Pushing Forward:
Examining Client Motivation in a Family Treatment Drug Court

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In response to the growing drug epidemic in the 1980s, Family Treatment Drug Courts were established in the United States. Justice professionals noticed that the same parents would reappear in court for both substance dependence and child custody cases and decided there had to be a way to decrease recidivism and to increase the number of sober, stable caregivers once child custody cases closed ("History" 2014). Family Treatment Drug Courts (FTDC) are treatment programs that serve to establish permanent welfare for the child by providing comprehensive, intensive, individualized substance abuse services to the addicted parents after a child protection order has been filed by the Department of Health and Human Services (DHHS) (State of Maine 2011). FTDCs collaborate with the court, child welfare system, local health providers, the family, and close friends to help clients achieve sobriety and implement a permanent plan for the children. While the program does not guarantee reunification following graduation, FTDCs are more likely to result in family reunification or in a child permanency plan at a faster pace (Green et al. 2007). The first Miami-Dade Drug Court was established in 1989, and 492 more drug courts opened within the following ten years ("History" 2014). Three hundred family drug courts, in particular, are operating in the U.S. as of 2012 (Marlowe and Carey 2012).

The motivation that it takes to overcome addiction is unfathomably challenging. However, motivation to overcome addiction is also absolutely necessary for the parents to return to a sober, healthy psychological state and regain custody of their children. However, motivation to succeed in an intense program, such as the Family Treatment Drug Court, often requires parents to face the problems they have learned to avoid, such as unhealthy relationships or life responsibilities, while remaining sober.

Family Treatment Drug Court Research

This study examined clients enrolled at a Family Treatment Drug Court, and the purpose of this research is to analyze motivational strategies and possibly implement motivational techniques that assist clients through the Family Treatment Drug Court program. This paper addresses the following three questions:

- What key internal characteristics, environmental influences, or objectives motivate a client to succeed in the program?
- What motivational technique or method can we tangibly implement into the Family Treatment Drug Court to improve its road to success and increase the graduate rate?
- How can motivational strategies be used to develop client progress over a long period of time?

Overview of the Problem

Substance Abuse

For some people, the idea of "quitting" a destructive substance seems easy to comprehend. However, there are too many physical, psychological, or environmental factors that contradict this general belief, even despite the severe consequences that follow use. Reflecting on a bio-psychosocial model of addiction risk, those who are susceptible to substance dependence may also face other factors that result in addiction, such as a negative home environment (either with parents who have used, chaotic relationships, or abuse), peer pressure, poor school achievement, and mental illness ("Drugs, Brains, and Behavior" 2010).

The neurochemistry in the brain alters dramatically for a substance dependent person, so much so, that he or she may go above and beyond to either continue feeding the addiction or trying tirelessly to heal. According to Miller and MacDonald (2011), addictive substances "hijack" the reward-related learning system in the brain. Dopamine, a neurotransmitter in the nucleus accumbens directly connected to pleasure, serves as the primary neurotransmitter-linked addiction (Danahay 2012). Despite where pleasure is derived from—whether it is through food, reward, sex, or a drug—the brain registers the dopamine activity in the same way ("Drugs" 2010). This reasoning in particular is why drugs and alcohol manipulate this specific transmitter—to feel good. Cocaine, for example, releases ten times the amount of dopamine than what a natural pleasure stimulant would release, whereas methamphetamine receptors *replace* dopamine receptors (Danahay 2012). Dopamine linked to glutamate, a receptor involved with learning and memory, takes over the reward-related learning and memory pathways in the brain (Miller and MacDonald 2011; Danahay 2012). As dopamine levels continue to increase, the brain becomes overwhelmed, and it adjusts by producing less and less dopamine, reducing the number of dopamine receptors. Substance users attempt to compensate the side effects of tolerance and low dopamine levels by increasing drug doses ("Drugs" 2010). Moreover, the desire transforms into intense cravings when the amygdala (emotion center in the brain) reveals intense memories of the drug, usually triggered by a stimulus (i.e., a friend or dealer's house). This particular moment is where people have the tendency to relapse. Approximately 40-60% of recovering individuals experience at least one relapse (Miller and MacDonald 2011).

The neurochemistry effects tend to be only one of many destructive obstacles related to substance abuse. In reality, recovering from an addiction often consists of reconstruction of thought process, behavior, and human functioning. The brain itself, for instance, is entirely restructured or even deteriorated after years of addiction, so much so, that recovery usually requires restoring brain matter. For example, for full dopamine restoration to occur, a methamphetamine addict would have to remain sober for 14 months (Danahay 2012). The major problem with this, however, is that a child custody case closes after 12 months, two months before a methamphetamine dependent parent has the time to make a full neurological recovery. In regards to other substance dependent parents, the Department of Health and Human Services (DHHS) is requesting for parents to not only make a full neurological recovery, but also recover from mental illness or conquer any environmental influences that could trigger addiction and become financially stable enough to care for a child.

The aftermath of a traumatic event, whether it is a violent home environment, childhood sexual trauma, or maltreatment, often results in posttraumatic stress disorder (PTSD), a

psychological disorder triggered by a traumatic event, causing the victim to experience severe anxiety, depression, or phobia ("What is" 2013). According to the National Co-morbidity Survey Replication study (NCS-R), 53% of 9,282 participants with a substance use disorder had experienced a traumatic event before the age of 18 years old (Green et al. 2010). Known as the self-medication hypothesis, drugs and alcohol are often used to modify intense emotional states, such as anxiety and depression symptoms of PTSD; individuals utilize substances as a coping mechanism (Nordfjærn 2011; Jacobsen, Southwick, and Kosten 2001). However, according to Jacobsen, Southwick, and Kosten (2001), the physiological arousal triggered by withdrawal may intensify PTSD symptoms, often escalating to more severe anxiety and depression symptoms. Due to a number of external and hereditary influences, mood and personality disorders are often co-morbid with substance abuse. A person diagnosed with a mood or anxiety disorder, for example, is twice as likely to also have a substance use disorder, and the same statistic is true of the reverse ("Drugs" 2010).

Addictive Thoughts, Behaviors, and Feelings

Hopwood and his colleagues (2011) concluded that people suffering from an addiction have very similar pathological traits. Due to neurological deterioration, personality disorders, and environmental influences, most individuals primarily experience the side effects of drugs and alcohol, which include negative temperament, mistrust, aggression, and eccentric perceptions. It was also observed that emotional and social detachment, disinhibition, self-harm, and a lack of self-esteem were common with substance dependence (Hopwood et al. 2011).

In addition to environmental and biological factors that cause stress for a person suffering from substance dependence, a perceived locus of control—the degree in which a person feels that life outcomes are due to his or her own behaviors, thoughts, or external to the environment—has the potential to make impaired habit control even more complicated for addicts to fully recover (Ersche et al. 2012; Haynes and Ayliffe 1991). According to Ersche et al. 2012), substance dependent individuals have a perceived *internal* locus of control over their addiction. This means they believe their addiction is due to their own actions, thoughts, and behaviors, and therefore the addiction itself is controllable. However, behaviors that reinforce addiction treatment, such as attending health appointments, are often related to an external locus of control—in which the outcomes are due to factors out of their own control (Haynes and Ayliffe 1991). Therefore, this disassociation between their addiction beliefs versus their outcomes points to a sense of control imbalance and stress.

The stress of cognitive imbalance is directly connected to lacking cognitive control, which subsequently presents itself through negative behaviors and characteristics, such as dishonesty, negative temperament, and other addictive traits. Lacking cognitive control can be defined as lacking the process in which the mind responds to its own errors and conflicts by enhancing attention to task relevant events and attributes (Botvinick et al. 2001). Lacking cognitive control is a detrimental consequence of stress, as studies show that "error" behaviors directly relate to cortisol regulation (a stress hormone released in the brain), which therefore directly associates error-response, such as making excuses or suppression, and stress (Compton, Hofheimer, and Kazinka 2013). The consequences of stress make it more challenging for the human mind to make reasonable decisions when under a severely overwhelming situation.

Motivation: Approaches and Evidence-Based Treatment

Even with psychiatric care, effective medication, and outstanding social support, a person can only overcome an addiction if there is full recovery engagement. According to current research, evidence-based therapy is supported by efficient research that demonstrates method effectiveness by closing the gap between science-based work and the community today (Miller et al. 2006). Therefore, it is highly recommended for professionals to work with clients strictly under the conditions set by evidence-based therapies.

Goals: Measuring Motivation

The motivation to treat an addiction is a complex, multidimensional thought process, which results in barriers to measuring outcomes and motivational success (Substance Abuse and Mental Health Services Administration 2013). However, members of the U.S. Department of Health and Human Services Consensus Panel recommended that substance abuse treatment be measured based on self-efficacy, value of change, readiness to change, decisional balancing, and motivation for using substances.

Trans-Theoretical Model of the Stages of Change

Prochaska's Trans-Theoretical Model of the Stages of Change (TTM) is a biopsychosocial model that examines changing behaviors and characteristics reflected through cognitive stages (Prochaska, Norcross, and DiClemente 1994). In the precontemplation stage, a person has never considered changing his or her patterns of behavior. An individual may feel that substance use is not a risk at all. In order to overcome this stage, Prochaska and his colleagues argue that consciousness raising and social liberation (ridding past feelings of demoralization that may have occurred leading up to substance dependence) are essential to transition to the next stage in recovery. The shift to the contemplation stage occurs when a person begins to see the risk behind the substance use and weighs out the costs and benefits of treatment. A person may start seeking information and looking into change. In order to shift to the stage of preparation, individuals must experience an emotional arousal and a self-revelation during contemplation, recognizing that the possibility for change exists. The preparation stage is the stage prior to treatment. This may begin with a person first experimenting with sobriety alone. This stage also includes planning, examining one's self-efficacy, or understanding self-capability. In order to shift to the action stage, the individual must be fully committed to treatment. A person in an action stage addresses his or her substance use. This is also the "honeymoon" stage, in which positive belief in one's sobriety may occur before maintenance. Maintenance is the final stage of the Trans-Theoretical Model. A person works to maintain sobriety and prevent relapse and learn how to avoid triggers and remain stable during this time. Maintenance requires total behavioral change. It occurs when a person begins to exchange unhealthy behaviors with permanent, healthy behaviors (known as countering), as well as taking control of his or her surrounding environment and building positive relationships with others. Rewards are extremely effective at this stage (Prochaska, Norcross, and DiClemente 1994).

Recurrence, also known as relapse to a previous stage, occurs regularly, especially when facing past triggers, such as people, memories, or addictive thoughts. This can happen at any

moment, and individuals must learn to set realistic, achievable goals to progress through stages (Substance Abuse and Mental Health Services Administration 2013). Prochaska, Norcross, and DiClemente (1994) demonstrate recurrence as an *upward* spiral. When relapse occurs during recovery, it is best to acknowledge that substance use occurred and examine the details of how and why it happened. Similar to an upward staircase, a client learns to avoid relapse and triggering environments the more often relapse occurs—moving step by step until he or she no longer sees the bottom (Prochaska, Norcross, and DiClemente 1994).

Motivational Interviewing

Motivational Interviewing is one of the most effective methods for professionals in changing the way recovering individuals perceive their own thoughts and behavior, as it facilitates a client-centered approach that allows for a person to come to conclusions on his or her own terms (Substance Abuse and Mental Health Services Administration 2013; Carroll et al. 2006). Motivational interviewing requires the professional to ask clear-cut, self-motivational questions that pinpoint ambivalent thought processes of the client. Addressing ambivalence towards substance use by focusing on intrinsic thoughts, rather than outside pressures, is a method that relieves frustrations of recovery and promotes self-directed decisions (Zuckoff 2013). Eventually those who are involved begin to draw independent conclusions regarding life decisions, consequences, and ambivalent thoughts. The motivational interviewing approach is geared to target thoughts and behaviors at each stage. For example, an individual who is shifting from the *preparation* to *action* stage may result in expressing the interest in joining treatment. This would require the counselor to ask questions, such as "why is this a good idea for you to go into treatment?" or "who is going to be impacted by this decision?" It is particularly effective because it applies to most substance abuse and mental illness thought processes, in addition to its effectiveness across gender, ethnicity, and age (Carroll et al. 2006).

Methods

Participants

Three Family Treatment Drug Court (FTDC) clients were interviewed for the study. Each client who participated in the program primarily struggles with substance dependence, but may also be facing additional challenges that have caused the child to leave the home. Some of the most common drugs of choice among the clients are alcohol, opiates, cocaine, and marijuana. However, clients claim they have experimented with other illegal substances as well. In order to graduate the program, clients must complete their GED, live in a stable home, and have a steady income. Therefore, the clients have a variety of educational backgrounds. While some have yet to complete their GED, others have completed their associate degree. Nonetheless, all clients are currently living below the state poverty level.

The study included an interview with the Family Treatment Drug Court Case Manager and the Supervisor of Case Management of the state's pretrial services. The FTDC has one primary case manager who works with each Family Treatment Drug Court client to ensure sobriety, safety, and accountability. The primary role of the case manager is to build a relationship with the client through check-ins, one-on-one meetings, and group sessions. Through this, the case manager is regularly updating and tracking client progress. One of the

most important parts of the case manager's role is to meet with the clients in the court setting in order to update the FTDC team. Additionally, the case manager assists clients in setting goals for themselves, such as housing steps, health appointments, or plans for attending treatment. This role also includes random drug testing at least two times a week and team meetings with clients' treatment providers, Department of Health and Human Services caseworkers, guardians ad litem, and attorneys in order to remain updated on the case and future stability plans. The supervisor of the state's pretrial services oversees the case management of the FTDC case manager.

The St. Mary's Intensive Outpatient Program (IOP) liaison for FTDC was interviewed for this study. The IOP liaison is a Licensed Clinical Social Worker and a clinician of St. Mary's IOP program that serves as a liaison in the Family Treatment Drug Court Program. While the clinician only has one-on-one interactions with clients who are a part of the clinician's specific IOP program, the clinician plays a strong role in the Family Team Meetings every Monday. As a segment of the Social Work Code of Ethics, a clinician is required to assist any client in need. Therefore, the liaison intervenes at times within the courtroom and during team meetings and represents the IOP programs.

One substance abuse counselor and the counseling supervisor of Tri-County Mental Health Services were interviewed for the study. While the counselor supervisor oversees the work of the counselors, the counselor acts as the liaison between client treatment and the Family Treatment Drug Court. Therefore, the role of the counselor is to conduct an assessment based on the bio-psychosocial model, evaluate whether the client is a good fit for the FTDC program based on the Child Protective Case and the assessment, and then finally act as a provider if a client does not already have a provider. The counselor also runs focus groups and programs, such as Seeking Safety for Trauma and Parents in Recovery. In this case, the counselor sees the clients approximately five hours each week that there is a Family Treatment Drug Court meeting. The counselor only provides substance abuse counseling, and refers clients to other mental health providers if needed.

Two counselors at the Blue Willow Counseling and IOP program were interviewed for the study. Both counselors see a few of the FTDC clients individually at least once a week, providing mental health and substance abuse treatment. However, they also run group support sessions a few times a week, focusing on stability and sobriety in everyday life.

Two caseworkers for the Department of Health and Human Services were interviewed for the study. In addition to implementing a long-term reunification plan, the Department of Health and Human Services (DHHS) caseworker is primarily responsible for the safety and security of the children through the Child Protection Dependency Matter. By collaborating with the FTDC team, treatment providers, the parents, and the children's caregivers, the caseworkers ensure children's welfare is being met. This may include ensuring the children are going to school, being properly fed, or receiving the mental, behavioral, or physical health services that they need. While the DHHS caseworker also tries to assist families in child-parent reunification, family reunification is not always possible, despite client success in the Drug Court. DHHS and the FTDC program are two separate entities; the primary goal of the department is child wellbeing, while the primary goal of FTDC is parent stability. Nonetheless, the DHHS caseworker and the FTDC team meet regularly to ensure both parties understand the client in a similar matter.

Three parent attorneys/guardians ad litem were interviewed in the study. The key role that parent attorneys play is to represent the parents or their children (if they are guardians ad

litem) in the open Child Protective Custody case. Therefore, these participants play a key role in the legal aid for parents during the FTDC program. The attorney liaison for the FTDC, in particular, plays a key role in bridging the work of DHHS and FTDC with the clients, as they understand both the case and the progress in the Family Treatment Drug Court.

The state coordinator for Drug Courts does not have direct contact with the clients. However, the primary role includes attending major FTDC meetings across the state, while also implementing suggestions for greater success. The coordinator is also the one who implements new drug court programs where needed across the state.

Finally, one judge was informally interviewed for the study. The presiding judge of the Family Treatment Drug Court program is responsible for conducting and overseeing all FTDC hearings, which includes enforcing implementation of treatment plans to maintain stability and sobriety. The role of the judge in the Family Treatment Drug Court is to ensure that Family Team meetings are productive and effective for the clients. Additionally, it is also the role of the judge to impose sanctions and rewards that will effectively and smoothly assist clients through the program. The judge closely collaborates with the FTDC team to ensure this occurs.

Procedure

Seventeen participants were interviewed for this study. Initial contact was either through the state's pretrial case manager or via email, and interviews were scheduled at a time and place that was convenient for the participants, while still allowing confidentiality and professionalism to occur during the interview. Before beginning the interview, participants were informed of the research process and were required to sign a consent form, indicating they understood the purpose and the procedure of the interview (See **Appendix 1** for clients and see **Appendix 2** for professionals). The consent form indicated that the interview was confidential and not directed to the outcomes of clients' cases. Additionally, participants were well informed that if any questions made them feel uncomfortable, they were more than welcome to leave the interview or pass on questions without penalty. As an incentive for clients to participate in the interview, they were entered into a raffle for a $25 gift card for a location of their choosing. All interviews were recorded and approximately 30 minutes long. Due to the differences in experience and perspective, two sets of interview questions were used—one set for the clients (see **Appendix 3**) and one set for the professionals (see **Appendix 4**). However, the two sets of questions targeted similar content. This was to ensure participants could address the study questions based on their own experience and background.

Because all data is derived from interviews, the sessions were audio recorded after participant consent was obtained. The recordings were immediately taken to a lab at the college. Interviews were too large to be stored on a secure online storage area. Therefore, each interview was burned to a compact disk and secured in the lab. All recordings were transcribed, and the notes taken were also secured in the lab. For confidentiality purposes, all CDs and transcriptions were destroyed by May 2014.

Coding and Thematic Analysis

Transcribing the interviews was considered the first read-through. This first read-through was to establish an impression and a familiarity of the interviewing process; detailed and close note taking was conducted.

Coding for potential themes was conducted after the first read-through. The intention behind the coding was to expose meaning, patterns, and possible themes brought up during the interview. Some of the codes included behaviors and outcomes, communication, intrinsic motivation, and visible turning points. These codes moved beyond descriptive analyzing by utilizing descriptive codes, analytic codes, and categories.

Utilizing repetition, comparisons, and transitions, frameworks were constructed prior to the third read-through. The frameworks were established based on the patterns observed through coding. Opinions and quotes from each interview were documented and categorized within the frameworks. For example, if a framework is "Clients are extrinsically motivated," then participants who mention they are recovering just to regain custody of their children are placed in this framework. Once each interview was coded, analysis of thematic connections took place. The frameworks provided a tool to implement conclusions utilizing a grounded theory research approach. Themes, comparisons, and repetition within these frameworks allowed conclusions to be drawn and webbed together.

All procedures have been approved by the college's Institutional Review Board and the representatives of the district court involved with this FTDC.

Results

Clients and professionals associated with the Family Treatment Drug Court were interviewed to establish motivational factors that drive clients to graduate the program. Coding the interview transcriptions resulted in the following themes: 1) intrinsic motivation, 2) mental illness, 3) readiness to change, 4) motivational interviewing, and 5) participant feedback: opinions for growth.

Intrinsic Motivation

Based on participant feedback, intrinsic motivation, in which the client is enrolled in the program for one's own goals and personal strides (rather than for others, such as a family member or for material awards) was concluded to be the most significant indicator of client motivation. Some behaviors that suggest a client is intrinsically motivated are first-person statements, perceptions of accomplishments and accountability during sobriety, a lack of determination to change only for the sake of others (such as changing in order to reunify with their children or to "prove" themselves to the Department of Health and Human Services). An example of a graduating client's intrinsic drive is reflected below:

> Q: What keeps you going through the program?
> A: Seeing how far I've come in life, and my kiddos are a constant reminder of being sober and do what I do, and I do just get a lot out of it… I have the most sober time, and seeing all of the new people coming in and struggling, it hurts to see them, but it reminds me of why I don't do that anymore. And it makes me feel good because people look up to me and ask me for support… I like counseling groups. I was the one who put myself into them, they didn't tell me to… I get a lot out of it, and it keeps me accountable, and I think that's one of the reasons why I like it. You know, I used to pull one under people's eyes, like "oh I'm sober in 6 months" and nobody would ever know, but now I can legit be like "look I am sober, and I can prove it," and it feels really good to be honest and not be judged… I love it.

Clients, counselors, case managers, and attorneys alike mentioned intrinsic motivation as a powerful indicator that progressive, manageable change is likely to occur. This is because change often occurs when thoughts and behaviors begin to agree with one another (Sobell et al. 1993). In this case, once a client's mindset shifts to a more self-motivating, self-directing mentality, physical changes begin to align. For example, he or she will begin to realize counseling is important, not just required. Therefore, intrinsic motivation was one of the most prominent factors influencing self-efficacy, behavior change, and motivation to graduate the Family Treatment Program. Because of this, the following themes found from the interviews are targeted towards highlighting characteristics and evidence-based methods that affect the overall goal of intrinsic motivation.

Readiness to Change

Readiness to change implies aligning the client's state of mind and motivation to change with treatment that he or she currently needs in order to progress to sobriety and stability. A client's readiness to actually make a physical and mental change derives from connecting attitude and decision making to realistic, physical behaviors. A majority of participants mentioned that clients enter the program with a completely precontemplative mindset, indicating a lack of commitment and externally motivated decision making. Case managers, for example, note that the lack of personal readiness to make the change is often exposed early on in the program:

> "…because I have a lot of people that actually go to the information session but don't sign up… because they're not ready for that level of supervision, where here they have to report to one supervisor versus a whole team… but some of them start because they think they have to do it… sometimes they're not ready even when they complete the program… there are so many other things going on…and that can be frustrating for people who are in drug court and doing really well."

For these clients, intrinsic motivation to change is slim to non-existent. The clinical supervisor, for example, observes extrinsic motivation in the FTDC quite often:

> "If clients are just motivated by their kids, they might be like 'as soon as I'm done [with the program], I'm going back to drinking because drinking wasn't my problem.' You hear that and you see different levels of motivation."

This statement reflects FTDC's team ideology of personal motivation. Many FTDC team members were clear that clients can only succeed if they are personally motivated to become healthy. Clients have a tendency to be dismissed from the program if their motivations are directed by finishing the program without goals of becoming sober. For example, some of the participants mentioned that clients who are at risk for dismissal may show up to appointments and pass drug tests, but will search for any opportunity to cheat their way to graduation through lying, fake testing, or making excuses. However, the clients who succeed in the program eventually evolve these negative behaviors into full efforts to avoid triggers and develop honest relationships with the FTDC team. The reason for this is due to the personal motivation they have to become healthy and sober.

Trans-theoretical Model of the Stages of Change and the FTDC

While the ultimate goal is to become intrinsically motivated, the process to reach that stage is reflected heavily though a particular evidence-based theory—the Prochaska's Trans-theoretical Model of the Stages of Change (Prochaska, Norcross, and DiClemente 1994) (See **Figure 1**). As mentioned, clients who enter the Family Treatment Drug Court program are likely not intrinsically motivated to become sober and stable, and this is often the reason that clients will *state* their interest in graduating and regaining custody of their children, but will not have a complete understanding of the required behavior to do so (parent attorney, personal conversation, 2013). Through an evidence-based perspective, participants have seen success stories of clients who have completely shifted their mentality throughout the program, regaining control of their sobriety and their child custody case.

Based on participant feedback, in addition to observation of the FTDC, a majority of clients first enter the program with a completely precontemplative mindset, directed by the status of their child custody case and their attorney's strong recommendation to join the program. Intrinsic motivation to complete the program is misguided or, at times, non-existent, as clients may not completely realize the extent of their addiction. Rather than rehabilitation, many clients actually need to be *abilitated* particularly because their whole life has lacked structure, rules, and guidelines (state coordinator, personal conversation, 2013).

> Q: Why do clients participate in the program?
> A: They do it because they think they'll get their kids back if they do it. Sometimes clients are individually motivated to get their life back together, and that's their motivation, but I think many times they think their best shot at getting their kids back is to do the program if it's a substance abuse case. It's like they feel this pressure because Judge B will make it pretty clear that it's a good program and "I'm referring you to here," even though its voluntary, and even though it's not the right fit, even though I might have concerns that they're going to be successful, but they feel that DHS, Judge, attorneys are telling them to do it, which is not always the right reason, but sometimes that's all it takes, you have to get in there somehow, and maybe it will change over time, but there definitely is a pressure. (parent attorney, personal conversation, 2013)

Similar to Proshaka's recommendations, counselors, case managers, and attorneys work with clients in this precontemplative stage to raise consciousness of their treatment needs. Clients who are likely to succeed in the FTDC eventually shift their mindset and transition from external factors taking control of their lives to internal motivations, such as taking care of themselves or their children and priding themselves in their accomplishments:

> "I think a lot of their beliefs change. CBT and self-efficacy that they *can* do it, start recognizing that they can do it… that they really start to change their friends, environment… structure is *huge*…people who don't have structure when they leave IOP makes or breaks." (counselor, personal conversation, 2013)

Comparable to Prochaska's model, a sense of arousal, self-revelation, and commitment exists in clients who are successful at the FTDC. Also similar to the characteristics of intrinsic motivation and the TTM, the rewards of succeeding and becoming stable in the program are often related to the children, a move forward in the child custody case, becoming employed, or renting an apartment, rather than more immediate rewards, such as gift cards, or time off from case

management-client check-ins. Similar to the action and maintenance stage, participants have claimed that successful clients take control of their environment, their case, and their sobriety:

> "That's when you see the things we had talked about earlier… people saying, wow I really need to revisit where I am living, I need to change who I hang out with, daily routine (not sitting in front of the TV until I am depressed). You really start seeing people take control over their environment and the external factors that they think control their use.. I think that is really the biggest change, when someone says 'I want to…' versus 'tell me what to do' … when the 'I' statements come around, then you know it helps…" (parent attorney, personal conversation, 2013)

Client relapse seen at the FTDC mirrors relapse patterns of Prochaska's model. Prochaska perceives relapse as an upward spiral, a concept that through each relapse (which is bound to occur during recovery) the client learns how to manage future potential relapses (Prochaska, Norcross, and DiClemente 1994). Similar to an upward spiral, clients may decline, but learn how to manage future triggers and relapse patterns. Despite the number of times it occurs, clients eventually learn to control their relapses until they reach a turning point (Prochaska, Norcross, and DiClemente 1994). This sort of positive behavior is reflected upon by a parent attorney of the FTDC:

> "…but that final relapse was his turning point for him… he said, before that, he was doing what he was supposed to do, but it wasn't internalized… and it was that final relapse that turned him around… and that was the turning point for him, because when you looked on paper, it seemed like a hopeless situation for him… his case was open for over a year, and he was about to lose his child forever, and I hear from him time to time and he's doing really, really well… it's one of these successes that I'll hold on to, you know, when another client is not doing well, I think of him… I think the motivator varies… but sometimes it's that feeling of 'you're done'…"

Motivational Interviewing

Discussions with attorneys, substance abuse counselors, and the case management team revealed that motivational interviewing was foundational for employee and counseling methods. It was interesting to see how each member of the FTDC took a personal approach in assisting clients through motivational interviewing.

Used particularly by the counselors and case management, motivational interviewing was said to be the core of intrinsic motivation for the clients. Using a method of "change talk" during therapy and in the court room has helped clients align their thoughts with their behaviors, developing an understanding of what choices they are responsible to make independently. According to participants, motivational interviewing is also a powerful tool to help parents understand why battling addiction is necessary for their children. Counselors, the judge, and case managers help parents become intrinsically motivated to stay on track during recovery. As a clinician of the FTDC points out, motivational interviewing helps parents become independent and responsible during recovery:

> "Change talk… people are out to get me versus people tried to help me… it's all about talking to the client… motivational interviewing… Helping them realize what choices they have… what they actually want to do… it's up to them though… same in the FTDC… It's very important to

> take care of their own treatment and well-being. Some past clients were very focused on others, and changed when they started to think about themselves and their kids at stake."

What the clinician referred to as the Columbo Approach of motivational interviewing, consciousness awareness of the addiction is not only seen at the FTDC, but also a standard approach in Prochaska's model. Raising consciousness in order for clients to transition out of the precontemplative stage was a theme that the FTDC team acknowledged to be extremely helpful:

> "Their addictive mind thinks differently than their non-addicted mind… it's a slow and painful process for the clinician…sometimes you just have to go with it. Start raising some doubts… the work is going to happen when they walk out the door denying… eventually they will be thinking about it." (clinician, personal conversation, 2013)

Motivational interviewing is a foundational method in Prochaska's model, allowing for clients to transition from one psychological-behavioral stage to another. Therefore, the emphasis on motivational interviewing has been profoundly helpful at the FTDC and a primary example of how Prochaska's model could be implemented in the program.

The primary case manager who works with these clients using evidence-based techniques to establish independent motivation, meaning that clients work on motivating themselves, rather than depending on others. Using techniques, such as motivational interviewing, the FTDC team uses these particular evidence-based treatment strategies daily. This self-directed motivation is often a key factor for the FTDC team in understanding if the client is potentially on a track to graduate. This is often when the team also sees clients making "tangible changes, such as employment" (case manager, personal conversation, 2013) or "understanding personal accountability to succeed" (DHHS case worker, personal conversation, 2013).

Participant Feedback: Opinions for Growth

Immediate feedback and proximity are two elements that have had a tendency to work well for clients at the FTDC, but are said to be weaker aspects of the program. The team check-ins, for example, occur at the FTDC every other Monday. While there are one-on-one case management meetings every week, there are times where clients will be sanctioned or rewarded for behavior that occurred over two weeks prior. FTDC team members have found this extremely challenging in the program, as immediate feedback is one of the only ways clients will learn and recover:

> "What would be very helpful would be an immediate response…. Two weeks later? We must be addressing those issues immediate… we get emails from a pre-trial worker on Thursday, but things happen on Monday or Tuesdays… we need to push those immediate responses. They don't feel supported. If I was in their position, and I have DHHS, clinicians, etc., and no one was responding to my needs, I would feel that the team is so big, but no one is there for me. Then what's the point?... 'if I call my druggie friend, they'll be there for me.' Pre-trial workers need to be more responsive." (clinician, personal conversation, 2013)

It is evident through clinicians and case managers that immediacy and proximal, rather than distal, feedback is extremely important in early stages of the recovery process. Immediate feedback assists clients in managing priorities, and allows for growth in decision making.

According to participants, FTDC clients would truly benefit from immediate feedback, and hopefully gain the ability to motivate themselves independently.

Participants also emphasized that treating mental illness could provide huge opportunities for increasing intrinsic motivation in the FTDC. In this case, mental illness is defined as the following: A clinically significant behavioral or psychological syndrome or pattern that occurs in an individual associated with present psychological, social, or physical distress that obstructs a client's ability to recover from drug and alcohol dependence and be a stable, functioning caregiver of his or her child.[1]

According to the FTDC team, untreated mental illness can create an unwanted cause-and-effect barrier to intrinsic motivation. Undiagnosed mental illness can cause misunderstood, negative behaviors. Untreated mental illness may also inhibit positive behaviors that progress towards intrinsic motivation. It will impede the readiness someone has to change his or her behaviors, as mental illness often fogs life-affecting choices and thought processes, such as personal fault, that result in positive turning points for substance abuse (parent attorney, personal conversation, 2013). Because of this, there is a barrier between intrinsic motivation, positive self-esteem, high self-efficacy, interest to remain accountable for one's actions, and openness to treatment options. The causes and inhibitions of untreated substance abuse may lead a client to a downward spiral, as negative thoughts often decrease self-efficacy and self-esteem. However, because of this, strained personal relationships with the caseworker, case manager, counselor, family members, and the children may occur. This is where "dead ends" in treatment and perceived external locus of control are also major players. The added stress can potentially trigger substance use or cause more severe mental illness, causing greater unnecessary confusion to case outcomes, and leaving the FTDC unclear of the DHHS decisions.

> "…For mood disorders, PTSD, you know, bipolar disorder, things that are common… you've got to catch that, if you don't identify it, you're not going to treat it, if you're not going to treat it, then it triggers relapse and affects quality of life… and it affects parenting, too… so it is a problem…" (State coordinator, personal conversation, 2013)

Additional Productive Strategies

All three clients and almost all of the professionals mentioned that the support and care provided by the FTDC team was a huge strength. The dedication provided by the team, to work out of the ordinary and establish accountability is a new occurrence in many clients' lives. Clients claim that the FTDC is the one place they can go and not feel judged. Additionally, the passion of Judge Beliveau keeps the program at high momentum.

> "I like the structure, the stability, I love the support, I love that they treat you like human beings, not like criminals or pieces of shit, they treat everyone the same, but everyone works their own program, and they try to assist you and help you out, you know and better your life" (client, personal conversation, 2013)

[1] The DSM-IV classifies substance dependence as a psychological disorder (American Psychiatric Association 2000). However, for the case of this study, mental illness is defined as a syndrome or mental disorder that obstructs a client's ability to recover from substance dependence (American Psychiatric Association 2000).

Reflection of Research Questions

What key internal characteristics, environmental influences, or objectives motivate a client to succeed in the program?

For many of the clients in the Family Treatment Drug Court program, graduating the program means more than just regaining stability, becoming sober, and even regaining custody of their children. Participants in this study made it extremely apparent that graduating the program means changing brain chemistry, breaking ties with loved ones, learning new coping styles, recovering from mental illness, avoiding people and places that could cause triggers, improving personal identities, and becoming overall different caregivers than before. For most clients, becoming intrinsically motivated to graduate the FTDC really means becoming motivated to change the only life that they have ever known, and pushing forward to a life that *begins* with withdrawals, loneliness, a lack of self-control, and no easy self-medicating route out. At this point, it seems acceptable to acknowledge that intrinsic motivation is not the magic key to a healthy, stable lifestyle. Rather, intrinsic motivation is a key goal that every successful client has reached, as it indicates a lifestyle transition and a union between a productive mentality and positive behavior. Because of this, intrinsic motivation is a powerful internal characteristic that promotes positive environmental influences (good friends, for example) to reach the most valuable objectives—his or her children's well-being and the client's own personal recovery.

What motivational technique or method can we tangibly implement into the Family Treatment Drug Court to improve its road to success and increase the graduate rate?

As mentioned, one of the most profound challenges for the FTDC team is altering client mentality from an addicted mind to a recovery-driven mind. Motivational interviewing is an example of a strategy that is used in the courtroom and during therapy that slowly alters a client's mentality. FTDC team members who have utilized motivational interviewing have claimed to see changes in behavior because thoughts towards those behaviors have changed. Therefore, based on research and interviews, using the motivational interviewing technique at all times could be an exceptional way to promote client motivation and independence.

How can motivational strategies be used to develop client progress over a long period of time?

Intrinsic motivation requires a complicated, challenging journey for clients who are struggling with life-altering substance dependence, and Prochaska's Transtheoretical Model of the Stages of Changes focuses on breaking down the psychological stages needed to recover. Focusing on Prochaska's model would be a very interesting way for the FTDC to discriminate behavior and mindset while in the program over time. Furthermore, because the Prochaska's model has been well researched, it could potentially be used to measure motivation, target therapy needs, and catch signs of relapse or stage reversal in the FTDC program. According to interviews and client experience, characteristics and qualities of Prochaska's model seem to already exist in the drug court—from precontemplation in clients who relapse or were dismissed to positive intrinsic motivation of successful clients. Therefore, it would be extremely interesting to examine client motivation through the lens of Prochaska's model over a long period of time.

Additional Note

Mental illness was mentioned as a significant barrier to client motivation, as it often results in a lack of self-awareness or psychological functioning required to be influenced by motivational interviewing, or understand the necessities of changing lifestyles. Mental illness also creates challenging barriers when assessing recovery needs, as clinicians have a difficult time determining if behavior is due to addiction or mental illness. This was a major factor that was addressed during the study, and one that significantly affects clients' opportunities for success.

Concluding Statements

Parental substance dependence not only affects the parent, but it is a serious detriment on the physical and psychological well-being of the children involved. Because of this, Family Treatment Drug Courts focus on a vital need in the judicial court system—parent recovery. Intrinsic motivation is a key characteristic of clients who have been successful in the program because it indicates that the personal interests and beliefs of the client are the leading forces behind behaviors and decisions they are making. It means that the behavior is reflecting the clients' mentality and desires to improve themselves, rather than the behavior mirroring the wishes of the FTDC judge and the rest of the team. Intrinsically motivated clients are more willing to find strength and incentive to avoid triggers and unhealthy relationships, to find a job or housing. However, intrinsic motivation also indicates that the clients want to recover so their children are not affected by a harmful environment. Hopefully through Prochaska's model, motivational interviewing, and other intrinsically-oriented evidence-based therapies, FTDCs could potentially make a difference in clients' journeys to recovery and stability, and help clients understand their vital role in their children's futures. Family Treatment Drug Courts are incredible establishments to improve parents and children who are in need.

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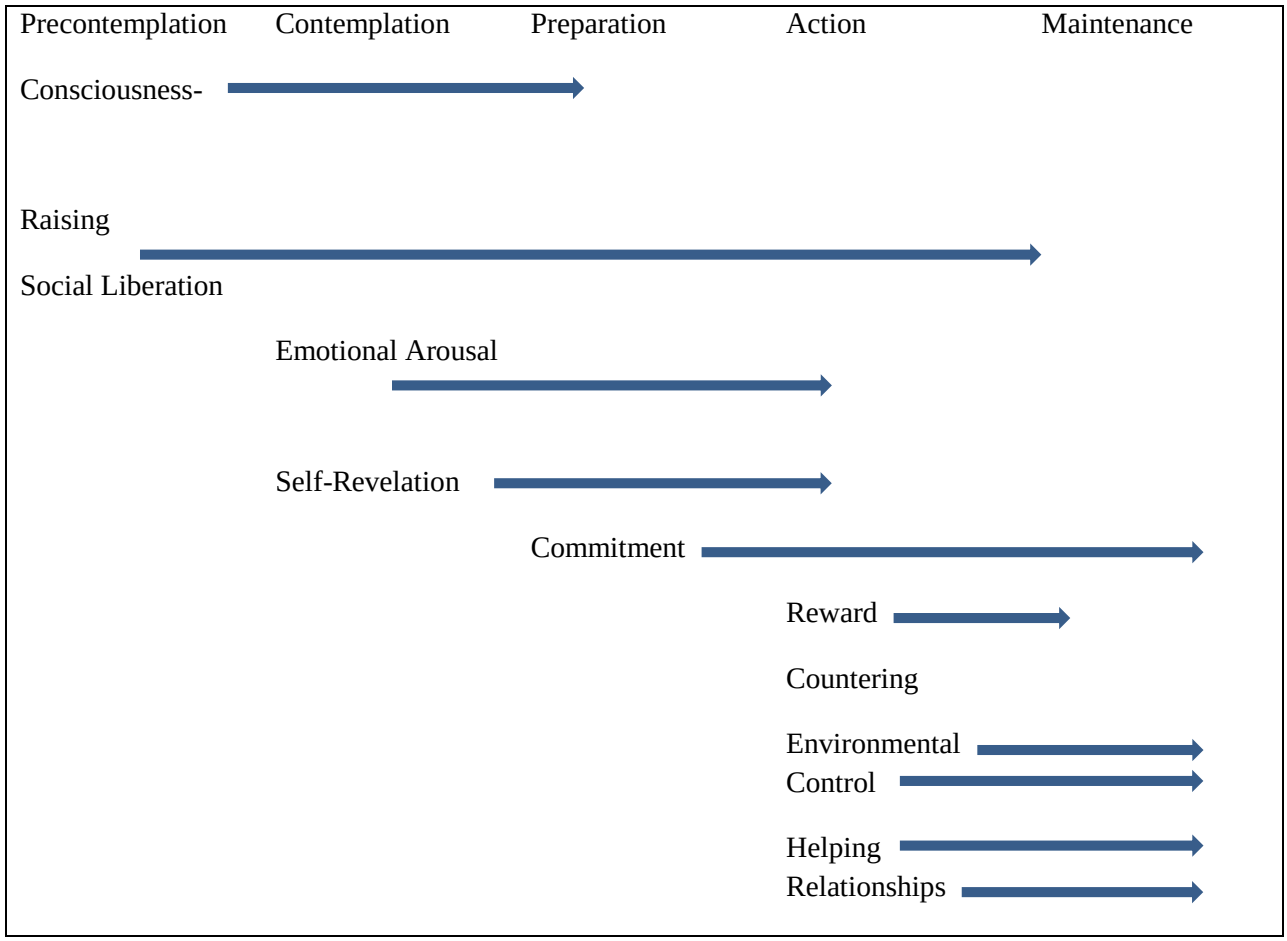
I would like to express my gratitude to Dr. Robert Greene of Case Western Reserve University for his incredible guidance and mentorship, to Dr. Krista Aronson of Bates College for her support and encouragement, and to Honor John Beliveau for fostering my interest in Family Treatment Drug Court research.

Figure 1. ***Prochaska's Stages of Change and the Most Useful Change Processes***
The figure below represents the Prochaska's Trans-theoretical Model of the Stages of Change. Each component shown below represents the psychological requirement needed to pass on to the next stage of recovery.



Appendix 1

Family Treatment Drug Court
Client Consent Form

The Family Treatment Drug Court is a great option for families to collaborate with the justice system, treat substance dependence, and develop a stable environment for the children. However, in order for families to graduate the program, they must be motivated to succeed.
I am conducting research to determine what **motivational strategies and goals** will benefit families to graduate the Family Treatment Program.

If you consent to participating in the program, you will be asked a set of questions about your experience with the Family Treatment Drug Court, what pushes people to graduate the program and what has worked and not worked for you in the past.

Things to know:

- The interview will take about **30 minutes**, and it will be scheduled at a time that works for you.
- I understand that this is a sensitive topic, so *please do not answer questions that make you feel uncomfortable!*
- You may leave at any time without penalty.
- The interview will be *audio recorded*. However, this session is **confidential**, which means your files and program information will only be open to individuals who already have access to these files (case manager, the judge, etc.). You may have a copy of the interview recording if you would like it. Otherwise, all personal interviews will be destroyed following the completion of the research. If for some reason you do not feel comfortable with audio recordings, let me know, and we can discuss other recording possibilities, such as note taking.
- Findings from this research will be confidential, and your personal information will not leave the Courthouse.
- **For clients:** *This interview has nothing to do with your case*, which means whatever you say will not affect what happens in the courtroom. You should feel free to say what you would like during the interview! I will keep all information confidential unless you mention new information that potentially harms yourself or others.
    - Additionally, I will try to ask all of the questions necessary to the study. However, any pertinent research information will be taken from your Family Treatment Drug Court file.

You can enter your name in a **raffle for a $25 gift card** to thank you for participating in the project! Your participation would be greatly appreciated and would help us to learn how to improve the Family Treatment Drug Court process! If you consent to participating in the project, please sign below.

Signature _____

Thank you for your time and if you have any questions feel free to contact me!

Aisling Ryan
Krista Aronson

Appendix 2

Family Treatment Drug Court
Consent Form

The Family Treatment Drug Court is a great option for families to collaborate with the justice system, treat substance dependence, and develop a stable environment for the children. However, in order for families to graduate the program, they must be motivated to succeed.
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- You may leave at any time without penalty.
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- Findings from this research will be confidential, and your personal information will not leave the Courthouse.

Your participation would be greatly appreciated and would help us to learn how to improve the Family Treatment Drug Court process! If you consent to participating in the project, please sign below.

Signature _____

Thank you for your time and if you have any questions feel free to contact me!

Aisling Ryan
Krista Aronson

Appendix 3

Client Interview Questions

Signals *Defense mechanisms and* *Mental Health*
Relapse *Characteristics* *Tangible solutions*

Thesis Questions
➢ What key internal characteristics, environmental influences, or objectives motivate a client to succeed in the program?
➢ What motivational technique or method can we tangibly implement into the Family Treatment Drug Court to improve their road to success and increase the graduate rate?
➢ How can motivational strategies be used to develop client progress over a long period of time?

Intro question

What's your daily schedule like being a part of the FTDC?
Who do you see? What appointments do you have? How long are they?

Motivation

- Why did you decide to participate in the program?
- Why do you want to graduate?

Older clients: The program seems really hard to keep up, but you seem to have done an amazing job so far. What keeps you going?
Newer clients: What do you hope to get out of this program?
Have things been overwhelming? Has it been difficult to start?

The Program

- What do you feel is the hardest part about graduating the program?
- Have things become easier or more difficult over time?
  - *Do you find it easier or harder to maintain sobriety and keep up with the program?*
- What would you want to see change in the Family Treatment Drug Court Program?
- What do you like about the Family Treatment Drug Court Program?

Appendix 4

Employee Interview Questions

Signals *Defense mechanisms and* *Mental Health*
Relapse *Characteristics* *Tangible solutions*

Thesis Questions
➢ What key internal characteristics, environmental influences, or objectives motivate a client to succeed in the program?
➢ What motivational technique or method can we tangibly implement into the Family Treatment Drug Court to improve their road to success and increase the graduate rate?
➢ How can motivational strategies be used to develop client progress over a long period of time?

Intro question

- **Can you tell me about your daily interactions with Family Treatment Drug Court Clients?**
    - When do you see them, how long, what do you usually talk about?

Motivation

- Why do clients decide to participate in the program?
- **What drives a client to graduate the program?**
- What keeps a successful client in the program?
    - Do you see a difference between successful clients and unsuccessful clients?
        - For example: motivation, behaviors, defense mechanisms

Behavior

- **What client behaviors or thoughts do you see change over time?**
    - Do you notice any patterns the longer clients are in the program?
- **What are some reoccurring behaviors you tend to see from the clients**?

Relapse

- What do you see when a client is beginning to relapse?
    - **What are the signs?**
    - What are their behaviors and thoughts?
- What influences usually lead to relapse?
- **When clients are struggling, what seems to pick them back up?**

Mental Health

- **What role does mental health play on a treatment plan?**
- Do you feel clients are receiving sufficient mental health assistance in this program? Would you prefer to see more or less?

Program

- What do you feel is the most successful method to assist clients in gradating the program?
- ***Only 18% of clients graduate from the FTDC. Do you have any suggestions of how we can bolster this number?***
    - ***Overall, what do you think works well in the family treatment drug court program?***

Appendix 5

Debriefing Statement

Thank you for your participation in this study! The primary purpose of this study is to determine what can be done at the Family Treatment Drug Court to improve the graduation rate through motivational strategies and techniques, and your assistance with this is much appreciated!

If you have any questions, comments, or concerns relating to this study, please contact:

Aisling Ryan

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