

REINTEGRATION STRATEGIES TO MITIGATE CHILD ABUSE AND NEGLECT BY
SUBSTANCE ABUSERS IN WEST VIRGINIA COMMUNITIES

Reintegration Strategies to Mitigate Child Abuse and Neglect by Substance Abusers -WV

A Thesis

by

CHERYL WILSON LAWS

Submitted to the Graduate School

at Appalachian State University

in partial fulfillment of the requirements for the degree of

MASTERS OF ART

May 2016

Department of Appalachian Studies

REINTEGRATION STRATEGIES TO MITIGATE CHILD ABUSE AND NEGLECT BY
SUBSTANCE ABUSERS IN WEST VIRGINIA COMMUNITIES

A Thesis

by

CHERYL WILSON LAWS

May 2016

APPROVED BY:

Dr. William Schumann

Chairperson, Thesis Committee

Dr. Sarah Beth Hopton

Member, Thesis Committee

Dr. Michael Potter

Member, Thesis Committee

Dr. William Schumann

Chairperson, Department of Appalachian Studies

Max C. Poole, Ph.D.

Dean, Cratis D. Williams School of Graduate Studies

Copyright by Cheryl Wilson Laws 2016

All Rights Reserved

Abstract

REINTEGRATION STRATEGIES TO MITIGATE CHILD ABUSE AND NEGLECT BY SUBSTANCE ABUSERS IN WEST VIRGINIA COMMUNITIES

Cheryl Wilson Laws

R.B.A., West Virginia State University

M.A., Appalachian State University

Chairperson: Dr. William Schumann

This thesis evaluates the effectiveness of current intervention strategies employed by organizations that provide socially necessary services (SNS) to Kanawha County, West Virginia parents whose drug addictions pose an impending danger to the continued safety of their children and led to substantiated allegations of child abuse and neglect. These organizations, known as administrative service organizations (ASO), are referred to these maltreating parents by Child Protective Services (CPS) to control or mitigate impending dangers to the safety of abused/neglected children posed by maltreating parents with drug addictions. The current modus operandi of the state of West Virginia is to facilitate an intervention, provide treatment and reunify the family. However, there is an omitted and crucial piece to the sustainability of the family unit once they are released from the supervision of the state, which is in the form of a community reintegration strategy that will support the family's success as a functioning social unit upon release from the child welfare system. This thesis intends to show that without this integral piece of the circle, the cycle of drug abuse cannot be broken therefore fails at the sustainability of the sobriety of the maltreating parent as well as the family as a functioning unit.

Acknowledgements

I would first like to thank Appalachian State University and the Center for Appalachian Studies for an incredible educational experience. To my Thesis Director, Dr. William Schumann for his respect of my vision and his commitment to prepare and guide my research towards my goal. I would also like to thank my Thesis Committee, Dr. Sarah Beth Hopton and Dr. Mike Potter for their time and contributions to ensure my research was scholarly and professionally written.

I would not be where I am today if it weren't for the support of several of my family members. The trust, patience and devotion of my daughter, Sydney Atkins, her willingness to take this adventure with me to Boone, North Carolina and belief in my vision has given me the strength to complete my degree and this research. I am also grateful for the love and support of my mother through both my undergraduate and Masters Degree and the time my sister, Denys Snodgrass, devoted to editing this thesis. A special thank you to Cat Talley from the Appalachian State University Writing Center for teaching me writing skills that will stay with me throughout my career and for her encouragement.

I would also like to acknowledge my long-time friend and therapist, J.R. Keener, for his guidance in teaching me to believe in myself, to trust my instincts and pursue only and all things that enhance my life. Lastly, I would like to thank my friend, colleague and business partner, Dr. Sundjata ibn-Hyman for helping me create the story I have tried to tell within this thesis and for sharing my vision to keep children throughout West Virginia safe while an opportunity is provided for substance abusers to reset and recreate a new life for themselves and their families.

Dedication

This work is dedicated to my son, Nicholas Gregory Laws, my daughter, Sydney Juliann Atkins and to my granddaughters, Jamesyn Audra and Emeri Rayne Laws. You are the reason I do all that I do- to inspire you not only with my words, but by the example of the richness of my life. May you know that it is never too late to follow your passion. Dream big, work hard and make beautiful memories.

I also dedicate this work to every parent who has ever lost custody of their child, for the children who miss them and to Stacy Dawn Parsons and other fallen angels this epidemic has taken away long before they had the opportunity to recreate themselves and this world.

“Unless someone like you cares a whole awful lot, nothing is going to get better. It’s not.”

-Dr. Seuss

List of Figures

Figure 1- Child Protective Services (CPS) Procedure for Abuse and Neglect Referrals

Figure 2- Child Protective Services (CPS) Adjudication Process for Out-of-Home Placement

Figure 3- Bronfenbrenner Ecological Model

Table of Contents

Abstract.....iv

Acknowledgments.....v

Dedication.....vi

List of Figures.....vii

Chapter 1: Introduction to the Socioeconomics of Drug Addiction

History of Drug Use.....1

Susceptibility to Substance Abuse.....3

Substance Abuse and the Demise of the Family Unit.....8

Substance Abuse and the Maltreatment of Children.....10

Child Welfare System.....13

Treatment Obstacles.....14

Stress, Relapse and Re-Offending Maltreatment.....15

Post-Treatment Hardships.....17

Chapter 2: Policy Context of West Virginia

Substance Abuse in West Virginia.....20

Child Protective Services Policy for Abuse and Neglect Referrals.....21

Child Protective Services Procedure for Abuse and Neglect Referrals.....25

Provision of Services for In-Home Safety Plans.....	31
Adjudication Process for Out-of-Home Safety Plans.....	33
Three Key Gaps within the Current System.....	36

Chapter 3: Critical Engagement- Literature Reviews and Case Studies

Community-Level Change.....	44
Literature Review.....	45
Case Studies.....	50

Chapter 4: Methods of Research

Research Introduction.....	58
Research Process.....	59
Survey Results.....	61
Interview Results.....	65
Analysis of Research.....	68
Research Conclusion.....	78

Chapter 5: Treatment, Prevention and Reintegration

Treatment.....	80
Prevention.....	84
Reintegration.....	87

Healthy Kids and Families Coalition.....89

Pollen8, Inc.....91

Chapter 6: Thesis Conclusion

Thesis Overview.....97

Further Research.....99

Long-Term Objectives.....100

Challenges and Obstacles.....102

References.....108

Chapter 1: Introduction to the Socioeconomics of Drug Addiction

Chapter Introduction

This chapter discusses the history of drug addiction, the role that drug addiction plays in the demise of the family unit, how the socioeconomics stressors such as unemployment, class identification and role ambiguity in low-income communities contribute to the propensity for relapse in drug addicts and the effects that stress has not only on initial parenting roles, but also in exasperating the propensity for relapse and delay of recovery. Lastly, scholarly literature is utilized to build a theoretical framework, explaining the degrees to which children living with substance abusing parents are susceptible to danger and maltreatment.¹

Substance abuse is a significant health and social problem plaguing families throughout the United States. Substance abuse often occurs within an environment of emotional, social and economic deprivation that can include poverty, mental illness, domestic violence, economic and housing uncertainty, dangerous neighborhoods and stress, which are often correlated with higher incidences of maltreatment (Semidei, Radel, & Nolan, 2001; Orme & Rimmer, 1981; Walsh, MacMillan & Jamieson, 2003). Substance abuse has also been found to have a negative impact on family functioning (Bijur, Kurzon, Overpeck, & Scheidt, 1992; Kumpfer, 1987). Parental substance abuse either directly or indirectly, places a child at higher risk of maltreatment and family life is more likely to deteriorate when parents abuse drugs.

History of Drug Use

Johann Hari (2015) spent 10 years researching his book, "*Chasing the Scream*," to try and better understand the plague that had swept into the worlds of his loved ones. He wanted to

¹ "maltreatment" meaning cruel or violent treatment of a person; abuse.

better comprehend not only addiction but the effects that prohibition (War on Drugs) has had on the advancement and increase of drug usage within the United States and throughout the world. Also, his research sought to further identify the driving forces behind why certain people become severely addicted to drugs and why others can use it recreationally and never become addicted (Hari, 2015).

Hari (2015) states that humans have a history of wanting to alter the mind. There has never been a society in which humans didn't seek to alter their mental capacities. In the Andes in 2000 B.C., people were smoking hallucinogenic herbs through pipes they made themselves. Ovid said drug induced ecstasy was a divine gift. The Chinese were cultivating opium by 700 AD and hallucinogens and chemicals caused by burning cannabis were found in clay pipe fragments from the home of William Shakespeare. Our founding president, George Washington, insisted that soldiers be given whiskey as part of their rations every day (Hari, 2015). Small children instinctually are drawn to the sensation that is provided to them when they spin themselves round and round in circles. The nausea this can cause isn't even a deterrent from the euphoric, dizzy feeling that happens within the brain. A physician, Andrew Weil expresses that seeking this altered state must represent a basic human instinct, which enables Professor Robert Siegel to claim that the desire to alter our consciousness is the "fourth" drive in human minds, in conjunction with the desire to eat, drink and have intercourse. He feels it is biologically predictable and provides humans with moments of freedom and reprieve (Hari, 2015).

Hari (2015) further shares that only ten percent of drug users have a problem with their substance of choice. Ninety percent are not harmed by it (United Nations Office on Drug Control, 2010). The United Nations Office on Drug Control (2010), reports that non-addicted users still comprise the vast bulk of America's drug involved population (United Nations Office

on Drugs & Crime, 2010). However, all we see in the public eye are the ten percent which are the casualties. These are the damaged users who are the only ones you would ever see using on the street in public, committing crimes and are also one hundred percent of the ones that the media brings to our attention. Included in these number are the parents who are at risk of losing custody of their children due to the abuse and neglect that is a direct side effect of addiction. Maté (2010) regards that nothing is addictive in and of itself. It is always a combination of a potentially addictive substance or behavior and a susceptible individual (Maté, 2010).

Susceptibility to Substance Abuse

Physical dependency.

The vast majority of society believe that drug addiction is a moral choice people make and do not understand the mental and physical aspects of addiction. Besides Christianity, one of the ways this belief was injected into the American psyche was through a 1980s experiment conducted through sponsorship by the Partnership for a Drug-Free America. The experiment was simple. Scientists place a rat alone in a cage with two water bottles. One was just water and the other was water laced with heroin or cocaine. Almost every time this experiment was conducted, the rat became obsessed with the drugged water and kept going back for more until it killed itself (Deroche-Gamonet, Belin & Piazza 2004). Since this experiment, addiction specialist have focused only on the physical dependency of drug addiction where the body becomes addicted to a chemical and the addict will experience physical withdrawals if they stop. Therefore, society is lead to believe that the main source of addictive behaviors is because of this physical withdrawal. This would explain the side effects of drug addiction as crime, abuse and neglect of children, dysfunction, chaos, violence and the reason substance abusers do not participate in society.

DeGrandpre (2006) conducted a study of the theory of addiction using nicotine patches. The Office of the Surgeon General labels nicotine as a deadly addiction, alongside heroin and cocaine yet nicotine kills 650 of every 100,000 users and cocaine kills 4 of every 100,000 users (Davis, Novotny & Lynn, 1998). The purpose of a nicotine patch is to continue to give the drug to the user, without the “unhealthy” habit of smoking, and amounts of nicotine are lessened over time. To date, nicotine patches have only aided 17.7% of users quit (DeGrandpre, 2006). This study shows that withdrawal symptoms were lowered and eventually alleviated through the patch. Furthering research could show that if addiction was merely based on chemicals then why do people relapse long after the chemical is removed from the body? The drugs are removed from the body and chemical cravings pass, therefore they are no longer physically dependent but they are still addicted. The physical dependency is an aspect of drug addiction, but only a small one.

Personal history as a precursor.

During a 2003 study looking at over two thousand mothers seeking treatment at fifty substance abuse rehabilitation programs between 1993 and 2000, Connors et al. (2003) found that psychological illness was found in more than half of the subjects, the most prevalent diagnoses being depression, trauma and bipolar disorder. Forty-eight percent of the women were unemployed, fifty-two percent lacked a high school education and seventy-one percent received public assistance. One-third of the sample had been homeless during the previous two years and two-thirds had criminal records. Fifty-seven percent reported having been abused by their parents and seventy-four percent reported being abused by a non-parent (Neger & Prinz, 2015). This research contributes to our understanding of the linkage between personal history and drug abuse as strategy often adopted as a coping mechanism for the stresses of life.

The Adverse Childhood Experiences Study was conducted in 2003 to examine the relationship between illicit drug use and 10 categories of adverse childhood experiences (ACEs) and total number of ACEs (ACE score). The study consisted of 8613 adults who attended a primary care clinic in California. The cohort completed a survey about childhood abuse, neglect, household dysfunction and illicit drug use, along with other health-related issues. The main outcomes measured were their own self-reported use of illicit drugs, including 3 different age categories: 14 years, 15 to 18 years or as an adult (19 years +). Four birth cohorts were examined, dating back to 1900, studying drug use problems, addiction and parental drug use. The findings of the study concluded that each ACE increased the likelihood for early initiation of drug use 2 to 4 times. The ACE score had a strong relationship to initiation of drug use in all 3 age categories as well as to drug use problems, addiction and parenteral drug use. Compared with people with 0 ACEs, people with 5 ACEs were 7 to 10 times more likely to report illicit drug use problems, addiction and parenteral drug use. For each of the 4 birth cohorts examined, the ACE score also had a strong graded relationship to lifetime drug use (Dube et al., 2003).

The high correlation of the relationship between the ACE score and initiation of drug use for 4 successive birth cohorts dating back to 1900 suggests that the effects of adverse childhood experiences transcend secular changes such as increased availability of drugs and social attitudes toward drugs. Research shows that drugs make people forget about the pain they have endured and proves that the issues facing substance abusers were issues long before the mind altering drugs came into play (Dube et al., 2003). Further research would need to be conducted on childhood trauma, brain development and utilizing stories of addicts to provide a coherent theory of addiction.

Stress as a precursor.

While dependency and personal history plays a significant part in a person's susceptibility to drug addiction, there are other denominators. Social Stress Theory states that a person's placement in their social environment greatly impacts exposure to stress, perceptions of stress and resources available for coping with stress (Aneshensel, 1992; Pearlin, 1989).² Stress is often a direct result of social position and the level of stress associated with social position is a predictor of distress.³ People who belong to groups of lower social status often experience greater distress than those higher in social status (Mirowsky & Ross, 1986; Mirowsky & Ross, 2003). Gender, race/ethnicity and low socioeconomic status (SES) are among the social categories associated most highly with stress and distress. Social positioning or one's place on the continuum of social status, is often associated with exposure to stressors, how a person experiences stress and subsequent psychological distress that is created from repetitive stressful situations (Wahler, 2012).

Stressors can be serious and short-term, such as experiencing a change by a sudden move or loss of a job or chronic, long-term economic (poverty) hardship and issues with relationships (domestic violence). Often, chronic strains have a greater impact on the psychological well-being of an individual than short-term, more serious stressors. Ongoing strains such as poverty, health problems, living in unsafe neighborhoods or single parenthood can greatly affect the mental health of an individual. Certain abilities that individuals have facilitate how that individual responds to stress, including coping skills, social support, self-confidence, perception

² "stress" meaning a state of mental or emotional strain or tension resulting from adverse or very demanding circumstances.

³ "distress" meaning extreme anxiety, sorrow or pain.

of life and personal resilience. If an individual does not inherently possess these skills, their coping abilities are a reflection of their social group (Pearlin, 1989).

Life events often lead to role strain,⁴ which can diminish self-confidence and self-reflection, subsequently increasing effects of stress (Pearlin et al., 1981). Addicts and alcoholics often times experience this type of role strain because their addiction can cause difficulty in retaining employment, effective parenting or other roles held. Poverty and economic hardship increase role strain with the inability to provide for one's self and family. Furthermore, children in the home increase economic hardship and psychological distress, particularly for unmarried women (Brown & Moran, 1997; Mirowsky & Ross, 2003). Ross (2000) found that ongoing stress from living in disordered neighborhoods significantly impacted depression for poor, single mother-head of household. Inadequate support systems, difficulty parenting, inaccessible resources and financial difficulties significantly affect coping skills and create depressive symptoms in single mothers (Baffour, Gourdine, Domingo & Boone, 2009; Wijnberg & Reding, 1999).

While all single mothers are at risk for increased depression, ongoing poverty in rural environments, such as Appalachia, impacts their mental health more. Rural single mothers have additional stressors and experience more subjective distress due to the arduous undertaking in obtaining employment, adequate and affordable housing, transportation and fewer resources for assistance (Wahler, 2012; Raikes & Thompson, 2005). As previously stated, lower socioeconomic status (SES), as defined by income, education level and employment, are consistently associated with higher levels of psychological distress and could potentially decrease self-confidence due to

⁴ "role strain" meaning the stress or strain experienced by an individual when incompatible behavior, expectations or obligations are associated with a single social role.

the fact that rural single mothers have little control over their life circumstances (Mirowsky & Ross, 2003; Wahler, 2012). Additionally, literature shows that stress often instigates initial drug and alcohol use and dependency (DeHart, Tennen, Armeli, Todd & Mohr, 2009; Frone, 2008; Hatzenbuehler, Nolan-Hoeksema & Erickson, 2008; Liu & Weiss, 2002; Mattoo, Chakrabarti & Anjaiah, 2009). The connection between socioeconomic stresses (SES) and family functioning are documented in the child maltreatment literature (Belsky, 1980; 1984; Garbarino & Sherman, 1980; Wolock & Magura, 1996). Poverty and other characteristics that place individuals at a social disadvantage, such as unemployment and lack of education, are correlated with mental health problems and addiction, leading to substance abuse in low income families (Hatzenbuehler et al., 2008; Mulia, Ye, Zemore, Greenfield, 2008; Williams, Mohammed, Leavell & Collins, 2010).

Substance Abuse and the Demise of the Family Unit

As previously stated, stress is a significantly common cause of both parental substance abuse and parenting difficulties (Hilson & Kuiper, 1994). Substance abusing parents experience a greater number of stressors based on life histories, difficulty locating and keeping employment and limited social support. Murphy et al., (1991) examined substance abuse in a sample of two hundred and six serious child abuse or neglect cases before a Boston juvenile court. In forty-three percent of the cases, at least one of the parents had a documented problem with either alcohol or drugs. Black and Myer (1980) interviewed two hundred alcohol- or opiate- addicted Boston families at an addiction treatment center, inquiring about the relationship between child care and child injuries. Forty-one percent of the children met criteria for serious neglect, abuse or both. All were felt to be at least mildly neglected (Magura & Laudet, 1996). Child maltreatment involves numerous factors that compound to create family role malfunction and dysfunctional adaptation by caregiver and child (Belsky, 1980). These findings suggest that external

distractions and stress impact the behaviors of a parent and their level of aggressiveness toward the child. Risk factors are diverse. Some are inherent personalities of the child or parent and others point to the broader family context or the social-cultural environment, such as socioeconomic stresses (Hashima & Amato, 1994). Although many aspects of parents and families have been studied, a significant portion of research suggests an association between child maltreatment with family stress, particularly amongst young or single parents living in impoverished conditions and in communities that do not provide adequate social support and guidance from other adults (National Committee for Injury Prevention & Control, 1989; Sack, Mason & Higgins, 1985; Schloesser, Pierpont & Poertner, 1992).

Drug addiction takes its toll not only on the individual but on every single member of the family. Drug abusing families, compared with their non-abusing equivalents, are more isolated from typical social situations and spend less time with their children (Kumpfer, 1987). Drug abuse also leads to higher rates of illness, which makes it difficult or even impossible to function properly as a parent (Goldstein et al., 1987). Heavy substance abuse can lead to the deterioration of parents' basic views and values about their family and themselves and makes difficult financial demands on the user and compromises the parent's ability to provide even the basic necessities for their families (Haskett et al., 1992). Economic hardships for children may result from the drug addicted parent's inability to hold down employment or even to pursue the appropriate steps necessary to maintain public assistance eligibility to lessen the financial burden of the family and alleviate further demise. Often, drug-dependent parents become desperate and resort to crime to satisfy their drug addictions which results in a lifestyle of instability and drug-seeking behavior, leaving little or no time to nurture their children or assist in their most basic needs in the form of dressing

them, feeding or sending them off to school, supervising their safety or activities or providing any sort of emotional support (Besharov, 1989; Magura & Laudet, 1996).

The addictive nature of alcohol and illicit substances lend themselves to an increased risk for child neglect when considering the psychological and financial costs to maintain a drug addiction. For many families, time, effort and money typically spent to fulfill a child's needs are instead spent to seek and attain drugs (Barnard & McKeganey, 2004; Dunn et al., 2002; Neger & Prinz, 2015). Therefore, a child's basic necessities such as food, clothing, shelter, educational needs and medical attention are neglected. In worst-case scenarios, children have been forced into illegal drug selling activities and even prostituted by their parents to obtain drugs (Magura & Laudet, 1996)). Even in less exaggerated situations, chronic drug use increases the risks to the safety and well-being of infants and young children.

Substance Abuse and the Maltreatment of Children

Children who live with drug-addicted parents and are at a socioeconomic disadvantage are more likely to receive less than adequate parenting, face economic hardships, family dysfunction and physical abuse (Magura & Laudet, 1996; VanDeMark, Russell, O'Keefe, Finkelstein, Noether & Gampel, 2005). Parents' drug addiction may further economic difficulties because the lifestyle of drug-abusing parents is often unstable and living arrangements can become unsatisfactory, over-crowded and precarious. Lack of supervision and economic stability for their children leaves the children susceptible to neglect and domestic violence because household disorganization has been associated with heightened parental stress and consequent maltreatment of children (Bays, 1990; Takayama, Wolfe & Coulter, 1998; Belsky, 1980; Kurtz, Gaudin, Howing & Wodarski, 1993). Impaired judgment and emotional disconnect also contribute to the potential of child maltreatment because drug or alcohol

problems decrease the ability to parent effectively, increase the level of aggressiveness toward their children and elevate the risk of child abuse or neglect (Miller, Smyth & Mudar, 1999; Ammerman et al., 1999, Magura & Laudet, 1996; Williams-Petersen et al., 1994).

Due to the aforementioned impairment, parents who have difficulty regulating their own negative emotional states also have difficulty accurately assessing and attending to their children's emotions. Slade (2005) labeled these empathetic skills “reflective functioning” and described parents who are able to conceptualize, regulate and experience their own emotions while simultaneously reflecting on their child's emotions and responding to their needs as being high in reflective functioning. In substance abusing parents, reflective functioning is generally low as they struggle to separate their feelings of anger towards their addiction and situation from anger towards their children (Borelli et al., 2012). Such parents are more likely to attribute negative feelings towards their children and respond with hostility instead of rationalizing and placing the anger where it belongs (Dunn et al., 2002; Suchman et al., 2010). Lack of emotional regulation combined with drug withdrawal situations when drugs cannot be located, limit parents' abilities to focus on alternative explanations for their children's negative behavior or anticipate the negative consequences of their own violent reactions towards their children (Jansson & Velez, 1999; Neger & Prinz, 2015).

Deregulation of emotions place young children at a significant increase for abuse. Similarly, Pajulo et al. (2006) found that substance abusing parents have difficulty identifying what their children are capable of and what skills they possess. The parents could not accurately understand the children's current developmental stage, expecting too much at inappropriate ages and attributing misbehavior to malevolent intentions that the child is not developmentally capable of possessing (Neger & Prinz, 2015). Lack of proper expectations and strategies to deal with child

behavior problems can result in use of inappropriate and aggressive discipline, which furthers the abuse cycle (Magura et al., 1999; Neger & Prinz, 2015). Such inefficiencies in parenting have been correlated with parents' intellectual impairments, as well as a deficiency in access to proper parenting education resources (Clausen, Aguilar & Ludwig, 2012).

Often it is expected that adults who are biologically capable of conceiving children automatically comprehend and understand the process of effective parenting. Proper parenting is not an innate attribute, it must be taught or mirrored, positively. Without effective parenting techniques, drug abusers may have distorted views of their children which reinforces anger and aggression towards the children or they will simply ignore them (Black & Mayer, 1980; Magura & Laudet, 1996). Furthermore, data suggests that the children themselves who are exposed to parental substance abuse have higher rates of emotional instability, poor behavior, psychological and emotional disorders which places them at higher risk of child maltreatment than other children (Giancola, 2000; Christensen & Bilenberg, 2000; Chatterji & Markowitz, 2001; Weissman, McAvay, Goldstein, Nunes, Verdelli & Wickramaratne, 1999). Poor behavioral adaptation can also interfere with a child's experience in their external environment such as school and their community, leading to further exploitation and neglect of their emotional needs. Constant exposure to the dysfunction and chaos of substance abuse perpetuates the transmission of the potential for violent behavior and child maltreatment and substance abuse to be repeated across generations (Ertem, Leventhal & Dobbs, 2000; Lieberman, 2000; Walsh, MacMillan & Jamieson, 2003; Green, 1998; Widom & Hiller-Sturmhofel, 2001). Furthermore, parental substance abuse may also increase the vulnerability of a child to victimization by others inside or outside the family (Zuravin, 1998).

Child Welfare System

Inevitably, Child Protective Services (CPS) becomes involved in the family and referrals for drug induced abuse and neglect cases are reported in a myriad of ways. These include professionals (child daycare providers, educators, legal and law enforcement personnel and medical personnel), nonprofessional (family, friends and neighbors) and unclassified (anonymous others). In 2013, professionals submitted sixty-two percent of reports. The highest percentages of reports came from education personnel (17.5%), legal and law enforcement personnel (17.5%) and social services personnel (11.0%). Nonprofessionals submitted nineteen percent of reports and included parents (6.7%), other relatives (6.9%) and friends and neighbors (4.7%). Unclassified sources submitted the remaining twenty percent of reports (Dept. of Health and Human Resources, 2013).

In 2013, 865,643 children throughout the United States experienced maltreatment (Dept. of Health and Human Resources, 2013). An estimated fifty percent to eighty percent of child welfare cases are connected to parental substance abuse (Osterling & Austin, 2008; Young, Boles & Otero, 2007). Substance abuse has also been identified as a contributing factor for up to two-thirds of American children who are in out-of-home placements (U.S. Department of Health and Human Services, 1999; Semidei, Radel & Nolan, 2001). Current federal and state legislation does not make it mandatory for parents who are charged with abuse and neglect of their children to be sentenced to rehabilitation. Resources are made available, but it is a parental choice to participate. This leads to an insufficient treatment program for substance-abusing parents who are referred to social services for abuse and neglect.

Treatment Obstacles

The official risk assessment tools used by Child Protective Services (CPS) agencies include parental drug and alcohol abuse as potential risk factors for harm and maltreatment (Berkowitz, 1991; Magura et al., 1987; Magura & Laudet, 1996). Yet, research shows that most cases of substance abusing parents who are referred to CPS go unnoticed by social workers (Chuang, Wells, Bellettiere & Cross, 2013). Consequently, only half of the parents who are flagged by child welfare to receive services actually attend treatment and only thirteen percent in some studies complete treatment (Ungemack et al., 2015). This in part is due to a disconnection between CPS and the courts because of collective challenges to collaboration between the systems. These disconnects include limited understanding of addiction, lack of knowledge in services needed by parents who abuse substances, limited access to adequate treatment options, different timeframes and criteria for achieving outcomes, lengthy court proceedings, children at risk of delayed permanency decision-making and future maltreatment, lack of cooperation between the response time of the agencies to address the parent's needs and differences in agency missions, cultures and opposing agency perspectives and practices (Marsh & Smith, 2012). The key stakeholders within each agency, including administrators, social workers, treatment providers and judicial employees, have historically made little effort towards collaboration and often perceive each other as opponents instead of allies (Ungemack et al., 2015).

Unavoidably, there are varying levels of parental reluctance to participate in treatment which include fear of detoxification, inadequate availability of services, lengthy wait lists and inconsistent processes and expectations between CPS, treatment programs and judicial systems (Young, Gardner, Whitaker, Yeh & Otero, 2005; Marsh & Smith, 2012). Coordination of services across systems is further strained when women refuse to enter a substance abuse program or when

they are inhibited to admit to substance abuse problems in child welfare assessments for fear of losing custody of their children (Jessup, Humphreys, Brindis & Lee, 2003). Mothers who become involved with CPS are at risk because those who have substance abuse problems are more likely to lose their parental rights compared to mothers who are non-substance abusing (Marcenko, Kemp & Larson, 2000). Mothers in need of treatment are more likely than fathers to be concerned about losing custody of their children, therefore creating an additional obstacle for the recovery of drug-abusing mothers (Grella & Joshi, 1999).

Multiple studies have shown that half or more of all women who have had some sort of contact with child welfare and are entering substance abuse treatment have dependent children (Conners et al., 2004; Grella, Scott, Foss, Joshi & Hser, 2003). Although, at the time of admission to treatment, less than half are living with all of their children and up to one-third have already lost their parental rights to at least one of their children (Knight & Wallace, 2003; Schilling, Mares & El-Bassel, 2004). Custody situations and family dynamics have rarely been taken into consideration during evaluations of substance abuse treatment outcomes and should be further explored for efficacy (VanBremen & Chasnoff, 1994). With regard to the women whose children have been taken from their custody and placed into foster care or who have had their parental rights terminated, dealing with their feelings of angst, disgrace and loss should be a crucial part of the recovery process, but is often dismissed or ignored altogether in treatment protocols (Kovalesky & Flagler, 1997).

Stress, Relapse and Re-offending Maltreatment

Previously stated, substance abuse has not only been coupled with socioeconomic stressors and identified as significant predictors of initial substance abuse, but also of re-offending maltreatment and addiction relapse after periods of abstinence (English & Aubin, 1991; Wolock

& Magura, 1996; Alverson, Alverson & Drake, 2000; Mattoo et al., 2009; Wahler, 2012). When parents who are recently released from substance abuse programs return to the same socioeconomic situations, they appraise these stressors and recognize a disconnect between their needs and resource options. When the needs outweigh the resources, their reactions are often maladaptive, such as engaging in additional drug use as an escape, as well as taking frustrations out on their children, recreating the same abyss of chaos and discord (Nair, Schuler, Black, Kettinger & Harrington, 2003; Neger & Prinz, 2015).

The association between stress and relapse has been noted for numerous drugs of abuse, including alcohol, cocaine and opiates (Mattoo et al., 2009; Wahler, 2012). Stressors contribute to shortened periods of time between treatment completions and relapse when compared to individuals experiencing fewer stressors. Stress is also associated with greater addiction severity upon relapse (Wahler, 2012). Specific stressors such as unemployment and economic hardships that affect housing options, have been implicated as specific relapse risk factors (Festinger et al., 2001; SAMHSA, 2010; Wahler, 2012). For example, both poor urban and rural inhabitants are often forced to live with other family and friends who may be using substances as a result of inability to afford independent housing (Padgett & Drake, 2008). Fewer options for housing may place impoverished recovering addicts and alcoholics at high risk for relapse.

Researchers discuss substance abuse treatment as a concern with the process of recovery from addiction, based upon a philosophy that addiction is a chronic disorder with constant threat of relapse (McLellan, Lewis, O'Brien & Kleber, 2000). Therefore, recovery from addiction may take longer than expected, if not a lifetime of treatment, similar to other chronic diseases such as diabetes, asthma or hypertension (McLellan, 2002). Often, addicts relapse multiple times and numerous exposures to treatment are necessary before successful liberation. This lifelong

commitment to sobriety breeds disconnect between CPS, the court system and treatment facilities where efforts of collaboration are absent (Hser, Anglin, Grella, Longshore & Prendergast, 1997).

Post-Treatment Hardships

Time constraints and poverty heighten stress, chronic strain and depressive symptoms, increasing risk of relapse (Mirowsky & Ross, 2003). Moreover, unemployment and lack of education are primary indicators of low socioeconomic status and are highly associated with substance abuse and dependence (SAMHSA, 2010). Notably, a study of alcohol and opiate addicts found that stable employment history was a strong predictor of long-term abstinence from drugs and alcohol than any other factor, including severity and length of addiction or inpatient treatment participation (Vaillant, 1988). In fact, heroin addicts with stable employment for four years preceding treatment were nearly four times as likely to remain abstinent twelve years after treatment as individuals who did not have a stable work history. Even more striking, sixty percent of participants who reported working half of their adult life or more were abstinent twelve years after treatment, while zero percent were abstinent who had not worked for half of their adult life (Vaillant, 1988).

Unfortunately, individuals addicted to drugs and alcohol are often convicted of substance-related crimes, leaving them with criminal records. Depending on the severity of the crime, these records can produce a misdemeanor or felony. Both lessening the likelihood of moving forward with their lives or successful reintegration back into society due to the difficulty in gaining lawful employment. Individuals with drug felonies also have trouble meeting financial obligations after conviction and require assistance from charitable organizations, including nutrition assistance (Kubiak, Siefert & Boyd, 2004). However, many recovering addicts are disqualified from receiving federal financial aid and food assistance, due to U.S laws pertaining to drug felonies.

In 1996, the Federal Government created the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which established Temporary Assistance for Needy Families (TANF) to provide food, cash and medical assistance for people with dependent children who meet income eligibility. This program includes a restriction (§115) banning assistance for anyone who is convicted of a felony for the distribution, use or possession of illicit substances. Under the same guidelines, The Quality Housing and Work Responsibility Act of 1996 includes a prohibition against providing income-based housing for people convicted of drug crimes, permitting landlords the right to deny housing if a member of the household has been charged distributing, using or in possession of illegal substance, making housing and other assistance virtually impossible for people who have been convicted of a drug crime, especially for women who have dependent children remaining in their custody (Wahler, 2012). Since employment and safe, stable housing is important for preventing relapse, the ban on income-based housing might contribute to relapse rates for low-income individuals with substance abuse disorders (Padgett & Drake, 2008). The inability to find income-based housing, leaves many low-income people attempting to recover from substance abuse problems homeless or forced to live with unsafe family or friends who may still abuse substances, which reintroduces the family unit to dangerous environments that increase the potential of substance abuse relapse and childhood maltreatment (Padgett & Drake, 2008).

Chapter Conclusion

Chapter two will discuss the issue of substance abuse throughout the state of West Virginia and the effect it is having on families, in the form of a growing number of abuse and neglect cases. This chapter will also review the current CPS policy and procedures built to address the issue of child maltreatment and will identify three key gaps within the current system: Family Dynamics-

Time Allocation for Rehabilitation, Institutional Impediments- Inefficiencies of DHHR Policies and Procedures and Community-Level Support Lacking a Reintegration Strategy.

Chapter 2: Policy Context of West Virginia

Chapter Introduction

In Chapter one, the history of drug use across civilization was discussed, as well as an innate need for human beings to alter their consciousness, especially to deal with socioeconomic stressors or to cover emotional wounds that are caused by adverse childhood experiences. Drug and alcohol used as a means to cope affects not everyone who participates, but ten percent of the nation's drug users. The dysfunction of those afflicted, through media, became the nation's idea of what drug use looks like and shaped current policies and procedures that are put into place through laws that aim to protect the safety of children. Personal histories of an individual and the socioeconomic stresses that they face make people of lower incomes more susceptible to drug addiction than most. Drug abuse has a direct correlation to the maltreatment of children and the child welfare system eventually becomes involved through the referral of abuse and neglect cases to Child Protective Services (CPS). As a solution, substance abuse treatment is offered through the state, however, a lack of collaboration between CPS, the court system and treatment centers cause an inefficiency in rehabilitation services. These disconnects cause obstacles for treatment and a reluctance in parental participation. Federal laws currently in place pose a threat to relapse and re-offense to those parents who do participate in treatment.

This chapter will provide an overview of the current policy and procedures for CPS referrals, investigations and assessments of family functioning, the socially necessary services (SNS) currently provided by administrative service organization (ASO) providers to control/mitigate impending dangers posed by substance abuse and how the state ensures the implementation of these provisions. This chapter will conclude by outlining (3) three key gaps within the current system that allow for children and families to inadequately receive the services

that are necessary for their successful reunification (1) family dynamics- the time period allotted the families to rehabilitate, (2) institutional impediments to efficient interventions by the Department of Health and Human Resources (DHHR) and (3) support- community-level weaknesses to efficient allocations of resources that support the social reintegration of drug-affected families. This chapter will outline these issues, as well as identify where external services would need to be provided to ensure the families are receiving the provisions necessary for reunification.

Substance Abuse in West Virginia

West Virginia has a population of approximately 1.85 million people. The average household income for a family of four is \$41,043 and eighteen percent of the population are living below the poverty line, including children. As of August, 2015 there are only fifty-four percent of West Virginians in the labor force. Based on the research explored throughout this chapter, West Virginia suffers from extreme poverty and it is of significant interest that the economic conditions can be correlated to the rising use and abuse of illegal substances (West Virginia Census Bureau, 2014).

As a direct side effect of poverty, the proportion of child abuse/neglect cases in West Virginia that involve maltreating parents with drug addictions has grown at an alarming rate, along with an increased and widespread availability of inexpensive street drugs which have flooded many of the state's fifty-five counties (Lofton, 2013). Over the past few years, Kanawha and the adjacent Cabell counties have commanded national attention by exhibiting a disproportionate number of drug overdoses (Center for Disease Control and Prevention, 2007). On October 21, 2015, President Obama visited Charleston, the capital of West Virginia, to discuss the drug epidemic plaguing the state and committed to sending federal dollars to help rectify the situation,

unfortunately these federal dollars are to support medication-assisted treatment only (The White House- Office of the Press Secretary for President Barack Obama 2015). This could likely perpetuate the dependency of prescription medication abuse instead of alleviating the deeper causes of drug addiction as mental health, personal history and socioeconomic stressors (Paulozzi et al., 2009).

By the end of 2014, 628 lives were lost to drug overdoses in the state of West Virginia; or 31 overdoses for every 100,000 people. Of those 628 overdoses, the highest contributors to deaths were Alprazolam (Zanax) and Oxycodone (Christy, 2013). When doctors became more cautious of the amount of pain prescriptions they were administering, as well as a crackdown on “pill mills” heroin made a reappearance throughout the state. Heroin overdoses have risen from 34 in 2010 to 165 in 2014, with 97 overdoses reported as of June, 2015 (Kercheval, 2015). These numbers only represent the mortalities of drug addiction and show a clear implication that the rise in cases of abuse and neglect of West Virginian children could be a direct side effect.

As stated above, West Virginia leads the nation in accidental drug overdoses and therefore abuse and neglect of children became one of the social problems created as a causality of the drug addiction epidemic. This epidemic can further be implied through the amount of children who are in the foster care system throughout the state due to abuse and neglect by a drug addicted parent. The most recent numbers reported are 4,454 children who have been confirmed by the Department of Health and Human Resources (DHHR) as being victims of child abuse and neglect (Annie E. Casey Foundation, 2012). Children placed in state care have endured emotional abuse, medical neglect, neglect, physical abuse, sexual abuse and other/missing maltreatment type. Statewide, child abuse and neglect is directly responsible for the placement of approximately 4,300 children

in foster care (Adopt US Kids, 2015). Unfortunately, the numbers of cases that are due to the maltreatment by drug addicted parents are not reported nor calculated at this time.

The foster care placements mentioned above only represent that proportion of abused/neglected children in West Virginia whose maltreating parents have been or are currently being adjudicated by the court as a consequence of the DHHR petitioning the court to remove the children from the unsafe home.⁵ Not all maltreating parents find themselves facing adjudication for child abuse and neglect. Less egregious cases of child abuse and neglect, in which a DHHR investigation has found impending dangers to child safety that have not risen to the threshold of imminent danger are treated as non-custody cases. These cases require voluntary safety plans that prescribe socially necessary services (SNS) as a combination of preventative and treatment objectives/tasks.

Maltreating parents in West Virginia with drug addictions present themselves as an interesting subset of abusive/neglectful parents who possess distinct characteristics that are largely influenced and shaped by values, behaviors and lifestyle propensities unique to the drug subculture. Consequently, it will later be argued that the addition of a community reintegration strategy to administrative services organization (ASO) provider interventions will (1) broaden its approach by rendering it more teleological, with the side effects of substance abuse being diminished, (2) remove maltreating parents with addictions from the drug lifestyle and subculture and reintegrate them into their communities with appropriate supports and resources and (3) strengthen self-efficacy by reestablishing socially useful roles and family bonds.⁶ These goals

⁵ “adjudicated” meaning the legal process in which a judge reviews evidence and argumentation, set forth by opposing parties to come to a decision which determines rights and obligations between the parties involved.

⁶ “teleological” meaning the individual preventive and treatment strategies function to address identified individual problems that contribute to impending dangers within the distressed family, and combine to function together as an overall corrective to the community-level social problems to which the individual behaviors of

keep with the current implementation in Kanawha County of “wraparound” services as a national best practice centered on assessments of what is required by the distressed family to mitigate impending dangers in the household (McCormick, 2015). This approach is inclusive of both preventative and treatment services, intended to alleviate imminent danger of abuse and neglect and facilitate the improved function of the distressed family to avoid placement of the abused/neglected children in foster care (McCormick, 2015). However, prevention and treatment services are often times devalued by maltreating parents with addictions and there exists no other safety nets through which this population of maltreating parents could be made aware of available resources, gain access to those resources or be encouraged to participate in strengthening their families.

Child Protective Services Current Policy for Abuse and Neglect Referrals

As previously mentioned in Chapter one, children who fall victim of abuse and neglect are detected through various avenues such as professionals (child daycare providers, educators, legal and law enforcement personnel and medical personnel), nonprofessional (family, friends and neighbors), and unclassified (anonymous others) (Dept. of Health and Human Resources, 2013). Accounts of potential abuse and neglect are reported to CPS, which is a subsidiary division of the West Virginia DHHR. These are called “referrals” and begin the involvement of CPS through an investigation into the child’s potential endangerment. Once reported to CPS, the intervention strategy is influenced and shaped by both DHHR and CPS policy, which identifies imminent and

maltreating parents with addictions contribute. Examples of these community-level social problems would include the drug subculture, purchase and distribution of street drugs, crime, straining DHHR social services, misuse of SNAP, and etcetera

impending dangers that maltreating parents with drug addictions pose to the safety of their abused/neglected children (McCallister, Harper, Prillaman & Stewart, 2015).

The intervention strategy includes the preventive and treatment SNS provided by ASO providers who service distressed families with child abuse/neglect allegations throughout West Virginia. DHHR/CPS policy seeks to control and/or mitigate these impending dangers either through petitioning the 13th Circuit Court to adjudicate maltreating parents or through voluntary safety plans that prescribe a combination of preventative and treatment objectives/tasks referred (SNS). Socially necessary services that are preventative involve the application of “best practices” skill acquisition through individualized parenting and adult life skills. Socially necessary services that are treatment-oriented would involve detoxification and rehabilitation.

Child Protective Services Procedure for Abuse and Neglect Referrals

An intake assessment, also known as a “referral” is made to the CPS hotline through the aforementioned avenues. An effective intake assessment depends on successfully gathering sufficient, relevant information which reveals whether or not there is reasonable cause to suspect that child abuse or neglect exists. A CPS Intake Specialist (IS) supervisor makes screening decisions based on the legitimacy and egregiousness of the referral and a response time is assigned. The response time is the maximum amount of time that the CPS social worker has to make face to face contact with the family (McCallister, Harper, Prillaman & Stewart, 2015). It is recommended that contact with the child (potential victim) and family be made as soon as possible unless contact will jeopardize the safety of the child based upon information provided in the intake assessment.

Once a referral is accepted, it is sent to the local CPS office and assigned to field staff (social worker/case manager). The CPS social worker assigned to the family makes a preliminary

visit to conduct an initial assessment (investigation of report). During this first visit, present and impending dangers are evaluated and information is gathered. The initial assessment addresses various aspects of the allegation which includes the type of maltreatment (description, severity and location), the nature (surrounding circumstances) around the allegation, child functioning (pervasive behaviors, feelings, intellect, physical capacity and temperament), the overall ubiquitous parenting practices (understanding of child's needs and capabilities, knowledge and general skill of parenting and feelings regarding parenting), parenting discipline (types and severity of punishment) and adult functioning (use of drugs or alcohol, social relationships and personality traits) (McCallister, Harper, Prillaman & Stewart, 2015).

Upon completion of the initial assessment, if present danger is identified, a protection plan is constructed to enable the CPS social worker to complete a Family Functioning Assessment (FFA), while impeding the danger to the child. The protection plan requires that an informal support (family, friend or neighbor) can be brought into the home or the child could stay with for seven days. If an informal support cannot be located there is the potential that an emergency ratification can be sought (removing the child from the home). The FFA is the ongoing investigation into the alleged abuse and neglect and whether or not the maltreatment occurred (McCallister, Harper, Prillaman & Stewart, 2015). During the FFA, the CPS social worker must conduct interviews with all parents, caregivers, children and other adults residing in the home, persons allegedly responsible for abuse and/or neglect and collaterals. Collaterals are any third party (e.g., friends, neighbors, relatives or professionals) with information about the alleged abuse and/or neglect and threat of serious harm to the child. Collaterals are contacted to corroborate information provided by individuals previously interviewed, to obtain additional information about the family and to assess as protective resources.

Along with the FFA, a safety evaluation identifies the safety of a child and is a distinct function within CPS which is separate from determining whether child abuse or neglect occurred. The safety evaluation brings about a conclusion that must be completed in all FFA and is based upon a consideration for threats of impending danger. That conclusion must provide information regarding the current situation of the child and whether or not there are impending or imminent dangers to the safety of the child. Maltreatment is considered to have or have not occurred when a majority of the credible evidence indicates that the conduct of one or both parents falls within or without the boundaries of the statutory and operational definitions of abuse or neglect (WV Code 49-1-201). Children are only supposed to be removed from the home based on imminence and the inability to control safety in the home with formal and informal services (McCallister, Harper, Prillaman & Stewart, 2015).

The safety evaluation will conclude whether the child is safe or unsafe and whether or not the family will be open for on-going CPS case. The safety evaluation determines key factors in the decision of a referral. First, there are no impending dangers to the safety of the child and the case will be closed. Secondly, that one or more impending danger threats were identified which threaten the safety of a vulnerable child and there are not sufficient parental protective capacities to assure that impending danger can be offset, mitigated and controlled. If this is the circumstance, the CPS social worker opens an ongoing CPS case against the family, which is court ordered. Lastly, there were no children in the household identified as unsafe, however, maltreatment was proven (WV Code 49-1-201). If maltreatment is substantiated, policy mandates that a plan be implemented where every abused or neglected child in the state is provided an environment free from abuse or neglect. For this reason, the case will be open for ongoing CPS services and will become court ordered (WV Code 49-4-408).

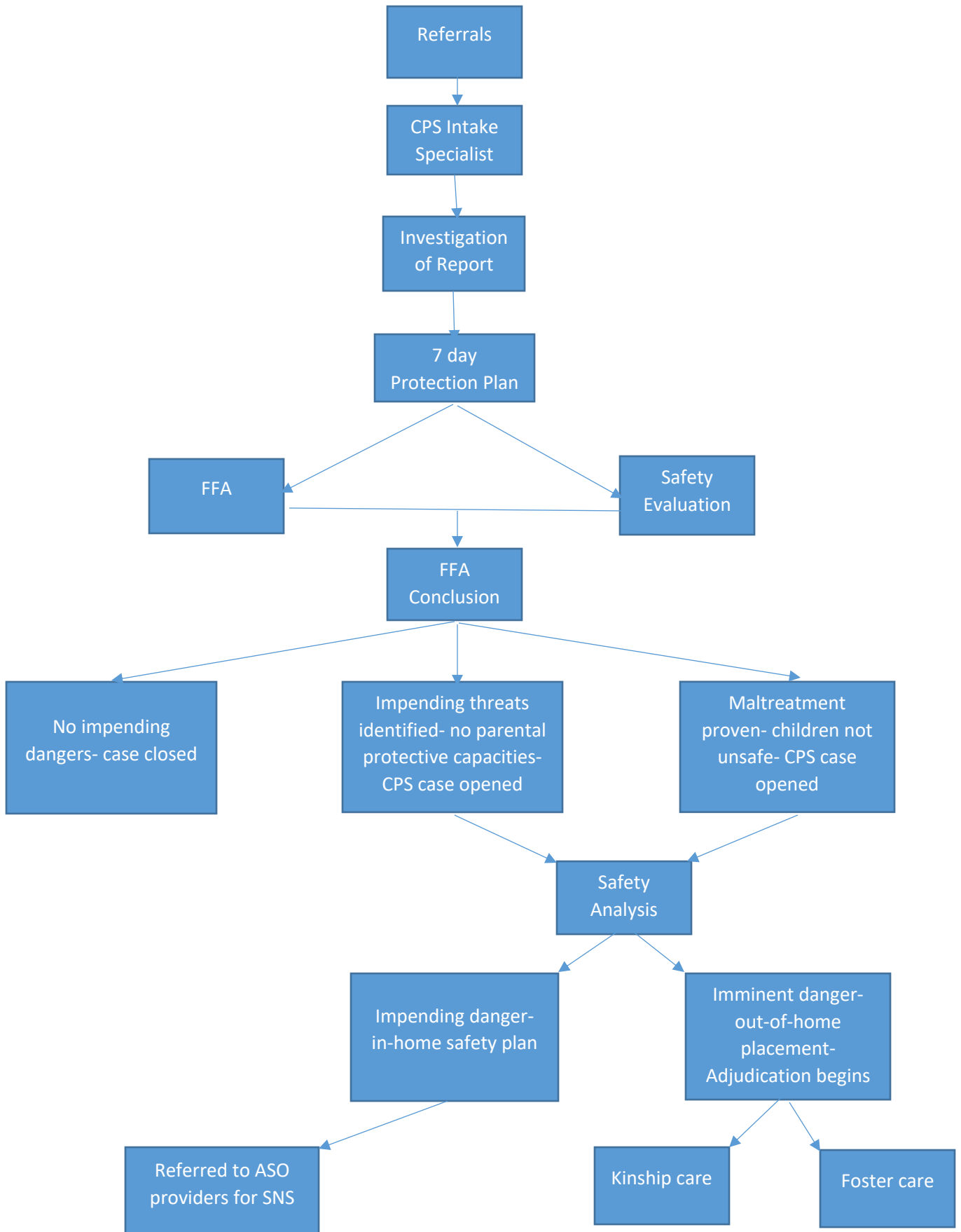


Figure 1- CPS Procedure for Abuse and Neglect Referrals

Should a family be identified with impending danger of abuse and neglect of a child, the safety analysis, which determines the level of CPS intrusiveness with the family in order to manage impending danger and assure child safety is implemented. Safety analysis results in the development and implementation of sufficient safety plans (in-home or out-of-home care which require court intervention) to manage identified impending danger. The appropriate safety plan must be executed the same day that a child was identified as in need of protection as a result of the safety evaluation conclusion (McCallister, Harper, Prillaman & Stewart, 2015).

Safety plans are a written arrangement between parents and CPS that establish how impending danger threats will be managed. The safety plan is utilized as an improvement period and remains active for 90-days or as long as danger exists and parental protective capacities are insufficient to ensure a child is protected. The safety plan specifies what impending dangers exist, the safety services to be utilized in managing impending dangers and who will participate in those services. The safety plan also describes the circumstances, agreements, specific time requirements and the accessibility of those involved. Impending dangers are not rated as severe as imminent dangers, therefore an in-home safety plan can be administered to address the dangers and ensure the safety of the child. The in-home safety plan refers to safety services, actions and responses that assure a child can be kept safe in their own home and with their parents. In-home safety plans include activities and socially necessary services that may occur outside of the home, but contribute to the child remaining primarily in their home (McCallister, Harper, Prillaman & Stewart, 2015).

In-home safety plans are constructed to face multiple impending dangers that could lead to the abuse and neglect of a child. These dangers include living arrangements that seriously endanger a child's physical health (drug activity in the home, unsanitary living conditions,

decaying physical structure and hazardous means of heating source), family does not have the means to meet the basic needs (food, clothing and shelter), one or both parents intend to hurt the child (premeditated abuse with no remorse), child is perceived in extremely negative light by one or both parents (feeling that the abuse and neglect was warranted due to unrealistic expectations of the child), the parent is unwilling or unable to perform parental duties and responsibilities, which could result in serious harm to the child (pervasive drug use, lack of supervision, physical or mental disability), one or both parents fear they will hurt their child and/or request placement, one or both parents lack parenting knowledge, skills or motivation, which affects child safety (intellectual capacities affect parenting, teenage parents without parental knowledge), domestic or general violence and the child has exceptional needs that the parent cannot provide (mental/physical conditions that need particular treatment) (McCallister, Harper, Prillaman & Stewart, 2015).

Under the Federal Adoption Assistance and Child Welfare Act of 1980, parental rights are protected to the custody of their child. This act ensures that prior to the removal of a child from the home and placement in out-of-home care, reasonable efforts are provided to prevent or eliminate the need for removing the child from the home (Sheldon, 1997). “Reasonable efforts to prevent removal” is the term used to describe those actions taken by the DHHR to prevent or eliminate the need for removing the child from the home and to stabilize and maintain the family situation. Before initiating any procedure to take custody of a child, DHHR must first determine that there are no appropriate or available services that would alleviate or mitigate the safety threat to the child. In-home safety plans are different than the department requiring that the child and parent be separated due to impending dangers. Children cannot be placed outside of the home on an in-home safety plan. Although this precaution is in effect to protect the parents’ custody of their child, for parents who are suffering from addictions and need to enter a substance abuse

treatment program, there is a potential and time-limited option for this to occur, which poses significant threat of the child eventually being removed from the home due to the absence of the parent.

Provision of Services for In-Home Safety Plans

The aforementioned in-home (non-custody) safety plan cases are typically referred to ASO providers of SNS by CPS in order to control impending dangers to child safety in the home and to improve overall family functioning. Distressed families under these voluntary safety plans avail themselves of SNS to strengthen the diminished protective capacities of maltreating parents and thereby mitigate any identified impending dangers to child safety. Thus, under the in-home safety plan, the family remains physically intact and the abused/neglected children remain in the custody of their maltreating parents while assigned ASO providers work in tandem with CPS social workers to control the impending dangers in the home. Maltreating parents voluntarily subject themselves to the provisions and conditions of a safety plan for a 90-day period, at which time the plan is reviewed for efficacy (McCallister, Harper, Prillaman & Stewart, 2015).

CPS prescribes the method and mode of intervention within distressed families by identifying impending dangers, assessing family functioning and determining the SNS needed to strengthen protective capacities among maltreating parents. Based upon the philosophy of CPS, the service area should cover supervision (eyes on oversight of the child or family which provides an active, ongoing assessment of stresses, which affects safety and may result in necessary action), parenting assistance (direct face-to-face services to assist parents in performing basic parental duties or responsibilities which the parent has been unable or unwilling to perform), family crisis response (unlike traditional individual or family counseling, but aiding in an immediate crisis), crisis home management (housekeeping, grocery shopping and food preparation), social/emotional

support (social connections and emotional support of parents), emergency respite (unplanned or planned breaks for parents), child-oriented activities (structured activities under adult supervision), transportation (both private and public), hospitalization (routine medical or mental outpatient), alcohol or drug abuse treatment (outpatient and inpatient), child care (direct care provided for a portion of the day by an approved program), financial services (provision of financial assistance), housing (provision of or more affordable) and food and clothing (provision where the child is lacking). Services can be provided by informal or natural supports (family members, community services or friends) without payment and/or may be provided by the CPS social worker. It is the responsibility of the CPS social worker to identify all external resources (McCallister, Harper, Prillaman & Stewart, 2015).

The primary services that are provided through the ASO are safety services. The safety services are a bundle of services for families to assist in ensuring safety for children by controlling impending dangers identified during the FFA. These services include supervision, parenting assistance, family crisis response, crisis home management and social/ emotional support. These are the SNS that ASO providers can bill as a fee for service to DHHR. The bundled services must be carefully coordinated by the CPS social worker with any other formal or informal services that are put in place. The safety services bundle is available twenty-four hours, seven days a week and must commence within twenty-four hours of referral. The ASO provider must be available to respond to crisis within the family during business and non-business hours. Eighty percent of the services must occur in the family's home or community (McCallister, Harper, Prillaman & Stewart, 2015). Each family may receive two hundred hours of the safety services over a 90-day period and may be reauthorized as needed. These services may be more intensive at the beginning of the service period and less intensive at the end of the service period. The CPS social worker

should specify the intensity/frequency of the services in the safety plan. All services in the bundle do not have to be provided to every family, but may be provided. The services must be apportioned according to the need to control impending danger and must be specified in the safety plan.

Adjudication Process for Out-of-Home Placements

Should a parent refuse to cooperate with CPS and voluntarily agree to a safety plan, fail to abide by an agreed-upon safety plan or upon imminence of further abuse and neglect, children are removed from the home and a petition or ratification is filed with the West Virginia Prosecuting Attorney's Office. This process varies by county throughout the state and ratification can be signed by a magistrate or judge. The removal and placement of the child in kinship or foster care occurs immediately after either document is signed. A preliminary hearing is set 7 to 10 days after the initial petition or ratification. This hearing is simply for the judge to rule on probable cause to remove the child from parental custody or to dismiss based on lack of evidence (McCallister, Harper, Prillaman & Stewart, 2015).

Upon the court's ruling of abuse and neglect and an out-of-home placement has been assigned, the case moves on to the adjudication phase, which based upon evidence presented by both sides and the interpretation of the law by the appointed Circuit Court Judge, the process to parental rights termination begins. The adjudication hearing is set thirty to forty-five days after the preliminary hearing. At the adjudication hearing, also known as the fact-finding hearing or jurisdictional hearing, the court decides whether CPS can prove the allegations. The CPS attorney presents evidence through the testimony of the CPS caseworker, law enforcement or other witnesses. These other witnesses, if needed, may include expert professional witnesses (doctors and psychologist). Documents such as photographs and medical records may be entered into evidence and the attorneys for the parents and the child have the right to cross-examine any

witnesses and to present their case. The CPS agency needs to present enough evidence to convince the court that the maltreatment alleged in the petition occurred. Although there is still the potential that custody can be returned to the parents, this is a small opportunity. Most typically, improvement periods are offered to the parents (or not), depending on the severity of the maltreatment and the egregiousness of the case (McCallister, Harper, Prillaman & Stewart, 2015).

Typically during the improvement period, the child is removed from custody of the parents and guidelines are set based on the initial determination of the circumstances for the abuse and neglect, with the parents responsible to complete the tasks assigned to remove the danger to the child for a period not to exceed six months (WV Code 49-4-604). During this period, the court requires the parent to rectify the conditions upon which the determination was based. If an improvement plan was given, every ninety days there is a review until treatment (whatever the court has required of the family) is completed or six months is exhausted. The same services that are provided through DHHR during an in-home safety plan are also provided to the family during out-of-home safety plans, the difference being that the child is no longer in the custody of the parents.

If the parents do not receive an improvement period or refuse to complete the treatment, the next hearing is forty-five days out from the adjudication hearing, which is the disposition hearing. Prior to the disposition hearing, DHHR must file with the court a copy of the child's case plan, including the permanency plan for the child. This plan includes a description of the type of placement (kinship or foster care) in which the child has been placed and includes a discussion of the appropriateness of the placement. The plan also describes the services provided to the parents, in order to improve the conditions that made the child unsafe in their care. This includes any reasonable accommodations in accordance with the Americans with Disabilities Act of 1990, to

parents with disabilities in order to allow them meaningful access to reunification and family preservation services. The case plan will also contain a plan to facilitate the return of the child to his or her own home or the concurrent permanency plan of the child.⁷ The needs of the child will also be addressed while in kinship or foster care and services are provided to the child and foster parents (WV Code 49-4-604).

The case plan must document efforts to ensure that the child is returned home within approximate time lines for reunification. However, reasonable efforts to place a child for adoption or with a legal guardian should be made concurrent with reasonable efforts to prevent removal or to make it possible for a child to return to the care of his or her parents safely. If reunification is not the permanency plan for the child, the plan must state why reunification is not appropriate and detail the alternative, concurrent permanent placement plans for the child to include approximate timelines for when the placement is expected to become permanent (WV Code 49-4-604). The disposition hearing is the last hearing where termination of parental rights can occur, and, again both CPS and the parents receive an opportunity to be heard. A successful completion of an improvement period at the disposition hearing signifies the child will be released into the parents care and the family is reunified. Under current time constraints, the process of terminating parental rights varies from three and a half to fifteen months. Timeframes depend upon the circumstances of the case, the appointed judge and the diligence of parental participation.

⁷ "permanency plan" refers to that part of the case plan which is designed to achieve a permanent home for the child in the least restrictive setting available.

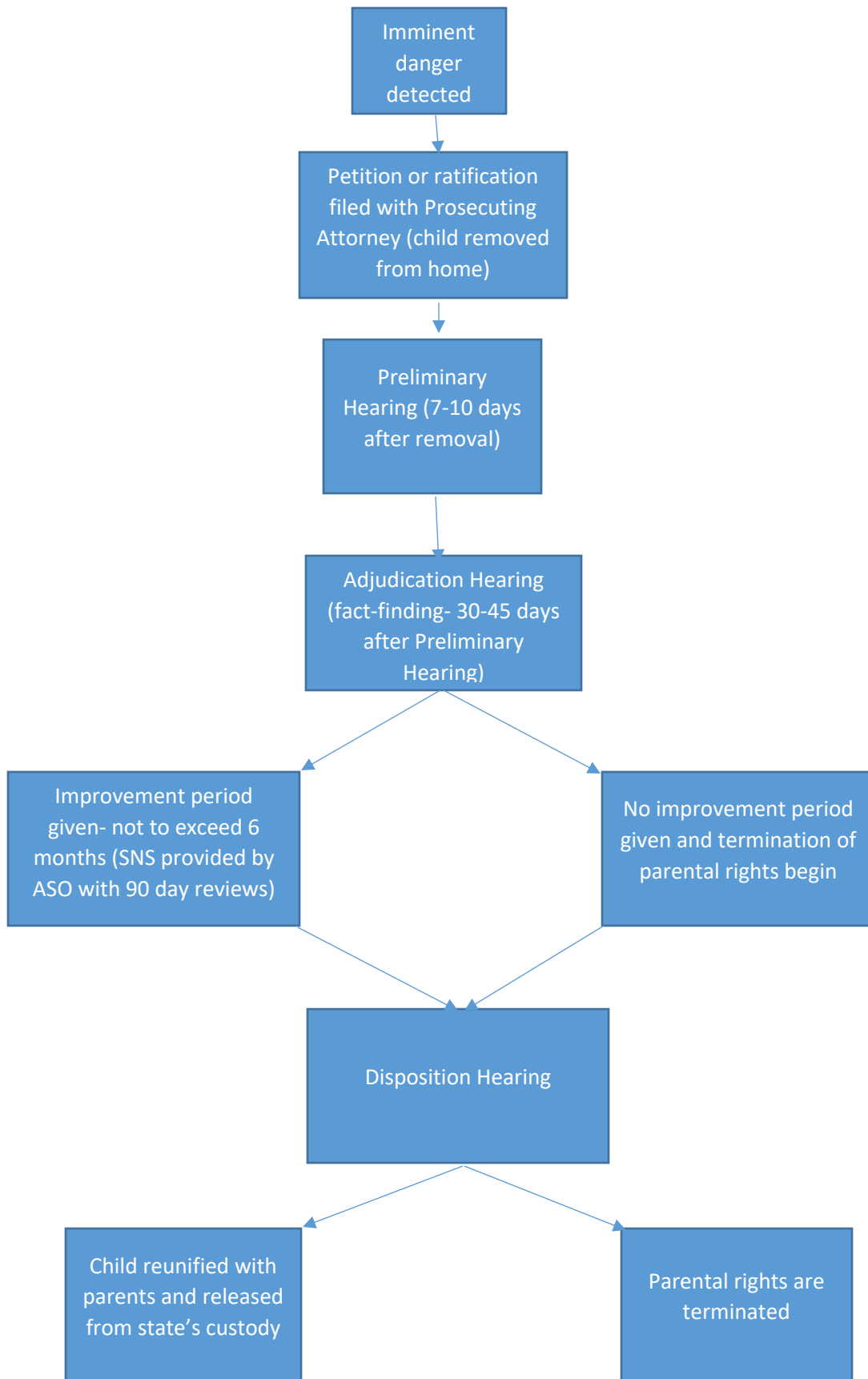


Figure 2- Adjudication Process for Out-of-Home Placement

Three Key Gaps within the Current System

Family dynamics- time allocation for rehabilitation.

The primary focus in any CPS case is on the welfare of the child, DHHR has the goal of making a determination on the permanency of placement as soon as possible, as mandated by the Adoption and Safe Families Act (ASFA) of 1997. ASFA established requirements and influenced policy for outcomes of permanency planning in the state of West Virginia. This permanency plan is a time-limited reunification plan, created with the end result being either reunification with the child's parents or adoption (McCallister, Harper, Prillaman & Stewart, 2015). Time-limited reunification is the amount of time given to maltreating parents to alleviate the dangers to abuse and neglect and follow the treatment plan that the court has assigned the family. The purpose of time limited reunification is to indicate that a child has a permanent home whether reunified with his or her parents or adopted within a timeframe does not exceed fifteen months.

Resources are offered to the parents at the adjudication hearing and are provided during fifteen of the most recent twenty-two months a child has been in foster care. These resources include:

- Individual, group and family counseling
- Inpatient, residential or outpatient substance abuse treatment services
- Mental health services
- Assistance to address domestic violence
- Services designed to provide temporary child care and therapeutic services for families,
- Transportation to or from any such services

However, participation is not mandatory nor are parents aided or supported through the processes which can cause pressure and place stress upon the parents making participation less appealing. Although resources are made available, within the state of West Virginia they are limited.

The Adoption and Safe Family Act (ASFA) created haste in terminating parental rights proceedings and the increased number of children who have been placed into out-of-home care because of parental substance abuse (Meyer, McWey, McKendrick & Henderson, 2010). This impact has led to a greater demand for access to available substance abuse treatment than can be accommodated within the current treatment system (O'Flynn, 1988). West Virginia suffers from a lack of long-term substance abuse treatment programs and those that are in existence have a waiting list. Unless substance abusers are in a current state of trauma and in threat of suicide, the wait list is insurmountable (Murray, 2015). The unavailability of beds and wait list poses a problem to the current time restraint of fifteen months even if the parents are willing to enter treatment. Moreover, the open-ended nature of the addiction recovery process and the time it takes to alleviate an addiction is at odds with the necessity to determine placement decisions within a specified timeframe for children placed into out-of-home care. As discussed in Chapter one, recovery from addiction may take longer than expected, if not a lifetime of treatment, similar to other chronic diseases such as diabetes, asthma or hypertension (McLellan, 2002).

Placing time limitations, while not absolute, is a clear statement that the permanency needs of children should be met within a reasonable period of time (McCallister, Harper, Prillaman & Stewart, 2015). Yet, policies that force parents to choose whether to complete substance abuse treatment programs when the time restraints pose a threat to the custody of their children cause significant barriers. Current policies place parents in the unfortunate situation where either choice

may be considered wrong by the judicial system or other influential parties with the authority to decide the future of both the parent and child (Jansson & Velez, 1999). Furthermore, the separation of children from their substance-abusing parents often removes a powerful motivation for the parent to recover (Magura & Laudet, 1996). Participation in services that address both substance abuse and parenting difficulties simultaneously enables parents to have both needs addressed without having to choose between one or the other.

Without the pivotal step of substance abuse treatment, achievement of these time limited reunification services, as well as other requirements placed upon the parents by the courts will become obsolete. Substance abusing mothers in the United States are twice as likely to lose custody of their children as non-substance abusing mothers and when children are taken into state's custody, substance abusing mothers are least likely to comply with court orders and most likely to lose custody permanently (Suchman, DeCoste, Leigh & Borelli, 2010; Barnard & McKeganey, 2004; Grella et al., 2009). Parents with addictions often leave substance abuse treatment early or refuse to participate initially for fear that they will lose custody of their children or face criminal prosecution (Niccols & Sword, 2005). This fear places additional stress on the maltreating parents with the knowledge that loss of their parental rights is a potential outcome. Further research within this thesis will show that allowing parents the opportunity to focus on their recovery from addiction while knowing their children are being well taken care of could facilitate a more harmonic healing for the entire family unit.

Institutional impediments- inefficiencies of DHHR policies and procedures.

Research shows that Kanawha County experiences high turnover rates among child protective services workers, inadequate resources and in many instances, sheer incompetence stretch CPS to its operational limits by challenging consistency in the case management of both

in-home and out-of-home placement cases and in prescribed prevention and treatment interventions for distressed families (Nuzum, 2015; Blackburn, Auvil & Simpson, 2013; Gutman, 2015). Until recently, little attention was paid to training child welfare caseworkers with regard to the nature of addiction, methods for screening and assessing substance abuse or dependence and the process of treatment and recovery. These impediments within a significant treatment area can cause a breakdown in the entire CPS process.

In 2014, West Virginia CPS faced attrition with an employee turnover rate of thirty-seven percent with a sixteen percent vacancy rate (Nuzum, 2015). In 2015, the West Virginia Legislature passed Senate Bill 559 to address the growing shortage of social workers in the state of West Virginia and the bill allows for DHHR to qualify social workers based on a four-year degree and experience to be equivalent to fulfilling the prior licensing requirements. Furthermore, CPS is financially and politically pressured to find permanent placements for children who have been removed from the home within an expedited timeframe, but successful substance abuse treatment requires a sufficient amount of time to devote to recovery (Grella, Hser & Huang, 2006). Should the maltreating parent be unsuccessful, the child is placed in either the permanent guardianship of an alternate family member or a licensed child welfare agency and adopted or placed in long-term foster care and the family unit is disassembled (Grella, Hser & Huang, 2006). In 2013, there were 1,364 West Virginian children in foster care awaiting adoption. Sixty-six percent had been in placement for twelve to twenty-four months and thirty-three percent had been in foster care for two to five years (Annie E. Casey Foundation, 2013).

Further research could show that if children who are removed from the custody of their substance-abusing, maltreating parents spend longer periods in the custody of DHHR as wards of the state of West Virginia, perhaps the time restraints placed upon the termination of parental rights

could be prolonged in order for parents to have efficient and ample opportunities to rehabilitate from substance abuse addiction and therefore more families could be reunified than dismantled.

Community-level support lacking a reintegration strategy.

Significant resources are provided to families who are in threat of losing custody of their child due to the aforementioned impending dangers. However, these services only propose to remove the impending dangers to the safety of the child and not to address long-term stability of the family unit. Nor do these services delve deeper into the underlying issues that create and perpetuate the abuse and neglect, such as socioeconomic stressors and self-efficacy deficiencies in the parents caused by adverse childhood experiences.

To fully address the complex problem of drug and alcohol addiction, it is not sufficient to only treat the individual user and ignore social factors impacting use and relapse of persons of low socioeconomic status (Wilkinson & Marmot, 2003). Nor is it responsible to leave out key ingredients to the successful reunification and the reintegration of the family back into their community. It must also be taken into consideration that parents with drug addictions do not always sustain sobriety once treatment goals are achieved. While changes in individual social agency are supported by intervention, prevention and treatment strategies employed by ASO providers, the overall intervention does not contain a critical community reintegration strategy that addresses socioecological stressors and factors known to enable substance abuse by maltreating parents with drug addictions.⁸ For example, parents who are not given academic competency or trade/job skills will face the same stressors that were affecting them prior to the abuse and neglect implications. Consequently, as studies have shown, relapse into drug abuse typically reoccurs

⁸ "social agency" meaning the capacity of individuals to act independently and to make their own free choices.

within one year after treatment (McLellan, Lewis, O'Brien, & Kleber, 2000). Improving the success rate of prevention and treatment strategies employed by ASO providers would require the addition of a community reintegration strategy.

It is not enough to offer short-term solutions to a family only to remove impending dangers to the safety of the child. Nor can addictions be recovered or socioeconomic stresses be addressed in an allotted timeframe without truly understanding the situation of the family. Evaluations of family functioning can be assessed, but need to be coupled with implementation of long-term plans to remove the barriers that keep the family from properly functioning, not merely long enough to be reunited with their child. The focus should be to change the situations that have occurred that enable the family from functioning as a productive unit within their community. Concurrently, to treat addictions without addressing the roles and responsibilities of a parent leaves parents with insufficient skills to handle child behavior issues and makes them more vulnerable to drug relapse as a coping mechanism (Belt & Punamäki, 2007; Suchman et al., 2008; Whiteside-Mansell et al., 1999). Additionally, to address parenting without addressing addictions is likely fruitless, as effective parenting requires a significant amount of emotional aptitude and inherent motivation, both of which are absent with drug and withdrawal states (Robinson & Berridge, 2003). The combined treatment of addictions and parenting deficiencies has the potential to enhance outcomes in both areas by increasing self-regulation skills.

Community-level resources are available throughout West Virginia, mostly in the form of organizations that were created to aid in the short-term crisis situations that are plaguing our most vulnerable community members. However, there is a lack of services that address long-term issues deep within the family structure. Creating an environment for the family dynamics to shift away from a poverty and drug centered existence to one of self-determination filled with hope and

empowerment could allow space for the hard work to facilitate change. The missing link that can be validated by the amount of children being placed within the foster care system and the growing numbers of parental rights being terminated is greater support and understanding of not only the addiction process and the path to rehabilitation, but also the struggle of the individual parent as a human being and not only a maltreating parent.

Chapter Conclusion

Chapter three will discuss literature and case studies of organizations that have utilized nonprofit organizations to create inter-organization collaborations and community service organizations to alleviate social problems. In a later chapter, this thesis will introduce a nonprofit organization in West Virginia. Child Protective Services' policies address the immediate and short-term safety of the child, this organization supports the family from start to finish. The organization will provide on-going therapy, treatment for substance abuse and the alleviation of socioeconomic obstacles. Lastly, the inter-organization collaboration will seek to effectively change policy through legislative means to allocate the time that is necessary for long-term and successful recovery of families throughout West Virginia communities.

Chapter 3: Critical Engagement- Literature Review and Case Studies

Chapter Introduction

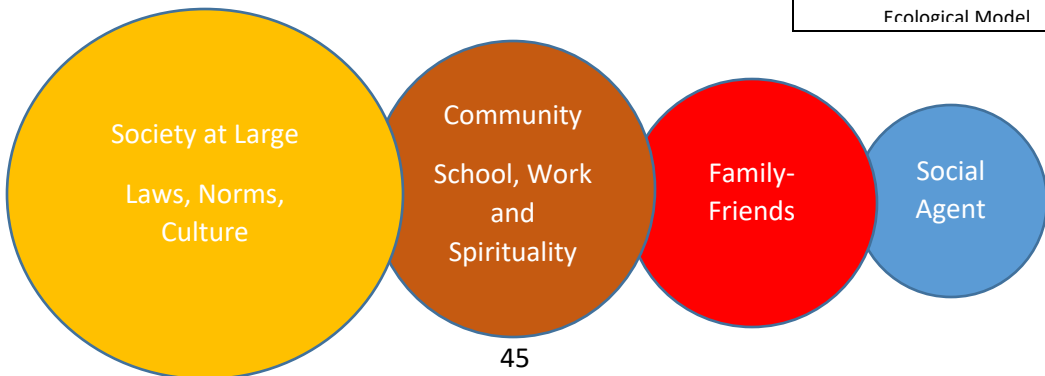
Chapter two reviewed the major challenges to family reintegration with West Virginia's child welfare services system, including time constraints on reunification of children with parents, the lack of available substance abuse treatment programs and a missing reintegration strategy for successful implementation of reunified families back into their communities. This chapter will discuss how a nonprofit organization/structure employed as an ASO provider would better assist to bridge the familial, institutional and community-level gaps identified in Chapter two. This chapter will also review scholarly literature on best practices to develop guidelines to use in inter-organizational collaborations within a community service organization (CSO), which could be utilized to mitigate the critical community reintegration strategy that addresses socioeconomic stressors, lack of substance abuse treatment availability and self-efficacy deficiencies that enable substance abuse by maltreating parents with drug addictions.

Community-Level Change

Bronfenbrenner (1979) used multilayered circles in his ecological theory as levels of influence that affects an individual social agent through interactions with social networks (family and friends), community (education, employment and religion) and the greater society (government). The inner-most circle being the individual social agent. The next circle is the most powerful circle where the individual social agent shows up in relationships (the family unit). This layer includes extended family (kin group) and friends. The next layer would represent the community that the family unit lives in and is embedded in the community through its interactions with institutional systems such as workplace, school or church. In a successful Bronfenbrenner

example, the community layer surrounding families would include informal support from helping networks of the kin group, friends and neighbors who are brought together through family cooperatives – to be centers for exchange and support neighborhood families which in turn would strengthen the community. The community layer would also represent interagency prevention services - more formally organized programs that proactively target families in situations or events that increase risk to children (socially necessary services). These could be in the form of substance abuse rehabilitation, familial/individual counseling and extensive training in the categories of education/domestic violence/employment, mental and physical health assistance and reintegration supportive services such as Alcoholics Anonymous (AA)/Narcotics Anonymous (NA), job placement assistance and family economics. The community layer also represents systems outside the service network with which families interact, such as law enforcement, public schools and welfare services (Bronfenbrenner, 1979). The outer-most layer would be state and local government, where policy is created that effects the community and society as a whole. These institutions, in turn, are responsible in a cultural context for what shapes the environment that occurs in the inner circles. If policy affects the resources provided on the community level and fails to meet the needs of the families, this can lead to a breakdown of not only the family unit, but the individual social agents. This explains Bronfenbrenner’s theory that deals with the relations of organisms (family members) to one another (kin group) and to their physical surroundings (community) (Bronfenbrenner, 1979).

Figure 3- Bronfenbrenner Ecological Model



Community-level change strategies must empower the individual social agents who make up a family unit to stand up for their basic needs and place expectations on the outer layer to create policies that create services designed to first, alleviate the stress factors that trigger the propensity for substance abuse which leads to the maltreatment of children through abuse and neglect. These triggers include but are not limited to poverty, unemployment, low education attainment, planned parenting education and self-efficacy deficiencies. Future research could show that empowering individual social agents while holding state and local government accountable could aid in the protection of children against maltreatment.

Literature Review

The following literature review summarizes research conducted on the concept of inter-organizational collaboration, using a nonprofit as a community service organization (CSO). Case studies will be used to represent both the inter-organization collaboration model and the nonprofit CSO. The purpose of this review is to formulate best practices in service delivery to integrate all facets of the collaboration amongst the various private, government and charitable organizations in Kanawha County involved in improving dysfunctional families to facilitate their holistic healing, as well as impact policy changes to social issues involving child and family welfare- like CARES and New. Both successes and obstacles were found, as well as suggestions for further research.

Nonprofits.

Starting in the 1970's, New Federalism began to affect the nonprofit sector. The political philosophy of devolution of government or the transfer of certain powers back to the states, began with the Nixon administration and perpetuated with Reagan. It was a philosophy that would

shrink the amount that the federal government was spending on social services and allow the nonprofit sector to grow. Instead of funding the social service programs through the federal budget, the government began distributing block grants, which were large sums of money that were given to individual states for social services. These funds were to be distributed at the discretion of the state representatives. The only jurisdiction the federal government had over the grant money was in the execution, implementation and evaluation of the programs that the money supported (Conlan, 2010). However, these block grants initiated competition between nonprofits and social service entities because the money used to be centralized to individual services and now it was up to the state and local governments to disperse the money, which bred competition among those agencies that financially relied upon these funds (Gramlich, 1987).

Throughout the latter part of the 20th Century, the nonprofit sector's financial support from the government waxed and waned. The peak was in the early 1970s, when nonprofits were the strength of the government's social service delivery. The low was during the Reagan era, when federal funding for social services was drastically cut (Brooks, 2000). In the 21st Century, in spite of the changing terms of partnership between the two, the nonprofit sector has continued to serve as the remaining public protection for America's most disadvantaged populations. It is also convenient for the government that the nonprofit sector provides a low-cost substitute for government funding, as well as largely volunteer driven (Berry, 2003).

By all indications, the capacity of nonprofit social service agencies is closely linked to government funds. The evolution of nonprofits engaged in social service delivery has largely duplicated state and federal funding patterns (Salamon, 1997; Estes & Wood, 1984; Liebschutz, 1992). For example, when the Federal government relied upon the nonprofits to provide the majority of the nation's health and social service delivery systems in the 1960s, this caused the

sector to grow. However, during the 1980s, Federal grants were reduced by twenty percent, causing the sector to lose more than \$30 billion in support and nonprofits declined in size and number. Nonprofits suffered difficulty in providing quality services that also allowed the agencies to financially sustain. Additional mandates that were required by the local government (state and county) made it tumultuous to provide services that were consistent and allowed providers to remain committed to their missions (Gramlich, 1997).

Dennis R. Young (1999) constructed three key views to the relationship between the nonprofit and the public sector. In his first, the complementary view, nonprofit organizations are seen as reciprocal partners with the public sector. This give and take relationship allows the government to decentralize without depriving citizens of public goods. Virtually all specialists agree that nonprofit social service organizations have become an integral component of the nation's social safety net for our most vulnerable citizens, such as the poor, children and elderly (Axinn & Stern, 2001; Jansson, 2001; Salamon, 1999; Young, 1999). Young's (1999) second view, the supplementary view, describes nonprofits as organizations that fill in the gaps with goods and services that the government fails to provide (Berry, 2003). Theorists argue that these opportunities arise because the government is responsible to provide services for the aggregate of the population (Weisbrod, 1988). Therefore, minorities lack the power to create these services through the political system and depend on private organizations as an alternative. Lastly, the adversarial view, allows the two to work towards a common goal of providing social services to those in need and also allows the government to become smaller. The two work together through checks and balances. The nonprofit sector is given the freedom to advocate for policy change and social reform and to speak out against any wrong doings of the government (federal or state), which is crucial for the healthy functioning of a democratic society with freedom of speech

(Alexander, 1999; Ryan, 1999). Nonprofit advocacy takes many different forms, from advocating on behalf of individuals (children and families) or to perpetuate some form of social justice (Magura & Laudet, 1996; Haynes & Mickelson, 2000; Richan, 2013). The government, in turn, provides policies and procedures for nonprofit organizations in order to ensure a level of public accountability and to limit the scope and impact of nonprofits' reform efforts so that special interest groups cannot promote their own interests (lobbying) while benefiting from tax exemptions (reward for providing the services and goods needed (Young, 1999).

The nonprofit sector was affected by the 1980 deficit cut and began to contract and sell services to the public sector. These new avenues of revenue to federal funding made the nonprofit sector merchants to the states (Smith & Lipsky, 1993; Wolch, 1990). The change in the relationship between the nonprofit and public sectors created a governmental over casting that shaped multiple oppositions for the autonomy of nonprofits. They no longer had the ability to scrutinize or criticize the state (Young's adversarial view) because of a deepening dependency on the financial support that the public sector provided. The states could favor organizations whose goals were aligned with their central purpose and the funding would flow that way, which omitted organizations with a difference of opinion. A state could also focus financial support only towards larger organizations who were deemed more efficient, which would redirect services and volunteers away from disadvantaged communities who are less likely to have community-based expertise. Lastly, a conservative political administration could require missions that only support their agendas (Wolch, 1990; Van Slyke, 2007).

The present-day challenges that face nonprofit organizations and local communities call for the need for increased inter-organizational collaborations. The devolution of government spending and the policies and procedures that facilitate for-profit competition, coupled with the

growing crisis that swells from within disadvantaged communities have produced a lack in social services. Communities that are most in need do not receive the services that are crucial for change. The concern today calls for not only a collaboration among nonprofit organizations, but for a collaboration across all sectors in order to encourage community-wide discussions of desired changes that need to be made and the resources to reach the expected outcomes (Connor, Kadel-Taras & Vinokur-Kaplan, 1999).

Traditionally, nonprofit organizational theorists have focused on the individual processes of single nonprofit organizations (Herman & Renz, 1998). However, Rogers and Whetton (1982) suggested that models should be studied from multiple layered organizations to examine partnerships of inter-organizational collaboration and development. They called for studies that would provide information on what the nonprofit sector might look like if organizations pulled resources and human capital to address a communities needs on a social level. Collaborations would allow for organizations to pull resources that allows each nonprofit autonomy within their respected area of expertise while also eliminating duplication of services. Outcomes could easily be observed for success and failure, while funds could be administered within an equitable proportion to those services that better served the overall mission.

Salamon (1999) argues that because funds have been drastically reduced, the third sector (nonprofit organizations) in the United States is at a critical juncture and the sustainability of social sectors should not be taken for granted. One of Salamon's (1999) recommendations is to use inter-organizational collaborations across multiple sectors as a means to provide avenues for nonprofit organizations to better respond to societal needs. Funding cuts do not change the fact that policymakers continue to charge nonprofits with leadership roles for community building through the delivery of social services utilizing partnerships as a vehicle. Therefore, to be successful, the

need arises to know more about the processes of implementing social services to communities through inter-organizational methods, the potential conflicts that may exist in the external environment and solutions others have used to work through and help resolve the presenting problems (Chaskin, Brown, Venkatesh & Vidal, 2001). Doing so allow these collaborations to be successful and an added value to the community. These challenges could include building trust, navigating territorial issues, developing a shared vision, creating a sense of inclusiveness, resolving conflicts, sustaining the effort beyond an immediate crisis and supporting implementation at all levels of the collaboration (Connor, Kadel-Taras & Vinokur-Kaplan, 1999). Responding to these challenges requires a variety of local-to-federal interactions between service providers and government agencies. The case of the CARES program in Boston reflects how inter-organizational collaborations can be used to address social issues.

Case Studies

CARES.

Mulroy (2003) conducted a study and reported findings from an inter-organizational collaboration among seven nonprofit organizations in Boston, Massachusetts. The organizations came together in 1990 under the umbrella of a five-year federal demonstration grant whose main goal was to reduce child abuse and neglect in one of Boston's most disadvantaged communities. The program, called Dorchester CARES (Coordination, Advocacy, Resources, Education Services), developed a multi-organizational network of community service with complementary programs (Mulroy, 1997; Mulroy & Shay, 1997; Mulroy & Shay, 1998). There was a major stipulation to the guidelines of the grant that the program deliver child maltreatment services as preventative services instead of responsive services, which were already being provided by the existing bureaucracies that handled child welfare, which were underperforming and failing to

adequately protect children (Melton, 1991). Therefore, a model was developed that focused on families and communities simultaneously (Shay, 1995; Coulton, 1996).

The participating agencies were all nonprofits, but they varied in years of experience, performance based knowledge and organizational size. The sponsoring agency had a mission and purpose theoretically grounded in the ecological approach to the prevention of child abuse and neglect (Sidebotham, 2001). The philosophy was that child maltreatment involves numerous factors that compound to create family role malfunction and dysfunctional adaptation by caregiver and child (Belsky, 1980). This implies that external distractions and stresses impact the behaviors of a parent and their level of aggressiveness with their child. Risk factors are diverse; some are inherent personalities of the child or parent while others point to the broader family context or the social-cultural environment (socioeconomic status; class). Although many aspects of parents and families have been studied, most could be placed in a framework that associates child maltreatment with family stress, particularly among young or single parents living in impoverished conditions and in communities that do not provide adequate social support and guidance from other adults (National Committee for Injury Prevention & Control, 1989; Sack, Mason, & Higgins, 1985; Schloesser, Pierpont, & Poertner, 1992).

The participating agencies shared values and a common purpose in their mission statements: to enhance the well-being of children and families (Mulroy & Shay, 1998). Uncertainty of funding streams made it difficult for the organization to plan programs beyond the initial year and there was a need for continuous grant writing to sustain the programs. The inability to deliver services evenly that required time sensitive interventions, along with a constant change to the programs that were initially planned in the original proposal, made it difficult. However, to survive, the inter-agencies pulled all of their individual resources to fill in the financial gaps in

the process. At the onset of the CARES program, due to prior financial cutbacks, the relationship between the city's largest child and family agencies that were currently providing the SNS and the state Department of Social Services (DSS), the provider of child welfare, had deepened. Since DSS was the ticket for distribution of large amounts of federal dollars reserved for child welfare purposes, it was the largest source of funding for programs related to children and families in the state. Therefore, all nonprofit social organizations in the state were seeking these funds which created a competition among smaller organizations.

The larger nonprofits had also adapted to the child welfare philosophies of DSS and therefore, received the largest grants. Smaller organizations, which did not have the same philosophies received smaller service grants. Both types of nonprofits who received contracts from the state to perform SNS became dependent on DSS. Not mentioning the fact that the larger organizations fell victim to mission drift and created such an alliance on the principles of CPS that one could not be told apart from the other (Mulroy & Shay, 1998). CARES was not created to replace the existing processes. The state's child welfare agencies and the vendor nonprofit organizations continued to operate in the traditional way. CARES was intended to be an alternate with outreach services to introduce a community to prevention alternatives. The CARES partnership's goal was to strengthen both the families and the communities and to prevent child abuse from taking place. The goal was to mitigate families reaching the state level in the first place.

The families who participated in the community-based activities in Boston that CARES serviced presented multiple unmet needs in addition to very low incomes and high incidence of child abuse. The internal situations found within the community were substance abuse, homelessness and mental illness—all requiring a range of service responses. The residents had

unmet basic needs for food, clothing, child care, substance abuse treatment, housing, education (including English as a second language), health and socialization. The unmet needs were beyond the responsibility of the family to prevent child abuse and neglect. Services were needed to rebuild the community and others were geared towards strengthening and counseling the individual families. The question was raised as to what body of knowledge was required to understand these problems and who was qualified to deliver services in the community in the way the community wanted to receive them (Mulroy & Shae, 1998).

The next step in the program development was to encourage and foster the residents to become active members of their communities. First, CARES reconfigured services into three levels of service: primary, secondary and tertiary. Primary services were immediately provided and secondary prevention-oriented services (food pantry, clothing exchange, parent-education classes, peer-support mentoring group and home-health visits) were appropriately intensified by tertiary interventions (substance abuse treatment and mental health services) provided by an outside agency as an outreach program. The community organizers wanted to succeed at one community driven activity to encourage and enable participation by the community members, a family cooperative was created where food, clothing and childcare could be exchanged for volunteer work by community members. This began the process of empowering members to facilitate change in their own families and community by their individual contributions (Mulroy & Shay, 1998).

Once the community's primary and secondary needs were met, the larger task at hand was to address the deeper issues that the families faced and to create a network across all five of the participating organizations that would serve as a safety net so none of the families could fall through the cracks. Representatives from all of the tertiary levels were included: substance abuse,

mental health, family-parent counseling, educational resources and the frontline- which were the community members who were incorporated to provide a grass roots type of assembling the families themselves to get involved. This brought frontline workers closer together which facilitated the service network to operate efficiently. Families were better served and collaboration and relationships among community institutions became stronger. A series of cross-trainings were created to increase family, organization and worker awareness of the resources available (Mulroy & Shay, 1998).

To fulfill the final requirements of the federal government who administered the grant funds, the project manager developed relationships with university-based researchers who agreed to create and facilitate a long term outcome evaluation. A baseline study was completed, new community-level instruments were designed and a four-wave quantitative study was planned with the goal of publishing preliminary results (Earls, McGuire, & Shay, 1994). As with any grant, there was a planned termination date. However, the collaboration has been so successful that not only do the original partners continue to collaborate, but have also expanded their inter-organizational relationship that now involves more than twenty-five partner organizations and operates under the name of My Dorchester.⁹

The initiatives demonstrated through the CARES organization shows an evolution in thought processes for appropriate modes of securing the protection of vulnerable children and exhibiting a conscious shift in mandating a directional change in federal responsibility. Shifting both social and welfare reforms toward community based solutions developed by inter-organizational partnerships and collaborations (Prince & Austin, 2001; Carnochan & Austin,

⁹ Mydorchester.org

2001). But community care and the protection of children are only as good as the capacity of the organizational infrastructure in each organization. The commitment, skills and leadership of community-based executives and their community workers are imperative to successful collaborations. The findings of the CARES study suggest that an initiative to build communities through investment of time and devotion is key to the implementation of improvements in child welfare reform (Fabricant & Fisher, 2002). This coupled with the desire and enthusiasm of the community and their work experience, generated a strong commitment to the community and its residents as the organizer of change to reduce child abuse and neglect.

NEW.

Another form of inter-organizational collaboration is the utilization of a nonprofit management support organization (MSO) to help with challenges that nonprofits are facing today. MSOs are local nonprofits that provide support to other nonprofits through training and consulting on such issues as leadership, planning, fundraising, marketing and human resource development. Their purpose and standing in the community can vary widely from these core tasks, however, the organizations typically serve as an umbrella of resources to be used by other nonprofits and greater availability of mission success. Research suggests that MSOs are in a unique position to organize, facilitate and sustain community collaborations and should consider making this role a central function of their mission. Seaburn (1996) finds that the initiator of collaboration “is often a systems thinker and is often the one who fosters relationship” (Seaburn, 1996;54).

Nonprofit Enterprise at Work (NEW) is one MSO that has taken on this role. NEW has spent the past several years working with and examining inter-agency collaborations in Washtenaw County, Michigan, an area with a mix of rural and urban settings that includes the organization’s home office in Ann Arbor. NEW has also approached the promotion of

collaboration from the perspective outlined by O’Looney (1996) that the process of collaboration amongst nonprofit agencies will facilitate in system change and these system changes have both a social service responsibility component and a community capability component. When services are integrated and communities are more organized, one can expect to begin to see changes in the lives of families and children. The collaboration allows for a protection of families from falling through the cracks.

The case studies of NEW’s work provide examples of two types of integration that O’Looney (1996) identified. The first is program-centered integration, in which agencies collaborate around the services to be delivered and the administrators of the programs. The second is policy-centered integration, through which higher-level stakeholders engage in the assessment of needs, the priority to supply the services, in the capacity the services will be allocated and how to monitor the entire system. NEW’s financial stability depends on earned revenue from fees for services from the local government and on foundation, corporate and individual contributions. This allows NEW the ability to maintain a relatively impartial position in the community in relation to other nonprofits, governmental agencies and funders. At the same time, NEW has a mission to improve the experience of life within communities by aiding nonprofits to succeed in inter-organizational relationships (O’Looney, 1996).

Chapter Conclusion

This chapter shows how 20th Century changes in federalism affected the delivery of social services. The relationship between the nonprofit and the private sector shifted because of devolution of federal funding and a new way of providing services was created. Inter-organizational collaborations and the use of nonprofit management service organizations can better

address social issues through providing the basic needs of the community while creating a streamline of services that allow for the nonprofit sector to efficiently pull resources to sustain.

Continued research could further explain what might lead and/or hinder nonprofits as they seek to participate in multisector collaborations. A better understanding of bottom-up learning would aid nonprofit managers in creating programs that incorporate participation not only from various nonprofit agencies but from the local residents, themselves (Snavely & Trcy, 2000). This would allow for a truly sustainable community and foster the families to create their own futures through taking initiative to strengthen familial bonds, as well as speak out for the social reform their communities need (Sen, 1997). This way, inter-organization collaborations would share alongside partner organizations and the community, the risks and rewards.

Chapter 4: Methods of Research

Research Introduction

This thesis provides a qualitative study of socially necessary services (SNS) provided to maltreating parents with addictions, as well as an in-depth review of the current policy and procedures of the state of West Virginia surrounding child abuse and neglect. Reviews of scholarly literature and case studies are appraised for best practices of a nonprofit organization to serve as a community service organization (CSO) to facilitate an inter-organization collaboration to mitigate child abuse and neglect.

The researcher chose qualitative research because it is the preferred methodology in the social sciences. The primary research was conducted on human beings to better understand their perception of the services they provide and their interpretation of the success of those services. Therefore, qualitative methodology allows for a greater personal reflection of the research. Michael Quinn Patton describes that there are three types of qualitative research: surveys; in-depth, open-ended interviews; and analysis of written documents (Patton, 2005). All of which were included in this research.

The first type of qualitative research utilized was evidence-based practice questions in the form of an online survey to evaluate the ability of SNS delivery by ASO providers in Kanawha County to sustain the control/mitigation of impending dangers posed by maltreating parents with addictions. The survey sought to answer two main research questions: “What are the organizational strategies for reintegrating children and families back into the communities upon completion of treatment services?” and “What factors influence the longer-term outcomes of reintegration strategies for families?”

Next, in-depth interviews with two (2) CPS social workers were conducted to reveal the omission in their intervention of a community reintegration strategy/approach that is critical to sustaining improvements in the diminished capacity of maltreating parents with substance abuse problems to maintain the safety of their children within the home and further concur that the need for greater substance abuse rehabilitation is a necessity to mitigate impending dangers to children and long term sustainability of the family unit.

Lastly, the third type of qualitative research and secondary source was the analysis of written documents such as the policies and procedures of DHHR/CPS and the current legislation mandates of the State of West Virginia. These documents were reviewed to assess for their abilities to facilitate intervention, treatment and provide reintegration strategies to the families they are intended to aid. Scholarly literature was also reviewed and case studies were referenced to not only give credence to the research area, but also formulate best practices to the research idea that the use of a nonprofit as a community service organization (CSO) to facilitate an inter-organizational collaboration between local lawmakers, the judiciary branch, local government (DHHR/CPS), administrative service organizations (ASO) and afflicted families could incorporate a currently omitted reintegration strategy to maltreating parents and could therefore address the socioeconomic deficiencies of families throughout the state of West Virginia while reducing the amount of parental rights being terminated and children entering the foster care system for multiple, long-term exposure.

Research Process

Appalachian State University requires that any research that is conducted on human beings must be approved through the Institutional Review Board (IRB), which is an entity that grants exemptions for research based on the type of research being conducted. An application was

submitted with a list of questions for the survey and the interviews, as well as consent forms informing the human subjects that their anonymity would be protected and that their participation was voluntary and could cease at their discretion. The research was approved with IRB exemption on December 18, 2015.

The online survey was conducted to identify what the ASO organizational strategies were, if any, for reintegrating children and families back into the communities upon completion of treatment services and what factors they believe influence the longer-term outcomes of reintegration strategies for families. Concurrently, two CPS social workers were interviewed to identify the absence of a community reintegration strategy/approach to maintain the safety of children once the families are released from the child welfare system and that there is a need for greater substance abuse rehabilitation to ensure the safety and the long term sustainability of the family unit.

Stratified sampling was chosen above random sampling to choose the subjects, not only because it reduces sampling error, but also because stratified sampling uses a stratum, a subset of the population that share at least one common characteristic (Troost, 1986). For the survey, the stratified samples included ASO providers of SNS and for the interview CPS workers, both having the common characteristic of working within the child welfare system and servicing families in Kanawha County, West Virginia. Random sampling was then used to select a sufficient number of subjects from each stratum. "Sufficient" refers to a sample size large enough to be reasonably confident that the stratum represents the population. Currently, there are four ASO providers servicing Kanawha County families and all four were selected: Home Base, New Horizons, Hudson Forensic Psychology and Children First. The Kanawha County CPS division has a high turnover rate, therefore, the sample size was smaller for the interview due to experience and the

two social workers chosen were tenured, with one being a substance abuse specialist. The researcher felt that it would be insignificant data to gather information from new employees.

Survey Results

The survey was electronically distributed and anonymity of the subjects were protected. An initial email was sent out to ten subjects (social workers) employed by the four different ASO providers, introducing the researcher, the research and to contact Dr. William Schumann (Thesis Director) with questions. The survey was created within Qualtrics, a compliance software and a link was generated that would take the subjects directly to the survey. The survey consisted of six survey questions. Nine of the ten subjects agreed to take the survey, seven completed.

1. What services does your organization provide specifically to families to mitigate impending dangers applicable to children who are under supervision of DHHR for threat of abuse and neglect?

Response: Seven responses were given to this question and the services collectively provided are individualized parenting, adult life skills, in-home supervision, social and emotional support, crisis response, supervised visitation with children and transportation.

2. What two factor do you feel contributes MOST to the abuse and neglect cases you see?
Please select two options.

- a. Poverty
- b. Substance abuse (including alcohol)
- c. Unemployment
- d. Low education attainment

- e. Young parent households
- f. Physical and/or mental health
- g. Single parent households
- h. Other (please specify)

Response: Seven responses were given to this question with substance abuse (100%), physical and/or mental health (71%), poverty (43%) and low education and young parenting (14%).

3. Is substance abuse rehabilitation a component of the service strategies your organization provides to families in threat of losing custody of their children?

Response: Seven responses were given to this question with forty-three percent (3) answering “yes” and fifty-seven percent (4) answering “no”.

- For the subjects that answered “yes”, a follow up question was asked for them to explain the rehabilitation component and if the provisions were for 30-day detoxification only.
- Two responses were given in explanation to this follow up question that their organizations assist clients in obtaining substance abuse evaluation and treatment and that in or out-patient programs are researched, recommended and help can be given to patient access.
- Three responded “no” that the rehabilitation provisions were for 30-day detoxification only.

The four subjects that answered substance abuse rehabilitation was not a component of the service strategies provided by their organization were asked a follow-up question as to why substance abuse rehabilitation was not offered and they responded:

- We assist them in locating a facility but we are not trained to provide the actual rehabilitation services.
 - We help people access the service but do not provide it within our agency.
 - A referral is used to other service agencies that are licensed and certified.
 - We help with skills associated with rehabilitation but actual drug therapy is not in our scope of professionalism.
4. What strategies does your organization practice to facilitate the reintegration of children and families back into the communities upon completion of treatment services? Examples might include follow-up services or community-based support programs.

Response: Seven responses were given to this question to include:

- 90 days of follow up services, and we link them to community services such as AA/NA and outpatient services.
- We link families who have been reunified to other agencies for ongoing support such as ongoing therapy, tutoring, psychiatric services and etc.
- Direct intervention and community support referrals.
- Share knowledge of community based support.
- In-home supervision and linkage to other services.

- Continuation of services as well as helping families access ongoing community services/supports that will keep the threat of reoccurrence at a minimum.
 - Follow-up services and counseling.
5. In your opinion, what programs or protocols within your organization most support the long-term success of family reintegration?

Response: Five responses were given to this question to include:

- Support and linking them to support systems in the community.
 - We have a PHD who provides parental fitness evaluations and helps us to know what the families really need to work on most.
 - Social and emotional support, the skills learned through meeting a case manager.
 - Mental health referrals/stabilization and substance abuse treatment.
 - The grass roots work we are able to do with the families. Our ability to establish a trusting, professional relationship which leads to better compliance.
6. In your opinion, what are the greatest institutional or bureaucratic challenges to supporting long-term family reintegration?

Response: Seven responses were given to this question to include:

- We do not have enough resources to support these people once we are out of their lives.
- Limited funding, constant changes in DHHR staff due to them being overworked and underpaid, too many different people being involved and not really knowing the families from the state and etc.
- Policy and laws with the state.

- Lack of service providers, lack of effective therapy and counseling, general dearth of programs.
- DHHR is overwhelmed and cannot respond as needed.
- Service definitions do not encourage thinking outside of the box. Safe at Home wrap-around services are now in place for this purpose but why recreate the system? Also DHHR has never increased pay which discourages potential employees.
- Substance abuse.

Interview Results

Two interviews were conducted with social workers employed by CPS. Both have been with the organization for over three years, which is tenured for a DHHR employee. The social workers were contacted via email to gain an interest in participating in the interview. The interview questions were emailed as attachments to the subjects and one was returned electronically and the other was through the US Postal Service. The respondents both mailed with their signatures the consent to participate in the interview. Both subjects agreed to participate and were asked the following questions:

1. What are the current successes and weaknesses of the organizational strategy surrounding abuse and neglect?

Response:

Interview 1- If wraparound could be utilized effectively it would be great. There are good resources for some issues, but not all. The weaknesses are in the implementation of getting together effective treatment.

Interview 2- “Successes “in organizational functioning (strategy) to address the inordinate amount of abuse/neglect cases in Kanawha County are purely accidental. The current “fad” is family-centered “wraparound services” that are theoretically designed to be a holistic invention. However, neither past nor current strategies address the root causes of current abuse/neglect cases (e.g., substance abuse, mental health issues)

2. What factor do you feel contributes MOST to the abuse and neglect cases you see?

Response:

Interview 1- Clearly substance abuse.

Interview 2- Substance abuse, mental health issues

3. Is substance abuse rehabilitation a significant component of the service strategies your organization provides to families in threat of losing custody of their children or those who are currently being adjudicated?

- a. Are these referral services for 30-day detoxification only?
- b. What are the obstacles regarding substance abuse rehabilitation?
- c. Do you believe it should be a significant component of the service strategies?

Response:

Interview 1- No. Typically there will be drug screens done but there is limited resources available for long term treatment. a. Detox typically is 5 to 7 days. b. Not enough resources and the willingness of clients to participate is another obstacle. c. Yes, when substance abuse is noted.

Interview 2- Of course NOT! The Department has NO CONCEPT of the impetuses driving the current explosion of abuse/neglect cases. It is not oriented toward prevention

or solution. a. The issue here is the availability of beds in scarce treatment facilities. b. The availability of beds in scarce treatment facilities, few treatment facilities, dearth of resources, useless chemical treatment facilities. Also, willingness of clients to participate in treatment. c. Yes.

4. What are the organizational strategies to facilitate the reintegration of the children and families back into the communities upon completion of treatment services? (Example: follow up services or community support)

Response:

Interview 1- It depends on the Social Worker. Some are willing to take the time to follow up, others either can't or won't.

Interview 2- There exists no organizational strategy to facilitate the reintegration of the children and families back into the communities upon completion of treatment services. "Organizational strategy" is restricted to standard operating procedures for managing daily crises connected to referrals of abuse/neglect cases, broken safety plans, clients' unwillingness to abide by conditions of their cases, etc. The sheer amount of cases on individual workers' caseload prevent "going the extra mile" to adequately follow-up.

5. What factors do you believe influence the longer-term sustainable outcomes of reintegration strategies for the families? (i.e. aid in the success of families staying in tact and sustaining recidivism rates)

Response:

Interview 1- Client willingness, client's ability to persevere longevity of use while in active addiction.

Interview 2- The ability of the intervening organization to demonstrate care and interest in the client and their issues, its ability to actually manage the clients' cases, its ability to command resources both in the addiction and recovery communities, its ability to design, implement and deliver MEANINGFUL, QUALITY ASO services in life skills, parenting, role expectations, and subcultural behaviors.

6. What do you believe to be the greatest obstacle to reunification of families who are under the state's supervision due to abuse and neglect caused by drug addiction?

Response:

Interview 1- Lack of resources, client willingness.

Interview 2- Refer to question #5.

Analysis of Research

Introduction to the socioeconomics of drug addiction.

This chapter discussed the history of substance abuse and why people become abusers. Research suggests that it is a susceptibility of certain people due to a combination of personal history (ACE) and stress (SST). Substance abuse leads to the demise of the family unit because parents become disengaged and this deepens when there is a lack of social support for adults. Therefore, basic needs are not met of the child or the family, which leads to the maltreatment of children. With an inability to provide basic necessities for a child, neglect shows up in the form

of dangerous living situations, lack of supervision and basic resources to provide for a child. With impaired judgement and aggression, coupled with low reflective functioning and expectations of a child's levels, a parent can become abusive. Deregulation of emotions that are compounded with a lack of parenting education create a need for the child welfare system to become involved.

This involvement comes in the form of referrals to CPS yet treatment obstacles arise because CPS is not trained to address substance abuse. Only half of the parents who are referred to CPS flagged for substance abuse attend treatment and only thirteen percent in some cases complete treatment. Research further shows this is a result of lack of collaboration between key stakeholders to work on treatment obstacles that include:

- Limited understanding of addiction
- Lack of knowledge on what parents need who are substance abusers
- Limited access to adequate treatment
- Timeframes for achieving permanency for children
- Lengthy court proceedings
- Difference of opinions and missions for agencies involved

These discrepancies cause a parental reluctance due to:

- Fear of detox
- Lengthy wait lists/unavailable services
- Varying timeframes between services and judicial systems
- Mothers on drugs are at a greater risk of losing custody of their children because of time constraints and are afraid to commit and/or complete treatment

Treatment obstacles even if addressed are followed by the threat of relapse and re-offense. Research shows that returning parents to the same socioeconomic conditions after treatment increases relapse and re-offense. The cycle continues when services are provided only to mitigate impending dangers and not underlying issues. Unemployment and inadequate housing options are stresses that lead to relapse. Furthermore, research states recovery is a chronic disorder that needs a life-long commitment much like diabetes. Recovery and prevention of relapse may take longer than the courts allow.

Post-treatment hardships face recovering substance abusers upon release of treatment. Research shows that employment helps with retention but most substance abusers have criminal records which makes it difficult to gain employment. However, studies show employment is dependent upon successful rehabilitation and reintegration. The 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which created TANF (food stamps) and The Quality Housing and Work Responsibility Act includes prohibitions against anyone with a felony to receive assistance for food, shelter and employment (basic needs). This makes it difficult if not impossible for recovering substance abusers to recreate their lives, especially for women who have dependent children.

Policies and procedures of the state of West Virginia.

In 2014, West Virginia ranked 49th in the nation with an average household mean of \$41,043. Substance abuse is a direct result of this poverty and in 2014 West Virginia had the highest rate of accidental drug overdoses in the country. The clear implication that abuse and neglect of West Virginian children could also be a direct side effect, especially with the rise in substance abuse impacting the state. Currently, 4,454 children have fallen victim to child abuse and neglect and approximately 4,300 are currently placed in foster care, which is encompassed by

the child welfare system. Child Protective Services (CPS) becomes involved in these cases and policies and procedures are created to facilitate the protection and safety of the children through trying to control and mitigate impending danger to children living within the homes of substance abusing parents. Assessments are completed to decide the egregiousness of the cases and upon completion, the child is either kept in the home and the family is referred to ASO providers for SNS or the child is removed from the custody of the parents and placed in out of home care (kinship care or foster care).

The Department of Health and Human Resources creates the policies and procedures that are implemented by CPS and although their policies state a wide variety of services that could be beneficial for the families, the only services that are reimbursed to ASO providers are the safety services that are limited (supervision, individualized parenting and adult life skills, family crisis response, crisis home management and social/emotional support). These services are strictly intended to address the crisis, alleviate the impending threat of danger to the child and secure the family unit. Should parents be unable to remove the risk of abuse and neglect to their children the child is removed from the custody of the parent and the adjudication process begins with an end result to terminate the parental rights to the child.

Discrepancies and deficiencies.

Within these policies and procedures are several discrepancies that cause obstacles for family reunification. The first of which is the Adoption and Safe Families Act (ASFA) of 1997 that mandates a determination on the permanency of placement be as soon as possible. This means that every child should have a permanent home whether reunified with his or her parents or adopted within a timeframe that does not exceed fifteen months. Research showed in Chapter two that

sixty-six percent of the children in 2013 that were waiting for adoption had been in foster care placement for twelve to twenty-four months and thirty-three percent had been for two to five years.

Other discrepancies within the current child welfare system of West Virginia include the lack of a community reintegration strategy that addresses the underlying causalities of substance abuse, child abuse and neglect and relapse. As previously stated, the services provided by ASO providers are intended to alleviate the threat of abuse and neglect and address crisis level responses. Eighty percent of these services must be provided in the home or the community, which makes community involvement an important missing link. The services provided do not address the families' socioeconomic stresses, adverse childhood experiences that cause self-efficacy deficiencies and physical and mental impairments. If these situations are identified through the FFA, the resources are shared with the families and left to their discretion to pursue.

The crisis situations that arise from within the family units that are addressed through current treatment have built over time and to apply surface level solutions to these issues will not address the underlying causes that keep the families from functioning as healthy and viable social units. Without adequate treatment to address these underlying causes, families will continue to face the obstacles that initially created the crisis. Environments need to be created to shift the family unit away from a poverty and drug centered lifestyle into one of self-determination and efficacy filled with the tools and skill sets to change.

Although the Federal Adoption Assistance and Child Welfare Act of 1980 protects the parental rights of substance abusers allowing that reasonable efforts must be made to allow the parents to remove threats of danger to the child before the removal of the child from the home. The time-allocation placed upon the opportunity for change poses a threat and added stress to the

substance abusers, which can make participation overwhelming and unappealing. Research also shows that separation of parents from their children removes a powerful motivation to recover.

Institutional impediments that involve DHHR include the overworked and underpaid employees that cause high attrition amongst social workers. Coupled with the lack of training and experience in the area of substance abuse, there are not enough service providers or experienced social workers to address the growing number of child abuse and neglect cases in Kanawha County. Concurrently, time sensitive decisions mandated by the courts pushes DHHR/CPS to work faster to terminate parental rights versus to reunify the family because of the obstacles they must overcome to truly mitigate the long-term threat of danger to children of substance abusers from low socioeconomic communities.

Lastly, community-level support must be provided but is missing from the current child welfare system. There is a lack of long-term stability that does not address the socioeconomic stresses nor the adverse childhood experiences as underlying causes to substance abuse. There are no long-term plans implemented for families upon release from the child welfare system that address the ability to meet their basic needs (employment, education and housing). There are no current treatment plans or services that include job skills training or educational attainment to change the socioeconomic outcomes. Furthermore, combined treatment that addresses addiction while addressing parenting deficiencies is essential for long-term success and reintegration of families back into communities and is absent from the current treatment model.

Literature review.

The literature review created a framework for incorporating the responsibility of society as a whole. This includes the individual social agent, the family and friends that support that agent,

the community in which the family resides and the resources that are made available to them in the form of employment, education and spirituality. These resources are created and allocated through funding and legislation from local and state government. There is a level of responsibility that forms a top-down approach to communities which holds local and state government responsible for creating legislation and funding opportunities for communities to provide services that enables and empowers individual social agents.

If there is a discrepancy in policy and procedures it can directly affect the breakdown of individual social agents. Where government leaves off and there are gaps within the services system, nonprofit organizations are created to provide social services on a community level that the government won't or can't provide. Community-level support programs could empower individuals to demand resources so that their basic needs are met. However, it is also the responsibility of the individual social agents to participate in the services that are provided to support change within their families.

Often, communities that are most in need do not receive the services that are crucial for change and therefore there is a call for collaborations among nonprofit organizations and across all sectors in order to encourage community-wide discussions of desired results to social problems. Collaborations allow organizations to pull resources and when successfully implemented eliminate duplication of services and show inefficiencies in others.

Case studies.

The CARES study conducted by Mulroy (2003) pulled together multiple organizations across the Boston area to mitigate child abuse and neglect. However, the collaboration was not created to replace the existing child welfare system, but to serve as preventative services instead

of reactive services. The model focused on the families and communities simultaneously. This philosophy provided a way to empower the families that were at risk of child abuse and neglect by working with other nonprofits to create community-level resources to address the needs of the families that live within that community. This research validates that there are external distractions and stresses that impact the behaviors of parents that not only lend way to substance abuse but also heightens the level of aggressiveness parents may have towards their children. Socioeconomic stressors, substance abuse, mental illness and inadequate support were named as internal situations found within the families of the community. The CARES organization set out to alleviate the immediate needs of the families (food, clothing, shelter), followed by support services (parent-education classes and peer-support groups) and then the more peripheral services were provided through community partners (substance abuse and mental health).

The participating agencies shared values and a common mission to enhance the well-being of children and families and set out to deliver services to community members. The collaborative aspect of the CARES organization allowed for the service providers across the child welfare sector to gather the resources necessary to provide the needs of the community members effectively by forming a network of expertise and following the families through the entire process, which kept families from falling through the cracks. The most important part to empower the families to facilitate and participate the change that healed their families.

The NEW organization takes the inter-organizational collaboration one step further by utilizing a nonprofit as a management support organization (MSO) to help nonprofits with the challenges they face today. Resources are provided to help with issues such as leadership, fundraising and marketing. The purpose of the MSO is to keep everyone within the collaboration focused on the mission and working together. The NEW organization provided two examples of

integration that had a service responsibility component and a community capability component. This research shows that when services are integrated and communities are more organized, changes can begin to be seen in families and in children. NEW also focuses on a program-centered integration, in which agencies collaborate around the services to be delivered and the administrators of the programs. NEW also focused on a policy-centered integration where higher-level stakeholders engage in the assessment of needs, the priority to supply the services, the capacity in which the services will be allocated and how to monitor the entire system. NEW focused on improving the experience of life within the communities it serviced by facilitating and overseeing the inter-organizational collaboration.

Survey.

The survey was sent to ten social workers employed by ASO providers that service Kanawha County families in the child welfare system because of abuse and neglect. The questions were created to identify that substance abuse is the key precursor for child abuse and neglect cases, as well as to identify that there is a weakness of service options and lack of reintegration strategies for families once they are released from the child welfare system. The survey corroborated these assumptions. The ASO providers listed the services that they provide, which are the only services that can be reimbursed by DHHR. These services include the “safety services” that were identified in Chapter two that only serve to mitigate impending dangers and not address the deeper causes for substance abuse that leads to child abuse and neglect.

As the results indicated from the survey, substance abuse (100%) and physical and/or mental health (71%) were both identified as underlying causes for child abuse and neglect cases by Kanawha County ASO providers, poverty was third (43%). The survey also inquired if substance abuse rehabilitation was a component of the services provided to the families and

although there were different interpretations of the question, the 7 agreed that their organization does not offer rehabilitation services yet “links” the families to other resources that do. When asked what strategies their organizations use to facilitate the reintegration of children and families back into their communities, the responses were conclusive that the ASO providers “link” the families to other resources within the community that can help them once they are released from the child welfare system.

The survey asked the ASO providers their opinion on what programs or protocols their organization offers that most support long-term success of family reintegration and only five responded to identify that their services again “link” the families to outside community resources while one organization has a PhD on staff that provides evaluations that helps the ASO provider know what the families need to work on most. The final question asked in the survey was what the greatest institutional or bureaucratic challenges were to supporting long-term family reintegration, in which 7 responded corroborating the literature review that there is a lack of resources available to support the families once ASO providers are out of their lives, limited funding with constant changes in DHHR staff due to social workers being overworked and underpaid, too many people being involved in making decisions for families that do not personally know the families, policy and laws with the state, DHHR not responding to cases and that service definitions of treatment do not encourage thinking outside of the box.

Interview.

The interview with two CPS social workers had similar outcomes to the survey that there are inefficient services to provide for the families and that the “wraparound” services are just another way of redefining the current treatment services and negate the root causes of current abuse and neglect cases, which is substance abuse and mental health. When asked if substance abuse

rehabilitation was a significant component of the service strategies of DHHR, both social workers answered that it is not. Both claim there is a shortage of treatment facilities and that the child welfare system is not geared towards prevention or solution. One social worker identified that the willingness of clients to participate was also a hindrance to effective substance abuse treatment.

When asked if a strategy was included to reintegrate the families back into the communities it became aware that there is not one because their fellow social workers either can't because they are overworked or because they won't. One interview subject stated that the focus of the organization (DHHR) was restricted to standard operating procedures for managing daily crises connected to new referrals, addressing broken safety plans by current clients, and the unwillingness of the clients to abide by conditions of their cases, which leaves no time for follow-up. Both concur that social workers within the organization are overworked with caseloads that prevent them from contributing to successful reintegration of families back in to their communities.

In regards to longer-term sustainable outcomes of reintegration strategies, it was stated that the intervening organization must demonstrate care for the success of the family upon release and to command resources both in the addiction and recovery communities. The intervening organization would need to design, implement and deliver meaningful and quality ASO services in life skills, parenting, role expectations and subcultural behaviors to allow the families to succeed upon release from the child welfare system. The client's willingness and ability to persevere drug addiction without treatment must also be taken into account.

Research Conclusion

The researcher anticipated that the ASO service providers and CPS social workers would identify the need for additional, more culturally appropriate and socially necessary services to

reintegrate maltreating parents with drug addictions back into the community and to sustain their improved protective capacities. This research will now introduce a nonprofit organization that will operate as a community service organization to facilitate and administer inter-organizational collaborations to address the key gaps within the current child welfare system of West Virginia to address the rising cases of child abuse and neglect caused by substance abusing parents.

Chapter 5: Treatment, Prevention and Reintegration Strategies

Chapter Introduction

This chapter will introduce the development of a nonprofit in West Virginia, which was organized for the purpose of addressing the rising rural phenomenon of maltreating parents with addictions. Operational details will be provided of an inter-organization nonprofit, Pollen8, Inc., as a solution to the existing gaps within the current system, as a community service organization (CSO) that ensures the three core requirements are administered.

- **Treatment:** Substance abuse treatment and rehabilitation services for maltreating parents;
- **Prevention:** Socially necessary services provided to the *entire family* to keep the children from being placed within the foster care system and prevention of post-treatment relapse;
- **Reintegration:** Empowerment strategies and training that equip families with skills needed to become active members of their communities.

Treatment

Treatment addresses the substance abuse rehabilitation services provided to maltreating parents. In the past 10-15 years, specialized treatment programs and services were developed for substance-abusing women who are parents, including interventions that intend to improve parenting ability and to increase the collaboration of treatment providers with the child welfare system (Jansson, Svikis, & Beilenson, 2003; Moore & Finkelstein, 2001; Wingfield & Klempler, 2000). However, fewer than half of all substance abuse treatment programs actually provide “parenting” services, although programs in which there are greater proportions of

women are more likely to provide these services (Grella & Greenwell, 2004). Yet even in such specialized programs, services directed at improving parenting ability may not be consistently available (Olmstead & Sindelar, 2004). In one study, only one-quarter of women who were treated in a specialized substance abuse treatment program reported that they had received family counseling services, even though the program was intended specifically for women who were involved with the child welfare system (Smith & Marsh, 2002). This is problematic because substance abuse is not the only issue within family dynamics. Programs that focus solely on the treatment of substance abuse and do not address parenting inefficiencies do not prepare nor educate the maltreating parent on effective parenting.

Alternative studies have shown that mothers who are able to retain their children with them while in residential drug treatment or who retain custody of their infants while in intensive day treatment have higher rates of treatment retention, particularly among those who are involved with child welfare or who are mandated to treatment (Chen et al., 2004; Nishimoto & Roberts, 2001). Data suggests that interventions that are aimed to break the cycle of substance abuse and child abuse and neglect are more successful when they are family-centered (DiLeonardi, 1993; Scannapieco, 1994). Because women are typically the primary caretakers, even when a male partner is present, family centered services are targeted to engage substance-abusing parenting women. Programs that provide comprehensive, coordinated, holistic treatment are both better at engaging parenting women and more effective for them (Beckman & Amaro, 1986; Beschner & Thompson, 1981; Colton, 1982; Marsch & Miller, 1985; Reed et al., 1982; Magura & Laudet, 1996). Programs must address a parent's substance abuse in the context of their personal health and their relationships with their children and other family members, as well as the community and society because to change individual social behaviors, the entire

person must receive treatment that address all aspects of their social lives (Center for Substance Abuse Treatment, 1994).

Modern research shows that maternal-child bonds and family life hold an importance during recovery, for a mother, and the children included in her treatment plan is significant. Although the presence of children in the treatment setting may introduce certain challenges, it provides an atmosphere of love, nurturing and concern from the mother for the child which strengthens the treatment community (Magura & Laudet, 1996). The inclusion of children in the treatment plan also encourages greater submission to treatment and is beneficial to both recovering mothers and the children. Allowing for the presence of children and even providing child care in treatment programs, is not enough. Many recovering mothers need assistance in basic parenting skills as well. Often times, expectations of themselves as parents are impractical, especially at the beginning of the recovery period, when they feel they must instantly become exceptional mothers (Saunders, 1993). Moreover, any difficulty the child may experience (emotional, physical or intellectual) is likely to add to the mother feeling inadequate and having trained professionals on site to manage expectations would allow for an understanding of where both mother and child currently are, where they can go and how far they have come.

Thus the problem of substance abuse in parenting cannot be solved with traditional methods. The addicted parent cannot be treated in isolation because addiction does not occur in isolation. It occurs during the day to day activities of life. Instead, given the experiential evidence for the family's role in the conception and maintenance of drug addiction, family-oriented interventions may be more effective than individual approaches to overcoming addiction and in the prevention of relapse. Consequently, the focus of the treatment model should be shifted from placement of the addicted parent in isolation to face recovery alone to

recovery in the context of the total family needs. In this model, services which relate to parents and children as families and as members of the community become a tool for recovery. These efforts are consistent with research conclusions that demonstrate the importance of including family members and significant others in substance abuse treatment programs. One study results identified that both men and women cocaine abusers during a 12-week behavioral program found that a significant other's participation in treatment was the best predictor of abstinence (Higgins et al., 1994). It must be noted that the level and willingness of significant other and family members' participation in the treatment process varies greatly and unless there is full cooperation from all parties this theory will not work.

Due to the growing awareness of the connection between parental substance abuse and child maltreatment, efforts are underway to improve the collaboration of services to families who come into contact with the substance abuse treatment and child welfare systems. Greater awareness of the association between parental substance abuse and child abuse and neglect has made it imperative that the two systems interact and coordinate services for parents who are simultaneously involved with both systems (Azzi-Lessing & Olsen, 1996; Young, Gardner, & Dennis, 1998). Substance abuse treatment providers and child welfare agencies are increasingly called upon to collaborate to provide services and to make determinations of parental fitness and recommendations for child placement outcomes (McAlpine, Marshall, & Doran, 2001; Peterson, Gable, & Saldana, 1996). However, historically these two service delivery systems have had differing orientations, goals and organizational cultures which have led to fragmentation and lack of coordination of services and case planning (Reed & Karpilow, 2002). A nonprofit administrative services organization (ASO) can be viewed as a strong leadership and inter-organizational collaboration model. Recovery Specialist Voluntary Program (RSVP), a joint

initiative of the Connecticut Department of Children and Families (DCF), the judicial branch, the Department of Mental Health and Addiction Services (DMHAS) and Advanced Behavioral Health (ABH), has facilitated changes in policy and procedures in the state of Connecticut based on a collective commitment to children and families. The agencies shared data and utilized evidence-based practice to deliver an effective program for parents whose children have been removed by the court. The partnering agencies began building a coordinated network of support services to help parents in their recovery, promote the well-being of their families and achieve more timely permanency (Ungemack, 2015).

Prevention

Prevention refers to the socially necessary services provided to the entire family to keep the children from being placed within the foster care system as well as the prevention of post-treatment relapse. As stated in Chapter two, child welfare agencies are faced with increased caseloads and often decreased funding, therefore such agencies are forced to reevaluate the effectiveness of “traditional” solutions. In the context of the present national policy where preservation and reunification of the family is seen as essential, a paradigmatic shift must take place where the child welfare sector recognizes the need to deal with substance abuse as it relates to issues of family dynamics and early childhood intervention (Magura & Laudet, 1996; Van Bremmen et al., 1994). Programs must be designed to preserve and restore families by offering a comprehensive and integrative mix of services with equal importance given to substance abuse treatment and to parenting and family needs. These programs focus on the family as a potential ally during treatment instead of the addicted parent facing isolation during recovery. Rather than adopting an authoritative and punitive stance, agencies should include parents in the decision-making process, empowering them with the skills and resources necessary to create a safe and

nurturing home environment. After all, the ultimate goal of these services is to engage at-risk families before serious child abuse or neglect occurs.

Most prevention programs provided to substance-abusing parents are delivered within drug and alcohol services and focus only on adults addressing their addictions. There are however, a small number of programs focused specifically on children that seek to address the issues in family functioning associated with the parent's substance abuse. For example, Catalano et al., (1999) compared a standard program of families on methadone treatment to an intensive group-based treatment program (Catalano et al., 1999). The intervention was geared mostly towards parents, but included parent skills training that not only significantly reduced parental drug use, but also reduced family conflict and improved family functioning (Lewis, Holmes, Watkins, & Mathers, 2015).

Few treatment programs have designed preventions that could be considered family focused. Those that have been developed specifically for children are generally delivered in a group format and aim to improve the child's coping skills, interpersonal relationships, positive identity and self-esteem (Roosa et al., 1989; Lewis, Holmes, Watkins & Mathers, 2015). Most parent treatment programs focus only on the addicted parent recovering from substance abuse and little emphasis is given to addressing the parent as an individual with a personal history from childhood. The implementation of treatment programs that address the social, biological and socioeconomic deficiencies that parents experience could have significant effects on whether that parent succeeds or relapses.

Even though social situations are often associated with patterns for abuse of substances, traditional prevention interventions for relapse focus on making individual social changes to reduce the likelihood of relapse. Often times these traditional ways seem to ignore the presence

of social factors such as learning to identify personal “triggers” that set an individual up to use or reuse, followed by learning to avoid these identified triggers when possible and increase coping skills to effectively deal with unavoidable triggers (Brandon, Vidrine, & Litvin, 2007). Social factors such as being a single-mother and having a drug or alcohol-using support system, all have been associated with relapse (Wahler, 2012). Progressive social support is a significant factor in helping impoverished parents cope effectively with stress and reduce distress, therefore, significantly lowering the risk for relapse (Baffour, et al., 2009).

Biological and socioeconomic factors should also be considered when attempting to understand and prevent a return to substance use after periods of abstinence. Biological factors such as having low self-esteem and co-occurring psychiatric disorders, as well poor coping ability, increased cravings, interpersonal difficulties and a lower level of commitment to abstinence have also been associated with a return to substance use post-treatment (Wahler, 2012). Unemployment and low educational levels are associated with higher rates of substance abuse and dependence, therefore, people of low socioeconomic status may have additional risk factors than their higher-income counterparts (SAMHSA, 2010). For example, empirical research shows that education increases opportunity for higher-income employment and is the main predictor of upward mobility and higher education levels are associated with decreased depression in both men and women when compared to less-educated counterparts (Lewis, Holmes, Watkins, & Mathers, 2015). Employment often parallels identity, therefore, persons employed in jobs that allow creativity and are fulfilling with continued growth experience lower distress than those employed in tedious and demotivating jobs (Mirowsky & Ross, 2003). Although income is often related to employment, however in prevention, it should be considered separately because it represents a person’s ability to meet financial obligations. Financial strain

is a predictor of both the onset and maintenance of depression and anxiety, which leads to initial use and relapse of substance abuse (Mirowsky & Ross, 2003; Weich & Lewis, 1998).

Prevention and interventions might be more successful when family members and significant others are involved in treatment. Including families might help parents avoid regression associated with the abrupt termination of services upon completion of treatment programs and child protective services. It is recognized that some families are rurally isolated, which necessitates community leaders working together with treatment partners to provide support once a family is released from treatment and services are removed. Additionally, cultural considerations must be taken into account when choosing or designing interventions for this diverse population. Common obstacles to seeking follow-up care include lack of program availability, transportation, unsupervised children and the stigma associated with substance abuse. Interventions need planned strategies for addressing each of these such as providing vouchers or courtesy rides, meals, child care and a safe, supportive and non-judgmental environment (Neger & Prinz, 2015).

Reintegration

Reintegration strategies empower and train families to equip them with skills needed to become active members of their communities. Once a family has been released from the supervision of child protective agencies, follow-up care by the Department of Health and Human Resources (DHHR) is lacking, due to an influx in new referrals coming into Child Protective Services (CPS) on a daily basis. Therefore, the use of a community service organization that provides not only the socially necessary services during the treatment, intervention and prevention stage of the recovery process, but also creates follow up care that is not geared

towards the short-term impeding danger to a child, yet the long-term reintegration of the family back into society as a functioning social unit.

Resources available to substance abusers will have an impact on the course of their addiction and on relapse after treatment. Social resources (individual relationships with family, spousal and friends) and personal resources (employment and a stable place to live) are related to successful program completion and the absence of recidivism and is key to reducing the likelihood of relapse (Ellis et al., 2004). Researchers found that the presence of family members in a person's social network was significantly relevant to abstinence one year after treatment and that having families participate in treatment in combination with regular aftercare support programs contributed to greater abstinence (Ellis et al., 2004; Moos & King, 1997; Johnsen & Herringer, 1993). Furthermore, helping clients improve and build their social networks while in treatment improves substance abuse treatment outcomes for when they are released (Knight et al., 2001).

Many researchers have concluded that whether discussing family, spousal or peer support, substance abuse by any member of an abusers social group, post-treatment plays a significant role (Havassy et al., 1995; Longabaugh et al., 1993). Making changes in one's social networks, including severing ties with friends and family who continue to participate in drug usage is significant, just as re-establishing ties with positive and healthy influential friends and family members will predict better treatment outcomes. Post-treatment resources such as abstinence support groups can provide positive social support and help to prevent relapse. The social support provided by regular AA attendance, regular participation in aftercare and participation in other support groups has been significantly related to greater abstinence (Hser et al., 1999; Johnsen & Herringer, 1993; Ellis et al., 2004). A supportive post-treatment social

network (whether through family relations, peer relations or spousal relations) is key to reducing the likelihood of post-treatment relapse. In addition, these results support the suggestion that helping clients improve and build their social networks while in treatment improves substance abuse treatment outcomes (Knight et al., 2001).

Research regarding personal resources (employment and a stable place to live) indicates that children from families facing multiple or significant stressors are at higher risk of re-referral to CPS. Family or community-level poverty significantly increases the likelihood of recurrent allegations of maltreatment (Inkelas & Halfon, 1997; Way, Chung, Jonson-Reid, & Drake, 2001; Wolock, Sherman, Feldman, & Metzger, 2001). Poverty and its associated circumstances that were mentioned earlier in this chapter may increase the likelihood of child maltreatment initially and significantly post-treatment, particularly in the form of neglect, if the needs of a child are compromised by limited personal resources (Drake & Pandey, 1996; Connel et al., 2007).

Healthy Kids and Families Coalition

Currently in Kanawha County, there is a nonprofit organization that functions as an inter-organization collaboration and community service organization. Healthy Kids and Families Coalition (HKFC) was created in 1998 to improve the statistics for children in West Virginia, which rank low on various child well-being reports such as poverty, over-all well-being and education. In the summer of 2012, HKFC convened a handful of other groups, with the goal of building a new kind of campaign, one that was deeply collaborative and based in communities led by low-income families. Those goals became the Our Children, Our Future Campaign (OCOF), a 177-partner alliance that includes West Virginians from every sector including unions and big business, Catholics and reproductive rights leaders, community development organizations, teachers, social workers, lawmakers and so on. The coalition focuses mainly on

health care issues of children and the policies that can be changed around these issues. They have a huge presence throughout the state by lobbying in the political arena, based on their yearly platforms for issues such as welfare reform, childhood obesity and adding free lunches and breakfasts for low-income children. Their mission is to train and lead development with a strong claim to the value of collaboration. The organization has also created a grassroots initiative to empower low-income communities' members to vote called, "Our Vote, Our Future." The organization goes door-to-door to educate and register voters, which claims to have added 10,500 registered voters throughout the state of West Virginia (Healthy Kids and Families Coalition, 2015).

In spite of this organizations efforts, The Kids Count Data Book, released by the Annie E. Casey Foundation- a yearly report on the well-being of children across the nation- has noted that West Virginia is currently ranked 43rd in overall well-being, a six ranking plummet from the 2014 ranking of 37th. In 2014, 92,000 children were living in poverty in the state of West Virginia, 5,000 more than in 2008 (The West Virginia State Journal, 2015). The Healthy Kids and Families Coalition is an excellent example of a community service organization, through collaboration amongst cross-sector organizations to the changing of policies. However, a major missing link that is currently being overlooked in the state of West Virginia is the admittance that substance abuse is a major determinant of the well-being of the children. A prioritized initiative towards rehabilitation must be fostered for the children and families throughout the state of West Virginia. No organizations representing the foster care community are included in the OCOF initiative and therefore a missing population is not being serviced from a CSO standpoint.

Pollen8, LLC

The development of more appropriate services to meet the needs of families who have been plagued by substance abuse is essential if child welfare agencies are to reduce the risk of initial and recurrent allegations among families faced with economic challenges. One of the primary factors impacting post-treatment substance use is stress. When considering the documented successes and challenges of the inter-organizational model and the management support organization, it is conceivable to combine their best practices in service delivery to model a more effective response to West Virginia child abuse/neglect cases by maltreating parents whose substance abuse is implicated in the maltreatment. Much of the efficaciousness of such a model will be centered on adapting these best practices in service delivery to the unique sociocultural conditions of West Virginia in order to better promote sustainability as an ongoing concern. However, Pollen8 Inc., will be a community service organization (CSO) instead of a MSO.

Pollen8, Inc. is a proposed nonprofit organization whose mission, purpose and goals are predicated on the best practices of the inter-organizational model and the management support organization. Pollen8, Inc. will be committed to building the social capital and community infrastructures that empowers affected families of maltreating parents with substance abuse issues to take ownership of their service systems and ensure proper investment in making these services successful. Most counties in West Virginia are in search of strategies to strengthen nonprofits and improve community life, however do not already have an established CSO. The primary mission of Pollen8, Inc. will be to build the capacity of all sectors to work together to improve the rate of children entering the foster care system and facilitate greater numbers of family reunification focusing on treatment, intervention and reintegration.

The CSO would facilitate family reunification by working in partnership with all key stakeholders to ensure reintegration, which would include:

- Local government legislatures and judicial authorities,
- Department of Health and Human Resources (DHHR) and Child Protective Services (CPS),
- Local service providers both nonprofit and for-profit,
- City government officials to ensure resources are available upon reintegration back into community and;
- Local colleges and universities for volunteers and interns.

Conglomeration of these stakeholders under one umbrella further facilitates the sustainability of the actual intervention and delivery of services in the local communities of affected families in regards to the sharing of not only knowledge but resources. Collaboration would effectively reduce the duplication of services that currently happens, as well as the inefficient allocation of funding among service providers who draw revenue from the same funding sources. The organization is also committed to efficiency and transparency to create space for measurable outcomes of all services provided to families.

Through research of social systems and best practices, distribution and publication of information, assembling of cross-sectoral groups, facilitation of collaboration and reports to funders and policymakers, the organization would attempt to build the most effective inter-organizational collaboration throughout the state of West Virginia. Pollen8, Inc. as a newly created CSO would have a positive impact not only on the work of the nonprofit sector, but also on its efforts to achieve larger community goals. Community goals would include the

improvement of family functioning and child development by removing substance abuse as a contributing factor in child abuse/neglect. In fact, Pollen8, Inc.'s long term goal is to organize and establish duplicate organizations in high risk communities throughout West Virginia to do this necessary work and to consult others on how community support can be provided in a variety of locations. After all, the main goal for improving the work of nonprofit organizations is to better serve communities.

As mentioned throughout the chapters of this thesis, West Virginia currently has the highest overdose rate in the country and there are currently over 4,300 children who are in the foster care system (Paulozzi et al., 2009; WV Kids Count Data Center, 2014). Based on current criteria through West Virginia law, the maltreating parents have fifteen months to recover from substance abuse, gain lawful employment and secure adequate housing, to be granted reunification with their children. These families must be offered a holistic approach to gain sobriety before they can be expected to acquire adequate housing and employment. Pollen8, Inc.'s mission is to become a service provider to the maltreating parents and mainstream them to the appropriate rehabilitative services, while creating a safety net for the children to begin their own road to treatment. Services provided will address the aforementioned focus areas of treatment, prevention and reintegration and should include the following components:

- Access to physical necessities including food, housing and transportation
- Life skills training including parenting, financial management, assertiveness training, stress management and coping skills
- Educational and vocational assessment, counseling, training and opportunities (including language and literacy competency)

- In-home substance abuse counseling and individual/family therapy
- Health education and medical care
- Child care, social services and social support
- Psychological assessment and mental health care
- Family planning services
- Comprehensive continuing care after program completion

These services will be provided in-home for non-custody cases where no imminent danger was found by DHHR and the child was allowed to remain in the care and custody of the parents. Licensed social workers will work in tandem with CPS to control impending dangers to the child while facilitating a more holistic approach to encouraging the family to address their deficiencies, beginning with substance abuse and take the necessary steps to remove obstacles that keep the family from functioning. Services for more egregious cases where the child has been removed from the care and custody of the parents due to imminent danger of abuse and neglect will be administered in a more controlled environment, known as The Appalachian Village. The children will come directly to the property while their parents are immediately admitted to a drug rehabilitation facility. Once the parents have successfully completed a treatment program, based on the illicit drug of choice, they will then come to the property and begin social reintegration back into their child's life.

Upon acceptance into either program, both child and parent will undergo a mental, physical and educational assessment so that an appropriate and individual treatment plan can be created. The family will be immersed in extensive individual and group therapy to address

personal histories of the parents and prevent further emotional damage to the child. Members will be taught family skill building throughout every interaction happening in their day to day lives that will allow them opportunities to alleviate socioeconomic stressors. The entire project will be built solely on the premise to remove the core problem of substance abuse and then rebuild the individual members of the family so that they can learn- through time- to function as a unit- first together and then reintegrated back into society. While the family receives the rehabilitation they need, Pollen8, Inc. will work alongside the communities that the families represent (county) to ensure that post-treatment systems are created within that community to allow the families to reintegrate successfully.

This model development is influenced by a commitment to empowerment of the people who will be serviced and seeing them as partners instead of clients. The founders believe that utilizing the commitment to empowerment and to a community asset approach, will foster the community and its members to utilize Bronfenbrenner's model that was discussed in Chapter two (Solomon, 1976; Kretzmann & McKnight, 1993; Shiffman & Motley, 1990). Beginning the work from the inner circles (family, kin group and community) and the outer circle (state and local government) at the same time allows the treatment, prevention and reintegration programs offered through both Pollen8, Inc. and The Appalachian Village to successfully change treatment throughout West Virginia (Bronfenbrenner, 1979). This approach will facilitate change through an overlay of community education, planning and collaboration, as a means to achieve empowerment goals in every circle in the Bronfenbrenner model. Thus, the preventive intervention will have a multipronged strategy consisting of alliance, advocacy, resource development, education and provision of services.

Initially, community planning will be facilitated to link the CSO across system networks to coordinate and thereby strengthen the formal and informal support programs in the project's own network and also to integrate it into the existing and emerging statewide health and family support consortia and coalitions. Pollen8, Inc. founders will facilitate a round table discussion between the key stakeholders of the project to include representatives from the West Virginia State Legislature, the Department of Health and Human Resources (DHHR), nonprofit/for profit providers, community representatives such as city government officials, elementary/secondary schools, universities and families. Second, the education overlay will propagate knowledge of the Pollen8, Inc. treatment model to involve the families through participation, to program staff through cross-training, to the health and human services community through annual communitywide conferences/reports/media stories and the general public through greater education regarding substance abuse as a disorder and not a personal choice.

Chapter Conclusion

Strengthening families and communities is a long-term goal and multisector cooperation is needed. Parents' capacity to nurture their children is enhanced by reducing their social isolation and strengthening informal and formal family support systems. There are external, invisible arms that directly affect the success of a family including economic, political and social influences. Local groups and resources influence service access and difficult conversations must exist among diverse institutional entities and must be brought together to ensure a successful implementation of an inter-organizational unity that is pertinent to the successful reintegration of West Virginia families back into society.

Chapter 6: Thesis Conclusion

Chapter Introduction

Chapter five discusses the development of a nonprofit in West Virginia which was organized to address the rising phenomenon of maltreating parents with addictions in rural West Virginia. The introduction and operational details were provided of an inter-organization nonprofit, Pollen8, Inc., as a solution to fill the gaps that currently exist within the current child welfare system of West Virginia. The nonprofit will function as a community service organization (CSO) to ensure three core requirements for effective reunification and reintegration of families throughout West Virginia. These requirements are treatment, prevention and reintegration of the family unit back into society, through facilitating an inter-organizational collaboration between Pollen8, Inc., the court system, DHHR/CPS, ASO providers, community leaders and afflicted family members.

Research and certification of Pollen8, Inc. will be discussed that specifically addresses the unique problems of maltreating parents with addictions and the most holistic ways to mitigate impending threats of abuse and neglect, sustain sobriety of addicted parents and, thereby, prevent the removal of children from their homes and families. Information gathered throughout the project will influence best practices created for Pollen8, Inc. that will be based on current literature and the specific problems of rural West Virginia communities. The conclusion will outline the next steps and long-term objectives required to uncover challenges and obstacles that could arise during the implementation of the nonprofit organization, as well as opportunities for further research.

Thesis Overview

Personal history and socioeconomic status play a significant role in the propensity for substance abuse. However, regardless of precursors, children who live with substance abusers are at a greater risk for maltreatment. Once child abuse and neglect have been identified and authenticated, child welfare must intervene to protect the welfare of children. Procedures that are implemented are created through policies that are constructed through the legislative process, currently following guidelines constructed in the 1980-1990s. These procedures that are influenced by outdated research must be solution oriented, which is to address a crisis, intervene on behalf of the child with services, and to mitigate the threat of further maltreatment.

Services cannot be solely provided by the government so community services provide the socially necessary services (SNS) that are intended to defuse the crisis. However, if the services are influenced by the governing body (DHHR)- services are merely an extension of the beliefs and mission of that governing body, which leaves little room to explore alternative treatment. Understanding Bronfenbrenner's model and the research regarding the purpose of nonprofits, it makes sense to introduce a solution that is mandated to reinvest income earned back into the services provided and also has the ability to seek grants to introduce new services where there are gaps in the current system due to exemption.

Using this model as the organizer of an inter-organizational collaboration increases the chances of an inclusive participation and will allow representatives from the judicial branch, the governing body (DHHR/CPS), community-level ASO providers, treatment facilities, therapist and the families- decide what services and treatments are needed and then the nonprofit acting as an activist can address the legislation with data to change policies that will aid in the success of substance abusers and not in the demise of West Virginia families. Facilitating the collaboration

brings everyone whose focus is currently scattered throughout the social problem of substance abuse together to collectively share knowledge and resources. This will not only address the families in crisis but also implement community-level change as a preventative model. The inclusion of the afflicted families empowers and encourages self-efficacy within the family members.

Further Research

This thesis does not proclaim to have solved the issues that surround substance abuse and child abuse and neglect. Throughout the research there were thoughts and discrepancies that arose which would need further attention by future scholars. What was accomplished was the bringing together of prior research to tell the story of the complexities that surround substance abuse and the influence it has on child abuse and neglect. This work is a start, but there is much to do to further understand the propensity for substance abuse and how it affects the family unit.

- This thesis shows significant correlation between personal history and low socioeconomic status and the use of drugs as a coping mechanism. However, further research would need to be conducted on childhood trauma, brain development and utilizing stories of addicts to provide a coherent theory of addiction.
- Current legislation such as the AFSA mandates policies and procedures that place time allocated treatment guidelines on maltreating parents that cause further stress and discord. Further research could show that allowing parents the opportunity to focus on their recovery from addiction with the security their children are taken care of could facilitate a more harmonic healing for the entire family unit.
- Furthermore, these time allocated guidelines often times place children within the foster care system for upwards of two years. Further research could also show that if children

who are removed from the custody of their substance-abusing, maltreating parents spend longer periods in the custody of DHHR as wards of the state of West Virginia, perhaps the time restraints placed upon the termination of parental rights could be prolonged in order for parents to have efficient and ample opportunities to rehabilitate from substance abuse addiction and therefore more families could be reunified than dismantled.

- This thesis addresses the use of inter-organization collaborations within rural communities to bring cross-sector involvement in combing resources and bodies of knowledge to address the social problem of child abuse and neglect due to substance abusing parents. Further community-based research is needed to better understand the effects of multifaceted relationships amongst various nonprofit agencies in disadvantaged communities, in order to better understand the impact inter-organizational programs can have on afflicted communities, as well as what might lead and/or hinder nonprofits as they seek to participate in multisector collaborations.

Long-Term Objectives

Long-term objectives of Pollen8, Inc. is to use inter-organizational collaborations to create a streamline of support from top to bottom of all stakeholders in order to provide the best services for families facing abuse and neglect allegations. These services are often duplicated and resources are thin and create a competition instead of unity. Starting at the top with lawmakers and state/local government who are charged with creating policies that no longer shame addicts but instead empower them to build a new life. Shaming addicts does not work. People who become addicted are often times humiliated, isolated and shamed with the end result- further addicted. Addicts have to feed their habits and do so by persuading others to purchase drugs from them, which only creates more addicts. If we build treatment services that

help people get better instead of punishing them for their addictions, they will in turn help others get better and the cycle of abuse changes directions towards healthy living. When society shames a person, cages or isolates that person, armed with laws that makes them unemployable and keeps them from social services, it traps them in addiction.

In the United States, ninety percent of federal money goes to policing and punishment of drug abusers and only 10% towards treatment and prevention (Hari, 2015). If we took that money and used it instead to help recovering addicts get jobs, homes and decent lives, this might make it possible for many to stop. Solutions could be to encourage the government to give substantial tax incentives to businesses that will hire recovering addicts so they have employment post-treatment. Cooperatives of businesses that are built to employ recovering addicts like sustainable flower and vegetable farms, landscaping, café's that provide healthy nourishment to rural communities- if recovering addicts work as a group and someone relapses, the group will work to get that person back on track. Then, an army of employed addicts is created to go out into the communities and offer the same resources to others.

We as a society need to change focus from individual recovery in isolation or with fellow addicts to social recovery. Building communities where people don't feel so alone or afraid of what life is like without drugs. Addiction allows people release to escape their emotions and reduces their senses to real life by offering an addictive lifestyle as a substituted. Cohen (2015) writes that we should teach people to connect and bond with one another instead of using addiction to stop the pain. If people fail to bond with other human beings, they will find something else to bond with as a human instinct and it could be drugs, alcohol, food or shopping, but once they find it they will return to it obsessively. Cohen further believes that addiction is a disease caused by the loneliness of people who are faced with mediocre lives, isolated in rural

communities with their future being at best a low paying job with monotony that forces them to live in stress with a want for material objects that others possess.

Addiction can become a subculture, typically with others to bond with that offers the chase of the high, rush of the drug, committing crime, dodging the police and trying to stay alive. Cohen believes that the world may be hostile towards an addict, but at least they feel like they exist and are alive through that hostility (Hari, 2015). Alexander (2008) concludes in his philosophy that human beings only become addicted when they cannot find anything better to live for and when they desperately need to fill the emptiness that threatens to destroy them (Alexander, 2008). Living creatures need to bond and we live in a society that makes people feel not only separate, but socially or culturally isolated from one another. Stresses are heightened in low socioeconomic communities and childhood trauma, which was discussed earlier, makes people distrust others and isolates them like the lab rats in Alexander's experiment.

Challenges and Obstacles

Politicians who serve as lawmakers represent society and therefore laws are created based on beliefs that come from the people. Until further research is conducted and made available to the public regarding addiction, lawmakers will not create legislation to support help for drug addiction as if it were a chronic disease such as diabetes. Without ideas of drug addiction being changed on the community level, people will not allow more supportive laws to be created. Therefore, the current laws will be an obstacle because of AFSA that mandates the limitation of time for a child to be in limbo. However, through the current policies, children are in foster care for years at a time. These policies could be adjusted to lengthen the treatment time if upon release of substance abuse treatment, families could be reunified in supervised, supportive

communities that allows for family oriented treatment to continue to address drug addiction of the parents, but also rehabilitate family functioning and dynamics.

Alexander (2008) conducted a follow-up study on lab rats, called Rat Park. In this study, he creates two situations to place rats in. One is isolated as the prior study and has nothing to do and the rat is offered two mixtures. One is made of water and sugar, the other is watered down cocaine. The isolated rat tries both mixtures, but continues to drink the watered down cocaine repetitively until it dies. During the counter experiment, there are several rats so that the rats were not alone in isolation. The rats were able to form bonds through interaction and had things to do such as exercise wheels. The rats were of both sexes so that they could also have intercourse. The only similarity between the two experiments were the same two mixtures for the rats to choose from yet in the Rat Park habitat, the rats preferred the sugar water and only 5% of the watered down cocaine was consumed (Alexander 2008).

Final Thoughts

The use of drugs is merely a symptom of deeper suffering and we have to reach the reasons why addicts find everyday life unbearable and to help them overcome the need to be out of their minds most of the time. Once the reasons are found out, help should be offered to allow them to lead healthy, happy and productive lives. Because ACEs seem to account for one half to two third of serious problems with drug use, treatment to rehabilitate, address and reduce drug use should necessitate serious attention to these types of common, stressful and disturbing childhood experiences. A person can stop the use of drugs for a while, but if underlying problems are not solved, issues will continue to arise that call on the same coping skills and drug behaviors as before. Things of the mind that are not dealt with always come back. Only when the trauma is dealt with can you change the way a person deals with it.

To provide addicts with a safe environment to express emotions and tell their story in a truthful way liberates them from the secrets and allows the old behaviors and style of coping to be replaced with more productive and life enhancing behaviors. Rewards should be given for steps made towards more productive and positive behaviors, congratulations on efforts and accolades should be doled out regularly to reinforce positive behaviors, personal autonomy and options should be given to help addicts build a better life. Decisions regarding the recovering families should not be made without their input to build individual and group self-efficacy.

Pollen8, Inc. will create and provide treatment to support research that shows women who are allowed to keep their children with them during treatment programs helps with commitment to enter and complete substance abuse treatment programs. Family-oriented treatment must be provided because it is not only the drug user that carries out participation in the drug culture, every member of the family plays a role and therefore must be treated to reverse the behaviors of living within a drug culture. Pollen8, Inc. believes that treatment must be refocused away from the placement of substance abusers in isolation to focus on their addiction, but instead treat the parent while inefficiencies in family functioning are addressed. Pollen8, Inc. also understands that participation in treatment by significant others aids in commitment to rehabilitation and relapse prevention. Treatment for the entire family unit, individually and collectively, significantly increases the substance abusers chance at abstinence and the family's chance at successful reintegration back into society as a functioning social unit.

Prevention services that are geared towards treating the family as a unit will only be successful if they address the key ingredient to the demise of the West Virginia family. Without placing substance abuse treatment participation at the forefront of the intervention, the cycle will continue. Family focused recovery allows for every member of the family to be healed as

individuals while facing social, biological and socioeconomic deficiencies. These deficiencies cause each member to behave as they are conditioned to do through repetition of life experiences. Education improves self-efficacy and leads to better jobs that can remove socioeconomic barriers. Pollen8, Inc. will assess every member of the family unit for educational deficiencies and provide services to any member that falls below their level of educational attainment. GED, trade school and higher education will be offered for parents, as well as tutors for children in primary and secondary educational levels.

Reintegration strategies must be implemented to provide follow-up care for members once they are released from the supervision of child welfare. Stability must be taught throughout the treatment program that allows family members to believe in their ability to continue their new behaviors outside of the drug culture and within society. Currently, there is no long-term follow-up care provided through the current child welfare system because of the lack of staff in DHHR and the number of new referrals that come into CPS on a daily basis. Creating a CSO, such as Pollen8, Inc. to serve this population will allow for greater retention because the current follow-up care is provided in the form of services reapplied to reoffending parents. Relationship building, educational attainment, safe living environments and employment opportunities are the key ingredients to successful reintegration of families back into their communities. These support mechanisms are imperative to relapse, post-treatment.

Policymakers on a federal and local level should join along with philanthropic funders to commit funding for social movement organizations and community organizing activities. Although purchasing of services and contracting to provide social services have increasingly changed the direction of funding streams away from community-building organizations (Fabricant and Fisher, 2002). The goal as a provider of any social service should be a long-term

commitment to communities and a search for best practices derived not from traditional social services delivered in bureaucratic social agencies but to small grass-roots social action organizations committed to community building and empowerment goals. The smaller agencies cannot compete with the larger, more traditional agencies, however, they can most definitely serve as a safety net for the services that are overlooked by the larger bureaucracies. Better understanding bottom-up learning would aid nonprofit managers in creating programs that incorporate participation not only from various nonprofit agencies but from the local residents, themselves.

Pollen8, Inc. will not be successful alone, collaborations must happen between all stakeholders to ensure successful intervention, treatment and reintegration for West Virginia families who are afflicted by substance abuse. These collaborations include local and state government entities working together with DHHR/CPS to create legislation that supports the creation of policies and procedures that are in line with the success of family rehabilitation. Collaboration between these government entities would allow for money that is currently being spent on punishment and prosecution of maltreating parents to be re-allocated to build state of the art, holistic treatment facilities. These new facilities would allow the family unit to address substance abuse and family dynamics concurrently while the family stays together instead of separation that can weaken family bonds.

Pollen8, Inc.'s ultimate goal is to organize work within nonprofits and across the various sectors so that West Virginia rural communities can move methodically toward lasting change (as opposed to responding in a haphazard fashion to each emerging crisis). The members realize that getting to this new reality will require collaboration at all levels, as well as a better understanding of immediate realities—for example, how citizens are progressing, what

nonprofits are currently providing, and what funding streams are currently available. This philosophy allows for less change of duplication of services, which wastes not only time but money (O’Looney, 1996). This would allow for a truly sustainable community- to foster the families to create their own destinies through taking initiatives to better their familial bonds, as well as speaking out for the social reform their communities need. This way, inter-organization collaborations would share alongside partner organizations and the community, the risks and rewards.

References

- Adopt US Kids (2015). *West Virginia foster care and adoption*. Retrieved from <http://www.adoptuskids.org/>
- Alexander, B. (2008). *The globalization of addiction: A study in poverty of the spirit*. Oxford: Oxford University Press.
- Alverson, H., Alverson, M., & Drake, R. E. (2000). *Addiction services: An ethnographic study of the longitudinal course of substance abuse among people with severe mental illness*. *Community Mental Health Journal*, 36(6), 557-569.
- Ammerman, R. T., Kolko, D. J., Kirisci, L., Blackson, T. C., & Dawes, M. A. (1999). *Child abuse potential in parents with histories of substance use disorder*. *Child Abuse & Neglect*, 23(12), 1225-1238.
- Aneshensel, C. S. (1992). *Social stress: Theory and research*. *Annual Review of Sociology*, 18, 15-38.
- Annie E. Casey Foundation, (2014). *West Virginia Kids Count Data Book*. Retrieved from <http://www.aecf.org/where-we-work/location/wv/>
- Axinn, J., & Stern, M. J. (2001). *Social welfare: A history of the American response to need* (5th ed.). Boston: Allyn & Bacon.
- Azzi-Lessing, L., & Olsen, L. J. (1996). *Substance abuse-affected families in the child welfare system: New challenges, new alliances*. *Social Work*, 41(1), 15-23.
- Baffour, T., Gourdine, R., Domingo, C., & Boone, K. (2009). *Rural hassles and coping strategies among pregnant and parenting African American women*. *Families in Society: The Journal of Contemporary Social Services*, 90(2), 183-188.
- Barnard, M., & McKeganey, N. (2004). *The impact of parental problem drug use on children: what is the problem and what can be done to help?* *Addiction*, 99(5), 552-559.

- Bays, J. (1990). *Substance abuse and child abuse. Impact of addiction on the child*. Pediatric Clinics of North America, 37(4), 881-904.
- Beckman, L. J., & Amaro, H. (1986). *Personal and social difficulties faced by women and men entering alcoholism treatment*. Journal of Studies on Alcohol, 47(2), 135-145.
- Belsky, J. (1984). *The determinants of parenting: A process model*. Child Development, 83-96.
- Belt, R., & Punamäki, R. L. (2007). *Mother–infant group psychotherapy as an intensive treatment in early interaction among mothers with substance abuse problems*. Journal of Child Psychotherapy, 33(2), 202-220.
- Berkowitz, S. (1991). *Key Findings from the state survey component of the study of high risk child abuse and neglect groups*. Westat. Rockville, MD.
- Berry, J. M. (2003). *A voice for nonprofits*. Brookings Institution Press.
- Besharov, D. J. (1990). *Recognizing child abuse: A guide for the concerned*. Free Press.
- Beschner, G. M., & Thompson, P. (1981). *Women and drug abuse treatment: Needs and services (Vol. 2, No. 2)*. National Institute on Drug Abuse, Division of Resources Development, Services Research Branch, US Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration.
- Bijur, P. E., Kurzon, M., Overpeck, M. D., & Scheidt, P. C. (1992). *Parental alcohol use, problem drinking, and children's injuries*. JAMA, 267(23), 3166-3171.);
- Blackburn, K., Auvil, K., & Simpkins, R. (2013, April 29). *Addicts in West Virginia not getting the help they need*. Mountaineer News Service-West Virginia News.
- Borelli, J. L., West, J. L., Decoste, C., & Suchman, N. E. (2012). *Emotionally avoidant language in the parenting interviews of substance-dependent mothers: Associations with reflective*

- functioning, recent substance use, and parenting behavior.* *Infant Mental Health Journal*, 33(5), 506-519.)
- Brandon, T. H., Vidrine, J. I., & Litvin, E. B. (2007). *Relapse and relapse prevention.* *Annual Review Clinical Psychology*, 3, 257-284.
- Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by design and nature.* Harvard University. Cambridge, MA.
- Brown, G. W., & Moran, P. M. (1997). *Single mothers, poverty and depression.* *Psychological Medicine*, 27(01), 21-33.
- Carnochan, S., & Austin, M.J. (2001). *Step by Step: Building the Infrastructure for Transforming Public Social Service Organization into Learning Organizations: BASSC Implementation Report.* BASSC Practice Monograph, BASSC, School of Social Welfare, University of California at Berkeley.
- Catalano, R. F., Hawkins, J. D., Kosterman, R., Abbott, R., & Hill, K. G. (1999). *Preventing adolescent health-risk behaviors by strengthening protection during childhood.* *Archives of Pediatrics & Adolescent Medicine*, 153(3), 226-234.)
- Centers for Disease Control and Prevention (2007). *Division of Healthcare Quality Promotion.* Atlanta, Georgia Center for Substance Abuse Treatment.
- Chatterji, P., & Markowitz, S. (2001). *The impact of maternal alcohol and illicit drug use on children's behavior problems: Evidence from the children of the national longitudinal survey of youth.* *Journal of Health Economics*, 20(5), 703-731.
- Chen et al., (2004)
- Christensen, H. B., & Bilenberg, N. (2000). *Behavioural and emotional problems in children of alcoholic mothers and fathers.* *European Child & Adolescent Psychiatry*, 9(3), 219-226.
- Christy, (2013)

- Chuang, E., Wells, R., Bellettiere, J., & Cross, T. P. (2013). *Identifying the substance abuse treatment needs of caregivers involved with child welfare*. *Journal of Substance Abuse Treatment*, 45(1), 118-125.
- Clausen, J. M., Aguilar, R. M., & Ludwig, M. E. (2012). *Fostering healthy attachment between substance dependent parents and their infant children*. *Journal of Infant, Child, and Adolescent Psychotherapy*, 11(4), 376-386.
- Colton, (1982)
- Conlan, T. J. (2010). *From new federalism to devolution: Twenty-five years of intergovernmental reform*. Brookings Institution Press.
- Connell, C. M., Bergeron, N., Katz, K. H., Saunders, L., & Tebes, J. K. (2007). *Re-referral to child protective services: The influence of child, family, and case characteristics on risk status*. *Child Abuse & Neglect*, 31(5), 573-588. doi:<http://dx.doi.org/10.1016/j.chiabu.2006.12.004>
- Connors, N. A., Bradley, R. H., Whiteside Mansell, L., Liu, J. Y., Roberts, T. J., Burgdorf, K., & Herrell, J. M. (2004). *Children of mothers with serious substance abuse problems: An accumulation of risks*. *The American Journal of Drug and Alcohol Abuse*, 30(1), 85-100.
- Connor, J. A., Kadel-Taras, S., & Vinokur-Kaplan, D. (1999). *The role of nonprofit management support organizations in sustaining community collaborations*. *Nonprofit Management and Leadership*, 10(2), 127-136.)
- Coulton, C. J., Chow, J., Wang, E. C., & Su, M. (1996). *Geographic concentration of affluence and poverty in 100 metropolitan areas, 1990*. *Urban Affairs Review*, 32(2), 186-216.
- Davis, R.M., Novotny, T.E., & Lynn, W.R. (1998). *Report on nicotine addiction*. Center for Health Promotion and Education. Office on Smoking and Health United States. Public Health Service. Office of the Surgeon General.

- DeGrandpre, R. (2006). *The cult of pharmacology: how America became the world's most troubled drug culture*. Duke University Press.
- DeHart, T., Tennen, H., Armeli, S., Todd, M., & Mohr, C. (2009). *A diary study of implicit self-esteem, interpersonal interactions and alcohol consumption in college students*. *Journal of Experimental Social Psychology*, 45(4), 720-730.
- Deroche-Gamonet, V., Belin, D., & Piazza, P. V. (2004). *Evidence for addiction-like behavior in the rat*. *Science*, 305(5686), 1014-1017.)
- DiLeonardi, J. W. (1993). *Families in poverty and chronic neglect of children*. *Families in Society: The Journal of Contemporary Human Services*, 79, 557-562.
- Drake, B., & Pandey, S. (1996). *Understanding the relationship between neighborhood poverty and specific types of child maltreatment*. *Child abuse & neglect*, 20(11), 1003-1018.
- Dube, S. R., Felitti, V. J., Dong, M., Chapman, D. P., Giles, W. H., & Anda, R. F. (2003). *Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: the adverse childhood experiences study*. *Pediatrics*, 111(3), 564-572.
- Duncan, G. J., & Brooks-Gunn, J. (2000). *Family poverty, welfare reform, and child development*. *Child Development*, 71(1), 188-196.
- Earls, F., McGuire, J., & Shay, S. (1994). *Evaluating a community intervention to reduce the risk of child abuse: Methodological strategies in conducting neighborhood surveys*. *Child Abuse & Neglect*, 18(5), 473-485.
- Ellis B., Bernichon, T., Yu, P., Roberts, T., Herrell, J. M. (2004). *Effect of social support on substance abuse relapse in a residential treatment setting for women*. *Evaluation and Program Planning*, 27, pp. 213-221 <http://0-dx.doi.org.wncln.wncln.org/10.1016/j.evalprogplan.2004.01.011>

- English, D. J., & Aubin, S. (1991). *Impact of investigations: Outcomes for child protective services cases receiving differential levels of service*. Washington State Department of Social and Health Services.
- Ertem, I. O., Leventhal, J. M., & Dobbs, S. (2000). *Intergenerational continuity of child physical abuse: How good is the evidence?* *The Lancet*, 356(9232), 814-819.
- Estes, C. L., & Wood, J. B. (1984). *A preliminary assessment of the impact of block grants on community mental health centers*. *Psychiatric Services*, 35(11), 1125-1129.
- Fabricant, M., & Fisher, R. (2002). *Settlement houses under siege: The struggle to sustain community organizations in New York City*. Columbia University Press.
- Festinger, D. S., Marlowe, D. B., Merikle, E. P., Kirby, K. C., & McLellan, A. T. (2001). *Multidimensional assessment of perceived treatment-entry pressures among substance abusers*. *Psychology of Addictive Behaviors*, 15(2), 97.
- Finkelstein, S. N., Greenberg, P. E., Stiglin, L. E., & Berndt, E. R. (1993). *Depression: A neglected major illness*. *Journal of Clinical Psychiatry*.
- Frone, M. R. (2008). *Are work stressors related to employee substance use? The importance of temporal context assessments of alcohol and illicit drug use*. *Journal of Applied Psychology*, 93(1), 199.
- Garbarino, J., & Sherman, D. (1980). *High-risk neighborhoods and high-risk families: The human ecology of child maltreatment*. *Child development*, 188-198.
- Giancola, P. R. (2000). *Executive functioning: a conceptual framework for alcohol-related aggression*. *Experimental and Clinical Psychopharmacology*, 8(4), 576.

- Goldstein et al., (1987 Magura, S., & Laudet, A. B. (1996). *Parental substance abuse and child maltreatment: Review and implications for intervention*. Children and Youth Services Review, 18(3), 193-220.
- Green, (1998) Walsh, C., MacMillan, H. L., & Jamieson, E. (2003). *The relationship between parental substance abuse and child maltreatment: Findings from the Ontario Health Supplement*. Child abuse & neglect, 27(12), 1409-1425.
- Grella, C. E., & Joshi, V. (1999). *Gender differences in drug treatment careers among clients in the national drug abuse treatment outcome study*. The American Journal of Drug and Alcohol Abuse, 25(3), 385-406.
- Grella, C. E., Hser, Y. I., Joshi, V., & Anglin, M. D. (1999). *Patient histories, retention, and outcome models for younger and older adults in DATOS*. Drug and Alcohol Dependence, 57(2), 151-166.
- Grella, C. E., & Greenwell, L. (2004). *Substance abuse treatment for women: Changes in the settings where women received treatment and types of services provided, 1987–1998*. The Journal of Behavioral Health Services & Research, 31(4), 367-383.
- Grella, C. E., Hser, Y. I., & Huang, Y. C. (2006). *Mothers in substance abuse treatment: Differences in characteristics based on involvement with child welfare services*. Child Abuse & Neglect, 30(1), 55-73.
- Grella, C. E., Needell, B., Shi, Y., & Hser, Y. I. (2009). *Do drug treatment services predict reunification outcomes of mothers and their children in child welfare?* Journal of Substance Abuse Treatment, 36(3), 278-293.
- Gutman, D. (2015, October 17). *How did WV come to lead the nation in overdoses?* Charleston Gazette Mail. Retrieved March 28, 2016.

- Hari, J. (2015). *Chasing the scream: The first and last days of the war on drugs*. Bloomsbury Publishing USA.
- Hashima, P. Y., & Amato, P. R. (1994). *Poverty, social support, and parental behavior*. *Child Development*, 65(2), 394-403.
- Haskett, M. E., Miller, J. W., Whitworth, J. M., & Huffman, J. M. (1992). *Intervention with cocaine-abusing mothers*. *Families in Society*, 73.
- Hatzenbuehler, M. L., Nolen-Hoeksema, S., & Erickson, S. J. (2008). *Minority stress predictors of HIV risk behavior, substance use, and depressive symptoms: Results from a prospective study of bereaved gay men*. *Health Psychology*, 27(4), 455.
- Havassy, B. E., Wasserman, D. A., & Hall, S. M. (1995). *Social relationships and abstinence from cocaine in an American treatment sample*. *Addiction*, 90(5), 699-710.
- Haynes, K. S., & Mickelson, J. S. (2005). *Affecting change: Social workers in the political arena*. Allyn & Bacon.
- Healthy Kids and Families Coalition, (2015). Retrieved from <http://wvhealthykids.org/>
- Herman, R. D., & Renz, D. O. (1998). *Nonprofit organizational effectiveness: Contrasts between especially effective and less effective organizations*. *Nonprofit Management and Leadership*, 9(1), 23-38.
- Chaskin, R., Brown, P., Venkatesh, S., & Vidal, A. (2001). *Community capacity and capacity building: A definitional framework*. *Building Community Capacity*, 7-26.,
- Higgins, S. T., Budney, A. J., Bickel, W. K., Foerg, F. E., Donham, R., & Badger, G. J. (1994). *Incentives improve outcome in outpatient behavioral treatment of cocaine dependence*. *Archives of General Psychiatry*, 51(7), 568.

- Hillson, J. M., & Kuiper, N. A. (1994). *A stress and coping model of child maltreatment*. *Clinical Psychology Review*, 14(4), 261-285.
- Hser, Y. I., Anglin, M. D., Grella, C., Longshore, D., & Prendergast, M. L. (1997). *Drug treatment careers A conceptual framework and existing research findings*. *Journal of Substance Abuse Treatment*, 14(6), 543-558.)
- Inkelas, M., & Halfon, N. (1997). *Recidivism in child protective services*. *Children and Youth Services Review*, 19(3), 139-161.
- Jansson, L. M., & Velez, M. (1999). *Understanding and treating substance abusers and their infants*. *Infants & Young Children*, 11(4), 79-89.
- Jansson, L., Velez, M., Svikis, D., Jones, H., Walters, V., & Chilcoat, H. (2001). *Physical, sexual and emotional abuse in pregnant substance dependent women*. *Drug Alcohol Dependence*, 63(supply 1), S163.
- Jansson, L. M., Svikis, D. S., & Beilenson, P. (2003). *Effectiveness of child case management services for offspring of drug-dependent women*. *Substance Use & Misuse*, 38(14), 1933-1952.
- Jessup, M. A., Humphreys, J. C., Brindis, C. D., & Lee, K. A. (2003). *Extrinsic barriers to substance abuse treatment among pregnant drug dependent women*. *Journal of Drug Issues*, 33(2), 285-304.
- Johnsen, E., & Herringer, L. G. (1993). *A note on the utilization of common support activities and relapse following substance abuse treatment*. *The Journal of Psychology*, 127(1), 73-77.

- Kercheval, H. (2015, October 21). *Acknowledging West Virginia's Drug Problem*. West Virginia Metro News. Retrieved from <http://wvmetronews.com/2015/10/21/acknowledging-west-virginias-drug-problem/>
- Knight, W. G., Frank, D. A., Augustyn, M., Pell, T., & Zuckerman, B. (2001). *Growth, development, and behavior in early childhood following prenatal cocaine exposure: A systematic review*. *Jama*, 285(12), 1613-1625.
- Knight, D. K., & Wallace, G. (2003). *Where are the children? An examination of children's living arrangements when mothers enter residential drug treatment*. *Journal of Drug Issues*, 33(2), 305-324.
- Kovalesky, A., & Flagler, S. (1997). *Child placement issues of women with addictions*. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, 26(5), 585-592.
- Kretzmann, J. P., & McKnight, J. (1993). *Building communities from the inside out* (pp. 171-176). Northwestern University, Evanston, IL: Center for Urban Affairs and Policy Research, Neighborhood Innovations Network.
- Kubiak, S. P., Siefert, K., & Boyd, C. J. (2004). *Empowerment and public policy: An exploration of the implications of Section 115 of the Personal Responsibility and Work Opportunity Act*. *Journal of Community Psychology*, 32(2), 127-143.
- Kumpfer, K. L. (1987). *Special populations: Etiology and prevention of vulnerability to chemical dependency in children of substance abusers*. Database: PsychInfo. Retrieved March 24, 2016.
- Kurtz, P. D., Gaudin, J. M., Wodarski, J. S., & Howing, P. T. (1993). *Maltreatment and the school-aged child: School performance consequences*. *Child Abuse & Neglect*, 17(5), 581-589.

- Lewis, A. J., Holmes, N. M., Watkins, B., & Mathers, D. (2015). *Children impacted by parental substance abuse: An evaluation of the supporting kids and their environment program*. *Journal of Child and Family Studies*, 24(8), 2398-2406.
- Lieberman, (2000 Walsh, C., MacMillan, H. L., & Jamieson, E. (2003). *The relationship between parental substance abuse and child maltreatment: Findings from the Ontario Health Supplement*. *Child abuse & neglect*, 27(12), 1409-1425.
- Liebschutz, S. F. (1992). *Coping by nonprofit organizations during the Reagan years*. *Nonprofit Management and Leadership*, 2(4), 363-380.
- Liu, X., & Weiss, F. (2002). *Additive effect of stress and drug cues on reinstatement of ethanol seeking: exacerbation by history of dependence and role of concurrent activation of corticotropin-releasing factor and opioid mechanisms*. *The Journal of Neuroscience*, 22(18), 7856-7861.)
- Lofton, K. L. (2013). *Drug overdoses claiming West Virginia youths*. WV Public Broadcasting.
- Mattson, M. E., Allen, J. P., Miller, W. R., Hester, R. K., Connors, G. J., Rychtarik, R. G. & DiClemente, C. C. (1993). *Project MATCH. Alcoholism: Clinical and Experimental Research*, 17(6), 1130-1145.
- Magura, S., Goldsmith, D., Casriel, C., Goldstein, P. J., & Lipton, D. S. (1987). *The validity of methadone clients' self-reported drug use*. *International Journal of the Addictions*, 22(8), 727-749.
- Magura, S., & Laudet, A. B. (1996). *Parental substance abuse and child maltreatment: Review and implications for intervention*. *Children and Youth Services Review*, 18(3), 193-220.

- Marcenko, M. O., Kemp, S. P., & Larson, N. C. (2000). *Childhood experiences of abuse, later substance use, and parenting outcomes among low-income mothers*. *American Journal of Orthopsychiatry*, 70(3), 316.
- Marsh, J. C., & Miller, N. A. (1985). *Female clients in substance abuse treatment*. *International Journal of the Addictions*, 20(6-7), 995-1019.
- Marsh & Smith, (2012 Ungemack, J., Giovannucci, M., Moy, S., Ohrenberger, K., DeMatteo, T., & Smith, S. (2015). *Making it work without a family drug court: Connecticut's approach to parental substance abuse in the child welfare system*. *Child Welfare*, 94(4).
- Maté, G. (2010). *In the realm of hungry ghosts: Close encounters with addiction*. Berkeley, California: North Atlantic Books.
- Mattoo, S. K., Chakrabarti, S., & Anjaiah, M. (2009). *Psychosocial factors associated with relapse in men with alcohol or opioid dependence*. *Indian J Med Res*, 130(6), 702-8.
- McAlpine, C., Marshall, C. C., & Doran, N. H. (2001). *Combining child welfare and substance abuse services: A blended model of intervention*. *Child Welfare*, 80(2), 129.
- McCallister, Harper, Prillaman & Stewart, (2015). *Child Protective Services Policy*. West Virginia Department of Health and Human Resources Bureau for Children and Families Office of Children and Adult Services. Retrieved from <http://www.dhhr.wv.gov/bcf/policy/Documents/CPS%20Policy%20Sept%202015.pdf>
- McCormick, (2015). *Safe at home West Virginia: A family's guide to wraparound*. Bureau for Child Protective Services. West Virginia Department of Health and Human Resources.
- McLellan, A. T. (2002). *Have we evaluated addiction treatment correctly? Implications from a chronic care perspective*. *Addiction*, 97(3), 249-252.

- McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). *Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation*. *Jama*, 284(13), 1689-1695.
- Melton, G. B. (1991). *Preserving the dignity of children around the world: The UN Convention on the Rights of the Child*. *Child Abuse & Neglect*, 15(4), 343-350.
- Meyer, A. S., McWey, L. M., McKendrick, W., & Henderson, T. L. (2010). *Substance using parents, foster care, and termination of parental rights: The importance of risk factors for legal outcomes*. *Children and Youth Services Review*, 32(5), 639-649.
- Miller, B. A., Smyth, N. J., & Mudar, P. J. (1999). *Mothers' alcohol and other drug problems and their punitiveness toward their children*. *Journal of studies on alcohol*, 60(5), 632-642.
- Mirowsky, J., & Ross, C. E. (2003). *Social causes of psychological distress*. Transaction Publishers.
- Moore, J., & Finkelstein, N. (2001). *Parenting services for families affected by substance abuse*. *Child Welfare*, 80(2), 221.
- Moos, R. H., & King, M. J. (1997). *Participation in community residential treatment and substance abuse patients' outcomes at discharge*. *Journal of Substance Abuse Treatment*, 14(1), 71-80.
- Mulia, N., Ye, Y., Zemore, S. E., & Greenfield, T. K. (2008). *Social disadvantage, stress, and alcohol use among black, Hispanic, and white Americans: findings from the 2005 US National Alcohol Survey*. *Journal of Studies on Alcohol and Drugs*, 69(6), 824-833.

- Mulroy, E. A. (2003). *Community as a factor in implementing inter-organizational partnerships: Issues, constraints, and adaptations*. *Nonprofit Management and Leadership*, 14(1), 47-66.
- Mulroy, E. A., & Shay, S. (1997). *Nonprofit organizations and innovation: A model of neighborhood-based collaboration to prevent child maltreatment*. *Social Work*, 42(5), 515-524.
- Murray, B. (2015). *Health officials feel state struggles in offering addiction treatment*. West Virginia Hospital Association. Retrieved from <http://www.wvha.org/Media/NewsScan/2015/November/11-9-Health-officials-feel-state-struggles-in-offe.aspx>
- Nair, P., Schuler, M. E., Black, M. M., Kettinger, L., & Harrington, D. (2003). *Cumulative environmental risk in substance abusing women: Early intervention, parenting stress, child abuse potential and child development*. *Child Abuse & Neglect*, 27(9), 997-1017.
- National Committee for Injury Prevention & Control. (1989). *Child abuse. Injury prevention: Meeting the challenge*. *American Journal of Preventive Medicine*, 5, 213–222.
- Neger, E. N., & Prinz, R. J. (2015). *Interventions to address parenting and parental substance abuse: Conceptual and methodological considerations*. *Clinical Psychology Review*, 39, 71-82.
- Niccols, A., & Sword, W. (2005). *New Choices for substance-using mothers and their children: Preliminary evaluation*. *Journal of Substance Use*, 10(4), 239-251.
- Nishimoto, R. H., & Roberts, A. C. (2001). *Coercion and drug treatment for postpartum women*. *The American Journal of Drug and Alcohol Abuse*, 27(1), 161-181.

- Nuzum, L. (2015, February 22). *Social services workers bear heavy caseloads despite state recommendations*. The Charleston Gazette Mail. Charleston, WV. Retrieved from <http://www.wvgazettemail.com/article/20150222/GZ01/150229831>
- O'Flynn, M. (1999). *Adoption and Safe Families Act of 1997: Changing Child Welfare Policy without Addressing Parental Substance Abuse*. The Journal of Contemporary Health Law & Policy, 16, 243.
- Olmstead, T., & Sindelar, J. L. (2004). *To what extent are key services offered in treatment programs for special populations?* Journal of Substance Abuse Treatment, 27(1), 9-15.
- O'Looney, J. (1996). *Redesigning the work of human services*. Greenwood Publishing Group.
- Orme, T. C., & Rimmer, J. (1981). *Alcoholism and child abuse: A review*. Journal of Studies on Alcohol, 42(3), 273-287.
- Osterling, K. L., & Austin, M. J. (2008). *Substance abuse interventions for parents involved in the child welfare system: Evidence and implications*. Journal of Evidence-Based Social Work, 5(1-2), 157-189.
- Padgett, D. K., Henwood, B., Abrams, C., & Drake, R. E. (2008). *Social relationships among persons who have experienced serious mental illness, substance abuse, and homelessness: Implications for recovery*. American Journal of Orthopsychiatry, 78(3), 333-339.
- Patton, M. Q. (2005). *Qualitative research*. John Wiley & Sons, Ltd.
- Paulozzi, L. J., Logan, J. E., Hall, A. J., McKinstry, E., Kaplan, J. A., & Crosby, A. E. (2009). *A comparison of drug overdose deaths involving methadone and other opioid analgesics in West Virginia*. Addiction, 104(9), 1541-1548.

- Pearlin, L. I., Menaghan, E. G., Lieberman, M. A., & Mullan, J. T. (1981). *The stress process*. Journal of Health and Social Behavior, 337-356.)
- Pearlin, L. I. (1989). *The sociological study of stress*. Journal of Health and Social Behavior, 241-256.
- Peterson, L., & Brown, D. (1994). *Integrating child injury and abuse-neglect research: Common histories, etiologies, and solutions*. Psychological Bulletin, 116(2), 293.
- Peterson, L., Gable, S., & Saldana, L. (1996). *Treatment of maternal addiction to prevent child abuse and neglect*. Addictive Behaviors, 21(6), 789-801.)
- Prince, J., & Austin, M. J. (2001). *Innovative programs and practices emerging from the implementation of welfare reform: A cross-case analysis*. Journal of Community Practice, 9(3), 1-14.
- Raikes, H. A., & Thompson, R. A. (2005). *Efficacy and social support as predictors of parenting stress among families in poverty*. Infant Mental Health Journal, 26(3), 177-190.
- Reed et al., (1982 Magura, S., & Laudet, A. B. (1996). *Parental substance abuse and child maltreatment: Review and implications for intervention*. Children and Youth Services Review, 18(3), 193-220.
- Reed, D. F. & Karpilow, K. (2002). *Understanding the child welfare system in California: A primer for service providers and policymakers*. Berkeley: California Center for Research on Families.
- Richan, W. C. (2013). *Lobbying for social change*. Routledge.
- Robinson, T. E. & Berridge, K. C. (2003). *Parsing reward*. Trends in Neurosciences, 26(9), 507-513.

- Roosa, M. W., Gensheimer, L. K., Short, J. L., Ayers, T. S., & Shell, R. (1989). *A preventive intervention for children in alcoholic families: Results of a pilot study*. *Family Relations*, 295-300.
- Ryan, R. M., Deci, E. L., & Koestner, R. (1999). *A meta-analytic review of experiments examining the effects of extrinsic rewards on intrinsic motivation*. *Psychological Bulletin*, 125(6), 627.
- Sack, W. H., Mason, R., & Higgins, J. E. (1985). *The single-parent family and abusive child punishment*. *American Journal of Orthopsychiatry*, 55(2), 252.
- Salamon, L. M., Anheier, H. K., List, R., Toepler, S., & Sokolowski, S. W. (1999). *Global civil society*. Dimensions of the Nonprofit Sector. Baltimore.
- Saunders, (1993 Connell, C. M., Bergeron, N., Katz, K. H., Saunders, L., & Tebes, J. K. (2007). *Re-referral to child protective services: The influence of child, family, and case characteristics on risk status*. *Child Abuse & Neglect*, 31(5), 573-588. doi:<http://dx.doi.org.wncln.wncln.org/10.1016/j.chiabu.2006.12.004>
- Scannapieco, M. & DePanfilis, D. (1994). *Assessing the safety of children at risk of maltreatment: Decision-making models*. *Child Welfare*, 73(3), 229.
- Schilling, R., Mares, A., & El-Bassel, N. (2004). *Women in detoxification: Loss of guardianship of their children*. *Children and Youth Services Review*, 26(5), 463-480.
- Schloesser, P., Pierpont, J., & Poertner, J. (1992). *Active surveillance of child abuse fatalities*. *Child Abuse & Neglect*, 16(1), 3-10.
- Seaburn, D. L., Gunn, A., Gawinski, W., & Mauksch, B. L.(1996). *Models of collaboration: A guide for mental health professionals working with health care practitioners*. New York: Basic Books.

- Semidei, J., Radel, L. F., & Nolan, C. (2001). *Substance abuse and child welfare: Clear linkages and promising responses*. *Child Welfare*, 80(2), 109.
- Sen, A. K. (1997). *Choice, welfare and measurement*. Harvard University Press.
- Sheldon, J. (1997). *Fifty thousand children are waiting: Permanency, planning and termination of parental rights under the Adoption Assistance and Child Welfare Act of 1980*. *BC Third World LJ*, 17, 73.
- Shiffman, R., & Motley, S. (1990). *Comprehensive and integrative planning for community development*. Retrieved from digitalcommons.unomaha.edu.
- Sidebotham, P. (2001). *Culture, stress and the parent-child relationship: A qualitative study of parents' perceptions of parenting*. *Child: Care, Health and Development*, 27(6), 469-485.
- Smith, S. R., & Lipsky, M. (1993). *Nonprofit for hire*. Cambridge, MA. Harvard University Press.
- Smith, B. D., & Marsh, J. C. (2002). *Client-service matching in substance abuse treatment for women with children*. *Journal of Substance Abuse Treatment*, 22(3), 161-168.
- Solomon, B. B. (1976). *Black empowerment: Social work in oppressed communities*. ERIC.
- Snaveley, K., & Tracy, M. B. (2000). *Collaboration among rural nonprofit organizations*. *Nonprofit Management and Leadership*, 11(2), 145-165.)
- Substance Abuse Mental Health Services Administration (SAMHSA). (2010). *Results from the 2009 national survey on drug use and health: Volume I. Summary of National Findings* (Office of Applied Studies, NSDUH Series H-38A, HHS Publication No. SMA 10-4586 Findings). Rockville, MD.

- Suchman, N., DeCoste, C., Castiglioni, N., Legow, N., & Mayes, L. (2008). *The Mothers and Toddlers Program: Preliminary findings from an attachment-based parenting intervention for substance-abusing mothers*. *Psychoanalytic Psychology*, 25(3), 499.
- Suchman, N. E., DeCoste, C., Leigh, D., & Borelli, J. (2010). *Reflective functioning in mothers with drug use disorders: Implications for dyadic interactions with infants and toddlers*. *Attachment & Human Development*, 12(6), 567-585.
- Takayama, J. I., Wolfe, E., & Coulter, K. P. (1998). *Relationship between reason for placement and medical findings among children in foster care*. *Pediatrics*, 101(2), 201-207.
- The West Virginia State Journal, (2015) *Child poverty numbers point to need for change*. The State Journal. Retrieved from <http://www.statejournal.com/story/29610365/child-poverty-numbers-point-to-need-for-change>
- The White House- Office of the Press Secretary for President Barack Obama (2015). *FACT SHEET: Obama administration announces public and private sector efforts to address prescription drug abuse and heroin use*. The White House Office of the Press Secretary. Retrieved from <https://www.whitehouse.gov/the-press-office/2015/10/21/fact-sheet-obama-administration-announces-public-and-private-sector>
- Trost, J. E. (1986). *Statistically nonrepresentative stratified sampling: A sampling technique for qualitative studies*. *Qualitative Sociology*, 9(1), 54-57.
- Ungemack, J. A., Babor, T. F., & Hernandez-Avila, C. A. *Substance-related disorders: Alcohol-related disorders*. *Psychiatry*, Fourth Edition, 1401-1434.
- Ungemack, J., Giovannucci, M., Moy, S., Ohrenberger, K., DeMatteo, T., & Smith, S. (2015). *Making it work without a family drug court: Connecticut's approach to parental substance abuse in the child welfare system*. *Child Welfare*, 94(4).
- United Nations Office on Drugs, & Crime. (2010). *World drug report 2010*. United Nations Publications.

- Vaillant, G. E. (1988). *What can long-term follow-up teach us about relapse and prevention of relapse in addiction?* *British Journal of Addiction*, 83(10), 1147-1157.
- VanBremen, J. R., & Chasnoff, I. J. (1994). *Policy issues for integrating parenting interventions and addiction treatment for women.* *Topics in Early Childhood Special Education*, 14(2), 254-274.
- VanDeMark, N. R., Russell, L. A., O'Keefe, M., Finkelstein, N., Noether, C. D., & Gampel, J. C. (2005). *Children of mothers with histories of substance abuse, mental illness, and trauma.* *Journal of Community Psychology*, 33(4), 445-459.
- Van Slyke, D. M. (2007). *Agents or stewards: Using theory to understand the government-nonprofit social service contracting relationship.* *Journal of Public Administration Research and Theory*, 17(2), 157-187.
- Wahler, E. A. (2012). *The relationship of social stress, economic hardship, and psychological distress to addiction severity among Kentucky substance abuse treatment participants.* Retrieved from uknowledge.uky.edu.
- Walsh, C., MacMillan, H. L., & Jamieson, E. (2003). *The relationship between parental substance abuse and child maltreatment: Findings from the Ontario Health Supplement.* *Child Abuse & Neglect*, 27(12), 1409-1425.
- Way, I., Chung, S., Jonson-Reid, M., & Drake, B. (2001). *Maltreatment perpetrators: A 54-month analysis of recidivism.* *Child Abuse & Neglect*, 25(8), 1093-1108.
- Weich, S., & Lewis, G. (1998). *Poverty, unemployment, and common mental disorders: Population based cohort study.* *Bmj*, 317(7151), 115-119.
- Weisbrod, B. A. (1988). *Nonprofit Economy.* Harvard University Press, Cambridge, Massachusetts.

- Weissman, M. M., McAvay, G., Goldstein, R. B., Nunes, E. V., Verdeli, H., & Wickramaratne, P. J. (1999). *Risk/protective factors among addicted mothers' offspring: a replication study*. *The American journal of drug and alcohol abuse*, 25(4), 661-679.
- West Virginia Census Bureau. (2014). *West Virginia poverty*. Retrieved from <http://www.census.gov/quickfacts/>
- West Virginia Legislature. (2015). *West Virginia code*. Retrieved from <http://www.legis.state.wv.us/wvcode/ChapterEntire.cfm?chap=49>
- Whiteside-Mansell, L., Crone, C. C., & Conners, N. A. (1999). *The development and evaluation of an alcohol and drug prevention and treatment program for women and children: The AR-CARES program*. *Journal of Substance Abuse Treatment*, 16(3), 265-275.
- Widom, C. S., & Hiller-Sturmhofel, S. (2001). *Alcohol abuse as a risk factor for and consequence of child abuse*. *Alcohol Research & Health*, 25(1), 52-52.
- Wijnberg, M., & Reding, K. (1999). *Reclaiming a stress focus: The hassles of rural, poor single mothers*. *Families in Society: The Journal of Contemporary Social Services*, 80(5), 506-515.
- Wilkinson, R. G., & Marmot, M. G. (2003). *Social determinants of health: The solid facts*. World Health Organization.
- Williams, D. R., Mohammed, S. A., Leavell, J., & Collins, C. (2010). *Race, socioeconomic status, and health: Complexities, ongoing challenges, and research opportunities*. *Analysis of the New York Academy of Sciences*, 1186(1), 69-101.
- Williams-Petersen, M. G., Myers, B. J., Degen, H. M., Knisely, J. S., Elswick, R. K., & Schnoll, S. S. (1994). *Drug-using and nonusing women: Potential for child abuse, child-rearing*

- attitudes, social support, and affection for expected baby*. International Journal of the Addictions, 29(12), 1631-1643.
- Wingfield, K., & Klempler, T. (2000). *What works in women-oriented treatment for substance abusing mothers?* What Works in Child Welfare, 113-124.
- Wolch, J. R. (1990). *The shadow state: Government and voluntary sector in transition*. Foundation Center.
- Wolock, I., & Magura, S. (1996). *Parental substance abuse as a predictor of child maltreatment re-reports*. Child Abuse & Neglect, 20(12), 1183-1193.
- Wolock, I., Sherman, P., Feldman, L. H., & Metzger, B. (2001). *Child abuse and neglect referral patterns: A longitudinal study*. Children and Youth Services Review, 23(1), 21-47.
- Young, N. K., Boles, S. M., & Otero, C. (2007). *Parental substance use disorders and child maltreatment: Overlap, gaps, and opportunities*. Child Maltreatment, 12(2), 137-149.
- Young, N. K., Gardner, S. L., & Dennis, K. (1998). *Responding to alcohol and other drug problems in child welfare: Weaving together practice and policy*. Citeseer.
- Young, N. K., Gardner, S. L., Whitaker, B., Yeh, S., & Otero, C. (2005). *A review of alcohol and other drug issues in the States' Child and Family Services Reviews and Program Improvement Plans*. Irvine, CA: Children and Family Futures.
- Zuravin, S. J. & DePanfilis, D. (1998). *Rates, patterns, and frequency of child maltreatment recurrences among families known to CPS*. Child Maltreatment, 3(1), 27-42.)