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CHILD WELFARE PROFESSIONALS' PERCEPTIONS OF DRUG
TREATMENT FOR FOSTER YOUTH: A NEEDS ASSESSMENT

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Edward Basil Dehar

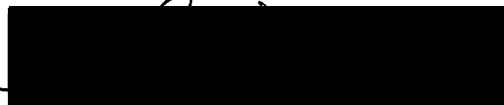
June 2004

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June 2004

Approved by:



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5/26/04
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ABSTRACT

Current research reveals that parental Alcohol and other Drug (AOD) issues are a contributing factor in the out-of-home placement of at least 53% of the over 482,000 children and youth in custody of the child welfare system, and that over 80% of Child Protective Services (CPS) cases involve problems with AOD. In addition up to 60% of infants with prenatal AOD effects have at least one foster care placement. Using a qualitative research design, this study focuses upon the skills and knowledge that both CPS workers and Foster Care Professionals have regarding AOD issues, these same professionals' perceptions of whether or not more education in this area is needed, and the impact that these AOD issues are having upon the child welfare/foster care systems.

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Finally, I wish to convey my sincerest gratitude to Dr. Joyce Wade-Maltais, for her mentorship and ongoing faith in my abilities.

DEDICATION

To my wife Mary, without whose support, love, and sacrifice none of this would have been possible. To my children, Marni, Aaron, Elizabeth, Erik, Monica, Seth, and Megan: my heart, my future, my soul. I will always be grateful for the gifts you have given me. Your laughter, tears, sadness, joys, and for making my life better, my heart softer, and for helping me become a better human being. To my friend Gary G and sponsor Jimmy N, for there continued support, guidance, encouragement, and direction. To my brother Az, for keeping the dream alive and the light burning bright, and my brother's Rich and Rock for always having my back.

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CHAPTER ONE
INTRODUCTION

This section will begin with a problem statement concerning alcohol and other drug issues, and how they impact the foster care system. A description of the purpose of this study, and its significance in the social work arena will also be discussed.

Problem Statement

Children from families with Alcohol and Other Drug (AOD) problems tend to come to the attention of child welfare agencies younger, and are more likely to have been the victims of severe and chronic neglect, as compared to other children within the system. These children are also more likely to be placed in care, and once in care are likely to remain in care longer.

The Child Welfare League of America (1997) found that parental AOD issues was a contributing factor in the out-of-home placement of at least 53% of the 482,000 children and youth in custody of the child welfare system, and according to the Children's Defense Fund (2003), 40-80% of Child Protective Services (CPS) cases involve problems with AOD. Furthermore, 88% of all states named AOD abuse as one of the two problems challenging today's

families, the other being poverty (National Committee to Prevent Child Abuse, 1997). In fact, as of 1999 over 547,000 children are in foster care, a 35% increase since 1990, and some experts predict that number to double by the first part of the 21st century (Children's Defense Fund, 1995; Gleeson & Craig, 1994), and in the State of California alone, there are over 95,000 children in out of home care, and of these over 5,000 reside in Riverside County (California Department of Social Services/Research & Development Division, 2003).

Furthermore, a 1999 report to Congress on Substance Abuse and Child Protection stated that AOD problems are a critical child welfare issue, and timely AOD services are key to achieving permanency for children (Gregoire & Schultz, 2001). In addition, caseworkers attribute both new entries and longer stays in foster care, mostly due to parental AOD issues (Tatara, 1992; Children's Defense Fund, 1995). Available literature also consistently reports the coexistence of AOD abuse and child maltreatment in the same families.

In fact, the incidence of AOD issues during pregnancy is alarmingly high, and it appears that the number of AOD affected births will remain stable, if not increase in the near future (Burry & Noble, 2001). Recent studies indicate

that up to 60% of infants with prenatal AOD effects have at least one foster care placement (Barth, Courtney, Berrick, & Albert, 1994; Jaudes & Ekwo, 1997).

Additionally, parental substance abuse, especially when it involves the prenatal exposure of children to drugs or alcohol, has been called the biggest threat to the well being of children entering the foster care system today, and well into the next century (Barbell & Wright, 1999). Prenatal substance exposure cannot be reversed, nor can other high-risk elements of the prenatal and early environmental conditions; such as traumas, or losses, these children experience prior to placement be erased (McCarty & Waterman, 1999).

Additionally, children of addicted parents are the highest risk group of children to become AOD abusers due to genetic and family environmental factors (Kumpfer, 1999), and one in four children residing in the United States has been exposed to AOD abuse in their family of origin, thereby increasing the likelihood of them becoming substance abusing adults (Grant, 2000).

In recent years, increasing attention has been given to the difficulties of foster youth ageing out of the foster care system. However, even though the well being of these youths has long been of significant interest to

child welfare practitioners, very little is known about how these youths fare when they make the transition to independence. Every year an estimated 20,000 youths age out of the foster care system, and in most cases find themselves completely on their own (Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001).

In a study done in Wisconsin, a significant proportion of foster youths have been found to have a difficult time making the transition to self-sufficiency. Moreover, 24% of those youths studied had been drunk in a public place, 28% had interfered with the work of law enforcement authorities, and 22% had been involved in dealing drugs. Also, 18% of the youth's studied had been arrested at least once since discharge from the foster care system (Courtney et al., 2001).

According to the annual statistical report for the federal fiscal year, October 1, 2001-September 30, 2002, of the over 95,000 children who are part of California's foster care system, 33,253 youths have been offered access to the Independent Living Program (ILP), of which, slightly over 23,000 received those ILP services (California Department of Social Services, Data Systems and Survey Design Bureau, 2003). These children, the majority of which came from backgrounds of substance use

or abuse, either genetic, or environmental, are therefore at a higher risk for AOD abuse problems themselves (Grant, 2000). Yet, at this point in time, there are few, if any facilities geared toward helping adolescents within the foster care system with these issues.

Purpose of the Study

The purpose of this study is to determine the perceptions of those professionals working within the foster care system regarding the existence of, or the need for, an infrastructure able to adequately implement both training and education regarding AOD issues. There exists a large body of research findings documenting the existence of an increase in parental AOD issues, and as a result, a great influx of children entering the foster care system (Gregoire & Schultz, 2001; Gregoire, 1994; Smith, 2002). There is also a great deal of literature that determines the relationship between parental AOD abuse, child abuse and neglect, and the increased possibility of these children becoming substance abusing adults (Besinger, Garland, Litrownik, & Landsverk, 1999; Grant, 2000; McAlpine, Marshall, & Doran, 2001).

However, the existing body of research available only alludes to any type of programs available within the

foster care system. Yet, there is much discussion of how some form of education and treatment programs are considered vital for both foster care professionals, and the population they serve.

This research project, which will be qualitative in nature, will attempt to uncover the perceptions of foster care drug treatment among child welfare professionals. If an infrastructure is in existence, its perceived effectiveness will be examined. On the other hand, if no infrastructure is perceived to exist, an attempt will be made to determine both the forces hindering and helping its implementation.

This will be accomplished by manufacturing a series of questions geared toward discovering the foster care professional's views regarding these issues. The answers will then be coded, statistically evaluated, and studied to see if any existing pattern, theme, or direction can be found.

Significance of the Project for Social Work

The abuse of alcohol and other drugs is inextricably linked with both personal and economic adversities, not only for the individual, but also for society itself. The human suffering caused by AOD issues is incalculable, and

extracts a devastating toll on everyone involved, especially the most vulnerable members of families, young children and adolescents (Grant, 2000). Approximately 77% of public child welfare agencies do not have a written policy or risk assessment protocol that addresses AOD issues of those entering out-of-home care, 94% of the states cannot identify the number of children and youths in out-of-home care that have AOD issues, and only 13% of states have a written policy requiring foster parents/kinship care providers to report a child's AOD abuse (Child Welfare League of America, 2002a).

Needless to say, AOD issues are affecting not only our society, but the foster care system as well. The consequences of addiction are particularly severe in child welfare practice, and exact a high toll. In 1987, Van Wormer (as cited in Gregoire, 1994) noted that social work has a "tradition of neglecting the problems of AOD issues, and that "most social workers complete their entire academic experience with little or no formal training about addiction" (p. 70). During the past almost two decades not much has changed. Therefore, it appears evident that a need for a change is long overdue. Perhaps by addressing the perceptions of the professionals themselves some light may be shed upon this issue. Hence,

the proverbial tiger may be finally taken hold of, and some long needed change perhaps may begin to take place.

This study will therefore improve the quality of life for those children and youths in the foster care system with active or potential AOD problems. It will also improve the overall well-being of the foster care system by improving training and education not only for the professional, but for their charges as well.

CHAPTER TWO
LITERATURE REVIEW

Introduction

Alcohol and other drugs have had a profound effect upon both child welfare services and the foster care system. There appears to be a need for interdisciplinary scholarships across the fields of child welfare, foster care, and drug treatment. Children in out-of-home placement that come from a family of origin that has AOD issues are more likely to experience negative and detrimental conditions. This chapter discusses the history and legislation that guides the child welfare and foster care system. The literature pertaining to these issues are also discussed, as well as the theories that help guide the conceptualization of this population. This literature review will also support the justification of this research project.

Background History

The recognition that alcoholism and substance abuse have a profound impact upon social work practice is not a new concept. In 1917 Mary Richmond wrote of the importance of the social workers role in combating alcoholism (Gregoire, 1994). However, almost 100 years later, alcohol

and other drugs (AOD) continue to have a negative impact on social workers and their clients. The consequences of addiction are particularly severe in child welfare practice, and exact a high toll from the most vulnerable members of society, the young and yet to be born children. In 1987, Van Wormer (as cited in Gregoire, 1994) noted that social work has a tradition of neglecting the problems of alcoholism and other substance abuse" and that "most social workers complete their entire academic experience with little or no formal training on addiction. Perhaps as a result, social workers tend to avoid dealing with alcohol and other drug problems in their clients" (p. 70).

According to Tracy and Farkas (1994), even though substance abuse treatment and child welfare are overlapping areas of practice, they have traditionally not been viewed as such. Additionally, parental substance abuse is but one challenge facing an already stressed child welfare system, and based on several different sources of information, 79% of caregivers were found to meet the criteria for substance abuse (Besinger, Garland, Litrownik, & Landsverk, 1999). Unfortunately, these estimates vary widely (43%-90%) due to the inconsistent methodologies used for classifying substance abuse, and

the non-standardized and frequent lack of operational definitions within studies. Those children currently in out-of-home placements due to parental AOD issues have perhaps suffered the most severe impact. These children, as compared with children placed for other reasons, stay in out-of-home placements longer, move from one placement to another more frequently, are less likely to return home to their biological parents, and have lower rates of adoption. This is particularly true for minority children who leave out-of-home care only to return to placement at some later point (Tracy & Farkas, 1994).

Consequently, there has been much public, political, and professional concern regarding the growing number of families affected by both AOD issues, and maternal substance abuse (Azzi-Lessing & Olsen, 1996; Department of Health and Human Services, 1999; Duerr-Berrick & Karski, 1995; Ellertson, 1994). The major thrust of these concerns has been the impact these families have upon the size of the foster care population, and service system inadequacies (McNichol, 1999; Smith, 2002). Over the past two decades, failure to reach reunification goals has greatly contributed to the foster care population doubling in size and children remaining in care (Azzi-Lessing & Olsen, 1996). To a major extent this is due to the current

laws that are in place, and how these laws shape the decisions made by child welfare agencies.

Child Welfare Policy

Prior to 1974, the Federal Government was only minimally involved in child welfare policy (Erikson, 2000). Increased focus on violence against children during the 1960's led to the passage of the Child Abuse Prevention and Treatment Act (CAPTA), which was implemented in 1974. This was a key piece of Federal legislation addressing child abuse and neglect. However, policy is constantly changing, and CAPTA has frequently been amended and rewritten (U.S. Department of Health & Human Services, 2003). Then in 1980, the Adoption Assistance and Child Welfare Act (P.L. 98-617) was instituted, which included built in timelines for the decision making process; six months case reviews and 18-month dispositional reviews (Besinger, Garland, Litrownik, & Landsverk, 1999). To a large extent welfare practice is still driven by this piece of legislation. In 1997, in response to the escalating concern for child maltreatment, the Adoption and Safe Families Act (ASFA) was implemented. This piece of legislation represented a dramatic shift in child welfare policy, turning the focus

away from family preservation, and going toward out-of-home permanency (U.S. Department of Health & Human Services, 2003).

A growing body of research (Child Welfare League of America, 1998; U.S. General Accounting Office, 1999; U.S. Department of Health and Human Services, Children's Bureau, 2000) demonstrates that ASFA has caused a shift in child welfare policy by shortening the time lines for the reunification of families. Currently in California, the guidelines have been shortened from 12 months to six-months, when children under the age of three are involved.

Then, in 1996, the Independent Living Initiative was passed (P.L. 99-272) to help those youth formerly in out-of home care, to successfully transition into society. Three years later H.R. 3443 (Foster Care Independence Act of 1999) was approved, which increased funds to states due to recognizing the need for special help for youths 18-21 who have aged-out of the foster care system. This offered greater flexibility in designing independent living skills programs (ILP) and established accountability for states implementing ILP programs (Child Welfare League of America, 2002a).

Relevancy of Alcohol and Other Drug
Education and Treatment in the
Foster Care System

"In its broadest sense, the continuum of child welfare services is concerned with the well being of all children. In a narrower sense, however, child welfare is primarily concerned with children whose needs are unmet within a family or other social institutions charged with their care" (Kadushin, as cited in Tracy & Farkas, 1994, p. 60). Research shows that children entering out-of-home care are at a greater likelihood of having medical and social risk factors (higher rates of acute and chronic medical conditions, developmental delays, and mental health problems) than those found among the general population (Burry, 1999; Fox, & Gilbert, 1994; Gustavsson, 1991; Silver, DiLorenzo, Zukoski, Ross, Amster, & Schlegel, 1999; Tarter et al., 1999;). It has also been shown that typically, children entering out-of-home care have histories of prenatal exposure to alcohol and other drugs, as well as experiences of neglect, abuse, and fragmented medical care (West & Prinz, 1987; Simms, Freundlich, Battisetelli, & Kaufman, 1999; Silver et al., 1999).

In fact, according to Simms, Freundlich, Buttistelli, and Kaufman (1999), recent changes in welfare policy,

particularly regarding poor children and families, "likely means that more poor children will enter out-of-home care over the next decade" (p. 167), and significant health problems are often linked with this population. Yet, even though those children placed in out-of-home care have a wide range of health care needs, most children in care do not receive the health care services they need (U.S. General Accounting Office, 1999). In fact, 95% of the children placed for adoption in California during 1993-1994 had one or more physical or emotional problems (California Department of Social Services, 1995). In addition, typically those children entering out-of-home care have histories of prenatal exposure to AOD, have parents with AOD problems, as well as experiences of neglect, abuse, and fragmented medical care (Halfron, Mendonca, & Berkowitz, 1995; Moffat, Peddie, Stulginskas, Pless, & Steinmetz, 1985; Takayama, Bergman, & Connell, 1994; Silver et al., 1999).

Many studies and reports have recognized that substance abuse is a critical factor in the families involved with the child welfare system (Child Welfare League of America North American Commission on Chemical Dependency, 1992; Young, Gardner, & Dennis, 1998; U.S. Department of Health and Human Services, 1999; Semidei,

Radel, & Nolan, 2001), yet few studies have specifically addressed how many child welfare clients have any AOD problems. Regardless, more children are entering care because of abuse and neglect due to parental AOD use; in fact, increasing numbers of them are coming into care with their own AOD problems (Child Welfare League of America, 2000).

Substance abuse is a factor in 40-80% of the families and children who are confirmed by child protective services as victims of abuse and neglect, and more than one-half of the children placed in foster care have parents with substance abuse problems. In fact 80% of AOD related cases where the child entered foster care was the result of extreme neglect (Child Welfare League of America, 2002b). Furthermore, both public agency reports and private research studies have demonstrated a significant overlap between child maltreatment and parental substance abuse (Besinger, Garland, Litrownik, & Landsverk, 1999). However, even though the statistics appear striking, it is significant to point out that these relationships between child maltreatment and AOD abuse are correlational in nature (Tracy & Farkas, 1994).

In the last decade, reports of child maltreatment, fatalities, and the numbers of children placed in

out-of-home care placement as a result of AOD related problems has increased, yet not only is there a shortage of treatment facilities, but few treatment facilities deal with matters of parenting and the well being of children (Meyers, & Moss, 1992). There also appears to be a great need for line workers, caregivers, adoption, and foster care workers to be knowledgeable in the area of AOD issues as well (Tracy & Farkas, 1994; Burry & Noble, 2001).

In 2001 the Child Welfare League reported that few agencies were able to track AOD data, only three states could provide the number of children and adolescents in out-of-home care who themselves had AOD problems, and approximately one-third of the states reported that CPS staff receive no training in their dealing with AOD issues. In addition, increased need for placements has far outstripped the number of placement options available, and foster parents are often overwhelmed, poorly trained, and underpaid, particularly considering the special needs of AOD exposed infants and children (McCarty & Waterman, 1999; Burry & Noble, 2001). Finally, the lack of supplementary support services makes it difficult for the child welfare system to respond adequately to the needs of AOD exposed children placed in its care (Child Welfare League of America, 1997).

According to Smith (2002) "the child welfare delivery system was criticized due to its lack of information and training in the area of chemical dependency, and unfair treatment towards chemically dependent mothers, involving stereotyping and discrimination" (p. 42). Furthermore, Smith noted that, "chemically dependent mothers, child welfare service providers, and substance abuse service providers each identified existing service gaps for the children of these families" (p. 44).

Nevertheless, the number of infants and toddlers entering out-of-home care has increased dramatically in the past few years, and these children are experiencing higher rates of medical, developmental, and mental health problems than those in the general population (Simms, Freundlich, Buttistelli, & Kaufman, 1999; Silver et al., 1999). These same children who are placed into out-of-home care also have a higher "prevalence of psychopathology among children in family foster care [that] is higher than would be expected from normative data, even when this population is compared with children who have backgrounds of similar deprivation" (Schneiderman, Connors, Fribourg, Gries, & Gonzales, 1998, p. 30).

Indeed, even though historically data on AOD have shown higher rates of use of all substances among boys

than among girls, this gender gap no longer exists among youths 12 through 17 years of age (Amaro, Blake, Schwartz, & Flinchbaugh, 2001; Molidor, Nissen, & Watkins, 2002). As a result, not only is adolescent drug use on the rise, but adolescent girls, many of whom are in out-of-home placement are giving birth to drug addicted infants (Trad, 1993). In the mean time many young adults are aging out of the foster care system emotionally scarred, and lacking the social attachments and support structures necessary to make a successful transition to independence (Altshuler, & Poertner, 2002; Mech, 1994).

Theories Guiding Conceptualization

In a study conducted by McNichol and Tash (2001), 268 school age children placed in out-of-home placement were examined. Both the foster parents and teachers rated these children's behaviors, and the results revealed that 29% of these children had scored in the significant range for behavioral problems. In addition, those children exposed prenatally to drugs had a significantly higher incidence of behavioral problems at school compared to their family foster care peers.

It has been shown that many children in foster care have come from violent neighborhoods and homes where

family dysfunction, criminality, domestic violence, and AOD problems are prevalent. Consequently, when these early life experiences are compounded by multiple losses caused by temporary or permanent out-of-home placement the predictable negative impact on the child's mental health can be profound (Schneiderman et al., 1998).

According to Bowlby (1988), attachment is a biologically based system of behavior that exists between the attachment figure, and the child to ensure the child's closeness to the attachment figure. Hence, the primary function of attachment behaviors is to protect the young and maintain their survival. During the past several years interest in attachment theory has grown considerably, and there now exists not only a large empirical knowledge base, but researchers have also started to examine its usefulness for conceptualizing various types of problematic relationship patterns such as: domestic violence, child maltreatment, maladaptive behaviors, and families with substance abusing members among others (Bolen, 2000).

After reviewing the existing literature on attachment theory, Bolen (2000) performed a meta-analysis on the findings, and found enough support to determine the validity of the following hypothesis of attachment theory:

attachment is "stable, predictive, and dynamic; attachment is intergenerationally transmitted; attachment is transmitted from the caregiver to the child; and the temperament of the child influences his or her attachment" (p. 145-146).

Parental AOD issues and poverty are the two major factors associated with the out-of-home placement of children (National Committee to Prevent Child Abuse, 1997), and as mentioned previously, these children are more likely to have been the victims of severe and chronic neglect, as compared to other children in the system, (Halfron, Mendonca, & Berkowitz, 1995; Silver et al., 1999; Takayama, Bergman, & Connell, 1994) and also have higher rates of both acute and chronic medical conditions, developmental delays, and mental health problems than those found among the general population (Silver et al., 1999; Tarter et al., 1999; Burry, 1999)

Coupled with this is the fact that children coming from backgrounds of AOD abuse and poverty stay in out-of-home placement longer, move from one placement to another more frequently, are less likely to return home to their biological parents, and have lower rates of adoption (Tracy & Farkas, 1994). As a result of these mitigating factors this population of children is at greater risk of

being able to form secure attachments (Klaus et. al, 1972; Gray, Cutler, Dean, & Kempe, 1979; Egeland & Vaughan, 1981; Schaffer, 2000). In addition, substance abuse was found to be strongly associated with the onset of both physical abuse and neglect, and when other variables were controlled for, substance abuse tripled the risk for physical abuse and neglect (Widom, 1989; Meyers et al., 2002).

Furthermore, those children who have also been maltreated (physical abuse or neglect), or who have either drug exposed or teenage mothers are more likely to develop either resistant, avoidant, or disorganized attachment styles, and with alcohol abuse of the mother taken into consideration were most often to have disorganized attachment (Bolen, 2000). Resistant attachment is associated with the child becoming adult oriented and emotionally dependent, leading to frustration, anger, and wary of novel situations and people. Avoidant attachment is associated with the child becoming fearful, angry, and defensive while those children that are disorganized-disoriented attached express avoidance, undirected expressions of fear, distress, apprehension, or confusion; dazed or disoriented expression; and behavioral stilling (Bolen, 2000; Schaffer, 2000; Berk, 1998).

Furthermore, since attachment is stable, predictive, and intergenerationally transmitted, if left untreated the cycle of abuse, neglect, and AOD abuse will remain a self-perpetuating cycle.

This pattern also holds true for adolescents who have either grown up in or entered out-of-home care as well. According to Developmental Theory, adolescence is a time when children separate and individuate from their families, become more assertive, and begin to integrate their personalities and identities into some form of cohesiveness (Erikson, 1963). This is also a time of experimentation and vulnerability, as they begin to place more emphasis upon interaction with their peers, their individual sexuality, and risk taking behavior. In addition, if a child comes from a background of AOD abuse, either genetic or environmental, they have a much higher risk of becoming AOD dependent themselves (Grant, 2000; Ray & Ksir, 1996; Lawson & Lawson, 1998), and were found to demonstrate significantly lower self-esteem (Cavaiola & Schiff, 1989).

Summary

Infants, children, and adolescents that are placed in out-of-home care must be able to access not only proper

and timely medical and psychological treatment, but must also be exposed to psycho-educational and treatment regarding AOD issues. Not only is this population more at risk, but also experience difficulties with attachment, achieving self-esteem, and successfully negotiating the transitional period from adolescence to young adulthood. As a direct result of the shift in child welfare policy caused by ASFA, and the lack of skills and knowledge regarding AOD issues, those adolescents ageing-out-of the foster care system are in dire straights. Hence perpetuating the cycle of use and abuse, and ultimately increasing an already over taxed and over burdened child welfare, and foster care system. Therefore this research project will explore the perceptions of foster care drug treatment among child welfare professionals.

CHAPTER THREE

METHODS

Introduction

This research project was qualitative in nature. The study utilized a standardized open-ended face-to-face interview format. Core questions posed addressed the perceived strengths, challenges, and norms among child welfare professionals regarding AOD issues in the foster care system.

This research project explored the perceptions of foster care drug treatment among child welfare professionals. Other variables that were taken into consideration were: age, gender, ethnicity, marital status, and length of time working in the child welfare/foster care field. How long the individual/facility had been licensed was also a factored in. Sampling methods, procedures, protections of human subjects, and data analysis were also discussed.

Study Design

The purpose of this study was to explore the perceptions of foster care drug treatment among child welfare professionals in Riverside County, California. This study was qualitative in nature, and used

face-to-face interviews designed to capture the perceptions of foster care drug treatment among child welfare professionals. This study also offers a provisional need assessment that was based upon the perceived importance of such needs among child welfare professionals.

Limitations of this study included geographical constraints. At the time the study was implemented there were only eight areas of Riverside County that have Children Protective Services agencies, and the locations of the foster care agencies did not include all areas of Riverside County. In fact, many of the foster care facilities used by the Riverside County Child Protective Services are located outside of Riverside County. Also, the sample used was random, but unrepresentative. Therefore, the external validity of the study was also affected. Another limitation was the possible impact of social desirability in regard to the professionals who will be interviewed.

We wanted to find out what the professionals in the child welfare and foster care field think about drug treatment in regard to the foster care system. We expected the attitudes, norms, and beliefs of the respondents offered a deeper understanding of drug treatment as it

impacts the foster care system. We also expected the respondent's expertise to deepen our understanding of the dynamics involved in either implementing such a treatment plan, or improving upon such a system if one already existed.

Sampling

The population of interest for this study was child welfare and foster care professionals residing in Riverside County, California. These professionals were selected by using a sampling frame that consisted of two separate lists. The first list contained all Child Protection Service Agencies in Riverside County, and the second list consisted of all Foster Care facilities/agencies in Riverside County that are either state run or financed. Foster Care facilities/agencies used by Riverside County Child Protective Services those that were located outside of Riverside County were not included.

Respondents were selected from the various agencies throughout Riverside County. Professionals that were employed by Riverside County Child Protective Services were selected by first calling the supervisor in charge of the facility and allowing that individual to determine the

person to be interviewed. Therefore, availability sampling was utilized. For those professionals working in the foster care system, quota sampling was used, and each professional was called randomly from the second list. Foster care agencies were called until we located respondents who were willing to be interviewed. For those professionals working within the foster care facilities, licensure of at least one year was a criterion in the selection process. A written informed consent (see Appendix A) was obtained from each professional, prior to any interview.

Data Collection and Instruments

The respondents were asked the following series of questions: 1) what are the systemic strengths concerning AOD use and treatment in the foster care system; 2) What are the systemic challenges concerning AOD use and treatment in the foster care system; 3) What do other people whom you respect think about AOD issues and treatment in the foster care system; 4) Are there any other comments or concerns you have about AOD issues and treatment in the foster care system. In case the respondents either felt the questions were either too open ended or vague, or if at the conclusion of the interview

the researcher felt the interview didn't cover everything required, the following series of prompt questions were available if needed (see Appendix B).

At the conclusion of the interview the respondents were asked to fill out a brief anonymous background survey in order to gather demographic information (see Appendix C). The responses of the interview were recorded, transcribed, and then analyzed for thematic content.

Procedures

The data source used for this study was personal face-to-face interviews of those professionals working in either State/County run or contracted foster care agencies. The respondents were categorized in regard to geographical sections of Riverside County that had Child Protection Services, which were: Banning, Blythe, Corona, Hemet, Indio, Perris, Riverside, and Temecula. One professional from Child Protective Services and a Foster Care agency was then selected for an interview from each of the specific geographical areas.

Prior to each interview, the researcher explained the purpose and nature of the research, reminding the respondent that their participation and responses during the session will be kept absolutely confidential;

explaining that there are no right or wrong answers; and informing the respondent that they should not hesitate to ask questions and were also able to ask for clarification at any time during the interview process. Each interview lasted approximately 15-30 minutes. At the conclusion of the interview, the respondent was then debriefed (see Appendix D). Each respondent was offered a three-dollar coupon for Starbucks Coffee, and guaranteed they will never be contacted again.

The interviews were audiotaped (per respondents consent) and were then later transcribed. To ensure the participants' confidentiality, no names were included in either the audiotapes or the transcripts. At the conclusion of the study the audiotapes were destroyed, however, the transcripts were saved for future use.

Before making contact with the professionals, a brief summary of the research proposal was sent to Crystal Shackelford, supervisor of interns and research projects for Riverside County Department of Social Services. This proposal was then sent to three supervisors from various departments affiliated with adoptions and foster care. After being viewed by these persons the project was approved after the required revisions were included.

Protection of Human Subjects

In order to ensure confidentiality of the professional respondents that were involved in this research project their names and identifying data was not be used. A random research number was assigned to each respondent interviewed, and no information was made available to identify the individual professional. Furthermore, each professional was guaranteed that any information given will not be made available to any member of either their or any other agency or individual, and that complete confidentiality will be maintained at all times.

Debriefing statements were included, and contact information for the research projects research supervisor were made available. Additionally, each participant was able to contact this researcher's faculty advisor regarding any questions they may have had regarding the study.

This research project was sent to the Department of Social Work Sub-Committee of the Institutional Review Board of California State University, San Bernardino, and the Riverside County, Department of Social Services Research Review Committee for the protection of human subjects.

Data Analysis

Qualitative analysis was used to examine thematic patterns that emerged. The Narrative data was assigned a thematic code that identified important topic and sub-topic categories. In order to develop this coding system, all phenomena relevant to the research questions were highlighted for each transcribed interview conducted, these pieces of data were then compared and contrasted, and given a conceptual label. The demographic data was also analyzed and examined for relevancy and themes.

During the code mapping process the researcher read through the transcripts, placing marks where different codes started and ended. After code mapping the first transcript, the researcher then designed an overview chart to illustrate the different codes and their relationship. This chart was then used to code the remaining transcripts, and additional codes created as both new topics and/or topics of special interest materialized.

The thematic data obtained was then placed into a matrix table, and cross tabulation of the categorical data was then analyzed. Given the qualitative nature of the data that was gathered, a considerable amount of subjective judgment was involved in the interpretation and analysis of this data.

Studies concerned with the prediction of behavior from attitudinal and normative variables have used the related frameworks of the Theory of Reasoned Action (Ajzen & Fishbein, 1980) and the Theory of Planned Behavior (Ajzen, 1991). While both theories share the components of intention, attitude, norms, and beliefs as determinants of behavior, this study used a qualitative framework incorporating the idea that attitudes, norms and beliefs are significant factors in understanding current and future behavior. Support for intention, attitude, norms, and beliefs as determinants of behavior have been summarized in a meta-analysis (Armitage & Conner, 2000) and in a review of the literature (Sutton, 1998).

Summary

This study examined child welfare professional's perceptions of drug treatment for foster youths. The coded thematic content was analyzed and the resulting matrix was then examined.

CHAPTER FOUR

RESULTS

Introduction

The data obtained in this chapter was gathered during face-to-face interviews with Child Welfare Professionals. Fifteen professionals were interviewed, eight within the Department of Public Social Services, and seven within different Foster Care agencies. The results were analyzed, and a matrix designed to obtain reoccurring themes. During the interview process the participants were asked about and commented upon a number of factors that they felt related to alcohol and other drug issues, and how they affected the foster care system. Upon examination of the information, three core themes emerged from the narrative data: (a) experience and/or training, (b) structure blame, (c) negative impact on the foster care system. Certain demographic factors were also analyzed in order to discern certain characteristics of the professional's interviewed: (a) gender, (b) Length of time working within the Child Welfare/Foster Care System, (c) ethnicity, (d) marital status.

Presentation of the Findings

Qualitative analysis was used to examine the thematic patterns that emerged from the narrative data. Three core themes presented themselves. The following three tables display the results of these corresponding themes. The interviewees will be numbered one through 15 to maintain both anonymity and confidentiality. Numbers one through eight correspond to those professionals interviewed that work within Children Protective Services, whereas numbers nine through fifteen correspond to those professionals working within the foster care system.

Demographics

The following are the some of the demographic findings: 33.3% of the participants were male, 66.7% were female, the most frequent ethnicity identified was Anglo, and the majority of respondents were single (Refer to Table 1).

The average time working within the child welfare/foster care system was 8.67 years, and the average age was 37.2 years (Refer to Table 2).

Table 1. Demographics-Frequencies

	Frequency	Percent	Valid Percent	Cumulative Percent
Gender				
Valid male	5	33.3	33.3	33.3
female	10	66.7	66.7	100.0
Total	15	100.0	100.0	
Ethnicity				
Valid Afro-American	3	20.0	20.0	20.0
Anglo	6	40.0	40.0	60.0
European	1	6.7	6.7	66.7
Latino/Hispanic	5	33.3	33.3	100.0
Total	15	100.0	100.0	
Marital Status				
Valid single	6	40.0	40.0	40.0
married	4	26.7	26.7	66.7
separated	1	6.7	6.7	73.3
divorced	4	26.7	26.7	100.0
Total	15	100.0	100.0	

Table 2. Demographics-Descriptive

	N	Minimum	Maximum	Mean	Std. Deviation
Length of Time in System					
Valid N (listwise)	15	3	20	8.67	4.670
	15				
Age					
Valid N (listwise)	15	26	53	37.20	8.222
	15				

Qualitative Data

Experience/Training.

1. "I think for most of us we rely on our own assessment skills and that depends on our level of training and expertise in this area. Quite frankly some social workers have more skills than others and what they bring to the table, you know, we have many that have chemical addiction background and have been trained in that area so obviously their assessment skills are much more in depth than some of our more layman social service workers. Once again I run into a problem when we talk about teenagers because that assessment is usually based upon my observation and maybe a Psych Social History of this individual."
2. "Yea, through child welfare a few trainings over the years regarding drug and alcohol treatments. There needs to be more."
3. "Yes, on my own."
4. "As far as drug issues I think we could use a lot more training. I really do. No, I haven't had extensive training. I have not had any real

classes as far as drug abuse, over a period of time I have basically learned what I know in the field."

5. I have had lots of training dealing not necessarily dealing with but how I guess to identify someone that is under the influence of narcotics or alcohol or abusing narcotics or alcohol and I know what signs to look for and if I think that something is causing neglect their children sleeping all day, dirty house, dirty kids, going out all hours of the night not watching the kids. I used to work for the school system probably ten years and I also took drugs and behavior courses. I think it is something that needs to be out there."
6. "Through graduate school and some through work like extracurricular type training that were offered but not specifically to the foster youth population."
7. "Quite an extensive knowledge base. I am a recovering alcoholic, so I have plenty of experiential knowledge. I also have my CAADAC, so I am a licensed Alcohol and Drug counselor. I also have a MSW, and have taken numerous courses

related to this topic at both the graduate and undergraduate level. However, unfortunately, I am also an exception to the rule."

8. "No nothing other than what I learned in grad school. Nothing specifically."
9. "Very little training. Just what you learn, you know, just generally from life and the media."
10. "I have been in this business for a long time now and more and more infants are coming into my care who have been exposed to drugs prenataly. You wouldn't believe the behavior problems, medical problems, adjustment problems these children have. I've had to go and take numerous classes. If you work in this field today, you better know about it or you are going to be in trouble."
11. "Yes. I completed a thirty-two unit chemical dependency certificate program at a Junior college."
12. "I have a health background, so I have learned of the effects of drugs and alcohol on the nervous system, and the effects they have on a person's physiology. I also work with medically fragile infants, and most of them have been

exposed to the effects of alcohol and drugs prenatally. Therefore I have been trained in the behavioral effects also."

13. "I've taken a few classes, nothing really substantial. I understand the basic concepts. I am definitely not an expert on the matter."
14. "I grew up with an alcoholic father, so I know how much damage it can do to a family, especially to the children. I have also taken courses on my own to find out more about the disease of alcoholism."
15. "Just minimal. Some aspects of the effects they have and how to determine if someone is under the influence. Other than that, no."

Structure Blame.

1. "The only organizational strengths I see is the willingness and cooperation to research and develop this area. I think it is inadequate in its present form. There are some efforts to educate social workers and foster care providers in relation to the dynamics of substance abuse and the role that it plays in child neglect but I think it is inadequate. It just does not give the people who are working with these children

the knowledge that they need to effectively not only monitor the behavior but help the agents of change. So it seems to me we are really missing the boat in that we have children who are removed from chemically dependent families who have their own issues yet we are not dealing with the dynamics involved. We are not addressing the next generation of CPS cases because we know past behavior is a great indicator in what is going to come next. There is an overwhelming feeling of despair in that we know the problem exists. We know it needs to be dealt with, yet it does not seem to be systemically dealt with. There is inherent denial in our system that somehow the children from these abused families don't have the same problems as the adults or parents. For the most part my opinion is that the organization turns kind of a deaf ear to drug, alcohol, and sexual problems."

2. "We do not have adequate means to deal with alcohol and drugs. Again, it is financial, we've got waiting lists à mile long so we are unable

to—we just don't have enough resources. There are not enough resources."

3. "I don't think that there is an organizational strength in the foster care system at this point. I think the organizational challenges come from the lack of financial resources. I think that there is a financial problem therefore it kind of slips under the rug and the child becomes labeled as a difficult child and all that when in fact if addressed in a structured environment then..."
4. "My coworkers as far as their views on it all I think that they pretty much coincide with mine. We all feel that we are not able to provide adequate services to clients, I mean you cannot expect long term drug user to go into a 60 day inpatient program and come out free of drugs and never wanting to use them again. And it just, there again we don't have the funds. It's, just, I mean it's like not a priority."
5. "We tell our clients, yea go test for us but they are not going to classes to be reminded this is what this drug or alcohol is doing to your family. This is why your kids have been

taken away. You need to do this and this and this in order to get them back. But they can't do this, this and this because the class is full and they can't get into the class, therefore they can't get their kids back and when they go to court in six months if they haven't gotten into the program the judge is looking at it and extends it another six months. We have little 2-year olds in foster care that want to go home but the parent can't get the program in order for them to come home. So I think there is a problem with what whether it is budget or whether it is just lack of resources, we got to solve something here."

6. "As far as alcohol and drug treatment I think a huge challenge is finding a foster parent that is willing to even deal with a child that is dealing with any issues of alcohol or drug abuse. I know that I am sure that there are younger kids that use alcohol and drug abuse too but probably the majority of kids we are talking about would be in their teens or preteens and there are not even many foster parents that are willing to take those children so I think a lot

of times these teens with maybe alcohol and drug treatment issues aren't even in a foster parenting home. There are more in the group home setting which then becomes its own unfortunately kind of criminal little house where they are having more access to drugs and alcohol and it is harder to be clean and sober if they wanted to be because there is more access and more bad influence. I think the epidemic of having to place kids with these types of problems in a group home setting nobody likes that because I think we feel that (I am thinking of the peers I am thinking of my colleagues) we feel that it almost is going to exacerbate their drug and alcohol problem being in group it is not going to actually help it because group home staff are young and they are not necessarily highly professionally trained. It is just kind of scary for these kids and then educationally the same way. Who is looking out for them? Who you know? Is the foster care parent doing all they can do? Do I need to do more? Can I do more? I've got this many kids to look out for it is hard to keep track of everybody. Is the school system

looking out for them like they should? It is kind of scary that whole world."

7. "There appears to be a systemic problem. Everyone knows that more and more referrals are due to parental use and abuse. Most of us are aware of what this is doing to the children of our clients. We are starting to see generational cases of alcohol and drug abuse in the child welfare system. Yet the child welfare system tends to turn a deaf ear to the problem. We are just putting band-aids on open sores, when what we really need to do is operate."
8. "It could be budget, it could be a lot of different stuff, but a lot of times you know it is short term and there are some aftercare programs but I think if it was more intense see what I mean a longer amount of time I should say for the actual intensified treatment they could benefit. And I think the people I work with agree with that."
9. "I wasn't required to go to any training that deals with either alcohol or drugs. Training about drugs and alcohol are not mandated. They should be, but they are not required."

10. "You got to be kidding. If you wait for the system to educate you about this stuff you better not hold your breath."
11. "The system doesn't require enough training to become a foster care worker or parent. In fact, many foster parents abuse alcohol themselves, which negatively impacts the children in there care. They don't adequately screen the candidates, or do a rigorous enough background check."
12. "I only work with children under the age of 10. Teenagers, that is, if they are using, are sent to group homes. It's just the way the system works. Older kids are high maintenance, training, education, counseling, just not cost effective."
13. "Unless you work with medically fragile children you get no real training. I believe it is a problem, but no one in the licensing bureau seems to care too much about it. If they did you would think there would be some mention of it in the training you have to take in order to get licensed. Or at least in the training you go to on a yearly basis."

14. "The system only provides a minimal amount of material about addiction. They should provide more. They don't even offer classes if someone was interested."
15. "Ask the licensing committee. I went through orientation. I took the required courses to receive my license. If they would have given me more courses I would have taken them."

Negative Impact on Foster Care System.

1. "I think we are going to get to a point where change must come just because of the sheer numbers of cases that are drug and alcohol involved just the sheer volume that we are dealing with year after year the numbers continue to go up and now we are seeing generational cases were we have families that are involved in alcohol and methamphetamines whose children and grandchildren go on to be the same kind of abuser. It is just going to burden the system with just too many families and children that we have start focusing our energy on an effective solution."

2. "I guess I would say the more kids that are using the more difficult it will be to maintain our placements in foster care settings."
3. "The people that I talk to understand that it is absolutely necessary, especially when you have a teenage population that and they come from an alcohol or drug addicted family system and if they are not given that intervention they do not know how to change the pattern. In the absence of treatment or intervention you've got probably a higher percentage of children in placement and running and all of that."
4. "Most definitely, 99% of our cases are drug related and when you are using drugs there is invariably neglect, abuse, but a lot of it is just neglect they are so busy doing drugs that they can't take care of their children. They can't feed them. They can't clothe them. They can't make them go to school. These same kids end up in foster placement."
5. "It is that I think it is going to get worse. We have only seen the beginning of it they are coming with some different exotic drugs, ecstasy and pills and glass and everything it is just

going to make people even more addicted and it is sad because we have all the kids being born positive so and so's child tested positive and it is ongoing now, so now we have to treat the family and we have to treat the child, the child is going to grow up maybe abuse drugs and alcohol as well cause it is already in his system that is the sad thing. I think it is going to get worse its not getting better any time soon."

6. "We need more people willing to deal with and me too, you know. I am not sure if people are really in that arena. I think that it is something that needs to be more thought of. Ninety percent of our cases have drug abuse and alcohol abuse parentally so why wouldn't we be more aware that these children have grown up as that s a model so they very well could have their own addiction issues and I am not sure that it is something we even deal with. It is getting worse, and we are not even really doing anything about it."
7. "More and more children of all ages are coming into the system due to alcohol and drug

problems. Not only infants, but 8, 10, 13, 16, year olds with alcohol and drug problems of their own. These children aren't even placed into foster homes, but due to lack of training and availability are placed in group homes. It's not only affecting they entire system, it's affecting the future of our world."

8. "I know that just recently we had a case where we have a child who is in foster care who needs to go into a substance abuse treatment program and it is really tough to find that really tough so we are really having a hard time."
9. "Most definitely. More and more babies are coming into care that are prenataly exposed to drugs."
10. "It seems that is all that we are getting these days. Every year more and more children are coming into care as a direct result of drug and alcohol abuse."
11. "Without training foster parents are less likely to observe warning signs of potential abuse with the children they are caring for. This is having a real impact not only on the families but the

children as well. It's impacting not only the foster care system but CPS as well."

12. "Infants exposed to drugs and alcohol have reached epidemic proportions. More and more are coming into the system. It's progressively getting worse."
13. "Drugs and alcohol are definitely affecting the foster care system. Kids used to get here because of other stuff, like domestic violence or neglect. Now they get here for domestic violence or neglect but now it is because the parents are either in jail for drugs, in a treatment program somewhere, or just out there not caring about their children because drugs are more important."
14. "Wherever you look you see the aftermath of alcohol and drugs. It's like a virus that keeps spreading and infecting everything it touches. More and more of our kids are here because of family problems with alcohol and drugs. More and more they just keep coming."
15. "Yea. I mean of course. Look at all the children that come to us because of their parents

problems with drugs and alcohol. It just keeps getting worse."

Summary

Three core themes emerged from the 32 pages of transcribed narratives. These themes addressed the following areas. First, how much training/experience the professionals had in the area of AOD treatment, intervention, and general knowledge; second, blaming the agency structure for lack of proper training, resources, or financial support; and third, the negative impact that AOD issues are having on the child welfare/foster care systems. Extracted from these narratives are individual quotes from each of the professionals interviewed addressing these three core themes. The age, gender, and ethnicity of the professionals were also addressed, as well as their marital status and length of time working within the child welfare/foster care arena.

CHAPTER FIVE

DISCUSSION

Introduction

Chapter Five includes a discussion of the conclusions of the study as they relate to the three core themes that emerged from the narrative data. A comparison of the core themes to the available existing research literature is also addressed. Finally, a discussion of the limitations of this study, recommendations for social work practice, policy, and research, as well as an extraction of the important conclusions from the study are discussed.

Discussion

As stated earlier, the purpose of this study was to uncover the perceptions of child welfare and foster care professionals regarding their awareness of AOD issues; treatment, intervention, and dissemination of information to children in the foster care system. The study also examined these professionals' perceptions as to whether or not AOD issues are properly addressed, and if AOD issues are having any type of impact upon the child welfare/foster care system.

According to the results of this particular study, it was determined that, no, there is not enough training to

properly address AOD issues. Consequently, there is an overwhelming feeling that the cause of this is systemic, and that no real infrastructure exists to properly address these issues. Finally, that AOD issues are negatively impacting the child welfare/foster care system, and it is going to get worse before it gets better. The discussion below under Research - Thematic Code I, Research - Thematic Code II, and Research - Thematic Code III, provide more detail as to the specifics of these findings.

Research - Thematic Code I

Did the child welfare/foster care professional interviewed feel as though they received adequate training or possessed adequate experiential knowledge to effectively deal with AOD issues involving their clients?

To a greater or lesser degree all 15 of the professionals interviewed felt as though they did not possess an adequate amount of education or experience to successfully deal with the issues of AOD use and abuse. In addition, the majority reported that the knowledge they did possess was mostly obtained by either acquiring the information on their own time through outside sources, or through everyday clinical labor. Furthermore, the majority felt as though they could use more education in this area, but due to a variety of reasons was unable to do so.

Following are a few examples of the reasons given that were extracted from the narratives. The numeric number used corresponds to the previous professionals responses from the table in Chapter Four.

#2 "there are not enough resources to do it." #4 "it takes us so long to get up to any place plus trying to manage a caseload it is hard to take time off for training." #6 "No extracurricular type training offered to specifically deal with the foster youth populations." #9 "Training about drugs and alcohol are not mandated." #12 "I don't deal with that population of children. We send those to a group home. Anyway, I have too many other matters to attend to" #15 "I just don't have the spare time to take additional training or courses."

However, every professional interviewed indicated that if their agencies provided classes on AOD issues or if classes were mandated they would be more than willing to comply. Also, even those professional who have extensive knowledge and background in the field of the addictions feel as though they could still benefit from more information. In fact, all the professionals interviewed revealed concern about how lack of knowledge in this area would affect not only their clients, but the

future of the all the clients that will be serviced by the child welfare/foster care system in the future as well.

Evidently, it can be inferred that both the child welfare and foster care systems are not providing the standard of education needed to competently prepare their workers to properly deal with a vast population of the clients they serve. It is clear that all the professionals interviewed perceived that there was not only a lack of training, but also a partially deaf ear turned to AOD issues. In addition, there was also a grave concern about how these issues are affecting not only the parents and children, but also extended family and the community.

Research - Thematic Code II

Did the child welfare/foster care professional feel as though both their lack of training, and the problems they are having with those client's (approximately 90%) dealing with AOD issues are due to external causes or internal causes related to their agencies infrastructure?

All of the 15 professional's interviewed either directly or indirectly indicted their agencies for not properly equipping them with the necessary education and training to effectively deal with AOD issues. They also faulted the system for the negative impact AOD issues are having upon the client's they serve. Furthermore, there

also appeared to be a resignation due to the lack of funding, resources, and agency support.

Following are a few examples of the reasons given that were extracted from the narratives. The numeric number used corresponds to the previous professionals responses from the table in Chapter Four.

#1 "There are some efforts to educate social workers and foster care providers in relation to the dynamics of substance abuse and the role that it plays in child neglect, but I think it is inadequate. It just does not give the people who are working with these children the knowledge that they need to effectively not only monitor the behavior but help the agents of change." #3 "I don't think there is the same number of resources for the kids as for the adults." #5 "We say yea, we need to do this, we need to treat the babies, we need to treat the adults, we need to treat the siblings, we need to treat everybody, but where are we getting all of this money to treat everybody? We need to get more staff, but where is the money coming from. Look at the budget, it is ridiculous right now we had to get a 15 billion dollar bond I believe just to try and help us out a little bit but where is this going to come from man? They have the money and that is another thing that gets me there is so much money to buy

drugs and a lot of it is contributed by the welfare system. Yea, we are giving these people AFDC and cash aid and food stamps and they are trading it in for drugs and then we got to treat them..." #6 "and quality of course is always something that we need more of. I am not sure we have enough quality in our foster care system." #8 I think it is really needed as far as educating us about drug treatment. I think it is really needed because I think a lot of us don't get a lot of training. I know that a lot of law enforcement they go through classes regarding how to recognize because they want to know when do you do the DUI's and all that kind of stuff and I think it could benefit us to learn that too." #13 "It's crazy. They know what is going on. They know what the problem really is, but they are too busy worrying about their image with the public. There has always been a lot of talk, but that is all it is, talk. It just never seems to really change."

All of the professional's interviewed expressed their concerns about budget, finances, priorities, and the seemingly lack of any real change within the system. They also felt as though they were almost fighting a losing battle and not getting the full support of the agency. I get the impression that the line workers know they need more education, more resources, more support, but have

almost resigned themselves that these things will not be coming, and if they do it won't be for a long time.

They are all working with overly large case loads, and do too many different agency polices are not able to give their clients the time that they feel they rally need. Looking at the demographic data regarding the length of time these professional's have been working in the child welfare/foster care system it appears that at about eight years apathy sets in. Around this time it also appears that many child welfare/foster care personal leave there agencies and find work in different arenas, especially the private sector.

Research - Thematic Code III

Did the child welfare/ foster care professional interviewed feel as though AOD issues were having a negative effect upon the foster care system?

All of the professional's interviewed agreed that AOD issues were in one way or another impacting both the child welfare and foster care systems. There was also an overwhelming agreement that not enough funding, resources, time, effort or concern were being given to helping to find a solution to the problem. There was also an overwhelming consensus that there was adequate attention being given to adults with AOD issues, but that there was

no real attention being given to the children in their care.

Following are a few examples of the reasons given that were extracted from the narratives. The numeric number used corresponds to the previous professionals responses from the table in Chapter Four.

#1 "There are very few teenage treatment centers and there are very few programs that deal specifically with the substance abuse issue that teenagers have to deal with. The children in our system that have such a plethora of problems, they come from poverty, they come from disadvantaged groups. They come from domestic violence, substance abuse, mental illness. All of these issues cannot be addressed with one rubber stamp solution." #6 "Well, you know I am not sure how strong the foster care system is dealing with those things. Drugs or alcohol is something that is oftentimes not even mentioned." #7 "The treatment is very short term and I think that has to with a lot of different things. It could be budget; it could be a lot of different stuff. What we are seeing are the same clients over again. Not only the same clients but their children as well." #11 "Drug and alcohol abuse is directly tied into neglect and domestic violence for that matter. What we are getting are children growing up without an

attachment figure, and a predisposition to alcohol and drugs. They in turn begin to use and abuse different substances and before you know it we have children giving birth to children who end up in the foster care system. We have to break the cycle somehow."

There is an awareness that we are not really having a permanent and lasting effect upon those client's that suffer from AOD issues. As mentioned before, both the professional's interviewed and recent research supports the fact that these client's make up over 90% of the cases that child welfare and foster care agencies deal with (Child Welfare League of America, 2002a). Coupled with this is the lack of services for teenagers, and what has been noted as a revolving door policy.

Comparison of Findings to Literature

There is quite a bit of research that supports Thematic Code I: Do child welfare/foster care professionals receive adequate training or possess adequate experiential knowledge to effectively deal with AOD issues involving their clients? In fact, in 1987, Van Wormer (as cited in Gregoire, 1994) noted that "social work has a tradition of neglecting the problems of alcoholism and other substance abuse" and that "most

social workers complete their entire academic experience with little or no formal training on addiction" (p. 70). Fifteen years later Smith (2002) stated that "the child welfare delivery system was criticized due to its lack of information and training in the area of chemical dependency, and unfair treatment; towards chemically dependent mothers, involving stereotyping and discrimination" (p. 42). Furthermore, Smith noted that, "chemically dependent mothers, child welfare service providers, and substance abuse service providers each identified existing service gaps for the children of these families" (p. 44).

In addition, in 1994 Gregoire noted that the abuse of alcohol and other drugs was the cause of most of the problems that child welfare had, yet most workers received little training to cope with this population of clients. In fact, in 2001 Burry and Noble initiated the "Staff Project" in South Carolina in order to give foster parents and other caregiver's specialized training regarding the unique needs of drug-exposed infants and mothers. They concluded that this project "was a timely response to the needs of increasing numbers of infants with prenatal substance abuse exposure, to the needs of workers to be prepared to work with these infants and to new

legislation." They also concluded that there was a need for elaboration of training with content focused on older children as well. It is now 2004, and this present research has replicated the findings of previous research on this subject.

It is a little more difficult to find literature that directly indicts the system, yet there is some literature that supports Thematic Code II: Are the problems the child welfare/foster care agencies are experiencing with AOD issues due to external causes or internal causes related to the agencies infrastructure? In 1992 the Child Welfare League of America North American Commission on Chemical Dependency and Child Welfare reported that on the organizational level agencies tended to focus on "mandated services with little or no orientation to the nature of alcohol and other drug treatment services." Then in an article published in Child Welfare in 1994, (Gregoire) it was noted that "impediments in the workplace make implementing change difficult" (p. 69).

Furthermore, as a result the lack of coordination between child welfare and drug treatment communities, including frequent animosity and differences in philosophy and background, the child welfare system is struggling to meet the needs of chemically involved young people and

their families (Child Welfare League of America, 1998). Finally, in 2001, an article published in Child Welfare (Semidei, Radel, & Nolan) ended with this statement, "Systemic, mainstream improvements are essential if families are to be afforded real opportunities for recovery within ASFA timeframes" (p. 126).

Lastly, Thematic Code III concerns this question: Are AOD issues having a negative effect upon the foster care system? Volumes of research and literature directly address this issue. However, I will present just a few of the more recent ones. The results for the 2002 National Survey on Drug Use and Health: National Findings, which due to better tracking techniques has formed a new baseline for future comparisons, reports that an estimated 19.5 million Americans aged 12 or older were current illicit drug users. The survey also reveals that the prevalence estimates from the 2002 survey are uniformly higher than their corresponding estimates from the 2001 report (Substance Abuse and Mental Health and Human Services Administration).

Therefore, we know have the evidence that the prevalence rates are higher, ergo, more people using and abusing drugs and alcohol. Gregoire and Schultz (2001) estimate that the number of children in the United States

affected by parental substance abuse range from 8.3 million to 17.5 million. Consequently, since the literature consistently reports that AOD abuse and child maltreatment coexist in the same families, which lead to foster placement for the children (Arellano, 1996; Barth, Courtney, Berrick, & Albert, 1994; Grant, 2000; Jaudes & Ekwo, 1997; Jaudes, Ekwo, & Voorhis, 1995; Reid, Macchetto, & Foster, 1999; Tracy & Farkas, 1994) it is logical to state that, yes, AOD issues are definitely having a negative impact upon the foster care system.

Limitations

There were several limitations to this study. First of all before interviewing any of the professional that worked for Child Protective Services (CPS) I first contacted the supervisor and asked them who I would be able to speak with. Therefore, there is the possibility that the person they chose was someone they believed would speak well about the child welfare and foster care system. Hence, the self-reports could have been slightly biased. Given that the foster care professional were called from a list, and only those who responded were interviewed, there could have also been a negative bias present. Since only

those who may have had issues with the foster care system agreed to be interviewed.

Secondly, the sample size was small ($n = 15$) and was basically a localized convenience sample, therefore, not totally representative of those professional working within their respective agencies. Finally, even though the respondents were guaranteed that no one would know what they said, and that the tape would be destroyed to eliminate any type of voice recognition, after the tape was shut off many of the respondents became more animated and disclosed information that was more critical of the system than they reported while being taped.

Recommendations for Social Work Practice, Policy and Research

This study corroborated the existing literature. Moreover, it appears that at the present time no real solution has been implemented by either the child welfare or foster care system. These problems have existed for decades, vast amounts of research have been conducted, yet only minimal gains have been made. Social work practitioners need to address these issues at the line level, and take the time to educate themselves about the damaging effects AOD have upon their clients. There should also be more education as to how to effectively deal with

and handle these issues in an empowering, strength based manner.

On an organizational level, policy should be put into operation to address these issues: education, training, inter and intra-agency collaboration. In addition, monies should be allocated directly to programs that will specifically address these issues. Furthermore, many pilot programs have been implemented in other states, and perhaps these programs should be investigated and then put into effect within Riverside Counties child welfare and foster care agencies.

In regards to future research, there is still a great need to determine exactly how the children affected by family AOD use and abuse, and foster care placement cope with their own unresolved issues. How does AOD issues and consequent placement affect their bonding not only with an attachment figure, but how it affects their ability to bond with others in their life, and the possible affect it may have on them achieving intimate relationships in the future. Finally, presently there exist an abundant amount of theories, models and speculations surrounding the treatment, issues, damage, and consequences that AOD have upon the family, child, and the surrounding community.

These have to be examined more closely, and a working solution must be identified and put into place.

Conclusions

As mentioned previously, in 1917 Mary Richmond wrote of the importance of the social workers role in combating alcoholism (Gregoire, 1994). Yet, almost 100 years later, alcohol and other drugs continue to have a negative impact upon the child welfare and foster care system. Alcohol and other drugs continue to exact an extremely high toll from the most vulnerable members of our society, the young and yet to be born children. As social workers we are committed to advocate, empower, and help those disenfranchised members of our society.

However, we must also ask ourselves some hard and difficult questions. Are we as professionals doing everything we can to ensure that we have the proper tools at our disposal to adequately address the concerns and issues facing our clients? The results of this research confirm the fact that AOD issues have been an underlying cause of abuse and neglect, and that this has been a problem since the beginning of the Social Work profession.

Programs have been developed. Other states have adopted some of these programs, which provide not only

education and training to the professional, but to the client and their family as well. Pilot programs have been in operation, and many of these programs have produced positive and encouraging outcomes. Inter and intra agency collaboration and cooperation have been established in order to more fully help the populations we serve. A solution does exist. What we need to do is embrace this solution, place our individual differences aside, and join in a spirit of cooperation so that we may ethically and competently address the needs of the clients we so desperately want and need to help.

APPENDIX A
INFORMED CONSENT

INFORMED CONSENT

Hi, my name is Edward Dehar. I am a graduate student at California State University, San Bernardino. I am also a social work intern for the Department of Social Services, Riverside County. The Department of Social Work California State University, San Bernardino's subcommittee of the Institutional Review Board has approved this study.

I would like to invite you to participate in a research project concerning the perceptions of foster care drug treatment among child welfare professionals. It is believed that a professional's attitudes, norms, and beliefs are significant factors in understanding current and future behavior. This study will adhere to an interview type format, which will last approximately one-half to three-quarters of an hour. With your permission the interview will be audiotaped.

There are no foreseeable risks attached to this study, and all information will be kept strictly confidential. Your interview will be given a number, and neither your name, nor that of the agency you work for will be connected with the interview. Only myself, and my research advisor, Dr. Thomas Davis, California State University, San Bernardino, Department of Social Work, will see or hear the information shared. After the research is completed, the tapes will be destroyed. However, the transcripts will be saved for use, and the same confidentiality guarantees given here will apply to future use of any information.

Your participation in this research is strictly voluntary; and there will be no cost to you except for your time. If you wish to withdraw from this study you may do so at any time and do not need to give any reasons or explanations for doing so. If you either participate in, or withdraw from this study, it will have no effect on your relationship with the Department of Social Services, or the facility you are affiliated with.

If you have any questions about the research please do not hesitate to either call or write to Dr. Thomas Davis. Dr. Davis' phone number is; (909) 880-5501. Send correspondence to: Dr. Thomas Davis, California State University, San Bernardino, Department of Social Work, 5500 University Parkway, San Bernardino California, 92407. Whether or not you decide to finish this interview you will receive a \$3 gift certificate for Starbucks. Upon completion of the interview you will receive a debriefing statement.

By placing an X in the box below, I acknowledge that I have been informed of, and that I understand the nature and purpose of the study, and I freely give my consent to participate. I also acknowledge that by placing my mark in the box below I am at least 18 years of age, and have voluntarily agreed to have the interview audiotaped.

Please place mark: _____ Date: _____

Agree to be audiotaped: _____ Yes _____ No

APPENDIX B
PROMPT QUESTIONS

Prompt Questions

1. How long have you been in the foster care field?
2. Have you ever received any training in the field of addiction?
3. Do you have any knowledge or education concerning the issue of drug abuse?
4. Are you aware of the intervention process in regards to AOD issues?
5. Are you aware of the behavior that may be exhibited by an individual under the influence of AOD?
6. Are you aware of the effects different drugs have on an individual's behavior?
7. Is there any specific procedure to follow if you suspect someone in your charge to be under the influence of a controlled substance or alcohol?
8. Do you think that AOD issues are having any type of impact upon the foster care system?
9. How do you feel about drug treatment and education?
10. Do you think your agency (the foster care system) has adequate ways and means to deal with AOD issues?
11. Are you familiar with how your colleagues feel about these issues?

APPENDIX C
DEMOGRAPHICAL QUESTIONNAIRE

Demographical Questionnaire

Gender:

Male _____ Female _____

Age _____

Length of Time Working within the Child Welfare/Foster Care System _____

Ethnicity:

- _____ African American
- _____ American Indian
- _____ Anglo
- _____ Asian
- _____ Eastern Indian
- _____ European
- _____ Inuit/Pacific Rim
- _____ Latino/Hispanic
- _____ Other _____

Marital Status:

- _____ Single
- _____ Married
- _____ Separated
- _____ Divorced
- _____ Widowed/Widower
- _____ Other _____

APPENDIX D
DEBRIEFING STATEMENT

DEBRIEFING STATEMENT

The study you have just participated in was designed to gather information about the perceptions of professionals in the foster care system regarding drug treatment within the foster care system. This will be accomplished by using a qualitative framework incorporating the idea that attitudes, norms, and beliefs are significant factors in understanding current and future behavior, and that it is possible to predict behavior from attitudinal and normative variables.

It is hoped that this study will increase the present knowledge base concerning drug treatment within the foster care system. We hope to reveal whether or not there presently exists any perceived form of drug treatment or psycho-educational programs, and if not, the perceived importance of the need for one to be implemented. It is also hoped to discover those forces that are either helping or hindering such a program.

This study has been conducted by Edward Dehar, a graduate student at California State University, San Bernardino. Any concerns about this study may be addressed to Dr. Thomas Davis, Project Advisor, (909) 880-5501. In return for your participation you may view the results in the University's John M Pfau Library after September 2004.

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