



Sacramento County Dependency Drug Court: The First Four Years

**Prepared for:
Sacramento County Juvenile Dependency Drug Court Committee**

**Produced under Contract to:
Children and Family Futures
4940 Irvine Boulevard, Suite 202
Irvine, CA 92620
714-505-3525
Fax : 714-505-3626
www.cffutures.com**

**Authored by Sharon Boles, Ph.D.
Nancy K. Young, Ph.D.**

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Executive Summary

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. The Sacramento County Dependency Drug Court (DDC) began in October 2001. The Sacramento DDC operates parallel to the dependency case proceedings, which are conducted on a regular family court docket. The parent is offered specialized court services before any noncompliance of court orders regarding substance abuse recovery occurs. The compliance reviews and management of the recovery aspects of the case are heard by a specialized court officer throughout the life of the parents' participation in the dependency drug court. The Sacramento DDC was developed as part of a system-wide reform effort to address the needs of families with substance use disorders in the child welfare system.

Evaluation Objectives

The objectives of the dependency drug court (DDC) evaluation study are to determine the impact to parental involvement and engagement in treatment and child placement outcomes associated with outcomes of participation in DDC, relative to an equivalent group of parents in the child welfare system. Specifically, the evaluation examines whether participation in DDC:

- Increasing clients' alcohol and other drug (AOD) treatment compliance rates
- Increasing the number of parents with AOD involvement who are screened, assessed, and timely placed in the most appropriate treatment modality
- Increasing successful family reunification rates
- Decreasing the average length of stay of children in out-of-home care
- Decreasing related out-of-home costs
- Increasing collaboration between the Court, Child Protective Services (CPS), and AOD treatment agencies

This evaluation report includes information on six groups of parents and children, a comparison group and five cohorts of DDC participants. Comparison participants are those who entered the dependency system prior to Early Intervention Specialist (EIS) and Specialized Treatment and Recovery Services (STARS) implementation (January through May 2001) and met the criteria for DDC. This group received standard CPS and ADS Divisions services. Thus, a client who is identified as having an AOD problem is directed to the Alcohol and Drug Service Division (ADS) 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. Court-ordered participants are those who entered the dependency system between October 1, 2001 and September 30, 2006 who received EIS and STARS services and were court-ordered to receive DDC supervision. Each court-ordered cohort begins on October 1 and ends on September 30 of the next year. For the purposes of this report, the court-ordered cohorts have been combined.

Program Outcomes

Program outcomes were assessed in two primary areas: AOD treatment outcomes and child protective services outcomes. Process measures and outcomes of AOD treatment included differences between groups on participating in treatment, the timeliness of treatment services, length of stay in treatment, and satisfactory completion of treatment. Child protective services outcomes included collecting data on placement types at 12, 18, and 24 months and measuring recidivism and re-entry into care following reunification.

Major Findings

Sacramento Child Welfare Population

- **For both families and children, the number of hotline referrals has remained relatively stable from project Year Two to project Year Four and increased in project Year Five.**

For families, the number of hotline referrals remained relatively stable from project Year Two to project Year Four, averaging almost 2,000 referrals per year. During project Year Five, however, there was an increase in the number of family-related hotline referrals accepted for investigation, with the number rising to 2,130.

The same trend was found for child-related hotline referrals. For children, the number of hotline referrals remained relatively stable from project Year Two to project Year Four, ranging from 3,388 to 3,620 referrals per year. During project Year Five, this number rose to 3,728.

- **The percent of the referrals in which an intake petition was filed increased steadily during the first four project years and declined somewhat during the last project year**

During project Year Two, 43.7% of the families referred for investigation had subsequent intake petitions filed. This percentage rose to 65.6% during project Year Four and fell to 63.5% in project Year Five. This same trend was found among child-related intake petitions filed.

- **The DDC children have represented an increasingly larger percent of the hotline referrals and intake petitions. A slight decline in these numbers was seen in the past year.**

In project Year Two, the DDC children represented 11.9% of the hotline referrals and 27.0% of the intake petitions filed. These percentages rose to 20.9% and 31.6%, respectively, during project Year Four. There was a slight decline in these percentages during project Year Five to 19.6% and 30.6%, respectively.

Dependency Drug Court Participants

- **The percentage of parents with Alcohol or Other Drugs (AOD) in the petition steadily decreased from project Year One to project Year Four and rose in project Year Five.**

Based on Early Intervention Specialist (EIS) statistics, the percentage of parents with AOD in the petition steadily decreased from Year One (70.4%) to Year Four (58.5%) and rose in Year Five (68.0%).

While the percent of those parents who subsequently receive a preliminary assessment has increased from project Year One to Year Four, it fell during the past year.

The percent of parents with AOD in the petition who received a preliminary assessment has increased from Year One (31.8%) to Year Four (37.6%) but fell during Year Five to 30.1%. Thus, almost two-thirds of parents with AOD in the petition never engage in EIS services.

The numbers receiving a preliminary assessment prior to being court ordered to DDC and STARS represent only 30-40% of the eligible parents. Thus, 60-70% of parents with AOD in the petition are not engaging in EIS services. Many of these parents, however, are later assessed after being court ordered to DDC and STARS at the dispositional hearing or their cases are transferred to voluntary services (i.e., informal supervision) where they receive Specialized Treatment Recovery Specialist (STARS) only services.

- **In the past two years, there has been a dramatic increase in the number of parents who have been court-ordered to the DDC. As a result, the number of children in the DDC cohorts has also dramatically increased.**

The Year Four numbers represent a 38.6% increase in parents and 71.5% increase in children over the Year One cohort. This increase in participants remained stable over the past year.

- **The study sample was primarily women with high unemployment and low educational attainment**

There were no differences between the comparison and DDC participants on any of the parent demographic characteristics, including gender, age, or race/ethnicity. Almost 70% percent of the comparison and DDC parents were women, with an average age of 32.3 years of age. The majority of the comparison and DDC parents were Caucasian (52.0%). In contrast to previous years, Hispanics now make up the second largest racial/ethnic group of DDC clients.

No cohort differences were observed in any of the baseline characteristics. Parents in the comparison and DDC groups were largely unemployed; 46.0% had less than a high school education; 30.9% had a disability impairment; 31.3% reported a history of chronic mental illness, and 41.1% were homeless at treatment admission. In addition, 22.0% of the comparison and DDC women reported being pregnant at treatment admission.

No cohort differences were found in regard to primary drug problem. Almost 51% of the comparison and DDC parents reported methamphetamine as their primary drug problem. Marijuana was the second most frequent primary drug (18.0%), followed by alcohol (16.3%), cocaine/crack (9.5%), and heroin (2.5%).

Women differed from men on all of the baseline characteristics

The male participants were significantly more likely to be employed and to have obtained at least a high school education than the women. The female participants were more likely to have a disability impairment, have higher rates of chronic mental illness, and to be homeless at treatment admission than the male participants.

Male participants were more likely to report alcohol as their primary drug type; whereas the women had significantly higher rates of methamphetamine and cocaine/crack use. This represents the first time that the women had significantly higher rates of methamphetamine use than male participants.

- **Children of participants were predominately school aged**

There were no gender differences between the cohorts of children. There were significantly more American Indian/Alaskan Native children in the comparison group than the DDC group. No other race/ethnicity differences were observed. Children in the comparison group were also significantly older than the DDC children. The comparison children were on average 7.9 years of age versus 6.2 years for the DDC children.

Differences were also observed in terms of the race/ethnicity comparison of the DDC sample to Sacramento County statistics. For example, there are a lower percentage of Asian/Pacific Islanders in DDC with substantiated cases than are in the county population. In contrast, there is a higher percentage of African American children in the DDC program and having substantiated cases than in the county population.

Program Outcomes

Treatment Participation

- **Court-ordered participants had higher rates of treatment participation, including the mean number of treatment admissions**

Court-ordered participants had higher rates of treatment participation, including the mean number of treatment admissions, than the comparison group. Women had higher rates of treatment participation and more treatment admissions than men.

Timing of Treatment

- **Over two-thirds of the participants were admitted to their first treatment episode prior to the project start date**

Data regarding timeliness of participation in DDC program components were analyzed using the case start date of the various program elements. Since many cases were served in voluntary Family Maintenance for extended periods prior to a child's removal from parental care and dependency court intervention, the date at which the family is ordered into Family Reunification services at the dispositional hearing was used to calculate timeliness. For the purposes of this report, we are calling this date the "project start date."

The court-ordered and comparison parents were equally likely to attend their first treatment episode prior to their project start date. Court-ordered parents, however, were more likely to have been in treatment in the three months prior to or after their project start date than comparison parents.

Regardless of cohort, women were significantly more likely to be admitted to their first treatment episode prior to their project start date compared to men. In addition, there were gender differences in how long prior or after the project start date the treatment episode occurred.

Treatment Discharge Status

- **Court-ordered parents had higher rates of satisfactory discharge from treatment**

The court-ordered group had significantly higher rates of satisfactory discharges than the comparison group. No gender differences were observed in terms of treatment discharge status, with both men and women averaging approximately 65% satisfactory discharge rates from treatment.

- **Treatment is often successful regardless of primary drug type; 64.9% of parents had a successful treatment outcome**

Satisfactory treatment completion rates were highest for parents who reported their primary drug as alcohol and lowest for users of heroin. Users of methamphetamine also had higher satisfactory discharge rates than users of cocaine/crack.

There were no gender differences found when examining the interaction of primary drug type and discharge status.

Time in Treatment

- **Almost 44% of the comparison and DDC parents in treatment stayed in treatment for more than six months**

No cohort differences were observed in the number of months in treatment. The comparison group, however, spent more total time in treatment and averaged more days per treatment episode than the court-ordered parents. This is the first year in which the total time in treatment significantly differed between the comparison and DDC cohorts. The shorter time in treatment for the DDC group may be due to the impact of the STARS program in preparing parents for treatment and 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 also reduced.

Women were more likely to spend more than a total of six months in treatment and had significantly more total days in treatment. Men, however, averaged more days per treatment episode than the women.

Treatment Modality

- **Almost 58% of all the treatment episodes for the comparison and DDC parents involved outpatient treatment**

Although the majority of parents participated in outpatient treatment, significantly more court-ordered parents had participated in residential treatment. It should be noted that the majority of parents in residential treatment typically transfer to outpatient facilities for subsequent treatment. Among those in outpatient treatment, comparison parents averaged longer stays in treatment than court-ordered parents.

There was no difference in the numbers of participants receiving outpatient or residential services based on gender. There were, however, racial/ethnic differences among those attending outpatient treatment.

Compliance

The average number of urine toxicology tests requested was highest for the Year Two cohort and has decreased over the subsequent years. It should be noted that the Year Four and Year Five parents are still currently engaged in the STARS program and data is still being collected for these cohorts. It is also important to point out a change in the frequency of requested drug tests. In January 2006, the Dependency Drug Court Work Group recommended a “slight reduction in the frequency of drug testing.” The frequency of testing was changed to be based on the client’s progress and track level. Track levels indicate time elapsed in the STARS program.

The percent of parents in the DDC who had a positive urine toxicology test was extremely low. Parents in the Year One and Year Three cohorts had significantly fewer positive urine toxicology tests than parents in the Year Four and Year Five cohorts. It is important to note that as the frequency of urine testing has decreased, the number of positive urines has increased.

The average number of face to face and phone contacts has decreased steadily since Year Three. In addition, the first three DDC cohorts had the highest rate of missed contact and the first two DDC cohorts had the highest rate of missing group sessions.

Graduation from the Dependency Drug Court

Out of the 1,738 parents that have taken part in the DDC, 28.8% graduated from the DDC after 180 days of continuous compliance, 28.0% received certificates for 90 days of continuous compliance, 43.2% did not meet either landmark. The graduation rates have increased by cohort, rising from 22.8% in Year 1 to 33.2% in Year 3. The graduation rates for the Year 4 and Year 5 cohorts are 30.5% and 28.5%, respectively. It should be noted that some of the parents in the Year 4 and Year 5 cohorts are still participating in the DDC and it is expected that the graduation rates for these cohort will continue to rise.

Child Protective Services Outcomes

Permanency of Child Placement

- **More court-ordered children reunified with their families**

At 12 months, significantly more court-ordered (35.5%) children had reunified with their families than comparison (18.5%) children. The 12 month reunification rates have steadily risen with each DDC cohort. The reunification rates for each of DDC cohorts are: 33.3% in Year One, 28.9% in Year Two, 36.9% in Year Three, and 39.7% in Year Four cohort.

At 18 months, significantly fewer comparison (24.9%) children had reunified with their families than court-ordered (44.7%) children. As with the 12 month reunification rates, the reunification rates for the DDC cohort continue to increase over time. The 18 month reunification rate for the Year One cohort was 42.8%, 43.8% for Year Two, and 47.0% for the Year Three cohort.

At 24 months, fewer comparison (27.2%) children had reunified with their families than court-ordered (43.6%) children. The 24 month reunification rates for the DDC cohorts continue to increase over time. The 24 month reunification rate for the Year One cohort was 41.9%, 42.2% for Year Two, and 46.4% for Year Three.

Comparison group children were more likely to be in adoption, guardianship or long-term placement and less likely to be in continued reunification services at 12, 18, and 24 months than the court-ordered children.

Time to Reunification

- **There was no difference in time to reunification**

There was no difference between the groups in terms of time to reunification among those who reunified within 12, 18, or 24 months. In September 2002, state law was clarified that individuals would still 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. This change may account for the lack of differences in time to reunification between the cohorts.

At 12 months, the times to reunification were lowest for the Year One cohort (M=166.59 days) and then rose for the Year Two (M=210.94 days) and Year Three (M=208.50) cohorts. The time to reunification fell for the Year Four cohort to 19.2 days.

The trend was similar at 18 and 24 months with the Year One cohort having the shortest time to reunification and the time to reunification rising for the Year Two cohort and falling for the Year Three cohort.

Impact of Parental Graduation from the DDC on Child Reunification Rates

- **Children whose parents graduated from the DDC were significantly more likely to reunify at 12, 18 and 24 months**

Parents who graduated from the DDC after 180 continuous compliance were significantly more likely to have reunified with their children at 12 months than parents who only completed 90 days continuous compliance or those parents who did not reach either landmark. For example, 58.9% of the children whose parents graduated from the DDC were reunified by 12 months. In contrast, 42.0% of the children whose parents received a 90 day certificate for continuous compliance had reunified by 12 months and only 15.6% of the children whose parents did not meet either landmark were reunified by 12 months.

Impact of Parent's Primary Drug on Child Placement

- **Child placement outcomes were affected by the primary drug of the parent**

Parents who reported heroin as their primary drug problem were significantly less likely to reunify with their children at 12 months compared to all other parents. In addition, parents with alcohol as their primary drug problem were less likely to reunify with their children at 12 months than parents with methamphetamine or marijuana as their primary drug problem.

Parents with heroin as their primary drug problem continued to have the lowest rates of reunification with their children at 18 months and parents with methamphetamine or marijuana as their primary drug problem had significantly higher reunification rates than parents with alcohol or cocaine/crack as their primary drug problem.

At 24 months, parents with heroin and cocaine/crack as their primary drug problem continued to have the lowest rates of reunification with their children at 24 months and methamphetamine users had the highest rates of reunification. There were also differences in terms rates of being in adoption, long-placement, and continued reunification services based on the parent's primary drug problem.

- **Child placement outcomes were affected by the race/ethnicity of the child**

African American children were significantly less likely to have reunified with their families at 12 months than Hispanic or Caucasian children.

African American children continued to be less likely to have reunified with their families at 18 and 24 months than Hispanic and Caucasian children. In addition, the African American and Caucasian children were more likely to be in continued reunification services at 18 and 24 months.

Recidivism and Re-Entry

- **There were extremely low recidivism rates among comparison and DDC participants.**

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. None of the comparison cases and only 2.4% of the court-ordered cases who reunified by 24 months experienced recidivism.

Re-entry 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 their case was closed. DDC children (21.1%) had higher re-entry rates than comparison children (10.6%). These differences were not statistically significant, however. The re-entry rates have dropped over time. For example, the Year One cohort experienced a 26.0% rate of re-entry. This has dropped to 18.2% for the Year Three cohort.

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

Cost Analyses

- **The DDC program produced substantial cost savings due to increased reunification rates**

During the past four years, it is estimated that the DDC has saved \$10,851,934 due to the higher 12 month reunification rate of court-ordered children relative to the comparison group.

Policy Recommendations

- **There is a continued need for additional ancillary services to address the multiple needs of this population.**

The participants deal with multiple issues such as unemployment, low educational attainment, homelessness, chronic mental illness. For example, 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.

- **Strategies for dealing with the increasing caseloads must be addressed**

It is important to monitor treatment participation rates of the latest DDC cohorts given the substantially higher numbers of parents being court-ordered to participate in the DDC. The higher numbers of parents entering the program may put a strain on available treatment and STARS resources.

Although there has been a substantial increase in the number of parents court-ordered to the DDC, it is still important to examine ways to increase the rate of participation of eligible parents into the DDC. Given the dramatic increase in parents and children who entered the DDC during the past two years, it will be important for the Court, AOD treatment system, and CWS system to come up with ways to be able to effectively treat these families and manage their cases. The availability of adequate resources to meet the increasing caseload should be addressed.

- **It is important to monitor the increasing rates of positive urine tests**

Although the rate of positive urine results is low, it has been increasing. The increase coincides with the decreased demands of requested urine tests. This rate of positive urine tests should be monitored to see if they continue to rise. If so, it will be important to re-evaluate the frequency of drug testing among the DDC participants.

- **Strategies for increasing the graduation rates from the DDC should be explored**

It is important to explore ways to increase the graduation rates of DDC participants as it has been shown to affect whether or not they reunify with their children.

- **There is a need to monitor the re-entry rates among DDC children who have reunified with their families**

The increase in the number of re-entry cases among the DDC children is of concern. It will be important to monitor the reunification cases to determine if and why children re-enter care.

Introduction

This is the fourth annual report on the Sacramento County Dependency Drug Court. The first report, issued in April 2002, specified the DDC model and described programmatic components (for a complete description of the DDC model and programmatic components, please refer to the April 2002 report). The focus of this report includes: (1) a brief description of the program model to clarify data collection points; (2) a description of the evaluation plan and information systems being used to document program process and outcomes measures; (3) a description of the program participants; (4) findings regarding treatment engagement, retention and completion; and (5) 12, 18, and 24 month findings regarding child safety and permanency.

Program Description and Data Collection Systems

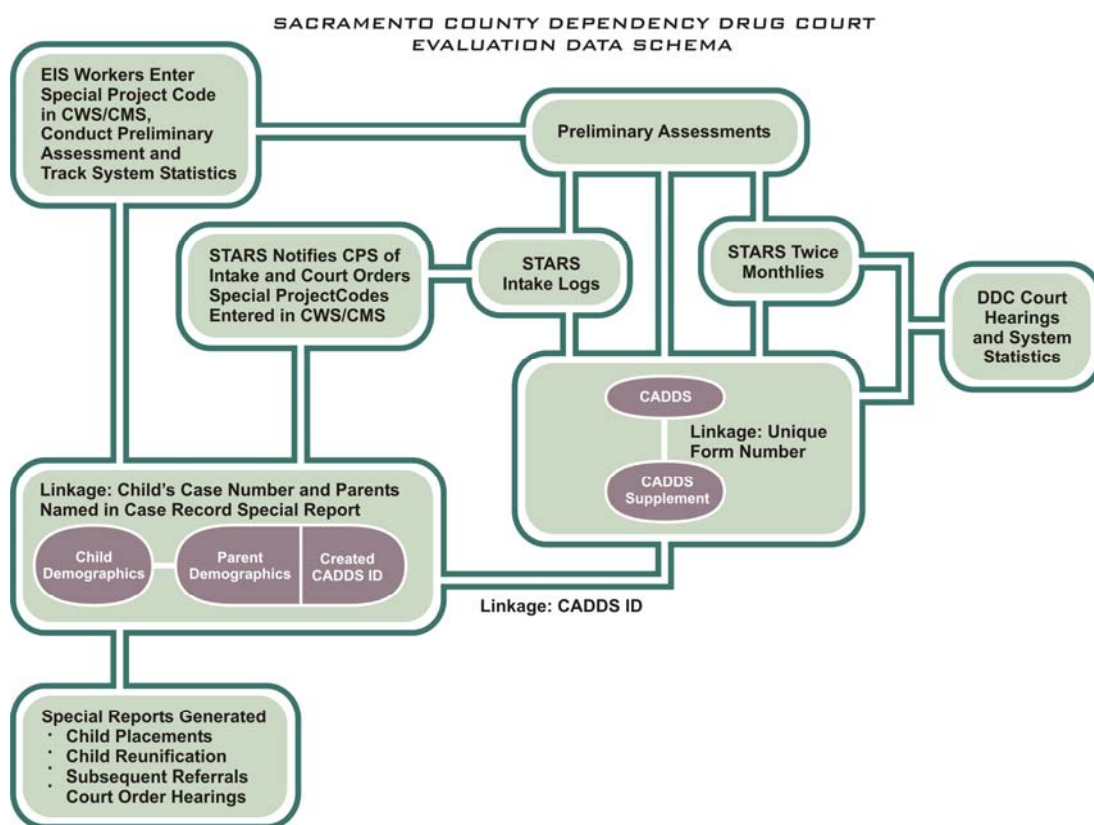
The Sacramento County Dependency Drug Court is system-wide in its approach. Unlike many jurisdictions in which the DDC operates in one court docket, all Sacramento County families with substance abuse issues are included in the program and interventions. In brief, the parent is offered the opportunity to participate in the DDC, which oversees compliance with court orders regarding the parents' alcohol and drug treatment participation and recovery. Compliance with treatment and recovery is rewarded and graduated sanctions are applied for non-compliance. The DDC manages only the compliance with the alcohol and drug services component of the case, and the home court hears and adjudicates all matters regarding the child's dependency and custody status.

In Sacramento County, offering parents alcohol and drug treatment services begins with the identification of parents who meet criteria for participation at the detention hearing. An Early Intervention Specialist (EIS) employed by the Child Protective Services (CPS) Division initially administers a preliminary assessment to those parents present at the Detention hearing with AOD-related problems. Prior to conducting preliminary assessments, EIS workers review every detention hearing report to determine if there are allegations regarding parents' substance use affecting the safety and/or permanency of the child. Compliance reports are sent to CPS, legal counsel and the Dependency Court two times each month and are referred to as "Twice Monthlies." Parents are court-ordered into STARS and volunteer for either home court drug court or DDC at the Jurisdiction hearing. Those cases with AOD allegations are coded in the CPS Division's data system (Child Welfare Services/Case Management System [CWS/CMS]) for future data abstraction.

Based on the results of the preliminary assessment, the EIS worker makes referrals to appropriate level of substance abuse care and to the Specialized Treatment and Recovery Service (STARS) program (see Figure 1). The primary duty of the STARS worker is to maintain a supportive relationship with the parent(s), with an emphasis upon engagement and retention in treatment while providing recovery monitoring for the CPS Division. STARS workers monitor drug testing, treatment and self-help group compliance and provide regular reports to the court, DDC Coordinator, social worker, parent(s), and minor(s)' counsel. Drug testing is administered on a random basis and is always an observed collection.

Information regarding treatment were collected through the state’s California Alcohol and Drug Data System (CADDs). CADDs was developed by the California Department of Alcohol and Drug Programs (ADP) and implemented in July 1991. ADP, in conjunction with the counties and direct contract providers, has used CADDs for the last fifteen years to collect and report basic information on the clients receiving treatment services through public funding. ADP, working with its stakeholders in the field, developed the California Outcome Measurement System (CalOMS) that replaced CADDs and also expanded the data being collected to include client outcome measures. The CalOMS system includes the same data elements as CADDs plus approximately 35 new data items designed to better identify clients and measure client outcomes in seven life domains. CalOMS became effective in California on January 1, 2006.

Figure 1: Data Schema



A primary tenet specified by the County was to conduct the evaluation 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 multiple CPS and ADS Divisions’ 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. The various data sets of both pre-existing reports and data sets utilized for the evaluation included:

Child Protective Services Division	Alcohol and Drug Services Division
<ul style="list-style-type: none"> • Child Demographics • Parent Demographics • Child Placements • Child Reunifications • Subsequent Referrals • Court Orders 	<ul style="list-style-type: none"> • Preliminary Assessments • STARS Intake Log • STARS Twice Monthly Data • California Alcohol & Drug Data System (CADDSS)/CalOMS • CADDSS Supplemental Data • DDC Court Hearings

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. Data from monthly reports of system statistics were collected via EIS workers' reports of their activities. EIS workers read each detention hearing report and make a determination on those cases that include allegations via CPS workers identification of substance abuse among parents. The court sends the court order to STARS and ADS informing them that the parent is to be included in the DDC. Upon receiving the court order, ADS enters the parent's information into their database and that information is carried over to CPS where all corresponding children attached to the petition are identified and tagged in the CWS/CMS system.

The common linkage between the overall CPS Division data system and the ADS Division data system is the ADS Division client identifier, the CADDSS/CalOMS identifier, which is comprised of client's last and first initial, gender (1=male, 2=female), and date of birth (e.g., Mary Smith, born on January 1, 1955=SM2010155). This identifier was not originally in the CWS/CMS database or in the court hearings file. The evaluator created a CADDSS/CalOMS identifier, based on information from CPS Division files so that the CADDSS/CalOMS identifier was present in CWS/CMS, DDC court hearings and linked to the ADS Division databases.

The primary components of the program for data collection and analysis are:

- Identification of parents with AOD problems at the detention hearing
- Completion of a preliminary assessment by an Early Intervention Specialist (EIS)
- Intake at the Specialized Treatment and Recovery Specialist (STARS) program
- Participation in alcohol and drug treatment/recovery services
- Compliance with court orders
- CPS Division data systems detailing child placements and outcomes
- Dependency Court system statistics

Evaluation Objectives

The objectives of the dependency drug court (DDC) evaluation study are to determine the impact to parental involvement and engagement in treatment and child placement outcomes associated with outcomes of participation in DDC, relative to an equivalent group of parents in the child welfare system. Specifically, the evaluation examines whether participation in DDC:

- Increasing clients' alcohol and other drug (AOD) treatment compliance rates
- Increasing the number of parents with AOD involvement who are screened, assessed, and timely placed in the most appropriate treatment modality
- Increasing successful family reunification rates
- Decreasing the average length of stay of children in out-of-home care
- Decreasing related out-of-home costs
- Increasing collaboration between the Court, Child Protective Services (CPS), and AOD treatment agencies

Research Questions:

The following section details the research questions included in the evaluation.

1. What are the Child Protective Services (CPS), Alcohol and Drug Services (ADS), Dependency Court (DC), and Dependency Drug Court (DDC) systems' statistics regarding client flow, caseload demographics, and trends?
2. To what extent do the various systems (ADS, CPS) provide timely access to assessments and treatment referrals?
3. What is the length of time that clients are involved in the various service systems?
4. Are service patterns differentiated by key client variables including race/ethnicity and gender?
5. What are the family demographics among DDC participating families (e.g., age of children and adults, ethnicity, education, employment status, etc.)?
6. What are the contributing factors in the case (e.g., legal status, mental illness, homelessness, etc.)?
7. What are the alcohol and drug use factors of DDC clients at the initial assessment?

Primary Impact Questions Include:

Case Management and Alcohol and Drug Treatment

1. What is the time between the detention hearing and participation in the various aspects of the DDC system (e.g., EIS assessment, STARS, AOD treatment entry) for DDC and comparison clients?
2. How long do DDC and comparison clients remain in AOD treatment?
3. What are the AOD treatment completion and drop out rates for DDC and comparison clients?
4. What are the toxicology screen results for DDC and comparison clients?
5. What are the compliance rates of DDC and comparison clients (e.g., court appearances, required services, toxicology screens)?

Child Protective Services

1. How many placement changes will children of DDC and comparison clients have before a permanent plan has been developed?

2. What is the length of stay in out-of-home care for DDC and comparison children?
3. What is the percentage of family reunifications, adoptions, guardianships, long term foster care placements, and foster care re-entries for DDC and comparison families?
4. Among families that reunify, what is the timing to family reunification for DDC and comparison families?

Dependency Court

1. Is there a difference in the rate of cases that meet the statutory timelines for permanency between DDC and comparison groups?

Primary Cost Questions Include:

1. What is the estimated total investment in treatment, CPS and court expenses as compared to the total monetary value of outcomes for the DDC program and standard interventions?

Characteristics of the Sacramento Child Welfare Population

Table 1 presents the number of families and children who were the subject of child abuse and neglect hotline referrals that were accepted for follow-up investigation and the number of intake petitions filed. These data are broken down by project year.

For both families and children, the number of hotline referrals has remained relatively stable from project Year Two to project Year Four. During project year Five, however, there was an increase in the number of hotline referrals accepted for investigation.

The percent of referrals in which an intake petition was filed steadily increased from project Year Two to project Year Four and declined somewhat during the last project year (see Table 1). For example, during project Year Two, 43.7% of the families referred for investigation had subsequent intake petitions filed. This percentage rose to 65.6% during project Year Four and fell to 63.5% in project Year Five.

Table 1: Sacramento County Child Welfare Statistics								
	Project Year Two Oct 1, 2002 – Sept 30, 2003		Project Year Three Oct 1, 2003 – Sept 30, 2004		Project Year Four Oct 1, 2004 – Sept 30, 2005		Project Year Five Oct 1, 2005 – Sept 30, 2006	
	N	%	N	%	N	%	N	%
Families								
Hotline Referrals Accepted for Investigation	2081	100.0	1973	100.0	2049	100.0	2130	100.0
Intake Petitions Filed	909	43.7	1044	52.9	1344	65.6	1353	63.5
Children								
Hotline Referrals Accepted for Investigation	3620	100.0	3388	100.0	3552	100.0	3728	100.0
Intake Petitions Filed	1589	43.9	1812	54.3	2347	66.1	2386	64.0
DDC Child Participants								
Percent of Hotline Referrals Accepted for Investigation*	429	11.9	485	14.3	741	20.9	731	19.6
Percent of Intake Petitions Filed*	429	27.0	485	26.8	741	31.6	731	30.6

*These numbers represent a subset of all child hotline referrals and intake petitions filed during the equivalent time frame. Information regarding hotline referrals and intake petitions filed in Sacramento is not available for Project Year One and contains information on families (not individual parents).

The DDC children have represented an increasingly larger percent of those hotline referrals and intake petitions. In project Year Two, the DDC children represented 11.9% of the hotline referrals and 27.0% of the intake petitions filed. These percentages rose to 20.9% and 31.6%, respectively, during project Year Four. There was a slight decline in these percentages during project Year Five to 19.6% and 30.6%, respectively.

In summary, while the number of hotline referrals has remained relatively stable over the first few years, a change was seen during the last project year. A slight change was also seen in the percent of the referrals which led to the filing of child welfare services intake petitions and representation of DDC child participants in terms of the percent of hotline referrals and intake petitions filed.

Characteristics of DDC Evaluation Participants

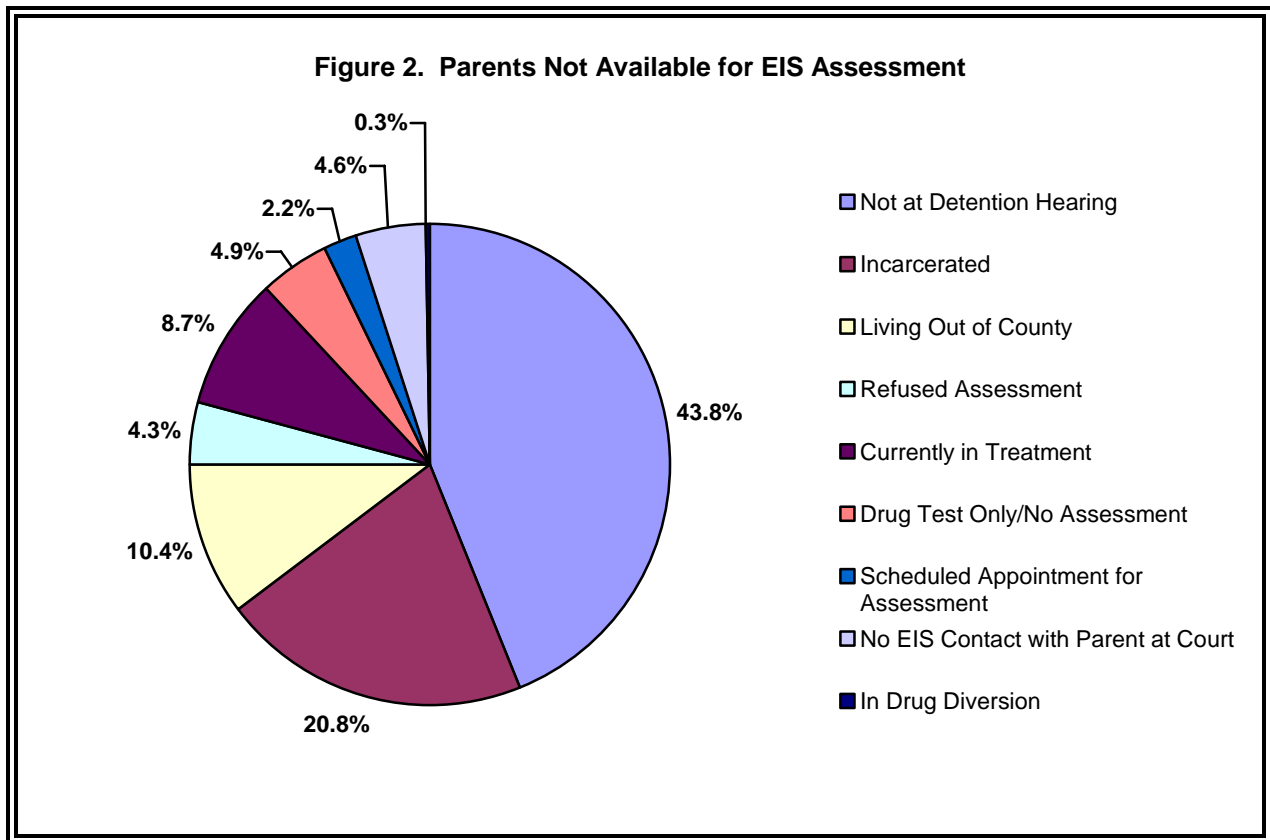
From January 1, 2001 to September 30, 2006, there were 9,168 parents named in CWS/CMS petitions (see Table 2). It is estimated that 63.7% (n=5,840) of parents named in petitions had AOD allegations, however, only 33.4% (n=1,948) were administered a preliminary assessment conducted by Early Intervention Specialists (EIS) at or near the detention hearing. The percentage of parents with AOD in the petition steadily decreased from Year One (70.4%) to Year Four (58.5%) and has risen in Year Five (68.0%) . The percent of parents with AOD in the petition who received a preliminary assessment increased from Year One (31.8%) to Year Four

(37.6%) but fell during Year Five to 30.1%. Thus, almost two-thirds of parents with AOD in the petition never engage in EIS services.

Table 2: Dependency Drug Court Statistics

	Project Year One Oct 1, 2001 – Sept 30, 2002		Project Year Two Oct 1, 2002 – Sept 30, 2003		Project Year Three Oct 1, 2003 – Sept 30, 2004		Project Year Four Oct 1, 2004 – Sept 30, 2005		Project Year Five Oct 1, 2005 – Sept 30, 2006	
	N	%	N	%	N	%	N	%	N	%
Total Parents in Petition	1818	100.0	1662	100.0	1916	100.0	2074	100.0	1698	100.0
Parents Having AOD in Petition	1279	70.4	1063	64.0	1130	59.0	1214	58.5	1154	68.0
Parents Administered a Preliminary Assessment	407	31.8	338	31.8	400	35.4	456	37.6	347	30.1

There were a variety of reasons why the parents may never have completed the EIS assessment. For example, 43.8% did not attend the detention hearing, 20.8% were incarcerated, 10.4% lived out of county, 8.7% were currently in treatment, and the remainder had various other reasons for their non-availability (see Figure 2).



This evaluation report includes six groups of parents and children (see Table 3 and Figure 3). Comparison participants are those who entered the dependency system prior to EIS and STARS

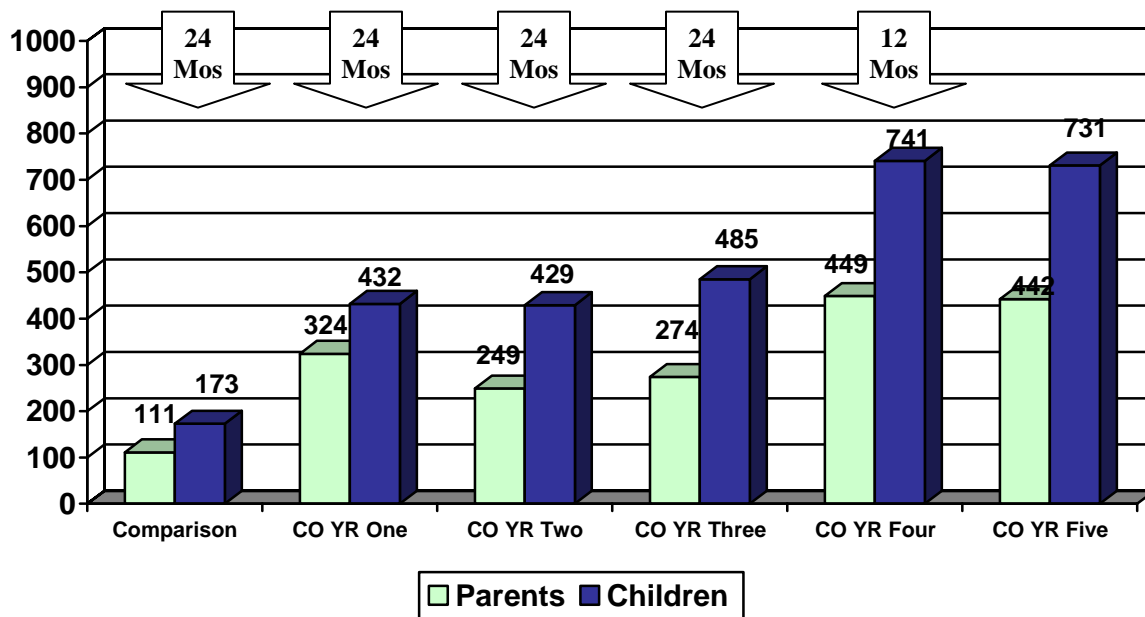
implementation (January through May 2001) and met the criteria for DDC. This group received standard CPS and ADS Divisions services. Thus, a client who is identified as having an AOD problem is directed to the ADS Division for a preliminary assessment and then directed to participate in outpatient or residential treatment without the benefit of a recovery specialist or the specialized court services in the DDC model.

Table 3: Participant Cohort Groups		
	Parents	Children
	N	N
Comparison	111	173
Court-Ordered Year One	324	432
Court-Ordered Year Two	249	429
Court-Ordered Year Three	274	485
Court-Ordered Year Four	449	741
Court-Ordered Year Five	442	731

Court-ordered participants are those who entered the dependency system between October 1, 2001 and September 30, 2006, who may have received EIS services and were court-ordered to receive DDC and STARS supervision. Each court-ordered cohort begins on October 1 and ends on September 30 of the next year.

Figure 3 provides the number of parents and children in each cohort and indicates where the cohort is in the data collection process. For the purposes of this report, the court-ordered cohorts have been combined. As seen in Figure 3, the Year Four participants represent a 38.6% increase in parents and 71.5% in children over the Year One cohort. The increase in participants remained stable over the past year.

Figure 3. Parents and Children in the Evaluation



In summary, the percentage of parents with AOD in the petition decreased from Year One to Year Four and rose in Year Five. While the percent of those parents who subsequently receive a preliminary assessment has increased from project Year One to Year Four, it fell during the past year. Almost two-thirds of parents with AOD in the petition never engage in EIS services. There has been a dramatic increase in the number of court-ordered parents and children over the past two years.

Findings

Parent Demographic and Baseline Characteristics

Table 4 shows the demographic characteristics for parents in the comparison and DDC group. No cohort differences were in terms of gender, age, or race/ethnicity. The comparison and DDC parents were 69.7% women, with a mean age of 32.3 years of age. Race/ethnicity information for the comparison and court ordered cases is limited (n=104 and 1472 respectively). These data are reported from the CADDs/CalOMS treatment admission data and not all parents have been admitted to treatment. Overall, the majority of the comparison and DDC parents were Caucasian (52.0%), 20.2% were Hispanic, and 20.0% were African American. American Indian/Alaskan Native and Asian/Pacific Islander clients each represent 3% of the comparison and DDC parents. In contrast to previous cohort years, Hispanics now make up the second largest racial/ethnic group of DDC clients.

Table 4: Parent Demographic Characteristics					
	Comparison (n=111)		DDC (n=1738)		Significance
	<i>N</i>	%	<i>N</i>	%	<i>p</i>
Gender					
Male	39	35.1	521	30.0	.252
Female	72	64.9	1217	70.0	
Race/Ethnicity					
American Indian/Alaskan	2	1.9	45	3.1	.17
Asian/Pacific Islander	3	2.9	45	3.1	
African American	25	24.0	290	19.7	
Hispanic	19	18.3	300	20.4	
Caucasian	54	51.9	766	52.0	
Other	1	1.0	26	1.8	
Mean Age (range)	33.4 (21-55)		32.2 (18-67)		

In addition to parent demographic information, CADDs/CalOMS is the data set with the most complete data on parent baseline characteristics and contains data from all the publicly funded treatment programs that the parents have attended. It should be noted that CADDs/CalOMS information for the comparison group is limited. These data are shown in Table 5.

There were no cohort differences in any of the baseline characteristics. Results indicate that 84.2% of the parents in the comparison and DDC groups were unemployed. In addition, 46.0% of the comparison and DDC parents had less than a high school education, 30.9% had a disability impairment, 31.3% of the parents reported chronic mental illness, and 41.1% reported being homeless at treatment admission. Overall, 22.0% of the comparison and DDC women reported being pregnant at treatment admission.

No cohort differences were found in regard to primary drug problem. Almost 51% of the comparison and DDC parents reported methamphetamine as their primary drug problem. Marijuana was the second most frequent primary drug (18.0%), followed by alcohol (16.3%), cocaine/crack (9.5%), and heroin (2.5%).

Table 5: Parent Baseline Characteristics					
	Comparison (n=59)		DDC (n=1473)		Significance
	<i>N</i>	%	<i>N</i>	%	<i>p</i>
Employment					
Employed (Full or Part Time)	13	22.0	229	15.5	.180
Unemployed	46	78.0	1244	84.5	
Education					
Less than High School	28	47.5	677	46.0	.821
At least a High School Education	31	52.5	796	54.0	
Pregnant At Admission*	10	21.7	234	22.0	.970
Disability Impairment	19	32.2	450	30.8	.819
Chronic Mental Illness	15	25.4	460	31.5	.33
Homelessness	30	50.8	595	40.7	.121
Primary Drug Problem					
Methamphetamine/amphetamines	26	44.1	752	51.1	.193
Alcohol	11	18.6	238	16.2	
Marijuana	12	20.3	264	17.9	
Heroin	4	6.8	34	2.3	
Cocaine/Crack	6	10.2	139	9.4	
Other	0	0.0	46	3.1	

*Note: Males are excluded from the analyses. Thus, there are 46 women in the comparison group, 1065 women in the DDC group.

In summary, there were no significant differences between the groups in terms of gender, age, race/ethnicity, or other baseline characteristics such as employment, education, being pregnant at treatment admission, disability impairment at admission, rates of chronic mental illness, and homelessness. In contrast to previous cohort years, Hispanics now make up the second largest racial/ethnic group of DDC clients.

Gender Analysis of Baseline Characteristics

In addition to examining cohort differences in terms of the baseline characteristics, we also examined gender differences (see Table 6). Men (25.6%) were significantly more likely to be employed than women (12.2%). In addition, men (60.4%) were significantly more likely to have obtained at least a high school education than the women (51.6%).

In contrast, women (34.1%) were more likely to have a disability impairment than the men (22.0%). Women (38.1%) also had higher rates of chronic mental illness than men (12.7%). In addition, women (44.4%) were more likely to be homeless at treatment admission than men (32.3%).

There were also gender differences in terms of primary drug type. Men (22.2%) were more likely to report alcohol as their primary drug type than women (14.0%). In contrast, the women had significantly higher rates of methamphetamine and cocaine/crack use than men. This is the first time that the women had significantly higher rates of methamphetamine use than male participants.

Table 6: Baseline Characteristics by Gender					
	Male (n=414)		Female (n=1118)		Significance
	<i>N</i>	%	<i>N</i>	%	<i>p</i>
Employment					
Unemployed	308	74.4	982	87.8	<.001
Employed (Full or Part Time)	106	25.6	136	12.2	
Education					
Less than High School	164	39.6	541	48.4	.002
At least a High School Education	250	60.4	577	51.6	
Disability Impairment	90	22.0	379	34.1	<.001
Chronic Mental Illness	52	12.7	423	38.1	<.001
Homelessness	132	32.3	493	44.4	<.001
Primary Drug Problem					
Methamphetamine/amphetamines	192	46.4	586	52.4	<.001
Alcohol	92	22.2	157	14.0	
Marijuana	87	21.0	189	16.9	
Heroin	10	2.4	28	2.5	
Cocaine/Crack	25	6.0	120	10.7	
Other	8	1.9	38	3.4	

In summary, there were significant gender differences in the rates of employment, level of education, disability impairment at admission, rates of chronic mental illness, homelessness, and primary drug type. In addition, this is the first time that women had significantly higher rates of methamphetamine use than the men.

Preliminary Assessments

The preliminary assessments contain information that is useful to describe the DDC program participants. The assessment includes a rating by the worker as to the participant’s level of functioning in several domains. It is important to note that not all parents have received a preliminary assessment. Those with private insurance or who were court-ordered to the DDC but never reported to the STARS program for the preliminary assessment are not captured here. Thus, the total numbers represented below may be smaller than the total cohort sample size.

Table 7 shows the number and percent of clients who were rated as “low” functioning in a variety of domains. There were no differences between the comparison and DDC parents in all but one of the areas. For example, 10.0% of the comparison and DDC parents reported low functioning in terms of health status, 27.3% on emotional stability, 33.0% on family-related problems, 43.3% on social supports, 35.2% on job/education, 31.9% on housing, and 26.0% of the comparison and DDC parents reported low overall biopsychosocial functioning.

There were significant differences in functioning in one area: legal problems. Significantly more court-ordered (61.0%) parents reported “low” functioning regarding legal problems than the comparison (36.8%) parents.

	Comparison (n=68)		DDC (n=1592)		Significance
	<i>N</i>	%	<i>N</i>	%	<i>p</i>
“Low” on:					
Health Status	11	16.2	155	9.7	.08
Emotional Stability	19	27.9	434	27.3	.90
Family Relations	22	32.8	525	33.0	.97
Social Supports	22	32.4	697	43.8	.06
Legal Problems	25	36.8	964	61.0	<.001
Job/Education	17	26.6	551	35.6	.14
Housing	16	23.9	506	32.2	.15
Overall Biopsychosocial Functioning	17	25.4	407	26.0	.91

Overall, cohort differences were observed in the area of legal problems. No cohort differences were observed in any of the other areas: including health status, emotional stability, family relations, social supports, job/education, housing, and overall functioning.

Gender Analysis of Preliminary Assessments

Analysis of the preliminary assessments revealed gender differences in all but three areas. There were no gender differences in terms of functioning in the areas of social supports, job/education, and housing (see Table 8).

Women (11.0%) reported lower functioning regarding their health status than the men (7.6%). Consistent with the higher rates of chronic mental illness, women (31.0%) were also significantly more likely to report lower functioning in the area of emotional stability than men (18.5%). Women (35.6%) were also more likely to report lower functioning in the area of family relations than men (27.0%). In addition, women (28.3%) reported lower overall biopsychosocial functioning than the men (20.5%). Men (63.7%), however, reported lower functioning regarding legal problems than women (58.4%).

	Male (n=489)		Female (n=1173)		Significance
	<i>N</i>	%	<i>N</i>	%	<i>p</i>
“Low” on:					
Health Status	37	7.6	129	11.0	.04
Emotional Stability	90	18.5	363	31.0	<.001
Family Relation	132	27.0	415	35.6	<.001
Social Supports	211	43.2	508	43.3	.98
Legal Problems	310	63.7	679	58.4	.05
Job/Education	151	32.0	417	36.6	.08
Housing	144	30.1	378	32.7	.30
Overall Biopsychosocial Functioning	99	20.5	325	28.3	<.001

In summary, although the women had lower rates of education, disability impairment, and homelessness at baseline, they did not report any lower functioning in the related areas of job/education or housing on the preliminary assessments. Women were consistent with their baseline characteristics in terms of their reported lower functioning in the areas of health status, emotional stability and overall functioning than the men. Gender differences were also observed in the area of family relations. Men were more likely to report lower functioning regarding legal problems, which is consistent with their higher rates of baseline legal problems.

Child Characteristics

Characteristics of children of parents in the comparison group and DDC program are shown in Table 9. No differences were found between the groups in terms of gender, with 51.4% of the comparison and DDC children being girls and 48.6% being boys. There was one significant race/ethnicity difference between the cohorts. There were significantly more American Indian/Alaskan Native children in the comparison group (4.6%) than the DDC group (1.6%). No other race/ethnicity differences were observed. Children in the comparison group (Mean=7.9 years), however, were significantly older than the DDC children (Mean=6.2 years).

	Comparison (n=173)		DDC (n=2818)		Significance <i>p</i>
	<i>N</i>	%	<i>N</i>	%	
Gender					
Male	78	45.1	1375	48.8	.344
Female	95	54.9	1443	51.2	
Race/Ethnicity					
American Indian/Alaskan	8	4.6	45	1.6	.018
Asian/Pacific Islander	3	1.7	93	3.3	
African American	56	32.4	779	27.6	
Hispanic	31	17.9	579	20.5	
Caucasian	75	43.4	1322	46.9	
Mean Age (range)	7.9 (1-19)		6.2 (0-18)		<.001

We also explored similarities between children of parents involved in the DDC program and county population statistics. There are small differences in the percentage of court-ordered children involved in the DDC program compared to those represented in the population of children with substantiated abuse/neglect cases. However, there are larger differences between race/ethnic breakdown of court-ordered children and substantiated cases compared to the overall county child population. As shown in Table 10, a lower percentage of Asian/Pacific Islanders are in DDC or have substantiated cases than are in the county population. In contrast, there is a higher percentage of African American children in the DDC program and having substantiated cases than are in the county population.

	DDC	CPS Substantiated¹	All County²
Race/Ethnicity	%	%	%
American Indian/Alaskan	1.6	.80	2.0
Asian/Pacific Islander	3.3	4.9	14.3
African American	27.6	27.2	14.3
Hispanic	20.5	23.8	27.1
Caucasian	46.9	38.0	36.5
Other	0.0	5.3	5.7

Overall, there were no gender differences between the cohorts of children. There were, however, cohort differences in terms of race/ethnicity and age of the children. Differences were also observed in terms of the race/ethnicity comparison of the DDC sample to Sacramento County statistics.

Program Outcomes

Program outcomes were assessed in two primary areas: AOD treatment outcomes and child protective services outcomes. Process measures and outcomes of AOD treatment included differences between groups on participating in treatment, the timeliness of treatment services, length of stay in treatment, and satisfactory completion of treatment. Child protective services outcomes included collecting data on placement types (i.e., reunification, adoption, guardianship, etc) at 12, 18, and 24 months and measuring recidivism and re-entry into care following reunification.

Alcohol and Other Drug Treatment Outcomes

Treatment Participation

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 CADDs/CalOMS data system. Analyses indicate that there was a significant difference between groups of parents who have ever been in treatment (see Table 11). Significantly fewer comparison parents (53.2%) had ever been in AOD treatment than court-ordered participants (84.8%). In addition, there were significantly more treatment admissions for the court-ordered (N=4258, Mean=2.9) parents than the comparison (N=158, Mean=1.4) parents. It is important to note that a parent can have multiple treatment admissions. 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.

¹UC Berkeley CWS/CMS Data System 2005 Extract.

<http://cssr.berkeley.edu/CWSCMSreports/referrals/ratesFrameset.asp?whichForm=byAgeEth&data=data&rdate=2005&county=34>

² UC Berkeley CWS/CMS Data System 2005 Extract.

<http://cssr.berkeley.edu/CWSCMSreports/referrals/ratesFrameset.asp?whichForm=byAgeEth&data=data&rdate=2005&county=34>

	Comparison (n=111)		DDC (n=1738)		Significance
	<i>N</i>	%	<i>N</i>	%	<i>p</i>
Ever in Treatment	59	53.2	1473	84.8	<.001

In summary, court-ordered participants had higher rates of treatment participation, including the mean number of treatment admissions, than the comparison group.

Gender Analysis of Treatment Participation

Female (86.7%) participants were significantly more likely to have ever been admitted to AOD treatment than their male (73.9%) counterparts (see Table 12). Similarly, female (N=3565 admissions, Mean=2.8) participants had significantly more treatment admissions than the male (N=851 admissions, Mean=1.5) participants.

	Male (n=560)		Female (n=1289)		Significance
	<i>N</i>	%	<i>N</i>	%	<i>p</i>
Ever in Treatment	414	73.9	1118	86.7	<.001

Overall, gender differences were found in terms of treatment participation rates and mean number of admissions to treatment.

Timing of Treatment

Data regarding timeliness of participation in DDC program components were analyzed using the case start date of the various program elements. Since many cases were served in voluntary Family Maintenance for extended periods prior to a child’s removal from parental care and dependency court intervention, the date at which the family is ordered into Family Reunification services at the dispositional hearing was used to calculate timeliness. For the purposes of this report, we are calling this date the “project start date.”

There was no cohort difference in terms of when the comparison and DDC parents entered their first treatment episode. Almost 69% of the comparison and DDC parents were admitted to their first treatment episode prior to the project start date (see Table 13). The timing of this first episode may range from a day prior the project start date to several years before the project start date. As noted above, the court-ordered and comparison parents were equally likely to attend their first treatment episode prior to their project start date.

Table 13: Timing of Treatment Episodes					
	Comparison		DDC		Significance
	<i>N</i>	%	<i>N</i>	%	<i>p</i>
First Treatment Episode					
Prior to Project Start Date	41	69.5	1009	68.5	.83
After Project Start Date	18	30.5	455	30.9	
Same Day as the Project Start Date	0	0.0	9	0.6	
Timing of Episodes Prior to Project Start Date					
0 to 3 Months	20	26.3	960	44.9	.001
4 to 6 Months	19	25.0	280	13.1	
More than 6 Months	37	48.7	897	42.0	
After Project Start Date					
0 to 3 Months	15	18.3	999	47.1	<.001
4 to 6 Months	15	18.3	443	20.9	
More than 6 Months	52	63.4	678	32.0	

Note: All treatment episodes are represented here, except for when discussing the first treatment episode

To further explore the issue of parents in treatment who have subsequent CPS cases referred to the DDC, the number and percent of parents admitted to treatment before the project start date are also presented in Table 13. These are presented for both pre- and post-project start date and admissions registered date in CADDs/CalOMS. There were significant differences between groups in both the pre- and post-project start date. Court-ordered parents were significantly more likely to have been in treatment in the three months prior to and after their project start date than the comparison parents.

These differences may possibly be due to a voluntary STARS program that was initiated in June 2001 allowing the parents to access services prior to their court order. These differences may also be due to the change in state law that allowed for parents with failed prior treatment not to be ordered reunification services. The court-ordered participants were also more likely to enter treatment within the first three months following the project start than comparison parents. Because of the advent of the STARS program and the DDC, parents are entering treatment much more quickly than previously.

In summary, no differences were observed in the timing of the first treatment episode. Differences were observed, however, in terms of how long before or after the project start date a treatment episode occurred.

Gender Analysis of Timing of Treatment

Regardless of cohort, women (73.0%) were significantly more likely to be admitted to their first treatment episode prior to their project start date compared to the men (56.5%) (see Table 14). Gender differences were also observed in terms of how long before or after the treatment episode occurred relative to the project start date. Men were more likely to attend treatment within the three months prior to and after their project start date; where as the women were more likely to attend treatment at least six months prior to or after their project start date.

	Male		Female		Significance
	<i>N</i>	%	<i>N</i>	%	<i>p</i>
First Treatment Episode					
Prior to Project Start Date	234	56.5	816	73.0	.001
After Project Start Date	179	43.2	294	26.3	
Same Day as the Project Start Date	1	.2	8	.7	
Timing of Episodes Prior to Project Start Date					
0 to 3 Months	187	49.6	793	43.2	.043
4 to 6 Months	52	13.8	247	13.5	
More than 6 Months	138	36.6	796	43.4	
After Project Start Date					
0 to 3 Months	257	54.2	757	43.8	<.001
4 to 6 Months	96	20.3	362	20.9	
More than 6 Months	121	25.5	609	35.2	

Note: All treatment episodes are represented here, except for when discussing the first treatment episode

In summary, women were significantly more likely to be admitted to their first treatment episode prior to their project start date compared to men. In addition, there were gender differences in how long prior or after the project start date the treatment episode occurred.

Treatment Discharge Status

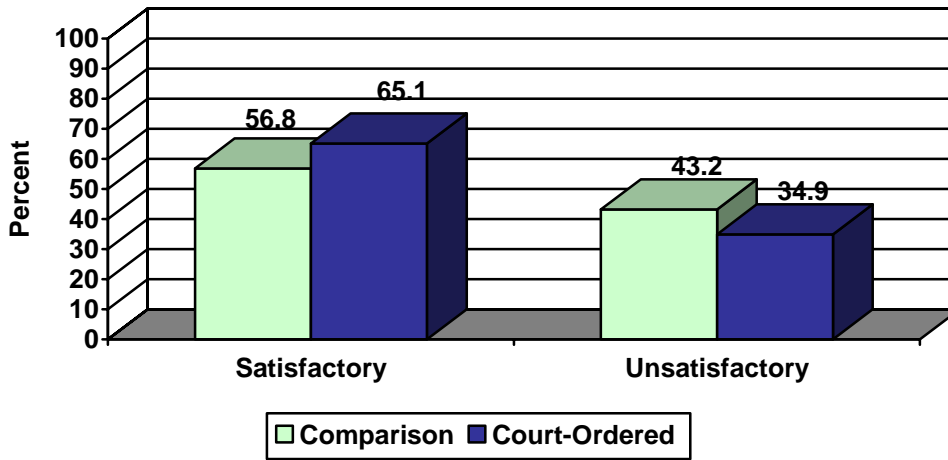
Table 15 and Figure 4 shows the status of parents at discharge from the treatment episode. CADDIS Discharge Status is coded as: completed treatment, left treatment before completion with satisfactory progress, left treatment before completion with unsatisfactory progress, and referred or transferred to another program. CalOMS has slightly changed their discharge status categories. Completed treatment and left treatment before completion now each have two categories, one for if the client was referred or transferred and one for those who were not referred or transferred. Satisfactory discharge status was identified as those who completed treatment (whether or not they were referred or transferred) or who left before treatment completion with satisfactory progress (whether or not they were referred or transferred). Those who left before treatment completion and had unsatisfactory progress were coded as unsatisfactory.

The court-ordered (65.1%) group had higher satisfactory discharges than the comparison group (56.8%). No gender differences were observed in terms of treatment discharge status, with both men and women averaging approximately 65% satisfactory discharge from treatment.

	Comparison (n=146)		DDC (n=3725)		Significance
	<i>N</i>	%	<i>N</i>	%	<i>p</i>
Satisfactory Status	83	56.8	2424	65.1	.041
Unsatisfactory Status	63	43.2	1301	34.9	

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

Figure 4. Treatment Discharge Status



In summary, the comparison group had lower rates of satisfactory discharge from treatment. No gender differences were found, however, when examining discharge status.

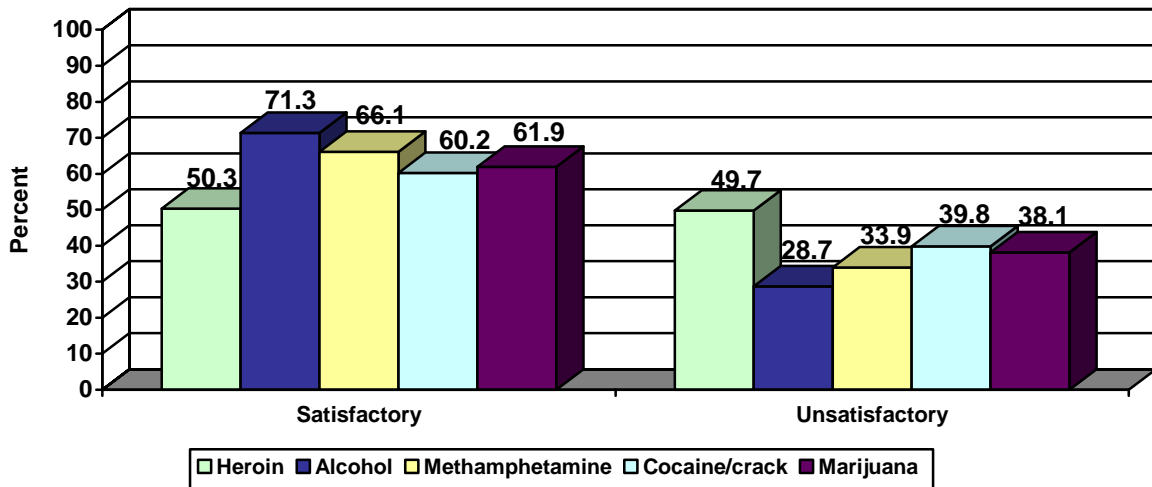
Impact of Primary Drug on Discharge Status

We also examined the relationship of the primary drug problem of the parents to treatment status and child placement outcomes (see Table 16 and Figure 5). We found that treatment is often successful, regardless of the primary drug problem, with parents averaging a 64.9% successful discharge rate. Parents with heroin as their primary drug problem were significantly less likely to have a satisfactory discharge status than users of all other substances. In contrast, those who reported alcohol as their primary drug problem had significantly more satisfactory discharges than users of all other drugs. Additional, methamphetamine users were more likely to have a satisfactory discharge than cocaine/crack users.

Primary Drug Type	Satisfactory		Unsatisfactory		Significance
	N	%	N	%	
Heroin	91	50.3	90	49.7	<.001
Alcohol	444	71.3	179	28.7	
Methamphetamine	1347	66.1	692	33.9	
Cocaine/Crack	280	60.2	185	39.8	
Marijuana	288	61.9	177	38.1	

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

Figure 5. Treatment Discharge Status by Parent Primary Drug Problem



Gender Analysis of the Impact of Primary Drug on Discharge Status

There were no gender differences found when examining primary drug type and discharge status (see Table 17). Within each drug, the discharge status was the same for men and women.

Primary Drug Type	Satisfactory		Unsatisfactory		Significance <i>p</i>
	<i>N</i>	%	<i>N</i>	%	
Heroin					.280
Male	16	57.1	12	42.9	
Female	75	49.0	78	51.0	
Alcohol					.266
Male	132	73.3	48	26.7	
Female	312	70.4	131	29.6	
Methamphetamine					.521
Male	230	66.1	118	33.9	
Female	1117	66.1	579	33.9	
Cocaine/Crack					.166
Male	23	52.3	21	47.7	
Female	257	61.0	164	39.0	
Marijuana					.233
Male	70	65.4	37	34.6	
Female	218	60.9	140	39.1	

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

In summary, satisfactory treatment completion rates were highest for parents who reported their primary drug problem as alcohol and lowest for users of heroin. Users of methamphetamine also had higher satisfactory discharge rates than users of cocaine/crack. There were no gender differences found when examining primary drug problem and discharge status.

Time in Treatment

Table 18 shows the number of parents and their average length of time in treatment per treatment episode. No cohort differences were observed in the number of months in treatment, with 43.9% of the comparison and DDC parents staying in treatment for more than six months. The comparison group (Mean=293.2 days) had more total time in treatment than the court-ordered participants (208.6 days). The comparison group (Mean=114.5 days) also averaged significantly more days per treatment episode than did the court-ordered parents (Mean=85.0 days). The shorter time in treatment may be due to the impact of the STARS program in preparing parents for treatment and 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 also reduced.

	Comparison (n=59)		DDC (n=1333)		Significance <i>p</i>
	<i>N</i>	%	<i>N</i>	%	
0 to 3 Months	17	28.8	347	26.0	.565
4 to 6 Months	14	23.7	403	30.2	
More than 6 Months	28	47.5	583	43.7	
Total Time in Treatment (Days)	293.2		208.6		.02
Average Days Per Treatment Episode (Days)	114.5		85.0		.01

Note: All treatment episodes in which there is an admission and discharge date are represented here. Not all episodes have discharge dates.

In summary, no differences were observed in the number of months in treatment. The comparison group, however, spent more total time in treatment and averaged more days per treatment episode than the court-ordered parents. This is the first year in which the total time in treatment significantly differed between the comparison and DDC cohorts.

Gender Analysis of Time in Treatment

Gender differences were observed in terms of total time in treatment and average days per treatment episode (see Table 19). Women (46.3%) were significantly more likely to total more than six months in treatment than the men (36.9%). Relatedly, the women (Mean= 226.3 days) had significantly more total days in treatment than the men (Mean=170.5 days). Interestingly, the men (Mean=99.2 days) averaged more days per treatment episode than the women (Mean=81.9 days).

	Male (n=352)		Female (n=1040)		Significance <i>p</i>
	<i>N</i>	%	<i>N</i>	%	
0 to 3 Months	113	32.1	251	24.1	.003
4 to 6 Months	109	31.0	308	29.6	
More than 6 Months	130	36.9	481	46.3	
Total Time in Treatment (Days)	170.5		226.3		.003
Average Days Per Treatment Episode (Days)	99.2		81.9		<.001

In summary, there were gender differences both in terms of total time in treatment and average days per treatment episode.

Treatment Modality

We also explored data in regard to the type of treatment the parents participated in (see Table 20). We classified programs by outpatient or residential care (as they represented almost all of the treatment modalities). The majority of treatment episodes for the comparison and DDC parents involved outpatient treatment. Significantly more court-ordered (42.9%) parents participated in residential treatment than comparison (27.8%) parents. It is important to note that the majority of parents who participate in residential treatment subsequently move to outpatient treatment to continue their care.

	Comparison (n=158)		DDC (n=4177)		Significance
	<i>N</i>	%	<i>N</i>	%	<i>p</i>
Outpatient	114	72.2	2383	57.1	<.001
Residential	44	27.8	1794	42.9	

Note: All treatment episodes are represented here.

As expected, there were statistically significant differences between those served in outpatient versus residential in terms of the average days spent in the different treatment modalities (see Table 21). These difference are expected due to the difference in program models. The comparison parents in outpatient treatment (Mean=143.6 days) had significantly longer stays in treatment than the court-ordered (Mean=90.2 days) group. No differences were found between the cohorts in terms of time in residential treatment.

	Comparison		DDC		Significance
	<i>N</i>	<i>Mean</i>	<i>N</i>	<i>Mean</i>	<i>p</i>
Outpatient	106	143.6	2142	90.2	<.001
Residential	42	49.4	1514	55.7	.564

Note: All treatment episodes in which there is an admission and discharge date are represented here. Not all episodes have discharge dates.

In summary, the majority of parents who entered treatment participated in outpatient treatment. More court-ordered parents participated in residential treatment than comparison parents. In addition, parents in outpatient treatment averaged longer stays in treatment than those in residential care. There were also cohort differences in terms of length of stay among parents in outpatient treatment.

Gender and Race/Ethnicity Analyses of Treatment Modality

We also conducted gender and race/ethnicity analyses of the treatment modalities. There was no difference in the numbers of participants receiving outpatient or residential services based on gender. These data are shown in Table 22.

	Comparison		DDC		Significance
	<i>N</i>	%	<i>N</i>	%	<i>p</i>
Outpatient					
Male	24	21.1	475	19.9	.423
Female	90	78.9	1908	80.1	
Residential					
Male	6	13.6	326	18.2	.293
Female	38	86.4	1468	81.8	

Note: All treatment episodes are represented here.

We did find differences in type of treatment program based on race/ethnicity, however. More Asian/Pacific Islander parents who were in outpatient treatment were from the comparison (8.8%) group than the court-ordered group (2.0%). No differences were found in terms of race/ethnicity among those attending residential treatment, however. These data are shown in Table 23.

	Comparison		DDC		Significance
	<i>N</i>	%	<i>N</i>	%	<i>p</i>
Outpatient					
American Indian/Alaskan	3	2.6	72	3.0	<.001
Asian/Pacific Islander	10	8.8	48	2.0	
African American	24	21.1	482	20.2	
Hispanic	23	20.2	498	20.9	
Caucasian	54	47.4	1254	52.6	
Other	0	0.0	28	1.2	
Residential					
American Indian/Alaskan	1	2.3	53	3.0	.167
Asian/Pacific Islander	2	4.5	43	2.4	
African American	14	31.8	309	17.2	
Hispanic	5	11.4	230	12.8	
Caucasian	22	50.0	1144	63.8	
Other	0	0.0	15	0.8	

Note: All treatment episodes are represented here.

In summary, there were no gender differences in terms of treatment modality. There were, however, racial/ethnic differences among those attending outpatient treatment.

Compliance

Data regarding parents' compliance with five areas of program requirements were analyzed. These data are reported twice a month by STARS to CPS, legal counsel, drug court coordinator, and the court. Table 24 shows these data. The twice-monthly reports of compliance begin immediately upon acceptance to the STARS program.

The average number of urine toxicology tests requested was highest for the Year Two cohort and has decreased over the subsequent years. It should be noted that the Year Four and Year Five parents are still currently engaged in the STARS program and data is still being collected for these cohorts. It is also important to point out a change in the frequency of requested drug tests.

In January 2006, the Dependency Drug Court Work Group recommended a “slight reduction in the frequency of drug testing.” The frequency of testing was changed to be based on the client’s progress and track level. Track levels indicate time elapsed in the STARS program.

The percent of parents in the DDC who had a positive urine toxicology test was extremely low. There were, however, cohort differences in the rate of positive urine tests. Parents in the Year One (3.4%) and Year Three (3.5%) cohorts had significantly fewer positive urine toxicology tests than parents in the Year Four (4.8%) and Year Five (6.5%) cohorts. There were also differences in the rate of negative tests. The Year One (74.4%) and Year Two (74.8%) parents had significantly more negative tests than the Year Three (70.9%) and Year Four (72.1%) parents. It is important to note that as the frequency of urine testing has decreased, the number of positive urines has increased.

The average number of required treatment sessions has increased over time. Year One (86.6%) attended the highest percentage of sessions compared to the other cohorts. In contrast, Year Three (18.2%) parents missed more treatment sessions than either the Year Two (16.4%), Year Four (16.6%), or Year Five (16.3%) parents. Although the Year One and Year Two parents had fewer absences overall, they had more unexcused absences than the Year Three, Year Four, or Year Five parents.

Interestingly, the average number of contacts, including face to face and phone contacts has decreased steadily since Year Three. In addition, the first three DDC cohorts had the highest rate of missed contacts. Lastly, the first two DDC cohorts had the highest rate of missing group sessions than the later cohorts.

	DDC Year One (n=293)	DDC Year Two (n=226)	DDC Year Three (n=266)	DDC Year Four (n=422)	DDC Year Five (n=432)
Table 24: Twice Monthly Reports of Compliance Total Number of Events					
Urine Toxicology***					
Average number of tests requested	65.9	81.4	78.9	70.5	45.7
Percent with positive tests	3.4	3.8	3.5	4.8	6.5
Percent negative tests	74.4	74.8	70.9	72.1	73.7
Percent pending tests	11.4	9.7	15.9	14.0	10.1
Percent failure to test	10.7	11.7	9.8	9.1	9.6
Treatment Sessions***					
Average number of required sessions	31.2	37.1	45.0	45.5	45.0
Percent of sessions attended	86.6	83.6	81.8	83.4	83.7
Percent of sessions missed	13.4	16.4	18.2	16.6	16.3
Absences***					
Average number of absences	4.1	5.8	7.6	7.2	7.0
Percent of absences which were excused	52.3	53.8	71.8	69.2	69.1
Percent of absences which were unexcused	47.7	46.2	28.2	30.8	30.9
Contacts***					
Average number of required contacts	48.9	59.5	51.2	49.5	44.0
Percent of contacts that were missed	11.3	12.6	11.9	10.5	9.0
Average number of face to face contacts***	44.7	51.9	45.0	44.2	39.8
Average number of phone contacts***	17.9	12.9	11.6	5.1	.90
Group Sessions***					
Average number of required sessions	70.7	76.1	75.9	80.0	68.7
Percent of group sessions attended	91.0	92.0	95.0	95.1	94.8
Percent of group sessions missed	9.0	8.0	5.0	4.9	5.2

*p<.01, ***p<.001

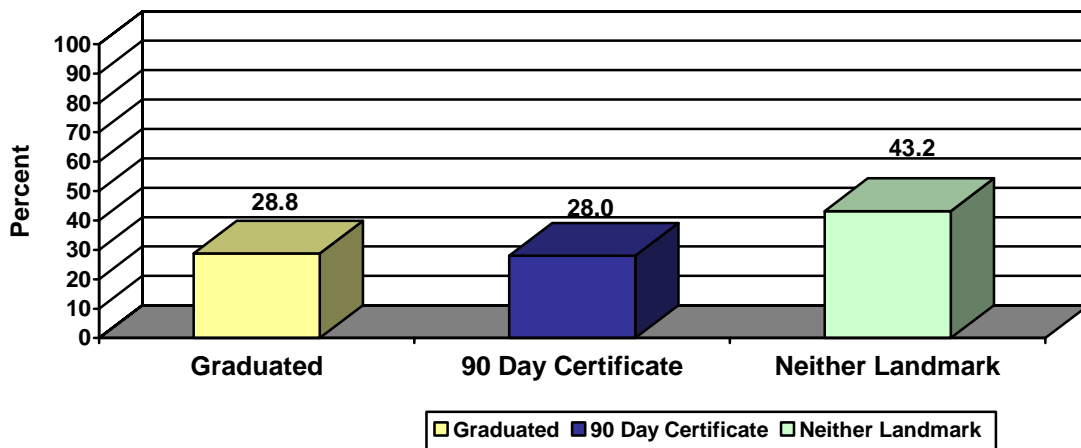
Graduation from the Dependency Drug Court

To graduate from the Sacramento Dependency Drug Court, a parent must complete the following for 180 consecutive days:

- Drug test negative 2-3 times weekly (random tests are employed);
- Attend all treatment groups or individual sessions required;
- Attend all scheduled meetings with their STARS Recovery Specialists;
- Attend three or more support group or 12-step meetings weekly;
- Attend all required DCC appearances; and,
- Complete all requirements of the Court.

Out of the 1,738 parents that have taken part in the DDC, 28.8% graduated from the DDC after 180 days of continuous compliance, 28.0% received certificates for 90 days of continuous compliance, 43.2% did not meet either landmark (see Figure 6). The graduation rates have increased by cohort, rising from 22.8% in Year 1 to 33.2% in Year 3. The graduation rates for the Year 4 and Year 5 cohorts are 30.5% and 28.5%, respectively. It should be noted that some of the parents in the Year 4 and Year 5 cohorts are still participating in the DDC and it is expected that the graduation rates for these cohort will continue to rise.

Figure 6. Parental Graduation Status



Child Protective Services Outcomes

One of the limitations of a comparison group evaluation design in which the comparison cases are selected from pre-intervention caseloads is that the longer a CPS case is opened, the more likely the final disposition and permanent outcome for the child has been achieved. In the short-run, this issue affects the interpretation of child welfare-related outcomes. Over time, as cases mature and resolution of the dependency case is finalized, differences in project start date decreases. We truncated the analyses for all groups at 12, 18, and 24 months post project start date to achieve comparability in the length of the CPS case across groups. Placement outcomes were measured by collecting data on the last placement type of comparison at 12, 18, and 24 months post project start. Children who reunified with a parent were located through a special report generated by the CPS Division. Data on alternate permanency placements were abstracted on a case-by-case basis from CWS/CMS.

12 Month Child Placement Outcomes

To date, 12 month data is available only for the comparison group and the first four DDC cohorts (see Table 25 and Figure 7). These data are presented below. Data collection and analysis for the Year Five cohort is ongoing. At 12 months, significantly fewer comparison (18.5%) children had reunified with their families than court-ordered (35.5%) children. The 12 month reunification rates have steadily risen with each DDC cohort. The reunification rates for each of DDC cohorts

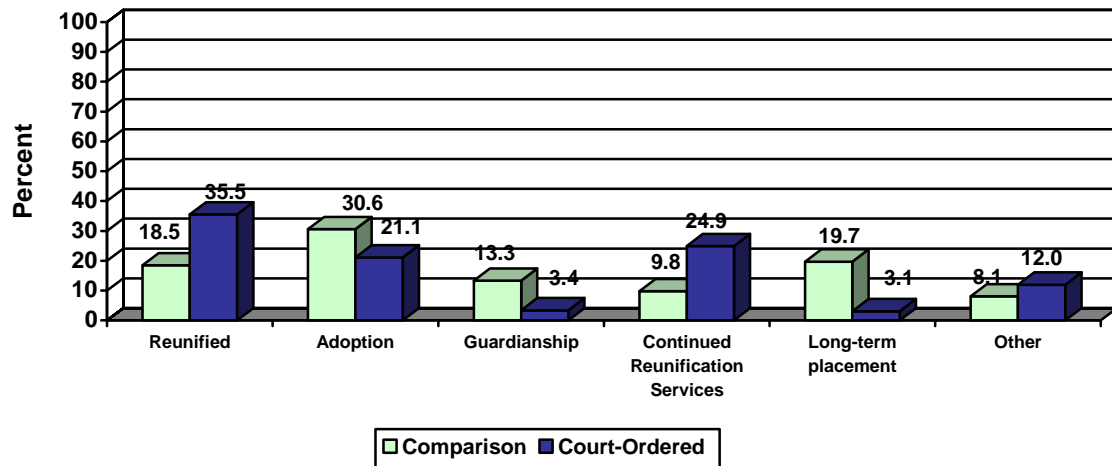
are: 33.3% in Year One, 28.9% in Year Two, 36.9% in Year Three, and 39.7% in Year Four cohort.

Table 25: 12 Month Child Placement Outcomes					
Total	Comparison		DDC		Significance
	173		2087		
	N	%	N	%	<i>p</i>
Reunified	32	18.5	741	35.5	<i>p</i> <.001
Adoption	53	30.6	441	21.1	<i>p</i> <.01
Guardianship	23	13.3	70	3.4	<i>p</i> <.001
Long term placement	34	19.7	64	3.1	<i>p</i> <.001
Continued reunification services	17	9.8	519	24.9	<i>p</i> <.001
Other	14	8.1	252	12.0	n.s.

Note: "Other" includes emancipation, death of a child, case transferred out of county, unable to view case due to limited access.

In terms of placements, comparison group children were more likely to be in adoption, guardianship, or long-term placement at 12 months than the court-ordered children. In contrast, the court-ordered children were significantly more likely to be in continued reunification services than the comparison children.

Figure 7. 12 Month Child Placement Outcomes



Among those who reunified within 12 months, the comparison group took longer to reunify with their families than the DDC children. This difference is not statistically significant, however. Among those who reunified, the average time to reunification was 210.8 days (or 7.0 months) for the comparison group and the for 194.3 days (or 6.5 months). These data are shown in Table 26. The times to reunification were lowest for the Year One cohort (M=166.6 days) and then rose for the Year Two (M=210.9 days) and Year Three (M=208.5) cohorts. The time to reunification fell for the Year Four cohort to 192.2 days.

	Comparison	DDC	Significance
Number of children who reunified	32	737	
Time to reunification (among those reunifying in 12 months)	210.8 Days	194.3 Days	n.s.

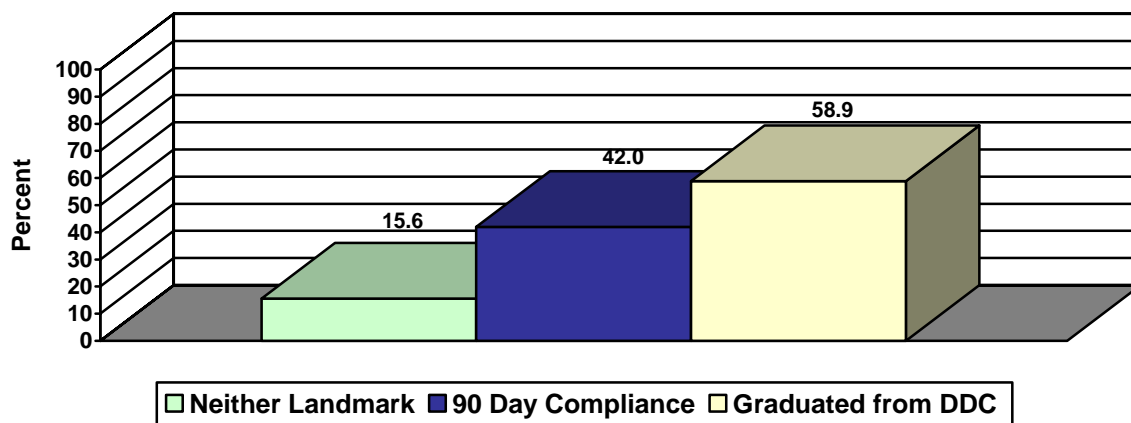
In September 2002, state law was clarified that individuals would still receive reunification services unless they had failed court-ordered treatment in the past. Prior to this change, parents who had failed prior treatment may have been excluded from reunification services unless they were able to show by clear and convincing evidence that it was in the minor’s best interest to receive services. This change may account for the lack of differences in time to reunification between the cohorts.

In summary, significantly fewer comparison children had reunified with their families at 12 months than court-ordered children. In addition, the 12 month reunification rates have steadily risen with each DDC cohort. In terms of placements, comparison group children were more likely to be in guardianship and long-term placement than the court-ordered group. There was no difference in time to reunification at 12 months. No differences were found in time to reunification. The times to reunification were lowest for the Year One cohort and then rose for the Year Two and Year Three cohorts. The time to reunification fell for the Year Four cohort.

Impact of Parental Graduation from the DDC on 12 Month Child Reunification Rates

Parents who graduated from the DDC after 180 continuous compliance were significantly more likely to have reunified with their children at 12 months than parents who only completed 90 days continuous compliance or those parents who did not reach either landmark (see Figure 8). For example, 58.9% of the children whose parents graduated from the DDC were reunified by 12 months. In contrast, 42.0% of the children whose parents received a 90 day certificate for continuous compliance had reunified by 12 months and only 15.6% of the children whose parents did not meet either landmark were reunified by 12 months.

Figure 8. Parental Graduation Status and 12 Month Child Reunification Rates

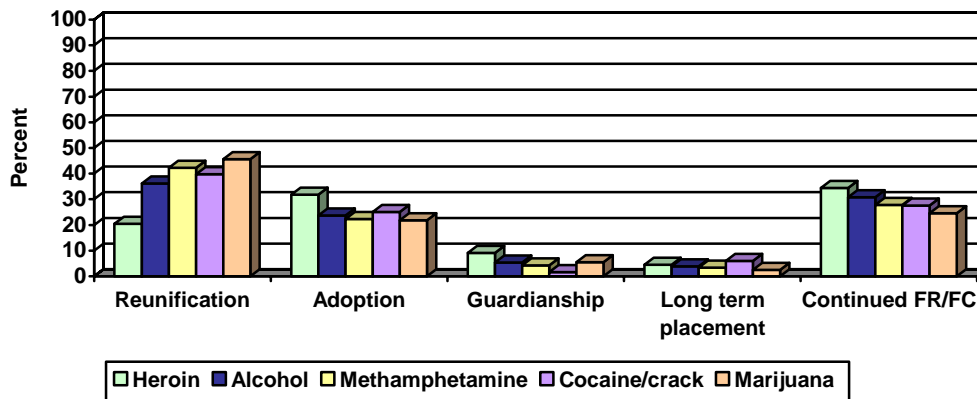


Impact of Primary Drug of Parents on 12 Month Child Placement Outcomes

Parents with heroin (20.5%) as their primary drug problem had the lowest rates of reunification with their children at 12 months compared to all other parents (see Table 27 and Figure 9). In addition, parents with alcohol (36.2%) as their primary drug problem were significantly less likely to reunify with their children at 12 months compared to parents with methamphetamine (42.3%) or marijuana (45.6%) as their primary drug problem.

	Heroin		Alcohol		Methamphetamine		Cocaine/Crack		Marijuana		Significance
Table 27: Primary Drug Type of Parent and 12 Month Child Placement Outcomes											
	N	%	N	%	N	%	N	%	N	%	<i>p</i>
Reunified	9	20.5	121	36.2	466	42.3	100	39.8	165	45.6	p<.01
Adoption	14	31.8	79	23.7	246	22.3	63	25.1	79	21.8	n.s.
Guardianship	4	9.1	18	5.4	46	4.2	4	1.6	20	5.5	n.s.
Long-term placement	2	4.5	13	3.9	37	3.4	15	6.0	9	2.5	n.s.
Continued reunification services	15	34.1	103	30.8	306	27.8	69	27.5	89	24.6	n.s.

Figure 9. 12 Month Child Placement Outcomes by Parent Primary Drug Problem



In summary, parents with heroin and alcohol as their primary drug problem had the lowest rates of reunification with their children at 12 months.

The Relationship of the Child’s Race/Ethnicity to 12 Month Child Placement Outcomes

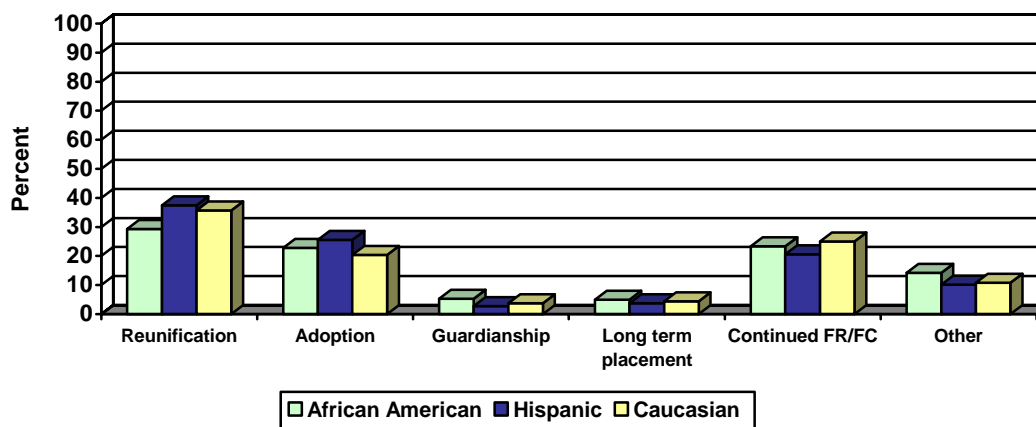
We examined 12 month child placement rates by race/ethnicity of the child (see Table 28 and Figure 10). We limited the analyses to African American, Hispanic, and Caucasian children as they represent 96% of the entire sample.

African American (29.3%) children were significantly less likely than Hispanic (37.4%) or Caucasian (35.7%) children to be reunified at 12 months. No other race/ethnicity differences were observed for any of the other placement statuses at 12 months.

	African American		Hispanic		Caucasian		Significance
	N	%	N	%	N	%	<i>p</i>
Reunified	187	29.3	163	37.4	389	35.7	p<.05
Adoption	146	22.8	111	25.5	222	20.4	n.s.
Guardianship	34	5.3	12	2.8	40	3.7	n.s.
Long-term placement	32	5.0	16	3.7	48	4.4	n.s.
Continued reunification services	149	23.3	90	20.6	273	25.0	n.s.
Other	91	14.2	44	10.1	118	10.8	n.s.

Note: "Other" status includes emancipation, death of a child, case transferred out of county, unable to view case due to limited access.

Figure 10. 12 Month Child Placement Outcomes by Race/Ethnicity of the Child



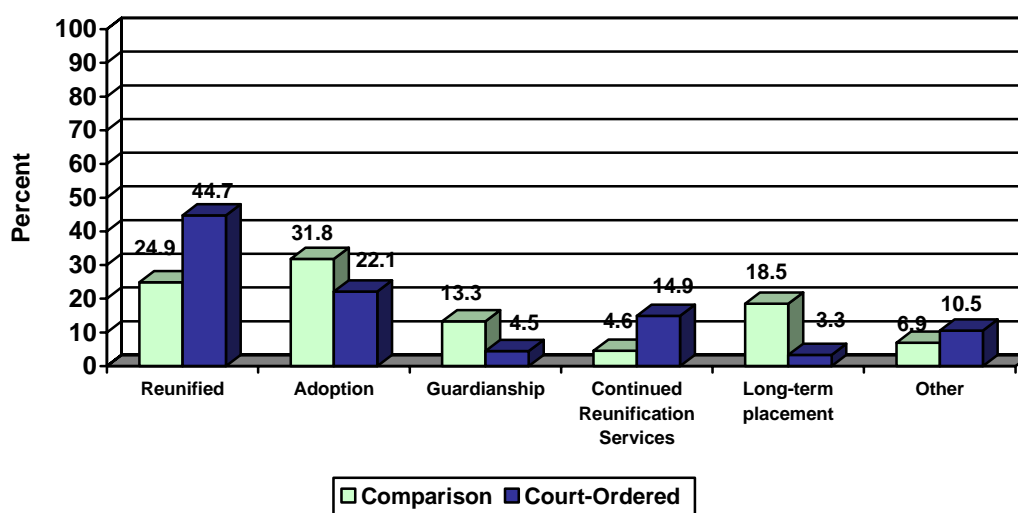
In summary, African American children were significantly less likely to have reunified with their families at 12 months than Hispanic or Caucasian children.

18 Month Child Placement Outcomes

To date, 18 month data is only available for the comparison group and the first three cohorts. At 18 months, significantly fewer comparison (24.9%) children had reunified with their families than court-ordered children (44.7%). As noted with the 12 month reunification rates, the reunification rates for the DDC cohort continue to increase over time. For example, the 18 month reunification rate for the Year One cohort was 42.8%, 43.8% for Year Two, and 47.0% for the Year Three cohort. Comparison group children continued to be more likely to be in adoption, guardianship, or long-term placement at 18 months compared to the court-ordered Year One children. Comparison children were also less likely to be in continued reunification services than the court-ordered Year One children at 18 months (see Table 29 and Figure 11).

	Comparison		DDC		Significance
Total	173		1346		
	N	%	N	%	<i>p</i>
Reunified	43	24.9	601	44.7	<i>p</i> <.001
Adoption	55	31.8	297	22.1	<i>p</i> <.01
Guardianship	23	13.3	60	4.5	<i>p</i> <.001
Long term placement	32	18.5	45	3.3	<i>p</i> <.001
Continued reunification services	8	4.6	201	14.9	<i>p</i> <.001
Other	12	6.9	142	10.5	n.s.

Figure 11. 18 Month Child Placement Outcomes



There was no difference between the groups in terms of time to reunification among those who reunified within 18 months. Among those in both groups who had reunified by 18 months, the average time to reunification was 8.9 months. Again, this result may be due to the effect in law changing who was allowed into the DDC. These data are shown in Table 30. The Year One cohort had the shortest time to reunification (M=234.0 days). The time to reunification rose for the Year Two cohort (M=298.8 days) and fell for the Year Three cohort (M=267.3 days).

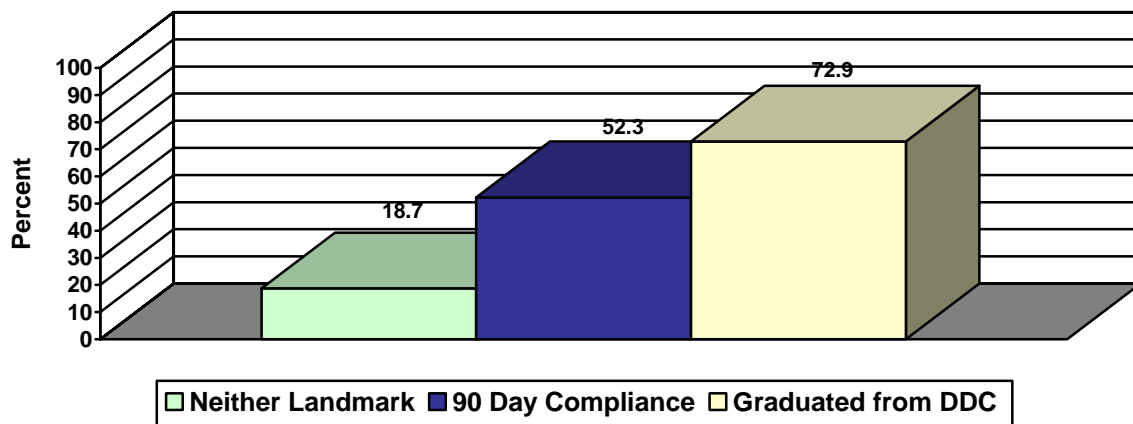
	Comparison	DDC	Significance
Number of children who reunified	43	601	
Time to reunification (among those reunifying in 18 months)	266.1 Days	266.0	n.s.

In summary, comparison children continued to have lower reunification rates than court-ordered children. As noted with the 12 month reunification rates, the reunification rates for the DDC cohort continue to increase over time. Comparison group children continued to be more likely to be in adoption, guardianship, or long-term placement at 18 months compared to the court-ordered children. No differences were found in the time to reunification between the cohorts. The Year One cohort had the shortest time to reunification. The time to reunification rose for the Year Two cohort and fell for the Year Three cohort.

Impact of Parental Graduation from the DDC on 18 Month Child Reunification Rates

Parents who graduated from the DDC after 180 continuous compliance continued to be significantly more likely to have reunified with their children at 18 months than parents who only completed 90 days continuous compliance or those parents who did not reach either landmark (see Figure 12). For example, 72.9% of the children whose parents graduated from the DDC were reunified by 18 months. In contrast, 52.3% of the children whose parents received a 90 day certificate for continuous compliance had reunified by 18 months and only 18.7% of the children whose parents did not meet either landmark were reunified by 18 months.

Figure 12. Parental Graduation Status and 18 Month Child Reunification Rates

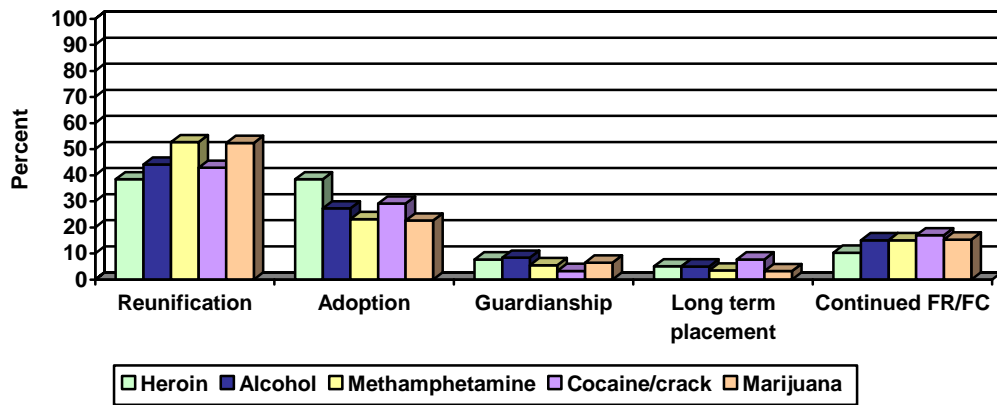


Impact of Primary Drug of Parents on 18 Month Child Placement Outcomes

We also examined 18 month child placement rates by primary drug type of the parent (see Table 31 and Figure 13). Parents with heroin as their primary drug problem continued to have the lowest rates of reunification with their children at 18 months. In addition, parents with methamphetamine or marijuana as their primary drug problem had significantly higher reunification rates than parents with alcohol or cocaine/crack as their primary drug problem.

	Heroin		Alcohol		Methampheta mine		Cocaine/ Crack		Marijuana		Significance
Table 31: Primary Drug Type of Parent and 18 Month Child Placement Outcomes											
	N	%	N	%	N	%	N	%	N	%	<i>p</i>
Reunified	15	38.5	105	44.1	404	52.7	78	42.9	130	52.4	<i>p</i> <.05
Adoption	15	38.5	65	27.3	178	23.2	53	29.1	56	22.6	n.s.
Guardianship	3	7.7	20	8.4	42	5.5	6	3.3	16	6.5	n.s.
Long-term placement	2	5.1	12	5.0	27	3.5	14	7.7	8	3.2	n.s.
Continued reunification services	4	10.3	36	15.1	116	15.1	31	17.0	38	15.3	n.s.

Figure 13. 18 Month Child Placement Outcomes by Parent Primary Drug Problem



In summary, parents with heroin as their primary drug problem continued to have the lowest rates of reunification with their children at 18 months and parents with methamphetamine or marijuana as their primary drug problem had significantly higher reunification rates than parents with alcohol or cocaine/crack as their primary drug problem.

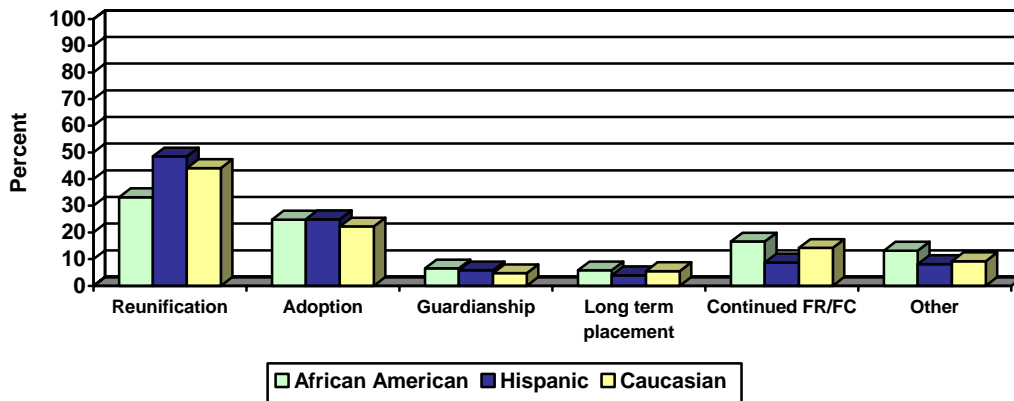
The Relationship of the Child’s Race/Ethnicity to 18 Month Child Placement Outcomes

We also examined 18 month child placement rates by race/ethnicity of the child (see Table 32 and Figure 14). Again, we limited the analyses to African American, Hispanic, and Caucasian children as they represent 96% of the entire sample.

At 18 months, Hispanic (48.5%) and Caucasian (44.1%) children continued to have significantly higher reunification rates than African American (33.2%) children. In contrast, the African American (16.6%) and Caucasian (12.2%) children had higher rates of continued reunification services at 18 months than the Hispanic (8.7%) children. Lastly, African American children were more likely than Hispanic or Caucasian children to have an “Other” status such as emancipation, death of a child, case transferred out of county, unable to view case due to limited access.

	African American		Hispanic		Caucasian		Significance <i>p</i>
	N	%	N	%	N	%	
Reunified	138	33.2	150	48.5	326	44.1	<i>p</i> <.001
Adoption	103	24.8	77	24.9	164	22.2	n.s.
Guardianship	27	6.5	18	5.8	35	4.7	n.s.
Long-term placement	24	5.8	12	3.9	41	5.5	n.s.
Continued reunification services	69	16.6	27	8.7	105	14.2	<i>p</i> <.01
Other Status	55	13.2	25	8.1	68	9.2	<i>p</i> <.05

Figure 14. 18 Month Child Placement Outcomes by Race/Ethnicity of the Child



In summary, African American children continued to be less likely to have reunified with their families at 18 months than Hispanic and Caucasian children. In contrast, the African American and Caucasian children were more likely to be in continued reunification services.

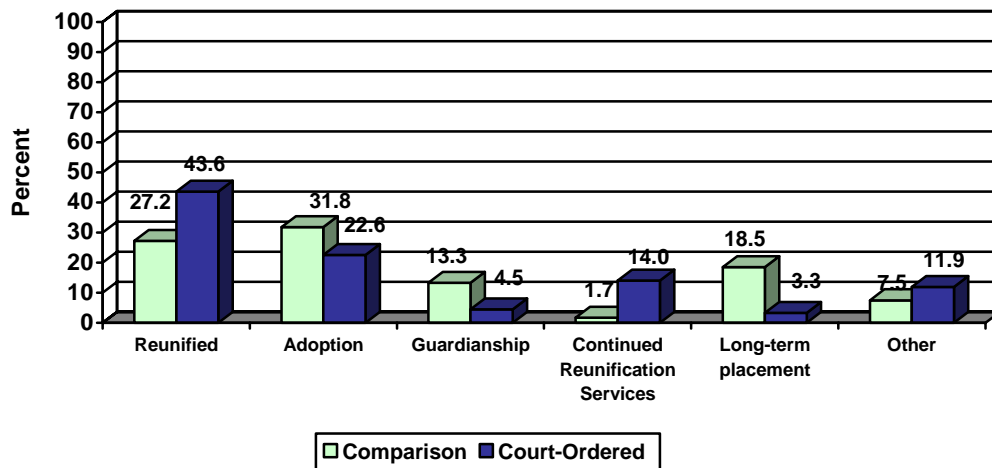
24 Month Child Placement Outcomes

To date, 24 month data is only available for the comparison and first three court-ordered cohorts. At 24 months, fewer comparison (27.2%) children had reunified with their families than court-ordered Year One children (43.6%). The 24 month reunification rates for the DDC cohorts continue to increase over time. The 24 month reunification rate for the Year One cohort was 41.9%, 42.2% for Year Two, and 46.4% for Year Three.

Similar to the previous 12 and 18 month findings, comparison group children continued to be 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 33 and Figure 15).

	Comparison		DDC		Significance
	N	%	N	%	
Total	173		1346		
					<i>p</i>
Reunified	47	27.2	587	43.6	p<.001
Adoption	55	31.8	304	22.6	p<.01
Guardianship	23	13.3	61	4.5	p<.001
Long term placement	32	18.5	45	3.3	p<.001
Continued reunification services	3	1.7	189	14.0	p<.001
Other	13	7.5	160	11.9	n.s.

Figure 15. 24 Month Child Placement Outcomes



Similar to the finding at 18 months, there was no statistical difference in time to reunification among those who had reunified by 24 months. Of the comparison children who reunified by 24 months, their average time to reunification was 300.7 days (10.0 months) and the for the court ordered children who reunified by 24 months, their average to time to reunification was 280.8 days (9.4 months). These data are shown in Table 34. Again, the Year One cohort had the shortest time to reunification (M=257.0 days). The time to reunification rose for the Year Two cohort (M=309.6 days) and fell for the Year Three cohort (M=276.8 days).

	Comparison	DDC	Significance
Number of children who reunified	47	587	
Time to reunification (among those reunifying in 24 months)	300.7 Days	280.8	n.s.

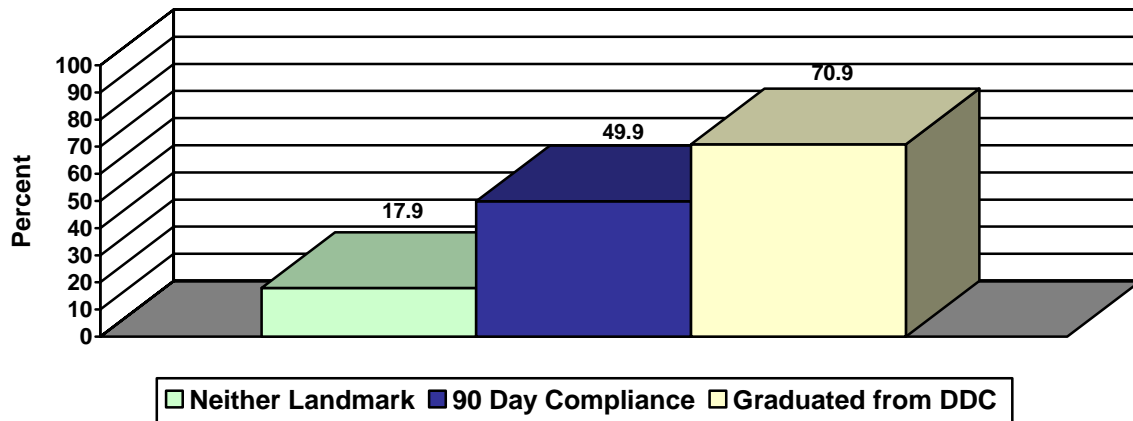
In summary, as was the case with the 18 months outcomes, comparison children continued to have lower reunification rates than court-ordered children at 24 months. The 24 month reunification rates for the DDC cohorts continue to increase over time. Comparison group children continued to be more likely to be in adoption, guardianship, or long-term placement at 24 months compared to the court-ordered. No differences were found in time to reunification. The Year One cohort had the shortest time to reunification. The time to reunification rose for the Year Two cohort and fell for the Year Three cohort.

Impact of Parental Graduation from the DDC on 24 Month Child Reunification Rates

Parents who graduated from the DDC after 180 continuous compliance continued to be significantly more likely to have reunified with their children at 24 months than parents who only completed 90 days continuous compliance or those parents who did not reach either landmark (see Figure 16). For example, 72.9% of the children whose parents graduated from the DDC were reunified by 18 months. In contrast, 52.3% of the children whose parents received a

90 day certificate for continuous compliance had reunified by 24 months and only 18.7% of the children whose parents did not meet either landmark were reunified by 24 months.

Figure 16. Parental Graduation Status and 24 Month Child Reunification Rates

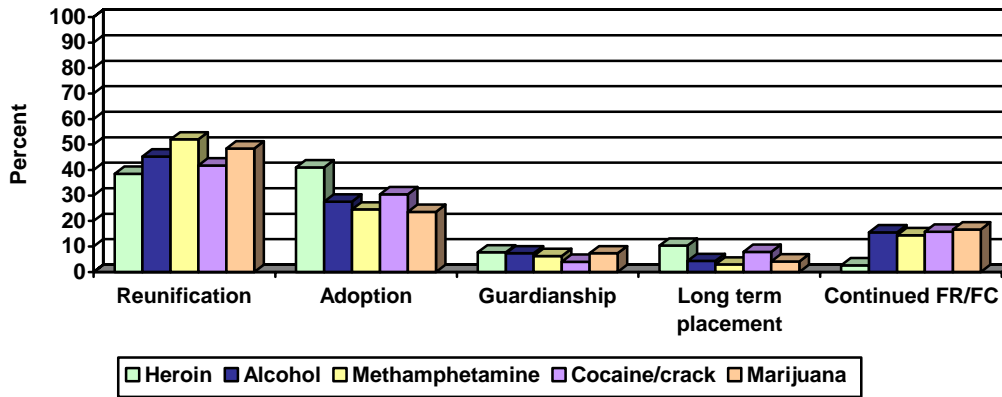


Impact of Primary Drug of Parents on 24 Month Child Placement Outcomes

We also examined 24 month child placement rates by primary drug type of the parent (see Table 35 and Figure 17). Parents with heroin (38.5%) and cocaine/crack (41.8%) as their primary drug problem were significantly less likely to reunify with their children at 24 months than methamphetamine users (52.0%). Children of heroin users (41.0%) were significantly more likely to be in adoption than children of methamphetamine (24.5%) or marijuana (23.6%) users. In addition, children of heroin (10.3%) and cocaine/crack (7.9%) users were more likely to be in long-term placement than children of methamphetamine users (2.9%). In contrast, children of heroin users were significantly less to be in continuing reunification services at 24 months than children of all other types of substances.

	Heroin		Alcohol		Methamphetamine		Cocaine/Crack		Marijuana		Significance
Table 35: Primary Drug Type of Parent and 24 Month Child Placement Outcomes											
	N	%	N	%	N	%	N	%	N	%	<i>p</i>
Reunified	15	38.5	105	45.3	397	52.0	74	41.8	119	48.4	<i>p</i> <.05
Adoption	16	41.0	64	27.6	187	24.5	54	30.5	58	23.6	<i>p</i> <.001
Guardianship	3	7.7	17	7.3	47	6.2	7	4.0	18	7.3	n.s.
Long-term placement	4	10.3	10	4.3	22	2.9	14	7.9	10	4.1	<i>p</i> <.05
Continued reunification services	1	2.6	36	15.5	110	14.4	28	15.8	41	16.7	<i>p</i> <.05

Figure 17. 24 Month Child Placement Outcomes by Parent Primary Drug Problem



In summary, parents with heroin and cocaine/crack as their primary drug problem continued to have the lowest rates of reunification with their children at 24 months and methamphetamine users had the highest rates of reunification. There were also differences in terms rates of being in adoption, long-placement, and continued reunification services based on the parent’s primary drug problem.

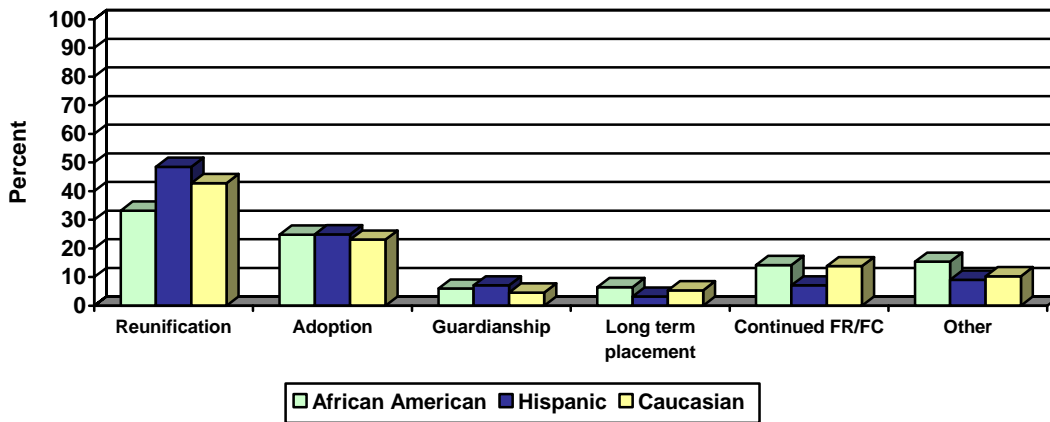
The Relationship of the Child’s Race/Ethnicity to 24 Month Child Placement Outcomes

We also examined 24 month child placement rates by race/ethnicity of the child (see Table 36 and Figure 18). We limited the analyses to African American, Hispanic, and Caucasian children as they represent 96% of the entire sample.

African American children (33.2%) continued to have significantly lower reunification rates than Hispanic (48.5%) and Caucasian (42.8%) children. In contrast, the African American (14.2%) and Caucasian (13.8%) children had higher rates of continued reunification services at 24 months than the Hispanic (7.1%) children.

	African American		Hispanic		Caucasian		Significance
	N	%	N	%	N	%	
Reunified	138	33.2	150	48.5	316	42.8	p<.001
Adoption	103	24.8	77	24.9	171	23.1	n.s.
Guardianship	25	6.0	22	7.1	34	4.6	n.s.
Long-term placement	27	6.5	10	3.2	40	5.4	n.s.
Continued reunification services	59	14.2	22	7.1	102	13.8	p<.01
Other Status	64	15.4	28	9.1	76	10.3	p<.05

Figure 18. 24 Month Child Placement Outcomes by Race/Ethnicity of the Child



In summary, African American children continued to have significantly lower reunification rates than Hispanic and Caucasian (42.8%) children at 24 months. In contrast, the African American and Caucasian children were more likely to be in continued reunification services at 24 months.

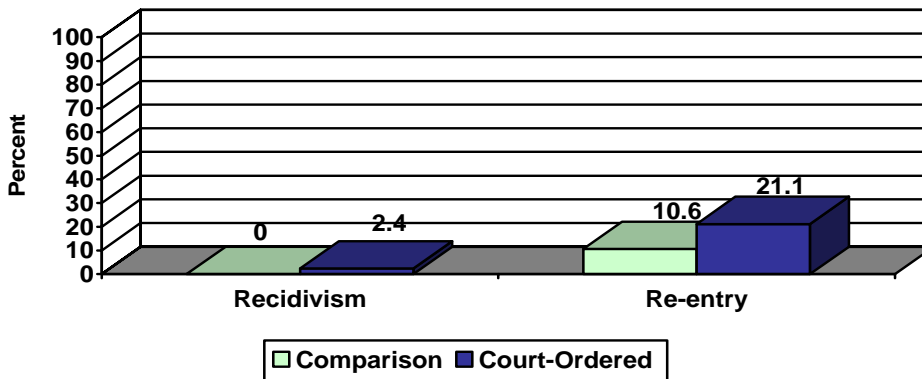
Recidivism and Re-Entry to Out-of-Home Care

In addition to examining placement outcomes, we wanted to examine recidivism and re-entry to out-of-home care.

Recidivism

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 is extremely low (see Figure 19). For example, 0% of the comparison group and only 2.4% (n=14) of the court-ordered children who reunified by 24 months experienced recidivism.

Figure 19. Recidivism and Re-Entry Rates



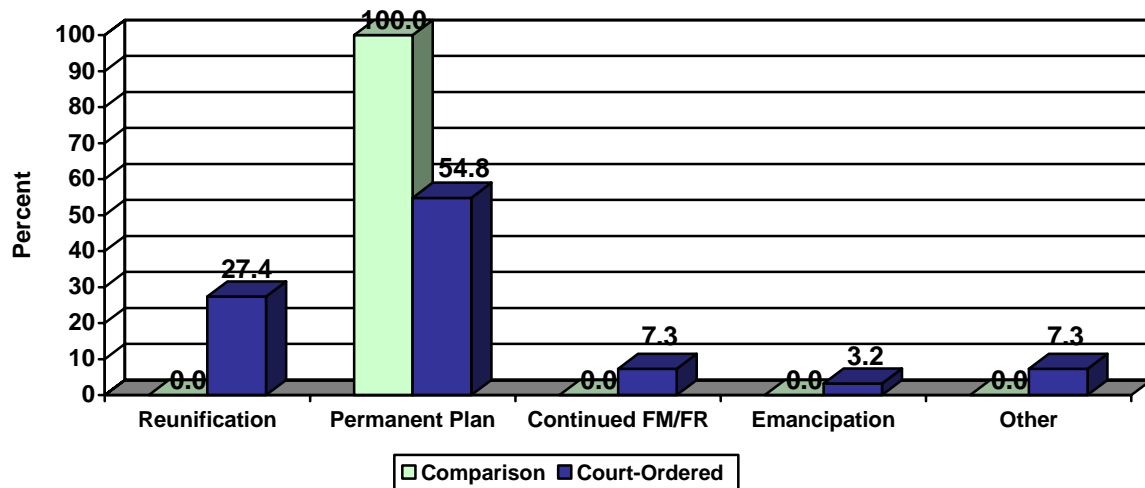
Re-Entry

In order to estimate re-entry rates, we examined whether children had reunified with their families and then came back into out-of-home care before their case was closed (See Figure 19). DDC children had higher re-entry rates (21.1%) than comparison children (10.6%). These differences were not statistically significant, however. The re-entry rates have dropped over time. For example, the Year One cohort experienced a 26.0% rate of re-entry. This has dropped to 18.2% for the Year Three cohort.

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 couple of the cases also had mental health issues in combination with substance use. It is not unusual for relapse to occur among substance abusers. With the instant drug test method and intense oversight of the court, social workers are contacted immediately when a DDC parent tests positive and 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 FM/FR services (see Figure 20). 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 124 court-ordered children (representing 67 families) that re-entered care. The majority of the court-ordered children had a permanent plan of adoptions or guardianship (54.8%) or were subsequently reunified with their parents (27.4%). The remainder were in continued FM/FR (7.3%), were subsequently emancipated (3.2%), or had other statuses such as incarceration (7.3%).

Figure 20. Subsequent Re-Entry Placements



Initial Cost Estimates

12 month estimates

Impacts of Costs Related to Increased Reunification Rates (see Table 37). During the past three years, it is estimated that the DDC has saved \$10,851,934 due to the higher 12 month reunification rate of court-ordered children relative to the comparison group. This is an average savings of over \$2.6 million per year. Cost estimates are available for the comparison group and first four court-ordered cohorts (n=2,087).

The 12 month reunification rate for the comparison group was 18.5%. The 12 month reunification rate for the court-ordered group was 35.5%, which accounted for 741 children. If we assumed a reunification rate of only 18.5% for the court-ordered group, then 355 fewer children would have reunified. By deducting the time to reunification for the court-ordered group (6.48 months) from the average length of out-of-home care for the comparison group (22.8 months), we find a 16.32 month difference. The savings due to the estimated additional 355 children who reunified through the DDC program totals \$10,851,935 (355 children multiplied by 16.32 months multiplied by \$1,873.09 out-of-home care costs).

Table 37: 12 Month Cost Savings Due to Increased Reunification Rates									
Number of children	Reunify rates	Children reunified	Assuming 18.5% reunification rate	Difference in children	Time to reunification	Time of out-of-home care	Time difference	Cost/month	Savings
Comparison Group									
173	18.5%	32				22.8 months			
Court-Ordered Group									
2087	35.5%	741	2087*18.5% =386	741-386 =355	6.48 months		22.8-6.45 =16.32 months	\$1873.09	\$1,873.09* 16.35*350 =\$10,718,758

18 month estimates

Impacts of Costs Related to Increased Reunification Rates at 18 months (see Table 38). At 18 months, the DDC has saved \$11,217,291 due to increased court-ordered reunifications relative to the comparison group. This means that each of the first two court-ordered cohorts saved over \$3.7 million during the first 18 months due to increased reunifications. Cost estimates are only available for the comparison group and first three court-ordered cohorts (n=1,346).

The 18 month reunification rate for the comparison group was 24.9%. The 18 month reunification rate for the court-ordered group was 44.7%, which accounted for 601 children. If we assumed a reunification rate of 24.9% for the court-ordered group, then 266 fewer children would have reunified. By deducting the time to reunification for the court-ordered group (8.87 months) from the average length of out-of-home care for the comparison group (30.9 months), we find a 22.03 month difference. The savings due to the estimated additional 266 children who reunified through the DDC program totals \$11,217,291 (266 children multiplied by 22.03 months multiplied by \$1,914.22 out-of-home care costs).

Table 38: 18 Month Cost Savings Due to Increased Reunification Rates									
Number of children	Reunify rates	Children reunified	Assuming 24.9% reunification rate	Difference in children	Time to reunification	Time of out-of-home care	Time difference	Cost/month	Savings
Comparison Group									
173	24.9%	43				30.9 months			
Court-Ordered Group									
1346	44.7%	601	1346*24.9% =335	601-335=266	8.87 months		30.9-8.87 =22.03 months	\$1914.22	\$1914.22* 22.03*266 =\$11,217,291

24 month estimates

Impacts of Costs Related to Increased Reunification Rates at 24 months (see Table 39). Over the 24 month time period, the increased reunification rate of the DDC children led to a savings of \$9,971,049. It appears that the longer time to reunification for the court-ordered cohort and cases of re-entry at 24 months are impacting the cost savings somewhat. Cost estimates are only available for the comparison group and first three court-ordered cohorts (n=1,346).

The 24 month reunification rate for the comparison group was 27.2%. The 24 month reunification rate for the court-ordered group was 43.6%, which accounted for 587 children. If we assumed a reunification rate of only 27.2% for the court-ordered group, then 221 fewer children would have reunified. By deducting the time to reunification for the court-ordered group (9.36 months) from the average length of out-of-home care for the comparison group (33.1 months), we find a 23.74 month difference. The savings due to the estimated additional 221 children who reunified through the DDC program totals \$9,971,049 (221 children multiplied by 23.74 months multiplied by \$1,900.50 out-of-home care costs).

Table 39: 24 Month Cost Savings Due to Increased Reunification Rates									
Number of children	Reunify rates	Children reunified	Assuming 27.2% reunification rate	Difference in children	Time to reunification	Time of out-of-home care	Time difference	Cost/month	Savings
Comparison Group									
173	27.2%	47				33.1 months			
Court-Ordered Group									
1346	43.6%	587	1346*27.2% =366	587-366=221	9.36 months		33.1-9.36 =23.74 months	\$1900.50	\$1,900.50* 23.74*221 =\$9,971,049

Overall, the increased reunification rates for the court-ordered DDC group led to substantial foster care savings. These costs do not include other administrative costs such as court, social workers, attorneys, and clerical staff time. Nor does it account for potential Dependency Court cost. Even if a child’s case goes on to permanency, the state and county are still accruing costs.

Programmatic Recommendations

Alcohol and Drug Services

Given the significant gender differences found in the baseline characteristics, particularly relating to education, employment, disability impairment, chronic mental illness, and homelessness, there is a continued need for additional ancillary services to address the multiple needs of this population.

It is important to monitor treatment participation rates of the latest DDC cohorts given the substantially higher numbers of parents being court-ordered to participate in the DDC. The higher numbers of parents entering the program may put a strain on available treatment and STARS resources.

Although there has been a substantial increase in the number of parents court-ordered to the DDC, it is still important to examine ways to increase the rate of participation of eligible parents into the DDC. Given the dramatic increase in parents and children who entered the DDC during the past two years, it will be important for the Court, AOD treatment system, and CWS system to come up with ways to be able to effectively treat these families and manage their cases. The availability of adequate resources to meet the increasing caseload should be addressed.

As the frequency of urine testing has decreased, the number of positive urines has increased. This rate of positive urine tests should be monitored to see if they continue to rise. If so, it will be important to re-evaluate the frequency of drug testing among the DDC participants.

Lastly, it is important to explore ways to increase the graduation rates of DDC participants as it has been shown to affect whether or not they reunify with their children.

Child Protective Services

The increase in the number of re-entry cases among the DDC children is of concern. It will be important to monitor the reunification cases to determine if and why children re-enter care.

Evaluation Recommendations

Continue utilizing the 10-digit client identifier, which links the STARS database and CWS/CMS, allowing for a more accurate link between the child and the parent receiving services.

As noted in previous reports, it remains important to link children placed back into out-of-home care following reunification to parent(s) who received STARS services. Currently, it is impossible to determine if the parent whom the child was returned is the same parent who received or is receiving STARS services.