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The Sacramento Dependency Drug Court: Development and Outcomes

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Abstract

Dependency Drug Courts (DDCs) have emerged as a promising method of enhancing the functional status and reunification success of families involved in child welfare and affected by substance use disorders, yet few evaluations have appeared in the literature to help inform the discussion about their effectiveness. This article reports 24 month outcome findings from the Sacramento DDC. Seventy percent of the participants were women and almost 51% reported methamphetamine as their primary drug problem. DDC participants had higher rates of treatment participation, with treatment being successful regardless of the parent's primary drug type. At 24 months, 42.0% of the DDC children had reunified versus 27.2% of the comparison children. Parents with heroin problems had the lowest rates of reunification and marijuana users had the highest rates of reunification. Rates of recidivism were extremely low for both groups**.** The DDC program produced substantial cost savings due to increased reunification rates.

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Introduction

Development and Characteristics of Dependency Drug Courts

The child welfare and family court systems have traditionally lacked sufficient resources to meet the needs of those families in which parental substance use disorders contribute to child maltreatment. After the 1997 enactment of the Adoption and Safe Families Act (ASFA), which required child welfare systems to renew their focus on child safety and ensuring permanent homes for children, the need intensified for improved models to address the needs of these families.

Dependency Drug Courts (DDCs),[1] have emerged as a promising method of enhancing the functional status and reunification success of families involved in child welfare and affected by substance use disorders. The DDC is rooted in practice models developed for the adult criminal drug court movement, which began in the early 1990s following the cocaine "epidemic" of the late 1980s.

The development of DDCs was not simply a matter of applying the adult criminal drug court model in the family court setting. DDCs are considerably more complex than adult drug courts for a number of reasons. Traditionally, the family/dependency court process is a civil matter, while substance abuse is a criminal matter. In traditional drug or criminal courts, only criminal matters are adjudicated and the criminal charge can be held over the head of the defendant. While the DDC operates in civil matters of child protection with the prime imperative being child safety, it also considers many aspects of the client's life such as their substance use (Oetjen, Cohen, Tribble, & Suthahar, 2003). In addition, the families served in DDCs often have

[1] The Sacramento County program is referred to as a Dependency Drug Court, other jurisdictions may refer to these specialized courts as Family Treatment Courts, Family Drug Courts or Family Drug Treatment Courts.

multiple needs that require specialized treatment and case management services, usually including mental health, domestic violence, vocational rehabilitation, and parenting and life management skills (Merrigan, 2000).

The DDC is intended to protect children from abuse and neglect and ensure timely judicial decisions through coordinated services, provision of substance abuse treatment, and increased judicial oversight. This approach depends on court-based collaboration among child welfare agencies, substance abuse treatment providers, the legal system and other community agencies.

The DDC is a complex model because each of the three systems–child welfare services (CWS), alcohol and other drug (AOD) services, and the courts–has its own specific goals, which may diverge from the goals of the other two systems. Achieving a common vision among all three systems demands extraordinary effort, since the mandates, training, values, timing, and methods of the three systems are often different (Young, Gardner & Dennis, 1998). One such difference is the system's definition of its primary client. In the CWS system, the identified client is the child, while in the treatment system, the identified client is the parent. Another difference involves the type of court hearing the case.

The DDC seeks to blend the goals of child safety and permanency and recovery of the parent. This shared goal reduces the potentially adversarial relationship among the representatives from each of the three systems. In a DDC, the judge requires the parent to consent to substance abuse treatment, urine testing, and court monitoring. The attorney representing the parent has the opportunity to advise the client to accept or reject the judge's offer of treatment. Child welfare professionals collaborate closely with substance abuse treatment providers and other social service agencies in monitoring parental compliance with

court-mandated treatment plans. A key component is the court's power to ensure that necessary services for substance abuse treatment are provided to parents in a timely manner, as dictated by ASFA.

Evaluations of Dependency Drug Courts

The first DDC was implemented in Reno, Nevada in 1994. Since then, the DDC model has been implemented in a variety of jurisdictions, and by the end of 2005, 150 family drug courts were in operation. Until recently, there was no concerted attempt to study the effectiveness of these courts or to document their outcomes. Evaluation efforts began in 2000. The results of preliminary studies of DDCs are encouraging. The DDC process appears to ensure timely substance abuse treatment for parents and stability for children, and the three systems work more effectively through new interagency partnerships (Cohen et al., 2001).

A retrospective study of five DDCs was conducted for the federal government in 2003 (Young, Wong, Adkins, & Simpson, 2003). A total of 299 DDC cases and 240 comparison cases were included in the analysis. There were 630 children in the DDC group and 505 children in the comparison group. Statistically significant results showed that across sites the DDC participants received more episodes of substance abuse treatment, entered treatment faster, were arrested less often, had fewer subsequent child abuse and neglect reports, and reunified with their children faster than comparison participants (Young et al., 2003).

Types of Judicial Oversight

There are three primary types of judicial oversight in DDCs (Young et al., 2003): 1) integrated, 2) dual track (two-tiered), and 3) parallel. Many jurisdictions use a combination of the three types, depending on their needs and resources. Each type of DDC is described below.

Integrated Dependency Drug Courts. In the integrated model, one family court judge oversees both the dependency-related petitions and the compliance with substance abuse treatment orders. This judge has primary responsibility for the child welfare case. The judge may preside over each of the court hearings from the initial temporary custody proceeding through the final disposition of the case, including termination of parental rights and adoption proceedings. Examples of the integrated model include the DDCs in Jackson County, Missouri; Santa Clara, California; Suffolk County, New York; and Washoe County, Nevada.

Dual Track or Two-Tiered Dependency Drug Courts. The dual track, or two-tiered model originated in San Diego County. Its two-track approach operates on a considerably larger scale than the other models. The first track consists of specific recovery management services and access to substance abuse treatment services *for every child abuse or neglect case in the county* in which there are allegations of parental substance abuse. The second track is a separate family drug court for parents who do not comply with court orders. This family drug court operates on a separate calendar from the family's dependency case, and is concerned only with the parent's compliance with substance abuse treatment court orders. One judge handles the child welfare case and another judge monitors the compliance with substance abuse treatment.

Parallel Dependency Drug Courts. In a parallel DDC, the dependency case proceedings regarding the child abuse/neglect including aspects of visitation and permanency are conducted on a regular family court docket, and the parent is offered specialized court services at the first appearance in court, before any noncompliance can occur. A specialized court officer hears the compliance reviews and manages the recovery aspects of the case throughout the parent's participation in the dependency drug court. The Sacramento County DDC is an example of a parallel DDC.

Although there are differences among the three types of judicial oversight, all DDCs have *several features in common*: more immediate access to an assessment of the parent's substance use disorder; increased access to more intensive levels of substance abuse treatment; increased case management, particularly those aspects of the case regarding substance abuse treatment; a team approach to case planning to better inform judicial decision making; more frequent judicial oversight and client monitoring; and, specialized cross-system training efforts.

Current Study

This article will focus specifically on the Sacramento Dependency Drug Court as an example of a well-developed DDC as part of a system-wide reform effort to address the needs of families with substance use disorders in the child welfare system. Sacramento County has a long standing history of efforts to improve outcomes for children and families in the county's Child Protective Services (CPS) Division, particularly those families affected by substance use disorders. These efforts have evolved over the past decade, beginning in 1995 with the implementation of the county's Alcohol and Other Drug Treatment Initiative (AODTI) in response to evidence that substance abuse was a problem for a large number of families served by county agencies (see Young et al., 1998 for a comprehensive description of the AODTI). The AODTI was enacted to ensure that AOD services were an integral part of the health and human services system. Until this initiative, county agencies provided information and referrals to some substance-affected clients, but they did not assure that these clients were provided with screening, assessment, and intervention services. The goal of the AODTI was to develop the ability of child welfare social workers, public health nurses, eligibility workers, and neighborhood-based services staff to provide systematic screening and intervention services to clients with substance use disorders by enhancing the workers' understanding of substance use,

abuse, and dependence.

In 1998, the Presiding Judge of the Sacramento County Juvenile Court, convened a meeting with representatives from multiple agencies to explore the feasibility of establishing a drug court for the dependency system. Implementation of the Sacramento County DDC initiative began after the meeting with the development of a planning committee that applied for funding to develop and sustain the DDC program. This priority was based on the high percentage of court cases in which parental substance abuse was a major contributing factor identified in the child abuse/neglect allegations.

The planning committee evolved over the subsequent year into the Juvenile Delinquency and DDC Committee. The committee formed various workgroups to develop program protocols and policies in several arenas, and to initiate applications for funding. These workgroups included legal issues, treatment, court operations and evaluation. The following partner agencies were included in the planning committee and in the Steering Committee established upon initiation of the project: The Juvenile Court; Human Assistance and Public Protection Agency; DHHS Alcohol and Drug Services Division; DHHS Children's Protective Services Division; Parents' Defense Attorneys; Sacramento Child Advocates – the attorney group representing children; County Counsel-representing social services in the Dependency court; Criminal Justice Cabinet – the heads of the various public agencies concerned with criminal justice and court matters in the county; Probation Department; Sheriff's Department; and, Bridges, Inc. – the non-profit treatment agency providing recovery management services.

The Sacramento DDC is system-wide in its approach. Over the past decade, Sacramento has instituted six critical system changes in child welfare and treatment practices for parents with substance use disorders. The system changes required a comprehensive view of the county's

response to substance use disorders among families in child welfare. Sacramento's system changes included:

- Comprehensive training—to ensure that all workers in the Department of Health and Human Services fully understand substance abuse and dependence and are trained with skills to intervene with parents (see Young et al., 1998 for more information);
- Early Intervention Specialists—Masters' level social workers with training and experience in AOD services and motivational enhancement therapy are out-stationed at the family court to intervene and conduct preliminary assessments, intervention, and treatment linkages to ALL parents with substance abuse allegations at the very first court hearing in the case;
- Improvements in Cross-System Information Systems—to ensure that communication across systems and methods to monitor outcomes are in place as well as management of the county's treatment capacity;
- Prioritization of Families in Child Protective Services—County-wide policy to ensure that families in the child welfare system have priority access to substance abuse treatment services;
- Specialized Treatment and Recovery Services (STARS)—provides immediate access to substance abuse assessment and engagement strategies conducted by staff trained in motivational enhancement therapy. STARS provides intensive management of the recovery aspect of the child welfare case plan and routine monitoring and feedback to CPS and the court; and,
- Dependency Drug Court—provides a system of more frequent court appearances for ALL parents with allegations of substance use with immediate rewards and sanctions

based on compliance with court orders regarding the recovery plan.

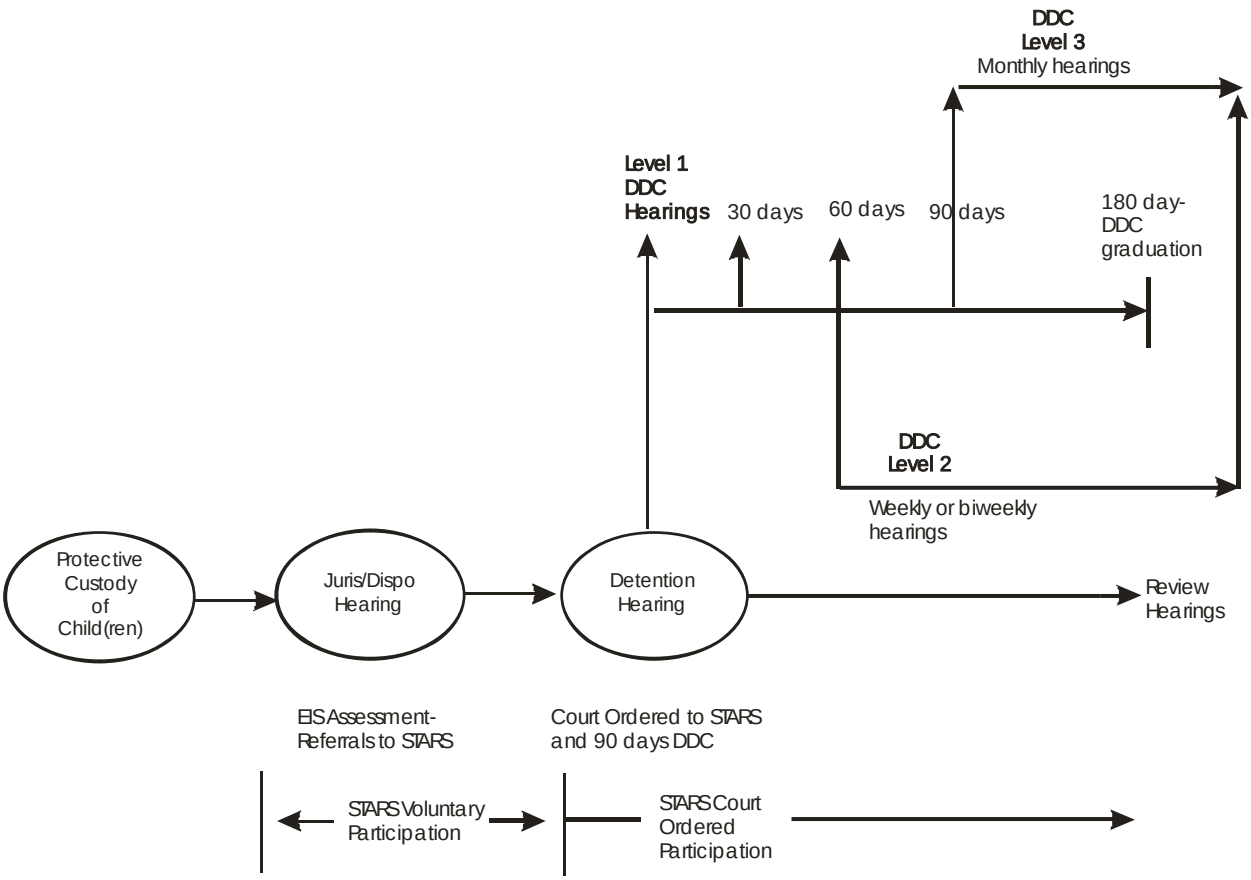
Goals of the Sacramento Dependency Drug Court

The Sacramento DDC has the following specific goals: Increase the number of parents with substance involvement who are quickly screened, assessed, and placed in the most appropriate treatment; increase the rates of compliance with substance abuse treatment; increase family reunifications rates; decrease the average length of time that children spend in out-of-home care; decrease related costs of out-of-home care; and, increase collaboration between the court, CPS, and substance abuse treatment providers.

The Sacramento Dependency Drug Court Program Model

The Court Process. The preliminary step in the court procedure involves the identification of parents who meet the DDC criteria at the Detention Hearing. An Early Intervention Specialist (EIS) reviews intake petitions from CPS and identifies petitions alleging neglect or abuse related to parental substance use, including cases in which a child tested positive for drugs at birth. An EIS worker employed by the CPS Division initially administers a preliminary AOD assessment and makes a referral both to an appropriate level of substance abuse treatment and to the Specialized Treatment and Recovery Services (STARS) program. Figure 1 provides a graphic depiction of the Sacramento DDC and STARS model and the process by which the parent proceeds through the system.

Figure 1. Sacramento Dependency Drug Court Model



The parent is offered the opportunity to participate in the DDC, which oversees compliance with court orders regarding the parent's substance abuse treatment participation and recovery. The defense bar encourages the parents' participation in the DDC and STARS Program at the detention hearing and explains that participation is voluntary. At the disposition court hearing, the CPS Division report states whether the parent is eligible for and whether the parent would benefit from DDC participation. If the parent agrees to DDC participation, the court issues orders to participate in AOD treatment programs and the DDC. If the parent refuses participation in the DDC, the home court orders participation in AOD treatment programs and sets the first, second and third compliance review hearings to be held in the home court.

The Sacramento DDC uses both incentives and sanctions to encourage the client to take responsibility for his or her actions. Positive rewards and incentives for compliance with the

DDC requirements are as important as negative sanctions for noncompliance. The DDC manages only the compliance with AOD services component of the case, and the home court hears and adjudicates all matters regarding the child's dependency and custody status. If the parent is compliant with the court orders, the bench officer encourages further compliance and administers appropriate incentives. The positive incentives valued most highly by DDC participants seem to be the handshake and words of encouragement of the judge, and the accolades of the other DDC participants.

The DDC operates in three Levels depending on the parent's compliance with the court order (see Figure 1). Level I includes the first, second and third compliance review (typically these reviews are calendared at 30, 60 and 90 days post-disposition. Parents who voluntarily participate in Level II (a more intensive level for those who are non-compliant) appear in court bi-weekly or as ordered by the court. Level III involves monthly contacts and includes aftercare.

If the parent is noncompliant, the parent's counsel explains the waiver of a hearing and the plea to contempt process. If the parent admits to the non-compliance, the bench officer administers the appropriate sanction. If the parent denies the non-compliance and requests a "show cause" hearing, the matter is continued for two weeks. The appropriate procedures for notice on the "show cause" hearing are conducted and the hearing is set for adjudication by the Presiding Judge. If the parent fails to appear for a compliance review hearing, the court may issue a bench warrant.

Level I sanctions are administered as follows, when appropriate: First finding of non-compliance at any compliance hearing (includes all non-compliance events occurring in the relevant time period) – Court reprimand; Second finding of non-compliance at a compliance hearing (includes all non-compliance for the period since last court hearing) – Court orders 2

days in jail (weekend); and, Third finding of non-compliance at any compliance hearing (includes all non-compliance events for the period of time from the last compliance hearing) – Court orders 4 days in jail. If parent agrees to participate in Level II, 2 days of jail may be lifted

The following are definitions of non-compliance events: Failure to timely enroll in AOD treatment programs; positive urine test or admission of use; unexcused missed urine test (administrative positive) or refusal to test; failure to participate in required AOD treatment program activities and treatment plan; use/possession of controlled substance without valid prescription; failure to comply with rules of the AOD treatment programs and dependency drug court; use of alcohol when ordered to abstain; failure to appear for a compliance hearing; and failure to cooperate with substance treatment program staff, children's protective services social worker or STARS recovery specialist.

Recovery Specialists. The Specialized Treatment and Recovery Services (STARS) program is operated by a local non-profit community-based organization that provides AOD treatment services through a contract with Sacramento County. The primary duty of the STARS worker, most often referred to as a recovery specialist, is to maintain a supportive relationship with the parent(s), with an emphasis on engagement and retention in treatment, while providing recovery monitoring for the CPS Division and the Dependency Court. Each parent is matched to a STARS worker. The STARS worker monitors urine testing, substance abuse treatment and self-help group compliance, and provides regular compliance reports to the court, social worker, and minor(s)' counsel. Urine testing is administered on a random basis and is always an observed collection. Compliance reports are sent to CPS, legal counsel and the Dependency Court two times each month.

As with the DDC, there are three levels of STARS contacts. Track I includes semi-weekly contact with STARS; Track II includes weekly contact with STARS; and Track III involves bi-weekly contact. STARS contacts will depend on the parents' progress in their recovery.

The Treatment Process. The full continuum of community-based substance abuse treatment services, including outpatient, intensive outpatient, and residential care, are utilized. Prioritization for timely access to AOD services was given for specific groups, particularly families and mothers with open cases in the CPS Division or with referrals from the CPS Division. All clients are assessed to ensure that clients who needed intensive levels of AOD services were appropriately referred to such treatment and monitored while receiving services.

Methods

Evaluation Design

A hybrid design, consisting of longitudinal and cross-sectional data, was selected for this evaluation for two reasons. First, since all clients who meet the selection criteria are being offered DDC intervention, random assignment of clients to an experimental and control condition was not possible. Second, through the use of multiple evaluation points over time and a comparison sample, most of the threats to internal validity (i.e., instrumentation, maturation, selection, regression to the mean, and testing effects) were controlled for.

Intent to treat sampling was used to include all clients enrolled in STARS and the DDC, regardless of whether or not they successfully completed the DDC program. Sacramento County required the evaluation of its DDC to be conducted using existing data collection activities and data sets, to the fullest extent possible. The evaluation plan was to minimize the creation of new data collection for County staff. Thus, the evaluation required the linkage of existing multiple

CPS, ADS, and Court data systems. The CPS Division created special reports from the CWS/CMS dataset that included the specific data elements needed for the evaluation. The ADS Division abstracted records for specific time periods and forwarded those data sets to the evaluation consultants. New data collection was implemented in the three new program components: (1) tracking intakes to the STARS program; (2) electronic storage of case monitoring reports required by the court and CPS Division; and (3) collection and electronic storage of data related to the actions taken with participants during the DDC court hearings. With the different information systems accessed by the Sacramento evaluation, none of which had the full range of data required for the evaluation, a certain amount of ad hoc extraction of data was also necessary to secure useful information on the different outcomes to be measured.

Tracking children and parents in the various data systems required entering identifying information that could be linked to other data systems, in each of the components of the programs. For example, at the Detention Hearing, EIS workers enter all children whose parents had allegations of substance abuse in the court petition into the CWS/CMS case record. As parents were subsequently ordered to participate in STARS and DDC, the STARS workers sent information to the CPS Division with information regarding voluntary progress for parents. At that point, the CPS Division staff entered a new special projects code, “Court Ordered STARS” to indicate that parents had been ordered to participate. For the comparison groups, special project code “Comparison” was entered in the case record of all children whose parents were selected as a comparison case. In addition, a 10-digit client identifier was created which links the STARS database and CWS/CMS, allowing for a more accurate link between the child and the parent receiving services.

Procedures

A comparison group was created from families who entered the dependency system in the six months prior to STARS implementation and met the criteria for DDC. Cross-sectional data for the DDC and comparison group concerning CPS characteristics were abstracted quarterly from the CPS database, Child Welfare Services/Case Management System (CMS/CWS). AOD Services characteristics and outcomes for both samples were abstracted quarterly from the ADS Division data system. These data allowed for a comparative evaluation of parental treatment progress and child safety and permanency outcomes for the treatment and comparison groups of clients.

Sample Characteristics

From January 1, 2001 to September 30, 2005, 1,402 parents and their 2,270 children were identified in CWS/CMS as having an allegation of AOD involvement. Two groups of families are used in the evaluation. They include:

- Parents who entered the dependency system prior to STARS implementation (January through May 2001) and met the criteria for DDC. The sample is 111 parents and their 173 children. This group received standard CPS and ADS Divisions services. Thus, a client who was identified as having an AOD problem was directed to the ADS Division for a preliminary assessment and then directed to participate in outpatient or residential treatment without the benefit of a recovery specialist or the specialized court services in the DDC model. This group was used as a comparison group.
- Parents who entered the dependency system between October 1, 2001 and September 30, 2004 and were court ordered to receive EIS and STARS services and DDC supervision. The resulting sample for the DDC group is 1,291 parents and 2,097 children

Measures

The primary components of the program for data collection and analysis were: Identification of parents with alcohol and drug related problems at the detention hearing; completion of a preliminary AOD assessment by EIS; intake at the STARS program; participation in alcohol and drug treatment/recovery services; compliance with court orders; and CPS Division data systems detailing child placements and outcomes.

Results

Program outcomes were assessed in two primary areas: AOD treatment status and child placement outcomes. Process measures and outcomes of AOD treatment status included differences between groups in participating in treatment, length of stay in treatment, treatment modality, and satisfactory completion of treatment. Child placement outcomes included collecting data on placements type at 24 months and measuring re-entry into care following reunification. In addition, out-of-home-care costs for the comparison are provided, along with cost savings associated with the reunification rates.

Demographic and Baseline Characteristics

Table 1 shows the demographic characteristics for parents in the comparison and court-ordered group. The sample was 70% women, with the comparison parents (Mean=33.4 years) were slightly but significantly older than the court-ordered parents (Mean=32.0 years). Race/ethnicity information for the comparison and court ordered cases is limited (n=104 and 1143 respectively). These data are reported from the treatment admission data and not all parents have been admitted to treatment. The treatment data set has the most complete data on parent characteristics and contains data from all the publicly funded treatment programs that the parents have attended.

No significant differences were found between the cohorts in terms of race/ethnicity with the majority of the participants being Caucasian (54.2%), followed by African American (20.4%), and Hispanic (17.2%). American Indian/Alaskan Native, Asian/Pacific Islander, and "other: clients represent 8.2% of the participants.

Table 1. Parent Demographic Characteristics

	Comparison		**DDC**		**Total Sample**	
Total	**111**		**1291**		**1402**	
Gender	**N**	**%**	**N**	**%**	**N**	**%**
Male	39	35.1	382	29.6	421	30.0
Female	72	64.9	909	70.4	981	70.0
Race/Ethnicity						
American Indian/Alaskan	2	1.9	41	3.6	43	3.4
Asian/Pacific Islander	3	2.9	28	2.4	31	2.5
African American	25	24.0	229	20.0	254	20.4
Hispanic	19	18.3	196	17.1	215	17.2
Caucasian	54	51.9	622	54.4	676	54.2
Other	1	1.0	27	2.4	28	2.2
Mean Age (range)*	33.4 (21-55)		32.0 (18-67)		32.1 (18-67)	

*p<.05

Overall, the majority of parents in both groups were unemployed, 46.4% had less than a high school education, 17.0% were pregnant at treatment admission, 31.9% reported a disability impairment (i.e., mental, visual, or mobility), 30.7% reported chronic mental illness at treatment admission, and 45.4% reported being homeless at admission (see Table 2). As expected, court-ordered parents (69.0%) were significantly more likely to have a legal status at treatment admission than comparison (54.2%) parents (X^2 (1, 1167) = 5.6, $\underline{p} < .05$).

Methamphetamine was identified as the primary drug for 50.9% of the participants. Although not statistically significant, more DDC parents reported methamphetamine as their primary drug problem than the comparison parents. There were significantly more heroin users (6.8%), however, in the comparison group than the DDC group (2.3%) (X^2 (1, 1167) = 4.4, $\underline{p} < .05$).

Table 2: Parent Baseline Characteristics

	Comparison		DDC		Total Sample	
Total	**59**		**1108**		**1167**	
Employment	**N**	**%**	**N**	**%**		
Employed (Full or Part Time)	13	22.0	179	16.2	192	16.5
Unemployed	46	78.0	929	83.8	975	83.5
Education						
Less than High School	28	47.5	513	46.3	541	46.4
High School, GED, or Some College	31	52.5	595	53.7	626	53.6
Pregnant At Admission	10	17.0	188	17.0	198	17.0
Legal Status At Admission*	32	54.2	764	69.0	796	68.2
Disability Impairment At Admission	19	32.2	353	31.9	372	31.9
Chronic Mental Illness	15	25.4	343	31.0	358	30.7
Homeless	30	50.8	500	45.1	530	45.4
Primary Drug Problem						
Methamphetamine/amphetamines	26	44.1	568	51.3	594	50.9
Alcohol	11	18.6	190	17.1	201	17.2
Marijuana	12	20.3	189	17.1	201	17.2
Heroin*	4	6.8	26	2.3	30	2.6
Cocaine/Crack	6	10.2	112	10.1	118	10.1
Other	0	0.0	23	2.1	23	2.0

Note: Incomplete employment information is contained in the treatment data (n=59 comparison, 1108 court ordered). Thus, the sum of values may equal less than the total. *p<.05

When examining baseline characteristics by gender, men (28.0%) were found to be significantly more likely to be employed either full or part-time than women (12.0%) (X^2 (1, 1167) = 41.9, $p < .001$). In addition, men (59.6%) were more likely to have at least a high school education than the women (51.5%) (X^2 (1, 1167) = 6.0, $p < .05$). There were no significant differences in terms of legal status at admission. Women (33.6%) were more likely to report having a disability at treatment admission (i.e., mental, physical, hearing, etc) than fathers (23.2%) (X^2 (1, 1167) = 11.6, $p < .001$). As would be expected, women (35.8%) were significantly more likely to report ever being diagnosed with chronic mental illness at treatment admission than men (13.%) (X^2 (1, 1167) = 56.7, $p < .001$). Women (46.9%) were also significantly more likely to be homeless at admission than men (35.7%) (X^2 (1, 1167) = 11.7, $p <$

.001). In terms of primary drug problem, men (22.6%) were more likely to report alcohol as their primary drug type than women (15.2%); whereas the women (11.5%) had significantly higher rates of cocaine/crack use than men (6.4%) (X^2 (1, 1167) = 17.9, $p < .01$).

Treatment Status

Participation in AOD treatment was determined by examining whether the parent had ever been admitted to a publicly funded treatment program. Unfortunately those who attended private treatment centers or had private insurance to pay for treatment are not included in the treatment data system. Results indicated that significantly more DDC parents had ever been in treatment than the comparison parents. Only 53.2% of the comparison group parents had ever been in AOD treatment versus 85.8% of the DDC participants (X^2(1, 1402) = 78.2, $p < .001$). In addition, there were significantly more treatment admissions among the DDC parents ($M = 2.7$, $SD = 2.2$) than the comparison parents ($M = 1.4$, $SD = 1.7$) (F (1, 923) = 30.3, $p = .000$). The differences in the number of admissions may be due to the fact that the comparison group did not have the advantage of a STARS worker keeping them connected with treatment services.

The comparison averaged more days per treatment episode (M =114.4, SD = 147.5) than did the DDC parents (M = 86.1, SD = 99.2) (F (1,1103) = 4.3, $p < .05$). The shorter time in treatment may also be due to the impact of the STARS program in preparing parents for treatment, monitoring their treatment progress, and providing aftercare services. When examining gender differences, we found that fathers (M = 101.6, SD = 162.7) averaged significantly more days per treatment episode than mothers (M = 82.6, SD = 68.7) (F (1, 1103) = 7.4, $p < .001$).

In regard to the treatment modality, 65% of all treatment episodes were for outpatient care. More DDC parents (35.4%) participated in residential treatment than comparison parents

(27.8%). This difference was not significant however. There was no difference in the numbers of participants receiving outpatient or residential services based on gender.

When examining discharge status, the DDC groups also had consistently higher satisfactory discharges (65.1%) than the comparison group (56.8%). These differences are not statistically significant, however (X^2 (1, 3298) = 4.2, $\underline{p} < .05$). No gender differences were observed in terms of treatment discharge status, with both men and women averaging approximately 65% satisfactory discharge from treatment.

Child Characteristics

Characteristics of children of parents in the comparison group and DDC program are shown in Table 3. The sample was evenly split by gender. Significant differences were found in race/ethnicity, however, with American Indian/Alaskan native children more likely to be in the comparison group (X^2 (4, 2270) = 10.4, $\underline{p} < .05$). Children in the comparison group were significantly older than the DDC children, with an average age of almost eight years.

Table 3. Child Demographic Characteristics

	Comparison		**DDC**		**Total Sample**	
Total	**173**		**2097**		**2270**	
Gender	**N**	**%**	**N**	**%**	**N**	**%**
Male	78	45.1	1022	48.7	1100	48.5
Female	95	54.9	1075	51.3	1170	51.5
Race/Ethnicity						
American Indian/Alaskan**	8	4.6	34	1.6	42	1.9
Asian/Pacific Islander	3	1.7	50	2.4	53	2.3
African American	56	32.4	584	27.8	640	28.2
Hispanic	31	17.9	410	19.6	441	19.4
Caucasian	75	43.4	1019	48.6	1094	48.2
Mean Age (range)* **	7.9 (1-19)		6.3 (0-18)		6.4 (0-19)	

Note: **p<.01; ***p=.000

24 Month Child Placement Outcomes

To date, 24-month data is available only for the comparison group (111 parents and 173 children) and the two DDC cohorts (573 parents and 861 children). These data are presented below. Data collection and analysis for the subsequent DDC cohorts is ongoing. Significant differences were found between cohorts in terms of their placement status at 24 months ($X^2(5, 1034) = 81.1$, $p = .000$) At 24 months, fewer comparison (27.2%) children had reunified with their families than court-ordered Year One children (42.0%). In contrast, comparison group children were more likely in adoption, guardianship, or long-term placement at 24 months relative to the court-ordered children. Comparison children were less likely to be in continued reunification services than the court-ordered children at 24 months (see Table 4).

Table 4: 24 Month Child Placement Outcomes

	Comparison		**DDC**		**Significance**
Total	**173**		**861**		
	N	**%**	**N**	**%**	
Reunified	47	27.2	362	42.0	p<.001
Adoption	55	31.8	197	22.9	p<.05
Guardianship	23	13.3	46	5.3	p<.001
Long term placement	32	18.5	44	5.1	p<.001
Continued reunification services	3	1.7	121	14.1	p<.001
Other	13	7.5	91	10.6	n.s

Among those who reunified within 24 months, the comparison group took longer to reunify with their families than the DDC children. This difference is not statistically significant, however. Of the comparison children who reunified by 24 months, the average time to reunification was 300.7 days or 10.0 months, and the for the DDC children who reunified by 24 months, the average to time to reunification was 283.3 days or 9.4 months. These data are shown in Table 5.

Table 5: Time to Reunification at 24 Months

	Comparison	DDC	Significance
Number of children who reunified	47	362	

Time to reunification (among those reunifying in 24 months)	300.7 Days	283.3	n.s

Impact of Primary Drug of Parents

We also examined the relationship of the primary drug choice of the parents to treatment status and child placement outcomes. We found that treatment is often successful, regardless of the primary drug problem (see Table 6). Except for heroin, the rate of successful discharge is around 64.8%. Parents with heroin (49.7%) as their primary drug problem were significantly less likely to have a satisfactory discharge status than users of other substances. In contrast, those who reported alcohol (71.4%) as their primary drug problem had a significantly higher number of satisfactory discharges than methamphetamine, cocaine/crack, and marijuana users ($X^2(5, 3298) = 31.2$, $p < .001$).

Table 6: Primary Drug Type and Treatment Discharge Status

	Satisfactory		Unsatisfactory	
Primary Drug Type***	N	%	N	%
Heroin	82	49.7	83	50.3
Alcohol	396	71.4	159	28.6
Methamphetamine	1143	65.6	599	34.4
Cocaine/Crack	241	61.6	150	38.4
Marijuana	235	61.5	147	38.5
Other	39	61.9	24	38.1

Note: All treatment episodes in which there is a discharge status are represented here. Not all episodes have a discharge status.***p<.001

In addition, we examined 24-month child placement rates by primary drug type of the parent (see Table 7). Parents with heroin as their primary drug problem had the lowest rates of reunification with their children at 24 months and marijuana users had the highest rates of reunification. Children of heroin users (40.0%) were significantly more likely to be in adoption than children of methamphetamine (22.5%) or marijuana (22.1%). In addition, children of heroin (11.4%) and cocaine/crack (9.0%) were more likely to be in long-term placement than children of methamphetamine users (4.2%). In contrast, children of methamphetamine users were

significantly more likely to be in continuing reunification services at 24 months than children of heroin users. Lastly, children of alcohol (8.4%), methamphetamine (8.1%) and marijuana (9.3%) users were significantly more likely to be in guardianship at 24 months than children of cocaine/crack (2.8%) users ($X^2(20, 1035) = 33.2$, $p < .05$).

	Heroin		**Alcohol**		**Methamphetamine**		**Cocaine/Crack**		**Marijuana**	
Table 7. Primary Drug Type of Parent and 24 Month Child Placement Outcomes*										
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Reunified	12	34.3	81	39.9	208	43.3	55	37.9	78	45.3
Adoption	14	40.0	50	24.6	108	22.5	41	28.3	38	22.1
Guardianship	2	5.7	17	8.4	39	8.1	4	2.8	16	9.3
Long-term placement	4	11.4	10	4.9	20	4.2	13	9.0	10	5.8
Continued reunification services	1	2.9	29	14.3	73	15.2	14	9.7	22	12.8
Other Status	2	5.7	16	7.9	32	6.7	18	12.4	8	4.7

*p<.05

Recidivism and Re-Entry to Out-of-Home Care

In addition to examining placement outcomes, we examined recidivism and re-entry to out-of-home care. Recidivism is defined as the percentage of children who came back into out-of-home care following a new allegation after their prior case had been closed and where dependency had been terminated. The overall rate of recidivism for both groups was extremely low. For example, the recidivism rate for those who reunified was 0.0% for the comparison group and 1.1% for the DDC group.

In order to estimate re-entry rates, we examined whether children reunified with their families during the 24 months following the project start date and then came back into out-of-home care. The re-entry rate for the comparison group was 10.6% versus 18.5% for the DDC group. With the exception of very few cases, almost all children who re-entered care were returned to placement due to alcohol or drug use on the part of the parents. A few cases involved

mental health issues in combination with substance use. It is not unusual for relapse to occur among substance abusers. With the instant drug test methods and intense oversight of the court, social workers are contacted immediately when a DDC parent tests positive while children are in their care, resulting in possible removal of the child from the household.

We examined the outcomes of these re-entry cases, including subsequent reunification, transition into a permanent plan of adoption, guardianship, long-term placement, or emancipation, and receiving continued family maintenance/family reunification (FM/FR) services. Of the five comparison children (representing four families) who re-entered care, 100% moved on to a permanent plan of adoption or guardianship. There were 100 court-ordered children (representing 55 families) that re-entered care. The majority of the court-ordered children were subsequently reunified with their parents (28.0%) or had a permanent plan of adoptions or guardianship (54.0%). The rest were in continued FM/FR (8.0%), were subsequently emancipated (3.0%), or had other statuses such as incarceration (7.0%).

Initial Cost Estimates

In examining estimates and cost savings, we examined a variety of methods, including examining yearly expenditures and child case rates. Both of these methods represented cost savings for the DDC. The cost analyses presented below capture the most comprehensive analyses that examine the impact of costs due to increased reunification rates. We calculated the out-of-home-care costs for the comparison and two DDC cohorts. Cost estimates are provided at 24 months.

Impacts of Costs Related to Increased Reunification Rates at 24 Months. The 24-month reunification rate for the comparison group was 27.2%. The 24 month reunification rate for the court-ordered group was 42.0%, which accounted for 362 children. If we assumed a reunification

rate of only 27.2% for the court-ordered group, then 128 fewer children would have reunified. By deducting the time to reunification for the court-ordered group (9.4 months) from the average length of out-of-home care for the comparison group (33.1 months), we find a 23.7 month difference. The savings due to the estimated additional 128 children who reunified through the DDC program totals $5,823,208 (128 children multiplied by 23.7 months multiplied by $1,919.57 out-of-home care costs).

Overall, the increased reunification rates for the DDC group led to increased foster care savings. These savings do not include other administrative costs such as court, social workers, attorneys, and clerical staff time which are saved by faster reunifications.

Discussion

The results indicate that the majority of families in the DDC are responding well to the Sacramento DDC program. Screening for substance abuse has improved because of the EIS caseworkers' close involvement in the DDC. Access to treatment services has greatly improved because of the efforts of the STARS workers. As a result, parents have been able to access appropriate treatment in a timely manner. This assertion is supported by the finding that more DDC parents enrolled in treatment, received more intensive levels of treatment, and completed more treatment episodes to a satisfactory degree the comparison parents. Treatment completion status was high for all primary substances except heroin.

Intensive monitoring is used to identify family needs and problems early so that assistance can be provided and the safety of the children can be ensured. The court receives comprehensive status reports that enable informed decisions concerning the placement of the children. Also, as a result of integrating services, new relationships have been developed among treatment providers, child welfare professionals, and the court. Program staff members believe

that the clear case plan and close monitoring of progress allows for informed decisions on the part of the judge concerning child custody and better quality of services for the families.

As a result, more of the DDC children had reunified by 24 months than in the comparison group. Comparison children were more likely to be in adoption, guardianship, or long-term placement at 24 months. In addition, the DDC children were reunified faster with their families. Children whose parents had marijuana and methamphetamine problems had the highest rates of reunification. Few parents had subsequent child abuse reports. Lastly, the effectiveness of the DDC is highlighted in the cost savings.

Limitations

One notable limitation to the study is that no primary data was collected. The intent was to minimize the impact of new data collection on the systems. Thus, data analysis was limited to the variables contained in the data systems. In addition, since Sacramento County initiated six systems changes over the past decade, it is impossible to tie the results of the evaluation directly to the effects of the DDC. It is believed that it is the combination of those changes which has led to the success outcomes noted among DDC participants.

Future Directions

During the past few years, Sacramento has experienced an increase in the number of families entering the DDC. This increase has been attributed to an increase in methamphetamine in the County and two child deaths that occurred during the summer of 2004. The Sacramento DDC is currently working on strategies to deal with the increase in caseloads.

In addition, the Sacramento DDC has recorded changing demographics among its parents. More parents are presenting with methamphetamine as their primary drug of choice. The parents are increasingly presenting with histories of chronic mental illness and homelessness.

These changes may be due in part to a change in state law (Welfare Institution Code 361.5 b12/b13) which occurred in September 2002. The state law was clarified that individuals would receive reunification services unless they had failed court-ordered treatment in the past. Prior to this change, parents who had failed prior treatment may have been excluded from reunification services unless they were able to show by clear and convincing evidence that it was in the minor's best interest to receive services. Thus, the sample that was admitted prior to the change in law may have had less severe etiology. Research indicates that prior treatment is associated with more severe levels of substance use, criminality, and use of drugs by injection (Hser, Grella, Hsieh, Anglin, & Brown, 1999).

There is a need for additional ancillary services such as housing, employment and/or mental health services among the parents in the DDC. A parent may successfully meet the case plan requirements for reunification, but due to lack of adequate housing, their children may not be allowed to reunify and return home with them. To address the mental health concerns, the Sacramento DDC recently received pilot funds to expand mental health services for its participants. These expanded services included comprehensive mental health screening and assessment, and timely access to mental health services.

One area that the Sacramento DDC recognizes as needing improvement is their services to children. Services are often provided to children of DDC parents as a byproduct of the parent's treatment. The Sacramento DDC plans to offer specialized services directly to children. Children need counseling to deal with the trauma of family breakup and reunification. They often have unmet medical and social service needs. Specialized services are being implemented to meet the needs of children and support improved outcomes, with an increasing emphasis on prevention and early intervention for children.

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