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CHAPTER 13

Dependency Drug Court

An Intensive Intervention for Traumatized Mothers and Young Children

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

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

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

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

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

MIAMI–DADE DEPENDENCY DRUG COURT

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

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

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

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

ENGAGING MOMS PROGRAM FOR DEPENDENCY DRUG COURT COUNSELORS

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

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

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

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

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

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

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

THE WORK OF THE DEPENDENCY COURT JUDGE

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

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

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

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

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

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

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

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

CASE ILLUSTRATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CONCLUDING REMARKS

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

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

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

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