
The Sacramento Dependency Drug Court: Development and Outcomes

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Dependency Drug Courts (DDCs) are a growing method of addressing the functional status and reunification success of families involved in child welfare and affected by substance use disorders. Despite widespread interest in DDCs, few evaluations have appeared in the literature to help inform the discussion about their effectiveness. This article provides a description of various types of DDCs and reports 24-month reunification rates from the Sacramento DDC. Results indicated that DDC participants had higher rates of treatment participation than did comparison participants. In addition, at 24 months, 42% of the DDC children had reunified versus 27.2% of the comparison children. There were no differences in treatment completion or child reunification rates by parent's primary drug problem. Rates of recidivism were extremely low for both the DDC and comparison groups and did not differ significantly. The results of the present study are encouraging and suggest that rigorous, controlled studies are merited to further evaluate the effectiveness of DDCs.

Keywords: *Dependency Drug Court; parents; child welfare; substance abuse*

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 families in which parental substance use

disorders contribute to child maltreatment. The need for improved models intensified to address the needs of these families after the 1997 enactment of the Federal Adoption and Safe Families Act (ASFA), which required child welfare systems to renew their focus on child safety and ensurance of permanent homes for children.

In response to this need, a number of communities developed Dependency Drug Courts (DDCs), alternatively known as family treatment drug courts. DDCs are an increasingly popular method of (a) meeting the requirements of ASFA and (b) enhancing functional status and reunification success among families involved in child welfare and affected by substance use disorders. The DDC approach 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 as a way to provide substance abuse treatment to criminals charged with drug-related offenses. Modeled after adult criminal drug courts, DDCs incorporate many of the same treatment elements, although under a

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quite different set of circumstances (Worcel, Furrer, Green, & Rhodes, 2006).

The development of DDCs, however, 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, whereas substance abuse is a criminal matter. In traditional drug or criminal courts, only criminal matters are adjudicated and the criminal charge can be used as leverage for compliance. DDCs, in contrast to the criminal courts, operate in civil matters of child protection with the prime imperative being child safety. They also consider many aspects of the client's life other than just substance abuse (Oetjen, Cohen, Tribble, & Suthahar, 2003). In addition, the families served in DDCs often have 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).

Similar to adult drug courts, DDCs typically involve regular (often weekly) court hearings, intensive judicial monitoring, provision of substance abuse treatment and wrap-around services, frequent drug testing, and rewards and sanctions linked to service compliance (Worcel et al., 2006). The DDC model 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. However, the DDC can be a complex model because each of the three systems—Child Protective Services, Alcohol and Drug Services, and the courts—has its own specific goals and mandates, which may diverge from those of other systems. Achieving a common vision among all three systems demands extraordinary effort because the mandates, training, values, timing, and methods of the three systems are often different (Young, Gardner, & Dennis, 1998). One such difference is each system's definition of its primary client. In child protective services, the identified client is the child, whereas the parent is the identified client in the treatment system. Yet the DDC seeks to blend the goals of child safety and permanency and recovery of the parent, reducing 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. 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. Necessary services include immediate access to an assessment of the parent's substance use disorder; increased access to 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; frequent judicial oversight and client monitoring; and specialized cross-system training efforts.

Evaluations of DDCs

Evidence to date suggests that DDCs are associated with more timely initiation of substance abuse treatment, more treatment episodes, fewer arrests, and greater stability for children as indicated by fewer subsequent child abuse and neglect reports and faster times to reunification (Child Welfare Training Program, 2000; Worcel et al., 2006; Young, Wong, Adkins, & Simpson, 2003). Although promising, however, these studies have several limitations. For example, the sample sizes in each of the sites are small, making it difficult to detect anything but large treatment effects. Furthermore, the use of comparison groups in these studies is either nonexistent or problematic, for example, comparison groups drawn prior to and following the implementation of AFSA (Child Welfare Training Program, 2000; Worcel et al., 2006).

Types of Judicial Oversight

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

Integrated DDCs. 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 DDCs. 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. Those clients who do not comply with court orders are offered the second track of the system, which is the DDC. This DDC operates in a separate court than the family's dependency case and is focused only on 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 DDCs. In a parallel DDC, the dependency case proceedings regarding the child abuse and/or neglect, including aspects of visitation and permanency, are conducted on a 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 DDC. The Sacramento County DDC is an example of a parallel DDC.

Sacramento County has a long-standing history of efforts to improve outcomes for children and families in the county's Child Protective Services, particularly those families affected by substance use disorders. These efforts have evolved throughout the past decade, beginning in 1995 with the implementation of the county's Alcohol and Other Drug Treatment Initiative 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 Alcohol and Other Drug Treatment Initiative). The Alcohol and Other Drug Treatment Initiative was enacted to ensure that substance abuse services were an integral part of the health and human services system. The goal of the Alcohol and Other Drug Treatment Initiative 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.

This article focuses on the Sacramento DDC as a real-world example of a parallel DDC developed as part of a systemwide reform effort to address the needs of families with substance use disorders in the child welfare system. As noted above, there are several

problems with existing evaluation studies of DDCs. This study attempts to provide more definitive information regarding the efficacy of DDCs by addressing some of the limitations inherent in the prior studies, including the use of a comparison group and a larger sample size. In addition, this study provides a longitudinal analysis of both parental treatment status and child welfare outcomes.

The Sacramento DDC 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, a master's-level social worker with training and experience in substance abuse services and motivational enhancement therapy, reviews intake petitions from Child Protective Services and identifies petitions alleging neglect or abuse related to parental substance use, including cases in which a child tested positive for drugs at birth. The Early Intervention Specialist, employed by Child Protective Services, is out-stationed at the family court and administers a preliminary substance abuse assessment and makes a referral both to an appropriate level of substance abuse treatment and to the Specialized Treatment and Recovery Services program. The Specialized Treatment and Recovery Services program provides immediate access to substance abuse assessment and engagement strategies conducted by staff trained in motivational enhancement therapy and provides intensive management of the recovery aspect of the child welfare case plan and routine monitoring and feedback to Child Protective Services and the court. Figure 1 provides a graphic depiction of the Sacramento DDC and the Specialized Treatment and Recovery Services program and the process by which the parent proceeds through the system.

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 parent's attorney encourages the parents' participation in the DDC and the Specialized Treatment and Recovery Services program at the detention hearing and explains that participation is voluntary. It is at the detention hearing that the court reviews allegations to ensure that there are sufficient grounds to remove the child. At the jurisdiction and disposition court hearings (where the court determines if the abuse and neglect allegations are true and the court determines the child's placement and establishes a service plan), Child Protective Services reports whether the parent is eligible for, and would benefit from, DDC

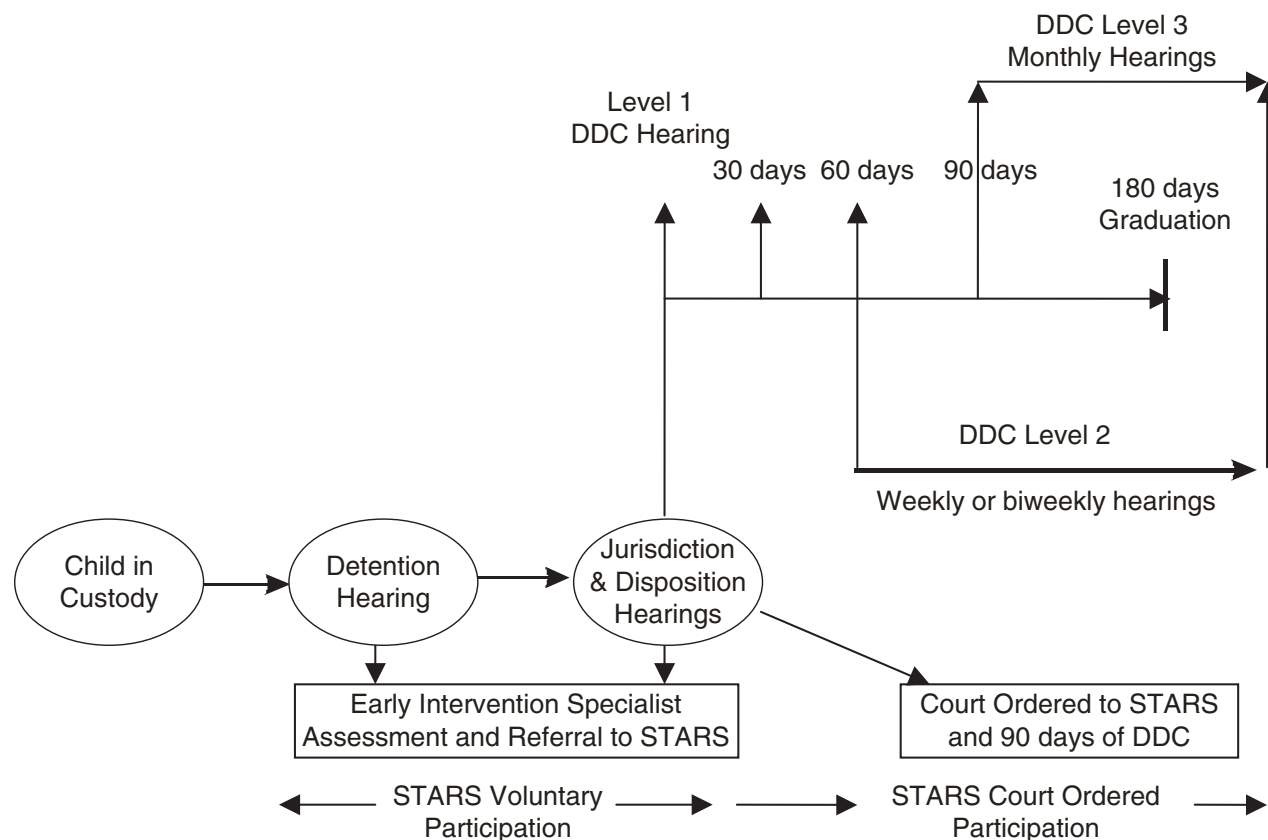


FIGURE 1: Sacramento Dependency Drug Court Model

NOTE: DDC = Dependency Drug Court; STARS = Specialized Treatment and Recovery Services.

participation. If the parent agrees to DDC participation, the court issues orders to participate in substance abuse treatment and the DDC. If the parent refuses participation in the DDC, the home court orders participation in treatment programs and sets the first, second, and third compliance review hearings to be held in the original home court.

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 postdisposition). Parents who voluntarily participate in Level II (a more intensive level for those who are noncompliant) appear in court biweekly or as ordered by the court. Level III involves monthly contacts.

The following are examples of noncompliance events: failure to timely enroll in treatment; positive urine test or admission of use; unexcused missed urine test (administrative positive) or refusal to test; failure to participate in required treatment program activities and treatment plan; use/possession of controlled

substances without valid prescription; failure to comply with rules of the treatment program and DDC; use of alcohol when ordered to abstain; failure to appear for a compliance hearing; and failure to cooperate with substance abuse treatment program staff or the Specialized Treatment and Recovery Services program.

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 the treatment 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.

At the first compliance review, all clients receive a Specialized Treatment and Recovery Services program medallion, which is a symbol of the commitment the

parent is making to recovery and reunification. At the second consecutive compliance hearing, compliant clients receive a Serenity Stone; at the third consecutive compliance hearing, they receive a 90-day certificate and have their picture taken with the judicial officer; at the fourth, they receive a Recovery Stone; at the fifth, it is a Success Stone; and at the sixth consecutive compliance hearing, they receive a graduation certificate, take a picture with the judicial officer, and have the opportunity to share their success with the group. Special incentives also are used, such as a Courage Stone for when a client has made a difficult decision (e.g., chosen to go into residential treatment, admitted relapse, left an abusive relationship, or made the decision to terminate reunification services and have child adopted) or a Hope Stone, which is given to clients who need a little extra encouragement. The parents report that the 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.

If the parent is noncompliant at any level, the parent's counsel explains the waiver of a hearing and the plea to contempt process. If the parent admits to the noncompliance, the bench officer administers the appropriate sanction. If the parent denies the noncompliance and requests a "show cause" hearing, the matter is continued for 2 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 (although this has not occurred to date).

Level I sanctions are administered as follows, when appropriate. At the first noncompliance, the participant receives a court reprimand. This includes all noncompliance events occurring in the relevant time period. A second finding of noncompliance results in a 2-day court-ordered stay in jail (weekend). A third finding of noncompliance at any compliance hearing (includes all noncompliance events for the period of time from the last compliance hearing) results in a 4-day stay in jail. If parent agrees to participate in Level II, the 2 days in jail may be stayed.

Recovery specialists. The Specialized Treatment and Recovery Services program is operated by a local, nonprofit, community-based organization that provides treatment services through a contract with Sacramento County. The primary duty of the Specialized Treatment and Recovery Services 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 Child Protective Services and the DDC). Each parent is matched to a Specialized Treatment and Recovery Services worker, who 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 Child Protective Services, legal counsel, and the DDC two times each month. There are three levels of Specialized Treatment and Recovery Services contacts, which are based on the parents' progress toward their recovery. Track I includes semiweekly contact with the Specialized Treatment and Recovery Services program, Track II includes weekly contact, and Track III involves biweekly contact.

The treatment process. In Sacramento, the full continuum of community-based substance abuse treatment services, including outpatient, intensive outpatient, detoxification, and residential care, are utilized. It is a countywide policy that prioritization for timely access to treatment services is given for specific groups, particularly families and mothers referred to Child Protective Services or with open cases. All clients are assessed to ensure that clients who needed intensive levels of treatment services were appropriately referred to such treatment and monitored while receiving services.

Program Outcomes

Sacramento DDC program outcomes were assessed in two primary areas: parental treatment status and child placement outcomes. Four primary analyses were conducted to examine differences between cohorts for parental treatment participation: length of stay in treatment, treatment modality (residential vs. outpatient), and satisfactory completion of treatment (completed vs. not completed). Three primary analyses related to child placement outcomes were conducted, including child placement type (reunification vs. other outcomes) at 24 months, time to reunification among those who reunified, and total time in out-of-home care.

A separate follow-up analysis restricted to children who were reunified was conducted to examine rates of reentry into out-of-home care. In addition, secondary analyses were conducted on the relationship of the parent's primary drug to both treatment completion and the child's placement status at 24 months.

METHOD

Participants

The data presented in this article include two groups of participants for which 24-month outcome data are available. The first is a comparison group of families who entered the dependency system in the 6 months prior to the implementation of the Specialized Treatment and Recovery Services program and met the criteria for DDC. This sample included 111 parents and their 173 children. This group received standard Child Protective Services and Alcohol and Drug Services. Thus, a client who was identified as having a substance abuse problem was directed to the Alcohol and Drug Services for a preliminary assessment; he or she was 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.

The second group consisted of those families who entered the dependency system between October 1, 2001, and September 30, 2003, and were court ordered to receive Specialized Treatment and Recovery Services and DDC supervision. This DDC sample included 573 parents and 861 children.

Design

The current study compares the outcomes for DDC participants with the outcomes for a comparison group whose members did not participate in the DDC. 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 Child Protective Services, Alcohol and Drug Services, and court data systems.

Child Protective Services created special reports from the Child Welfare Services/Case Management System data set that included the specific data elements needed for the evaluation. Alcohol and Drug Services abstracted records for specific time periods and forwarded those data sets to the evaluation consultants. New data collection was implemented for the three new program components: (a) tracking intakes to the Specialized Treatment and Recovery Services program, (b) electronic storage of case-monitoring reports required by the court and Child Protective Services, and (c) 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 also was necessary to secure useful information on the different outcomes to be measured.

Cross-sectional data for the DDC and comparison group were abstracted from the Child Welfare Services/Case Management System. Treatment services characteristics and outcomes for both samples were abstracted from the Alcohol and Drug Services 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.

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, Early Intervention Specialists enter all children whose parents had allegations of substance abuse in the court petition into the Child Welfare Services/Case Management System case record. As parents are subsequently ordered to participate in the DDC, the Specialized Treatment and Recovery Services workers send information to Child Protective Services regarding voluntary progress for parents, and Child Protective Services staff enter a special projects code—"court ordered"—to indicate that parents had been ordered to participate.

For the comparison groups, the 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 that links the Specialized Treatment and Recovery Services database and the Child Welfare Services/Case Management System case record, allowing for a more accurate link between the child and the parent receiving services.

Confidentiality

Given the sensitive nature of the data involved, a Memorandum of Agreement was signed by key court and evaluation staff, allowing the evaluation team access to client records for evaluation/research purposes and to ensure client protection. All identifying information was kept in a locked file by evaluation staff and all data are presented in aggregate form.

Analyses

One-way analyses of variance (ANOVA) and chi-square analyses were performed concerning the baseline comparability of the DDC and comparison group. Descriptive statistics yielding means, standard deviations, ranges, frequency distributions, and percentages were generated to run group comparisons. For

TABLE 1: Parent Demographic Characteristics

	<i>Comparison</i>		<i>DDC</i>		<i>p</i>
	<i>N</i>	<i>%</i>	<i>N</i>	<i>%</i>	
Gender					
Male	39	35.1	179	31.2	.42
Female	72	64.9	394	68.8	
Race/ethnicity ^a					
American Indian/Alaskan	2	1.9	20	3.8	.68
Asian/Pacific Islander	3	2.9	13	2.4	
African American	25	24.0	118	22.2	
Hispanic	19	18.3	76	14.3	
Caucasian	54	51.9	290	54.6	
Other	1	1.0	14	2.6	
<i>M age (range)</i>	33.4 (21-55)		32.1 (18-56)		.08

a. Race/ethnicity information for the comparison and Dependency Drug Court (DDC) cases is limited ($n = 104$ and 531 , 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.

continuous variables, one-way ANOVA tests were conducted. For categorical variable distributions, where specified proportions were the measures of interest, chi-square analyses were performed.

Multivariate models were developed that examined parental treatment variables, with DDC and comparison cohorts entered as predictors, controlling for parental demographic and baseline characteristics. All parental demographic and baseline characteristics were entered into the multivariate models as independent variables. Multiple logistic regression utilizing backward stepwise regression was used to examine dichotomous treatment variables (i.e., treatment modality, treatment completion). Multivariate linear regression utilizing backward stepwise regression was used to examine continuous treatment variables (i.e., time in treatment).

Multivariate analyses using backward stepwise regression also were conducted to examine child placement outcomes. Dichotomous outcomes (i.e., reunification vs. other placements) were examined using multiple logistic regression and continuous outcome variables (i.e., time to reunification and time of out-of-home care) were examined using multivariate linear regression. In addition to the child's cohort (DDC vs. comparison group), the following independent control variables were included in each of the analyses of placement outcomes: child's age, child's gender, child's race/ethnicity, parent's age, and parent treatment history (ever in treatment vs. no treatment history). Children's models included parent characteristics that differed between the DDC and comparison cohorts in bivariate analyses.

RESULTS

Parent and child demographic characteristics. Table 1 shows the demographic characteristics for parents in the comparison and DDC groups. The sample was 68.1% women, with a mean age of 32.3 years of age. No significant differences were found between the cohorts in terms of race/ethnicity, with the majority of comparison and DDC parents being Caucasian (54.2%), followed by African American (22.5%), and Hispanic (15.0%). American Indian/Alaskan Native, Asian/Pacific Islander, and "other" clients represent 8.4% of the comparison and DDC parents.

Characteristics of children of parents in the comparison group and DDC program are shown in Table 2. The sample was evenly split by gender. Significant differences were found in terms of race/ethnicity, however, with American Indian/Alaskan native children more likely to be in the comparison group, $\chi^2(4, 1034) = 16.2, p < .01$. Children in the comparison group ($M = 7.8, SD = 4.4$) also were significantly older than the DDC children ($M = 6.2, SD = 4.8$), $F(1, 1031) = 18.1, p < .001$.

There were no differences in most caregiver baseline characteristics between the comparison and DDC groups. Overall, the majority of parents in both groups were unemployed, 45.9% had less than a high school education, 17.6% were pregnant at treatment admission, 63.7% had a legal status, 30.3% reported a disability impairment (i.e., mental, visual, or mobility), 30.1% reported chronic mental illness at treatment admission, and 49.5% reported being homeless at admission (see Table 3). In addition, methamphetamine was identified as the primary drug for 48.4% of the participants.

TABLE 2: Child Demographic Characteristics

	<i>Comparison</i>		<i>DDC</i>		<i>p</i>
	<i>N</i>	<i>%</i>	<i>N</i>	<i>%</i>	
Gender					
Male	78	45.1	417	48.4	.42
Female	95	54.9	444	51.6	
Race/ethnicity					
American Indian/Alaskan	8	4.6	7	0.8	.03
Asian/Pacific Islander	3	1.7	20	2.3	
African American	56	32.4	250	29.0	
Hispanic	31	17.9	170	19.7	
Caucasian	75	43.4	414	48.1	
<i>Mean age (range)</i>	7.9 (1-19)		6.2 (0-18)		< .001

NOTE: DDC = Dependency Drug Court.

TABLE 3: Parent Baseline Characteristics

	<i>Comparison</i>		<i>DDC</i>		<i>p</i>
	<i>N</i>	<i>%</i>	<i>N</i>	<i>%</i>	
Employment					
Employed (full- or part-time)	13	22.0	87	17.5	.39
Unemployed	46	78.0	410	82.5	
Education					
Less than high school	28	47.5	227	45.7	.80
At least a high school education	31	52.5	270	54.3	
Pregnant at admission	10	16.9	87	17.7	.89
Legal status at admission	41	69.5	310	63.0	.33
Disability impairment	19	32.2	148	30.1	.74
Chronic mental illness	15	25.4	151	30.7	.41
Homelessness	30	50.8	243	49.4	.83
Primary drug problem					
Methamphetamine/amphetamines	26	44.1	243	48.9	.46
Alcohol	11	18.6	91	18.3	
Marijuana	12	20.3	78	15.7	
Heroin	4	6.8	15	3.0	
Cocaine/crack	6	10.2	58	11.7	
Other	0	0.0	12	2.4	
Ever been in treatment	59	53.2	492	85.6	< .001

NOTE: Baseline characteristics for the comparison and Drug Dependency Court (DDC) cases are limited. 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.

There were differences in whether the participants had ever been in treatment, however. Participation in treatment was determined by examining whether the parent had ever been admitted to a publicly funded treatment program. In California, those who attend private treatment centers or have 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 (see Table 3). Significantly

fewer comparison group parents (53.2%) had ever been in treatment than DDC participants (85.9%), $\chi^2(1, 684) = 63.5, p < .001$.

All subsequent primary analyses regarding treatment status and completion controlled for parent demographic and baseline characteristics. The analyses regarding child placement outcomes controlled for child demographics and the two parent characteristics that were significant in the bivariate analyses.

PRIMARY ANALYSES

Treatment Status and Completion

No differences were found between the groups in terms of the timing of the treatment episode. Overall, 56% of the participants had a treatment admission following inclusion in the DDC or comparison group and 43.6% entered treatment prior to inclusion in the DDC or comparison period. There were also eight DDC participants (.4%) who entered treatment the same day as they were court ordered to the DDC.

There were significantly more treatment admissions among the DDC parents ($M = 2.6$, $SD = 2.4$) than the comparison parents ($M = 1.3$, $SD = 1.7$), $F(1, 683) = 29.5$, $p < .001$. These effects held in the multivariate linear regression, controlling for the parental demographic and baseline characteristics ($\beta = .354$, $SE = 0.132$, $p < .01$).

The comparison group parents, however, averaged more days per treatment episode ($M = 114.4$, $SD = 147.5$) than did the DDC parents ($M = 89.4$, $SD = 69.2$), $F(1, 539) = 5.0$, $p < .05$. In the multivariate linear regression, controlling for parent characteristics, comparison parents still averaged more days per treatment episode ($\beta = -13.6$, $SE = 5.5$, $p < .05$). In regard to the treatment modality (i.e., residential vs. outpatient), significantly more of the DDC parents (54.9%) had treatment episodes involving residential treatment than did the comparison parents (39.0%), $\chi^2(1, 551) = 5.3$, $p < .05$. However, this difference was no longer significant when controlling for the parent demographic and baseline characteristics using the multiple logistic regression. No cohort differences were observed in terms of treatment completion rates. The comparison and DDC groups had an average of 63.9% satisfactory treatment episode completions.

24-Month Child Placement Outcomes

Significant differences were found between cohorts in terms of their placement status at 24 months. At 24 months, more DDC children (42.0%) had reunified with their families than comparison (27.2%) children, $\chi^2(1, 1034) = 13.3$, $p < .001$. In the multiple logistic regression model, controlling for child characteristics and the two significant bivariate parent characteristics, DDC children were almost 1.4 times as likely (odds ratio [OR] = 1.38, confidence interval [CI] = 1.14, 1.68, $p = .001$) to reunify as comparison children. There was no difference, however, in the time to reunification among those who did reunify in either the bivariate or multivariate analyses. For those who had reunified by 24 months, the average time to reunification was 285.3 days. DDC children ($M = 641.5$, $SD = 464.3$), however, spent fewer days in out-of-home care

than did comparison children ($M = 993.0$, $SD = 683.4$), $F(1, 981) = 67.1$, $p < .001$. These effects held when controlling for child characteristics and parent characteristics ($\beta = -157.9$, $SE = 21.3$, $p < .001$).

Recidivism and Reentry to Out-of-Home Care

In addition to examining placement outcomes, we examined recidivism and reentry 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. Reentry is defined as the percentage of children who reunified with their families during the 24 months following the project start date and then came back into out-of-home care before the case was closed.

There were no statistical differences in recidivism rates between the two groups. The overall rate of recidivism for both groups was extremely low, with less than 1.5% of children experiencing recidivism during the study period (1.7% in the DDC group and 0% in the comparison group). There were also no statistical differences in the rates of reentry, with 21.7% of the children experiencing reentry following reunification. Eighty-three (22.9%) of the 362 DDC children who reunified within 24 months experienced reentry into care compared to 10.6% of the comparison group children (5 of the 47 children who reunified experienced reentry). With the exception of very few cases, almost all children who reentered 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.

SECONDARY ANALYSES

Impact of Parent's Drug Problem on Treatment Completion

The relationship of the primary drug problem to rates of treatment completion was examined. Independent of the cohort, we found similar rates of treatment completion, regardless of the primary drug problem. Except for heroin, the rate of treatment completion was 63.9%. Parents with heroin as their primary drug problem were significantly less likely (46.7%) to complete treatment than were users of all other substances, $\chi^2(5, 1741) = 16.7$, $p < .01$. The treatment completion rates were similar for users of methamphetamine compared to all other substances of abuse, except heroin.

Impact of Parent's Drug Problem on Child Placement Outcomes

There were no differences in child reunification rates when examining the parent's primary drug

problem. Parents who used heroin (33.3%) had the lowest rates of reunification with their children at 24 months and marijuana users had the highest rates of reunification (45.4%). Parents who used alcohol, methamphetamine, and cocaine/crack had reunification rates between 36.9% and 42.4%.

DISCUSSION

The results of the study are encouraging with respect to DDCs, which appear to facilitate receipt of treatment services and child reunification. The findings show that more DDC parents enrolled in treatment and completed more treatment episodes than did the comparison parents. They did, however, have shorter lengths of stay per treatment episode. The higher number of treatment admissions for the DDC participants may be due to the fact that the comparison group did not have the advantage of a Specialized Treatment and Recovery Services worker keeping them connected with treatment services. The shorter time in treatment for the DDC parents may be due to the impact of the Specialized Treatment and Recovery Services program in preparing parents for treatment, monitoring their treatment progress. In Fiscal Year 2001-2002, the average length of residential treatment and the number of times a client could enter residential and detoxification treatment in Sacramento was reduced.

The relationship of the parent's primary drug problem to treatment completion also was examined. This was an important issue given the recent emphasis on the methamphetamine epidemic. The results show that treatment completion rates were similar, regardless of the primary substance of abuse, except for heroin. The parents who used alcohol, methamphetamine, cocaine/crack, or marijuana all had treatment completion rates of 60.3% to 68.5%. This implies that if parents can access treatment, they have a very good likelihood of treatment completion. We did not find an impact of the parent's primary drug problem on child reunification rates, however.

In terms of child welfare outcomes, children in the DDC group had significantly higher rates of reunification by 24 months than did the comparison group and they spent fewer days in out-of-home care. There was no difference in the time to reunification among those who reunified by 24 months, however. It is believed that this result is due to the high rate of homelessness among both cohorts. For example, a parent may successfully meet the case plan requirements for reunification but, due to lack of adequate housing, her children may not be allowed to reunify and return home with her. It is believed that increases

in reunification rates could be associated with unprecedented cost savings due to decreases in use of the foster care system.

In terms of recidivism and reentry to out-of-home care, few parents had subsequent child abuse reports. Recidivism rates for both were extremely low at less than 1.5%. Although not significantly different, the reentry rates for the DDC group were higher than for the comparison group. It is possible that this nonstatistical difference is due to the small sample size of the comparison group children who reunified and experienced reentry and that a larger sample size would have led to statistically significant differences in reentry rates. The DDC parents are under more intensive supervision and 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.

Limitations

One notable limitation to the study is that no primary data were 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, the sample size of the comparison group is considerably smaller than that of the DDC group. A 6-month time frame was utilized to collect comparison group data, resulting in only 111 parents and 173 children. Although the large difference in the size of the two groups is concerning, analyses indicated that there were few differences between comparison and DDC groups on baseline characteristics, and those differences that were present were controlled for in all analyses.

Future Directions

Although the first DDC began in 1994 and there are nearly 200 DDCs in operation, there have been relatively few evaluation studies. Outcome research in this area is in its infancy and often suffers from methodological problems, such as small sample sizes, lack of comparison groups, and lack of randomization. To truly assess the effectiveness of DDCs and its components, studies are needed where participants are randomly assigned to DDC and to various components. For example, studies designed to include a matched comparison group (treatment as usual), a recovery specialist only, a DDC-only group, and a DDC group that receives the services of a recovery specialist would help to identify the truly effective parts of the program and would help to advance the field in conducting outcome research with this population.

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