However, there were more successful completers in 2002 (N= 5, 33.3%) followed by 2001 (N= 5, 29.4%) and 2003 (N= 5, 25.0%). Although there were more participants being admitted to the DDC program in 2004 the rate of successful completion declined with seven successful program completers in 2006 (20.6%) six in 2005 and one (2.9%) successfully completing in 2007.

Table 4-10. Year of Admission

Year of Admission	Successful		Total
	No	Yes	
	N (%)	N (%)	N (%)
2001	12 (70.6)	5 (29.4)	17 (9.1)
2002	10 (66.7)	5 (33.3)	15 (8.1)
2003	15 (75.0)	5 (25.0)	20 (10.8)
2004	20 (80.0)	5 (20.0)	25 (13.5)
2005	30 (83.3)	6 (16.7)	36 (19.5)
2006	36 (83.7)	7 (16.3)	43 (23.2)
2007	28 (96.6)	1 (3.4)	29 (15.6)

In summary, when examining the relationship of all variables together on successful completion of the Dependency Drug Court program, the chi-square test revealed there were significant differences for CPS involvement. The most significant difference being clients who reporting three prior open cases ($X^2 (1) 4.116, p = 0.042$). Among the successful completers, there were 28 (15%) of the participants who reported having had three prior CPS cases. In addition, successful completers reported more social support from friends/family/spouse/partner ($X^2 (1) 4.358, p = 0.037$) and other institutions ($X^2 (1) 3.834, p = 0.050$). There were 64 (34.5%) who reported receiving social support from friends/family/spouse/partner and 19 (10.3%) who reported receiving social support from other institutions.

Hypothesis Testing

This study addressed the following hypotheses:

Ho1: There is no contribution to the prediction of successful completion of Dependency Drug Court of participant's drug of choice, frequency of drug use, treatment history, criminal status, sources of social support, and involvement with Child Protective Services.

Ho2: There is no relationship between successful completion of Dependency Drug Court and participant's drug of choice.

Ho3: There is no relationship between successful completion of Dependency Drug Court and participant's frequency of drug use.

Ho4: There is no relationship between successful completion of Dependency Drug Court and participant's treatment history prior to program admission.

Ho5: There is no relationship between successful completion of Dependency Drug Court and criminal status of the participant at time of program admission.

Ho6: There is no relationship between successful completion of Dependency Drug Court and sources of social support among participants at time of program admission.

Ho7: There is no relationship between successful completion of Dependency Drug Court and participant's prior involvement with Child Protective Services.

Data Analysis

Hypothesis 1: There is no contribution to the prediction of successful completion of Dependency Drug Court of participant's drug of choice, frequency of drug use, treatment history, criminal status, sources of social support, and involvement with Child Protective Services.

Hierarchical logistic regression was conducted to test Hypothesis 1 of the research questions. The independent variables were entered hierarchically in the following order: drug of choice (DC), frequency of use (FU), prior treatment (PT), criminal status (CS), social support (SS), and prior CPS involvement (CPS). The dependent variable was the dichotomous variable of successful or unsuccessful treatment completion. Hierarchical logistic regression enters the variables in a specific order specified by the researcher. The final model includes all of the variables but it is possible in a hierarchical regression to note changes in the model as the different variables or sets of variables are entered into the model. Table 4-11 presents summed coefficients for each category and illustrates the classification of the participants for each step in the hierarchical regression. When comparing the predicted values for the dependent variable based on the logistic regression model with the actual observed values from the data, the final model indicated 84.9% of the participants were correctly identified or predicted in their groups

by the model. The Wald statistics indicated drug of choice, prior treatment, and social support were significant predictors of successful or unsuccessful completion of the program.

There was a significant difference reported among marijuana as a drug of choice. There were more unsuccessful completers ($N=78$, 51.7%) for those identifying marijuana as their drug of choice and fewer successful completers ($N=12$, 35.3%) who identified marijuana as their drug of choice. For prior treatment, there was a significant difference between participants with no prior treatment history and participants with at least one prior treatment episode. The majority of participants ($N=81$, 53.6%) who were unsuccessful completers had no prior history of treatment. Statistical differences were also found for social support, with the majority of successful as compared to unsuccessful completers reporting that they received support from friends/family/spouse/partner ($N=31$, 91.2%).

The final model indicated an overall model fit of three predictors was marginally satisfactory (-2 Log Likelihood 149.701) but was acceptable in distinguishing between successful versus unsuccessful participants ($X^2(1) = 17.825$, $p < .001$) at the fifth step. In the analysis, criminal status and prior CPS involvement did not enter the model at their respective steps. Given these findings we can reject hypothesis 1 because drug of choice, prior treatment, and social support were found to be significant.

Table 4-11. Regression Coefficients for Hierarchical Logistic Regression

Step	Variable	β	Wald	df	p	Odds	CI
1	DC	-.470	2.445	1	.118	.625	.347-1.126
2	DC	-.492	2.658	1	.103	.612	.339-1.104
	FU	19.925	.000	1	.999	.000008	.000
3	DC	-.507	2.659	1	.103	.601	.327-1.108
	FU	20.598	.000	1	.999	.0000008	.000
	PT	1.028	4.997	1	.025	2.795	1.135-6.881
4*	DC	-.507	2.659	1	.103	.602	3.27-1.108
	FU	20.598	.000	1	.999	.0000008	.000-.000
	PT	1.028	4.997	1	.025	2.795	1.135-6.881
	CS*						
5`	DC	-.726	4.553	1	.033	.484	.148-.943
	FU	20.364	.000	1	.999	.0000008	.000-.000
	PT	1.011	4.455	1	.035	2.747	1.075-7.022
	CPS*						
	SS	2.273	15.836	1	<.001	9.709	3.169-29.741
6	DC	-.726	4.553	1	.033	.484	.248-.943
	FU	20.364	.000	1	.999	.0000008	.000-.000
	PT	1.011	4.455	1	.035	2.747	1.075-7.022
	SS	2.273	15.836	1	<.001	9.709	3.169-29.741

Hypothesis 2: There is no relationship between successful completion of Dependency Drug Court and participant's drug of choice.

Logistic regression was conducted for the grouped variable: drug of choice (DC), The dependent variable was the dichotomous variable of successful or unsuccessful treatment completion derived from the stage of treatment with phases one to four being unsuccessful and successful completion. Drug of choice was found to be significant with marijuana (DC3) showing statistical significance. When comparing the predicted values for the dependent variable based on the logistic regression model with the actual observed values of data in participant's drug of choice, the final model indicated 81.6% of the participants were correctly identified or predicted in their groups by the model. Table 4-12 presents the coefficients. Given these findings we can reject Hypothesis 2 because drug of choice was found to be significant.

Table 4-12. Logistic Regression Coefficients for Drug of Choice

Step	Variable	β	Wald	df	p	Odds	CI
1	DC1	0.341	0.584	1	.445	1.406	.259-7.124
	DC2	0.097	0.053	1	.818	1.102	.118-5.404
	DC3	0.831	4.050	1	.044	2.296	.697-116.220
	DC4	1.398	1.103	1	0.205	4.048	*
	DC5	20.095	0.000	1	1.000	*	*

Hypothesis 3: There is no relationship between successful completion of Dependency Drug Court and participant's frequency of drug use.

Logistic regression was conducted for the grouped variable: frequency of use (FU). The dependent variable was the dichotomous variable of successful or unsuccessful treatment completion derived from the stage of treatment with phases one to four being unsuccessful and successful completion. Among the grouped variable frequency of use (FU), no categories were found to be statistically significant. When comparing the predicted values for the dependent variable based on the logistic regression model with the actual observed values of data in

participant’s frequency of use, the final model indicated 81.6% of the participants were correctly identified or predicted in their groups by the model. Table 4-13 presents the coefficients. Given these findings, we failed to reject Hypothesis 3 as frequency of use was not found to be significant.

Table 4-13. Logistic Regression Coefficients for Frequency of Use

Step	Variable	β	Wald	df	p	Odds	CI
1	FU1	-20.287	0.008	1	.999	0.000	.386-18
	FU2	-19.677	0.000	1	.999	0.000	.524-22
	FU3	-20.104	4.353	1	.999	0.000	.430-20
	FU4	-18.564	1.646	1	.999	0.000	*
	FU5	-19.306	2.502	1	.999	0.000	*

Hypothesis 4: There is no relationship between successful completion of Dependency Drug Court and participant’s treatment history prior to program admission.

Logistic regression was conducted for the grouped variable: prior treatment (PT). The dependent variable was the dichotomous variable of successful or unsuccessful treatment completion derived from the stage of treatment with phases one to four being unsuccessful and successful completion. Among the grouped variable of prior treatment, no categories were found to be statistically significant. When comparing the predicted values for the dependent variable based on the logistic regression model with the actual observed values of data in participant’s prior treatment, the final model indicated 81.6% of the participants were correctly identified or predicted in their groups by the model. Table 4-14 presents the coefficients. Given these findings, we failed to reject Hypothesis 4 as prior treatment was not found to be significant.

Table 4-14. Logistic Regression Coefficients for Prior Treatment

Step	Variable	β	Wald	df	p	Odds	CI
1	PT0	-0.577	61.687	1	.448	0.562	.049-27.196
	PT1	-0.825	1.000	1	.223	0.438	.000-*
	PT2	-0.697	1.000	1	.335	0.498	.003-0.837
	PT3	-1.092	*	1	.095	0.335	.011-2.565
	PT4	-1.055	*	1	.275	0.348	.073-1.323
	PT5	-0.298	*	1	.745	0.743	*

Hypothesis 5: There is no relationship between successful completion of Dependency Drug Court and criminal status of the participant at time of program admission.

Logistic regression was conducted for the grouped variable: criminal status (CS). The dependent variable was the dichotomous variable of successful or unsuccessful treatment completion derived from the stage of treatment with phases one to four being unsuccessful and successful completion. Among the grouped variable criminal status, no categories were found to be statistically significant. When comparing the predicted values for the dependent variable based on the logistic regression model with the actual observed values of data in participant's criminal status, the final model indicated 81.6% of the participants were correctly identified or predicted in their groups by the model. Table 4-15 presents the coefficients. Because criminal status was not found to be significant, we failed to reject Hypothesis 5.

Table 4-15. Logistic Regression Coefficients for Criminal Status

Step	Variable	β	Wald	df	p	Odds	CI
1	CS1	0.981	0.000	1	.320	2.667	.587-3.368
	CS2	1.232	0.000	1	.199	3.429	.483-2.514
	CS3	1.086	0.000	1	.985	2.963	1.022-5.158
	CS4*						

Hypothesis 6: There is no relationship between successful completion of Dependency Drug Court and sources of social support among participants at time of program admission.

Logistic regression was conducted for the grouped variable: social support (SS). The dependent variable was the dichotomous variable of successful or unsuccessful treatment completion derived from the stage of treatment with phases one to four being unsuccessful and successful completion. Among the grouped variable social support, support from friend/family/spouse/partner was found to be a statistically significant predictor of social support. When comparing the predicted values for the dependent variable based on the logistic regression model with the actual observed values of data in participant's sources of social support, the final model indicated 81.6% of the participants were correctly identified or predicted in their groups by the model. Table 4-16 presents the coefficients. Given these findings we reject Hypothesis 6. Social support was found to be significant.

Table 4-16. Logistic Regression Coefficients for Social Support

Step	Variable	β	Wald	df	p	Odds	CI
1	SS1	0.140	0.008	1	.931	1.154	.386-18.419
	SS2	18.268	0.000	1	.997	*	.524-22
	SS3	-2.934	4.353	1	.037	0.053	.430-20.409
	SS4	-1.784	1.646	1	.200	0.168	*
	SS5	-1.171	2.502	1	.114	0.310	*

Hypothesis 7: There is no relationship between successful completion of Dependency Drug Court and participant’s prior involvement with Child Protective Services.

Logistic regression was conducted for the grouped variable: prior child protective service involvement (CP). The dependent variable was the dichotomous variable of successful or unsuccessful treatment completion derived from the stage of treatment with discharge from phases one to four classified as unsuccessful completion and completion of phase IV as successful completion. Among the grouped variable prior involvement with child protective services, no categories were found to be statistically significant. When comparing the predicted values for the dependent variable based on the logistic regression model with the actual observed values of data in participant’s prior involvement with Child Protective Services, the final model indicated 81.6% of the participants were correctly identified or predicted in their groups by the model. Table 4-17 presents the coefficients. Because prior involvement with child protective services was not found to be significant, we failed to reject Hypothesis 7.

Table 4-17. Logistic Regression Coefficients for Prior Child Protective Service Involvement

Step	Variable	β	Wald	df	p	Odds	CI
1	CP1	0.307	0.000	1	.717	1.359	.259-7.124
	CP2	-0.223	0.000	1	.819	0.800	.118-5.404
	CP3	2.197	0.000	1	.092	9.000	.697-116.220
	CP4	-3.379	0.000	1	.092	0.034	*

Summary of Findings

In this study, the majority of participants were unsuccessfully discharged in phase I ($N=121$, 65.4%) of the DDC program, followed by those participants discharged in phase II ($N=16$, 8.6%), phase III ($N=7$, 3.8%) or in phase IV ($N=7$, 3.8%). Thirty-four participants (18.4%) successfully completed the DDC program. There were more females ($N=163$, 88.1%) admitted to the Dependency Drug Court program than males ($N=22$, 11.9%). In the total sample, participants were evenly distributed across age groups with 49 participants (26.5%) between 18-25 years of age, 46 participants (24.9%) between 26-30 years of age, 44 participants (23.8%) between 31-36 years of age, and 46 participants (24.9%) 37 years of age or more.

Among the demographic information (age, gender, race, and education) collected, age was found to be a variable associated with successful and unsuccessful completion of Dependency Drug Court. The majority of participants who successfully completed were thirty-seven years of age or older (38.2%) and between 31-36 years old (32.4%). Participants under age thirty were less likely to successful complete with 14.7% completing between 26-30 years of age and 18-25 years of age.

No significant differences were found by participant's racial group or educational level. The racial/ethnic composition of the study consisted of 88 African-Americans (47.6%), 92

Caucasians (49.7%), two Hispanics (1.1%), two mixed ethnic (1.1%), and one American Indian (.5%). None of the participants identified themselves as Asian-American. Ninety-five (51.4%) of the participants reported having less than a high school diploma, fifty-four (29.2%) reported having a high school diploma, 26 (14.1%) reported having some college, seven (3.8%) reported having an Associate's Degree, and three (1.6%) reported having a Bachelor's Degree. There were no participants who had earned graduate degrees (Master's or Doctoral).

Of the variables under examination in this study, significances were reported by successful and unsuccessful participants in the sources of social support. However, Chi Square findings may be invalid as there were cells with counts of less than five. The majority of participants ($N=31$, 91.2%) who successfully completed the program reported receiving social support from friends/family/spouse/partner, followed by support from other institutions ($N=9$, 26.5%), and support from support groups ($N=3$, 8.8%). There were two participants (5.9%) successfully completing reporting no social support system ($N=60$). None of the participants successfully completed reporting they were in serious conflict with and/or had been pressured to receive treatment by their support system.

The participants of the study did not have a great deal of prior CPS involvement with 132 (71.4%) reporting one prior open case with Child Protective Services. However, there were significant differences in the level of involvement with child protective services. Among the successful completers, 26 (76.5%) reported one prior open case, five (14.7%) reported two prior open cases, one (2.9%) reported three prior open cases, and two (5.9%) reported prior termination of parental rights.

While the Chi Square analysis revealed significant differences for prior child protective services (CPS) involvement among participants reporting three prior open cases and for sources of social support, regression analysis did not reveal significant differences for prior CPS

involvement. The findings of the hierarchical logistic regression using the summed incidents of criminal status, drug of choice, frequency of use, prior CPS involvement, prior treatment history, and sources of social support found only the summed drug of choice, prior treatment history, and social support were statistically significant predictors of successful or unsuccessful treatment. As a result, we failed to reject Hypothesis 1.

Logistic regression was also completed for each set of predictor variables criminal status, drug of choice, frequency of use, prior CPS involvement, prior treatment history, and social support. There were no significant predictors of successful or unsuccessful outcome for frequency of use, prior treatment, criminal status, and prior CPS involvement. Therefore, we failed to reject Hypotheses 3, 4, 5, and 7. However, marijuana (DC3) was found to be a statistically significant predictor of drug of choice and support from friend/family/spouse/partner was found to be a statistically significant predictor of social support. As a result, we reject Hypotheses 2 and 6.

Chapter 4 presented the findings of the analysis of the data for the study. The study group was described and descriptive characteristics articulated. Analysis of the data for the research questions was presented and statistically significant models noted.

CHAPTER 5 DISCUSSION

The examination of treatment drug courts, family treatment drug courts specifically, has been of growing interest over the past few years. To further explore issues contributing to successful completion, this research examined seven variables believed to be relevant to successful completion of Dependency Drug Court in the 8th Judicial Circuit. Specifically, the study examined the extent to which the variables of criminal status, drug of choice, frequency of use, child protective services (CPS) involvement, prior treatment, and source of social support were associated with successful completion by participants of a family treatment drug court program.

This chapter includes a discussion of the limitations of the study and the research findings related to each study hypotheses. Implications for future research, theory, and practice are also provided along with recommendations for future research.

Limitations

There are some inherent limitations in using archival data. Due to the archival nature of this study, this investigation did not lend itself to the purposeful collection of data nor allow for adding more research participants. Data obtained from the study was limited to existing data generated from a common assessment protocol. Although standardized evaluation documents were used at the treatment facility, clinical interpretation of variables was determined by the evaluating clinician. There were 6 clinicians from January 19, 2001 and January 1, 2008 who used this protocol which lends itself to 6 possible diagnostic interpretations and evaluations. For example, determination of number of relapses for participants throughout their participation in the program could not be accurately gathered as documentation of these occurrences varied among treatment clinicians. While some clinicians documented relapse by each occurrence,

some documented relapse by number of times each participant restarted a phase of the treatment program.

Accuracy of assessment of the variables (i.e., drug of choice, frequency of drug use, treatment history, and criminal status) was also dependent on the full disclosure of program participants at the time of their evaluation. However, participants who had lost custody of their children may have been guarded at the time of their evaluation and therefore reluctant to fully disclose information they believed would be harmful to their custody case. Although there were participants who became therapeutically engaged during their participation in the DDC program and provided more accurate self-reports later in treatment, data for this study only included information obtained at the point of entry.

There was also the potential for rater bias on the part on the investigators in assessing and coding the data, as both raters had prior knowledge and/or experience in working with this population. The raters may have coded data based on prior knowledge and experience in working with this population. In addition, although standardized evaluation documents were used at the agency under study, these documents were revised in 2003 and 2005. As a result, the investigator found that some of the evaluation questions were reworded, deleted, or substituted. While the investigator was able to locate the necessary information to code the data, rewording of evaluation questions could influence the reliability of participant responses. In addition, outcomes of the data were based solely on the self-report of participants at the time of their clinical assessment. Moreover, the coding of data was based only on information collected at the time of the participant's evaluation; therefore, accuracy of responses could not be verified.

Furthermore, the data analytic procedures used in this study could be improved upon. Hierarchical logistic regression analysis was used because it fit most with the archival nature of

the study. However, certain independent variables, such as sources of social support, had mutually exclusive response categories thus using summed data for this variable may not have been appropriate for the regression model. Therefore, logistic regression was conducted for each separate category (criminal status, drug of choice, frequency of use, child protective services (CPS) involvement, prior treatment, and source of social support). There was also a substantial difference in the number of unsuccessful completers ($N=151$) and successful completers ($N=34$). This unequal group size may not have allowed for accurate comparison of the groups.

Finally, the Dependency Drug Court program structure/design has remained consistent over time, however, the composition of the DDC team has changed multiple times as individual staff have changed. The DDC team is responsible for evaluating successful and unsuccessful completion of program participants, therefore, changes in team membership may have influenced evaluation and discharge criteria from participant to participant. In addition, DDC team membership may have influenced the nature of admission and treatment protocols for the program. For example, the DDC program made changes in their admission criteria between 2004 and 2007 resulting in an increase in the number of participants admitted to the program during this period.

Discussion of Findings

Drug of choice, prior treatment, and sources of social support were found to be significant indicators of successful and unsuccessful completion of participants of the DDC program. Significantly more unsuccessful completers ($N=78$, 51.7%) than successful completers ($N=12$, 35.3%) identified marijuana as their drug of choice. In contrast, more successful completers as compared to unsuccessful completers reported cocaine ($N=23$) as their drug of choice, followed by alcohol ($N=18$), marijuana $N=12$), opiates ($N=1$), and heroin ($N=0$). This is inconsistent with national data collected by the Substance Abuse and Mental Health Services Administration

(SAMHSA) (2004), which found that more (36%) clients who were successfully discharged from intensive outpatient treatment reported alcohol as their drug of choice at admission, followed by marijuana (22%), cocaine (18 %), opiates (10%), and other substances (2%). SAMHSA (2004) also found that clients who reported marijuana as their primary substance had stayed in treatment for the longest length of time and were more successful among intensive outpatient participants (60 days), while clients who reported cocaine had the shortest stay and were less successful (48 days).

For the prior treatment variables, there were more unsuccessful than successful completers who reported no prior treatment history ($N=81$). In contrast, there were fewer unsuccessful than successful completers who reported more than one outpatient admission ($N=9$). There were more successful than unsuccessful who reported no prior treatment history ($N=14$) and fewer successful completers who reported more than one outpatient admission ($N=3$) or more than one residential admission ($N=3$). This finding is consistent with data gathered by SAMHSA (2004) which found that clients with fewer prior treatment episodes were more likely to complete intensive outpatient treatment than were clients with more prior treatment episodes. However, research has shown that the majority of substance dependent individuals only achieve stable recovery after 3 to 4 treatment episodes over multiple years (Anglin, Hser, & Grella, 1997).

Source of social support was the most significant indicator of successful versus unsuccessful completion of the family treatment drug court program under study. Successful completers reported more social support from support groups (AA/NA) (8.8%), 26.5% reported receiving support from other institutions, and 91.2% reported receiving social support from friends/family/spouse/partner. In contrast, only 5.9% of the successful participants reported

having no social support system and none of them reported that they were in serious conflict with and/or having been pressured to receive treatment by one's support system. Moos & Moos (2007) found that family and social resources were strong predictors of positive outcomes among substance dependent individuals. They also found that participants achieved long-term positive outcomes following treatment through developing and enhancing "protective resources" such as financial resources, better health, and participation in AA (Moos & Moos, 2007). Because research has demonstrated that addiction treatment outcomes can be compromised by the lack of sustained recovery support services (White & Kurtz, 2006) it is imperative that family treatment drug court programs examine how they might strengthen the support systems of program participants

Although no significance was found for participants who reported having one prior case, two prior cases, and termination of parental rights for CPS involvement; a significant difference was reported between successful and unsuccessful completers with unsuccessful completers more likely to have three prior cases ($N=27$, 17.9%) than successful completers ($N=1$, 2.9%). There were also more successful completers who reported having only one prior case with CPS ($N=26$, 76.5%), or two prior open cases ($N=5$, 14.7%). This is consistent with past research which has found that successful completers have significantly less involvement with child protective services (Kelly, Blacksin, & Mason, 2001).

Age was also found to be a significant indicator of successful completion as the majority of participants who successfully completed their treatment were either thirty-seven years of age or older (38.2%) or between 31-36 years old (32.4%). In this study, participants under age thirty were less likely to successfully complete as only 14.7% of the participants who completed the program were between the ages of 26 to 30 and of 18 to 25. It was not anticipated that there

would be differences in successful completion by age as clients were evenly distributed across categories of age. However, this finding underscores the need to look at ways of improving program structure to increase the rate of successful completion among participants under age 30.

Implications

Results from this study have contributed to an increased understanding regarding those factors which influence successful completion of family treatment drug court. While there are not significant differences there are trends that need further examination. Although several of the predictor variables examined in this study did not achieve statistical significance for the criterion successful and unsuccessful completion, significance was reported for the following variables: drug of choice, prior treatment, CPS involvement, and sources of social support. Age was also found to differentiate successful from unsuccessful completers of the Family Treatment Drug Court program. These findings suggest that theorists, researchers, and practitioners should consider these factors when conceptualizing the factors affecting successful and unsuccessful completion of family treatment drug courts and when developing programs for this population.

The influence of drug of choice on participants of family treatment drug court programs needs further investigation to determine the extent to which a participant's primary drug of choice impacts their successful or unsuccessful completion of treatment. The findings of this study showed marked differences between successful completion of the Dependency Drug Court program, an intensive outpatient treatment program, and national data on successful completion rates of intensive outpatient programs. There was a significant difference between successful completers ($N=12$, 35.3%) and unsuccessful completers ($N=78$, 51.7%) who identified marijuana as their drug of choice. In contrast, the successful completers reported cocaine as their drug of choice. Research has found that more clients successfully complete intensive outpatient treatment who report alcohol as their drug of choice (SAMHSA, 2004). Further study is needed

to examine possible differences between participants of family treatment drug court programs and participants of other intensive outpatient programs.

Findings of this study also suggest that researchers, practitioners, and program developers of family treatment drug court programs might benefit from examining the prior treatment history of program participants when determining admission criteria and program design. When examining the differences between program participants with no prior treatment history and participants with one or more treatment episodes, there were more unsuccessful completers among participants with no prior treatment history. Practitioners need further information on the viability of individuals successfully completing family treatment drug court programs who have had no history of treatment. These individuals may be more appropriate for less intensive forms of treatment while family treatment drug court program may need to be reserved for individuals with more extensive treatment experience. Involvement with child protective services also showed significance for participants who reported three prior open cases. This may suggest that participants who have a history of prior cases may need an alternative treatment program and/or additional services to assist them in achieving successful completion outcomes within the family treatment drug court program.

In addition, researchers, practitioners, and program developers of family treatment drug court programs should consider social support as an indicator of a participant's likelihood of successfully completing this program and look for ways of improving and/or enhancing the participant's social support systems to assist them in reaching successful completion outcomes. Many family treatment drug court programs have program requirements that require participants to strengthen their recovery support systems through support group (AA/NA) attendance and obtainment of a 12-step sponsor. In addition, some require participants to obtain and maintain

employment to demonstrate self-sufficiency and the ability to provide for their child(ren). However some programs, such as the program under study, incorporate these requirements at later stages of the treatment program which may lessen the impact these sources of support may have on participants in the early stages of their treatment. The importance of certain sources of social support indicated by the data, suggests the need to thoroughly assess the participant's social support system prior to their admission to determine what services and assistance is needed at treatment onset to increase successful completion outcomes.

Data also suggests that researchers and practitioners should look more closely at which factors may contribute to successful completion of family treatment drug court among participants over 30 years of age as compared with those under 30 years of age. In this study, there were more unsuccessful completers who were under 30 years of age. These participants may require alternative treatment approaches (i.e. treatment groups for young adults) to assist them in reaching successful completion outcomes. Further exploration is needed to determine which interventions are more effective with this population.

In addition, data reported in this study was consistent with research which has shown that the longer a participant spends in treatment the greater their chances for a favorable treatment outcome (Peters & Murrin, 1998, Lawental et al, 1996, Trone & Young, 1996). However, the majority of the study participants were discharged in phase I or phase II with a majority of participants being discharged in phase I (N=121, 80.1). Only 18.4% (N=34) of the study participants in the study successfully completed the Dependency Drug Court program. This low rate (18.4%) of successful completion of this family treatment drug court program is of great concern. SAMHSA (2004) found that approximately 40% of individuals who participate in intensive outpatient treatment programs complete it successfully. The family treatment drug

court program under study may have differed from the treatment programs examined in the SAMHSA study as there are variations in the duration and design of intensive outpatient programs. However, more information is needed to determine if there are distinct differences among family treatment drug court participants and participants of other types of intensive outpatient treatment programs. Furthermore, researchers and practitioners should continue to look at ways of improving client retention within family treatment drug court programs to increase the likelihood of participants obtaining successful completion outcomes.

Recommendations for Future Research

More research is needed on both participants and practitioners of Family Treatment Drug Court (FTDC) programs to improve the effectiveness of these programs. Reproduction of this study would entail a redesign of the methodology conducted. Qualitative methods would be incorporated which would include focus groups and in-depth interviews of subsets of FTDC participants and practitioners who provide clinical treatment to this population. The purpose of the interviews would be to obtain qualitative data regarding which components of the FTDC program participants found either helped and/or hindered their success in the program. For example, age was a variable found to significantly differentiate between successful and unsuccessful completers. There were more successful completers among participants 37 years of age or older or between 31-36 years of age, and fewer successful completers for participants under 30 years of age. Interviews could be conducted with a subset of participants over 30 years of age and under 30 years of age to examine which interventions of the program contributed to their successful or unsuccessful continuation/completion of treatment. Inquiries would also be conducted on the characteristics of these different age groups which may influence their treatment outcomes.

Prior to conducting the study, a focus group would be held with practitioners of FTDC programs to examine their beliefs on which client characteristics may influence successful completion of these programs. Variables included in the original study may be omitted as practitioners may identify different variables believed to be influential in treatment outcomes, for example, participants with co-occurring mental health and substance abuse disorders. In-depth interviews would also be conducted with practitioners that explored the nature of the work involved in FTDC programs. The longevity of practitioners in this program is a concern as there were six different practitioners who provided treatment services during the time period included in this study. It is important to explore what aspects of the program and/or client characteristics may deter practitioners from continuing to work with this population.

In addition, further investigation is needed into motivation to participate and successfully complete FTDC programs. There was an increase in the number of participants admitted to the FTDC program under study in 2004 which followed a change in admission criteria. Initially, FTDC participants who were found appropriate for the program were required to request admission to the program prior to being admitted. However, in 2004 all participants found appropriate for the program were recommended by the court for participation resulting in some coercion of participants to participate. As a result, the rate of successful completers of the FTDC program under study declined. Inquiry is needed from both participants and practitioners to determine the extent motivation to change influences successful completion of these programs. FTDC programs may be currently designed for voluntary participants with higher levels of motivation to change. Therefore, they may not be appropriate for participants who believe they have been mandated or coerced to participate.

Follow-up analysis and interviews could also be conducted on participants who successfully completed the program. Data could be collected at 3 months, 6 months, and 12 months following discharge from the FTDC program to determine if the participant was able to maintain abstinence. If the participant was unable to maintain abstinence, data would be collected on number of relapses which occurred and inquiries would be conducted on how the participant dealt with their relapse. Data would also be collected at 3 months, 6 months, and 12 months following discharge from the FTDC program to determine if the participant had any subsequent investigations for child abuse and neglect and investigations which resulted in the removal of their child (ren). Interviews could also be used to examine which components of the program participants believed to be helpful in continuing their sobriety, remaining out of the child welfare system, and which components participants continue to utilize.

The data from the qualitative interviews could be analyzed by means of comparative analysis. Information obtained by the FTDC participants and practitioners could be analyzed for conceptual themes or categories. This analysis could be used to detect commonalities and differences among participants and practitioners themes. The themes or categories would then be analyzed for comparisons across interviews for the purpose of generating a theory based on that data.

The results of this study could be used in the development of a structured interview to assess the individual's appropriateness for participation in a Family Treatment Drug Court program. The structured interview would be tailored to individuals involved with child protective services with identified substance abuse issues and used for the assessment of individual characteristics related to successful completion of FTDC programs, such as drug of choice, prior treatment, and sources of social support. The purposes for developing such a structured interview are twofold: (1) to develop a standardized interview for the assessment of FTDC participation, which can be used by trained

professionals; and (2) to design an interview with standard probes, internal consistency, inter-rater reliability by which symptoms are clearly defined.

To develop the structured interview, several questions would be written specific to FTDC participants. For example, questions would assess the source of social support reported by participants and the amount of support believed to be received by the participant. Each question would be given a set of scoring criteria and prompts to elicit information assisting in the scoring of the participants' answers. After pilot testing, the number of questions would be revised to reflect any need to add or eliminate questions. A series of item and scale analyses would then be conducted to determine further need for revision. The remaining items would result in the Family Treatment Drug Court Interview (FTDCI) which would be evaluated for inter-rater, internal, and retest reliability.

There are also several directions for research based on the results of this study. Although several of the predictor variables in this investigation (i.e., criminal status, drug of choice, frequency of use) did not achieve statistical significance for the criterion of successful completion of the family treatment drug court in this study, the finding from the variables of drug of choice, prior treatment, source of social support, and CPS involvement (participants reporting three prior cases) did show significant differences. These factors require further exploration to examine how they influenced successful completion of family treatment drug court. In addition, age was among the demographic variables which had significant difference.

There was no significant difference among participants for criminal status at time of admission with similar successful completion rates for participants who had no history of criminal involvement (20.0%), participants who were not under legal supervision at the time of admission but had at least one previous criminal change (16.3%), and participants who were under legal supervision at time of admission (18.4%). Previous researchers have reported that drug use and criminal activity are reduced for adult drug court program participants while they

are receiving treatment services (Belenko, 1999, 2001); however, more information is needed regarding rates of criminal activity and retention among family treatment drug court participants. Longitudinal research is also needed to determine the lasting impact of treatment by examining which family treatment drug court participants re-offend while in family treatment drug court programs or following discharge (successful or unsuccessful).

There were no significant differences found for drug of choice in this investigation. However, method of drug use (oral, inhalation, intravenous, etc.) was not distinguished for each participant. Drug of choice was coded by the classification of the substance reported by the participant and not the form of the substance. For example, crack cocaine was classified as cocaine and hashish was classified as marijuana. There may in fact be differences in the rates of successful completion of family treatment drug court participants based on type of substance used. Some substances which are administered intravenously or free based are highly addictive. For example, researchers (Schiff & Terry, 1997) have found crack cocaine use to be significantly and negatively related to completion of the drug treatment court program and have suggested that the use of this particular drug was an important factor in preventing offenders from successful completion.

There were no significant differences found in regard to gender; however, this study sample contained an overwhelming number of female participants (N=163) compared with male participants (N=22). Research suggests that gender differences are an important factor in addiction and recovery (Magura & Laudet, 1996). Gender differences have been reported to impact treatment initiation, retention, and completion. Surveys of national samples indicate that, in the general population, more fathers than mothers have a substance abuse disorder (DHHS, 1994) and men consistently outnumber women in all types of treatment (Gerstein, Johnson,

Larison, Harwood, & Fountain, 1997). However, there are a greater number of women entering treatment who are mothers (DHHS, 1999) which is evidenced by the participants in this study.

Men and women also differ in their alcohol and drug use and associated behaviors. For example, there are gender differences in initiation into substance abuse treatment, sources of referral and social support, and where they access treatment (Weisner, Greenfield, Room, 1995; Brennan, Moos, Kim, 1993). While men are more likely to receive familial support for treatment initiation and referral from employers and the criminal justice system, women receive lower levels of familial support and are more often referred by social service agencies. This may account for the disparity in the number of females and males admitted to the family treatment drug court under study; however, further investigation is needed to determine influences in referrals to family treatment drug court programs. Of those parents referred for treatment services by CPS agencies, mothers entering into treatment are more likely than fathers to be concerned about losing custody of their children and to indicate that their treatment participation may affect their custody status (Grellan & Joshi, 1999; Finklestein, 1994; Henderson, 1994). This may suggest that women require specialized services to address their unique needs and motivation for participating in treatment services, such as “family-oriented services providing comprehensive care as well as parenting and family skills training, all of which usually remain unaddressed in traditional drug treatment” (Magura & Laudet, 1996, p. 203).

In addition, researchers should begin to examine the impact of differences in motivation for treatment among couples (mothers & fathers) who have both been identified as having alcohol and drug abuse problems. Little is known about the differences in motivation to participate in family treatment drug court programs for couples and/or if child protective agencies have different criterion for referring couples to family treatment drug courts. While

many of the participants in the program under study identified themselves as married or unmarried couples, more research is needed to determine what factors influence couples to complete treatment successfully.

More research has now been conducted examining the impact of ethnicity/race on drug treatment. Although there were no significant differences in treatment completion by racial/ethnic group of participants in this study; previous research findings are contradictory. For example, Schiff and Terry (1997) examined adult drug court treatment outcomes and found that nonwhite participants were less successful than white participants. Their study also revealed that nonwhite offenders faced both cultural barriers and structural problems as clients of drug treatment court (Schiff & Terry, 1997). Sechrest and Shichor (2001) also reported a significant difference by ethnic group in adult drug treatment court outcome: 69% of the white clients graduating versus 32% of the African-American clients. However, other researchers have examined adult drug court outcomes and found no significant differences in treatment completion by ethnic group (Saum, Scarpitti, & Robbins, 2001; Logan, Williams, Leukefeld, & Minton, 2000). In this study, the ethnic/racial make-up of this sample was evenly split between white participants at 49.7% and persons of color at 50.3%. Successful completion of participants was also similar with 21.7% of whites successfully completing and 15.1% of persons of color successfully completing. However, further research is needed to determine whether there are differences in treatment outcomes for FTDCs due to ethnicity/race and to determine if more attention needs to be directed towards cultural barriers that may impede completion rates of FTDC participants.

Co-occurring mental illness and substance abuse is also a growing concern among theorists, researchers, and clinicians. Individuals with mental illness and co-occurring substance

abuse problems have become a common occurrence in treatment facilities, and may contribute to treatment non-compliance (George & Krystal, 2000). Approximately 50% of individuals with psychiatric disorders will meet DSM-IV criteria for drug or alcohol abuse or dependence at some point during their lives (Dixon, 1999). Moreover, co-morbid substance abuse and mental illness may contribute to noncompliance and treatment-resistance to pharmacologic and psychosocial treatments (George & Krystal, 2000). As a result, more and more programs have begun to integrate mental health and addiction treatment to improve outcomes for their clients.

Questions have been raised however, regarding the effectiveness of treating individuals with mental illness and co-occurring substance abuse disorders in the same programs as individuals having only substance abuse disorders. Mental illness and co-occurring disorders was not a variable under study in this investigation; however, research has shown that those with mental illness fare as well in drug and alcohol treatment programs (Galanter, Egelko, Edwards, & Katz, 1996). There have been advancements in the establishment of co-occurring treatment programs; however, there are few studies on the retention rates of individuals with co-occurring disorders in Family Treatment Drug Courts. Further research is needed to determine whether the rates of successful treatment completion is affected by parents with co-occurring mental illness as compared with those with substance abuse disorder diagnoses only.

Summary

The prediction of successful completion of family treatment drug court was examined by means of participant's drug of choice, frequency of use, prior treatment history, criminal history, source of social support, and prior involvement with child protective services. In addition, demographic information (age, gender, race, and education) was also gathered to determine if there were demographic differences between successful and unsuccessful participants. A hierarchical logistic regression analysis revealed that drug of choice, prior treatment, and social

support were significant predictor variables. A Chi square analysis also revealed that child protective service involvement significantly differentiated between successful and unsuccessful participants. Age was also found to be significant with more successful completers among participants between 31-36 years of age and 37+ years of age. The results of this study have implications for theory, practice, and research, and especially future research into family treatment drug courts. Substance abuse clinicians will be better able to design effective treatment interventions when they have greater knowledge and understanding of the factors which impact successful and unsuccessful completion of family treatment drug court programs.

APPENDIX A
DATA CODING

No = 0

Yes = 1

Criminal Status: A four point rating scale will be used to measure criminal status:

CS

- 1. 0 = no history of criminal involvement
- 2 1 = participant not under legal supervision at the time of admission but at least one previous criminal charge
- 3 2 = participant under legal supervision at the time of admission
- 4 3 = participant under legal supervision at the time of admission and concurrently admitted to Adult Drug Court program

Drug of Choice: A five point rating scale will be used indicating dependence:

DC

- 1 = cocaine
- 2 = alcohol
- 3 = marijuana
- 4 = opiates
- 5 = heroin

Frequency of Use: A five point rating scale:

FU

- 1 = No past month use
- 2 = 1 to 3 times in past month
- 3 = 1 to 2 times per week
- 4 = 3 to 6 times per week
- 5 = Daily use

Prior CPS Involvement: Four point scale will measure prior Child Protective Service involvement:

CP

1 = All parents who had have had one prior open case with the Department of Children & Families (whether the case was closed or not)

2 = Two prior cases

3 = Three prior cases

4 = Termination of parental rights

Prior Treatment History: Six point scale regarding prior treatment:

PT

0 = No prior treatment history

1 = One treatment admission (successful or unsuccessful completion) in a traditional outpatient program (once a week for 3 months of treatment minimum)

- 2 = One treatment admission in intensive outpatient treatment (3-5 days a week for 3 months of treatment minimum)
- 3 = One treatment admission in residential treatment (28 days minimum)
- 4 = More than one outpatient treatment admission (outpatient or intensive outpatient)
- 5 = More than one residential admission will be coded as 5.

Social Support: Five categories:

SS

- 1 = Having no social support system
- 2 = In serious conflict with and/or having been pressured to receive treatment by one's support system
- 3 = Support from friends/family, spouse/partner
- 4 = Support from support groups (AA/NA)
- 5 = Support from other institutions (i.e. employer)

Stage of Treatment: Participants phase of the DDC program at the time of discharge (five point rating scale):

ST

- 1 = Phase I
- 2 = Phase II
- 3 = Phase III
- 4 = Phase IV
- 5 = Successful Completion

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BIOGRAPHICAL SKETCH

Rosa West was born in Weisbaden, Germany, and raised in Melbourne, Florida. She was born of Walter and Alice West and is the youngest of three children. After graduating from Eau Gallie High School in 1997, Rosa attended the University of Florida, majoring in psychology and sociology. She then went on to pursue her master's, specialist, and doctorate degrees in the Department of Counselor Education at the University of Florida.

During that time she gained clinical experience working as a counselor in the community at a mental health and substance abuse facility for many years. There she had the opportunity to work with a family treatment drug court program and was inspired to explore ways of improving the structure of the program to assist parents in obtaining the services required to gain recovery and strengthen their families.