ABSTRACT

The Eleventh Judicial Circuit Administrative Office of the Courts (AOC) implemented Dependency Drug Court (DDC) in March 1999. Building on the existing DDC, we propose to expand and enhance DDC through implementation of two evidence-based intervention approaches that have been successfully piloted. This Initiative includes a case management intervention model for mothers and a parenting program for families with children ages 0-3. Activities include: screening, assessment, treatment plans and enhanced case management for an additional 120 dependency abuse/neglect cases and parenting sessions 40 parent-child dyads. The goals are: increase positive permanency outcomes (sole custody, joint custody, or permanent guardianship with family members with termination of parental rights when appropriate) which will be measured by outcomes upon completion of drug court; reduce likelihood of negative outcomes for children by addressing the substance abuse of parents and providing services for their children, which will be measured by re-entry. The evaluation will provide feedback regarding the implementation; present findings relative to data collected and outcome variables (including the performance measures); address the extent to which program implementation was consistent with the plans for implementation; identify the program's impact and effectiveness; and delineate lessons learned from the evaluation.

PROGRAM NARRATIVE

Statement of the Problem

Effects on Target Population and Community

Drug abuse among women with children is a serious public health problem that not only is damaging to the mothers but also places their children at risk of abuse, neglect, and other problem behaviors. Women drug users are at high risk of becoming HIV infected and

developing AIDS, being victims of abuse and crime (Dansky, Byrne & Brady, 1999; Tardiff et al. 1994), and neglecting or abusing their own children (Sagatun-Edwards, Saylor, & Shifflett, 1995).

Local Data

The DDC is a part of the Juvenile Division of the Eleventh Judicial Circuit of Florida, the fourth largest trial court in the nation. In 2008, 744 dependency abuse/neglect cases were filed (Criminal Justice Information System-CJIS) with 523 verified substance abuse allegations (Department of Children and Families-DCF Florida Safe Families Network-FSFN). Currently 54% of those offered DDC accept for a potential of 282 DDC eligible parents (DDC data).

One notable problem (locally and nationally) in the treatment of adults is high dropout rates among both male and female patients, and there are indications that female patients, especially those involved in the child welfare system, have exceptionally high dropout rates (Gregoire & Schultz, 2001; Morgenstern et al, 2006). Three studies were funded by the National Institute on Drug Abuse (NIDA), for the University of Miami Center for Treatment Research on Adolescent Drug Abuse (CTRADA) to work in partnership with the Eleventh Judicial Circuit Juvenile Division. These three studies focused on the Engaging Moms enhanced case management intervention to increase drug abuse treatment enrollment and retention among mothers in DDC and found that a higher proportion of mothers receiving the Engaging Moms intervention successfully graduated from dependency drug court (68% vs 53%).

Participants were all DDC mothers whose children were adjudicated dependent; the mothers voluntarily enrolled in drug court, and were randomized into the study immediately upon their enrollment in drug court. Participants were African-American (37%), Hispanic (35%), White, Non-Hispanic (22%), and 6% self-identified as other ethnicities. They averaged

30.7 years of age; had extremely low incomes, reporting an annual median family income of approximately $7,000; and were not well educated (43% high school graduates or GED). Participants primarily abused cocaine and alcohol, and they had considerable mental health problems with a high percentage of mothers showing symptoms of serious depression (52%) and anxiety (49%), with 12% reporting current suicidal ideation.

Results overall demonstrated significant promise. Sixty-eight percent of mothers had positive permanency outcomes (sole custody, joint custody, and permanent guardianship with family members without termination of parental rights). In all outcomes examined, significant time effects from intake through the 18 month follow-up period were found. Mothers decreased their self reported alcohol and drug use, and over time were increasingly less likely to produce a positive drug test. They showed improvement in their mental health and family functions, and decreased their risk for child abuse. Finally, the children of mothers enrolled in the study significantly decreased their internalizing, and externalizing behaviors between intake and 18 month follow-up. Participation was also associated with significantly better outcomes over time. For child welfare outcomes, almost twice as many mothers assigned to the control group in comparison to those randomized to the experimental group had their cases filed for termination of parental rights (43%vs. 23%) (Dakof, et al (2004).

Research/Evaluation Studies

Research and evaluation studies that relate to the problem and contribute to the understanding of causes and potential solutions show that dependency drug courts address complex family systems and family needs. Females comprise more than 85% of those served by dependency drug courts (Cooper 2001; Edwards & Ray, 2005). Because these courts are more likely to serve women, programs collaborating with the DDC, and the DDC program itself, are

inherently concerned with the specific issues that women face, including barriers to treatment entry and retention (Ingersoll, Lu, & Haller 1995; Rockhill, Green, & Newton-Curtis, in press), and the need for gender-specific treatment approaches that address such issues as parenting and domestic violence (Finkelstein, 1995; Grella, 1996; Dakof, 2000; Dakof et al 2004). Given that children's permanency, safety and well-being are the key concern of the DDC cases, it is important to note the overlay that exists in these cases that connects the mother's road to sobriety with child outcomes. Infants and toddlers make up one third of all admissions into the child welfare system and once they are in care, young children remain longer and are more likely to be abused and neglected (Wulczyn, Hislop, & Harden, (2002). Despite considerable scientific and research evidence (Shonkoff and Phillips, 2000), discussions on children's mental health during their time within the dependency system have consistently excluded babies and toddlers, focusing instead on school-age children and adolescents. Unfortunately within the public mental health system, the majority of mental health professionals who provide services for children know relatively little about those under the age of six years or how to serve them. Thus, the DDC Planning Team identified a need to expand capacity from 60 to 100 participants with focus on the mothers and to provide differential, developmentally appropriate services to their children.

Although the DDC has made great strides in innovating drug court procedures and methods, it has never received federal operational funding and has struggled with limited resources that have hampered attempts to fully sustain innovations and expand reach. The *Expansion and Enhancement Initiative*, if funded, will allow the DDC to increase capacity to serve clients who need services but are currently not able to access the program due to funding limitations, and also will allow the program to implement the enhanced program services for mothers and their children.

IMPACT/OUTCOMES AND EVALUATION/PERFORMANCE MEASURE DATA COLLECTION PLAN

The mandatory performance measures identified by OJJDP will be collected and submitted to the OJJDP online system (Data Collection and Technical Assistance Tool) on a regular basis by the evaluation team. The performance measures, the data that the *Expansion and Enhancement Initiative* will provide, and the method for collecting the data are indicated in the table below.

Performance Measures	Data Provided by DDC *Expansion And Enhancement Initiative*	Data Collection Methods (Data will be provided to evaluator electronically)
1. Number of family drug court participants. 2. Percent of participants who successfully complete the program. 3. Percent of participants who exhibit a desired change in the targeted behavior (e.g., a reduction in substance abuse, improved parenting skills). 4. Percent of participants with a new drug-related offense (arrest or referral to court). 5. Percent of participants who have a new CPS referral. 6. Percent of participants who have a new substantiated child protection case.	1. Number of family drug court participants. 2. Number of participants who exited the program; Number of participants who successfully complete the program. 3. Number of participants who exhibit a desired change in the targeted behavior (i.e., parenting knowledge and behavior; parental substance abuse). 4. Number of participants with a new drug-related offense. 5. Number of participants who have a new CPS referral. 6. Number of participants who have a new substantiated child protection case.	1. DDC Specialists collect the data in an Excel file. 2. DDC Specialists collect the data in the Excel file. 3. AAPI-2, KIDI will be administered pre and post-intervention. Clinicians will score the instruments. All drug screen results are collected in the Excel file or Eleventh Circuit Drug Court Application. 4. CJIS data checks at intake, and every 3 months until closing. 5. DCF Reports to the Court. 6. DCF Reports to the Court.

PROJECT/PROGRAM DESIGN AND IMPLEMENTATION

1. Collaborative Planning

Stakeholders, Planning Process/Participants, Cross-Training,

The DDC is a partnership among key stakeholders in the dependency court, including: the DDC Judge; the South Florida Provider Coalition (SFPC); the managing agency for the substance abuse and mental health providers; Our Kids of Miami Dade/Monroe, Inc., the

managing agency for child welfare providers; the Department of Children and Families (DCF) Substance Abuse/Mental Health Division; the Child Welfare Regional Legal Counsel; University of Miami CTRADA and UM Linda Ray Intervention Center (LRIC); defense counsel; DDC Alumni; and AOC staff (Juvenile Operations Director, Chief Deputy Court Administrator, Grants Administrator, DDC Program Coordinator).

In an effort to reach permanency (with reunification when possible) for the children within the 12 month timeframe required by Adoption and Safe Families Act (ASFA, Public Law 105-89), the collaborative group supports the DDC program which provides maximum support to the parents as they move towards sobriety. All stakeholders (above) have collaborated since the inception of DDC, and have provided input for this proposal to enhance and expand the DDC so that higher quality services can be offered to more mothers and children. If funded, the group is ready to begin detailed implementation of the proposed *Expansion and Enhancement Initiative.* During the first quarter, monthly meetings will be held. Following that, meetings will be held quarterly. Cross-trainings and staffing meetings prior to hearings occur regularly. These cross discipline events involve drug court partners, drug court staff, child welfare case managers and treatment providers and are elaborated upon in sections below.

Major milestones

1997	Collaborative DDC planning initiated.
1999	One of 3 family drug courts in SAMHSA CSAT Family Drug Court Initiative. Team of 13 attended and presented.
2000	"Beyond Dependency and Substance Abuse" training for all circuit dependency staff.
2000	Team of 13 attended and presented at Family Drug Court National Conference.
2002	Created child friendly, accredited daycare and children's programs in treatment facilities.
2002	Strengthening Families Parenting Initiative for DDC funded by SAMHSA.
2003	Engaging Moms Intervention for Family Drug Court funded by NIDA.

2007	*Seeking Safety* trauma model implemented at treatment centers.
2007	On-site psychiatrist at treatment centers.
2008	Expansion of DDC case referrals from all judicial sections.

2. Target Population, Screening, and Eligibility

Target Population and Eligibility Criteria

The population eligible for DDC and this project are parents named in new dependency petitions with substance abuse allegations who enter drug court voluntarily. Parents alleged to be sexual perpetrators, or mentally incompetent, or diagnosed with an un-stabilized, severe mental disorder (e.g., paranoia, hallucinations, delusions, mania, lack of stabilization on psychotropic medication, failure to follow medical regime, or other functional impairment that would inhibit effective program participation), or have an advanced terminal illness are excluded. Parents with a history of violent or criminal offenses or who are on methadone maintenance programs will be considered on a case by case basis. Drugs of choice for this population are cocaine, marijuana, alcohol, benzodiazepines and opiates in that order. Most parents are poly-substance abusers. Parents under dependency court supervision for child abuse and/or neglect will be screened and ordered to provide urine specimens on a regular basis. At the judge's discretion, any family member who desires custody or contact with children under the court's jurisdiction, and or significant others of drug court participants, may also be required to provide urine specimens.

Identifying and Screening Eligible Clients for Dependency Drug Court

Parents are identified in all 5 dependency courtrooms. Initial screening is based on the judges' or courtroom staff identifying parents who want to be the primary custodian and have allegations of substance abuse in the petition or stated to the court. If the possibility of reunification exists, these parents can be offered DDC services. The Judge ultimately determines

eligibility to be referred to the DDC program. The *Judicial Eligibility Checklist* (Attachment VIII) is completed by court staff to refer a parent to DDC for consideration.

Stage in Process Parents are Screened

After the initial screening at the first hearing, the DDC Program Coordinator conducts the intake assessment and then refers the client to the DDC Specialist and treatment provider with recommended services based upon the expressed and assessed needs of the participant.

Length of Time Between Child Welfare, Filing of Petition, First Appearance, Treatment

Parents are identified at the shelter hearing which occurs within 24 hours of filing of the detention petition. Assessment of the parent's status occurs within 7 days after screening and treatment begins within 7 days of the assessment, if it has not already commenced. In summary, the client's first appearance in DDC and enrollment in treatment occurs within the first month of the case and sometimes occurs within days of the first hearing.

Determine and Maintain Targeted Capacity

The current capacity of the basic DDC model is 60 participants per year, which is based on available funding. That capacity is ensured through an Administrative Memorandum requiring all judges across the dependency division to send potentially eligible cases to DDC for screening.

3. Clinical Assessment and Service Delivery

Clinical Assessment

DDC Intake, clinical screen and assessment of parents is conducted by the DDC Program Coordinator upon referral, identification, eligibility confirmation, and approval of the Judge. The intake consists of: an overview of the program components; completion of releases of

information and the client file information sheet; assessment of the client's mental status, suicide and homicide risk, and treatment motivation.

Instruments

The assessment protocol of the parent administered by the DDC Program Coordinator includes: the Mini International Neuropsychiatric Interview (MINI), the Addictions Severity Index-Female Version (ASI-F), and the ASAM Patient Placement Criteria. Intake and assessment measures were chosen to obtain the following information: assessment of physical health; alcohol and drug use history; evaluation of current alcohol and drug use; current degree of psychopathology; exposure to abuse or violence; and psychosocial history including family of origin information, employment history and capability, and history of involvement in the criminal or juvenile justice systems. The information is used to develop treatment plans and match treatment needs with services.

Treatment Plans and Service Delivery

In most cases, within 8-10 hours after intake and assessment the parent is referred to a DDC Specialist and a SFPC treatment provider. The dependent child(ren) whose parent(s) agree to participate in DDC are assigned to Family Resource Center (FRC), a full-case management agency within the community-based system of care, led by Our Kids of Miami Dade/Monroe, Inc. FRC has a drug court unit specific to DDC participants (see Services for details). The report from the screening and assessment with treatment recommendations is provided to the court, and the substance abuse treatment provider, and the FRC case manager. Medical referrals may be made to screen for infectious diseases, life threatening illnesses, birth control history, and health maintenance history. These referrals may come from the treatment provider or FRC case manager.

The FRC case manager conducts intake for the dependent child applying clinical standards to evaluate the nature of children's needs as they enter the child welfare system. Within 30 days of a case entering the system all children in out of home care receive Level of Care Assessments (LOCA) which evaluate all systems of a child's life and from which recommendations for needed services are made. The LOCA includes: Ages and Stages, Part C evaluations at the Early Steps Part C provider sites at the University of Miami or South Miami Hospital and the Florida Diagnostic and Learning Resources System for children.

The South Florida Provider Coalition (SFPC), composed of most of the substance abuse and mental health treatment providers in Miami-Dade County, provides services for co-occurring disorders. SFPC has the single Florida Department of Children and Families' (DCF) contract for managing the provision of substance abuse treatment services for the entire county which they do through sub-contracts with 29 service provider organizations. To ensure quality and effectiveness of treatment services, the DCF contract for managing the provision of substance abuse treatment services requires SFPC to subcontract with network providers who, together, provide community-based substance abuse and/or mental health services statutorily authorized for adults and children. SFPC provides oversight so that all network providers comply with all client-related and other requirements. (Attachment III)

Treatment Interventions

The specific treatment interventions are provided according to DCF protocols. Residential: Level 2 - 24 hour supervision, 20 hours of clinical service weekly and 20 hours of activities; Level 3 - 24 hour supervision, 10 hours clinical service and 10 hours activities; Level 4 – supervised housing with Outpatient Level of Care (individual and group), individual, trauma HIV +, therapy groups counseling. Workshops - 12-steps, relapse prevention, anger

management, problem-solving, parenting, developmental education, HIV prevention, child care, vocational training, case management, family therapy, psychiatric evaluation, medication management, mental health counseling, nutritional consults, bio-psychosocial and needs assessment, and Fellowship Meetings. Outpatient: 2, 3 hours weekly groups or continuing care which includes: parenting group, substance abuse group, weekly in-home case management, weekly individual counseling (some designed specifically for parents with children).

DDC seeks to keep children with their parents in treatment whenever possible. Four DDC treatment providers provide residential treatment for mothers and their children, and one facility provides residential treatment for children with fathers or with both parents. The court is involved with these providers in assuring quality services for children residing in the facilities.

Integration of Treatment Services with DDC

As mentioned previously, cross-trainings and weekly staffing occur both formally and informally on a regular basis.

Individual Needs of the Client, Gender Appropriate, Culturally Competent

Treatment plans are developed based on the intake interviews, results of assessments, and the individual needs of the client. Miami-Dade County is an extremely diverse community, with a kaleidoscope of cultures and languages. All service and treatment providers have bi- and many have multi-lingual staff. The DDC, service and treatment providers inquire of participants whether they have norms, beliefs and values that might either contraindicate placement in treatment *per se* or require that placements be made selectively in these regards. All services are provided in both English and Spanish.

Monitoring Quality and Effectiveness of Treatment Services

The court is very involved in monitoring the quality of services and demands that services are evidence based. For example, the court was integral in the inclusion of trauma informed services such as Seeking Safety, quality early childhood intervention programs and --most importantly-- identifying and treating co-occurring disorders (also see SFPC above).

Through written or oral communication the treatment provider must report progress to the DDC. DDC Specialists and treatment providers report progress of the parent to the court at hearings and additional drug testing is also conducted at hearings to enhance monitoring (Attachment IV).

Methods of Drug Testing and Analysis

Parents can drop urine specimens at treatment centers or on-site at the courthouse free of charge, even on days when they are not mandated to be in court. If alcohol is the drug of choice, then parents are placed on SCRAM bracelets. These devices cannot be removed and detect any amount of alcohol intake through a scientifically based alcohol detection system. In addition to tests at the treatment center, health technicians conduct the urinalysis test on site at the Juvenile Court. A 5-panel test is used. Urine is dropped at least twice monthly randomly or upon suspicion. Clients are observed by a same-sex staff member during the urine drop. Urine is analyzed in the presence of the client. Turnaround time for results at the hearing is within minutes. At treatment centers the test is sent to a lab, and it takes 48 hours to obtain the results (also see Component 6)

Continuum of Care for Children, Parents, and Families

There are long standing Linkage Agreements and Memoranda of Understanding between the DDC, SFPC, and Our Kids to meet the children, parents' and families' needs for additional services (Attachment IV).

The Family Resource Center of South Florida (FRC) is the Our Kids, Inc. subcontracted agency to provide service for children whose parent(s) are participating in DDC (Attachment V). The FRC provides a full continuum of services aimed at strengthening families. Services (available in English, Spanish and Creole) include family support, crisis intervention, housing location, family preservation, parent education and counseling. Referrals are made to other community providers for substance abuse, mental health, health, child care, educational, and/or social service needs of the children. Case management is provided for the entire case, meaning the parents, children, and entire familial system and includes: weekly meetings which transition to bi-monthly and monthly depending on the case progress, involvement of family members/support systems, urine analysis testing, monitoring of effectiveness of services, and weekly case staffings prior to court. Services provided by case management staff include: referral to program and services, monitoring case progress, coordination of system of care services, detailed case reports and recommendations to the court. The average caseload per case manager reflects best practice and does not exceed 15 families.

Strategies include involving family members/significant others in the treatment process. Family and collateral counseling is provided by recognized state/local authorities to provide such counseling. Parenting skills development classes are required for both fathers and mothers of school age children, and child care provision at the treatment facility is provided. Clients' family members are engaged to help motivate and support the client through successful completion of DDC. Clients in need are provided assistance with funding for use of public transportation. Coordination of treatment and recovery continuum with other services, such as vocational rehabilitation, education, legal aid, and transportation is provided through DDC, FRC and treatment providers.

4. Program Design and Length:

DDC Structure, Requirements

The Administrative Office of the Courts (AOC) of the Eleventh Judicial Circuit, Juvenile Division, implemented the Dependency Drug Court (DDC) in March 1999. There are 5 dependency judicial sections within the Juvenile Division, one of which is designated as the drug court.

Dependency Drug Court Protocol:

DDC participants progress through five phases for completion of the DDC program.

Phase I

Goals	Expectations	Advancement Requirements
* Screening and assessments * Assessment and referral for additional services (based upon individual needs) * Assessment of children's special needs * Placement in community-based treatment * Identification of treatment barriers * Decrease alcohol/drug use as evidenced by negative Urinalysis * Urinalysis Schedule * Resolve legal issues in Dependency Court * Acquire consistent visitation	* Weekly court appearances * Urinalysis testing 3x weekly or random * Enter substance abuse treatment * Compliance with court orders * Engage with Specialist * Visitation with children (establish schedule) * Attend AA/NA meetings * Plea to Dependency Allegations	* Regular court appearances * Team recommendation * Participation in substance abuse treatment program * Negative urinalysis for at least one week. * Completion of sanctions

Phase II

Goals	Expectations	Advancement Requirements
* Continued Abstinence * Enroll and participate in ancillary services * Attend family planning appointment * Identify home group for AA/NA meetings * Attend AA/NA meetings regularly * Maintain negative urinalysis results * Maintain safe, adequate, visitation with children based on the developmental needs of the children	* Every 2 weeks Court appearances * Urinalysis testing 3x weekly or random * Engagement in substance abuse treatment * Begin ancillary services * Continued attendance in AA/NA meetings and identification of home group. * Work toward service plan goals * Consistent visitation with children	* Regular court appearances * Team recommendation * Progress towards treatment plan goals * Negative urinalysis results for a minimum of two months * Compliance with sanctions * Express commitment to participation in services

* Medication compliance	* Begin to identify a sponsor * Cooperate with DDC Specialist/FRC case manager	

Phase III

Goals	Expectations	Advancement Requirements
* Continued abstinence * Internalization of recovery tools * Educational and vocational training * Attend parenting course(s) * Demonstration of effective parenting skills * Negative urinalysis results * Successfully complete treatment program and ancillary services. * Begin aftercare program * Obtain sponsor * Begin working 12 step program	* Monthly court appearances * Urinalysis testing as ordered * Completion of substance abuse treatment and other services * Demonstrate good parenting skills with children * Educational or vocational training * Cooperate with case manager * Remain self sufficient * Attend AA/NA meetings 3-4 times per week * Involvement with 12 step program	* Regular court appearances * Progress toward treatment plan goals * Team recommendation * Negative urinalysis for 4 months * Compliance with sanctions * Obtain sponsor

Phase IV

Goals	Expectations	Advancement Requirements
* Continued abstinence and recovery * Develop aftercare plan (client to complete with treatment counselor, inclusive of relapse plan) * No positive urinalysis * Maintain regular contact with sponsor * Behavior consistent with recovery lifestyle	* Every other month court appearances * Urinalysis testing as ordered * Complete treatment * Reunification with children and demonstration of good parenting skills * Remain self sufficient * Cooperate with DDC Specialist/FRC case manager	* Regular court appearances * Reunification with child (ren). * Completion of treatment programs as court ordered * Team recommendation * No positive urinalysis

Self Reliance Phase

Goals	Expectations	Advancement Requirements
* Continued abstinence and recovery * Participate in aftercare program (e.g. Project Safe) when available * Maintain stable housing * Maintain stable employment * Court approved permanency plan * Reintegration into community * No positive urinalysis	* Aftercare participants: court appearance at end of third month or as needed * Non-aftercare participants: monthly court appearances * Weekly urinalysis testing * Attend treatment * Compliance with court order * Court approved permanency plan * Stable employment * Stable Housing * Remain self sufficient * Cooperate with DDC Specialist/FRC case manager	* Completion of all graduation requirements (e.g. completion of services, employment, reunification, etc.) * Custody of children * Completion of parenting skills training * Completion of treatment program as court ordered * Maintain stable employment * Maintain safe and stable housing * Completion of all court

		conditions * No positive urinalysis results prior to graduation * Graduation

Termination

Termination from the program occurs if the goal for the child (ren) changes from reunification to termination of parental rights because parent has been consistently non-compliant or there are findings of egregious child abuse or neglect, or if the parent is not engaging over time, or the parent chooses not to seek reunification.

5. Judicial Supervision (also see Phases Chart above and Incentives and Sanctions below)

The DDC Judge seeks to establish a unique, therapeutic relationship with the parent through interactions during court appearances. The Judge supervises and reinforces treatment by reviewing reports from DDC Specialists, FRC Case Managers, and treatment providers and discussing recovery obstacles with the parent(s). Both positive and negative incentives (i.e. rewards and sanctions) are used to encourage compliance. The judge assumes the role of both task master and cheerleader. In this setting, the judge is able to reward successes, and provide additional motivation. Conversely, the judge can sanction noncompliance, thereby discouraging failure.

The DDC Program Coordinator facilitates a team staffing two days prior to court hearings which includes: FRC Case Managers, DDC Specialists, DCF attorney, treatment providers, defense attorney, and others as appropriate. Progress reports are shared and are discussed and recommendations regarding rewards and sanctions recommendations are prepared to present to the judge. The judge does not attend the staffings, however the DDC Specialist

provides a written report to the judge summarizing all the reports from providers prior to the hearing and provides copies to all appropriate parties at the court hearing.

Participant's progress in recovery is monitored by the DDC Specialist, who submits progress reports to the court, FRC, DCF and treatment providers. The progress reports contain: the results of every alcohol/drug test; attendance at required meetings and/or counseling sessions; participation in required treatment program activities; adherence to the rules of the DCF Case Plan and the rules of the treatment program; and compliance with the FRC Case Plan.

6. **Drug Testing**

<u>Method, Frequency and Randomization</u>

Urinalysis testing occurs 3 times weekly or randomly in Phases I and II; as ordered in Phases III and IV; and weekly in the Self Reliance Phases (also see chart above). Clients have a weekday call in schedule and from a preset calendar DDC staff tells them if they have testing that day, if they do then they go to court or a treatment center for urinalysis. If they do not comply it is considered a positive. Testing at DDC is conducted by Behavioral Health Technicians from The Village, a treatment provider. Typically, a 5-panel test is used. Clients are observed by a same-sex staff member during the urine drop. Urine is analyzed in the presence of the client, there is also the capability of testing if adulterants are suspected. Turn around time for results at a DDC hearing is immediate. At treatment facilities it may be immediate or, if sent to a lab, it may take 48 hours. Family members may be tested if they are seeking contact with or custody of the child.

7. Incentives and Sanctions:

<u>Guidelines for Applying, Consideration of Demonstrated Effectiveness</u>

The incentives and sanctions utilized in DDC are based on the Ten Key Components for drug courts produced by a diverse group of drug court practitioners and other experts from across the country and brought together by the National Association of Drug Court Professionals. Key Component #6 requires a coordinated strategy governing drug court responses to participants' compliance' through Performance Benchmarks http://www.nadcp.org/whatis/. (see chart below)

At each court hearing parents are subject to a range of sanctions or rewards based on their program compliance for the report period. The table below summarizes compliant and non-compliant behaviors and the corresponding rewards and sanctions.

ACHIEVEMENTS	REWARDS
* Attending Court Appearances * Negative Urinalysis Results * Attendance/Participation in Treatment * Attendance/Participation in AA/NA meetings * Attending Approved Visitation with Child(ren) consistently * Compliance with Case Plan * Phase Promotion	* Acknowledgment by Judge * Applause * Decreased Court Appearances * Decreased Urinalysis Testing * Phase Advancement * Phase Advancement Certificate * Case Called Early in Court * Gift Cards/Tokens/Vouchers (when available)
INFRACTIONS	**SANCTIONS**
* Violation of Order * Dishonest Statement * Failure to Perform Sanctions * Failure to Comply with Case Plan * Establishment of New Neglect * Failure to attend Visitation * Unauthorized Visitation * Leaving Treatment * Treatment Non-Attendance * Treatment Termination for Infractions * Positive Urinalysis * Missed Urinalysis * Tampering with Urine	* Reprimand from Court * Increased Court Appearances * Essay * Community Service Hours * Phase Demotion * Increased Urinalysis Monitoring * Recommendation for TPR * Good bye Letter to the Children

SANCTIONS SCHEDULE	
PHASE I	1st : Non-Compliant Event: 4 Community Service Hours 2nd : 8 Community Service Hours 3rd : 1 Page Essay / Speech

PHASE II	1st : 15 Community Service Hours 2nd : 20 Community Service Hours/Phase Reduction 3rd : 3 Page Essay / Speech
PHASE III	1st : 15 Community Service Hours 2nd : 20 Community Service Hours/Phase Reduction 3rd : 5 Page Essay / Speech, Reduction in Phase 4th : Program Discharge
PHASE IV	1st : 25 Community Service Hours 2nd: Good bye Letter to Children 3rd : Program Discharge
SELF RELIANCE PHASE *No Positive Urinalysis Results Allowed During Self Reliance Phase	1st : Phase Reduction, Increased Court appearances 2nd : Re-assessment of Needs

Proposed *Expansion and Enhancement Initiative*

This proposal is requesting funding for expansion to increase capacity from 60 to 100 per year, and enhancement of the current DDC primarily through implementation of two evidence-based intervention approaches that have been successfully piloted in the context of DDC, the Engaging Moms Project (EMP), an expanded case management model which enhances the work of the DDC Specialists, and a parenting program specifically targeting the families with children ages 0-3, *Project Hand-N-Hand.*

DDC functioning will be enhanced by integrating the EMP with the established court-based case management services. EMP is a science-based program that was adapted for use in a family drug court context and has shown particular promise in that setting. The model is a gender-specific and family-based intervention designed to help mothers succeed in drug court by complying with court orders such as attending and benefiting from substance abuse and other intervention programs (e.g., domestic violence counseling, parenting classes, etc), attending court sessions, remaining drug free, and demonstrating capacity to parent her children.

EMP was initially conceived as a brief, family-oriented intervention aimed at facilitating treatment entry and retention among mothers of substance-exposed infants. An initial study of this approach (Dakof, Quille, Tejeda, Alberga, Bandstra, & Szapocznik, 2004) showed that it successfully facilitated entry and initial retention of non-treatment seeking drug abusing mothers into drug treatment. Given the promising results of the initial EMP study, the model was adapted for use in DDC, and 2 pilot studies have been completed (see Statement of Need)

The three studies of the EMP are consistent in that each study shows promise for the EMP in (a) enrolling and retaining mothers in substance abuse treatment, (b) promoting positive child welfare outcomes, and (c) improving family functioning and parenting practice.

DDC Specialists will conduct individual and conjoint sessions with the mother and her family, focusing on six core areas of change: (1) motivation and commitment to succeed in drug court and to change her life, (2) the emotional attachment between the mother and her children, (3) relationships between the mother and her family of origin, (4) parenting skills, (5) mothers' romantic relationships, and (6) emotional regulation, problem solving, and communication skills. The EMP theory of change supposes that change in the core six areas are essential if the drug using mother is to achieve sobriety and be able to adequately care for her children.

The intervention is organized in 3 stages: Stage 1: Alliance and Motivation, a)Building a strong therapeutic alliance with the mother and her family, and enhancing mother and family motivation to change including total support to both the mother and her family; empowering validating, highlighting strengths and competence; and building confidence in the program. b) Enhancing motivation by acknowledging the pain, guilt and shame the mother and her family have experienced, and the high stakes involved (e.g., losing child to the child welfare system)

while simultaneously creating positive expectations and hope. Stage 2: Behavioral Change, a) Recognizing behavioral change in both the mother and her family/spouse. b) Exploring the emotional attachment between the mother and her children by helping her explore her maternal role. c) Facilitating the mother's relationship with court personnel (judge, child welfare workers, and attorneys) and treatment or other service providers. Stage 3: Launch to an Independent Life, a) Preparing the mother for an independent life by developing a practical and workable routine for everyday life. b) Addressing how the mother will balance self care, children and work. c) outlining a plan for dealing with common emergencies with children and families, d) developing a detailed relapse prevention plan; and addressing how the mother will deal with potential problems, mistakes, slips, and relapses.

Dr. Gayle Dakof, the developer of the EMP model will provide a 3 day introductory training to the DDC Specialists who will be implementing the EMP as well as cross-training to all members of the DDC team. Intensive training will be provided to the DDC Specialists consisting of didactic instruction, case consultation, and intensive videotape and live supervision of Specialist's sessions with mothers enrolled in drug court. Dr. Dakof will meet weekly with the DDC Specialists team to include case review and planning, supervision of videotaped EMP sessions, as well as live supervision. Once initial training is completed, Dr Dakof will provide sustainability training on a monthly basis to the specialists. A 1 day cross-training of the EMP approach will be provided to all DDC partners, including the Judge, child welfare case managers, attorneys, and substance abuse treatment providers. Thereafter, booster sessions, updates, and opportunities to train new DDC partners will be scheduled in quarterly half-day sessions (See Timeline).

The University of Miami Linda Ray Intervention Center will implement *Project Hand-N-Hand* (see Statement of Need Effect on Target Population and Community) for three cohorts of families with a child 0-3. Parenting groups will meet for 12 weeks for a 90 minute session that includes two segments. The first will be a 60-minute parent-only session for the facilitator to present sessions on the topics related to parenting young children that have been found to optimize child development (See Timeline). The topics include child development, developmentally appropriate expectations, how to create a home environment that is safe and stimulating, the connection between early experiences and brain development, establishing trust between parents and children, self-esteem, establishing routines, responsive parenting, facilitating language development and emerging literacy, guiding child behaviors, managing stress, and learning and having fun with art, music and movement. This segment will be followed by the second with parent-child interactive learning activities, which will help solidify the information that has been previously presented during the parent only session. During the parent-only session, qualified early-childhood caregivers will care for the children.

In this second segment, parents and their young children will engage in guided, structured play activities for 30-45 minutes. These opportunities will allow the parent and child to interact together using age-appropriate curriculum activities that focus on the development of language) building, social-emotional skills and self-help abilities and dealing with attachment issues that may be observed. The activities will: 1) add to the knowledge and skills-building information gained in the parent only component, 2) provide an opportunity for participants to practice being sensitive and responsive, to facilitate language, and to play appropriately with their children with modeling and guidance from facilitators, and 3) help establish a support network among the participants. Moreover, developmentally appropriate learning materials will be provided for each

family to take home weekly. This will allow parents to practice the skills gained in the intervention. Participant's incentives for on time participation are provided.

Three data elements will be collected pre/post:

1. The AAPI-2 Adult-Adolescent Parenting Inventory Form A (Bavolek & Keene, 1999) is used to measure improved parent knowledge and application of effective parenting practices, as indicated by increased awareness and application/demonstration of positive disciplinary practices. Project Hand-n-Hand has administered the AAPI-2 to 41 participants in 2008 and 90% of the participants improved their AAPI-2 scores from pre to post.
2. KIDI- Knowledge of Infant Development Inventory- (MacPhee, 1996). The KIDI measures parents' knowledge of child behavior and growth. This is administered on a pre and post test basis. The KIDI has been administered to 182 Project Hand-n-Hand participants to date and statistically significant improvements have been noted from pre to post ($t=2.17$; $p<.05$).
3. Behavioral observations will be conducted pre/post. These are coded videotapes of child/parent interactions including free play, guidance of a structured task and separation and reunion coding. This will also help determine what the relationship looks like from pre to post period while parent is in the DDC program.

8. **Management Information System and Evaluation**:

The evaluation team will employ various procedures to determine if the proposed strategies, systems, and activities utilized have a positive effect. The evaluation of the *Expansion and Enhancement Initiative* will be guided by the Context, Input, Process, and Product (CIPP) theory-based evaluation model (Stufflebeam, 2003). The evaluation will focus on the process and product dimensions of the model; specifically, "is the program being [conducted] properly" and "is it succeeding"? (Stufflebeam, 2003, p. 3). The CIPP model will be used to assess and report

the program's merit, worth, and significance as well as to present the lessons learned from its implementation.

The CIPP model will be utilized to examine and provide guidance in relation to the use of resources, quality of implementation, and supervision and training of staff (process evaluation). In addition, the following questions will be addressed:

(a) How closely did project implementation match the plan?
(b) What types of deviation from the plan occurred?
(c) What led to any deviations?
(d) What effect did any deviations have on the planned intervention and performance assessment?
(e) Who provided (program staff) what services (modality, type, intensity, duration), to whom (individual characteristics)?

The program Logic Model (Attachment I) will be used to guide the evaluation. All of the performance measures noted in the chart above, which are important program process and outcome variables, will be collected and incorporated into the evaluation. In addition, to address the process evaluation questions noted above qualitative data will be obtained from interviews with project administration and staff and other key stakeholders every six months. Furthermore, the evaluation team will be represented at all relevant Advisory Committee meetings to remain apprised of the status of project implementation. Satisfaction surveys will also be administered to all participants to obtain their perspective on various aspects of program quality upon discharge from the program. Additionally, surveys will be developed and utilized with project staff to obtain feedback relative to program trainings (administered after all trainings) and to the quality of staff clinical supervision (given every 6 months). Moreover, semi-structured interviews will be conducted with a sample of 6 to 8 participants annually to gain in-depth insight into their experiences in relation to the project. Qualitative content analysis techniques (Denzin & Lincoln,

2000) will be used to interpret the data obtained from interviews and focus groups and the NVivo qualitative research computer application will be used to facilitate this process.

The CIPP model will also be utilized to determine the impact, effectiveness, and sustainability of the *Expansion and Enhancement Initiative* program to affect continuation and expansion decisions (product evaluation). Questions addressed will include the following:

(a) What was the effect of the intervention on participants?
(b) What program or contextual factors were associated with outcomes?
(c) What individual factors were associated with outcomes?
(d) How lasting were the effects?

These questions will be addressed through examination of client demographics and pre/posttest results on the Adult-Adolescent Parenting Inventory-2 (addressing parenting knowledge and behavior) and the Knowledge of Infant Development Inventory (measuring knowledge of child behavior and growth) as well as drug screen results that will be administered on an ongoing basis. The assessment data noted above will be provided to the evaluation team on an ongoing basis in a secure de-identified manner. Additionally, dependency cases are processed by the court using the Criminal Justice Information System (CJIS) and by the Department of Children and Families (DCF) using FSFN. Currently the DDC uses an Excel spreadsheet to track additional data regarding drug court clients; however, a web-based application developed by the Eleventh Judicial Circuit for the Adult Drug Court will be made available to the DDC. The application allows treatment providers to submit reports to the court electronically. Reports from this application will be provided to the evaluator to track several of the process and outcome variables (see Performance Measures Table). The Statistical Program for the Social Sciences (SPSS) will be utilized by the evaluator to maintain a client database (including demographic and assessment instrument data). It will also be used to analyze the quantitative

data to determine the effects of program participation. Given the nature of the data that will be collected the repeated measures analysis of variance statistical procedure will be used to determine the extent of change on the outcomes variables.

Formative program evaluation will have a central role in this project. A quality improvement process will be implemented and will involve the: (1) ongoing assessment of salient process and outcome variables; (2) identification of program needs; (3) redirection of resources to make necessary changes to the program implementation; and (4) assessment to determine the appropriateness and effectiveness of programmatic changes. Formative evaluation reports will be prepared every 6 months to provide feedback regarding the implementation of the program and will include several key components. The reports will present findings relative to data collected on the process and outcome variables (including the performance measures). The evaluation reports will also address the extent to which program implementation was consistent with the plans developed for its implementation and will identify the program's impact and effectiveness. Finally, lessons learned from the program evaluation will be delineated. Prior to the issuance of the reports a feedback workshop with stakeholders will be scheduled (Stufflebeam, 2003). Draft reports will be sent to stakeholders about 10 days prior to scheduled feedback workshops. During the workshops the evaluator will use PowerPoint to present a summary of findings and recommendations and will seek input and suggestions from those present. At the conclusion of the workshops the evaluator will report on next steps, future reports, proposed revisions to the reports, and needs from the project staff especially in relation to data collection. Stakeholder input from the feedback workshops will be incorporated into the final draft of the reports. As indicated previously, the mandatory performance measures will be

reported to OJJDP by the evaluator on a regular basis using the Data Collection and Technical Assistance Tool.

The evaluation team will be represented at all required OJJDP grantee meetings. In addition, it is important to note that the evaluation team will work to participate fully in any cross-site evaluation of the program that may be implemented by OJJDP or one of its contractors.

For information on data-sharing agreements with treatment service providers, child protection services, the court, and other agencies, and how applicable local, state, and federal confidentiality guidelines and requirements will be met, see Memorandum of Understanding Attachment IV.

CAPABILITIES/COMPETENCIES

Organizational Structure

Miami-Dade County (MDC) is submitting this proposal as the applicant on behalf of the Eleventh Judicial Circuit of Florida Administrative Office of the Courts (AOC) as court funds are fiscally administered by the county. The AOC will serve as the lead partner for the *Expansion and Enhancement Initiative*, providing administrative oversight, maintaining AOC policies and procedures, and contracting with: Gayle Dakof, Ph.D; the University of Miami Linda Ray Intervention Center; Research & Evaluation Network on behalf of Marcelo Castro, Ph.D, and James Pann Ph.D., co-evaluators; DDC Specialists and Intake Specialist. The AOC will also manage the program and financial reporting to grantor.

Roles and Responsibilities of Current Project Staff

Current staff consists of a DDC Coordinator and four DDC specialists (Attachment VII) who focus on the parent(s) and are funded at the local level. These staff provide the critical link

between the parent, the child, the treatment provider, other services, and the court. The Coordinator is responsible for the alcohol and drug abuse screenings and assessments, and supervision of specialists and case managers, and facilitation of staffing meetings. The DDC Specialists are responsible for referral and enrollment in treatment services, alcohol and other drug testing, progress monitoring, crisis and therapeutic intervention, to engage and retain the parent in the dependency court process, advocating for the parent, and keeping the parent motivated to treatment and recovery throughout the long DDC process.

<u>Contracted Staff for the *Expansion and Enhancement Initiative*</u>

The two DDC Specialists will have the same responsibilities as the current specialists described above and the Intake Specialist will assist the DDC Coordinator by conducting alcohol and drug abuse screenings and assessments (Attachment VI).

Gayle Dakof, Ph.D is Research Associate Professor of Epidemiology and Public Health, Director of CTRADA, and the developer of the EMP intervention. Dr. Dakof has trained clinicians in EMP for several randomized clinical trials. For over 20 years, Dr. Dakof has been central to designing and implementing CTRADA's controlled trials and process studies is the creator of the EMP model. She will provide training and supervision for the EMP implementation (Attachment VII).

Lynne Katz, Ed.D is Director of the University of Miami's Linda Ray Intervention Center and a Research Assistant Professor in the Departments of Applied Psychology and Pediatrics. As Director of the Center since 1993, an early intervention service and research project for children at-risk due to prenatal cocaine exposure, she has maintained a leadership role from the early intervention perspective to create linkages with the community stakeholders of all on-going projects. Dr. Katz and her staff will implement and supervise Project Hand-n-Hand

(Attachment VII).

The program evaluation will be conducted by Drs. James Pann and Marcelo Castro of the Research & Evaluation Network. In addition, a research assistant will be utilized to assist with the evaluation. Drs. Pann and Castro have expertise, demonstrated by research and teaching, in the following areas: program evaluation, qualitative and quantitative research, survey methods, substance abuse, homelessness, and problem solving courts. In addition, particularly relevant to this program, they have conducted program evaluations of several federal initiatives including projects funded by OJJDP, Substance Abuse and Mental Health Services Administration, and the Department of Labor (Attachment VII).

Family Drug Court Team

Judge Jeri B. Cohen, DDC judge, has been a Circuit Court Judge for the State of Florida Eleventh Judicial Circuit for over twelve years. Judge Cohen founded the DDC in Miami which has become a national drug court model. She will provide leadership to the *Expansion and Enhancement Initiative* (Attachment VII). Members of the DDC team include SFPC as managing agency of the 29 treatment providers, Child Welfare Legal Services, an alumni of DDC, Defense Counsel, DCF supervisor for SA/MH Division, DCF attorney supervisor, DCF attorney on behalf of the child, Gayle Dakof Ph.D., Lynne Katz, Ed.D, (Attachment VI) AOC staff: Grants Administrator, Juvenile Division Operations Director, DDC Coordinator, and the Chief Deputy Court Administrator/CIO.

Interdisciplinary, Non-Adversarial Work Team

Most of the above members of the DDC have worked together since the inception with only a few changes and there are long standing MOUs between DDC and each treatment provider and between SFPC and Our Kids (Attachment IV).

SUSTAINABILITY PLAN

The Eleventh Judicial Circuit of Florida Administrative Office of the Courts (AOC) Grants Administration Office has worked collaboratively with justice system partners since 1995. Extensive work has been done with the Juvenile Division and the community to obtain funding for services for those who come in contact with the dependency system. The AOC's Grants Administration and Administrative Service Division (finance) have managed and administered many of these grants. The AOC is one of the project's primary stakeholders and will continue to serve on the Advisory Committee providing administrative support and liaison services for the EMP Initiative. There are high levels of commitment in appropriate places at the State level that the drug treatment courts now operating will be sustained. Similar expressions of intent are being expressed in the halls of local county government and by the Chief Judge and Administrative Judge of the Circuit's juvenile division. The Obama/Biden Administration's support for drug courts bodes well for the future and the AOC's past success in obtaining funding for individuals involved in the justice system provides a strong base for continued funding.

The DDC team already has many of the components necessary for successful sustainability: judicial leadership; committed team of drug court partners; strong institutional support from the AOC and Our Kids; and the recent establishment of a community based non-profit organization (Dependency Drug Court Angels) devoted to raising funds and community support for the DDC.