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Exploring the Well-Being of Foster Children of Parents with Substance Abuse Problems in Family Dependency Treatment Courts

Barbara M. Howes
Western Michigan University

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EXPLORING THE WELL-BEING OF FOSTER CHILDREN OF
PARENTS WITH SUBSTANCE ABUSE PROBLEMS IN
FAMILY DEPENDENCY TREATMENT COURTS

by

Barbara M. Howes

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Faculty of The Graduate College
in partial fulfillment of the
requirements for the
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Advisor: Kieran Fogarty, Ph.D.

Western Michigan University
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Barbara M. Howes, Ph.D.

Western Michigan University, 2011

The aim of this three-paper format dissertation is to explore how the well-being of foster children of parents with substance abuse problems is defined and promoted through Family Dependency Treatment Courts (FDTC) within the context of the Adoption and Safe Families Act (ASFA). The benefit to the author of the three-paper method is the task of submitting the findings of the study for publication is eased as the dissertation contains three stand-alone articles. A drawback for the reader of the three-paper method is that there is redundancy in reading the same sections in each paper. The reader is encouraged to keep in mind that some information may be redundant when read as a whole document.

The first paper is a policy analysis of ASFA. It specifically aims to analyze the mandates of ASFA as they pertain to the well-being of foster children of parents with substance abuse problems. One approach to implementing the mandates of ASFA is through Family Dependency Treatment Courts (FDTC). FDTCs serve parents with substance abuse and dependency problems that have contributed to the removal of their children from their care. Papers two and three report the findings of a grounded theory study conducted in FDTCs. Paper two aims to define *well-being*, and postulates a theory

to that effect, titled Emotional Permanence (EP). Paper three postulates a theory of Fostering as a basic social process that FDTC interdisciplinary teams use to promote the well-being of parents with substance abuse and dependency problems and their children. Although each paper is independent, the three are connected by the common theme of the well-being of foster children of parents with substance abuse problems.

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Acknowledgments—Continued

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Barbara M. Howes

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CHAPTER I

THE RELATED PURPOSES OF THREE PAPERS

The aim of this three-paper format dissertation is to explore how the well-being of foster children of parents with substance abuse problems is defined and promoted within the context of the Adoption and Safe Families Act (ASFA) in Family Dependency Treatment Courts (FDTC). Chapter I of this dissertation provides background information for the three papers. Chapters II through IV are three stand-alone, yet related, papers, each containing methods, results, and discussion sections. The final chapter of this dissertation integrates the findings and discussions of the three papers.

Paper one is a policy analysis of ASFA as it pertains to the well-being of foster children of parents with substance abuse problems. The method used in this analysis is Eugene Bardach's (2005) *Practical Guide for Policy Analysis: The Eight Fold Path to More Effective Problem Solving*. Papers two and three report the findings of a Grounded Theory (GT) study conducted in FDTCs in a Midwestern state. FDTCs are an approach to promoting well-being for the purposes of reunifying families under the auspices of ASFA. The lack of a common definition for "well-being" spurred the exploratory and inductive study for paper two, which aims to generate a comprehensive theory of well-being that can be applied in the field to assist in measuring well-being.

The second theory to emerge from the data in this study is *fostering* as the basic social process the FDTC interdisciplinary teams use to promote child and family well-

being. Fostering is the topic of paper three in this dissertation. The following section provides background information for the three papers within the context of ASFA. The origin, effectiveness, scope, structure, and cost benefits of FDTCs are explored, followed by a review of literature on the effects of parental substance abuse on children and the costs to society. A review of the Child and Family Services Review (CFSR) process, the method used by the federal government to measure states' performance in implementing the mandates of ASFA (1997) to ensure child safety, permanence, and well-being, is followed by definitions and theories of child well-being found in the literature.

Background and Significance

Across the nation, FDTCs operate within the context of ASFA in an attempt to address the safety, permanency, and well-being of court-involved children who have been abused or neglected by parents with substance abuse problems (Bureau of Justice Assistance [BJA], 2004). Of the approximately 500,000 children who live in foster care each year in the U.S., between 40-80% are there as a result of parental substance abuse (Badeau & Gesiriech, 2004; D'Andrade & Berrick, 2006; Kortenkamp & Erhl, 2002; Maluccio & Ainsworth, 2003; Smith, Elstein, & Klain, 2005). The use of methamphetamine increased by 72% between 1996 and 2006, particularly for women of child-bearing age (Child and Family Services Improvement Act [CFSIA], 2006). Methamphetamine production and use is reported as a major cause of child abuse and neglect and an increase in out-of-home placements for children (CFSIA, 2006). Providing services for a growing population of children exposed to illegal drugs was projected to be

a major challenge for state child welfare systems from 2007-2011 (U.S. General Accounting Office [GAO], 2007).

Studies indicate that FDTCs are an effective means of promoting well-being for children in foster care due to parental substance abuse (Green, Rockhill, & Furrer, 2007; Gregoire & Schultz, 2001; Smith, 2003). One study compared 250 FDTC program participants to a comparison group of parents in four different sites (Green, Furrer, Worcel, Burrell, & Finigan, 2007). Green, Furrer, et al. found that FDTC parents entered treatment more quickly, stayed in treatment longer, and completed more treatment episodes than parents in the comparison group. FDTC families reached permanency faster and were reunified more often. In addition, when compared to parents who entered treatment quickly and completed it successfully, but did not participate in FDTC, children of FDTC parents had an increased likelihood of reunification and a decreased likelihood of re-entry into foster care, suggesting a greater benefit to parents participating in FDTC than in traditional substance abuse treatment (Green, Furrer, et al., 2007).

Results of another study conducted by Worcel, Furrer, Green, Burrell, and Finigan (2008) supported these findings. FDTC families ($n = 301$) were compared to a matched sample of non-FDTC families with substance abuse problems who received traditional child welfare services. FDTC parents had significantly higher reunification rates with their children than parents in comparison groups.

The need for the research in this three-paper dissertation is well documented in the literature. In the document titled *Time for Reform: Investing in Prevention: Keeping Children Safe at Home – Kids Are Waiting – Fix Foster Care Now*, the Pew Commission states that the performance of family dependency courts could benefit from defined

measures of child well-being and called for research in this area (Pew Charitable Trusts, 2007). In a special research issue of the Drug Court Review published by the National Drug Court Institute, Marlowe, Heck, Huddleston, and Casebolt (2006) asked for researchers to define what makes drug courts work, suggesting that drug courts work in synergistic ways—that they are more than the sum of their parts (Cissner & Rempel, 2005; Marlowe, DeMatteo, & Festinger, 2003; Marlowe, Heck, et al., 2006).

Because of the complex nature of drug abuse and dependency, Marlowe, Heck, et al. (2006) suggested that future researchers go beyond strategies that test single items against each other for effectiveness, such as treatment versus punishment, and look inside the “black box” of drug courts to distinguish drug courts from past endeavors to decrease drug-related crime and child abuse and neglect. Specific recommendations are to explore the therapeutic alliance or relationship between drug court participants and the judge and the implications of the interdisciplinary team approach (Marlowe, Heck, et al., 2006). In addition, research into the effect on the therapeutic relationship of having treatment providers and case managers present during drug court review hearings is indicated (Marlowe, Heck, et al., 2006). A paucity of literature exists on FDTCs when compared to the extent that adult drug courts have been studied (Belenko, 2002).

This research aims to fill gaps in the literature. First, the legislative context that FDTCs operate within is analyzed. Second, the construct of well-being is explored in an attempt to move efforts to operationalize the construct forward. Finally, an exploration of the synergistic component of the relationship between FDTC interdisciplinary teams and program participants is conducted. The following section outlines the structure and operations of FDTCs.

Family Dependency Treatment Courts (FDTC)

FDTCs are based on the drug court model first implemented in Miami in response to the crack-cocaine epidemic of the 1980s. The FDTC model in Figure 1 is adapted from the drug court model figure by Cissner and Rempel (2005). The Eleventh Judicial Circuit Court of Florida implemented the first drug court in the United States in 1989 in an attempt to improve access to substance abuse treatment and reduce drug use and related crimes (Belenko, 1998). Jurisdictions that elect to implement a drug court are generally funded by competitive federal and state government grants. Drug courts bring together the justice and substance abuse treatment systems and attempt to use the coercive power of the court to reduce drug use and related criminal offenses (Belenko, 1998).

Individuals who have been coerced or mandated into treatment have longer stays in treatment than non-coerced patients (Marlowe, DeMatteo, & Festinger, 2003). The longer a person stays in treatment, the better treatment outcomes they are likely to have (Marlowe et al., 2003). One year of treatment has been shown to be the minimum effective length of treatment for positive outcomes (Marlowe et al., 2003). FDTCs use the coercive power of the court to keep parents in treatment for a duration long enough to be effective.

In traditional, non-coerced substance abuse treatment programs, 40-80% of patients drop out prior to the first 90 days of treatment (Marlowe et al., 2003). Even more startling is that 80-90% drop out in less than the 12-month threshold (Marlowe et al., 2003). In contrast, the participant retention rates in drug courts nationally range between

67-71% for the minimum 12-month stay (Center for Substance Abuse Treatment [CSAT], 1996; Hubbard et al., 1989; Marlowe et al., 2003; Simpson & Sells, 1983).

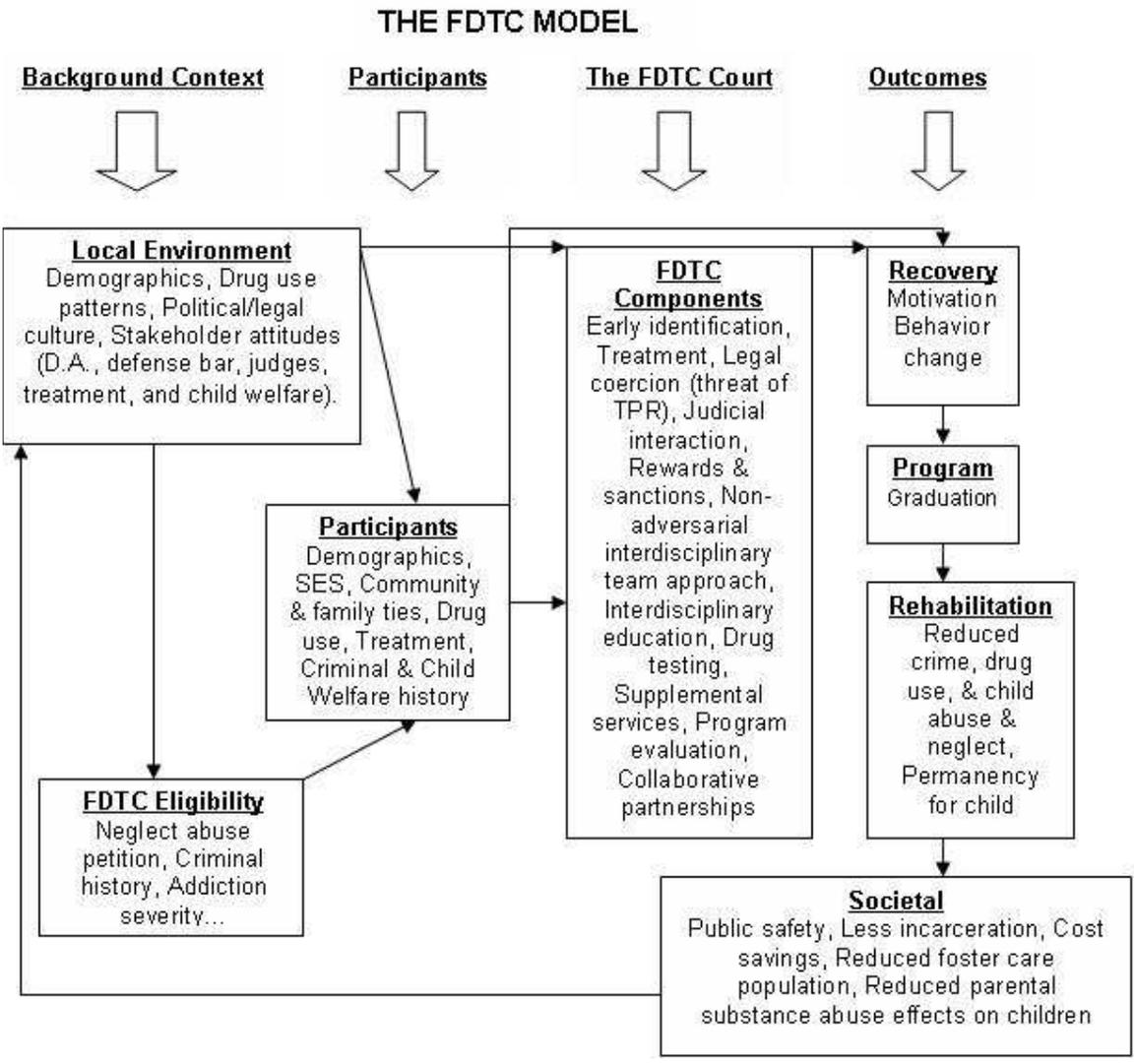


Figure 1. The FDTC Model

In 1994, the federal Violent Crimes Control and Enforcement Act provided for federal funding to support the planning, development, and implementation of drug courts for non-violent drug related crimes (Belenko, 1998). One year later, the U.S. Department

of Justice (DOJ) developed a Drug Courts Program Office and began funding drug courts. In 1997, the U.S. Accounting Office created a list of characteristics of drug courts in a report to Congress. From this list, the DOJ Bureau of Justice Assistance (BJA) compiled the Ten Key Components of Drug Courts to be used by jurisdictions interested in planning and implementing a drug court (Belenko, 1998).

FDTCs adhere to the Ten Key Components of Drug Courts to ensure fidelity to the drug court model (BJA, 1997). Key Component One requires courts to integrate drug and alcohol treatment services with justice system case processing. ASFA mandates that cases be reviewed by the judge at a minimum of every 6 months to determine if the goal for the family has changed from reunification to termination of parental rights (BJA, 1997). ASFA-mandated review hearings also ensure that the state is making reasonable efforts to support family reunification (BJA, 1997). The ASFA-mandated review hearings are integrated with FDCT hearings to alleviate the need for parents, attorneys, and social service workers to attend court twice and eliminate the costs of completing and filing duplicate paperwork if the hearings were held separately. By reviewing the progress of the parent more frequently in FDTC, the case is processed quickly and comprehensively (BJA, 2004; Smith et al., 2005).

Key Component Two requires that the prosecutor, defense counsel, and guardian ad-litem (GAL) (representative for the children) use a non-adversarial approach in processing the case (BJA, 1997). The prosecutor promotes public safety, while the defense counsel ensures the due process rights of the parents. The guardian ad-litem serves as a voice for the children (BJA, 2004). An interdisciplinary case staff meeting is held prior to each FDTC hearing, where defense and prosecuting attorneys, GALs, social

service workers, and treatment providers review the progress of the program participants on the court docket that day. Arguing one's case, as in traditional court proceedings, is not applicable in the FDTC process. Often a core group of defense and prosecuting attorneys are used for all FDTC cases in a jurisdiction due to the non-traditional approach and the intensive cross-training in substance abuse treatment that is required (BJA, 1997, 2004; Smith et al., 2005).

Key Component Three requires that eligible program participants are identified early and placed into the FDTC (BJA, 1997). Potential program participants are identified by child protection services workers, attorneys for the parents or children in the case, the prosecuting attorney, or the presiding judge (BJA, 2004; Smith et al., 2005). Crises, such as a drug bust resulting in the removal of a child from the care of a parent, often serve as the impetus for a referral to FDTC (Smith, 2003). As soon as cases are identified as abuse and neglect due to parental substance abuse, the screening process begins to fast-track parents into FDTC, and consequently into treatment (BJA, 1997, 2004; Smith et al., 2005). Enabling parents to access treatment quickly and to remain in treatment for long enough (a minimum of 12 months) to sustain lasting change increases the chances for families to reunite safely (CSAT, 1996; Hubbard et al., 1989; Marlowe et al., 2003; Simpson & Sells, 1983). Most FDTC programs are voluntary and have other eligibility criteria that are determined based on the results of a local needs assessment (Smith et al., 2005).

Key Component Four requires that FDTCs provide a continuum of drug and alcohol treatment services and other related treatment or rehabilitative services for the parents, children, and the family as a whole (BJA, 1997, 2004). Services extend beyond

substance abuse treatment for the parent and often include either direct provision or coordination of the following services: parenting education, housing, employment, transportation, education, physical and mental health needs, child care, pending criminal charges, and domestic violence (BJA, 2004; Smith et al., 2005).

Key Component Five requires that abstinence is monitored by frequent and random drug and alcohol testing of parents (BJA, 1997). In some jurisdictions, testing of extended family members and significant others occurs depending on familial circumstances (BJA, 2004; Smith et al., 2005). Drug and alcohol tests are a biomedical method of measuring sobriety. When positive test results are confirmed, the drug use is addressed swiftly by the court through the delivery of sanctions at frequent hearings (BJA, 1997).

Key Component Six requires that responses to FDTC participants' successes or challenges are guided by a coordinated strategy (BJA, 1997). Rewards for progress and sanctions for non-compliance are based on evidence of effective contingency management methods (CSAT, 1994; Marlowe, Festinger, Dugosh, Lee, & Benasutti, 2007). Treatment and services are reviewed and adjusted accordingly at each pre-hearing staff meeting by the interdisciplinary team. Support services such as transportation are leveraged to remove barriers to treatment (Smith et al., 2005).

Key Component Seven requires that FDTC judges have ongoing interaction with each parent (BJA, 1997). During each hearing, the judge addresses the parent directly, encouraging dialogue with the parent about concerns, or to offer praise and encouragement (BJA, 2004). In order to ensure that parents have ongoing interaction with the judge, FDTC hearings are held frequently—weekly, bi-weekly, or monthly.

Key Component Eight requires that program goals are measured and program effectiveness is gauged by monitoring and evaluation (BJA, 1997). Programs often conduct outcomes and process evaluations. Results are fed back into the FDTC program for continuous improvement. Findings of program evaluations are commonly disseminated at local, state, and national venues so that FDTCs across the nation can learn from each others' experiences (BJA, 1997).

Key Component Nine requires ongoing interdisciplinary training and education to promote effective planning, implementation, and FDTC operations (BJA, 1997). Each member of the interdisciplinary team brings expertise from their respective areas. Teams share information across disciplines including code of ethics requirements, and technical information regarding law, treatment, and social service policies. Team members often attend state and national trainings and conferences specific to FDTCs to remain current on evidence-based practices and recent research (Smith et al., 2005).

Key Component Ten requires a forging of partnerships among other problem solving courts, public agencies, and community-based organizations (BJA, 1997). The FDTC judge often spearheads partnerships on local, state, and federal levels in order to garner support for taking FDTCs to scale (institutionalizing FDTCs in every jurisdiction), to enhance program effectiveness, and to leverage resources (BJA, 1997; Smith et al., 2005).

Despite the positive outcomes of FDTCs, according to the National Association of Drug Court Professionals (NADCP, 2011), only 323 FDTCs were operating in 41 out of 52 states (including the District of Columbia and Puerto Rico). Over one third of the operational FDTCs (105) are in New York and California. Eleven states do not have an

FDTC in any jurisdiction to address the complex needs of children in care due to parental substance abuse (NADCP, 2011). The power of coercion is reserved for the clients of drug courts who are court ordered to treatment, but is not imposed on jurisdictions in terms of the mandatory use of FDTCs as an effort under ASFA (Fox & Wolf, 2004). The choice to implement a FDTC or not is usually at the discretion of the local judge. Not all judges choose to use this collaborative team approach.

Institutionalizing FDTCs in all jurisdictions presents challenges. Critics of FDTCs state that the small number of families served by FDTCs that pales in comparison to the number of families with substance abuse problems in the child welfare system is one reason not to implement a FDTC (Burress, Mackin, & Aborn, 2008). Jurisdictions resistant to implementing a FDTC claim that the number served is outweighed in benefit by the costs in time that a drug court requires (Burress et al., 2008).

FDTCs require a willingness to collaborate and do business in an alternate way for local judges, attorneys, treatment providers, and social service agencies. Jurisdictions reluctant to implement FDTCs cite a shortage of resources and staff to provide the level of intensive services, time, and energy required. Some courts retain a traditional view of the roles of judicial system representatives; for example, a judge's role is to decide cases, not to solve problems (Farole, 2006). Attorneys and social service workers sometimes struggle with the non-traditional team approach to making recommendations regarding rewards and sanctions for clients (Farole, 2006). Although preliminary cost benefit studies of FDTCs show a savings of over \$5,000 per family served, most courts continue to claim the investment in resources and staff needed for FDTCs is too financially intensive to be taken to a sufficient scale given the volume of children currently in care

due to parental substance abuse (Burrell et al., 2008). To fully understand the faultiness in this thinking, a review of the literature on the deleterious effects of parental substance abuse on children and the costs to society is needed.

Effects of Parental Substance Abuse on Children

Parental substance abuse has profound effects on children. Drug and alcohol use often negatively impacts parental employment, which correlates with childhood poverty and impaired access to health care, food, and housing for children (Substance Abuse and Mental Health Services Association [SAMHSA], 2009). Parents with substance abuse problems often have an impaired ability to provide age and developmentally appropriate discipline and are emotionally unavailable to their children (Haight, Carter-Black, & Sheridan, 2009). Child maltreatment and low levels of parental monitoring of children are hallmarks of the parenting styles of individuals addicted to substances (Haight et al., 2009).

Children of parents with substance abuse problems are commonly exposed to dangerous situations including domestic violence, adult substance abuse, and criminal behavior, further increasing their risk of harm (Haight et al., 2009). Such adverse childhood experiences correlate positively with juvenile delinquency, adolescent and adult addictions, mental health problems, and early sexual activity (Barnes, Welte, Hoffman, & Dintcheff, 2005; Fellitti, 2003; Lemmon, 2006; Peiponen, Laukkanen, Korhonen, Hintikka, & Lehtonen, 2006; Tyler & Johnson, 2006; Wareham and Dembo, 2007).

The Centers for Disease Control and Prevention collaborated with Kaiser Permanente's Health Appraisal Clinic in San Diego (an HMO) to conduct the Adverse Childhood Experiences (ACE) Study, now in its 16th year. This population-based analysis of over 17,000 middle-class American adults found addiction to be one of the top 10 causes of death in America (Fellitti, 2003). Findings of the ACE Study on the etiology of addiction attributes 78% of women's IV drug addictions to childhood trauma, which included parental substance abuse and dependency. Males with adverse childhood experiences had a 46-fold (4,600%) increased likelihood of becoming IV drug users than did males without childhood trauma (Fellitti, 2003). As these children become parents, they have an increased likelihood of perpetuating the cycle of child abuse and neglect (Skowrya & Coccozza, 2007).

A study by Brook and McDonald (2009) examined the re-entry into foster care of children in Oklahoma, through the Oklahoma Division of Children and Family Services, between January 1999 and September 2003 ($N = 2,682$). The findings suggest that children of parents with substance abuse problems have an increased likelihood of entering and re-entering the child welfare system. Once children are in the foster care system, the likelihood of reunification with their parents is less than that for children with parents without substance abuse problems and they tend to have longer stays (Brook & McDonald, 2009; Fuller & Wells, 2003; Gregoire & Schultz, 2001; Smith, 2003). The effects of parental substance abuse on children are reflected in the financial costs to our communities and to society at large in the next section.

Costs to Society of the Effects of Parental Substance Abuse

The adverse experiences and effects of child abuse and neglect as a result of parental substance abuse result in costly multi-systemic involvement. A study by Wang and Holton (2007) funded by the Pew Commission, estimated annual costs of child abuse and neglect to society at \$103.8 billion. Wang and Holton drew upon a variety of sources to determine this amount, including the National Institute of Justice, U.S. Department of Justice, the U.S. Department of Human Studies, Prevent Child Abuse America, U.S. Census Bureau, and a number of scholarly articles published in peer-reviewed journals. Costs were divided into direct and indirect costs. Direct costs associated with the immediate needs of victims of child abuse and neglect include hospitalizations (\$6.6 billion), mental health care services (\$1 billion), child welfare services (\$25.3 billion), and law enforcement (\$.33 billion). Indirect costs—those associated with long-term or secondary effects of child abuse and neglect—include special education (\$2.4 billion), juvenile delinquency (\$7.1 billion), mental health and health care (\$.67 billion), adult criminal justice (\$27.9 billion), and lost productivity to society (\$33 billion). Costs are expected to be conservative as estimates do not include expenses related to perpetrators or the victims' families (Wang & Holton, 2007).

Children enter the child welfare system with numerous physical, mental health, and educational problems. Once in care, they continue to suffer from high rates of developmental delays and emotional and behavioral problems (D'Andrade, Osterling, & Austin, 2008). Many have repeated grades in school and receive special education services (D'Andrade & Berrick, 2006). They have lower levels of school engagement and

are more likely to be suspended or expelled, to change schools, and to have lower grades (D'Andrade et al., 2008). Children who age out of foster care face serious challenges as adults including homelessness, lack of access to health insurance, health care, mental health services, increased incarceration, and high school drop out rates (D'Andrade et al., 2008). These costs demonstrate the significance of the problem under study in this document.

In order to achieve the mandates of ASFA to promote child safety, permanence, and well-being, the Children's Bureau of the U.S. Department of Health and Human Services (USDHHS) recommended that states conduct comprehensive assessments for children in care, with an emphasis on measuring child well-being (Lou, Anthony, Stone, Vu, & Austin, 2008). FDTCs are a service provided in some states to improve the well-being of children in foster care by addressing parental substance abuse. The following section describes the current process used to monitor the states' performance in the areas of safety, permanence, and well-being of foster children.

The Child and Family Services Review (CFSR) Process

Child well-being of foster care children is monitored under ASFA using the Child and Family Review (CFSR) process. The CFSR was launched by the USDHHS Administration for Children and Families' (ACF) Children's Bureau in 2001. The CFSR process aims to assess states' performance and progress in implementing the mandates of ASFA (1997) as they pertain to child safety, permanency (defined as a permanent home), and well-being. This section outlines the design of the CFSR process and how FDTCs fit within it, the results of CFSRs, concerns with the design of the CFSR, and the validity of

the results and the implications for states and the foster children of parents with substance abuse problems (Courtney, Beedell, & Wulczyn, 2004; D'Andrade et al., 2008; U.S. GAO, 2007; Lou et al., 2008; Schuerman & Needell, 2009a, 2009b; Tilbury, 2004).

The three parts of the first wave of the CFSR process are (1) a review of administrative data, (2) site visits, and (3) the development of a program improvement plan if indicated by the findings of parts one and two. States are not required to meet the minimal standards in their program improvement plan. Instead, states set their own goals for improvement and they are assessed on the achievement of these goals in subsequent waves of the CFSR (Schuerman & Needell, 2009a, 2009b).

Part one of the CFSR is a quantitative review of state administrative data. Each state, the District of Columbia, and Puerto Rico are required to submit data to national child welfare databases (U.S. GAO, 2007). These databases are the National Child Abuse and Neglect Data Reporting System (NCANDS) and the Adoption and Foster Care Analysis and Reporting System (AFCARS). Review of these data is the first step of the CFSR process conducted for each state (U.S. GAO, 2007). Part two of the CFSR process is qualitative in nature, consisting of interviews and case reviews conducted during site visits to each state. Interviews are conducted with child welfare-related stakeholders, including agency staff and administration, judges, attorneys, parents, and children (U.S. GAO, 2007). Part three is the development of a program improvement plan for states found to be out of compliance based on the quantitative and qualitative results of steps one and two in which states set their own goals for improvement (Schuerman & Needell, 2009a, 2009b). After a 2-year implementation phase of the improvement plan, if adequate progress is not made, financial penalties can then be imposed by the federal government

(Courtney et al., 2004; D'Andrade et al., 2008; Lou et al., 2008; Tilbury, 2004). However, because states set their own goals in the program improvement plans (PIPs), and since they are only assessed by the CFSR in attaining these goals, all states have passed the reviews of their PIPs.

The CFSR assesses seven child-related outcomes in each state in the areas of the safety, permanency, and well-being of foster care children or children who are wards of the court in their own home (U.S. GAO, 2007). Under the CFSR, child safety is defined as children who are protected from abuse and neglect and safely maintained in their homes whenever possible. Permanency outcomes are defined as permanency and stability in living situations and continuity of family relationships and connections (U.S. GAO, 2007). Family and child well-being are defined as a parent or foster parent's enhanced capacity to provide for children's needs, as well as appropriate and adequate services to meet the child's educational, physical, and mental health needs (Courtney et al., 2004).

Twenty-six different indicators are used to assess states' performance in attaining the child safety, permanency, and well-being. Child and family well-being are not differentiated (U.S. GAO, 2007). Of the 26 outcomes, 3 rely on quantitative data from NCANDS and AFCARS and 3 rely on both quantitative and qualitative data from the databases and site visits (Courtney et al., 2004). The remaining 20 child outcomes are assessed using qualitative data from site visits (D'Andrade et al., 2008). All data assessing well-being are gathered from qualitative data gathered in case reviews and interviews.

Child safety outcomes in each state are measured by the timeliness of the investigations of child abuse and neglect reports, the recurrence of maltreatment, and the

number of incidences of abuse or neglect in foster care. Safety is also assessed by the services provided to families to protect children, prevent removal from the home, and an assessment of the current risk of harm to the child (Courtney et al., 2004; D'Andrade et al., 2008; Lou et al., 2008; Tilbury, 2004).

Child permanency outcomes are measured by the number of foster care re-entries, and foster care placement changes, and the identification of permanency goals for the child in the case record. Permanency may consist of reunification with a parent, a guardianship, or permanent placement with a relative, adoption, or "other planned living arrangement" (Courtney et al., 2004; D'Andrade et al., 2008; Lou et al., 2008; Tilbury, 2004). Additional permanency measures include the length of time from removal of the child from the parents' care to reunification, or the length of time from termination of parental rights to a finalized adoption. Proximity of current placement to the parent and placement of children with their siblings is measured, as are the number child's visits with parents and siblings, documentation of the use of relative placements when possible, and evidence of an assessment of the relationship of the child in care with their parents, and documented efforts in place to preserve the emotional connections between family members (Courtney et al., 2004; D'Andrade et al., 2008; Lou et al., 2008; Tilbury, 2004).

Child well-being outcomes measured in the CSFR process include evidence of an assessment of the needs of the child, parents, and foster parents and the provision of services to address identified needs (Courtney et al., 2004; D'Andrade et al., 2008; Lou et al., 2008; Tilbury, 2004). Evidence of the involvement of the child and the family in case planning, as well as the number of times the worker visits with the child in care and the parent are also indicators of child well-being under CFSR. Additional well-being

indicators are evidence of the assessment of the child's educational, physical, and mental health needs and the services provided by the states to address these needs (Courtney et al., 2004; D'Andrade et al., 2008; Lou et al., 2008; Tilbury, 2004).

Results of the first wave of the CFSRs conducted in 2001-2003 reveal that no state was within compliance of the minimal standards set forth by the federal government (Courtney et al., 2004; D'Andrade et al., 2008; Lou et al., 2008; Tilbury, 2004). All 50 states, the District of Columbia, and Puerto Rico were required to develop program improvement plans (Courtney et al., 2004; D'Andrade et al., 2008; Lou et al., 2008; Tilbury, 2004). The CFSR process revealed two areas most frequently identified across states as needing improvement: assessing and providing for the needs and services of children, parents, and foster parents; and a shortage in assessment and services for the mental health of the child (U.S. GAO, 2007).

In response to the unfavorable findings of the first wave of the CFSR, states cite inadequate levels of mental health and substance abuse services available to children and families as barriers to improving their outcomes on child well-being (U.S. GAO, 2007). Results from the second wave of the CFSR process reveal that most states met the goals of their program improvement plans, but did still not meet minimal federal standards for child safety, permanence, and well-being (USDHHS, 2011). The following section highlights concerns with the design of the CFSR that renders the usefulness of the CFSR results as questionable.

Problems in the design of the CFSR process limit the meaningfulness of the results for each state. Concerns noted in the literature regarding the design of the CFSR include a lack of data collection for individual children or cohorts of children in care, the

methodology used to select the minimal acceptable levels of performance and data, and sampling methodological concerns (Courtney et al., 2004; D'Andrade et al., 2008; Lou et al., 2008; Schuerman & Needell, 2009a, 2009b; Tilbury, 2004; U.S. GAO, 2007).

First, data analyzed in the CFSR process do not reflect the characteristics of the individual children in care or cohort of children in care. Without this data, the historical contingencies that have impacted the foster care population, such as children of parents with substance abuse problems, cannot be tracked (Tilbury, 2004; Wulczyn, Kogan, & Dilts, 2001). The minimal standard of compliance of the length of time from the removal of children from the parents' care to reunification of these children with their parents is 12 months, which implies that a shorter stay in care is preferred (Tilbury, 2004).

However, for parents entering treatment for substance abuse and dependency, the optimal minimal length of stay for a positive prognosis is 12 months (CSAT, 1996; Hubbard et al., 1989; Simpson & Sells, 1983). In cases of parental substance abuse, returning the child to the parents' care prior to 12 months could be contraindicated to the child's best interest.

Without considering the risk factors within families, states can feel pressure to return children swiftly, contrary to research in the literature that shows that children who stay in care less than 3 months have a higher re-entry rate into foster care (Edwards, 2007; Smith, 2003;). Therefore, states that may be trying to reduce their lengths of stay in foster care rate may be simultaneously increasing the number of children who re-enter care, subsequently rendering the state out of compliance in this area. By not tracking individual children in care and their risk factors, the CFSR process may unintentionally influence states to focus more on attaining numbers and less on the quality of care children receive

(Tilbury, 2004). It cannot be assumed that swift reunification or adoption improves a child's well-being without measuring a benefit in the individual child's life (Tilbury, 2004).

A second concern in the CFSR process is that longitudinal data on individual children or cohorts who enter the system are not collected (Courtney et al., 2004; D'Andrade et al., 2008). Samples in the CFSR assessment process are snapshots of those in care at the end of the year. For example, the number of children who are in care at the end of a year includes children who have been in care for over a year, but not those who have entered and left care within the year. This increases the potential for over-sampling children who have been in care for long periods of time and for excluding children exiting care or with shorter stays in care (Courtney et al., 2004; Wulczyn et al., 2001). Without measuring progress at numerous points in time on entry cohorts of children in the foster care system, states cannot accurately measure their success with individual children over time (Barth, Wulczyn & Creas, 2005; Courtney et al., 2004; Schuerman & Needell, 2009a, 2009b).

A third problem with CFSRs is that ACF arbitrarily determined the cut off point for meeting minimal acceptable standards (Courtney et al., 2004; Schuerman & Needell, 2009a, 2009b). In addition, no procedures are reported by the ACF to account for variability between states or within states (such as between jurisdictions), for ensuring the accuracy of the data or for handling missing data (Courtney et al., 2004; D'Andrade et al., 2008; Schuerman & Needell, 2009a, 2009b).

Finally, sampling strategies in the CFSR are also areas of concern. The CSFR considers the 50 states, Washington, D.C., and Puerto Rico as a sample, when in fact it is

the population (Schuerman & Needell, 2009a, 2009b). In addition, the number of cases reviewed in each state during the first and second wave was 50 and 65, respectively. These sample sizes were chosen arbitrarily (Schuerman & Needell, 2009a, 2009b). The ACF does not employ power analyses to determine adequate sample sizes needed for generalization to each state's population. In addition, ACF does not report on the method used to determine how cases are chosen. Within the cases selected for review in each state, there are two subgroups: (1) cases with families who have not had their children removed from their care and are receiving services in their homes to prevent removal, and (2) foster care cases (D'Andrade et al., 2008; U.S. GAO, 2004). Because of the individual characteristics of the cases in each group, all the cases chosen for review cannot be assessed on all 26 indicators of child safety, permanence, and well-being (D'Andrade et al., 2008; U.S. GAO, 2004), further reducing the generalizability of the results to the entire state. For example, the subset of cases of children receiving services in their own home cannot measure a state's performance on the following indicators of child safety or permanence: incidence of abuse or neglect in foster care, foster care re-entry, stability of foster care placement, achievement of adoption, time to adoption, proximity of current placement, placement with siblings, or relative placement. These indicators can be measured only in the foster care subset of cases.

The experience in Wyoming illustrates the sampling problem in the CFSR. In the first wave of the CFSR, Wyoming was found to be out of compliance by 50% on the time to adoption indicator (U.S. GAO, 2004). Out of the 25 cases in Wyoming's foster care subset, only 2 had a permanency goal of adoption, so the other 23 cases could not be measured on this indicator. Of the 2 cases that involved adoption, 1 case did not meet the

federal standards in achieving adoption within 24 months following termination of parental rights (U.S. GAO, 2004). Because 1 out of the 2 foster care cases reviewed on this indicator was out of compliance, the CFSR generalized this to the state of Wyoming as out of compliance by 50%. Consequently, the state was required to design a program improvement plan for all cases in the state to improve the length of time between the termination of parental rights and adoption. To accommodate for the sampling problems within the states, the sample size in each state was increased to 65 during the second wave of CFSRs (USDHHS ACF, 2011). Assessing a state's progress or lack of progress based on a faulty sampling strategy may hide changes that are actually occurring (Wulczyn et al., 2001).

Under the auspices of ASFA, the CSFR process is an attempt to define and measure child safety, permanence, and well-being. Although concerns with the process are many, CFSR continues to be the national surveillance system used to determine trends over extended periods of time and provide investigators with national estimates.

CFSR measures child safety, permanence, and well-being as three independent constructs. In the context of CSFR reviews, child and family well-being are viewed as one construct. CSFR defines well-being as the enhanced capacity of a parent or foster parent to provide for children's educational, physical, and mental health needs including the provision of appropriate and adequate services (Courtney et al., 2004). The following section explores the extent to which the definition of well-being used in the CFSR process is based on the extant knowledge in the literature.

Definitions of Well-Being

Definitions of child well-being in the research literature vary due to the broad, elusive, and complex nature of the concept. Well-being can be viewed from a macro, mezzo, or micro perspective. Macro views use a broad lens that encompasses problems and strengths in society. Mezzo views take a more narrow perspective and consider issues of a child's family, friends, and immediate surroundings and issues. Micro views look within an individual. A review of the literature reveals that most attempts to define well-being rely on mezzo or micro perspectives that rely on indicators as opposed to actually defining the construct and often substitute indicators for a definition.

In a systematic review of the literature on child well-being, Pollard and Lee (2003) found little agreement on the definition and how to best measure it, and no standard method for assessment. They found 137 subjective measures and 36 objective measures for young children, 220 subjective measures and 36 objective measures for pre-adolescent children, and 245 subjective and 34 objective measures for adolescents. In research studies, multiple, separate measures are often used in an effort to gain insight through factors that affect a child's health and development (Federal Interagency Forum on Child and Family Statistics [FIFCFS], 2008; Pollard & Lee, 2003).

Positive indicators of children's physical health in the literature include availability of nutritious food; access to health care; prevention, treatment, and management of illnesses; health insurance; a primary care provider; dental health; and childhood immunizations. Negative indicators include exposure to contaminated or polluted air and water, housing problems, deaths from injury including firearms, low

birth-weight, chronic health conditions such as asthma and obesity, and hospitalizations (D'Andrade et al., 2008; FIFCFS, 2008; Pollard & Lee, 2003).

Children's mental health can be evaluated by attachment to primary caregivers, behavioral concerns, the quality of family interactions, exposure to distal and proximal stressors, and youth participation in high-risk or illegal behaviors (Shinn et al., 2008). Mental health concerns may also manifest as somatic complaints, social difficulties, and learning problems (Shinn et al., 2008).

Educational indicators of well-being can encompass intelligence and achievement, accomplishment of developmental milestones, educational experiences, attitudes pertaining to education, educational attainment, the quality of education in the jurisdiction where families live, grade retention, special education, suspensions and expulsions, change of schools, and grades (D'Andrade et al., 2008; Lou et al., 2008). Columbo defined child well-being similar to the definition used in the CFSR process in terms of physical and mental health, but substituted educational outcomes with social outcomes (Pollard & Lee, 2003).

Theories of Well-Being

Theories of well-being have emerged from the fields of human development, psychology, health, and, more recently, law. Predominant theories of child well-being are linked to risks the child experiences. Parental substance abuse is identified as a risk factor for child well-being outcomes (Lou et al., 2008). Child well-being theories addressed in this document are the cumulative risk theory, the inoculation theory, the developmental or

emotional asset model, the risk and resiliency theory, therapeutic jurisprudence, and an integrated model of wellness.

First, the cumulative risk concept of child well-being (Shinn et al., 2008) suggests that the interplay between multiple stressors exacerbate each other, resulting in negative outcomes for children. The more stressors present, the greater the interplay between the stressors, which move a child farther along the continuum to the extreme risk anchor and out of the range of acceptable level of risk, lowering the child's level of well-being (Lou et al., 2008). According to the cumulative risk model, the whole is more than the sum of its parts and the absence of stressors or risks result in a state of child well-being.

The second theory uncovered in the literature is Eysenck's stress inoculation model of child well-being. Eysenck suggests that exposure to chronic stressors, such as parental substance abuse and poverty, might inoculate a child to negative outcomes from future hardships and therefore reduce the effects of subsequent stressors (Lou et al., 2008). Under the stress inoculation model, what may be determined as a negative indicator (chronic stress) in other models, could be interpreted as a positive indicator in the stress inoculation model due to the proposed "vaccination" properties of the stressor (Lou et al., 2008). The stress inoculation theory posits that problem-solving strategies and personality characteristics such as perseverance in adverse situations that are developed by some individuals during periods of stress may heighten their tolerance to stressors in the future (Lou et al., 2008).

In contrast to the stress inoculation model, the third theory revealed in the literature is the developmental or emotional asset building model, which focuses on the exposure to positive experiences as prime contributors to well-being (Shinn et al., 2008).

For example, consistent exposure to a positive adult role model aside from the parent in a child's life, even in the presence of parental substance abuse, could lead to positive outcomes for the child. The asset building model assesses child well-being based on the amount of developmental or emotional assets at one's disposal that can be drawn on in times of stress (Shinn et al., 2008).

The fourth model on well-being reviewed in this document is the risk and resilience model (Lou et al., 2008). The risk and resilience model integrates both risk and protective factors as impacting a child's resilience, including the presence of positive or negative internal, external, biomedical, and developmental factors. Internal risk or resiliency factors can include a child's subjective perception of life satisfaction, their self-concept, and their temperament (Lou et al., 2008). This may explain how siblings differ in their ability to tolerate or react to various life stressors. External risk or resiliency factors can include the level of family support a child receives. Under the risk and resilience model, positive role models or mentors available to a child such as teachers, extended family members, or formal mentors are viewed as protective factors that may combat or outweigh risk factors, such as parental substance abuse (Lou et al., 2008). Biomedical and developmental risk and resiliency factors include a child's physical health and their intellectual abilities (Lou et al., 2008). The risk and resilience model incorporates both positive and negative indicators in assessing child well-being.

Wexler and Winick (1996) theorized that laws, legal rules and procedures, court procedures, and the people who implement them can produce physical and psychological well-being of people, a theory which they coined "therapeutic jurisprudence" (TJ). This

legal theory was first applied in the area of mental health law, and later extended into the areas of domestic violence, homelessness, family law, adult drug courts, and FDTCS.

Senjo and Leip (2001) researched the components of the theory of therapeutic jurisprudence. Their findings include the following as key components of therapeutic jurisprudence: judicial monitoring, provision of treatment, and legal rules and procedures of the court. TJ assumptions include the following:

1. The way laws are implemented in a court setting affects one's well-being.
2. Moments of crisis in one's life, such as arrest or loss of custody of one's children, are opportunities for courts to make the greatest impact on well-being.
3. Multidisciplinary efforts among courts and social scientists should guide the use of the law to impact well-being.
4. Individual rights and public safety are not abdicated under TJ.
5. Value judgments are inherent in maximizing the law as it affects well-being (Birgden, 2004).

In the TJ model of well-being, the law itself, the legal rules and procedures, court procedures, and those involved, including judges and attorneys, all have the potential to act or be used as therapeutic agents (Birgden, 2004). The drug court movement is a means to move therapeutic jurisprudence from theory to application (Senjo & Leip, 2001).

Roscoe (2009) conducted an extensive review of the literature on definitions, theories, and assessment measures of wellness, spanning from 1967 to 2009. According to Roscoe, most authors agree that "wellness is a multidimensional, synergistic construct that is represented on a continuum, not as an end state . . . wellness is not just the absence of illness" (p. 216). Roscoe synthesized the existing literature on wellness into an

integrated definition. Roscoe's wellness model is comprised of the following seven components: "social, emotional, physical, intellectual, spiritual, occupational, and environmental" (p. 221).

A commonly agreed-upon definition and theory of well-being, as well as how it is promoted and measured, is missing in the literature (Roscoe, 2009). The definitions and theories uncovered in the literature review are not grounded in data. There is considerable overlap in the theories as they address issues of physical and mental health, education, and relationships, but there are also gaps that are not accounted for, such as the concepts of time and predictability in determining one's well-being. Without a common definition of well-being, operationalizing this complex construct, as CFSRs attempt to do, is all but impossible.

Summary

The findings of the policy analysis and the GT study may contribute to improvements in the child welfare system at large. The research from these studies aims to inform both policy makers and practitioners in the fields of child welfare, mental health treatment, substance abuse treatment, and FDTCs as they strive to improve the well-being of foster children with parents with substance abuse problems.

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CHAPTER II

ADOPTION AND SAFE FAMILIES ACT OF 1997 (ASFA) AS IT PERTAINS TO PARENTS WITH SUBSTANCE ABUSE PROBLEMS AND THEIR CHILDREN

Background and Significance

The purpose of this paper is to conduct an analysis of three key components of the federal Adoption and Safe Families Act (ASFA) of 1997 (PL 105-89) as they pertain to foster children of parents with substance abuse problems in Family Dependency Treatment Courts (FDTC). The components of ASFA under study in this analysis are permanency, reasonable efforts within timelines, and aggravated circumstances. ASFA (1997) was enacted to reduce a booming foster care population by promoting adoption of children out of foster care.

This focus on parental substance abuse in this policy analysis is significant in that 40-80% of 500,000 children in foster care annually have parents with substance abuse problems (Badeau & Gesiriech, 2004; D'Andrade & Berrick, 2006; Kortenkamp & Ehl, 2002; Malluccio & Ainsworth, 2003; Smith, Elstein, & Klain, 2005). Providing services for a growing population of children who have been exposed to illegal drugs was projected to be a major challenge for state child welfare systems from 2007-2011 (U. S. GAO, 2007). In response to this need, Family Dependency Treatment Courts (FDTC) evolved out of the drug court movement to operate in some states under the reasonable effort mandate of ASFA as an attempt to move children with parents with substance

abuse problems out of foster care (Bureau of Justice Assistance [BJA], 2004). Drug courts are considered to be an especially effective method in addressing methamphetamine use in communities (Huddleston, 2005).

A special research issue of the Drug Court Review published by the National Drug Court Institute (Marlowe, Heck, Huddleston, & Casebolt, 2006) finds that there is a paucity of research on FDTCs (Belenko, 2001; Bryan & Havens, 2008). Because of the complex nature of drug abuse and dependency, Marlowe et al. suggest that future research go beyond strategies that test single items against each other for effectiveness, such as measuring the effectiveness of treatment versus punishment for substance abuse-related offenses, and to conduct research that explains how drug courts work. This research attempts to fill gaps in the literature beginning with an examination of the legislative constraints of ASFA, within which FDTCs operate.

FDTCs are based on the drug court model, promoted by the U.S. Bureau of Justice Assistance (BJA, 2007) as a comprehensive substance abuse treatment program that incorporates drug and alcohol treatment into the court process (Figure 1). FDTCs are a type of drug court that work exclusively with parents with substance abuse problems and their children who are involved in the child welfare system due to abuse and neglect (BJA, 2004; Hannett, 2007). Parental drug testing is conducted on a random and frequent basis. Judicial monitoring and supervision of parents is intensive. Timely substance abuse treatment is provided for parents. Success in treatment is rewarded and non-compliance is consequated with sanctions (BJA, 2004; Edwards & Ray, 2005).

FDTCs provide collaborative, coordinated, and comprehensive services using a non-adversarial approach (BJA, 2004; Wheeler & Fox, 2006). Interdisciplinary teams of

local representatives from the judicial and social service systems and mental health/substance abuse treatment providers meet on a weekly to monthly basis. These team members communicate frequently to coordinate services and provide close supervision, monitoring, and support for substance abusing parents (BJA, 2004; Wheeler & Fox, 2006). Parents appear on a weekly to monthly basis in front of the FDTC judge where they receive swift and appropriate responses to successes and challenges (Hannett, 2007; Wheeler & Fox, 2006). FDTCs operate under the auspices of ASFA as a reasonable effort to reunify families within the timeline of 12-15 months. FDTCs aim to support parents in recovery and to attend to the child's safety, permanency, and well-being (BJA, 2004; Hannett, 2007; Wheeler & Fox, 2006).

FDTCs may operate on either a parallel or an integrated judicial model. In the parallel model, one judge makes decisions during the substance abuse-related hearings for a family, and a separate judge makes decisions in the dependency or abuse and neglect hearings (Edwards & Ray, 2005). In the integrated or unified model, one judge makes all decisions for the family (Boles, Young, Moore, & DiPirro-Beard, 2007). Despite their success, FDTCs are not mandated or available in every state or local jurisdiction and are generally funded by competitive federal and state grants (Hannett, 2007). The conditions that served as an impetus for the enactment of ASFA are outlined below.

Prior to the enactment of ASFA, the U.S. experienced a near doubling in the number of children in the U.S. foster care system between 1985 and 1997—an increase from 276,000 to 500,000 (O'Neill-Murray & Gesiriech, 2004). The causes of this increase have been attributed in some studies to the crack cocaine and HIV/AIDS epidemics (O'Neill-Murray & Gesiriech, 2004). Studies by Swann and Sylvester (2006) suggest that

mandatory sentencing of the 1986 Anti-Drug Abuse Act was a dominant force in the increase in the foster care population. The increase in the rate of children entering foster care mirrored the rate of parents entering prison due to drug-related crimes (Smith & Young, 2003; Swann & Sylvester, 2006).

The belief held by many at that time was that drug abuse was an issue that affected people who were “morally inferior” and that the addicts brought these circumstances on themselves (Tupper, 2005). The climate in the nation was to declare war on drugs, not to research treatment that could be effective in decreasing the prevalence of this public health concern—depersonalizing it from the individuals afflicted with the disease (Tupper, 2005). People who were addicted were commonly deemed as unworthy of public funding due to the perceived flaws in their character (Tupper, 2005).

By the mid 1990s, public perceptions about the child welfare system were that too many children were in foster care for too long, and that they were experiencing multiple moves from one foster home to another (O’Neill-Murray, 2004). The length of stay and multiple moves children were experiencing in foster care were considered to contribute to residual cognitive and emotional problems for these children, extending into adulthood (O’Neill-Murray, 2004). A review of national data by the U.S. General Accounting Office (2002) revealed that of the children who were returned to their families, 33% re-entered foster care within 3 years (Badeau & Gesiriech, 2004). Critics of the child welfare system claimed that children’s safety was placed at risk by preventing them from entering foster care when it was indicated and that adoption was neglected a permanent placement option once a child was in care (O’Neill-Murray & Gesiriech, 2004). In response, ASFA was

introduced into the U.S. Congress in February 1997 by Representative Dave Camp, representing Michigan's 4th Congressional District with 31 co-sponsors.

In October of 1997, Jane Ross, the Director of U.S. Income Security Issues, Health, Education, and Human Services Division, testified before the Subcommittee on Human Resources Ways and Means Committee in the U.S. House of Representatives (U.S. GAO, 1997). In reference to the foster care population, Ross reported that no other reason for the removal of children from their parents' care accounted for such a large amount as parental substance abuse. Ross reported that the use of methamphetamine and other highly addictive drugs was rising (U.S. GAO, 1997).

Ross warned of the problem of reconciling the timelines being proposed in ASFA and the length of time needed in substance abuse treatment for a positive prognosis. She stated the cases with parental substance abuse were complex and required multiple ancillary services in addition to substance abuse treatment, over a longer period of time than the 12-15 months ASFA proposed for making a decision about a permanent home for children (U.S. GAO, 1997).

Ross cited a shortage of substance abuse treatment and the correlation between length of stay in treatment and a positive prognosis. She warned that without an enhancement of substance abuse treatment, the ASFA timelines would decrease the likelihood of reunification for these families. She went on to cite a shortage of foster and adoptive homes to care for the children (U.S. GAO, 1997).

Ross's concerns were not heeded. ASFA obtained unusually strong bipartisan support (416-5 in the House, unanimous in the Senate). One month after Jane Ross reported concerns, ASFA was signed into law by President William Clinton on

November 19, 1997, as PL 105-89 (U.S. House Report, 1997). Prominent entities that advocated for the passage of ASFA included the Child Welfare League of America (CWLA) and the Children's Defense Fund (CDF) (CWLA, 2003).

The interdisciplinary implications of foster children of parents with substance abuse problems are many. The child welfare system, criminal justice, educational, and health care systems are invested in reducing the foster care population due to staggering systemic costs from long-term adverse effects suffered by foster children and children of parents with substance abuse problems (Chalk, Gibbons, & Scarupa, 2002; Perez, O'Neill, & Gesiriech, 2003). Children in care often have cognitive, emotional, and behavioral issues that lead to multi-systemic involvement at an estimated annual cost of \$103.8 billion (Wang & Holton, 2007). Research shows that children of parents with substance abuse have a greater likelihood to have juvenile delinquency behaviors, adolescent and adult addictions, mental health problems, and early sexual activity (Barnes, Welte, Hoffman, & Dintcheff, 2005; Fellitti, 2003; Lemmon, 2006; Peiponen, Laukkanen, Korhonen, Hintikka, & Lehtonen, 2006; Tyler & Johnson, 2006; Wareham & Dembo, 2007). The deleterious effects of long stays in foster care coupled with the multi-systemic costs to society served as impetuses for an overhaul to the foster care system under ASFA. The following legislative history provides an abbreviated historical framework for the enactment of ASFA.

Efforts to address issues of child welfare in the U.S. date back to the 1700s when children with parents who were unable to care for them were indentured to work for wealthier families (O'Neill-Murray, 2004; O'Neill-Murray & Gesiriech, 2004). Private charities and religious organizations established the first orphanages in the early 1800s

(O'Neill-Murray, 2004; O'Neill-Murray & Gesiriech, 2004). By the mid-1800s, private agencies began placing orphans with foster families. In the early 1900s, some state laws were passed to prevent child abuse and neglect and the Federal Children's Bureau was established. In 1935, the Social Security Act authorized federal grants to states to provide for child welfare services and Aid to Dependent Children (ADC), cash benefits for poor children. In the 1960s, the Social Security Act was amended to, among other things, extend ADC to foster families (O'Neill-Murray, 2004; O'Neill-Murray & Gesiriech, 2004).

The Child Abuse Prevention and Treatment Act (CAPTA) was enacted in 1974. Key provisions of CAPTA include the requirement of mandatory reporting of child abuse and neglect by designated professionals and an expansion of foster care programming. In the 1970s, the foster care population grew and so did the length of time children were spending in foster care (O'Neill-Murray, 2004; O'Neill-Murray & Gesiriech, 2004). Legislators speculate that the foster care population growth may have been attributed to an increase in reporting due to CAPTA as well as an increasing drug problem in the U.S.

In response to concerns of a lack of oversight of the foster care system and the implications of the well-being of foster children, the federal government enacted the Adoption Assistance and Child Welfare Act (AACWA) in 1980. AACWA is considered to be landmark legislation as it was the first comprehensive federal act to give states a framework for addressing the problems associated with the burgeoning foster care system (O'Neill-Murray, 2004; O'Neill-Murray & Gesiriech, 2004).

Under AACWA, courts were required to review cases regularly in order to decrease the foster care population, preferably through family reunification (O'Neill-

Murray, 2004; O'Neill-Murray & Gesiriech, 2004). Resources were earmarked for states to make "reasonable efforts" to preserve families by preventing foster care placements or to reunify families with children in care. AACWA did not provide specific clarification of what were and were not considered "reasonable efforts" beyond the broad mandate of programming and services to prevent child abuse and neglect and preserve families. In cases where children were placed in foster care, AACWA emphasized family reunification efforts over other alternatives such as adoption or guardianship but again did not provide states with clear guidelines of what these efforts should consist (Humphry, Turnbull, & Rutherford-Turnbull, 2006; O'Neill-Murray, 2004; O'Neill-Murray & Gesiriech, 2004; Woodhouse, 2005;).

In 1986 the Omnibus Reconciliation Act (ORA) was enacted as another effort to reduce a growing foster care population. Under the auspices of ORA, the Independent Living Program was established as a first attempt to assist children who were aging out of foster care (O'Neill-Murray & Gesiriech, 2004). The Family Preservation and Family Support Services Program (FPFSSP) also was implemented under ORA. Under the FPFSSP, two key programs were implemented: the Court Improvement Program and the Child Welfare Waiver Program. Court Improvement Program funding authorized states to pilot programs that would improve juvenile and family court performances (O'Neill-Murray & Gesiriech, 2004). The Child Welfare Waiver Program authorized states to pilot and test innovative approaches to financing child welfare.

By 1997, the number of children in the U.S. foster care system nearly doubled between 1985 and 1997, increasing from 276,000 to 500,000, respectively (O'Neill-Murray & Gesiriech, 2004). Testimony before the Subcommittee on Human Resources

Ways and Means Committee in the U.S. House of Representatives indicated that the shortage of substance abuse treatment and the increase of highly addictive drugs were at the root of the problem (U.S. GAO, 1997).

Seventeen years following the enactment of AACWA, ASFA was enacted with the same goal: to reduce the foster care population. Under ASFA, the approach shifted away from front-loading services through family preservation and reunification services under AACWA. ASFA placed a greater emphasis on adoption as a means to move children out of foster care (O'Neill-Murray & Gesiriech, 2004; Smith & Young, 2003; Woodhouse, 2005); however, there was no provision addressing the impact of parental substance abuse on the foster care population.

Federal funding for foster care and adoption assistance increased under ASFA exceeding \$6.4 billion—nearly 10 times the amount allocated for abuse and neglect prevention, family preservation, and family reunification services (Pew Commission, 2004). However, each year since 1997 the foster care population has steadily remained between 500,000 and 560,000 (Pew Commission, 2004). This concerning fact invites a deeper look into the provisions of ASFA.

ASFA (1997) has 16 general provisions. For the purposes of this analysis, the following three key provisions and their effects on parents with substance abuse and their children are examined: (1) permanency—the provision of a safe, permanent home for abused and neglected children; (2) reasonable efforts made by the state within timelines either to reunite families or to pursue adoption or other permanency options; and (3) aggravated circumstances—situations that allow states to waive reasonable efforts to reunify families and move directly to the termination of parental rights.

Permanency efforts for a child under the ASFA emphasize either family reunification or adoption, moving away from the option of long-term foster care formerly provided for under AACWA as an acceptable permanent home (ASFA, 1997). ASFA recognizes timely and safe reunification with the parent as the first option to be considered for a child's permanent placement. However, if timely and safe reunification cannot be achieved within mandated timelines, reunification as a permanency goal is changed to termination of parental rights (TPR) and other permanency options are pursued including adoption, guardianship, and other alternatives. ASFA provides for financial incentives to states for each child adopted out of foster care (ASFA, 1997). No incentives are provided for states to prevent placement in foster care, reunify families, or pursue other permanency options such as guardianships with relatives under ASFA.

ASFA provided clarification for states regarding the definition of reasonable efforts first introduced under AACWA. Under ASFA, reasonable efforts include counseling, substance abuse treatment, mental health services, domestic violence services, temporary child care services, and "therapeutic services for families including crisis nurseries" (ASFA section 305, 1997; Smith et al., 2005). In addition, ASFA imposed timelines within which reasonable efforts can be provided. Under ASFA, reasonable efforts are provided within 12-15 months, after which permanency planning for the child must begin. When a child has been in care for 15 of the past 22 months (known as the 15/22 rule), the court must make a decision to either reunify the family or begin proceedings to terminate the parent's rights in order to "free the child" for adoption unless the court finds "compelling reasons" to act otherwise (ASFA, 1997; Edwards, 2007).

Certain circumstances exist under ASFA where states may choose to waive reasonable efforts and “fast track” the case to termination of parental rights. Under ASFA, aggravated circumstances range on a continuum in severity from the extreme of murder or manslaughter of another child of the parent, torture, chronic abuse, sexual abuse, and child abandonment to a parent who has had a prior termination of their rights (ASFA, 1997; U.S. GAO, 2003). States have discretion to add to the list of aggravated circumstances.

Permanency, reasonable efforts within timelines, and the aggravated circumstances provisions under ASFA have special implications for parents with substance abuse problems and their children (Hannett, 2007). These implications are further explored in the following analysis of ASFA as it pertains to foster children of parents with substance abuse problems.

Methods

Study Design

The method of analysis in this study is Eugene Bardach’s (2005) *A Practical Guide for Policy Analysis: The Eight Fold Path to More Effective Problem Solving*. Bardach’s framework consists of eight steps in the analysis of a policy: (1) telling a story, (2) assembling evidence, (3) defining the problem, (4) constructing alternatives, (5) selecting criteria, (6) projecting outcomes, (7) confronting trade-offs, and (8) making a decision. Bardach indicates that “telling the story” is actually the overall analysis and

not a separate step in the analysis. Therefore “telling the story” is not afforded a separate section in this paper as it encapsulates the analysis itself.

Analysis

Assembling Evidence

Evidence was assembled through a survey of peer-reviewed journals from systematic searches of the following databases: ProQuest Research Library, InfoTrac One File, Wilson Select Plus, Lexis Nexis Academic, and PsycINFO. Key words and phrases included: *Adoption and Safe Families Act, ASFA, foster care, permanency, child safety, child welfare policy, family reunification and preservation, termination of parental rights, and parental substance abuse*. These searches were confined to the years 1998-2011 and yielded 1,620 initial documents. The pool of literature was reduced to 111 documents using the following categories as inclusion criteria: (1) the intended and unintended outcomes of ASFA, and (2) the impact of ASFA on parents with substance abuse problems and their children.

Defining the Problem

Although adoptions out of foster care have increased by 57% since the inception of ASFA, the influx of children into care has increased at the same rate—the majority due to parental substance abuse (Barth, Lee, Wildfire, & Guo 2006; McDonald, Sidote-Salyers, & Testa, 2003). Despite the provisions of permanency, reasonable efforts within timelines, and aggravated circumstances, the foster care population has steadily remained

between 500,000 and 560,000 annually since 1997 (U.S. Department of Health and Human Services [USDHHS], 2011). The following section outlines the process used to assess the performance of states in achieving minimal standards of child safety, permanence, and well-being for welfare-involved families, and the problems inherent in the key provisions of ASFA under study in this analysis.

As an attempt to increase oversight of the foster care system, the U.S. Department of Health and Human Services (USDHHS) Administration for Children and Families (ACF) implemented the Child and Family Services Review (CFSR) process. The CFSR process assesses the performance of states in achieving minimal standards in the areas of child safety, permanency, and well-being.

Within the context of the CFSR, safety is defined as children who are protected from abuse and neglect and maintained safely in their homes (Courtney, Beedell, & Wulczyn, 2004). Permanency is defined as permanency and stability in living situations and continuity of family relationships and connections (Courtney et al., 2004). Family and child well-being are not separated as constructs and are defined as the capacity of a parent or foster parent to appropriately and adequately provide for children's educational, physical, and mental health needs (Courtney et al., 2004).

Therefore, state and local governments are left to interpret the loose definitions of safety, permanence, and well-being and to determine the level of risk to a child's well-being that warrants removal from the parents' care (Barth, Wulczyn, & Crea, 2005; Outley, 2004). Equally elusive are minimal standards that support a safe return to the parents' care. Given the broad definitions and lack of specific minimum standards, disparities naturally exist across jurisdictions (Barth et al., 2005; Outley, 2004). For

example, children may be removed from the home and parental rights may eventually terminated due to detrimental effects of parental marijuana use on the children in the home in one jurisdiction, while in a neighboring county an abuse and neglect case may not even be opened on a similar family. The lack of clarification of these standards and the subsequent different interpretations across jurisdictions impedes the effectiveness of the CFSR.

The CFSR process also has numerous methodological flaws that are cause for concern in the interpretation of the data (Schuerman & Needell, 2009a, 2009b). However, the CFSR is the national surveillance system to determine trends over extended periods of time and to provide investigators with national estimates.

CFSR reports reveal that since the enactment of ASFA, no state has been within compliance of these minimal standards for child welfare involved families and their children (USDHHS, 2007). In the first wave of CSFR reviews reported in 2003, only 38% of states met the national standard for reducing the recurrence of child abuse and neglect, and only 37% reduced the time in foster care to reunification without increasing number of children re-entering foster care. Only 28% of states met the national standard established for reducing the time children spent in foster care following termination of parental rights while waiting for adoption or other permanency options (USDHHS, 2003). According to the first wave of CFSR data, the average length of time a child spent in foster care from the termination of parental rights to adoption increased from 22 months pre-ASFA to 27 months post-ASFA (USDHHS, 2006). Consequently, under the CFSR process, all 50 states, the District of Columbia, and Puerto Rico were required to develop program improvement plans (Lou, Anthony, Stone, Vu, & Austin, 2008). The second

wave of the CFSR indicates that most states met the goals of their improvement plans but still fell short of achieving the minimal standards set by the federal government for child safety, permanency, and well-being (USDHHS, 2011). These concerns prompt a critical analysis of the three key components of ASFA: permanency, reasonable efforts, and aggravated circumstances.

In the simplest form, permanency is defined under ASFA as a stable and permanent home. The assumption under ASFA is that the legal termination of parental rights will “free the child for adoption” (Hannett, 2007). From a purely legal standpoint this is true. However, children often remain emotionally attached to their parents and extended family members; family connections are often not maintained with the child after parental rights have been terminated (Edwards, 2007). The loss through death or separation from a parent, even a substance-abusing parent, is mourned very deeply by children (Kroll, 2004). The loss of a sense of belonging and connectedness to their biological family, changing schools, moving, and losing touch with friends are additional stressors for these children (Kroll, 2004). Parental losses experienced in childhood are associated with hostility and depression in adulthood (Kroll, 2004).

Although children may experience increased stability and receive mental health services in foster care, the rates for emotional and behavioral problems of children in care continue to be above average (Kroll, 2004). The effects of the loss of a parent on children are especially pertinent for children with parents with substance abuse problems. Children of parents with substance abuse problems are more likely to have their parental rights terminated and to spend longer than average periods of time in foster care than children of non-parents with substance abuse problems (Brook & McDonald, 2009; Fuller & Wells,

2003; Smith & Young, 2003). Although these children may be legally free for adoption, they remain locked in the system, as there is a shortage of families willing to adopt children with these special needs (U.S. GAO, 2003).

ASFA does not recognize long-term foster care as an acceptable permanency option; however, it remains an unrecognized reality for many children (Edwards, 2007). Of the approximately 115,000 children freed for adoption each year through the termination of parental rights, only 50,000 are actually adopted, 41,000 “legal orphans” continue waiting in foster care for an adoptive home, and 24,000 turn 18 and age out of the system (Barth et al., 2005; Wertheimer, 2002; Woodhouse, 2005). The foster care system was not intended as a place for children to grow up (Edwards, 2007).

Children who age out of the system have poor outcomes as they enter adulthood, often without biological or adoptive family supports (Barth et al., 2005; Wertheimer, 2002; Woodhouse, 2005). These young adults leave foster care to face increased risks of homelessness, mental health problems, incarceration, as well as lack of health insurance and a high school diploma (D’Andrade & Berrick, 2006).

The states bear the costs of the tragic outcomes of legal orphans. The termination of parental rights also means the termination of parental responsibilities to pay child support for the child’s remaining stay in foster care, shifting the entire financial burden of foster care for these children to the states (Barth et al., 2005; Wertheimer, 2002; Woodhouse, 2005). Given the 41,000 legal orphans with no adoptive home identified and the 24,000 children who age out of the foster care system annually, one must question the effectiveness and efficiency of a policy that terminates parental rights and financial

responsibilities for a child when no adoptive home has been identified (Barth et al., 2005; Wertheimer, 2002; Woodhouse, 2005).

The provision of substance abuse treatment is considered a reasonable effort that states must provide under ASFA (1997) to reunify families. States report a shortage of available substance abuse treatment and a lack of funding for treatment as primary barriers to family reunification (Green, Rockhill, & Furrer, 2006; Hannett, 2007; USDHHS, 1999; U.S. GAO, 2007). In addition to the lack of accessible and appropriate substance abuse treatment, the mandated timelines under the reasonable efforts component of ASFA to either terminate parental rights or reunite families—the 15/22 rule—is problematic for parents with substance abuse and dependency issues, especially those who are incarcerated (Hannett, 2007).

Research shows a positive correlation between the length of stay in substance abuse treatment and a positive prognosis with 12 months as a minimum (Center for Substance Abuse Treatment (CSAT), 1996; Hubbard et al., 1989; Marlowe, D’Matteo & Festinger, 2003; Simpson & Sells, 1983). Waiting lists, however, are among the most common barriers reported by those seeking treatment (Edwards, 2007; Redko, Rapp & Carlson, 2006). For example, a study conducted by Rockhill, Green, and Furrer (2007) found that it takes mothers seeking substance abuse treatment approximately 3 months to enter treatment, and that once in treatment over, half were not able to complete. The 3 months these mothers wait for treatment equates to 25% of the 12-month ASFA timeline.

States can be sanctioned financially if they do not adhere to ASFA timelines (Courtney et al., 2004; Edwards, 2007). The average time served for mothers incarcerated due to drug delivery ranges from 80-103 months—far exceeding the time allotted for

family reunification under ASFA (Swann & Sylvester, 2006). Substance abuse treatment must first be available and then barriers to access must be removed before it can be effective (Hannett, 2007). The shortage of substance abuse treatment available, coupled with the minimum recommended length of stay, collide with the timelines of ASFA.

Under ASFA, states are allowed to deviate from the timelines if they find “compelling reasons” to do so (Hannett, 2007). States could reconcile the shortage of treatment and barriers to accessing treatment with the timeline for reasonable efforts by defining this problem as a compelling reason to extend the timeline for reasonable efforts to be provided; however, few states do so. For example, if a parent was substance free and progressing in treatment for 11 months, but then relapsed (not uncommon in the first year of treatment), the extended period of sobriety prior to the relapse could be deemed a compelling reason to extend the timelines in this case (Hannett, 2007). Broadening the interpretation of compelling reasons to extend the timelines could “lessen the sting of ASFA” for parents with substance abuse problems and their children (Hannett, 2007). Bardach (2005) identifies an overlooked or underused opportunity such as the “compelling reasons” option for states as a “latent opportunity.”

ASFA (1997) provides for states to waive reasonable efforts to reunify families and move directly to termination of parental rights in situations including the murder or manslaughter of another child of the parent, torture, chronic abuse, sexual abuse, and child abandonment, or a prior termination of parental rights (Day, 2005). This list of aggravated circumstance is a guideline that states may follow as written or modify at their discretion (Edwards, 2007). Six states have added the criterion of extensive histories of parental substance abuse as an aggravated circumstance (D’Andrade & Berrick, 2006;

Edwards, 2007). This is concerning given the shortage of substance abuse treatment available.

In summary, the problems under ASFA are many. Although adoptions have increased by 57% under ASFA, the size of the foster care population has remained steady and consists, to a large extent, of children with parents with substance abuse problems (Barth et al., 2006; McDonald et al., 2003). There are shortages of evidence-based substance abuse treatment for parents such as FDTCs (Hannett, 2007). The mental and physical costs for the children as well as the financial burden for society are untenable. The CFSR process requires methodological improvements. States need support and guidance based on research in their efforts to implement the mandates of ASFA of assessing, promoting, and measuring child safety, permanence, and well-being. The key provisions under ASFA of permanency, reasonable efforts within timelines, and aggravated circumstances need to be revisited in cases where children are in care due to parental substance abuse and dependency (Edwards, 2007). The next step in Bardach's policy analysis is to construct alternatives to ASFA.

Constructing Alternatives

Bardach (2005) recommends that the researcher consider letting the present trends continue under the policy as written as an option when analyzing policy. Therefore, to continue under the mandates of ASFA without revision is the first option in this analysis in addition to two proposed alternatives: (1) revise ASFA based on the recommendations of the Children's Defense Fund (CDF) (2006) and the Pew Commission (2004), and (2) adopt alternative number one and institutionalize FDTCs in all family dependency

courts and increase research efforts to support states in defining, supporting and measuring child safety, permanency, and well-being. According to the Bardach framework, examination of the possible outcomes of each alternative comes later in the process. The next section reviews both proposed alternatives.

The first proposed alternative is to revise ASFA based on the combined recommendations from the Children's Defense Fund (CDF, 2006) and the Pew Commission (2004). These recommendations include a redistribution of existing funding to cover a continuum of services that span from before a child enters care, to during care, and following their exit from care; the extension of financial incentives to states to include all permanency options; and an increase in states' accountability to improve the safety, well-being, and permanency outcomes for children in the care of the state.

The first recommendation of the CDF/Pew Commission alternative is to amend existing federal funding utility criteria. Under ASFA, 90% of federal funding is available only to parents and children once the children enter foster care. Only 10% of the funding is available for services to prevent child abuse and neglect placement or for family reunification. The CDF/Pew Commission alternative proposes redistribution of existing funding to cover a continuum of services that spans from services prior to placement, during care, and after care. Under this alternative, financial supports and services will be provided to help youth who age out of foster care as well as to support adoptions and all permanency options (CDF, 2006; Pew Commission, 2004). By redistributing existing federal funding, parents with substance abuse issues will increase their ability to access treatment prior to removal of their child, allowing for treatment of sufficient duration to positively impact child and family outcomes.

The second recommendation of the CDF/Pew Commission alternative suggests amending financial incentives to states, from incentives for adoptions only to incentives for all permanency outcomes, including long-term foster care based on differing needs of individual youth and families. This would shift the focus equally to all permanency options and reward states for achieving permanency based on the individual needs of children and families.

The final recommendation in the CDF/Pew Commission is to increase states' accountability of efforts to improve the safety, well-being, and permanency outcomes for children (Pew Commission, 2004). Each state's progress in implementing ASFA mandates is assessed through the Child and Family Services Review (CFSR) process. The findings of CFSR reports spurred this recommendation.

The second alternative in this analysis adopts the recommendations in the CDF/Pew Commission alternative with the two additional recommendations by this researcher: (1) institutionalize FDTCs in all jurisdictions; and (2) promote further research to support states' efforts in providing for the safety, permanence, and well-being of children in care.

Institutionalizing FDTCs in every jurisdiction increases the access to and availability of substance abuse treatment, furthering the efforts the National Association of Drug Court Professionals (NADCP, 2009) to "put a drug court within reach of every citizen in need." According to a research brief for the Center of Court Innovation titled "The Challenges of Going to Scale," there are two possible approaches to institutionalizing FDTCs in every jurisdiction: (1) increase the number of FDTCs, and (2) integrate FDTC practices into existing family courts (Farole, 2006). To increase the

number of FDTCS, the U.S. Bureau of Justice and a handful of states have provide substantial financial supports for jurisdictions planning, implementing, and enhancing FDTCS.

The second approach to institutionalizing FDTCS is to integrate the Ten Key Components of Drug Courts—the way of doing business in FDTCS—into traditional family court proceedings (Cissner & Rempel, 2005). The integration approach has not been systematically implemented, but anecdotal reports from judges and attorneys involved in both FDTC and traditional family dependency track cases indicate an “overflow” of some FDTC practices into traditional case processing.

Drug courts, including FDTCS, have widespread support at the federal level. The NADCP consists of professionals and private citizens who promote the expansion of drug courts in every jurisdiction. Their collaborative partner, the National Drug Court Institute (NDCI), promotes education, research, and scholarship that support and improve problem-solving courts such as FDTCS. The NDCI is supported by the White House Office of National Drug Control Policy; U.S. Department of Justice; Office of Justice Programs through the Bureau of Justice Assistance; Office of Juvenile Justice and Delinquency Prevention and the National Institute of Justice; U.S. Department of Health and Human Services, Substance Abuse & Mental Health Services Administration through the Center for Substance Abuse Treatment; and the State Justice Institute (NDCI, 2009).

In addition to adopting the recommendations of the CDF and Pew Commission and the institutionalizing of FDTCS in every jurisdiction, this alternative recommends increased research efforts. The proposed research areas are (1) defining, promoting, and measuring child well-being that includes the constructs of safety and permanency;

(2) improving the CFSR process and methodology; (3) the effects of projects who broaden the definition of compelling reasons in cases of parental substance abuse; and (4) a cost benefit analysis of not terminating parental rights for children in long-term foster care. The next step in the Bardach framework of policy analysis is to select criteria to measure the projected outcomes of each alternative.

Selecting Criteria

In keeping with the Bardach (2005) framework, evaluative and practical criteria are used in this analysis to measure projected outcomes of continuing under ASFA as well as for the proposed alternatives. Three criteria were selected by this researcher for use in this analysis. The evaluative criteria selected in this study include (1) efficiency—cost effectiveness, and (2) equality—access to resources and opportunities. The third criterion used in this analysis is a practical criterion: political feasibility—the ease of implementation of the policy. As supported by Bardach, the equality criterion is given more weight than the efficiency or political feasibility criteria in this analysis to accommodate for the marginalized populations of foster children and parents with substance abuse problems. Though separated for the purposes of this analysis, the constructs of efficiency, equality, and political feasibility are intertwined and overlap. The next step in this analysis is for the researcher to project possible outcomes for each alternative.

Projecting Outcomes

Outcomes of continuing under ASFA with no revisions and those of the two proposed alternatives are projected in the section. Each are evaluated using the criteria of efficiency, equality, and political feasibility, with equality being the most heavily weighted of the criteria.

Letting current trends continue under ASFA will likely continue to result in an annual foster care population of over 500,000. A 57% increase in adoptions of children out of foster care since the inception of ASFA has resulted in a savings of approximately \$1 billion per year, compared the costs of long-term foster care (Barth et al., 2006; McDonald et al., 2003). Due to the paucity of data collected and research prior to ASFA, the direct cause of increased adoption rates cannot be linked directly to ASFA (O'Neill-Murray, 2004). Additionally, costs have not been calculated for the 65,000 children in care each year whose parents' rights were terminated, shifting financial responsibilities for the child to the state (Barth et al., 2005; Wertheimer, 2002; Woodhouse, 2005). For every dollar spent on evidence based child abuse and neglect prevention programs, savings range from \$2.00 to \$19.64 (Reynolds, Temple, Robertson & Mann, 2001; Swisher, Scherer & Yin, 2004), yet ASFA appropriates only 10% of federal funds to child abuse and prevention programs (Pew Commission, 2004). When considering funding lost by terminating parents' financial responsibilities along with their rights and the allocation of only 10% of funding to abuse and neglect prevention, ASFA does not meet the efficiency criteria of being a cost-effective policy.

Barriers of access to substance abuse treatment and the lack of resources allocated for parents with substance abuse problems is projected to continue under ASFA without amendments. Even though 40-80% of the 500,000 children in care have parents with substance abuse problems, ASFA neither earmarks funding for mandated evidence-based treatment for parents, nor does it allow for timelines to be adjusted to accommodate for substance abuse treatment that is long enough to be effective (Badeau & Gesiriech, 2004; D'Andrade & Berrick, 2006; Kortenkamp & Erhl, 2002; Malluccio & Ainsworth, 2003; Smith et al., 2005). Without clarification of standards for providing and measuring child well-being, disparities across jurisdictions are likely to continue. Therefore, ASFA without amendments does not provide for equality, which is the most heavily weighted criterion in this analysis.

The intent of ASFA was to reduce the foster care population; however, this has not been achieved. ASFA without amendments does not meet the efficiency criteria as it is not cost effective. It does not meet the equality criteria when applied to parents with substance abuse and dependency treatment needs and their children. Due to the costs to society, continuing ASFA without amendments is not politically feasible. This option is not considered viable.

The CDF/Pew Commission alternative recommends redistributing existing federal funding from the current emphasis on services and treatment for parents with substance abuse problems and their children only after they have entered care, to funding of services across the continuum from prevention to aftercare. If evidence-based services are implemented and accessible, this redistribution of funds could yield financial returns. However, the redistribution of funding could be moot if the shortage of substance abuse

treatment is not addressed (Green et al., 2006; Hannett, 2007; USDHHS, 1999; U.S. GAO, 2007). Without accessible evidence-based substance abuse treatment, outcomes for parents with substance abuse problems and their children may not change. Substance abuse treatment for parents is the fulcrum for the foster care population (Hannett, 2007). For every dollar spent on substance abuse treatment, \$4 to \$7 are spent on continued stays in foster care (Hannett, 2007). Although the CDF/Pew Commission alternative will make improvements to ASFA, it will still not be cost effective because it does not specifically address the access and shortage problems in substance abuse treatment for parents. Because of this, the efficiency criterion is not met for the proposed CDF/Pew Commission alternative.

Under the CDF/Pew Commission alternative, even though services are projected to be more equally distributed along the continuum of prevention to aftercare, parents in need of substance abuse treatment will likely continue to be marginalized due to treatment shortages and the corresponding waiting lists (Green et al., 2006; USDHHS, 1999; U.S. GAO, 2007). Clarification of standards for assessing, providing, and measuring child safety, permanency, and well-being is not provided; therefore, disparities across jurisdictions are projected to remain. Although the CDF/Pew Commission alternative makes improvements to ASFA in that child abuse and prevention services and after care supports will increase, it also falls short of meeting the equality criterion, as parents with substance abuse and dependency problems and their children will continue to be marginalized.

Political feasibility to implementing a policy that aims to improve on ASFA is likely to be high considering the failure to reduce the foster care population under ASFA.

The potential cost effectiveness of providing evidence-based practices to prevent placement and reunify families is projected to appeal to the multiple systems that are currently bearing financial burdens due to the costly outcomes of children in care and for those who age out of care. The problems with equality for this alternative are projected to remain secondary for legislators at first glance when considering initial cost-benefit projections. However, the voice of the NADCP, supported by research, may bring to light shortcomings of this alternative as it pertains to parents with substance abuse problems and their children—the bulk of the foster care population. Unless legislators use available research on the effectiveness of FDTCs to address the shortage of substance abuse treatment for parents, the proposed CDF/Pew Commission is not projected to be politically feasible.

The CDF/Pew Commission recommendations will likely improve outcomes for children and families under ASFA. However, because these recommendations do not address the connection between parental substance abuse and the foster care population, the criteria of efficiency, equality, or political feasibility are not met. The next section projects the outcome of the second proposed alternative.

The last alternative builds on the recommendations of the CDF and Pew Commission. Recommendations include placing an FDTC in all local jurisdictions and increasing research efforts in the following areas: (1) defining, promoting, and measuring child well-being that includes the constructs of safety and permanency; (2) improving the CFSR process and methodology; (3) the effects of projects who broaden the definition of compelling reasons in cases of parental substance abuse; and (4) a cost benefit analysis of not terminating parental rights for children in long-term foster care.

The institutionalization of FDTCs in all jurisdictions will address the lack of substance abuse treatment. When comparing drug-related recidivism and mandatory substance abuse treatment either in place of or in tandem with incarceration, treatment is more effective and less expensive than incarceration (Caulkins, Rydell, Schwebe, & Chisa, 1997). The decrease in criminal recidivism rates associated with drug court participants amount to an estimated annual savings to taxpayers of \$1.5 million per drug court jurisdiction (National Institute of Justice [NIJ], 2006). The cost of substance abuse treatment under the drug court model has been found to be approximately 30% less than costs associated to traditional treatment models, saving between \$4 to \$7 for every dollar spent (NIJ, 2006).

Research on well-being is projected to provide states with a universal definition of well-being, which will improve the ability of states to assess, promote, and measure this construct uniformly. Improvements to the CFSR process and methodology are projected to produce results for states that are meaningful and can be used to improved effectiveness. Research on the broadening of the compelling reasons to extend ASFA timelines for parents with substance abuse problems is projected to align with previous research that supports longer stays in treatment. Successful treatment outcomes for parents are projected to result in less re-entry of their children into foster care. Reducing parental substance abuse will reduce the financial burden of the systems currently bearing the weight of the negative effects of parental substance abuse on children. Finally, by not terminating parental rights when there is no adoptive family identified for the child, parents with substance abuse problems who are not fit to act as custodial parents to the child could act as non-custodial parents. Visitation between the child, parent, and

extended family members could be maintained at an optimally safe level, supporting established emotional attachment and bonding. Parents could remain financially responsible for the child, similar to court orders for custody and visitation in divorce cases (Roberts, 1999).

Under family law, a non-custodial parent may lose visitation rights, but is still mandated to financially support the child. Financial support is viewed as the right of the child (Carlson, 1998; Carpenter-Emery, 2005; Roberts, 1999). For children in long-term foster care, if parental rights are not terminated, the parent could be held financially responsible for the child through mandated child support payments until the child turns 18, reducing the financial burden on the state. Applying visitation and child support practices from family law to children in long-term foster care is a latent opportunity—defined by Bardach (2005) as solutions that have been previously overlooked. Collection efforts of child support could continue as currently implemented prior to termination of the parents' rights.

Current research supporting the cost effectiveness of drug courts, in addition to projected cost savings by increasing the effectiveness of the CFSR process, broadening compelling reasons language for parents with substance abuse problems, and shifting the financial burden of children in long-term foster care back to the parent all point to increased efficiency. Based on these projected outcomes, this alternative meets the efficiency criterion.

In assessing the proposed FDTC and increased research alternative for equality, by providing access to and availability of substance abuse treatment, this alternative is elevated above the other options. In addition, other problems identified under ASFA,

including the need for clarification of standards for assessing, providing, and measuring child safety, permanence, and well-being, improvement in the CFSR process, broadening the compelling reasons to accommodate treatment for parents with substance abuse problems, and allowing for continued connections between children in long-term foster care and their families of origin, all speak to leveling the playing field for the vulnerable populations of foster children and parents with substance abuse problems. The FDTC and increased research alternative meets the equality criterion, as it addresses the needs of the marginalized population of parents with substance abuse problems and their children in care.

The cost effectiveness and low recidivism rates associated with drug courts are projected to ease some implementation challenges associated with institutionalization of the FDTCs. Resistance may come from critics who maintain that punishment is more effective than treatment for substance abusers, and that children's emotional ties to their parents are severed by terminating parental rights (Hannett, 2007). However, the research literature does not support this stance. Additionally, resistance may be decreased by holding parents financially responsible for the costs of long-term foster care for their children.

To increase the political feasibility of this alternative, FDTCs must be marketed to legislators and the public as associated with high returns on investment. A media campaign to raise awareness should focusing on the following points: (1) research findings on the genetic components of drug and alcohol addiction, (2) costs of treatment as compared to costs of incarceration and long-term foster care, (3) effectiveness of treatment as part of the court process for appropriate populations as opposed to attempts

to “punish” the addiction away, (4) the shortage of and barriers to accessing substance abuse treatment for the under- or uninsured, (5) prevalence and subsequent costs of substance abuse to society, and, finally, (6) research results that show bipartisan public support for reallocating funding to drug prevention, treatment, and recovery efforts as opposed to incarceration (Hannett, 2007). Under this plan, the FDTC and Increased Research alternative is a politically feasible option under this analysis. The next step in this analysis is to look at the trade-offs, or the pros and cons, of adopting one option or alternative over another.

Confronting Trade-offs

By mandating termination of parental rights to free children for adoption, ASFA shifts the entire financial burden of caring for children in long-term foster care to the state. ASFA also traded an increased emphasis on adoption for a decreased emphasis on preventing placement or reunifying families by offering financial incentives to states for each completed adoption. By neglecting to attend to the effect of parental substance abuse on the numbers of children entering care, the foster care population was not reduced under ASFA. While the number of adoptions did increase, the foster care population did not decrease and the number of children in long-term care remained constant, thus negating any cost savings that might have occurred. The costs to children, families, and society outweigh the increased number of adoptions.

If long-term foster care is formally recognized as an acceptable permanency option when there is no adoptive family identified, as proposed under both the CDF/Pew Commission and FDTC increased research alternatives, foster-adopt parents—families

who provide foster care solely as a means to adopt a child—may decrease. However, foster parents whose intentions are to provide short-term support for children until they are either reunited with their parent or adopted may increase. The next step in Bardach's (2005) framework for policy analysis is to decide which option or alternative to choose.

Results

Decide

Although adoptions of children from foster care have increased since ASFA, the foster care population remains at an intolerable 500,000 children annually. Letting current trends continue under ASFA without amendments is rejected, as it does not meet the efficiency, equality, or political feasibility criteria in this analysis. Although the recommendations under the CDF/Pew Commission alternative aim to increase the efficiency and equality of ASFA, it still falls short of meeting the criteria for this analysis and is rejected without the enhancements of the FDTC and Increased Research alternative.

The FDTC and Increased Research alternative builds on progress made under ASFA and adopts and enhances the recommendations of the CDF and Pew Commission. The FDTC alternative meets the efficiency, equality, and politically feasible criteria of this analysis. Based on the results of this analysis, adopting the CDF/Pew Commission with FDTCs and Increasing Research alternative is the preferred choice.

Discussion

ASFA is a complex policy that addresses complex needs. Proponents tout an increase in adoptions of children out of foster care. Critics point to the numbers of children continuing to enter care due to parental substance abuse and remaining in long-term foster care. Both perspectives are accurate. By providing incentives to states for the number of adoptions completed while neglecting to attend to the causes of children entering care, the foster care population under ASFA has not been reduced (Barth et al., 2006; McDonald et al., 2003). The effects of parental substance abuse on the foster care population were not considered under ASFA.

Children of parents with substance abuse problems continue to enter foster care and stay longer than children of non-parents with substance abuse problems, with decreased chances of reunification (Smith, 2003). The findings in the Child and Family Services Improvement Act (CFSIA) stated that methamphetamine use increased by 72% between 1996 and 2006, particularly in women of child-bearing age. Meth was reported as a major cause of child abuse and neglect and an increase in out-of-home placements for children (CFSIA, 2006).

Due to the special needs of children from parents with substance abuse problems, finding adoptive homes for them is less likely. The longer they remain in foster care, the less likely adoption becomes. Under ASFA, during the first 15-22 months in care, these children are waiting for their parents to be able to find, access, and successfully complete substance abuse treatment in hopes of reunification. If reunification is unsuccessful, the average child waits for 42 months to be adopted (Smith et al., 2005). Many languish in

foster care until they turn 18 and age out. Upon “graduation” from the foster care system, the wait is over for these children. However, lacking necessary supports for a successful launch into adulthood, their future is not bright. Without changes, the cycle of parental substance abuse and subsequent child maltreatment repeats itself when these children become parents (Skowrya & Cocozza, 2007).

ASFA imposed rigid eligibility for federal funding, which allows only 10% for evidence-based programs that prevent child abuse and safely preserve and reunify families. This mandate produced the unintended consequence that in order for children and families to access services, the children must be taken into care before parents can access substance abuse treatment. The problems under ASFA must be addressed.

The FDTC and Increased Research alternative in this analysis allows for states to access funds equally to prevent or reduce child abuse and neglect, to reunify families, to promote adoptions, and to preserve all forms of permanency. Institutionalizing FDTCs increases options to safely reunify families through substance abuse treatment. Supports are increased for achieving and preserving adoption and other long-term permanent homes for children. In 2005, according to the USDHHS (2007), 1,460 children died in the U.S. from abuse and neglect. Non-fatal child maltreatment cases ranged from 4,300 to 4,900 per 100,000 children (USDHHS, 2007). Preventing child abuse in any amount eases economic stressors across disciplines and systems as well as for society and is humane.

The FDTC and Increased Research alternative is an interdisciplinary approach to address societal and systemic contributors to the foster care boom. Research to support the alignment of legislation for parents of children in long-term foster care with

comparable legislation for non-custodial parents in family law will begin to address the problems of legal orphans and the financial burden on the states. Guidance in the development of a universal definition of well-being will increase the effectiveness of the CFSR process. Extending the timeline for reasonable efforts for parental substance abuse treatment under the compelling reasons clause will increase the likelihood of family reunification.

Changes of this scale are difficult and evolve slowly. The progress made under ASFA should be built on. Given that child welfare policies address the most vulnerable population in our society, deliberate consideration of intended and unintended consequences is necessary prior to any modification of the existing policy.

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CHAPTER III

HOWES' THEORY OF EMOTIONAL PERMANENCE: A GROUNDED THEORY STUDY OF WELL-BEING IN FAMILY DEPENDENCY TREATMENT COURTS

The aim of this study is to generate theory that is grounded in data in the area of well-being to inform policy makers and practitioners in the field of child welfare. Most of theories of wellness and well-being in the literature are conceptual in nature and are not grounded in data (Roscoe, 2009). No standard, universally accepted definition of well-being exists. However, the Adoption and Safe Families Act (ASFA) of 1997 mandates that states provide services that promote and maintain family and child well-being in order to safely preserve or reunify families or provide an alternative “permanent” home for the child in a timely manner. In order for states to carry out this mandate, an integrated comprehensive definition of well-being must be adopted by federal and state governments. Once a standard definition is identified, wellness inventories can be developed, studied, and explored to accurately measure the states’ abilities to promote and maintain the well-being of families and children with child welfare involvement.

Background and Significance

The need for the research for this paper is well documented in the literature. The U.S. Department of Health and Human Services (USDHHS, 2006) Administration for Children and Families (ACF) recommended that states conduct comprehensive assessments for children in care with an emphasis on measuring child well-being.

However, the ACF did not identify a standard definition of child well-being beyond the indicators previously stated (D'Andrade, Osterling, & Austin, 2008; Lou, Anthony, Stone, Vu, & Austin, 2008). In the document entitled *Kids are Waiting – Fix Foster Care Now*, the Pew Commission (2007) states that the performance of family dependency courts could benefit from defined measures of child well-being and called for research in this area. In addition, a paucity of literature exists on FDTCS when compared to the extent that adult drug courts have been studied (Belenko, 2002). In a four-site national study on the effectiveness of FDTCS conducted by Green, Rockhill, and Furrer (2007) and Green, Furrer, Worcel, Burrus, and Finigan (2007), research on assessing well-being is also recommend. Green, Rockhill, et al. and Green, Furrer, et al. refer to a common goal of FDTCS as improving child outcomes and that research on child well-being and steps towards determining the best way to assess well-being is needed. Green et al. also cite a need for research on families to assist judges and other professionals in making decisions that are based on the assessment of child safety and stability to prevent recidivism in child abuse and neglect.

Family Dependency Treatment Courts (FDTCS) are an optional, innovative approach that operate under ASFA to safely preserve or reunite families with the problem of child abuse and neglect primarily due to parental substance abuse (Wheeler & Fox, 2006). In FDTCS, an interdisciplinary team of defense and prosecuting attorneys, social workers, psychologists, judges, and social services representatives use a wraparound team approach. FDTCS address all life domains of both parents and children to provide substance abuse treatment and ancillary services in a non-adversarial manner (D'Angelo, 2002; Wheeler & Fox, 2006). Improving the well-being of participating parents and

children is a primary focus of FDTCs, making them a source of rich data for this explorative study.

This study is significant in that it explores the structure and dimensions of well-being or wellness using a method that is grounded in data, thus far lacking in the literature (Roscoe, 2009). The following section details the scope and depth of the problem of assessing, promoting, and measuring well-being without a universal definition.

Statement of the Problem

The problem under analysis in this study is the operationalization of the construct of well-being without a commonly agreed-upon definition. Without a definition, practitioners and researchers are hard pressed to uniformly assess, support, and measure progress of the well-being of children and families. Parental substance abuse contributes to 40-80% of the 500,000 children in foster care annually (Badeau & Gesiriech, 2004; D'Andrade & Berrick, 2006; Kortenkamp & Erhl, 2002; Maluccio & Ainsworth, 2003; Smith, Elstein, & Klain, 2005). The well-being of these children is guided by the mandates of ASFA and monitored by the CFSR process (U.S. GAO, 2003). The problems in the foster care system are many.

Children enter the child welfare system with numerous physical, mental health, and educational problems (Carlson, 1998; Vandivere, Chalk, & Anderson-Moore, 2003; Wulczyn, Lijun, & Hislop, 2006). Once in care, they continue to suffer from high rates of developmental delays and emotional and behavioral problems (Carlson, 1998; Vandivere et al., 2003; Wulczyn et al., 2006). Even after children are adopted from foster care, they have high levels of cognitive, emotional, and behavioral challenges and ongoing

emotional attachment to their biological parents and extended family members (Kortenkamp & Erhl, 2002; Perez, O'Neill & Gesirech, 2003). The scope of the problem is immense.

The number of children in the U.S. foster care system nearly doubled between 1985 and 1997—from 276,000 to 500,000 (USDHHS, 2006). In 1997, the Adoption and Safe Families Act (ASFA) was enacted to reduce the foster care population; however, it steadily remained between 500,000 and 560,000 for the next decade (Swann & Sylvester, 2006; USDHHS, 2007). Of these children, 40-80% (200,000- 448,000) are in care due to parental substance abuse (Badeau & Gesiriech, 2004; D'Andrade & Berrick, 2006; Kortenkamp & Erhl, 2002; Malluccio & Ainsworth, 2003; Smith et al., 2005). Providing services for a growing population of children who have been exposed to illegal drugs was projected to be a major challenge for state child welfare systems from 2007-2011 (U.S. GAO, 2007). Children with parents who abuse substances are at risk of suffering from problems with attention, language, learning, and behavior leading to emotional disorders, school failure, and conduct problems (Gwynne, Blick, & Duffy, 2009).

Of the numerous components of ASFA, two have implications for family and child well-being. The first is the requirement that states make reasonable efforts to provide a “safe, permanent home” for abused and neglected children. The second ASFA component that is challenging to family and child well-being is the timelines imposed on states to make these reasonable efforts.

Under ASFA, reasonable efforts include counseling, substance abuse treatment, mental health services, domestic violence services, temporary child care services, and “therapeutic services for families including crisis nurseries” (ASFA section 305, 1997;

Smith et al., 2005). One problem in implementing this mandate is a shortage of available substance abuse treatment and a lack of funding for treatment for Medicaid and indigent populations (Green, Rockhill, & Furrer, 2006; USDHHS, 1999). FDTCS are a reasonable effort to safely reunify families. Although 40-80% of families with children in foster care have parents with substance abuse problems, only 323 FDTCS existed in the U.S. as of 2010—an average of less than 7 per state (Badeau & Gesiriech, 2004; D'Andrade & Berrick, 2006; Kortenkamp & Erhl, 2002; Malluccio & Ainsworth, 2003; NADCP, 2011; Smith et al., 2005). FDTCS generally depend on competitive federal and state grants for funding.

The second ASFA mandate that impacts the well-being of child welfare-involved parents and children is the timelines that are imposed on states in which to provide reasonable efforts to achieve a safe and permanent home for children (Hannett, 2007). The timelines mandate was developed in response to reports that children were languishing in foster care for years. ASFA (1997) aims for states to reach permanency by providing a permanent home for each child through the use of reasonable efforts within 12 to 15 months from the date that the child was removed from their parent's care. At a maximum, ASFA requires that after a child has been in care for 15 of the past 22 months, the state must make a decision to either reunify the child with the biological family or begin proceedings to terminate the biological parent's rights in order to "free the child" for adoption. This is known as the 15/22 rule.

Theoretically, by terminating the rights of parents in accordance to the 15/22 rule, children are freed from the ties of their biological family and available for adoption in an effort to reduce the child's length of stay in foster care (Hannett, 2007). When parental

rights are terminated, the emotional attachment between the child and immediate and extended family members is disrupted, especially in cases when the child is not placed in care with a relative (Barth, Wulczyn, & Crea, 2005; Wertheimer, 2002; Woodhouse, 2005). The 15/22 rule creates “legal orphans” in cases where there is no adoptive family identified for a child and the parents’ rights are terminated.

Under ASFA, there are approximately 115,000 legal orphans waiting to be adopted each year (Barth et al., 2005; Wertheimer, 2002; Woodhouse, 2005). Only 50,000 (43%) are actually adopted, while approximately 24,000 (21%) age out, and the remaining 41,000 (36%) wait in foster care until they reach 18 years of age or an adoptive family comes along (Barth et al., 2005; Wertheimer, 2002; Woodhouse, 2005). As each year the child spends in foster care passes, the likelihood of adoption diminishes (Barth et al., 2005; Wertheimer, 2002; Woodhouse, 2005). When children age out of the system, they often leave with no source of financial or emotional support (Wertheimer, 2002). Their well-being is seriously compromised and they are likely to have substance abuse, health and legal problems, as well as lower educational levels, and higher levels of homelessness (Wertheimer, 2002).

The 15/22 rule is especially pertinent to parents with substance abuse problems (Hannett, 2007). When substance abuse treatment is accessed, the minimum duration proven to be most effective is 12 months (Center for Substance Abuse Treatment [CSAT], 1996; Hubbard et al., 1989; Simpson & Sells, 1983). However, the timelines mandated under ASFA do not allow for extra time for parents to access and complete substance abuse treatment (Hannett, 2007). Therefore, a parent could exit a substance

abuse treatment facility successfully after a year to find his or her parental rights being terminated due to the 15/22 rule (Green et al., 2006).

In 2001, as an attempt to assess the effectiveness of states' promotion and maintenance of the well-being of families and children with child welfare involvement, the U.S. Department of Health and Human Services Administration for Children and Families' (ACF) Children's Bureau launched the Child and Family Services Review (CFSR) (U.S. GAO, 2004). Under the CFSR, 14 outcomes are assessed for each state: 7 of these outcomes assess the child and family in terms of safety, permanency, and well-being, and 7 assess systemic outcomes (D'Andrade et al., 2008; U.S. GAO, 2004).

The CFSR does not provide a definition of well-being, yet attempts to measure it by the following indicators: the identified needs of the child, parents, and foster parents and the services provided; the involvement of the child and family in case planning; the number and frequency of child welfare worker visits with the child; the number and frequency of child welfare worker visits with the parent; the identified educational, physical, and mental health needs of the child and the services provided (D'Andrade et al., 2008, Tilbury, 2004).

The data quality problems of the CFSR are many (U.S. GAO, 2003). The CFSR uses only qualitative data to measure child well-being. Data are gathered from a small number of case reviews and interviews conducted at a few sites in each state. Site and case selection is not randomized and the sample size is not based on a power analysis to ensure a large enough sample for generalizability, yet the results are generalized to represent an entire state (U.S. GAO, 2004). State officials, child welfare experts, and

researchers question the reliability of the data and the validity of the measures used in CFSR (Courtney, Beedell, & Wulczyn, 2004; U.S. GAO, 2004).

Based upon the results of the initial CFSRs conducted in each state from 2001-2003, no state was within compliance of the minimal standards set forth by the federal government. As a result and to avoid financial sanctions, all 50 states, the District of Columbia, and Puerto Rico were required to develop program improvement plans (Lou, et al., 2008). According to the CSFR results, the two areas most frequently identified as needing improvement were assessing the needs and services of children, parents, and foster parents, and assessing the mental health of the child. States also consistently cited inadequate levels of mental health and substance abuse services available to children and families as barriers to improving their outcomes on child well-being (U.S. GAO, 2003).

Due to the methodology of the reviews, the CFSR could be over- or underestimating the degree that states are meeting the needs of child-welfare involved families. These results are the foundation for each state's improvement plan. In a 2004 report to Congress, the GAO recommended that the ACF use the best available data in the CFSR process—specifically longitudinal data that track children's experiences in placements over time. The GAO also recommended that states receive guidance on how to implement improvement plans and integrate oversight activities. ACF responded that they have provided extensive guidance to states on ways to improve the quality of data and that more improvements are underway (U.S. GAO, 2004).

At the heart of the foster care system are children. Much improvement is needed in the system in terms of the mandates of ASFA, the CFSR process, and parental substance abuse treatment. Before we can effectively assess, promote, and measure the

well-being of children in care, a common definition is needed. The next section explains the method employed in this study to identify a comprehensive uniform definition of well-being.

Methods

Study Design

This study uses the Classic Glaserian Grounded Theory (GT) as the method to generate a definition of well-being. GT is inductive and exploratory in nature. GT is a conceptual, not a descriptive method that aims to capture the essence of an experience by a person. In contrast, GT studies focus on patterns of behavior and social problems (Glaser & Strauss, 1967). The social problem under analysis in this study is the well-being of families with child welfare involvement due to parental substance abuse.

The goal of this study, as with all GT studies, is to generate a theory, not to prove or disprove a hypothesis (Glaser & Strauss, 1967). This researcher followed the recommendation of Glaser (1978) that novice researchers in GT begin by sampling groups exclusively within a substantive (specific) area. The substantive area in this study is FDTCS.

According to Glaser (1978), generated theories may be substantive or formal. If the theory is substantive, it will apply to a specific population in a given setting. If a theory is formal, it will be applicable across populations and settings, for example, to all people regardless of the setting. Once the theory from this study emerged from the data, the GT analyst integrated extant theories from the literature into the generated theory. The

purpose of GT studies is to contribute to the literature base in order to stimulate future dialogue and research in the scholarly community. Over time, the theory generated from this study is intended to be modified as data from future research are integrated (Glaser, 1978).

The generation of theory grounded in the data depends on the theoretical sensitivity of the researcher—the ability to take the data to a conceptual level perceiving categories, themes, and relationships in the data. The level of theoretical sensitivity in the researcher is determined by his or her reading of the literature, experience, and expertise in the field of study, as well as his or her skill in the data collection methods used (Glaser, 1978). This researcher has worked as a practitioner, an administrator, and a researcher in the field of Family Dependency Treatment Courts for 5 years. In addition, she possesses a Master of Social Work degree with training in interviewing, observation, and finding themes and patterns in both content and processes when working with individuals, groups, families, organizations, and systems. She has worked in the field with families involved with the legal system, social services, and mental health systems for over 15 years and teaches at both the bachelor's and master's levels in social work at a university. Therefore, the theoretical sensitivity of this GT analyst is considered to be high.

Theoretical sampling is the procedure used to select study participants in this substantive GT research. Groups were selected based upon their ability to provide the analyst with the maximum amount of theoretically relevant data to the problem under study—the well-being of foster children with parents with substance abuse problems (Glaser & Strauss, 1967). The groups selected are the FDTC participants (parents) and professionals participating in Family Dependency Treatment Courts at four sites. Data

from these groups were expected to be theoretically relevant as the target population of FDTCs is parents with substance abuse problems with children in the state's care.

Participants

The participant groups for this study are four Family Dependency Treatment Courts (FDTC) in a Midwestern state. Study participants at each site consisted of two groups: FDTC interdisciplinary teams ($n = 49$), and FDTC parents ($n = 25$). This study has been approved by the Western Michigan University Human Subjects Institutional Review Board (see Appendix A). All study participants gave fully informed consent prior to participation in the study.

Because FDTCs serve parents with substance abuse problems and their children are often in foster care (Wheeler & Fox, 2006), they meet the criteria of a source of theoretically relevant data for this study. The individuals involved in FDTCs are stakeholders in the problem of well-being of foster children. Stakeholders include family court judges, attorneys, psychologists, social workers, social service providers, community representatives, child advocates, and parents participating in FDTCs (Wheeler & Fox, 2006).

The FDTCs in this study were chosen based upon the following criteria: (1) maximization of theoretically relevant data collection, and (2) accessibility of the participant groups by the analyst. Additional FDTCs that met these criteria were not studied, as categories of data were saturated after the fourth site was visited. Therefore, no further sampling was required (Glaser & Strauss, 1967).

Measures

The four measures used in this study include interviews, observations, memos, and the review and integration of extant literature. The researcher recorded key words and phrases from interviews by hand in field notes (Glaser & Strauss, 1967). Memos were recorded throughout the data collection and analysis process and throughout the literature review employing the constant comparison method (Glaser & Strauss, 1967) (Figure 2).

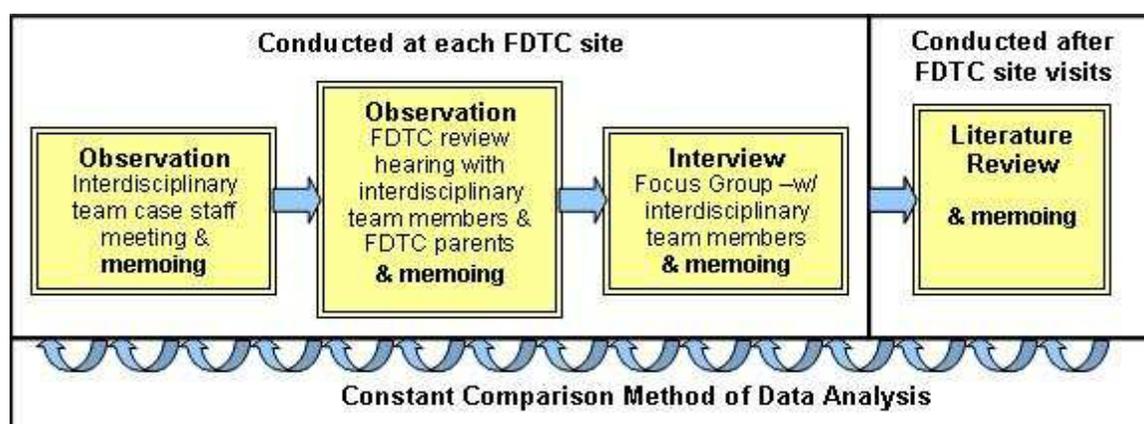


Figure 2. Constant Comparison Method of Data Analysis

Initially the researcher had planned to conduct a structured interview using a lengthy protocol or script. However, Glaser and Strauss (1967) recommend “following the data” as it emerges, asking open-ended and probing questions. Thus, the interviews consisted of asking group members three open-ended questions. The first question was, “How would you define child well-being both within the [substantive] area of FDTC and for all children in general, including your own children if you have them?” Probing questions were asked about some responses such as, “How are you defining a ‘productive’ member of society?”

The second question was generated from the selective coding of the interview data regarding the concepts of parental and child well-being. The second question asked during the group interviews was, “How do you separate parent and child well-being?” The third question was the use of the “miracle question” adapted from Solution Focused Therapy (Ramisch, McVicker, & Sahan, 2009). “If you awoke tomorrow and a miracle had occurred while you were sleeping and all children had what they needed, what would that look like?” Probing questions were asked as needed and included, “What would it take for that to happen? What would be the first step in making that happen?”

Two observations were conducted at each site. One occurred during the FDTC case staff meeting at each site while FDTC interdisciplinary teams of professionals met and reviewed each case that was scheduled on the court’s docket for that day. The second observation was during the FDTC review hearings in the courtroom at each site. Memoing of thoughts, experiences, revelations, and questions were written by the analyst throughout data collection and analysis. Memos were reviewed and coded to conceptualize the raw data. Relevant data from the literature were reviewed. Extant theories of well-being and models of wellness were integrated into the generated theory.

Data Analysis

The constant comparison method was used for data collection, coding, and analysis (Glaser & Strauss, 1967). In constant comparison, data collection, coding, and analysis occur simultaneously. The researcher constantly analyzed data line by line and coded them as they were collected. Initial data collection was “open” in that all data, regardless of the applicability to well-being, were collected through interviewing and

observation. Open coding allowed for collection of similarities and dissimilarities in the field in order to increase the density of the data. As themes and patterns emerged in the data, categories emerged and were labeled by the researcher. These initial categories provided the analytical framework for additional data collection from other participant groups.

When new data did not fit into an existing category, a new category was developed and labeled. While in the field, the researcher decided which areas to continue or cease collecting data in by constantly comparing new data to the existing categories. When there were no new data being collected in a category of data, the category was considered saturated and data collection on that conceptual category ceased (Glaser, 1978).

The decision of where to sample next is the central idea of theoretical sampling. The analyst followed the data through the emergence and saturation of subcategories until two core categories emerged. Categories are considered “core” when all other categories of data relate to them. Once the two core categories emerged, data collection and coding became selective—collecting only data related to the core categories to the point of saturation. Because data collection, coding, and analysis can go on for years, Glaser (1978) recommends that small studies such as those conducted for Ph.D. dissertations begin selective coding as soon as possible. In this study, selective coding began following the second site visit around the two core categories that emerged.

During the collection, coding, and analysis of data, the researcher documented thoughts and ideas about the data and the experience in the field in the form of memos (Glaser & Strauss, 1967). The process of memo writing forces the analyst to take the data

to a conceptual level, noting relationships between categories as well as themes that spanned across categories (Glaser, 1978). Memos were then sorted into conceptual theoretical categories rooted in the data. Memos were treated as data, analyzed line by line, and coded accordingly. In GT, literature is treated as data. Following data collection in the field, the researcher reviewed, coded, analyzed, and integrated relevant literature as it pertained to the emerging theory.

Relationships between the conceptual categories were identified, and two core categories or theories emerged (Glaser, 1978). According to Glaser, when two core categories emerge from the data, the researcher must demote one category and focus on one as the emergent theory for the purposes of writing the results. The results of this study focus on the first of the two core categories that emerged, that of “Emotional Permanence” as a theory of well-being. The second core category is the focus of Chapter IV.

Results

The Howes’ model of well-being, titled Emotional Permanence (EP), emerged as a theory grounded in the data of this study. Emotional Permanence defines well-being as health within relationships over time. Emotional Permanence is comprised of three core concepts: health, relationships, and time (Figure 3).

To fully understand Emotional Permanence, one must deconstruct these three core concepts both vertically and horizontally. First the theory is analyzed by the columns of categories and subcategories each concept is comprised of. Then it is analyzed horizontally or across the rows to identify the relationships between the concepts.

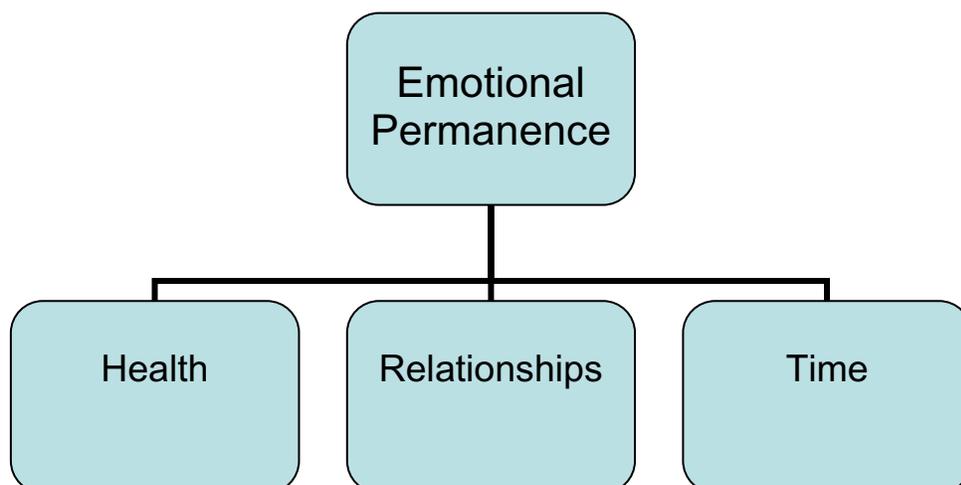


Figure 3. Emotional Permanence Core Concepts

Vertical Deconstruction of the Theory of Emotional Permanence

Each core concept of the EP theory emerged from a grouping of categories and subcategories that are grounded in the data collected from interviews with study participant groups. In this section, each of the three concepts of EP (health, relationships, and time) is deconstructed by the categories and subcategories that emerged from the data.

The conceptual category of “health” emerged from three subcategories: spiritual, physical, and mental health. The subcategory of spiritual health emerged from data referring to parental sobriety and belief in a higher power (Figure 4).

FDTC teams referred to the need for parental sobriety in families to attain well-being. When asked probing questions as to whether this applied to the parents or the children or both, team members stressed that parental sobriety was necessary for both parents and children to achieve well-being. In addition, teams reported that a belief in a

power greater than oneself contributes to spiritual health as a central component to overall health, particularly for individuals in recovery from alcohol or other drugs. Team members spoke at length of persons in recovery “working a twelve-step program” involving a focus on positive thinking, clear communication, healthy relationships, selfless activities and nurturing one’s self and one’s children.

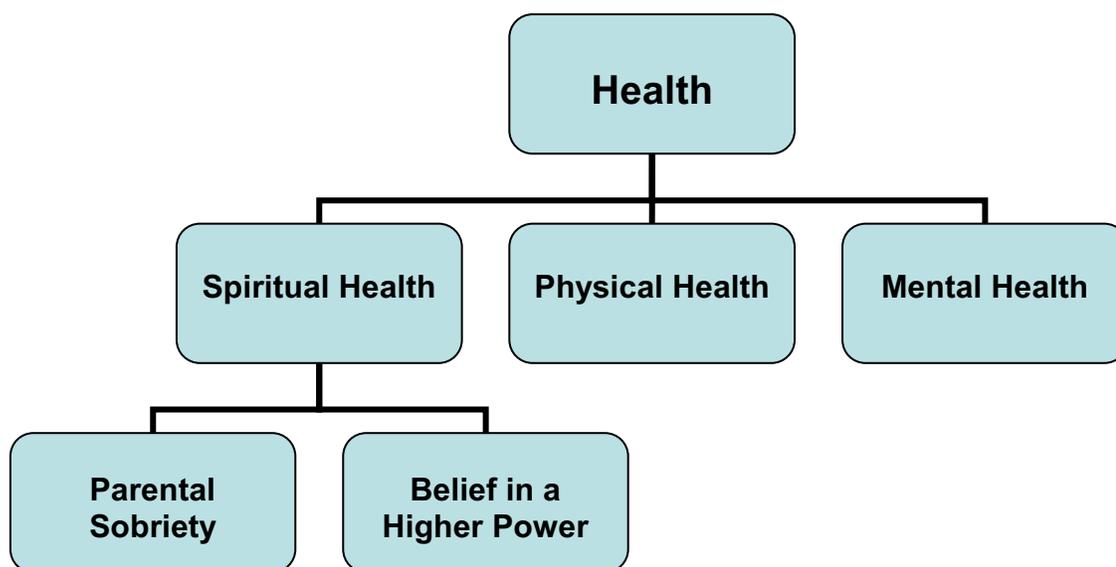


Figure 4. Spiritual Health

The second subcategory under “health” is physical health. Physical health emerged from data referring to health care services and having basic needs met (Figure 5).

Data from FDTC teams regarding health care services included the parent and child’s access to and utilization of physical and dental health care services including preventative services. One FDTC parent told the judge during an FDTC hearing, “My daughter had a procedure this week and everything went well. That was the best news. It

just made everything great.” Barriers to access and utilization of health care services cited by FDTC team members included transportation and the need for evening and weekend hours.

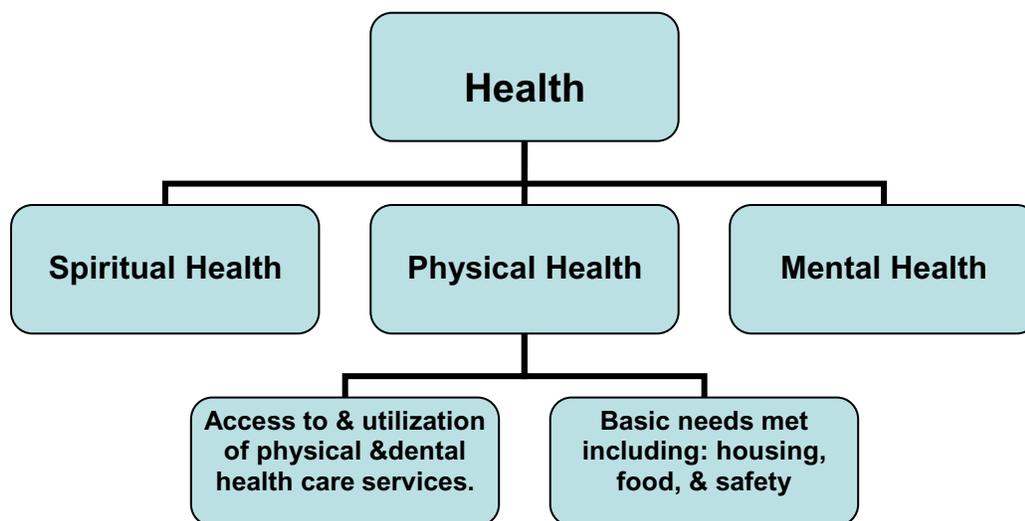


Figure 5. Physical Health

Data regarding basic needs included parents and children having adequate housing or shelter, nutritious food, and the expectation of physical safety in their home and in their community. Teams reported problems finding adequate housing for people with a felony on their criminal history, stating they could not qualify for subsidized housing. Teams described experiences negotiating with landlords who owned substandard housing in dangerous neighborhoods as commonplace. In a hearing, a FDTC parent told the judge, “I been dealing with problems with my 16-year-old. He wants to stay where he’s at [foster care]. I agreed. There are problems in my neighborhood.” Team members connected having more than just basic needs met as contributors to mental health.

The mental health subcategory emerged from data referring to access to and utilization of quality substance abuse treatment and mental health counseling, support services (such as employment services, transportation, and child care), employment or a purpose in life, and quality education (Figure 6).

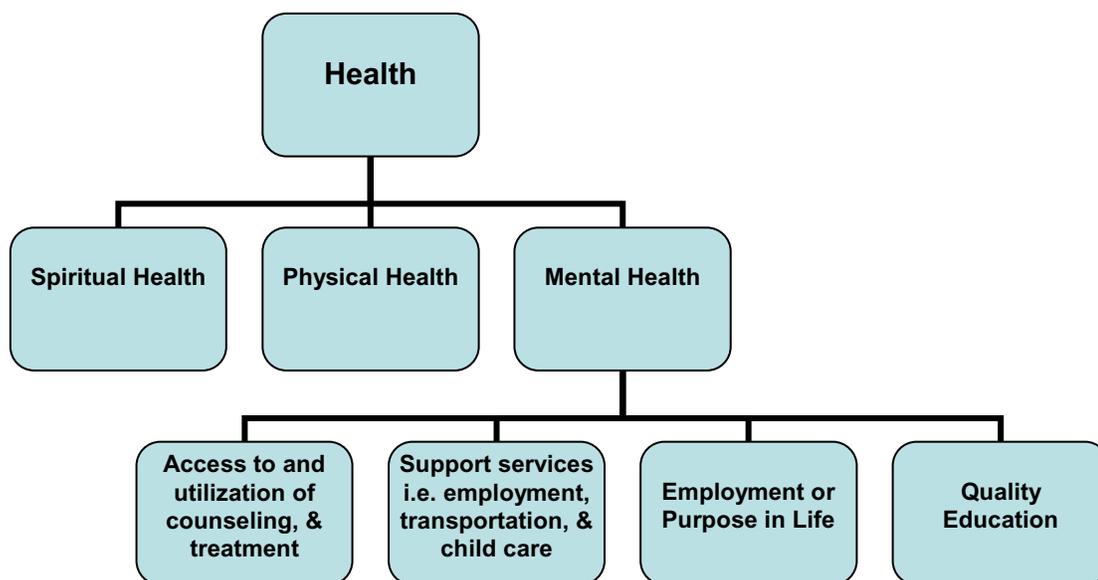


Figure 6. Mental Health

Counseling and substance abuse treatment involved access to and utilization of individual, group, and family counseling services as well as 12-step and other support groups in the community. Team members spoke at length about the traumas the parents and children in each program had endured. Many felt strongly that parental trauma was an underlying factor in most cases of child abuse and neglect and in substance abuse. Integrated counseling to address substance abuse, mental health issues, and trauma were cited as a need in order for families and children to achieve a state of well-being.

FDTC teams connected the level of support services such as assistance with transportation, finding and maintaining employment, and child care to the parent's mental health. They reported that with these supports in place, the level of stress in a family is reduced. The absence of a high level of chronic stress contributed to the well-being of the parent and the children in a family. Professionals reported frustration with state laws that mandate suspension of a driver's license for non-driving drug-related offenses and the fees charged over a period of years to the offender present often "insurmountable barriers" to regaining a license.

Having employment or a sense of purpose in one's life, such as caring for one's children, volunteer work in the community, or service work in a 12-step program were reported by team members as contributors to one's mental health. Team members also connected education for both parents and children to mental health. They stated that levels of education correlated with employment status and levels of achievement in life and, ultimately, well-being.

The following quotation from an FDTC parent illustrates the complexity of the subcategory of mental health and the integration of the concepts of health, relationships, and time:

I have a lot on my plate. I've had to down-size [drop a college course] and work on time management and get organized. I was doin' everything at the last minute and then I missed an [counseling] appointment. My one son's at home. The oldest is in day care. I've got to work and clean, do laundry, go to [college] classes and do homework. My son's about to start Head Start. I'm putting my other son in school. Both need clothes and supplies for school. The baby is movin' forward in [outgrowing] her car seat. Other than that, my life is great. I'm just a parent.

The FDTC judge responded to her that they [FDTC team members] had school supplies they could assist her with and could refer her to an agency that provides car

seats. The judge praised her for her perseverance and validated how difficult it can be to “juggle everything at once.” The judge stressed the importance of making treatment (counseling) a priority and that it was “the most important thing.” In response, she stated, “I will. Life threw things at me—more than I could chew. I love school. I’m doing well, just had to slow down a little bit.”

One FDTC team member described the struggles of a parent trying to enroll her children in school because she “doesn’t know which schools have special education” for her child. She stated that the mother had called the local board of education but was not getting calls back. Professionals stated that getting services for children with special needs was challenging for them and even more so for the parents who were often coping with multiple and chronic stressors.

The second conceptual category of Emotional Permanence is relationships. Relationships emerged from the subcategories of the quality of interactions between family, friends, and the community (Figure 7).

Family relationships are divided into two groups: (1) Relationships between parent and children, and (2) Relationships between the parent and children with extended family members.

Team members reported that parent and child relationships suffer due to substance abuse and mental health issues. Teams stated that prior to program entrance, when parents were using alcohol and other drugs (AOD), parents would often send children away, i.e., to their room, outside, or to someone else’s house, so they would not be exposed to the drug use. More of the parent’s time was spent using drugs or looking for drugs and less time was spent with the children. When parents and children were together, team

members stated that the parent was often either irritable from recovering, from using, or preoccupied with looking for opportunities to use again. Therefore the quality of the interactions between parent and child were poor. Team members focused on the importance of parents and children having positive interactions every day that supported the development of the child. They stressed the need for parent/child relationships to involve play and recreation as well as responsibilities such as homework and household chores and that parental/adult roles not be imposed on children.

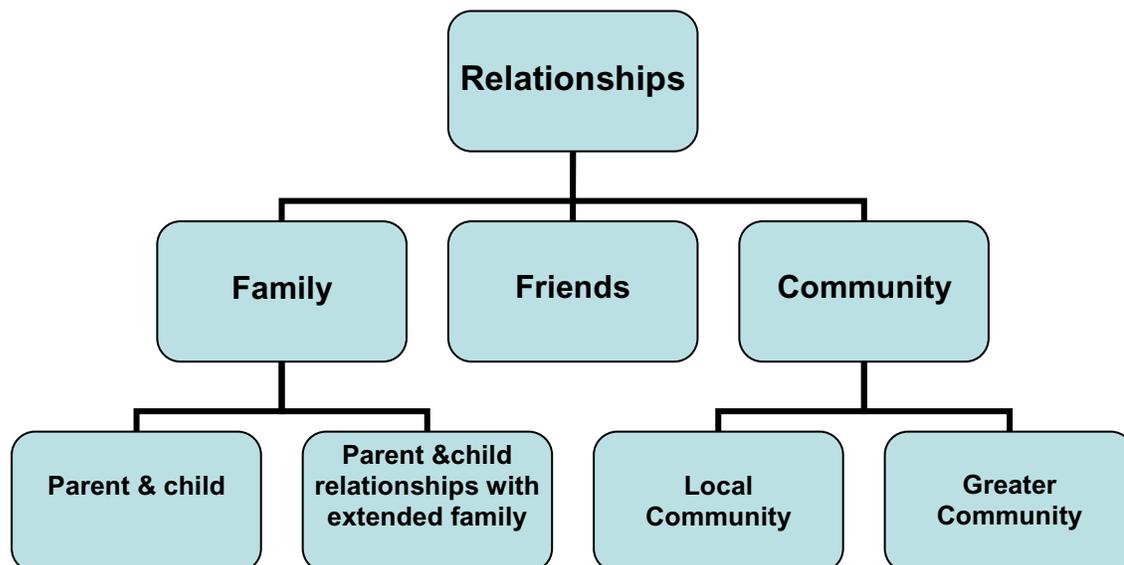


Figure 7. Relationships

Team members emphasized the importance of a positive, healthy, and supportive extended family as a significant influence on the well-being of the parent and the child. Parents with supportive families were more likely to be successful in their recovery and reunification than parents without supportive families. In a FDTC court hearing, one parent illustrated this point, stating to the judge, “It’s peaceful livin’ at my aunt’s house.

It's easy. Ain't had no problems. That's good. I'm lookin' for a job. I'm nervous about my kids being home. My kids are good. I'm alright. My kids are alright. I'm getting there."

In discussing the importance of familial relationships, team members stated that most children who "age out" of foster care or who are adopted struggle emotionally throughout their childhood and adulthood due to the disrupted relationships with their biological parents and extended families. They stated that these children usually "go back" to their families of origin when they turn 18 to rekindle familial relationships. Increasing "open adoptions" and replicating visitation between non-custodial parents and their children in cases of divorce were suggested as possible options to reduce the emotional struggles of these children and promote their well-being.

Community as a subcategory of relationships is defined as local and greater. The local community includes neighborhoods as well as groups of people that parents associated with, such as those at 12-step meetings, their child's school, a community college, or those in a "using" (substance) community. Having healthy, positive, and supportive relationships within one's local community, as well as parents and children "giving back" to their communities, were seen as contributors to one's well-being. The greater community included the relationships parents had within systems, specifically with the FDTC interdisciplinary teams, but also within the arenas of health care, mental health, judicial, educational, and employment. Teams stated that the relationships parents had with individuals in these systems needed to be healthy and supportive as well.

The third conceptual category of Emotional Permanence is time. Time was described by teams in terms of duration, or permanence, and was indicated as a need by

the teams due to ASFA timelines and as a need for the parents. Time was closely related to the concept of relationships. The connection between time and relationships is discussed under the horizontal deconstruction of the theory. Time emerged from the subcategories of the quality of time, the quantity of time, and the management of time (Figure 8).

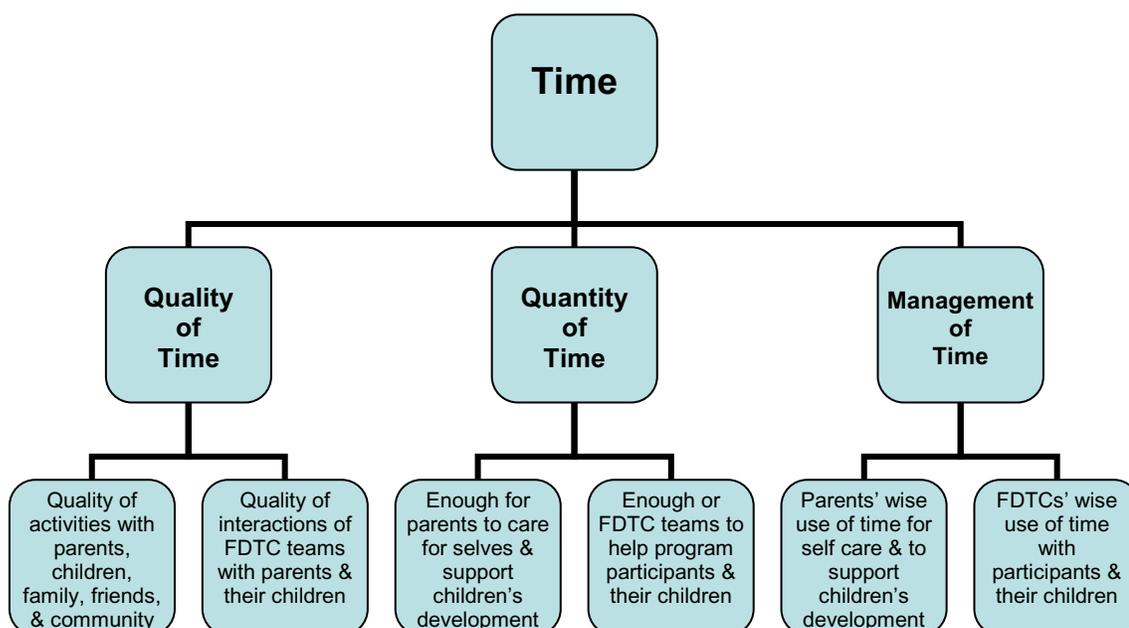


Figure 8. Time

Quality of time shared by parents and children was described in the data as activities that support the child's development. Quality of time spent together extended to activities between the parent and child and their extended family, friends, and their community. The quality of interactions between the FDTC team and the parents was a recurrent theme in the data in which the interactions within this relationship supported the development of the parent entitled Fostering. The theory of Fostering the parent by the

FDTC teams is explored and expanded upon in the third paper in this series (Chapter IV of this dissertation).

The need for an adequate amount of time emerged from the data. The data reflected a pervasive sense of too little time as a barrier to well-being. FDTC team members described parents struggling with not have enough time with their children, due to the barriers imposed by financial burden, and previous alcohol and other drug use. Teams stated that parents' socioeconomic status and educational levels often required parents to work more than one job, often in low-paying retail or fast food restaurants, with hours that are not conducive to spending time with their children. They cited that, in addition, parents spent excessive amounts of time on public transportation due to their license being suspended or revoked, contributing to a decrease in the amount of time spent with their children. In cases of relapse, parental drug and alcohol use decreased the amount of time parents spent with their children as described under the parent-child relationship category. The team stated that when children are in foster care, there is a lack of supervisors for parent-child visits. Team members expressed a need for more visit supervisors to allow parents to have longer and more frequent visits with their children in natural settings.

Team members cited that time constraints mandated by ASFA were especially frustrating. They reported that the 12-15 months ASFA allows for families to achieve "permanency" is too short. Because of the ASFA timeline as well as the developmental timelines of children, team members stated that time management by both the parents and the FDTC teams is critical. Parents need to ensure that they used their time wisely in healthy activities that promoted both their and their child's development. Team members

expressed that a positive of the ASFA timelines is that it increased their use of evidence-based interventions with families because there is no time or funding to waste. Teams felt that FDTC's are "a step in the right direction." They desired resources so that FDTC could be provided to all families with substance abuse problems.

Horizontal Deconstruction of the Theory of Emotional Permanence

Horizontal deconstruction of the theory of Emotional Permanence analyzes the relationships across the conceptual categories of health, relationships, and time. Each of these concepts is interdependent with the others. Within each category, the subcategories are inextricably linked to each other, the status of one affecting the others. Many of the subcategories were tied to two or all three of the conceptual categories of Emotional Permanence. For example, physical and mental health cannot truly be separated, but for the purposes of generating a theory to better understand well-being in this study, they were separated theoretically. Figure 9 depicts Emotional Permanence, the predictability of physical and emotional health and safety within relationships over time in a linear model. The italicized terms *within*, *over*, and *leads to* describe the relationships between the conceptual categories of EP. The level of one's health, *within* the quality of one's relationships, *over* a sufficient period of well-managed time, *leads to* the level of one's Emotional Permanence.

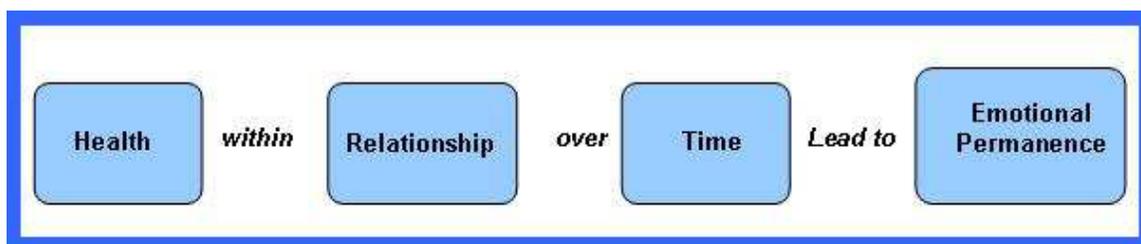


Figure 9. Emotional Permanence Theory

Because one's health, relationships, and time vary throughout life, so does one's level of Emotional Permanence. This writing is an attempt to capture a snapshot of the fluid, ongoing process of well-being from the perspective of study participants.

Trauma can destroy, or, at the very least, interrupt the predictability of life. For example, a chronic trauma in the area of mental health, such as parental substance abuse, will likely impact one's physical health and relationships. This trauma may impact spiritual health, either positively or negatively, as their faith or doubt may increase or decrease. Relationships within the family, with friends, and within the community will likely be affected. The quality of the activities between the substance-abusing parent and the child will be affected. If the child is removed from the substance-abusing parent's care, the timelines mandated under ASFA will be triggered. These timelines will limit the amount of time the parent and child have to recover from the chronic trauma imposed by parental substance abuse. The dynamic interdependence of all of these factors will determine the level of the parent and the child's Emotional Permanence: health within relationships over time. Figure 10 illustrates this example of Emotional Permanence as it pertains to families struggling with substance abuse.

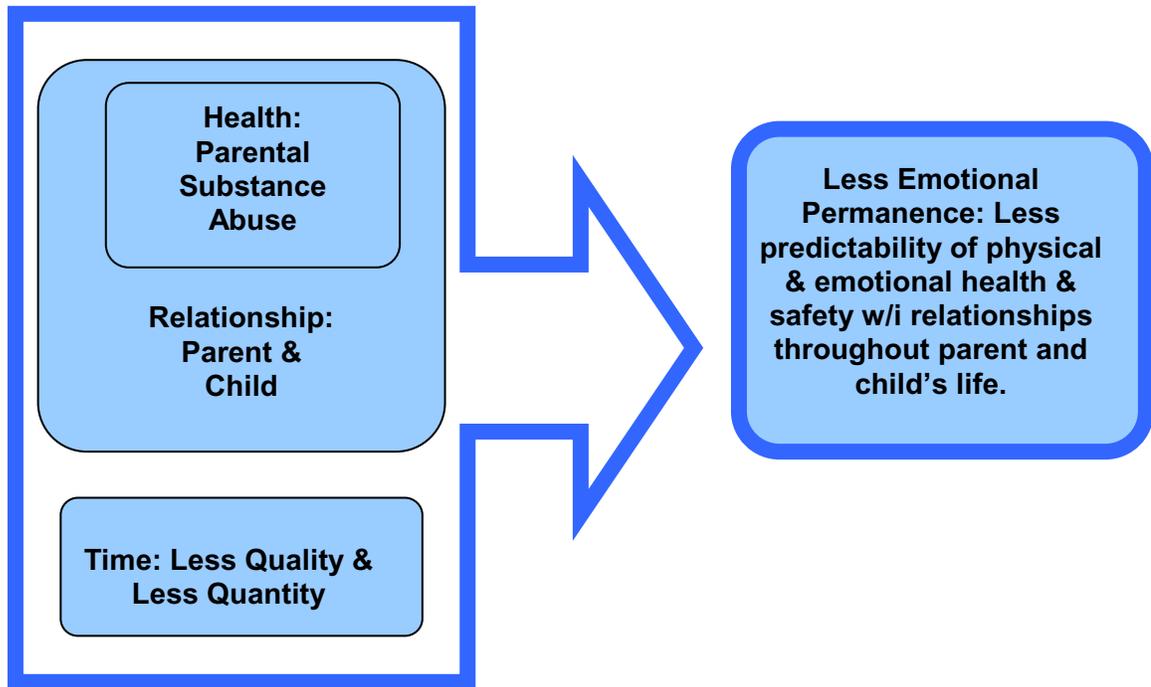


Figure 10. Application of EP to FDTC

Emotional Permanence emerged as the grounded theory of this study. Simply stated, EP is health within relationships over time. EP implies the importance of the predictability of spiritual, physical, and emotional health, including safety that occurs within relationships throughout one's life. EP meets the criteria of a theory according to GT:

1. It is grounded in the data.
2. EP accounts for the maximum amount of variation in well-being due to the premise of EP that child and parent or family well-being are perceived as inseparable.

3. EP is relevant to the key stakeholders in the problem, members of the interdisciplinary teams of FDTC teams and the parents (Glaser, 1978).

Integration of Extant Theories

Grounded Theory (GT) requires the analyst to strive for scholarly completeness in the review of literature and integration with the emergent theory with the caveat that one can never attain completeness (Glaser, 1978). There will always be studies that are missed. The goal of the GT analyst is to contribute to the literature, integrating existing theories into the emergent theory, not to replace or to prove existing theories wrong (Glaser, 1978). This section contains the results of the review of the relevant literature on existing theories on well-being and wellness and integration of each theory with EP. The extant theories in the literature integrated into the EP theory of well-being include cumulative risk theory, stress inoculation theory, developmental asset building theory, risk and resiliency theory, therapeutic jurisprudence, and Roscoe's integrated definition of wellness.

First, the cumulative risk theory of child well-being (Shinn et al., 2008) suggests that the interplay between multiple stressors, such as parental substance abuse and poverty, exacerbate each other, resulting in negative outcomes for children. Multiple stressors of the cumulative risk theory can be integrated into each core concept of EP. As stressors accumulate in the areas of health, relationships, and time, the level of well-being as defined by EP would likely decline. EP extends the cumulative risk theory to include the importance of time or duration and by applying EP to adults as well as children.

Contrary to the cumulative risk theory, the stress inoculation model of child well-being suggests that exposure to chronic stressors, such as parental substance abuse and poverty, might inoculate a child against negative outcomes from future hardships and reduce the effects of subsequent stressors (Shinn et al., 2008). The cumulative risk theory attempts to explain children who experience multiple risk factors, yet defy the odds and succeed in life. The term *chronic* in the stress inoculation theory is integrated into the core concept of time—specifically quantity of time—in the EP model of well-being.

Similar to the stress inoculation model of child well-being, the developmental asset building model of child well-being focuses on a child's exposure to positive experiences, such as role models or education as contributors to positive outcomes throughout life (Shinn et al., 2008). The EP theory extends the asset building theory to include the concept of time, the need for positive experiences *over* time into adulthood. Both the cumulative risk and the asset building theories of child well-being are extended by the broad scope of EP, which is applicable to adults as well as children.

The risk and resilience model of well-being (Lou et al., 2008) identifies both risk and protective factors that impact a child's resilience. The risk and resilience model includes internal, external, biomedical, and developmental factors as influencing a child's well-being. Internal factors can include a child's subjective perception of life satisfaction, his or her self-concept, or temperament. Internal factors integrate into the mental health and perhaps the spiritual health subcategories of EP. External factors of the risk and resilience model can include the level of family support a child receives, which is reduced in the presence of parental substance abuse as is the amount of social connections. However, positive role models or mentors available to a child and a parent such as

teachers, extended family members, or formal mentors are protective factors that may combat or outweigh risk factors. External factors integrate into EP in the relationship core concept. Biomedical and developmental factors, such as a child's physical health and intellectual abilities, integrate into the health concept of EP (Lou et al., 2008). EP extends the risk and resilience model of well-being to include adults as well as children and the importance of time, such as the duration of one's risks and resiliencies.

Wexler and Winick (1996) theorized that laws, legal rules and procedures, court procedures, and the people involved in the legal process can produce physical and psychological well-being of people—termed *therapeutic jurisprudence* (TJ). TJ assumes that the way the law is implemented by judges, attorneys, law enforcement, and others, especially during time of crisis for a person, can be a powerful therapeutic experience (Birgden, 2004). In addition, TJ assumes that social scientists should contribute to the process and that individual autonomy and public safety continue to be honored (Birgden, 2004).

EP extends therapeutic jurisprudence beyond physical and psychological health to include spiritual health within relationships over time. Therapeutic jurisprudence is integrated and extended in EP by including the relationships between people in the justice system to include all members of FDTC teams and their relationships with FDTC parents as contributors to one's well-being. EP also extends the theory of therapeutic jurisprudence as one of many contributors to the overall well-being of both adults and children by recognizing the two as inseparable in families.

In 2009, Lauren Roscoe conducted an extensive review of the literature on definitions, theories, and assessment measures of wellness, spanning from 1967 to 2009.

Following this review, Roscoe stated that most authors agree that “wellness is a multidimensional, synergistic construct that is represented on a continuum, not as an end state . . . wellness is not just the absence of illness” (p. 216). Roscoe went on to construct an integrated definition of wellness as a synthesis of the existing literature. Roscoe’s definition integrates with EP in that there are numerous factors or concepts in both models that interact in a synergistic manner. Both models propose a holistic approach, which includes the person and the environment.

The view of wellness as a continuum in Roscoe’s (2009) model integrates with EP. Roscoe’s wellness model includes seven components: “social, emotional, physical, intellectual, spiritual, occupational, and environmental” (p. 221). These seven components integrate well into the Howes’ EP theory that emerged from the data in this study. The components of emotional, physical, intellectual, spiritual, and occupational health from Roscoe can be integrated into the single, multi-dimensional concept of health in EP through the subcategories of spiritual, physical, and mental health and the data depicted in Figure 6. Roscoe’s social and environmental components integrate into the EP concept of relationships through the categories of family, friends, and community and the subcategories illustrated in Figure 7.

Howes’ EP theory of well-being or wellness extends Roscoe’s theory by including time as a primary concept in the structure of wellness as a construct. The need for quality, quantity, and management of time is critical to well-being and is a deeply rooted recurrent theme in the data of this study. The quotation from a parent to the judge in an FDTC hearing illustrates this: “Life threw things at me—more than I could chew. I love school. I’m doing well, just had to slow down a little bit.” EP is purposefully titled to denote the

importance of permanence—the presence and predictability of the multiple dimensions of health and relationships *over time*. Health and relationships, without considering the importance of these components over time, limits the concept of well-being to a static event. Measuring the multiple constructs of well-being at a single point in time does not account for changes in various domains throughout one’s life.

The theory of EP allowed for integration and the extension of other theories of well-being from the literature. In addition, EP extended other theories. The integration and extension of the data from the literature on other theories of well-being provide a segue to examining how validity is determined in a GT study.

The GT Criteria of Validity

Validity is defined in GT as fit, relevance, workability, and modifiability (Glaser, 1978; Glaser & Strauss, 1967). These four components of validity are not viewed as dichotomous, such as present or absent, but assumed to exist on a continuum of degrees (Glaser, 1978; Glaser & Strauss 1967). Fit is determined by how closely concepts align with data. The vertical deconstruction of the theory of EP demonstrates that EP is grounded in the data, revealing a high level of fit.

Relevance, the second criterion of validity in GT, is determined by assessing the degree to which the study addresses concerns of the study participants, and not only those of the researcher (Glaser, 1978). The concerns in this study emerged directly from the data gathered from study participants demonstrated in the vertical deconstruction of the theory. The results, specifically the emergent theory of EP, exhibit relevance to both the researcher and the study participants, suggesting that the criterion of relevance is met.

The third criterion, workability, is determined by the degree to which the theory allows for variation in exploring the problem under study (Glaser, 1978). As the scope of a theory broadens, generally so does the workability. Workability is assessed by analyzing the applicability of the theory across persons, situations, and time. EP encompasses the multiple components of one's health, the complexity of relationships, and the concept of time or permanence across four sites. Study participants at each site consisted of two groups: FDTC interdisciplinary teams and FDTC program participants (parents). The broad scope of EP allows for applicability to children and adults. The relationships concept extends beyond the individual to the family, friends, and the community. Allowance for these variations suggests that EP meets the criterion of workability.

Modifiability, the final criterion of validity, is determined by assessing the degree of malleability of the theory when new relevant data are compared to the data gathered during the study (Glaser, 1978). The aim of GT is not to verify or prove an hypothesis right or wrong, but to introduce new theory into the field of study that can be modified by new relevant data. Initial measures of modifiability are (1) the modification of subcategories and categories by the analyst as new data is gathered at each study site, and (2) the ease with which existing theories from the literature are integrated into the emergent theory during the literature review.

To address modifiability, the analyst in this study continued collecting, comparing, and analyzing data until the point of saturation of subcategories and categories. When new information was gathered at a site that did not fit into an existing category, the analyst coded the information in a new subcategory, as required by GT. Data from the literature review were integrated into the emergent theory of EP. Although

preliminary measures of modifiability appear to meet by the integration of data from multiple sites and from the literature, the criterion will continue to be determined as future studies introduce new relevant data and as researchers attempt to apply the theory of EP across person, place, and time.

Discussion

The problem under analysis in this study is the well-being of families with parental substance abuse that has contributed to child abuse and neglect. The overall result of this study is Howes' theory of well-being, Emotional Permanence. Emotional Permanence is defined as health within relationships over time.

Definitions of well-being or wellness vary in the literature due to the broad, elusive, and complex nature of the concept (Roscoe, 2009). Without a universal definition, it is impossible to operationalize the construct of well-being. The purpose of this study is to generate theory that is grounded in data to inform policy makers and practitioners in the field of child welfare. The purpose is not to confirm or validate a theory of well-being, nor is it intended to confirm the psychometric properties of any measure of wellness. The generation of a theory of well-being from this study is a prequel to these tasks. Using Emotional Permanence as a universal definition of well-being aims to provide a framework that moves the operationalization of the construct forward.

Emotional Permanence highlights conceptual constructs needed in order to achieve a level of well-being: physical, mental, and spiritual health; relationships with friends, family, and community; and the quantity, quality, and management of time. In contrast, ASFA (1997) defines the reasonable efforts the state must make to achieve an

acceptable level of well-being to reunify a family as counseling, substance abuse treatment, mental health services, domestic violence services, temporary child care services, and “therapeutic services for families including crisis nurseries.” The reasonable efforts mandate focuses solely on the micro level of the individual but does not include the mezzo and macro contexts in which families live and attempt to change, such as family, friends, and the local and greater community. The timeline for providing reasonable efforts limits efforts to promote well-being, as it does not take into consideration all of the experiences that led up to the crisis of the removal of the children or the trajectory of the rest of their lives. The necessity of assessing, promoting, and measuring levels of well-being within the areas of health and relationships over time indicates a need for revisiting the timelines mandated under ASFA for families to safely reunify.

Howes’ theory of Emotional Permanence identifies a need for clarification of the definition of “a permanent home” under ASFA. Under ASFA, a child living with a family that is *willing to adopt* the child (kin or not) is considered a permanent home, placing an emphasis on legal permanence (Sanders, 2003). Families assert that a child living with an extended family member, a neighbor, or fictive kin with whom the child is emotionally attached is a permanent home, placing the emphasis on emotional attachment (Sanders, 2003). The study supports reconsidering the legal definition of permanency that includes the emotional attachments of the children.

Once a common definition of well-being is accepted by legislators, the challenge of measuring well-being must be addressed. The Child and Family Services Review (CFSR) emphasizes that states measure child and family well-being as a part of

comprehensive assessments for children in care. Yet again, in absence of a definition of well-being, operationalizing this construct is impossible. If the well-being is to be defined as Emotional Permanence, the operationalization of the three conceptual categories—health, relationships, and time—will be a complex process. Operationalizing each conceptual category will require the use of multi-measures, multi-informants in multiple settings that are conducted over time (Achenbach, Krukowski, Dumenci, & Ivanova, 2005). Health, for example, according to Emotional Permanence, consists of one’s spiritual, physical, and mental health. To operationalize health, relationships, and time, each axis within these constructs will need to be measured. Much work is yet to be done in terms of identifying valid and reliable instruments to measure well-being using the conceptual categories of Emotional Permanence.

As with all research, there are strengths and limitations in this grounded theory study. The strengths of this study include that the population provided opportunities for rich data. Another strength is that EP meets the criteria of a theory according to GT:

1. It is grounded in the data.
2. EP accounts for the maximum amount of variation in well-being due to the premise of EP that child and parent or family well-being are perceived as inseparable.
3. EP is relevant to the key stakeholders in the problem—members of the interdisciplinary teams of FDTC and the parents participating in FDTCs (Glaser, 1978).

Another strength is that the study meets the criteria of validity as defined in GT by fit, relevance, workability, and modifiability (Glaser, 1978; Glaser & Strauss, 1967).

The limitations of this study are common to many qualitative studies. The preconceived ideas of the researcher could influence findings. However, the constant comparison method of data collection and analysis reduces this potential threat to validity in that it demands the researcher to continuously compare each emergent subcategory, category, concept, and, ultimately, the theory to the raw data. The participant pool in this study is limited to the substantive area of FDTCs, which could influence the results to that specific population. There is a need for additional research in different substantive areas that are rich in data pertaining to well-being in order to test the modifiability of EP. Social desirability of the study participants may have influenced them to portray themselves in an unduly positive light. Finally, the number of participant groups is small and therefore future studies could be conducted before results may be generalized.

Further research is needed on EP as it pertains to the implications of the theory for practice at micro, mezzo, and macro levels. On a micro level, the Emotional Permanence theory of well-being provides a comprehensive framework that counseling practitioners as well as state case workers may find helpful in assessing the multiple domains of a client's life. Identifying strengths and needs in a client's life can lead to the development of treatment and family service plans that are wellness focused. At the mezzo level, identifying deficits for clients using the Emotional Permanence model may lead to systems and structural change efforts at the local community level. For example, study participants routinely identified problems with transportation, housing, and employment across all sites. Data from the identified needs of clients could be collected and used to precipitate advocacy efforts to increase these resources and opportunities for parents with substance abuse problems in local, state, and national communities. At a macro level, the

following amendments to ASFA are suggested: amend the definition of permanency to include emotional attachment; adjust timelines based on research that is grounded in data; and amend the reasonable efforts mandate to include evidence-based practices and extend beyond the micro level of the individual parent or child to the mezzo levels of the extended family, friends, and the local community.

This study is a first step in many yet to be taken in researching the operationalization of well-being. Each concept of EP—health, relationships, and time—need to be deconstructed for the purposes of defining a minimally acceptable level for each category. Methods and instruments need to be studied for reliability and validity. All of this takes time. While these research efforts are underway, the current method of assessing child and family well-being under ASFA, the CFSR process, needs to be restructured. One step would be for CFSRs to be conducted by researchers. Flaws in the design of the CFSR would need to be corrected to ensure that the results can be generalized to the entire population of children and families who are involved in the child welfare system.

Although FDTCs provided a data rich substantive area of study for this research in order to extend the theory of Emotional Permanence, next steps in this research are studies in other substantive areas where issues of child and family well-being are promoted or maintained. The K-12 educational setting, child care settings, and health care providers are arenas where the interviews and observations conducted in this study could be replicated. The ability to integrate the results from studies in other substantive areas into EP would further define the modifiability of this theory, moving it towards the status of a formal theory of well-being.

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CHAPTER IV

HOWES' GROUNDED THEORY OF FOSTERING: A BASIC SOCIAL PROCESS IN FAMILY DEPENDENCY TREATMENT COURTS

The purpose of this study is to generate a theory on the experiences of the interdisciplinary teams in Family Dependency Treatment Courts (FDTC), specifically as it applies to their experience of Fostering FDTC program participants through the process of recovery from substance abuse and dependency in an effort to reunify with the children who have been removed from their care. This study aims to fill gaps in the drug court literature on how FDTCs work.

In a special research issue of the Drug Court Review, published by the National Drug Court Institute, Marlowe, Heck, Huddleston, and Casebolt (2006) state that the question of the effectiveness of drug courts has been answered. In the national research agenda for the second wave of research on drug courts, scholars ask researchers to define what makes drug courts work, suggesting that drug courts work in synergistic ways (Cissner & Rempel, 2005; Goldkamp, 2001; Longshore et al., 2001; Marlowe et al., 2006; Marlowe, DeMatteo, & Festinger, 2003).

Because of the complex nature of drug abuse and dependency, Marlowe et al. (2006) suggest that future research go beyond strategies that test single items against each other for effectiveness, such as treatment versus punishment, and look inside the “black box” of drug courts to distinguish drug courts from past endeavors to decrease drug-related crime and child abuse and neglect. One recommendation on the national research

agenda is to explore the importance of having a permanently assigned judge to a drug court. Additional research about the relationship between the judge and the drug court participants is recommended (Marlowe et al., 2006). In addition, Marlow et al. also call for research on the effect on the therapeutic relationship of having treatment providers and case managers present during drug court review hearings.

Frustration with the disconnect between research and practice is articulated by researchers and practitioners in the drug court literature (Fox & Wolf, 2004). This fracture is partially attributed to the need for the researcher to be able to speak the language of research as well as the language of the practitioner, stating that a translator is needed between the two worlds of the laboratory and clinical practice (Fox & Wolf, 2004). This study aims to bridge the gap between research and practice by using a participant observer approach. The researcher practices in an FDTC, which eased access to sites in this study. Through her understanding of the FDTC setting, treatment, conditions common to women in treatment, and knowledge regarding the impact of legislative mandates on FDTCs, she is well positioned to look inside the black box of FDTCs (Mackinem & Higgins, 2007). By speaking both the language of research and the language of practitioners, this researcher serves as a translator for the findings of this study.

A paucity of literature exists on FDTCs when compared to the extent that adult drug courts have been studied (Belenko, 2001; Bryan & Havens, 2008). This study contributes to the knowledge base in that it focuses on FDTCs and attempts to determine what makes drug courts (Goldkamp, 2001). The study aims to contribute knowledge on why any individual drug court works, to explain and understand the drug court process in

general (Wolfer & Roberts, 2008). In order to fully understand the complexity of FDTCs, the following section begins to provide background information on the legal context in which FDTCs operate, how FDTCs fit into the context of the court, social service and mental health treatment systems, the origin of FDTCs, and the key components of FDTC.

Background and Significance

In 1997, in response to hundreds of thousands of children languishing in foster care, the federal Adoption and Safe Families Act (ASFA) was enacted. Between 40-80% of these children in foster care have parents struggling with substance abuse and dependency that contributed to the abuse and neglect of their child (Badeau & Gesiriech, 2004; D'Andrade & Berrick, 2006; Kortenkamp & Erhl, 2002; Malluccio & Ainsworth, 2003; Smith, Elstein, & Klain, 2005). ASFA mandates that courts and social services systems in each state make reasonable efforts to provide safe and permanent homes for children within 12-15 months from the date of the removal from their parent's care.

Under ASFA (1997), a permanent home or "permanency" for the child is achieved either through reunifying families or by terminating the parental rights and moving these children towards adoption, guardianships, or alternative placements. To ensure that reasonable efforts are provided for reunification in a timely manner, ASFA mandates a minimum of biannual review hearings where parents' progress is reviewed. A Permanency Planning hearing is mandated after the child has been in care for 12 months with the purpose of determining if the plan is to reunify the family or to terminate parental rights and pursue other permanent alternatives based on the parent's progress.

This study focuses on FDTCs as one of the reasonable efforts mandated by ASFA, specifically the interdisciplinary team approach to providing services to substance-abusing parents with children in foster care (Bureau of Justice Assistance [BJA], 2004). FDTCs operate with the goal of achieving permanency for children by focusing on safely reunifying children with their parents (Bryan & Havens, 2008; BJA, 2004). FDTCs originated from the drug court movement based on 10 key components, set forth by the U.S. Bureau of Justice (BJA, 1997).

The Ten Key Components of Effective Drug Courts (BJA, 1997) require the FDTC judge, defense and prosecuting attorneys, guardian ad litem, social service workers, and mental health/substance abuse treatment providers to come together using a non-adversarial, interdisciplinary team approach to provide comprehensive and coordinated case planning and services for the parents and children in these cases (Bryan & Havens, 2008). These teams routinely participate in interdisciplinary training. Judges, attorneys, and social service workers increase their knowledge of addiction as a disease and effective treatment approaches in families with addiction. Treatment providers increase their understanding of the legal process and requirements of ASFA (BJA, 1997, 2004).

In accordance with the Ten Key Components, potential FDTC participants are identified early, often within days of the removal of the child from the parent's care. Once parents are screened and assessed for eligibility, they are admitted into FDTC and are "fast tracked" into an intense and comprehensive continuum of care. Services provided to the parent and children include mental health and substance abuse treatment as well as an array of ancillary services such as educational and employment support, assistance with

health care, housing, transportation, and childcare. Parents participating in FDTCs are subject to frequent and random drug and alcohol testing (BJA, 1997).

Parents participating in FDTC appear before the FDTC judge in court on a weekly to monthly basis, surpassing the minimum requirement of biannual reviews mandated by ASFA. During these FDTC review hearings, program participants receive swift responses to their progress or lack thereof through a graduated schedule of sanctions and incentives (BJA, 1997). The FDTC judge interacts with each FDTC parent participant during each hearing, focusing on the well-being of the parent and the children (Bryan & Havens, 2008). Review hearings mandated by ASFA to review the progress of the parent are integrated into the FDTC review hearings, along with the alcohol and drug treatment services in which clients participate (BJA, 2004).

FDTCs participants commonly matriculate through the FDTC program in three to four stages. The beginning phases in FDTC are more intense in terms of the frequency and dosage of treatment, the number of hearings per month, and the number of mandatory random drug and alcohol tests. As FDTC participants progress, treatment, court hearings, and drug and alcohol tests are often decreased somewhat and more energy is spent on ancillary services, such as education, employment, transportation, and childcare (Bryan & Havens, 2008; BJA, 2004).

In many FDTCs, clients relinquish their attorney-client privilege as well their right to confidentiality with treatment providers. To encourage client honesty, the prosecutor agrees not to bring new charges against a client for admitting a relapse in drug use while in treatment. By doing so, the comfort level of defense attorneys and treatment providers

is increased in sharing information regarding progress or lack thereof in staff meetings each week prior to the FDTC review hearing (BJA, 2004).

Responses to parental relapse and related issues are addressed in FDTC using a team problem-solving and decision-making approach based on evidence-based practices (Bryan & Havens, 2008; Marlow et al., 2003). The FDTC team frequently recommends adjustments to the case plan, such as increases in treatment dose and frequency and referral to ancillary support services (BJA, 2004).

The interdisciplinary team approach in FDTC challenges individual team members to relinquish their traditional adversarial roles and to stretch beyond the boundaries of their disciplines. Turf, power, and control must be surrendered to the team as the decision-making entity. Judges, attorneys, and social service workers are challenged to shift from the traditional adversarial, deficit-based, punitive paradigm of the courts to a strengths-based treatment-driven approach (BJA, 2004). Treatment providers are challenged to operate under a coercive paradigm and within the constraints of the ASFA mandates.

Statement of the Problem

The problem under analysis in this study is how FDTC teams move parents with addictions forward toward a level of well-being within the timelines of ASFA in order to reunite safely with their children. The deleterious effect of parental substance abuse on children is well documented in the literature. Of these children who end up spending much of their youth in foster care and eventually aging out of the system, the future holds increased likelihood of homelessness, poor mental and physical health, incarceration,

substance abuse, and elevated high school drop out rates (D'Andrade, Osterling, & Austin, 2008). The process faced by FDTC teams as one of the reasonable efforts of ASFA to move these families toward reunification is daunting.

The issues addressed by FDTC teams are emotionally charged, as children's futures are at stake and there are only 12-15 months to support and nurture the parent in their recovery due to legally mandated timelines by ASFA (BJA, 2004; Edwards, 2007). Unfortunately, the timeline for recovery from substance abuse extends far beyond 12-15 months. Twelve months in substance abuse treatment is the minimum amount of time recommended for a successful prognosis (Center for Substance Abuse Treatment [CSAT], 1996; Hubbard, Marsden, Harwood, Cavanaugh, & Ginsburg, 1989; Marlowe et al., 2003; Simpson & Sells, 1983). Successful recovery requires a permanent lifestyle change. The year provided for in ASFA to safely reunify families is only the first year in the recovery process and is commonly fraught with relapses and issues related to prolonged substance abuse, such as criminal charges, unemployment, lack of stable housing, and a loss of driver's license, all of which affect the chance of safely reunifying a family within 12 months.

A third timeline that competes with the recovery and ASFA timelines is that of the development of the child, often referred to as three competing clocks (Edwards, 2007). Although 12 months is a relatively short amount of time in an adult's life and in the recovery process, it is a significant amount of time in the life of a child (Edwards, 2007). The child's developmental timeline as well as the cost of keeping a child in foster care were impetuses in enacting the timelines mandated by ASFA. The three competing clocks

exert pressure on the FDTC teams as they work with participating parents throughout the year in efforts to safely reunify the family (Edwards, 2007).

Methods

Study Design

The Classic Glaserian Grounded Theory (GT) is the method of analysis used in this study to explore the phenomenon that occurs among FDTC professionals as they support parents who either matriculate through the process of recovery from substance abuse and reunite with their children, or recidivate and lose their parental rights. GT studies aim to generate a theory to explain a social phenomenon, condition, experience, or process (Glaser & Strauss, 1967). The purpose of this GT study is to generate a theory of the basic social process (BSP) that the FDTC team experiences in their relationship with parents attempting to recover from addictions and reunify with their children.

GT studies are inductive and exploratory in nature. In GT, data collection and analysis occur simultaneously using the constant comparison method. Data are collected using theoretical sampling. Theoretical sampling involves initially selecting study participants who can provide information in a substantive area such as FDTCs and to follow leads and cues from study participants. These cues lead to more relevant information allowing the study to unfold, as opposed to imposing the direction the study will take. For example, interview questions for this study were originally scripted to seek information from team members about child and family well-being. However, in addition to data on well-being, data on the intense emotional experience of the FDTC team

members in their relationship with FDTC parents emerged. GT requires the researcher to “follow the data” as it emerges. Therefore, once the topic of child and family well-being was saturated, interview questions were expanded and modified in order to capture the experiences of the FDTC team members in their journey to support and nurture parents in their efforts to recover and reunify with their children.

Participants

Study participants were recruited from nine FDTCs in a Midwestern state. Four sites volunteered to participate. At each site, two types of informants participated: (1) interdisciplinary FDTC teams ($n = 49$), and (2) parents participating in FDTC ($n = 25$). This study was approved by the Western Michigan University Human Subjects Institutional Review Board. All study participants were fully informed of the potential risks and benefits of participating in the study and signed consent forms accordingly.

Measures

The measures in this study include field notes of observations and interviews, theoretical memos, and a review of relevant literature. Theoretical memos are recordings of the thoughts, questions, and feelings experienced by the researcher during and after data collection. Memos serve to raise substantive data to a conceptual level, allowing for the core category or theory to emerge. In keeping with GT methodology, the literature review was conducted once a core category emerged.

Data Analysis

Data were collected, coded, and analyzed simultaneously using the constant comparison method. Data were gathered through observations, interviews, theoretical memos, and a review of the relevant literature. Observations were conducted by the researcher during the interdisciplinary FDTC team staff meetings held prior to each FDTC court review hearing, as well as during the FDTC court review hearings. Interviews were conducted with the FDTC interdisciplinary team members during focus groups following the court hearings. Memos were written by the researcher during and after observations and interviews and throughout data analysis. Upon emergence of the core category from the data, a review of relevant literature was conducted (Figure 11).

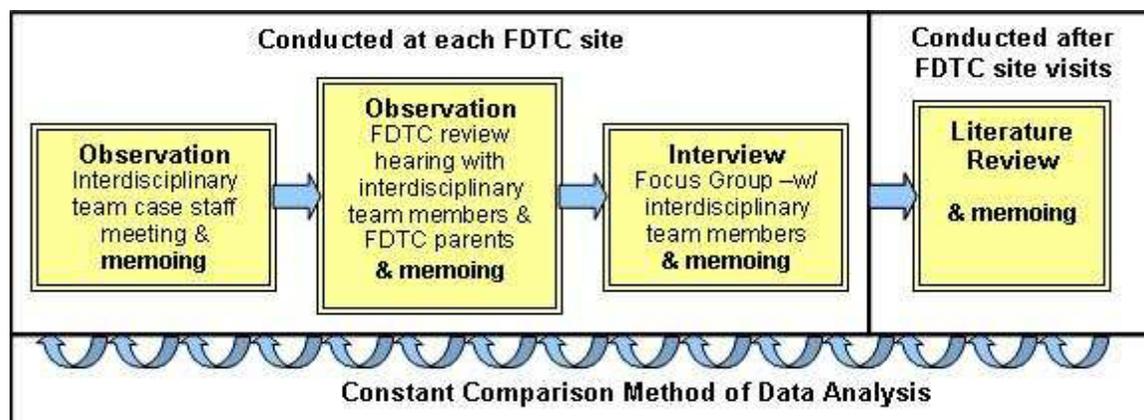


Figure 11. Constant Comparison Method of Data Analysis

Data were verbatim key words and phrases as well as the researcher's observations of behaviors and interactions during the FDTC case staff meetings, court hearings, and focus groups with FDTC teams. Theoretical memos were written by the researcher during and after data collection, coding, and analysis. According to Glaser and

Strauss (1967), “all is data.” Therefore, theoretical memos and information from the literature review were treated as data using the constant comparison method.

Data were coded using open, axial, and selective coding. Open coding involves the recording of what is actually happening or said in the field, resulting in subcategories that are substantive in nature (Glaser, 1978). During this initial coding, all data are recorded, whether or not it is perceived as relevant by the researcher. Data are delimited in selective coding, the next stage of coding (Glaser, 1978).

Axial coding was used to sort data by identifying the patterns across subcategories as well as the relationships between subcategories (Glaser, 1978). Identified patterns and relationships were used to sort the subcategories into conceptual groups, also known as theoretical categories. When all subcategories were saturated and broader theoretical categories emerged, selective coding began (Glaser, 1978).

Selective coding was employed to identify a core theoretical category that emerged from the data. The core category encompasses all categories and subcategories. In selective coding, the researcher delimits the data by continuing to collect only data that contributes to the core category, also referred to as the emerging theory (Glaser, 1978).

The following 11 criteria developed by Glaser (1978) for GT were used to assess if the emergent core category was truly “core”:

1. It is central, meaning it accounts for variability in behavior across sites.
2. It recurs frequently in the data.
3. It has more depth than other categories, meaning it takes longer to saturate than the other categories.
4. It connects theoretically to all other categories.

5. It has clear and “grabbing” implications beyond the substantive area of study.
The researcher can easily conceptualize applying the theory to other areas of study.
6. It has “carry through” in that it explains and is relevant to the data.
7. It can assimilate new data that is introduced into new variations of itself.
8. The core category is self explanatory.
9. It is the result of induction and exploration.
10. The researcher is tempted to apply it to all other areas of study (but resists).
11. The core category is one type of a theoretical code, i.e., a condition, a consequence or a basic social process (BSP).

Glaser’s (1978) criteria in determining if the emergent theory is a basic social process were employed. According to GT, a theory is defined as a BSP only when it meets the previously listed criteria and it has marked stages that involve change over time. According to Glaser, a BSP is a pervasive pattern of behaviors or interactions that go on in organizations, irrespective of time and place. Each stage of a BSP is marked by milestones that are achieved in order to process through to the next stage. BSPs transcend the boundaries of traditional social units or structures, such as the legal, health, or educational systems (Glaser, 1978).

GT states that when two equally qualified core categories emerge, the researcher must promote one to the center of the focus and demote the other to a subcore category for the purposes of writing (Glaser, 1978). In a separate article, the researcher then reverses the promoted and demoted categories in order to fully develop each as a theory

(Glaser, 1978). This paper aims to develop one of two core categories or theories that emerged from the data.

Validity was determined by assessing the emergent BSP theory on four constructs identified in GT: fit, relevance, workability, and modifiability (Glaser, 1978). Validity of a GT study is limited by the level of the researcher's theoretical sensitivity. Theoretical sensitivity is the researcher's ability to translate substantive data into theoretical concepts and the ability to explore an issue inductively, letting concepts emerge as opposed to being committed to following a certain path in the research based on a hypothesis. Theoretical sensitivity is also determined by assessing the researcher's openness to revisiting the data to ensure fit (Glaser, 1978).

This researcher has worked as a practitioner, an administrator, and a researcher in the field of Family Dependency Treatment Courts for 5 years. In addition, she possesses a Master of Social Work degree with training in interviewing, observation, and finding themes and patterns in both content and processes when working with individuals, groups, families, organizations, and systems. She has worked in the field of social work with families involved with the legal system, social services, and mental health systems for over 15 years and teaches at both the bachelor's and master's levels in social work at a university. Therefore, the theoretical sensitivity of this GT analyst is considered to be high.

Fit is assessed by examining how closely the core concept aligns with the data collected and makes sense of experiences in the field. If the theory does not fit the data, revisiting the data is necessary. Relevance is assessed by examining the degree to which the theory demonstrates the concerns of the study participants as well as those of the

researcher. Workability assesses the breadth of the theory by assessing the ease in which the theory allows for variations in behavior. Modifiability is the extent to which the theory allows for variation by assimilating new data and is assessed by constantly comparing new data to the core category that emerged from the data.

Results

The basic social process that emerged from the data is the Howes' theory of Fostering. Fostering explains the relationship between FDTC teams and FDTC parents. Two equally qualified core categories emerged from the data, but according to GT methodology, one core category is demoted for the purposes of this writing (Glaser, 1978). Further reading on the second core category that emerged from this study, Emotional Permanence (EP), can be found in Chapter III of this dissertation.

Howes' theory of Fostering consists of four stages and three milestones. The stages in Fostering are engaging, working together, maintaining, and launching. The milestones are stabilization, trust, and acceptance. The achievement of the milestones determines whether or not the process progresses to the next stage. The process of Fostering is depicted in Figure 12. Subcategories are noted in the squares. Milestones are noted in the arrows.

In contrast to the linear simple process depicted in Figure 12, FDTC teams described Fostering as "bumpy" and "scary," likened to the experience of preparing for and watching an Apollo launch. Everyone wants it to be successful, yet there is a constant gnawing concern and worry because of all the things that could go wrong at any point, as illustrated in Figure 13. The lightning bolts represent the threats to a successful launch.

The “no” symbols symbolize a parent’s return to substance abuse, the termination of his or her parental rights, and the children being put up for adoption or placed in a guardianship or long-term foster care.

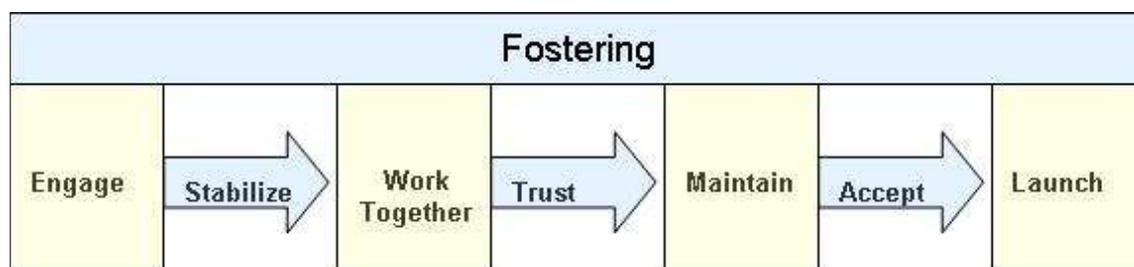


Figure 12. Stages of Fostering

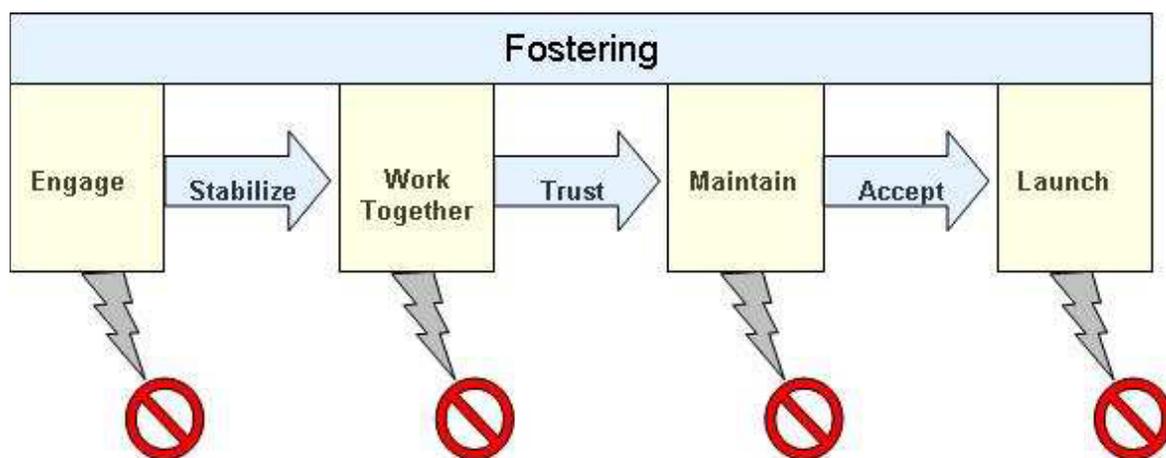


Figure 13. Stages and Milestones of Fostering

Fostering was described as “full of fits and starts.” Delays were described as “common” or “the norm,” while teams felt torn trying to balance the demand of timelines with the importance of not rushing through necessary and complex steps. FDTC teams described revisiting a previous stage of treatment with some clients—clients who were

“stuck” at times, and, in the worst cases, an unsuccessful launch where the parent returned to substance abuse. An unsuccessful launch was described as “heart wrenching” and “a helpless feeling.”

Engaging

The first stage in Howes’ theory of Fostering is engagement. Engaging is marked by the beginning of the development of a minimal level of trust between the FDTC team and the parent. The pace at which trust develops is determined in part by the parent’s days of (physical) sobriety, (emotional and cognitive) progress in treatment, and number of 12-step program meetings attended. In this stage, FDTC team members described holding the quantitative measures of days sober (measured by frequent and random drug test results) and the number of 12-step meetings attended in high regard when engaging with the parent.

Teams stated that during the engagement phase, they acknowledged the temporary nature of their relationship with the parents and compared it to the relationship of foster parents providing care for adolescents. Teams described their role with the parents as one of nurturing, setting and enforcing boundaries and limits, providing guidance, clarifying roles and rules, giving consequences and incentives, and “rolling with resistance and rebellion” as a natural part of the process.

During one FDTC court review hearing, the judge addressed a new participant in the program and described the first phase of the program to this parent as “confusing.” He encouraged her to be patient with the team and assured her that the team would be patient with her. During interviews with the researcher, teams described “engaging” with the

parents as “full of drama” and a period of time when the parent is “cleaning up messes left behind in the path of a tornado [of substance abuse].” Teams described a period of “testing behaviors” until they and the parents eventually recognized that the FDTC team and they shared the common ground of wanting to reunite the parents with their children. All teams described parents who had “90 days clean” and who had completed “90 in 90” (attended 90 twelve-step meetings in 90 days) as having “stabilized.” Once this initial milestone was achieved, teams described moving to the next stage in their relationship with parents as “working together.”

Working Together

FDTC teams described the second stage in Fostering as “where the real work is done” for the parent as they become more self aware. The “working together” stage was marked by increased expression of emotions by the team members. During staff meetings, team members verbally and nonverbally expressed a deep level of caring, frustration, pride, exasperation, fear, and hope when discussing parents who had already “stabilized” and were now attempting to change their friends and daily routines to support their recovery.

Team members expressed admiration of the courage and determination exhibited by some clients to address the “ghosts from their pasts.” All teams described the parents participating in their programs as having experienced “a lot of trauma” and attributed trauma to some extent as a root of the parent’s addiction. Teams expressed frustration at trying to break generational patterns related to substance abuse, family structure, family roles, and family rules.

FDTC team members recognized that many of them held dominant middle-class values and how that conflicts with those of most of the parents in their programs, who are from generations of poverty. They were passionate when describing their efforts to impose the value of education on the parents while simultaneously frustrated with the lack of resources and opportunities available for the parents. All teams complained of a lack of safe and affordable housing, educational resources, employment, transportation for the parents, and childcare, acknowledging the need to “do the best with what we have.”

When teams discussed parents who were struggling to make changes, who were making poor choices, or who had relapsed, the intensity of their level of emotional expression increased. For example, they described a mother who was collecting her children’s urine to use for her own drug tests in order to test negative. During this discussion, team members shook their heads and grunted in disgust and exasperation. One exclaimed “Are you serious?! I was just over there yesterday! She’s been doing so well!” In trying to decide how to have the judge respond to this mother’s behavior during the FDTC review hearing, team members struggled between being punitive and trying to be objective and address the mother’s behavior in a manner that would help “get her back on track.”

The “working together” stage presented as a period in which the clients and teams were able to navigate through ruptures in their relationship, thereby teams were able “push” the parents to do “real work” for lasting change. During staff meetings and interviews with the researcher, team members relied on remembering successes with previous clients as a strategy to cope with current disappointments and frustrations with a

parent, and also as a way to instill hope. One team member said, “She reminds me of Shelley (name changed). Remember when we all thought there was no way she would make it? But then she turned it around.” Others around the table nodded and this seemed to help the team “get back on track” in responding to challenges. Teams as well as clients could get “off track.”

As teams Fostered parents through the “working together” stage, the level of the team’s trust increased to the point that they felt the parent was ready to “try their wings.” Team members described this as similar to the feeling of “giving the car keys to your teenager. Sooner or later, you have to let them try on their own.” During an FDTC review hearing, the judge announced to a parent that she was being promoted to the next level in the program, which included the return of her children to her care. The judge smiled and congratulated the parent and went on to reassure her that the team would “still be here to support [you] acting as a home base when you need help until your case closes.” The mother cried and hugged a member of the FDTC team and thanked her. Team members in the court room exchanged hopeful and tentative glances. Once the milestone of “trust” was achieved, the team moved to the stage of “maintaining” in the Fostering process.

Maintaining

Team members described the “maintenance” stage of the Fostering process as one commonly marked by a lack of crises in the parent’s life or the parent’s ability to cope with crises, and to problem solve without substances. They discussed creating plans for the parent to follow to increase the likelihood of continued success. The plan was

described by one team member as “disaster preparedness planning,” including steps the parents must take to avoid relapse.

During team staff meetings, the least amount of time was spent discussing parents who were doing well. The bulk of time was spent on parents for whom the team members were “worried” about. “Red flags” and “using behaviors” were described and included “no show-no call” by parents for appointments with team members, a loss of employment, children suddenly struggling in school or missing school, a parent’s spending time with known drug users, and an increase in the parent’s resistance in treatment, reminiscent of the “engaging” stage. One member described the incongruence between what the parent is saying and what the parent is doing as “when two and two don’t equal four.” All teams discussed a common “fear of success” on the part of parents as they neared the end of their 12 months in FDTC coupled with “self defeating behaviors.” Teams emphasized the need to provide the parent with additional reassurance and supports at that point. For example, one site had FDTC “alumni” parents in the courtroom to serve as mentors for current FDTC parents.

In the maintenance stage, teams expressed a tentative hope with the acceptance that “there is always a possibility that it could all fall apart [for a parent], but everything that we could have been done in the past 12 months to build a strong foundation was done.” A team member stated, “We know this is just the beginning for these parents and many of them are facing a long hard life for a number of reasons. We just hope they use the tools they’ve been given.” Another smiled in irony as she referenced a line from the serenity prayer often recited at the 12-step meetings attended by the parents: “We [the FDTC team] accept the things we cannot change.” Teams described the end of the

maintenance stage as “preparing for launch,” filled with fear, anticipation, anxiety, and eventually acceptance. Teams expressed a great deal of frustration with the ASFA-mandated 12-15 month timeline and “wished [they] had more time with most of them.” The effects of the ASFA timeline on the achieving the milestone of “acceptance” and the transition to the “launching” stage is illustrated by one team member’s comment: “Sometimes ready or not, we have to move forward.”

Launching

Phrases expressed by FDTC team members that characterized the “launching” stage include “holding your breath . . . pray . . . keep your fingers crossed.” They described the “fragile state” of the parent as “an infant in the recovery process” but said it was also an exciting and bittersweet time for them with some of the parents. Team members said they would “miss” some of the parents and reminisced about program graduates, asking each other if they knew “how are they doing?” Various members contributed to updates on some of the past program parents, sharing both happiness and sadness about those who continued to progress and those who had “gone back out”—a phrase describing relapse in substance abuse. When team members spoke with parents in the launching stage, they provided reassurance and encouragement and reminded parents to continue to “work their [12 step] program.”

The final act in the FDTC process for successful program participants is graduation from the program. Unsuccessful FDTC participants are “terminated” from the program. If parents leave FDTC prior to graduation, they return to the “traditional track” in social services. These parents attend court only as required under legal mandates. The

ASFA timeline still applies; however, the level of support, treatment, and drug and alcohol testing is often less. Teams reported that most parents who were terminated from FDTC were often unable to reunify with their children due to a return to substances. When teams discussed parents who were unsuccessful in their recovery, they expressed sadness and emotional pain. Describing one such incident, a team member stated, “It broke my heart” and then became very quiet

Teams concurred that the longer a parent participated in FDTC and then failed, the more painful it was for the team members. They cited the ASFA timeline as unrealistic for many parents to “completely turn their life around.”

In talking with the researcher and sharing how they felt about being involved in FDTC, team members reported a renewed sense of hope since they joined the team. They cited parents who had succeeded as one reason they joined the team, as well as a more effective functioning between the court, mental health, and social services in FDTC than on the traditional track. Team members again drew a parallel of their experience in FDTC as they recounted times of frustration with each other, referring to their own tendencies to “relapse” into their “old ways of doing business,” such as trying to punish a person into recovery. Many stated that it was “more time consuming” than the traditional court process but “worth it.” However, even with the challenges, the additional time commitment, and the chances that they would be hurt and disappointed, teams expressed a strong commitment to the FDTC process.

The researcher asked FDTC teams a “miracle question” adapted from Solution Focused Therapy (Ramisch, McVicker, & Sahan, 2009), “If you awoke tomorrow and a miracle had occurred while you were sleeping and all children had what they needed,

what would that look like?” Most team members immediately smiled and a number of hands shot up in the air. A common response was that all parents with substance abuse problems would be involved in FDTC. In addition, plenty of safe, affordable, and long-term sober housing would be available for parents and their children. Team members stated that parents would have jobs and transportation. One member stated, “Children would at least have what they need, like sheets and towels.” A judge referred to the parents and their children stating, “Their traumas would not have happened to them.” All teams expressed a wish for more time to work with parents. One stated a wish that parents and children would have “all the services they needed for as long as they needed them.” Another spoke of her dream of building a sober living ranch with all the needed services on site. She described this “miracle” as a place where parents and their children could live as long as they needed.

In GT, the criteria for validity are fit, relevance, workability, and modifiability. To ensure fit and relevance, the findings of the researcher were reviewed with the FDTC teams who participated in this study to ensure that the Howes’ theory of Fostering made sense of their experiences and demonstrated their concerns. The Howes’ Fostering theory allowed for variations in observed behaviors and responses in interviews across sites, thus demonstrating workability. The researcher continually modified the Fostering theory as data were collected, coded, and analyzed through the constant comparison method. The findings of this study are considered to be a valid representation of the experiences of the study participants and extend the literature related to therapeutic relationships and the stages of the therapeutic relationship as covered in the following sections.

Integration of Literature

In GT methodology, a review of literature relevant to the emergent theory is treated as data, integrated with the emergent theory and reported as results (Glaser, 1978). In this study, the literature review revealed an absence of research on the experience of FDTC teams in their relationship with parents. The experiences of FDTC parent participants is documented in the literature and integrates easily into the theory of Fostering postulated in this study. Professionals delivering services individually is described in studies about the therapeutic relationship between the client and the individual professional. However, no studies were found that apply this concept to an interdisciplinary team. Relevant data from the literature that were integrated into the Howes' theory of Fostering include (1) FDTC parent perceptions of FDTC team members, (2) the relational model of psychological development of women, (3) 12-step self-help groups, (4) physicians, (5) mental health nurses and therapists, (6) public health nurses, (7) non-professional mentor-mentee programs, and (8) the theory of therapeutic jurisprudence.

All parents in the FDTC sites in this study were women. FDTCs appear to operate from the relational model of women's psychological development as a context for substance abuse treatment. FDTCs use the therapeutic relationship between women and the team to foster growth and provide a setting where women can experience healthy therapeutic relationships focusing on their strengths (Covington & Surrey, 1997; Price & Simmel, 2002). FDTCs leverage the value women place on relationships and connections

as motivation in the recovery process (Covington & Surrey, 1997; Price & Simmel, 2002).

In a study by Fisher, Geiger, and Hughes (2007), mothers participating in a drug court described the caring and commitment of members of the drug court team as the strongest component of the drug court experience. Court encouragement and positive interactions with therapists were attributed by drug court graduates as determinants of their success in a study by Wolfer and Roberts (2008). In regards to sanctions imposed by the drug court judge, graduates reported that they appreciated that the drug court judge and team “cared” enough about them to hold them accountable. Participants in Wolfer and Roberts’ study referred to drug court professionals as “parental figures” who treated them with respect and fairness.

In an article on the corrective emotional experiences provided by 12-step meetings, Khantzian (2001) likened the settings of the 12-step meetings to a tool that group members can use for self-regulation. A group can provide a social laboratory where members can practice new skills before generalizing them to relationships in other areas of their lives (Teyber & McClure, 2011). Because group members have a shared experience through addiction, they can often provide each other with empathic responses they may receive from non-addicted family and friends, therefore not re-enacting dysfunctional patterns of communication and relating (Teyber & McClure, 2011). Support that is respectful but direct in addressing the need for change is common between group members in 12-step group meetings. Twelve-step groups, like the FDTC teams, provide a group setting for clients to try out new behaviors and responses, to encourage and empower them to change (Khantzian, 2001). The corrective emotional experience

happens through a therapeutic relationship. In FDTCs, this relationship is one of Fostering between FDTC teams and parents participating in the program.

In the medical field, a minimal level of emotional engagement with the patient by the physician is seen as beneficial to patient care (Weiner & Auster, 2007). Weiner and Auster likened the physicians' experiences with patients to one of participant-observer by the physician, much like the relationship between FDTC teams and parents. Weiner and Auster cited a willingness of physicians to step outside of their professional boundaries as a hallmark of a caring therapeutic relationship between doctor and patient. This integrates well with this research on FDTC teams in terms of requiring team members to go beyond the boundaries of their disciplines and engage emotionally to some extent with parents. Responding on a personal human level is reported to bring reward of satisfaction of helping someone in need (Weiner & Auster, 2007). The data on physician patient relationships integrate well into the Howes' theory of Fostering. Fostering extends this data from the micro level of one professional and one client, to the mezzo level by applying the relationship to a group of people with a client.

In the mental health field, psychiatric nurses administering medications to involuntary patients parallels FDTC team's belief that the patient's life will be disastrous without the treatment. The intensity of feelings reported by psychiatric nurses when a patient was released without being medicated mirrored that of FDTC team members in the Fostering process when a parent left the program due to relapse. Both the psychiatric nurses and FDTC teams worried about the client's safety and level of vulnerability (Vuckovich & Artinian, 2005). Both nurses and treatment providers on FDTC teams

struggled with resorting to coercion through the court for mandated treatment (Vuckovich & Artinian, 2005).

In a study of psychiatric nurses involved in delivering electroconvulsive therapy (ECT), Gass (2006) described nurses struggling to adopt different roles with patients. Nurses described one of their roles as focusing on the therapeutic relationship with the patient and another role as focusing on getting the client to agree to treatment. Similar to the Fostering process in FDTC as team members support parents through the sometimes unpleasant experiences of getting sober, nurses in the Gass study described trying to support patients through the unpleasant but necessary ECT with respect and dignity. The FDTC team's discomfort of watching parents do "the hard work" in the "working together" stage parallels that of the psychiatric nurses watching the discomfort of the patient undergoing ECT. Both nurses and FDTC team members described reaching a level of some emotional detachment as a coping mechanism (Gass, 2006). The experiences of psychiatric nurses integrate easily into the Howes' theory of Fostering and, as with the physicians in the previous paragraph, extend it to the mezzo level.

Data on relationships between clients and psychotherapists are integrated into the Howes' theory of Fostering. Corrective emotional experiences for clients in their relationships with therapists are described by Mallinckrodt (2010) as a means of helping clients recover from previous traumas and negative relationships. The relationship between the client and therapist integrates with Fostering in FDTC teams. Individual therapists in the Mallinckrodt study and FDTC teams in this study both serve as a secure base for their respective clients. Similar to FDTC teams and their frustration with ASFA timelines, psychotherapists struggle with time limits imposed by managed care in

negotiating the depth of the therapeutic relationship with the client (Mallinckrodt, 2010). Corrective emotional experiences with psychotherapists allowed clients to re-experience old situations with new endings, similar to the social laboratory experience in 12-step meetings and in FDTC settings. Similar to FDTC parents when describing interactions with FDTC team members, clients confirmed the importance of having their therapist provide encouragement, compassion, and empathy during the change process (Bridges, 2006). The experiences of clients and their therapists integrate easily into the Howes' theory of Fostering and, as with the physicians and psychiatric nurses in previous paragraphs, it is extended it to the mezzo level.

In the field of public health, a study of the process of engagement between mothers and public health nurses revealed components similar to those in Fostering for FDTC teams, such as fear, trust building, identifying common goals, and differences in values between nurses and clients based on socioeconomic backgrounds (Jack, DiCenso & Lohfeld, 2004). The findings of Jack et al. support the importance of a connected relationship in regard to positive impacts on child development in home visiting programs when families did not indicate a need or desire for services, similar to the FDTC parents who are mandated to treatment and the value placed on the relationship with the FDTC team (Fisher et al., 2007; Wolfer & Roberts, 2008). The outcomes for patients were improved when physicians engaged emotionally (Weiner & Auster, 2007), and the FDTC parents support the importance of the relationship with the FDTC team (Fisher et al., 2007; Wolfer & Roberts, 2008). Mothers in the home visiting program described testing service providers before engaging in a working relationship with them, and valuing moments when nurses exchanged personal information and experiences as a

means to increasing feelings of mutuality (Jack et al., 2004). The experiences of mothers and home visiting public health nurses integrate easily into the Howes' theory of Fostering and, as with data in previous paragraphs, it is extended it to the mezzo level.

Studies of non-professional relationships that integrate into the Fostering theory include Aronowitz' (2005) description of the experience of mentoring youth and young adults to help them envision their future by feeling competent and elevating their expectations. Similar to FDTC parents, a mentee who was a teen parent stated that her mentor "showed her how to mother" and described her as "someone to lean on." Mentors, like FDTC team members, were willing to set and enforce limits and to express belief in the mentee's (FDTC parent's) potential. Mentors and FDTC team members both provided ongoing encouragement, support, and motivation and "pushed when the going got tough." Like FDTC team members, emphasis was placed on the importance of education by mentors who also provided concrete services such as transportation and child care for mentees to further their education. The data on mentor-mentee relationships integrates into the Howes' theory of Fostering and extends it to the mezzo level.

Like FDTC teams, Aronowitz (2005) refers to using the connection within a relationship as a means to help mentees form their identity, even though social forces such as doing things differently than is the norm in one's family may conflict. The mentor-mentee relationship described by Aronowitz used to decrease risk-taking behaviors in youth parallels the relationship between FDTC team members and clients.

A study of non-professional adults mentoring adults in a study by Cohen and Canan (2006) reflects characteristics of the Howes' theory of Fostering. Cohen and Canan described the relationship between child welfare-involved parents and parent mentors

who had successfully navigated the system as one that addressed concrete needs within the formal child welfare services system—the same context within which FDTCs operate. In addition, similar to the Fostering theory, and experiences of public health nurses visiting parents in their homes (Jack et al., 2004), finding common ground between the mentors and the clients and incorporating family strengths were viewed as important components of the therapeutic relationship. Parents discussed the change process as interactive in nature between mentors and parents, similar to the description by FDTC team members (Cohen & Canan, 2006). The data on mentor-mentee relationships integrates into the Howes' theory of Fostering and extends it to the mezzo level.

Wexler and Winicks' (1996) theory of therapeutic jurisprudence (TJ) states that laws, legal rules and procedures, court procedures, and the people who implement and uphold them can impact physical and psychological well-being of people. Fostering extends therapeutic jurisprudence not only by including the judges and attorneys as therapeutic agents (Birgden, 2004), but extends this concept to all members of the FDTC team and focuses on the relationship between the team and the program participant as a contributor to well-being.

Fostering demonstrates modifiability as a theory by integrating the data from the literature and holds promise to extend beyond the substantive area of FDTCs. This study begins to fill gaps in the literature on FDTCs and describes the basic social process of Fostering to promote well-being.

Discussion

The problem under analysis in this study is how FDTC teams move parents with addictions toward a level of well-being within the timelines of ASFA in order to safely reunite with their children. The result of this study is the Howes' theory of Fostering as a basic social process, experienced by FDTC teams as they support parents in their recovery from substance abuse with the goal of reunifying with their children. *Foster* is defined by Webster (1986) as "to nourish, bring up with care, rear, to help grow or develop, stimulate, promote, to encourage . . . having standing as a family member although not by birth or adoption." The Howes' theory of Fostering is composed of the following stages: engaging, working together, maintaining, and launching. It is the central process by which FDTC teams attempt to help families achieve well-being with a goal of reunification.

The Fostering process suggests that the relationship between the FDTC team (including the judge) and the FDTC parents is therapeutic in nature. The therapeutic alliance between FDTC teams and FDTC parents is one element inside of the black box of drug courts explaining, to some extent, how they work. The phenomenon of Fostering appears to be synergistic in that it is more than a sum of the individual relationships team members may have with the clients.

The findings of this study speak to the national research agenda for drug courts as it explores the need not only to have a regularly assigned judge to FDTCs, but to have regularly assigned attorneys, social service workers, and treatment providers to fully develop the Fostering relationship with parent participants. FDTC team members must be people who are willing to risk emotional vulnerability by engaging, working together,

maintaining, and launching parents with substance abuse and dependency problems, knowing that the stakes are the future of children. The issues of care, custody, and control of children are emotionally charged and can take their toll on team members (Edwards, 2007). FDTC team membership is not for the faint at heart.

The Fostering relationship between FDTC teams and parents parallels that between foster parents and children. The FDTC team is likened to a large, extended foster family helping the parent and his or her children to develop, achieve well-being, and reunite. FDTC teams Foster parents to develop a strong foundation in recovery from substance abuse, to obtain safe housing, and to pursue education or employment in order to provide a safe and permanent home for their children. During this process, FDTC teams, like foster parents, are constantly cognizant of the ASFA timeline looming above their heads, as well as an awareness of the threat that the parent may relapse to substance abuse.

As FDTC teams Foster a parent, their own emotional investment in the parents' success appears to increase with time, realizing that each passing day marks another day in the development of the children. In the Fostering process, teams initially engage with parents, providing supports for them to stabilize, marked by days of sobriety and their attendance at 12-step meetings. Accomplishing the milestone of stabilization leads teams and parents to the stage of working together when teams support, encourage, challenge, and push parents to grow emotionally and cognitively, until the team achieves a level of trust that the parents are ready to "test their wings" and move forward in the Fostering process to the stage of maintaining.

In maintaining, FDTC teams serve as a secure base for parents to return to as needed when they face challenges in their attempts to navigate life and parent their children without substances. The maintenance stage of Fostering ends when teams accept that the parent has reached at least a minimal level of well-being and the ASFA timeline is expiring. Teams then launch the parent by graduating them from the FDTC program.

The Fostering that FDTC teams experience appears to be an emotionally intense experience for them. Successfully completing the process by “launching” the parent is under the constant threat of being crushed between the competing clocks of ASFA, substance abuse recovery, and the development of the child. Although the time needed for recovery and the pace at which children develop cannot be legislatively mandated, the ASFA timeline is. The findings of this study serve as a stimulus to re-visit the 12-15 month timeline mandated by ASFA, as FDTC teams described a need for the option of more time in the Fostering process. The allocation of more resources to FDTCs in order to prevent children from languishing in foster care and from aging out of care is also indicated.

The strengths of this study include opportunities for mining rich data to the point of saturation with study participants. Fostering meets the criteria of a theory according to GT in that it is grounded in the data, and accounts for variation in patterns of behavior across time and place. The Howes’ theory of Fostering is relevant to the key stakeholders in the problem, members of FDTC teams, parents participating in FDTCs, and their children (Glaser, 1978). Fostering is within the parameters of validity, defined in GT as fit, relevance, workability, and modifiability (Glaser, 1978; Glaser & Strauss, 1967).

The limitations of this study include the threat that preconceived ideas of the researcher could influence the findings. To reduce this threat, the constant comparison method of data collection and analysis was employed to assure that the results emerged from the data and not the researcher's expectation (Glaser, 1978; Glaser & Strauss, 1967). In fact, the process of Fostering emerged from the data to the surprise of researcher. The emotional experience and investment of the FDTC teams as they supported parents to matriculate through the court and child welfare process continuously occurred in the data, concurrent with the well-being theory of Emotional Permanence (EP) described in Chapter III. The theoretical sensitivity of the researcher allowed for revisiting of the data to fully explore the recurrent theme of Fostering.

Another limitation is that the sample in this study is confined to the substantive area of FDTCs. Additional research is needed in different substantive areas where interdisciplinary team approaches are used in helping professions such as hospitals and special education. Social desirability is always a threat as study participants may give responses that portray themselves in an unrealistically positive light. Sampling across place and time was employed to control for this. Finally, this study is exploratory and inductive in nature. As with all GT research, it is the precursor to confirming a theory with the aim of generating a theory about a social problem (Glaser, 1978; Glaser & Strauss, 1967). Further studies are needed to modify and extend Fostering as a theory. Studies in other areas will serve to elevate Fostering from a substantive theory to a formal theory (Glaser, 1978; Glaser & Strauss, 1967).

The implications of applying the findings of this research in the FDTC field are many. The Fostering theory provides a framework for understanding the experience of

FDTC teams as they help parents and children achieve well-being. Team members may benefit from this framework as it normalizes their challenging and difficult experiences. Teams may experience a feeling of universality when informed of Fostering as a process common to interdisciplinary teams in the helping professions. FDTC teams may wish to use the Fostering process during orientation for new program participants to explain to parents new to the FDTC program what to expect from their interactions with the team as they work together to safely and permanently reunify their family. Incorporating the findings from this study in training for jurisdictions planning to implement an FDTC may also be helpful in preparing teams for the emotional intensity of the work.

Additional research of how FDTC teams function will contribute to the knowledge base of implicit key components that make some drug courts succeed and others dissemble. With this knowledge, FDTCs can more easily be “taken to scale” in order to promote the well-being of parents with substance abuse and dependency problems and their children in all jurisdictions. Society stands to benefit from the findings of this research at the micro, mezzo, and macro levels as the effects of parental substance abuse are far-reaching.

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CHAPTER V

CONCLUSION

The aim of this three-paper format dissertation is to explore how the well-being of foster children of parents with substance abuse problems is defined and promoted through Family Dependency Treatment Courts (FDTC) within the context of the Adoption and Safe Families Act (ASFA). Paper one is a critical analysis of the key components of ASFA with recommendations for amendments. Paper two postulates the comprehensive, grounded theory of “Emotional Permanence” (EP) as a universal definition of well-being. Paper three explains the critical component of “Fostering” experienced by interdisciplinary FDTC teams in their relationships with parents with substance abuse problems and their children. This research is relevant to foster children, parents with substance abuse problems, child welfare workers, judges, attorneys, and treatment providers, as the effects of parental substance abuse in our society are deep and broad.

Background and Significance

Children of parents with substance abuse problems do not fare well. They are vulnerable to child maltreatment, low levels of parental monitoring, developmental delays, behavior and emotional problems, juvenile delinquency, and early sexual activity (Barnes, Welte, Hoffman, & Dintcheff, 2005; Fellitti, 2003; Haight, Carter-Black, & Sheridan, 2009; Lemmon, 2006; Peiponen, Laukkanen, Korhonen, Hintikka, & Lehtonen,

2006; Tyler & Johnson, 2006; Wareham & Dembo, 2007). Children of parents with substance abuse problems are commonly exposed to domestic violence and criminal behavior (Haight et al., 2009). Substance abuse negatively impacts parental employment, which correlates with childhood poverty and impaired access to health care, food, and housing for children (SAMHSA, 2009).

Parents with substance abuse problems have children who are more likely to enter and re-enter the child welfare system. Once in care, these children have greater chances of staying longer and fewer chances of reunifying with their parents (Brook & McDonald, 2009; Fuller & Wells, 2003; Gregoire & Schultz, 2001; Smith, 2003). As young adults, children who age out of foster care often face increased risks of homelessness, poor mental and physical health, substance abuse, and criminal behavior (Barnes et al., 2005; Fellitti, 2003; Haight et al., 2009; Lemmon, 2006; Peiponen et al., 2006; Tyler & Johnson, 2006; Wareham & Dembo, 2007). The costs of child abuse and neglect to our society are estimated annually at \$103.8 billion (Wang & Holten, 2007).

ASFA was enacted in 1997 in response to the burgeoning foster care population and public concern for the children in care. The number of children in foster care doubled between 1985 and 1997, increasing from 276,000 to 500,000, respectively (O'Neill-Murray & Gesiriech, 2004). By 1997, 500,000 children were in foster care, with 40-80% due to parents with substance abuse problems (Badeau & Gesiriech, 2004; D'Andrade & Berrick, 2006; Kortenkamp & Erhl, 2002; Maluccio & Ainsworth, 2003; Smith, Elstein, & Klain, 2005). ASFA sought to move children out of foster care swiftly, if not through reunification with their parents, then preferably through adoption. Family Dependency Treatment Courts (FDTC) operate within the context of ASFA as an effective and

reasonable effort to safely reunify children with parents recovering from substance abuse and dependency (Bureau of Justice Administration [BJA], 2004; Green, Rockhill, & Furrer, 2007; Gregoire & Schultz, 2001; Smith, 2003).

Although ASFA increased adoptions out of foster care by 57% (Barth, Lee, Wildfire, & Guo 2006; McDonald, Sidote-Salyers, & Testa, 2003), the number of children entering care increased at the same rate. In designing ASFA, legislators did not heed concerns from the field of child welfare in designing the legislation (U.S. GAO, 1997). One month before ASFA was signed into law, in October 1997, during a prophetic testimony to the U.S. House of Representatives Subcommittee on Human Resources Ways and Means Committee, the Director of U.S. Income Security Issues, Health, Education, and Human Services Division, Janet Ross, reported the following points to Congress:

1. A shortage of foster and adoptive homes existed.
2. The majority of children in care were there because of parental drug abuse.
3. The use of highly addictive drugs such as methamphetamine was increasing.
4. A shortage of substance abuse treatment existed,
5. The timeline of 12-15 months proposed in ASFA to make efforts to reunify families conflicted with the minimum duration of time parents needed in substance abuse (12 months) to have a positive prognosis.
6. Without enhanced substance abuse treatment, the likelihood of reunification of foster children with parents with substance abuse problems would likely decrease (U.S. GAO, 1997).

The six points in Ross' testimony 14 years ago are true today. The lack of progress in addressing the needs of children in foster care due to parental substance abuse problems prompted this researcher to conduct a critical analysis of the key components of ASFA.

Summary of Paper One: Recommended Amendments to ASFA

The policy analysis focused on three key components of ASFA and the implications for children of parents with substance abuse problems. The key components are permanency (a permanent home for children), reasonable efforts to reunify families within timelines, and aggravated circumstances that allow states to waive reasonable effort and fast-track the case to termination of parental rights (ASFA, 1997).

The Child and Family Services Review (CFSR) process is the method used by the U.S. Department of Health and Human Services (USDHHS) Administration for Children and Families (ACF) to assess states' progress in ensuring safety, permanence, and well-being for children in care (Schuerman & Needell, 2009a, 2009b). Findings of this analysis reveal that the CFSR process attempts to measure safety, permanence, and well-being as separate constructs without a universal definition of well-being. In addition, the CFSR process is methodologically flawed. Although CFSR results may reveal trends, they are largely ineffective at helping states effectively implement the mandates of ASFA (Schuerman & Needell, 2009a, 2009b).

The bulk of funding under ASFA (90%) is allocated for children in care and their families. Only 10% of funding is available to prevent child abuse and neglect and to prevent children from entering foster care. ASFA provides for financial incentives to states for each adoption completed, but does not reward states for achieving other forms

of permanency such as family reunification, guardianships, or long-term foster care. Parental rights are terminated along with the parent's financial responsibility for children while in foster care in an attempt to increase adoptions out of foster care, thus shifting to the states the cost of children in care waiting for adoption. Annually, 115,000 children are "freed for adoption" by terminating their parents' rights. However, only 50,000 of these children are actually adopted each year; 41,000 are "legal orphans" who wait for adoption in foster care for an average of 42 months (Smith et al., 2005). The remaining 24,000 children turn 18 and age out of the system without the support of a family as they face the challenges of adulthood (Barth, Wulczyn, & Crea., 2005; Wertheimer, 2002; Woodhouse, 2005).

The Children's Defense Fund (CDF) (2006) and the Pew Commission (2004) recommend sweeping changes to ASFA. The consolidated recommendations include (1) redistribution of existing funding to provide services for children and families to prevent out-of-home placement, during placement, and following their exit from care; (2) extension of financial incentives to states to include all permanency options states achieve, including family reunification, guardianship, and long-term foster care; and (3) increase in the accountability of states in their efforts to improve the safety, well-being, and permanency of children in care.

This researcher supports the implementation of the recommendations of the CDF and the Pew Commission with the enhancements of institutionalizing FDTCs in every jurisdiction, and increased research that support (1) a comprehensive, universal definition of well-being for states to use as they assess, promote, and measure well-being; (2) improvements in the methodology of the CFSR process, (3) increase in the use of the

need for substance abuse treatment as a compelling reason to extend the timelines for states to provide reasonable efforts to reunify families; and (4) eliminating the requirement of terminating parental rights for children in long-term foster care to shift the financial burden of their care back to the parents and to maintain contact between parents and children at the safest optimum level. The recommendation for research to develop a universal definition of well-being is the focus of paper two in this dissertation, a grounded theory study in well-being.

Summary of Paper Two: Howes' Theory of Emotional Permanence

A universal definition of well-being has not been adopted by researchers, legislators, or child welfare practitioners, rendering the operationalization of the construct across person, place, and time impossible. Theories in the current literature on well-being are fragmented and are not grounded in data. Paper two reveals the Howes' theory of "Emotional Permanence" (EP) as a comprehensive theory of well-being that is grounded in data (Glaser, 1978; Glaser & Strauss, 1967). The Howes' theory of well-being, EP, is defined as "health within relationships over time."

EP emerged from data using an inductive and exploratory approach to research conducted at four FDTC sites. FDTCs are data-rich sources for well-being, as their primary goal is to promote the well-being of foster children and their parents with substance abuse problems with a goal of permanence, preferably through safe family reunification. Two groups of study participants provided informed consent to participate at each site: (1) interdisciplinary teams of professionals, and (2) parents participating in

the FDTCs. Observations and interviews were conducted at each site until EP emerged from the data.

EP encompasses safety and permanence and addresses well-being at the macro, mezzo, and micro levels of our society. EP extends the literature on well-being in that it emphasizes the importance of the need for spiritual, physical, and emotional well-being within individual, familial, and community relationships throughout one's life. EP focuses on the fluid, synergistic characteristics of well-being that cannot be captured in a snapshot, but must be considered at individual, family, and community levels over the period of a life. EP provides a universal definition of well-being as a first step in the operationalization of the construct.

During the observations and interviews at the four FDTC sites, another phenomenon emerged as a grounded theory. FDTC teams described their experiences of promoting the well-being through an emotionally intense therapeutic relationship with the parent participants in their programs. The researcher revisited the data and identified a second emergent theory grounded in the data, "Fostering," as a basic social process in FDTCs.

Summary of Paper Three: Howes' Theory of Fostering

The second core category or theory that emerged from the research at the FDTC sites is the Howes' theory of "Fostering" process FDTC teams go through with the FDTC parents. The process of Fostering consists of the stages engaging, working together, maintaining, and launching. Milestones precede each stage, including stabilizing, trust, and acceptance. Fostering, as defined by Webster (1986), means "to nourish, bring up

with care, rear, to help grow or develop, stimulate, promote, to encourage . . . having standing as a family member although not by birth or adoption.” Howes applies this definition as the basic social process experienced by FDTC teams in their relationship with parents recovering from substance abuse.

The Howes’ theory of Fostering in paper three answers the call for studies that contribute to the knowledge base of “how drug courts work” from the national research agenda of drug courts (Marlowe, Heck, Huddleston, & Casebolt, 2006). Marlowe et al. imply that drug court components have a synergy that is absent in traditional substance abuse treatment approaches. Research approaches that go beyond testing single measures against each other and explore the relationship between FDTC judges and program participants, the interdisciplinary team approach, and the implications of the presence of case managers and treatment providers during FDTC hearings is called for (Cissner & Rempel, 2005; Marlowe et al., 2006; Marlowe, DeMatteo & Festinger, 2003). The grounded theory of “Fostering” suggests that the relationship between the FDTC team as a whole (not just the FDTC judge) and the parent is more than the sum of its parts and is a critical element in the efficacy of drug courts.

The recurrent theme of the intensity of the emotional investment of FDTC team members in their relationship with parents was telling. Teams described operating under the competing clocks of the ASFA timeline for providing reasonable efforts (12-15 months) before moving to termination of the parental rights, the minimum duration of time needed (12 months) for substance abuse treatment to be effective with a constant threat of relapse, and the developmental timeline of children. Teams were ever cognizant of balancing the demands that “kids can’t wait” and treatment cannot be rushed.

The process of “Fostering” parents in FDTCs is likened to the experience of preparing for and watching an Apollo launch, filled with fear, frustrations, and hope, knowing that the stakes are high and that the nation is watching. The launch, when successful, is rewarding and gratifying to FDTC teams, knowing that they contributed something important to society. When the launch is unsuccessful and the parent returns to substance abuse, teams describe the Fostering experience as “painful” and “heart wrenching.” Teams reassure each other that in FDTC the parent received intense and comprehensive services, but often wish they had more time with them. Teams expressed reminiscing about past successes as a strategy to allay their fears and cope with their frustrations.

The process of “Fostering” is similar to therapeutic relationships between patients and their physicians, psychiatric nurses, public health nurses, and therapists. It is similar to relationships between non-professional mentors and their mentees and between foster parents and children. However, the Howes’ theory of Fostering extends the concept of the therapeutic relationship from existing between two individuals, to a synergistic relationship between a group of people, FDTC team members, and each FDTC parent.

Fostering extends the research on therapeutic jurisprudence (TJ). Wexler and Winick (1996) defined TJ as laws, legal rules and procedures, court procedures, and the people who implement and uphold them as a tool that can be used to impact the physical and psychological well-being of people. Fostering extends TJ to include all members of FDTC teams as people who implement and uphold the law, including child welfare workers and treatment providers and explains it as a process with stages and milestones.

Study Limitations

The limitations of this study are common to many qualitative studies. One limitation is that the perspective and experiences of the researcher could influence the findings. To control for this, the constant comparison method of data collection and analysis as recommended by Glaser and Strauss (1967) was employed. In addition, the researcher initiated the research in hopes of defining well-being; however, due to her theoretical sensitivity (Glaser, 1978), she was open to revisiting the data as the theory of Fostering unexpectedly emerged. The researcher's knowledge of FDTCs due to her dual role of researcher and practitioner is considered to add depth to the research while following the data where it led.

The participant pool in this study is limited to the substantive area of FDTCs. This limits the results to that specific population, indicating a need for additional research in other substantive areas that are rich in data pertaining to well-being, prior to generalization of the findings to other groups and settings. Study participants may portray themselves in an unduly positive light due to social desirability. However, themes in the data recurred frequently across sites. Finally, the number of participant groups is small and therefore future studies must be conducted before results can be generalized.

Questions for Future Research

Questions for future research include how to best institutionalize FDTCs in every jurisdiction to address the problem of parental substance abuse in the courts and the child welfare system. Research is needed to answer the question of how we can effectively

assess, promote, and measure well-being and improve the methodology of the CFSR process. This study is a first step in many yet to be taken to operationalize the construct of well-being. Each construct of EP, health, relationships, and time needs to be deconstructed for the purposes of defining a range of minimally acceptable levels of well-being.

A method of conducting CFSRs by researchers that includes multiple measures and informants across settings will need to be implemented, tested, and revised according to findings. Data and sampling problems in the CFSR need to be corrected and track children over time to ensure that results are accurate and meaningful. Studies on well-being need to be conducted in other substantive areas where issues of child and family well-being are promoted or maintained to answer the question of the generalizability of EP. The K-12 educational setting, child care settings, and health care providers are areas where this study could be replicated.

To answer the question of the generalizability of the Howes' theory of Fostering, additional research is needed in other areas, such as hospitals and special education, where interdisciplinary team approaches are used to promote well-being. With this knowledge, FDTCs can more easily be taken to scale in all jurisdictions in order to promote the well-being of more parents with substance abuse and dependency problems and their children. Progress in this area will benefit our society on micro, mezzo, and macro levels as the effects of parental substance abuse are far-reaching.

Summary

Policy makers and practitioners in the fields of family law, child welfare, and mental health can use the findings of this research to make changes at macro, mezzo, and micro levels of our society to ensure the well-being of the large population of foster children and parents with substance abuse problems. This research addresses the gap in the literature on FDTCs, how drug courts work, the synergistic nature of the interdisciplinary FDTC teams, a universal definition of well-being as Emotional Permanence, and the Fostering process to support well-being in the family court, child welfare, and mental health systems.

Changes of this scale are difficult and evolve slowly. The progress made under ASFA, the CFSR process, and the findings of this research should be built on. Given that child welfare policies address the most vulnerable population in our society, it is necessary that we give deliberate consideration of intended and unintended consequences prior to any modification of existing policies and practices.

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Appendix A

Human Subjects Institutional Review Board
Letter of Approval

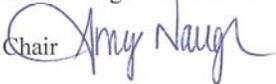
WESTERN MICHIGAN UNIVERSITY



Human Subjects Institutional Review Board

Date: May 6, 2009

To: Kieran Fogarty, Principal Investigator
Barbara Howes, Student Investigator for dissertation

From: Amy Naugle, Ph.D., Chair 

Re: HSIRB Project Number: 09-03-01

This letter will serve as confirmation that your research project titled "Exploring the Theoretical Determinants of the Attributes of Child Well-being in Michigan Family Treatment Courts" has been **approved** under the **full** category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may **only** conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: March 18, 2010