2021

A multigenerational perspective on caregiver substance use, trauma, & child welfare involvement

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A multigenerational perspective on caregiver substance use, trauma, & child welfare involvement

by

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A dissertation submitted to the graduate faculty

in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

Major: Human Development and Family Studies

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The student author whose presentation of the scholarship herein was approved by the program of study committee is solely responsible for the content of this dissertation. The Graduate College will ensure this dissertation is globally accessible and will not permit alterations after a degree is conferred.

Iowa State University

Ames, Iowa

2021

DEDICATION

I would like to dedicate my dissertation work to my five daughters, Alyssa, Serenity, Chloe, Paisley, and Hadley. May this serve as an example to always chase your dreams with strength, tenacity, and relentlessness – you are each capable of more than you believe. To my husband, Logan, who read countless drafts, pushed me in the hard times, and celebrated my wins. Your support and sacrifices are noticed and appreciated.

I dedicate this work to my family, most specifically my parents Brian and JoAnn Page, who have supported my ambitious dreams from day one and never doubted my ability to accomplish them. Thank you for helping with the girls, checking in, and always encouraging me.

Finally, I dedicate this work to my entire Happy Feet Academy team of employees. Thank you for picking up the slack when deadlines were near, for reminding me the purpose of this work, and for always cheering me on. My hope is, watching me through this process, that you hold tight to your goals and know that they are worth every ounce of blood, sweat, and tears.

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AKNOWLEDGMENTS

I wish to thank my committee members who were generous with sharing their time and expertise. A special thanks to Dr. Cassandra Dorius, my major professor, for her countless rounds of edits, frequent meetings, never ending encouragement, and most importantly patience through my entire graduate career. Thank you to Dr. Heather Rouse, Dr. Shawn Dorius, Dr. Clinton Gudmunson, and Dr. Diana Lang for agreeing to serve on my committee. Additionally, thank you Dr. Shawn Dorius and Dr. Cassandra Dorius for the use of the interview transcript data utilized in this study.

I would like to acknowledge and thank the Department of Human Development and Family Studies for allowing me to conduct my research and supporting me throughout the process. Thank you to the faculty, administration, and all of the Iowa State University staff and employees that have poured into my graduate career. Their willingness to provide feedback, support with navigating protocol, and assist me with the completion of this process made this a pleasant experience.

ABSTRACT

This dissertation examines patterns of substance use behavior and child welfare involvement through generational cycles. Additionally, parents' experiences with child welfare involvement were explored emergently and thematic, findings are highlighted. The secondary data utilized for this paper were derived from an assessment of two-generational substance use collected in partnership with Iowa Department of Public Health, Department of Human Rights, and Iowa State University. Data were collected from 41 individuals via in-depth qualitative interviews regarding how substance use has impacted their lives. Interviews were coded utilizing a combination of ethnographic and phenomenological approaches. This paper concludes with practical implications for policymakers and future research opportunities.

CHAPTER 1. INTRODUCTION

Nearly nine million American children have spent at least a part of their childhood living with a caregiver diagnosed with a substance use disorder (Lipari & Van Horn, 2017). Traditionally, these diagnoses have meant that a caregiver continues to use substances despite hazardous conditions, interpersonal conflict, or failure to fulfill major responsibilities (American Psychological Association, 2013). As a result, children raised in homes characterized by substance use are more likely to experience abuse, neglect, and other health or safety risks that warrant state intervention (Haight, Ostler, Black, Sheridan, & Kingery, 2007; Zhang, Huang, Wu, Li, & Liu, 2019). Notably, caregiver substance use has represented one of the most common reasons for coming into contact with the child welfare system (Bosk, Van Alst, & Van Scoyoc, 2017). Furthermore, child welfare cases that deal with substance use are often uniquely complex and exemplify how substance use is interwoven with child removals and trauma within and between generations (Petersen, Joseph, & Feit, 2014; Radel, Baldwin, Crouse, Ghertner, & Waters, 2018).

When caregivers have a history of using substances, their children are more likely to use substances as well. A significant body of work has concluded that substance use can be transmitted from caregiver to child across generations (Lipari & Van Horn, 2017; National Institute on Drug Abuse et. al, 2018; Simmons, Havens, Whiting, Holz, & Bada, 2009; Substance Abuse and Mental Health Services Administration, 2019; Tran, Clavarino, Williams, & Najman, 2018; Yule, Wilens, Martelon, Rosenthal, & Biederman, 2018). Not only are children who have been exposed to caregiver substance use more likely to become substance users themselves, they are also more likely to experience low academic achievement, poverty,

and/or to encounter the juvenile or criminal justice system (Chuang, Moore, Barrett, & Young, 2012; Zhang, Huang, Wu, Li, & Liu, 2019). For the purpose of this study, I utilize a broad working definition to encompass that substance use can be transmitted via disease, social learning, or epigenetic factors which all impact the translation of substance use, child maltreatment, and trauma replication patterns.

One of the biggest barriers caregivers have to maintaining sobriety and reunifying with children is access to quality treatment options. Accessing a bed in a treatment facility can be challenging, let alone finding programs that are family-friendly (Radel, Baldwin, Crouse, Ghertner, Waters, 2018). Substance use treatment must address family-related issues and promote healthy parenting in order to be effective. Drug overdose deaths and drug-related hospitalizations have a statistically significant relationship with child welfare caseloads. Additionally, substance use indicators have been correlated with more complex and severe child welfare cases (Radel, Baldwin, Crouse, Ghertner, & Waters, 2018). Ongoing support is invaluable to ensure and protect against relapse. Recovery from substance use is not a linear process and commonly includes periods of sobriety and recovery with relapse rates as high as 40-60 percent (Bosk, Van Alst, & Van Scoyoc, 2017).

In this study, I utilized ethnographic interviews with biological parents who have a history of substance use to explore the cyclical nature of multigenerational substance use and child removals. I explore the relationship of exposure to substance use and child removals in the parent's own childhood, the recurrence of child welfare involvement and relapse throughout the parent's life course, and the parent's perspective of child welfare interactions with families. The potential implications of the results for policy and programming are also explored.

Dissertation Organization

This dissertation is organized following the traditional dissertation format. The literature review informing the research project is discussed in Chapter 1. The theoretical framework guiding this project is discussed in Chapter 2. Chapter 3 describes the sample, data collection, and coding procedure for this study. The data and results applying the multigenerational model are discussed in Chapter 4. Chapter 5 contains results discussing individuals' experiences with their children and child welfare involvement. Finally, policy implications are discussed in Chapter 6.

Literature Review

Caregiver Substance Use and Child Welfare

Child welfare and caregiver substance use are intertwined and often reciprocal. When caregivers use substances, they are at increased risk of having their children removed from their home due to neglect, maltreatment, or medical necessity (Radel, Baldwin, Crouse, Ghertner, & Waters, 2018; Kim, Brook, & Akin, 2018). Furthermore, when caregivers experience the trauma of having a child removed from their home, it can trigger increased substance use (Dorius, Dorius, Talbert, Bartel, Van Selous, & Bahe, 2019).

The strong link between child removal and substance use goes beyond any single country's borders. An estimated 50 to 79 percent of worldwide child removal cases are tied to caregiver substance use (Testa & Smith, 2009). Within the United States, caregiver substance use is one of the most frequently cited reasons for child removals (Bosk et al., 2017). In fact, families in which alcohol or drug use is present are the most likely to be reported to Child Protective Services (CPS), to have subsequent CPS reports, have children removed from the home, and to

have extended out of home stays compared with other families (Barth, Gibbons, & Guo, 2006; Gregoire & Schultz, 2001; Smith & Testa, 2002).

The relationship between substance use and child removal is driven in part because children raised by caregivers who use substances are significantly more likely to experience abuse and neglect than children who are raised in families where substances are not present (Appleyard, Berlin, Rosanbalm, & Dodge, 2011). Between 40 and 80 percent of all substantiated maltreatment cases in the United States occurred in the context of caregiver substance use (Jones, 2004; Kim, Brook, & Akin, 2018), though the estimated rate varies due to discrepancies in the definition of what constitutes maltreatment across agencies and data systems (Young, Boles, & Otero, 2007).

Substance use also places children at higher safety risks to their physical and mental health and well-being (Haight, Ostler, Black, Sheridan, & Kingery, 2007; Hohman, Oliver, & Wright, 2004), all of which increase the likelihood of coming into contact with child welfare systems. Further, caregiver overdose hospitalizations and drug-related deaths are significantly related to child welfare caseloads (Radel, Baldwin, Crouse, Ghertner, & Waters, 2018). Importantly, the likelihood of having a child removed from a home varies by the extent and type of substance used. For example, children exposed to caregivers' methamphetamine use are both at higher risk of being placed in foster care and are less likely to reunify with their caregivers than children whose caregivers used only alcohol excessively (Carlson, Williams, & Shafer, 2012; Lloyd & Akin, 2014). Overall, the increased risk of residing with a caregiver who uses substances places the child at greater risk of child welfare involvement, which may be required to ensure the safety and well-being needs of the child are being met.

Generational Reproduction of Substance Abuse and Child Removals

Not only does the relationship between substance use and child welfare involvement usually span years in a child's life, but there is also evidence of a generational cycle of substance use where children grow up to replicate the same substance using behaviors they observed among their caregivers, creating a second generation at greater risk of children being removed from their home. This cycle is recreated over generations through mechanisms related to learned behaviors, contextual factors, and biological predispositions (Lipari & Van Horn, 2017; Simmons, Havens, Whiting, Holz, & Bada, 2009; Substance Abuse and Mental Health Services Administration, 2019; Tran, Clavarino, Williams, & Najman, 2018; Yule, Wilens, Martelon, Rosenthal, & Biederman, 2018).

When children are exposed to caregiver substance use during childhood, they are at increased risk of using substances throughout their own adolescence, emerging adulthood, and adulthood (Biederman, Faraone, Monuteaux, & Feighner, 2000; Chassin et al., 2002). Further, the risk of intergenerational transmission of substance use is greatest if both caregivers had a history of substance use (Clark et al., 2005; Stone et al., 2012). Biological predispositions and behavioral modeling help to explain the widely supported finding that substance use can be transmitted from one family member to another, from caregiver to child (Goldman, Oroszi, & Ducci, 2005; Verdejo-Garcia, 2020). Family context also plays an important role in the generational cycle of substance use. Caregivers with substance use disorders often raise children in a context of instability, including inconsistent or unstable access to housing and employment that increase family stress and decrease family functioning (Smith & Wilson, 2016). This context of instability also increases the likelihood of exposure to Adverse Childhood Experiences (ACEs) which were associated with persistent of negative health outcomes, family instability,

and substance use (Crandall et al., 2019). As a result, children whose caregivers use substances report lower academic achievement, higher rates of poverty, and are more likely to become involved in juvenile and criminal justice systems (Chuang, Moore, Barrett, & Young, 2012).

Furthermore, the disadvantages and traumatic experiences that characterize some of these children's lives, can themselves be precursors to substance use or influence the intensity and extent of the substances use (Dorius et al, 2019). As noted by Dorius and colleagues (2019), life events such as death of a family member or friend, homelessness, sexual assault/trafficking, prostitution in exchange for substances, removal of a child, and abandonment of support systems have drastic impacts on the interaction between the substance user and substances. In rare cases traumatic events have such a heavy impact that it creates motivation to stop using substances. However, in many cases these events and experiences further compound the addiction resulting in a search for a greater high via increasing frequency or amount of substances consumed or by seeking novel substances. With this draw for greater relief from substances it also increases the likelihood of overdose and willingness to partake in illegal activities to obtain the high. This desire to obtain a high at all costs opens up individuals and the children in their care to the possibility of further traumatic exposure.

Given the likelihood of exposure to a range of potentially traumatic events substance users might face, it is unsurprising that child welfare cases that are related to substance use are often quite complex. Prior studies that have examined the difference between substance using mothers who have been involved with CPS and those who have not been involved with CPS, have found that the greater number of service needs or challenges a parent faces, the less likely they are to be able to adequately care for their children (Gilchrist & Taylor, 2009; Grella, Hser, & Huang, 2006; Meier, Donmall, & McElduff, 2004). In particular, caregivers who use

substances often have multiple service needs including domestic violence, mental illness, and long histories of traumatic events and experiences (Radel, Baldwin, Crouse, Ghertner, & Waters, 2018). Up to 80 percent of maltreatment cases in the United States occur in the context of caregiver substance use, many of which have more than one substantiated reason for intake, creating more complex welfare cases (Chuang, Moore, Barrett, & Young, 2012; Radel, Baldwin, Crouse, Ghertner, & Waters, 2018). For example, one recent study reported that 75 percent of substance-using mothers have at least four service needs, making clear the complexity of these child welfare cases (Bosk, Van Alst, & Van Scoyoc, 2017). When caregivers experience extreme adversity, they are more likely to need the support of others to raise a child. Given the mutigenerational nature of substance use, parenting, and child removal, caregiver substance use can be both a risk factor and a consequence of child abuse and neglect (Petersen, Joseph, & Feit, 2014).

Child Welfare Approach is Crucial for Long Term Success

After child welfare staff become involved in cases where substance use is present, it is vital that recovery become a priority for individuals, for the sake of family preservation. A major limiting factor of entering treatment is the amount of beds and treatment opportunities available (Chuang, Moore, Barrett, & Young, 2012), particularly those programs that address both the substance use disorders and additional services needed for caregivers, predominantly mothers, involved with child welfare cases (Preis, Inman, & Lobel, 2020). Programming that simultaneously addresses substance use and other service needs has been shown to significantly improve beginning treatment, maintaining sobriety, and overall outcomes for the family as a whole treatment unit (Marsh, D-Aunno, & Smith, 2000). Therefore, a lack of quality treatment

programs represents a critical barrier for caregivers engaging and completing their case plans with the child welfare system.

Roughly half of mothers with dependent children who entered substance treatment facilities have had involvement with child welfare services (Grella, Scott, Foss, Joshi, & Hser, 2003; Isler, Mineau, Hunter, Callahan, Gelfman, Bustos, & Jason, 2017), and up to one third of those have lost their parental rights to at least one child (Van Scoyoc, Harrison, & Fisher, 2017; Schilling, Mares & El-Bassel, 2004). Women enter treatment for methamphetamine abuse at roughly twice the rate as men, with the highest percent difference between men and women found during the ages of 18 to 34 years, women's most fertile childbearing years (SAMHSA & CBHSQ, 2014).

Swift entry into treatment and completion of at least one treatment episode increases the likelihood of child reunification and decreases the amount of time children spend in out of home care (Green, Rockhill, & Furrer, 2007). Treatment improves outcomes for families, particularly if services are initiated shortly following child welfare becoming involved (Grella, Needell, Shi, & Hser, 2009; Ogbonnaya, Keeney, & Villodas, 2019). Tailored treatment programs decrease substance use, reduce co-occurring mental health symptoms while increasing employment rates of participants (Ashley, Marsden, & Brady, 2003; Marsh, D-Aunno, & Smith, 2000).

When treatment programs are difficult to find, difficult to get into, or require lengthy recovery stays (depending on the extent and context of the substance use) it impacts the caregiver-child dyad, especially with regard to the age of the child. Often, children must be removed from their primary caregiver so that individual can attend a treatment program, sometimes resulting in the child being placed in a kinship setting and other times placed in foster care. Child welfare then looks at the case contextually to determine the resources that can be

offered and the required steps an individual must take to conduct a trial reunification. Requirements may be lengthy, and the odds are stacked against the caregivers with the number of challenges they must overcome to reunify. The length a child is removed from their primary caregiver matters in the world of child welfare. Facilitating enough time for caregivers to recover properly and get required supports in place to successfully parent is necessary. Lengthier stays outside of the home, however, can have negative impacts on the long-term wellbeing of the child. Many studies have shown that children with very short first stays in foster care were more likely to re-enter foster care (Mowbray, Victor, Ryan, Moore, & Perron, 2017; Newton, Litrownik, & Landsverk, 2000; Maluccio & Ainsworth, 2003; Choi & Ryan, 2007; Goering & Shaw, 2017; Kimberlin, Anthony, & Austin, 2009). Additionally, longer stays in foster care are associated with lower rates of re-entry. Some researchers have deciphered these findings to suggest that shorter stays increase re-entry risk because families do not have enough time or support to make the changes necessary for a safe and stable reunification (Font, Sattler, & Gershoff, 2018; Kimberlin, Anthony, & Austin, 2009).

The Adoption and Safe Families Act (ASFA) was enacted in 1997 to address children residing in out-of-home care for lengthy time periods and experiencing lack of continuity of care. Under ASFA, caregivers have as little as 12 months to comply with reunification requirements, including substance use treatment, before risking permanent loss of parental rights. This legislation was enacted to protect healthy child development and promote permanency (Scott & Gustavsson, 2010). ASFA does a poor job taking into consideration the amount of time required to complete substance use treatment and achieve sobriety (O'Flynn, 2000). Conflicting permanency and substance use treatment timelines make it difficult for courts to serve these families effectively and results in many different interpretations and perspectives about the child

welfare processes and information sharing (Green, Rockhill, & Burns, 2008). ASFA legislation causes unique challenges for caregivers with substance use disorders due to required permanency hearings within 12 months of placement, this makes caregivers attempting to navigate the stressors of treatment programs particularly vulnerable to losing parental rights (Green, Furrer, Worcel, Burrus, & Finigan, 2007). This legislation was updated and amended as the Family First Prevention Act of 2018 to broaden the allowance of federal dollars attributed to more preventative measures and programs. This updated program can help families receive preventative services prior to child welfare involvement, allowing caregivers more time to achieve sobriety and work on recovery outside of the before-mentioned timelines.

For individuals recovering from substance addiction, relapse tends to be a common occurrence that can happen at any time. Individuals may be triggered to relapse from a variety of scenarios and life events, most commonly stressful or traumatic experiences. Some research has found that the process of working through a child welfare case, in and of itself, can result in relapse due to the stress and the uncertainty of the case and their families' future (Goering & Shaw 2017). This increases the likelihood of reintroduction of substances into the household but also makes the likelihood of re-involvement of child welfare more likely.

Children are less likely to reunify after foster care if alcohol or drug problems are present (Font, Sattler, & Gershoff, 2018). Also, children who were involved with the child welfare system and had a caregiver with a substance use disorder were more likely to experience lengthier stays in out-of-home placement. Children in these scenarios are at increased risk to experience recurrent involvement with child welfare and have lower rates of reunification (Brook & McDonald, 2007; Marsh, Ryan, Choi, & Testa, 2006; Grella, Hser, & Huang, 2006). When recurrent cases, or long-term foster care stays occur, child welfare must begin to examine

chances of long-term and permanent recovery and explore permanency planning options (Akin, Brook, & Lloyd, 2015). Family characteristics related to increased re-entry of child welfare cases include poverty, caregiver substance abuse, maltreatment type (neglect or dependency) and other caregiver characteristics such as lack of parenting skills, and lack of social support (Kimberlin, Anthony, & Austin, 2009; Font, Sattler, & Gershoff, 2018). Frame et al. (2000), analyzed the characteristics of a cohort of 88 reunified infants of whom 32 percent re-entered foster care within four to six years. Significant risk factors for re-entry included maternal substance abuse or criminal activity (usually associated with substance abuse), non-kin foster care placement, or being placed in care within the first month after birth. More recently, additional child and family factors have also been found to increase risks such as caregiver drug and alcohol concerns or removal from a single parent home (Goering & Shaw 2017). Approximately one third of reunifications fail due to lack of formal resources and fear of further allegations of maltreatment (Stephens & Gopalan, 2017). When issues arose in a caregivers' recovery journey, many hesitated seeking support from child welfare professionals, in fear of another report of maltreatment (Domian, Baggett, Carta, Mitchell, & Larson, 2010).

Model

Literature and theoretical perspectives have supported the premise that many trauma and substance use behaviors have been passed down across generations via casual force encompassing genetic influence, social learning, and epigenetic factors. Each of these mechanisms are most commonly reinforced through exposures in the family of origin. The model in Figure 1 depicts the cyclical, generational nature of exposure to substance use, trauma, and child removal/child welfare involvement. Behavior, biology, and environment originates in the

family of origin, exposes the children who were present (see box A), trauma behavior then develops in the child as they develop into young adults (see box B), who then follow the pattern of early partnering and child rearing (see box C), which starts the cycle over again with another generation of children being exposed to the substance use, trauma, or child welfare involvement (see box D). It is also imperative to note the opportunities within this cycle where intervention, resources, and more specific substance use treatment could be introduced in an attempt to moderate or contribute causal influence to minimize the likelihood of the patterned cycle continuing (see boxes 1, 2, and 3).

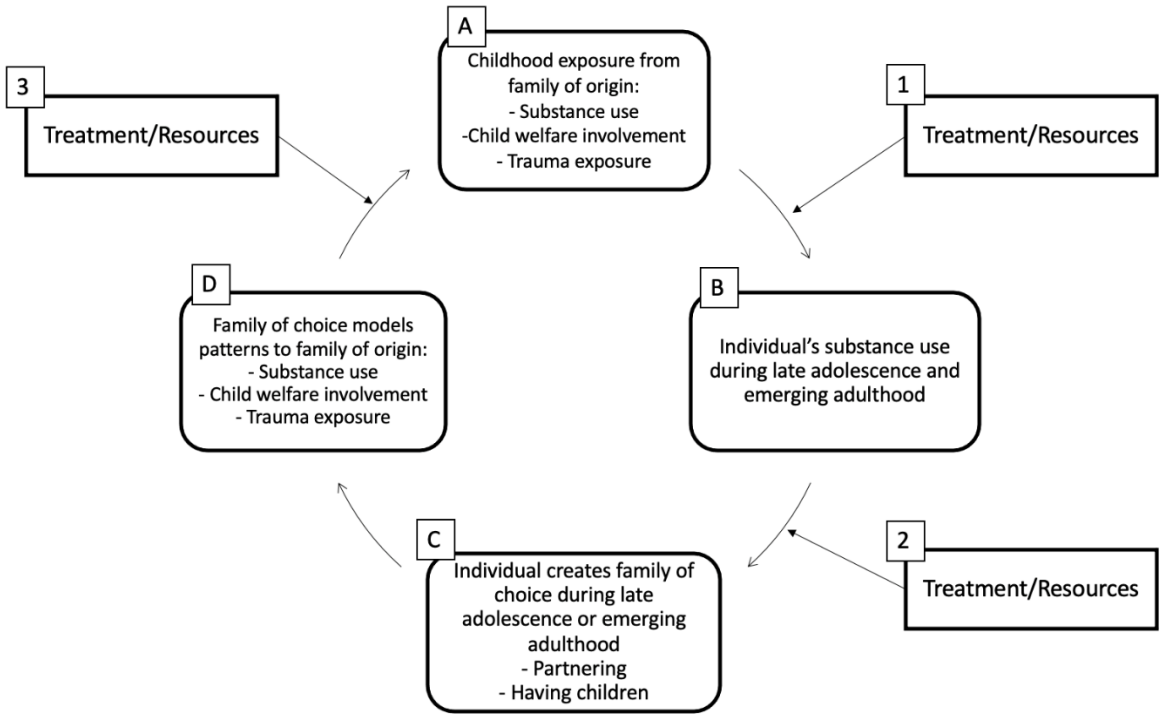

Figure 1. Multigenerational Model of Substance Use

CHAPTER 2. THEORY

Theoretical Framework

The color of our hair and eyes, temperament, and ability to multitask are all examples of things that can be passed down from our families generationally. We are influenced in many ways by our family of origin, including genetic predisposition, learned behaviors, or (mal)adaptive responses to an environment. Regardless of how behavior patterns are passed to our offspring, the cyclical model presented in this paper suggests that there are deep-rooted ties and also suggests behavior replication with life choices like substance use, child welfare involvement, and exposure to traumatic events and experiences. This model was developed utilizing components of Life Course Perspective, 2-Gen Perspective and Family Systems Theory.

These theoretical frameworks reinforce the presented model and each explain a component of the underlying story we see depicted in the lives of individuals. As with any research, there are underlying assumptions that must be understood and acknowledged prior to developing a theoretically-driven model. The first assumption of this generational model is that exposure and utilization of substances, trauma, and child welfare involvement have inherently negative impacts on individual development, relationships, and holistic systems. The second assumption is that individuals who are raised in an environment where substance use occurs, trauma is present, or child welfare involvement is necessary in childhood, are more likely to replicate these behaviors and choices, intentionally and unintentionally, in their adolescence or adult life.

Life Course Perspective

The Life Course Perspective examines the events and experiences of an individual's life and how previously-encountered events influence later-life outcomes (Elder, 1994). There are three overarching considerations this perspective takes into account: ontogenetic development, the influence of time on an individual's life trajectory, and individual change within a larger framework (White & Klein, 2008). While this theory can be implemented and utilized across various fields of study and has a wide array of components, the three focused on for this paper are timing of lives, linked lives, and human agency (Elder, 1994).

The first component is the **timing of lives**. This idea suggests that each individual experiences events throughout development which can impact the person in different ways (Elder, 1994). Timing of lives also suggests that moving through roles and stages, especially in childhood, out of sequence can negatively impact healthy and normative development. Integrating these principles into the multigenerational model, it must considered how children who experience trauma/disadvantage are contextually forced to move through life stages and roles at a faster pace. Many times, when children are raised in homes where substance users are caregivers, there are instances that require children to take on more role responsibility than is developmentally appropriate, due to child maltreatment and neglect. These things look differently depending on the extent of the substance use and the surrounding circumstances. Sometimes, that means caring for themselves through finding, feeding, or providing food, caring for their hygiene, and their education. Other times it also may result in caring for siblings, pets, household responsibilities, and finances. Regardless of the responsibilities, being raised in an environment where caregivers are utilizing substances can result in the child moving through roles at a faster sequence. It is also important to note that typically when a child is required to

take on these responsibilities at a young age they move into partnering and having children at a younger age, which results in the average rate of completing this generational cycle much faster than families who do not experience substance use, child maltreatment, and trauma (Berta, Dorius, Denlinger, & Dooley, 2017). Timing of lives ties into how individuals experience mistimed developmental trajectories due to moving through roles and stages at a faster pace or out of order sequence.

The second principle of Life Course Perspective that contributed to the development of Figure 1 was **linked lives**. This principle considers that humans are innately social beings and their lives are embedded within social relationships (Elder, 1994). The principle of linked lives refers to the interaction between the individual's social world over their life span (Elder, 1994). Within these social relationships, behavior regulation or behavior support occur based on interactions with the surrounding network. These processes are expressed across the life cycle via socialization, behavioral exchange, and generational succession. Generational succession is of particular interest to the cyclical generation model. This suggests that behaviors such as parenting strategies, substance use, employment patterns, education standards, and overall lifestyle are largely learned behaviors that are passed down via generational succession. Another important component of linked lives is that if problems with an individual's development arise, they can become an intergenerational pattern.

The third component of Life Course Perspective integrated into the generational model is **human agency**. The principle of human agency addresses the way individuals make decisions and interact with their environments to create and develop their own life trajectories (Elder, 1994). This principle expresses that within the constraints of their world people are planful and make choices among options that construct their life course. Humans are individuals, and all

have differences, this matters significantly when examining how individuals interact with changing environments, producing a variety of behavioral outcomes (Elder, 1994). When individuals are raised in an environment where substances and maltreatment are present, it tends to put constraints and parameters in place surrounding their decision-making processes that influences their life trajectory. It is also important to note that the act of utilizing substances is a choice made by the individual if they decide to replicate the behavior in their own adult life. Decisions like utilizing substances have influence across an individual's life that lead to a series of further decision-making patterns, and can impact things like employability, educational attainment, housing status, and overall ability to provide for a household (Font, Sattler, & Gershoff, 2018; Kimberlin, Anthony, & Austin, 2009).

Referring back to the cyclical model we now understand how The Life Course Perspective informs the model in three distinct ways: 1) events that happen to an individual impact each person in different ways, 2) humans are social creatures and their environments and social networks surrounding them influence their behavior across the lifespan, and 3) the decisions people make influence the course of their life trajectory (Elder, 1994). The final component that is important when examining the model at an individual level is where the critical timepoints are within the generational cycle. It is impossible to completely prevent exposure for children in situations where substance use and child welfare involvement are present, however there are opportunities for interventions where life choices are present. For example, an individual who has experienced a caregiver utilizing substances or has experienced child maltreatment of some kind, has some critical decision making in their late adolescence and emerging adulthood regarding creating their family of choice and replication of those behaviors they experienced in their own childhood. It is common around this time in development to begin

utilizing substances, pro-creating, deciding on employment, and partnering. This then leads to the family network and how individuals create social ties via pro-creating, cohabiting, marriage, or other forms of bonds.

A Two-Generational Lens

Unfortunately, the Life Course Perspective is most often used to consider periods of times in months, years, and occasionally decades. Central to the conceptual model is the notion of multiple life courses that span generations. 2-Gen Perspective takes into account two generations of individuals, which supports the consideration of the proposed multigenerational approach in this study. This generational mindset can be particularly difficult to navigate when considering the focal question- how do state-provided services best support families (an inherently two-generational lens)? A relatively new approach to thinking about delivering resources and interacting with families from a two-generational model was developed by Ascend at the Aspen Institute in 2014. The focus of this perspective is to place the family unit at the center of the discussion with intervention and support resources and to reimagine how government programs could be reallocated and organized to more effectively target the family as a holistic unit (Aspen Institute, 2020).

Rather than addressing one component of the family unit, one individual, or one point in time, this perspective suggests we incorporate the ‘whole family’ in our conceptualization to better meet family needs, such as minimizing parental stress, strengthening parentings skills, ensuring school readiness for children, increasing social and emotional development for children, improving parent-child relationships, supporting families in increasing income and financial security, supporting their ability to meet basic needs, and creating a stable and secure environment (Aspen Institute, 2020). This approach does not suggest that one agency or program

provides all resources to a family, but instead that the burden of navigating resources should not fall on the family. 2-Gen suggests agencies should network, create partnerships, and work together to navigate and connect families with eligible resources. When utilizing this framework there are many considerations that must be made. Equity and variety across individuals, family systems, class, family composition, race, and ethnicity should be considered and incorporated into all policies, programs, and research developed utilizing this lens. It is also vital that developments from this work incorporate as many individuals within the family unit as possible to most effectively target and wrap resources around them with the goal of better holistic outcomes.

Family Systems Theory

Like the Two-Gen lens, Family Systems Theory is centered on the notion that we must move past thinking about issues like substance use from the perspective of a single person (e.g., the parent, the child, the siblings) and consider the overlapping relationships that influence outcomes. In particular, our model builds from the Family Systems Theory central thesis that individuals are members of a family system and the manner in which systems operate under certain rules and constraints. This theory states that all components of the system are interconnected. Another key component is **spillover**, which encompasses the idea that nothing can occur within a family system without influencing the other components of the system. This is of particular interest when examining how an individual within the family unit may be using substances and not fulfilling their role as caregiver can influence the rest of the familial unit. Another concept that must be considered is the outside factors and influences within the environment that also play a role and have an impact on the system. For example, any **interactions** the family has with the child welfare system, treatment court, law enforcement, or

treatment facilities can impact the overall success or stressors incurred by the unit as a whole. Additionally, familial systems have **subsystems** nested within the larger unit. The subsystem I examine, for this study, within the family unit is the parent-child dyad. It is impossible to examine the subsystem dyad without acknowledging the fact it is nested within the greater system and all have influence on one-another.

The first and arguably the most pivotal assumption present in Family Systems Theory is that all components of a family system are interconnected. Therefore, nothing can occur within a family system in isolation of other individuals or subsystems. There are bonds and different levels of dedication, responsibility, and interaction with each individual within the system. There is constant give-and-take and role negotiation present within a family system to ensure equilibrium of the holistic unit. In order for equilibrium to be maintained there must be a balanced, not necessarily equal, amount of income and expenditures. When a substance user is nested within a family unit there are many behaviors and influences, they will have on the system. Because all individuals within a system are interconnected, their actions will influence each individual differently. Additionally, it is common for substance users to be untrustworthy, (e.g. utilizing capital on substances, lack of follow through on promises, inability to fulfill parenting responsibilities, and difficulties maintaining employment or contributing to the goals of the system) and expend more from a system or network than they deposit or contribute. This unbalanced interaction and dynamic creates disequilibrium and can often cause strain and breakdown in the overall system.

Spillover is another significant contributing factor to the notion that individuals and subsystems influence the entirety of the family system. This is especially important to address and consider, not only the choices that an individual makes but also the circumstances that occur

to an individual can spillover to the entire family. By having someone who is utilizing substances residing in the family unit, their choices and stressors will influence others in direct and indirect ways. For example, in a two-parent household where one parent is utilizing substances, a large amount of stress, parenting, and household burden tends to be placed on the other adult. This creates a system working at a constant deficit, oftentimes influencing children unintentionally via lack of resources to provide, lack of presence with healthy parenting strategies, and exposure to environments unhealthy for a child. There is then spillover and broken trust and confusion between the parent utilizing substances and the children as well. The complexity of substance use ripples and spills over rapidly and drastically throughout the family system. Sometimes this results in the need for firmer or clearer boundaries between individuals, subsystems, and the surrounding family unit. Boundaries can assist in protecting from unhealthy exposure from the environment, but also sometimes from exposure within the family unit itself.

Purpose and Goals of this Study

In this dissertation, I seek to better understand the multigenerational cycle of substance use and child removals from the parent's perspective. Both of these topics will be viewed through a cyclical multigenerational influence model (Figure 1) as self-reported by parents in our study. The current study strives to answer the following research questions:

1. Utilizing the multigenerational model (Figure 1) as a framing device, is there a typical cycle of substance use and child removals among parents in the sample, and does it correspond with the model?
    a. What are the experiences of individuals' in their family of origin with substance use, trauma exposure, and child welfare involvement?

b. What are the experiences of individuals' substance use in adolescence and emerging adulthood?
c. What are the experiences of individuals' partnering and childbearing in adolescence and emerging adulthood?
d. What are the experiences of individuals' in their family of choice with substance use, trauma exposure, and child welfare involvement?
e. How are treatment/resources offered to individuals throughout their life trajectory and at what time points are these treatment/resources offered?

2. What are the experiences, interactions, and reflections of families with the child welfare system and what positive or negative consequences does that have on achieving the child welfare goal of family permanency?

CHAPTER 3. METHODS

The data utilized for this secondary analysis were collected for the purpose of a program evaluation conducted for the Iowa Department of Public Health by Iowa State University in partnership with Iowa Department of Human Resources. As this was a program evaluation, the study was exempt from IRB. For the purpose of this project, I obtained anonymized files for re-analysis after the initial program evaluation was completed.

Data Collection Plan

Individuals involved with illicit substances can prove difficult to recruit and establish rapport with, which was crucial to promote rich and informative interviews. To this end, the Iowa State University research team strategized how to address this sensitive topic through brainstorming and integration of key stakeholders from the Bureau of Substance Abuse and the Family Development and Self Sufficiency (FaDSS) program (see Dorius, Dorius, Rouse, Richey, Talbert, Van Selous, and Bahe, 2020). Together, this state-university partnership brainstormed ideas for the interview protocol and established recruitment and incentive strategies. An extensive literature review was conducted, as well as a quantitative assessment of publicly available data (e.g., Census data and Robert Wood Johnson County Indicators data) on the social, economic, and demographic context surrounding substances users in Iowa to identify the key components to be included in the interview protocol. This interview protocol was derived from a thorough literature review regarding family, community, church, vocation, and way of life. Following these stakeholder meetings, the research team was able to refine and finalize an interview protocol, recruitment strategy, and incentive plan.

Sampling

For the initial program evaluation, there were four modes of recruitment developed and utilized with this study. In the **first** strategy, project leaders contacted treatment centers and spoke with administrators about the possibility of attending one of their outpatient meetings to meet potential participants, explain the project, and recruit individuals to participate. If the administrators were willing, one or two research team members attended as silent observers throughout the outpatient treatment meetings and watched for patients who met our inclusion criteria, including a history of substance use and having minor children. Following these meetings team members explained the project to the applicable individuals and inquired about their interest. This method of recruitment resulted in five interviews. The **second** recruitment strategy was developed from the initial partnership with the FaDSS program. A screening question asked of all new participants in FaDSS is whether they, or someone in their family, had a history of substance use. This list was generously shared with an intern placed in the department who worked on behalf of FaDSS. A comprehensive procedure was followed to blind results from FaDSS to preserve client confidentiality. The intern attempted to call and invite each of the 250 individuals from the screening question list to participate in the study. A carefully developed script, approved by the university team and FaDSS program, was used when reaching out to each family. Of the 250 individuals who screened in as possible participants 75 did not have a phone number listed, 35 phone numbers were disconnected, and 25 resulted in wrong numbers. The remaining 115 individuals resulted in 23 successful contacts that agreed to participate in the study, resulting in a final completion of 21 interviews. The **third** strategy resulted in eight participant interviews via collaboration with the Iowa Harm Reduction Coalition

(IHRC). Through this collaboration IHRC agreed to post information about the study to their Facebook page that included the work email and phone number of the faculty leader on the project. This recruitment method was effective in providing our sample with several individuals currently utilizing substances, especially intravenously, which added a critical addition to the overall data. The **fourth** recruitment strategy leveraged previously interviewed participants via snowball sampling. Each participant was asked if they knew any other parents with a history of substance use who might be interested to participate in the study. Nine participants were recruited using this method.

All participants were asked if they were interested in participating in a study about families and substance use. The participant could choose whether they would like the interview to take place in their home or their community. They were told the interviews would last approximately 90 minutes and would include questions about their life story and how substances have impacted them. Participants were informed that all information collected during the interview would be recorded and kept confidential. Following the interview, participants received a $40 gift card to a grocery store or gas station as compensation for their participation.

A total of 43 individuals were recruited across all four sampling strategies. The sampling strategy was not intended to geographically represent the entire state of Iowa, however the sample included 18 of 99 counties, including urban and rural populations. Individual interviews were conducted with each participant as well as two sets of couples who also completed individual interviews. Thirty-three of the participants self-identified as white, three as mixed-race, two as African-Americans, and four as Latino. Four of the participants were under the age of 25, seven were in their mid-to late twenties, roughly half of the participants were in their thirties, and ten were over the age of forty.

Ninety percent of the participants were parents of at least one child, with one participant having six children. Of these parents, 73 percent of them had their children removed from their home for some period of time. These removals varied from shorter removals of a couple weeks while the parent got into treatment, and some resulted in adoption or permanent loss of custody. Of the children that were removed 90 percent had DHS involvement of some kind and 10 percent either lost custody to another parent or it was unclear why the children were not currently living with the interviewee. Twenty-nine percent of the participants were removed from their own homes in their childhood, resulting in **83 percent of the people who were removed as children also had their own children removed as parents**. This highlights the multigenerational nature of substance use and child welfare involvement and speaks to the difficulty's substance users face when it comes to effectively caring for and parenting their children.

Data Collection

The interview protocol included questions about the way family members affect and are affected by substance use. Research targeting individuals who partake in substance use has proven to be an incredibly difficult population to recruit due to a variety of facets including fear of judgement, retaliation, and concern of admitting to taking part in illegal activities. In order to combat the barrier of entry to connect with this population, the ISU data collection team conducted many rigorous processes when determining a sample selection protocol and prior to conducting interviews: all research team staff completed human subjects training and participated in workshops and discussions on how to engage safely and ethically with vulnerable populations.

The original program evaluation data collection began in February 2019 and continued through August of the same year. During this time period, 44 interviews were collected. After initial contact was made, a post-doctoral intern scheduled the time, date, and location of the interviews and paired each participant with two interviewers. Qualitative interviews of participants were conducted utilizing a phenomenological framework, designed to help researchers understand an individual's lived experiences as well as explore the meaning people assign to their experiences by examining related reflections and perceptions (Bloomberg & Volpe, 2015). Prior to each interviews beginning, discussion of the informed consent and notification that participants could refuse to respond to any and all questions they felt uncomfortable discussing was given. Participants were also given the opportunity to choose their own pseudonym to be referred to throughout the interview and research process. Following this, the participants were notified that the audio recorder was being turned on and the first question was asked. A semi-structured interview protocol was utilized in qualitative interviews with all participants. The purpose of the protocol was to target and elicit responses and discussion surrounding the social context of their relationship with substance use. Due to the significance surrounding generational impacts on childhood, development, and general life skills, a significant portion of the questions surrounded the participants' family of origin (the family of one's childhood) and childhood experiences. To target the family of choice (the family created as an adult) and the influence drug use has had on the individual's current family setting questions were also asked about the effects and impacts substance use has had on their current living, working, and family situations. Every interview began by asking participants to tell the story of their lives. This tailored the setting for the interviewer to ask follow-up questions on important events, details, and values of their life. Most interviews addressed a majority of the interview

protocol by simply asking follow-up questions from their life story and then addressed the few areas that may have not been touched on towards the end of the interview.

In addition to addressing the individual's family life from childhood to current setting the protocol asked questions regarding their communities, employment history, beliefs, involvement in religious institutions (in childhood and currently), and what a typical daily routine looks like for them. Occasionally, discussing family and relationships that substance use had influenced brought up emotional responses such as tears or pauses to consider responses, however there was never a scenario where a participant refused to answer a question. Although this rarely happened, in situations where participants became emotional, interviewers were compassionate and allow the conversation to be directed away from the current topic if they sensed the participant was uncomfortable. Finally, interviewers intentionally avoided in-depth probing questions regarding their substance use and focused primarily on the impacts their substance use had on many areas of their lives and social networks.

Secondary data analysis for this study began by utilizing emerging themes, field notes, and individual profiles of ten participants that were selected based on their interactions with substances, recollection and discussion of their own childhood experiences with substances and child welfare, and their description of their family of choice and parenting events. Narratives regarding these individuals' lives were then developed compiling the interview settings described in the field notes, their life trajectory utilizing their profiles – tailored to the emerging themes, and quotes from their interviews to richly depict these individuals lived experiences. These in-depth narratives were utilized to discuss thematic findings and describe each individual's reflections and experiences regarding substances and child welfare.

Analytic Plan

All interviews were read and preliminarily coded into experience clusters prior to sample selection. Utilizing preliminary coding and demographic information, a table for the study was developed to summarize basic characteristics of participants (see Table 1 in appendix). I then added information regarding the number of children, whether or not they had child welfare involvement with their children, and if it was clear or discussed that child protective services were involved in their own childhood (See Appendix A). Of the 40 participants, four were excluded in the first round of selection due to not having children. Individuals were then selected only if they had experienced child welfare involvement as a child or with their own children, this eliminated another eight individuals. From the remaining thirty-one interviews, individuals who had experienced both child welfare involvement in their own childhood and with their children as an adult (n=11) were reviewed for depth of description and applicability to overall themes and reflection. Six of these eleven interviews contribute to our final sample. Both couples that were interviewed had child welfare involvement with their own children and were added to the sample to provide multiple perspectives on interactions throughout an open case plan. One individual from the couple interviews were previously selected to be one of the six initially selected participants, resulting in three unique individuals being added (n=9). This resulted in a final sample of nine individuals, of which two were couples, totaling nine individual and two couple interviews (eleven transcripts and eleven field notes) that were utilized as the key data for this study (See Appendix B).

Once the sample was selected, all interviews were iteratively coded to identify emergent themes surrounding generational patterns of substance use and child welfare involvement. Open and in vivo/verbatim coding strategies were utilized to perform a confirmatory analysis

specifically examining generational patterns of substance use and child welfare involvement to ensure the participant's lived experiences were accurately captured in my conceptual model, or to note how the model should be modified. Each interview was coded utilizing an iterative process of reading and reflecting on the experiences of the interviewees until no new themes emerged and saturation was achieved surrounding child welfare experiences. Emerging themes were then organized and presented in Chapter 5 in ways that most honored the participants' voices, reflected the range of unique experiences, and provided the most cohesive and representative story regarding substance use and child welfare involvement (Saldaña, 2015).

The second method incorporated an exploratory analysis utilizing phenomenological strategies, designed to help researchers understand an individual's lived experiences as well as explore the meaning people assign to their experiences by examining related reflections and perceptions (Bloomberg & Volpe, 2016). Each interview was then developed into singular, human-centered narratives for each participant that were written as a five-to-six-page profile utilizing context provided from interview notes, direct quotes to highlight individuals' voices and experiences, and overall life trajectory and events expressed throughout the conversations with participants. These profiles are utilized to provide illustrative examples in chapters 4 and 5.

Finally, in an effort to test the conceptual model, each participants' life experiences were compiled into tables to represent each component of the model to test the typical pattern observed across generations. The first table (box A) examines the exposure to substance use, trauma, and child welfare involvement our participant experienced during their childhood in their family or origin. The second table (box B) shares the patterns of substance use the participants followed in adolescence and emerging adulthood. The third table (box C) explores patterns of partnering/romantic relationships and childbearing experienced by our participants. The fourth

table (box D) looks at the exposure of substance use, trauma, and child welfare in the individual's family of choice, and ultimately restarting the cycle of exposure with an additional generation of children being exposed in the family of choice. Finally, table 5 (boxes 1-3) present the treatment that the individual came into contact with and shared with us during their interviews. Following the coding of this sample a comparative analysis was done with the initial coding table (Appendix A) to examine the continuity of findings across the selected sample and the larger study. This was done to ensure the participants in this study were not outliers and the overall generational trajectory was similar across all 40 participants. All results were reviewed by three faculty members that are on the collaboration project to ensure continuity of findings and overall rigor.

The study is limited in terms of its generalizability, as it was a non-random sample of biological parent substance users in a mid-west state. It was further limited in that the interview protocol was not designed to focus on child removals, and as such, in-depth exploration of some relevant topics were not possible. One of the goals for data collection was to examine substance use in a mostly rural sample within one state, while this does limit the generalizability of results it also allows for replication and further exploration across other populations. Another challenge that arose throughout data analysis was that the initial interview protocol was not designed to capture in-depth child welfare involvement, resulting in a lack of clarity in exact trajectories of participants who experienced child welfare involvement as children. For example, there were several participants that indicated their children were not residing with them anymore, but it was unclear if custody arrangements, child welfare involvement, or voluntary placement were the root of the children being placed elsewhere. Finally, it is important to consider the extent to which the individuals discussed in the results are biologically related to one another to

understand the amount of epigenetic transmission that could occur. Every interviewee was the biological parent of the children discussed in the narratives to follow. A more comprehensive look at caregivers generally could strengthen the value of this work in the overall literature.

CHAPTER 4. MULTIGENERATIONAL MODEL RESULTS

It is not uncommon for traditions, patterns, and genetic traits to be passed down from generation to generation. Many times, these can be positive holiday traditions or fun parenting ideas, however this can also mean we pass down unhealthy habits and destructive relationship patterns. This chapter will utilize a confirmatory analysis to address research question one: Utilizing the multigenerational model (Figure 1) as a framing device, is there a typical cycle of substance use and child removals among parents in the sample, and does it correspond with the model? Multiple qualitative approaches were incorporated in an effort to answer this question, including a brief recap of the model, descriptive stories of two individual's lives to represent an ethnographic lens allowing their stories to depict the proposed model. Finally, each component of the model will be broken down and all nine participants' experiences at each time point will be presented and discussed. The cycle will then be related to the original, larger sample in the conclusion of this chapter.

Although the focus of these interviews was to examine individuals' substance use patterns from a two generational lens and was not about child removals specifically, there was a clear theme that emerged regarding child welfare involvement, which will be the focus of the following stories and results. It is also important to note that trauma was central to every story we heard; every single participant that shared their substance use history also shared stories of extreme family, economic, and housing instability and traumatic events including family members passing away, intimate partner violence, sexual abuse, the removal of their children, homelessness, or severe food insecurity.

Generational Model of Typical Cycle for Substance Use, Trauma, And Child Welfare Involvement

Figure 1 was developed to help understand the nature of childhood exposure and whether it is passed on and replicated as the individual ages. As you can see in box A individuals are exposed to a variety of behaviors and experiences ranging from substance use, child welfare involvement, and overall trauma. Moving to box B I examine if individuals begin experimenting with substances while they are still in their adolescence. In box C I explore if individuals face disadvantage, and what patterns are present with partnering/marriage/cohabiting and childbearing. Box D in Figure 1 seeks to understand if the substance use, child welfare involvement, and trauma may be replicated in their adult lives, which could potentially result in the multigenerational cycle beginning again with their own children being exposed to these same disadvantages.

This chapter will present the confirmatory results to research question one, through a series of in-depth views into participants' lives followed by a short description of how their lives may be described utilizing the multigenerational cycle substance use model (Figure 1). Chapter 4 will conclude with discussion of detailed descriptions of how each of the nine participants were impacted by substance use, child welfare, and trauma at each of the given time points displayed in Figure 1. Chapter 5 will then be used to describe the exploratory analysis in an effort to expand this focus and explore how resources and family support might help to break this cycle.

Illustrative Examples of the Multigenerational Model

The following section provides illustrative and ethnographic depictions of Bailey's and Courtney's stories surrounding substance use. The purpose of these stories is to give an in-depth

look of how these individuals move through the multigenerational model presented above. How significant is exposure to substances, trauma, and child welfare in these individuals' lives? How many things did they experience that are outside of their control and what are active choices made within their control? How many of these individuals' experiences in their childhood or adolescence are replicated in their adult lives, resulting in another generation of exposure? These are all questions that were utilized as framing devices for sharing these lived experiences.

Bailey's Story

When Bailey sat down for her interview, she wore a t-shirt, tousled clothing, and was partially covered by a blanket. Bailey began the interview a bit groggy and slightly reserved but seemed to warm up and began to engage. She seemed to be sad during the interview and she sometimes talked in the third person, appearing to detach from previous experiences, when discussing her childhood experiences. She exhibited a wide array of emotions as she spoke, including happiness, sadness, anger, confusion, and pride.

"My birth mom, she gave us up for drugs." So begins Bailey's story of multigenerational substance use which illustrates the key concepts of Figure 1. Bailey describes how she was removed from her home and placed in foster care as a young child due to her mother's substance use, her powerful intervention of being adopted and raised by a religious family, how she became addicted to drugs as a teenager (an addiction that has continued throughout her life), and how her substance use has led to the removal of her own children. After living their lives apart for the last twenty years, Bailey now lives in the same apartment complex as her birth mother, where they both continue to struggle with substance use. Although their lives have taken similar paths following childbearing, Bailey views the DHS involvement and child removal in her own

childhood through a negative light though mentions very little responsibility for the removal of her own children.

Bailey began her life feeling and knowing she was unwanted by her birth mother when weighed against her substance use. Intervention for Bailey's mother was deployed in a fairly quick fashion resulting in her permanent removal from her birth mother. *"I was adopted when I was 2… I have seven [adopted] siblings and I am the youngest of all of them."* Bailey grew up in a two parent, Christian home following her adoption. "*We've been going to church, a Christian church my whole entire life. And so, it was like we were going from like Christian school, Christian church, so, and cause everybody looked at you like you had like the perfect family."*

Bailey was also asked about any biological siblings she has and she described fairly strained relationships with them.

> *Yep, I have two. I have a sister and a brother, and they are both older. And one lives in [location], and I think my sister she lives in [location] now, so, cause her middle son - her--his family lives in [location], so, they are all together in [location] so, yeah. We don't talk. And before I moved to [location], we, me and my brother got into and he put his hands on me, so I don't talk to him at all. And I don't talk to my sister at all either. So, it's way different not to [talk to them].*

Bailey describes her childhood as a perfect one following her adoption. Her family was very close and were always together. *"We went to Christian school from preschool to high school. I did band in the public school, and I did sports, I was all into sports. Sports my whole entire school. All of them; softball, basketball, um soccer, track, volleyball, everything. Like I did everything. Like I was never, like I was never home."* During high school Bailey had one of her healthy outlets of athletics taken from her following a repeated injury that required her to stop training. She reflects on this being an extremely challenging part of her childhood.

> *And then I tore my ACL three times. And the last time my doctors like you can't do any more. So, I just, I was pissed, because that was my life. Sports were my life. I did everything, so once he said no you can't do it anymore, I was like, ah man, it was*

> *horrible. Because I was used to getting up every day, doing like whatever training and stuff, to getting up and just doing nothing, and that was the hard part--hard part--of my life.*

Following high school Bailey attended some college and ended up dropping out and joining the work force at the age of 20. She met a man through her work connections and ended up getting pregnant unexpectedly.

> *Um, well her dad, I met her dad when I was working in [location], and I didn't even know I was pregnant. I was like eight weeks pregnant when I found out that I was pregnant with her. And I told him, and he was excited at first, but, then he just like walked away, and so I raised her my whole entire life. From twenty on I raised her by myself, so, it was hard, but it was fun. I mean because It was like having a little mini me, so, she looks just like me, yeah.*

At the age of 24, Bailey got pregnant with her second child from another man.

> *My son--we had--he was planned. So, my daughter wasn't planned but my son was. And, that was my first experience having a boy, and like, having siblings who had boys, I was like oh it's not that hard. Yeah, it was hard. Yeah. When they say boys and girls are different--oh yeah--they are very different. You would never sleep at all. I'm like okay, I'm done having kids. Nope, no more, so, I was fine with having a boy and a girl. That was my plan, so I got fixed after I had my son, so, and he looks just like his dad..*

Bailey's son's father became violent and she was adamant she did not want her children growing up seeing their mother experience domestic violence, so she left him and never looked back.

> *He, um, was abusive. So, he would put his hands on me like every day when we were together. We were together for three years, so, and I was the only one working. So, when I would come home from work, he would abuse me and everything. So, it was hard to have my kids see that. And I didn't want them to see that, so I was like nope, I'm done. So, I was done after that.*

In 2016, the news of Bailey's adoptive mother's cancer diagnosis was as a catalyst that led to her beginning to use substances consistently.

> *Because we found out my mom had cancer in 2016, so after that is when I started. Because I, you know like all of us kids, um once we found out we all were devastated, like I wanted to kill myself. Cause I was like no this is my best friend. I can't talk about that.*

Bailey remembers when her mom passed away her family fell apart completely. Bailey shared that watching her mom pass away was extremely traumatic for her and exacerbated her substance use. Bailey's substance use led to the involvement of child protective services in their household to offer protections and safety for her children. She said that someone suspected she was using drugs, but she hadn't used in a while.

> *Uh-huh. Like she was on floor--she was--I was sleeping, and there was a knock on the door, and I thought it was the cops, because they had the cop knock. You know I was just like who's at the door, you know? And I just opened the door, and--they started—they said they were DHS. So, we had to make a plan of not to use in front of her, and we weren't, at all. And then, even doing it, you have to take a test. You know like, after they have twenty days to do an evaluation. So, with the test that you have to take, like either hair test, like they cut your hair. Or there's like a patch you have to wear for twenty days, and like it will tell you, like you have to keep it on for twenty days. And you have to, if it's like all dirty when they get it back then, you know, you can tell someone is using, or not. And I didn't pass the test.*

Due to Bailey failing her drug test her daughter was removed and placed with her friend. Bailey's son was removed and placed with his father in a different state, and they talk almost daily. Bailey made sure to emphasize during her interview how great her daughter was doing in her friend's care.

> *She's going to school still. She's doing Girl Scouts and everything, so she's, she's having fun there. Cause when she's here, she's, like it's boring here, ya know? When they don't have school. She has nothing to do. But at [Friend's] house ya know? There's toys and [Friend's] daughters are her age. So, she has more fun over there, and that's what I want. I don't want her to be ya know? not to have fun, so.*

When we map Bailey's life onto the proposed model, she had early childhood exposure to substances while still residing with her biological mother. However, early intervention was put in place and she was removed as an infant and adopted by the age of two years old. Ideally, this type of massive early intervention would change the trajectory of Bailey's life, but in this case the intervention was only successful until the death of her adoptive mother. It appears her being adopted gave her a great childhood with a healthy home life and many great extracurricular

activities. There were three main life events that Bailey seemed to emphasize in her story that contributed to her drug use, her loss of sports due to the ACL injury removed one of Bailey's most cherished outlets and coping mechanisms. Following her injury, she had two traumatic events; the death of her adoptive mother and the removal of her children that seemed to escalate her substance use. Both of Bailey's children were exposed to her substance use, removed from her care by child welfare, and experienced living in a domestic violence situation. Although Bailey has had the opportunity to utilize resources from the child welfare system to attempt to get her children back in her care, at this time it does not appear she chose to do so.

Bailey is currently unemployed and is living in the same apartment complex as her biological mother, who is still using substances. Bailey spends each day differently depending on how she feels, some days she hangs out with her daughter and sometimes she feels like she sleeps all day. It is believed Bailey is still using substances due to a drug deal occurring during the interview, resulting in the interview being discontinued for the safety of the interviewers. At one point during the interview Bailey explained that she had rehab all set up but made no indication of when she planned to attend treatment. Ultimately, Bailey has found herself in a very similar path that she resented her biological mother for being on. Bailey experienced her mother choosing substance use over caring for her, and Bailey is now in a very similar situation with her own children.

Courtney's Story

Courtney's life has been a whirlwind of substance use, run-ins with law enforcement, and battles for custody of her children. Throughout the interview, the pain and weight of her life is evident as tears well in her eyes, however she maintains her composure while she depicts the story of her life. Courtney sat in the same position and displayed comfortable body language as

she talked with interviewers. Courtney was most detailed and passionate when talking about her family. Courtney has many tattoos that were visible throughout the interview and was slightly overweight. Her home was relatively large and very messy and cluttered with children's toys and unfolded laundry. Many of the doorways and windows had blankets over them as makeshift doors and curtains.

Growing up on a farm Courtney lived with her mom, brothers, and stepfather. Throughout her childhood Courtney was placed in unsafe living environments due to substance use and physical abuse. Courtney was close with her mom despite her mother's use of substances, but she had an extremely unhealthy and abusive relationship with her stepfather.

> *When I was eight, he started molesting me and that lasted until I was twelve. My mother took my brothers and I to California to see our cousin born and we came back. [Stepdad] kinda blurted out, and I'm not your fucking father anyways and that's when I learned that my, the man that raised me wasn't my father. Um, DHS was involved a lot, but they never took us, which I found out later was because my mother was having intimate relations with the DHS worker on several different occasions.*

At some point during Courtney's preteen years her biological mom decided she couldn't care for her and her brother anymore, so her aunt decided to take them in. While Courtney was with her aunt from the age 14 to 18, her life was great and the best it had been throughout her childhood. Although not living with her mother anymore seemed difficult for Courtney, she really valued how well her aunt cared for her and her brother. They were well fed, clothed, and taken care of. Courtney struggled to make friends throughout her childhood and recounts actually having the opportunity to build friendships when she changed schools to live with her aunt. Although Courtney described her teen years as the best of her childhood, she began to display rebellious behaviors and attributed much of this to the age she was removed from her mother.

At the age of 14 Courtney's journey with substance use began with cannabis and she started to run away. Courtney got in trouble for several things throughout high school including

getting caught having sex in school. Towards the end of high school Courtney found out that her biological father was looking for her and her brother via her grandfather. She chose to drop out of her school during her senior year and her aunt gave her a ticket to finally meet her biological father in Florida. She had struggled enough in school and been in trouble frequently, so she chose to go to Florida and meet her father and never went back to school after that.

> *And I met him when I was eighteen and that was just, my childhood was really messed up. My father was blocked from ever having any contact with us, whatsoever. When my mother found out that my biological father was in communication with my grandfather, she cut all communication with our grandfather, which was really hard because he was my reprieve.*

Courtney decided that since she had dropped out of high school she would continue to study to get her GED, but that got delayed when she got in trouble with the law and ended up in jail.

> *My ex at the time, well my boy, fiancé at the time, [fiancé], tried robbing to pay my management credit counselors and his mom, two of his ex-girlfriends, one of his aunts, and two of his sisters, and a whole bunch of his family are all clients at this place. They know him. He walked in with a mask over his face and they're like, [fiancé], please tell me this is a joke. I'm not [fiancé]. And because I was sitting in the car and claimed the gun as mine, I ended up spending three months in [County Name] County Jail on armed robbery. And I ended up with two felony charges, um, conspiracy to commit robbery in the first degree and extortion. That's what I had to plead guilty to get out.*

Following her time in jail Courtney tried to get back on her feet by getting her GED and gaining employment.

> *And then I got my GED, got a job, which is where I met my first husband and we ended up getting together and got pregnant right away. And had [Son] when I was twenty and then I had [Daughter] when I was twenty-three and then my new one.*

Courtney admitted that she was using drugs off and on while she was pregnant with both of these pregnancies. She ended up losing custody of her oldest two children when child protective services informed her if she could not provide a safe place for her kids, they would remove them from her care. This served as an accelerant for her substance use and she became

heavily addicted to her two main drugs of choice, methamphetamine and cannabis. Following her children's removal, she consulted with her lawyer, and was informed that she only had a 5 percent chance of getting her kids back due to her long-standing drug history and previous felony charges. At that point, Courtney chose to place her children for adoption when she agreed for their current foster mother to care for and adopt them because she acknowledged she wasn't in a position to care for them. Courtney emotionally recounted this time in her life,

> *Um, long story. My, I was living in Mississippi with my ex-husband and my boyfriend. And my ex-husband was not paying the power bill like he was supposed to, so the power got cut off at like six hundred dollars. I was in the process of finding work when the power got cut off. I took my kids to my cousin's house and DHS got involved anyways and said, If you can't find some place safe for your kids to go then we're going to have to take them from you and you won't get them back this time. So, I took the last hundred dollars that I had and brought them to my brother in Iowa. Well within three months my brother turned them over to DHS. And because I was addicted to methamphetamine and in an abusive relationship. I had gone and talked to, I was up here dealing with my kids and I talked to my lawyer and asked her what kind of chance I have of getting my kids back. And when she told me I had prob, she'd give me less than five percent chance, I called the foster mom and I talked, I asked her if I could talk to her. So, we met for lunch and I asked her just, it. I didn't even know what I was going to talk, well I didn't even know what I was going to say to her. You know, this woman's been caring for my children for a year and I'm no closer to progress, getting them back. And I just blurted out, 'Will you adopt my kids?' And she didn't even think about it. Her answer was, "yes" immediately. Within a matter of a heartbeat she said, "yes". And when we told the kids that they were being adopted and everything was going to be finalized. They were fine with it. They, they've had grown a relationship with the woman, and they were home. They had a family. They had smiles. They had love. They had laughter. They had everything they needed and then some. And I couldn't see where it would be right for me to take that from my kids. So, they got adopted in July, we terminated…[Courtney begins to cry] .Sorry.*

Courtney has four biological children and three stepchildren, the youngest of whom still lives with her. Her most recent and final biological child is three years old and had problems during pregnancy. Courtney was put on Zoloft during the pregnancy which caused the baby to have hypoglycemia when he was born. He also tested positive for opiates in his system at birth. Courtney also has three stepchildren with one of them being her niece because her current

partner had a relationship with her sister. Courtney lives with the four children, her current partner, her sister (also her current partner's ex), and her sister's boyfriend.

> *All of them. [Son] is eighteen. He's my oldest. Well not my oldest, but I had a little girl when I was eighteen and I gave her up for adoption. She'll be twenty-one this year. I have a daughter old enough to drink. Um, [Son] is eighteen. He is from my previous marriage. My one and only previous marriage. And then there's [Daughter] who is my beautiful little girl. She just turned fifteen. She'll be sixteen in August. And then, there's [Son] who is three. My last final and I'm done. No more babies. The stepchildren are [Stepchild], who is eight, and [Stepchild] who is five, and then our bonus baby who is [Stepchild], who is also three. She was born in September and [Son] was born in July.*

Courtney has had several ongoing cases with child welfare because she has a consistent pattern of using cannabis and meth. That is not to say she hasn't sought treatment. Whenever she was involved in treatment programs, she was sober long enough to satisfy the requirements of her case plan so that she could have her children back. Her youngest biological son has a current case with child welfare because of cannabis in the home.

> *Um, we had somebody we thought was friends come over and hang out, and while they were there, they wanted to smoke a cigarette. And they don't, they don't smoke weed. But we went in the bedroom and I lit up my blunt, they lit up their cigarettes, we all smoked, and within three days we had DHS knocking on the door. Because our so-called friends told DHS that we were smoking methamphetamine, crack cocaine, and marijuana in the living room with the kids running around. So, all four of the kids got tested. Only one came back dirty and that was my fault. So, we had to go through, um, abstinence, obviously, um, drug counseling, therapy, which we still do therapy because we both have mental health issues that need addressed. Um, I've got major depression. What is it called? Major depressive order with psychotic features, which I take Haldol for every day. If I don't take my Haldol, I'm a raging bitch. To say the least. Um. It's hard to say. I knew it was something that we had to do, so it was the less, lesser of two evils. Do the counseling or lose my kids again? So, it was a pretty easy decision to make. But as soon as the paperwork was finalized, we went right back to smoking. Just because I have fibromyalgia and the marijuana helps a lot with the pain and muscle spasms and irritable bowel syndrome and everything else that goes along with fibromyalgia. I don't know if you are familiar with it, but it's got a symptoms list that's like ten feet long. Everything from irritable bowel to depression to mental health issues to pain everywhere. I mean my sister reached over the seat one day and just poked me in my shoulder like that and it was like. You broke my arm bitch. So. But marijuana is just, that's our way of coping, so.*

Courtney still smokes cannabis regularly and occasionally still uses meth. She does not plan on ever stopping her cannabis use but hopes to someday end her meth use. Courtney said that she currently only uses meth when she has the money to pay for it, which is every few months or so. Courtney also mentioned that she had previously used sex as a way to get drugs and once got pregnant by her dealer. When asked what she would like her substance use to look like moving forward in her life she stated,

> *Hopefully not doing meth anymore. That, I mean I, I don't even know why we did it, why we do it, because it's just, it just keeps us up all night and we end up, just, I mean, there's good things to it.*

Courtney utilizes substances for physical and mental health purposes but finds more benefits from cannabis use than meth use.

Aside from the people she lives with, Courtney has very little familial support which makes getting sober or making life changes difficult.

> *Um, I've been, I have no contact with either one, either one of my parents. I mean no contact. Literally. The last time I had contact with my biological mother was at my grandfather's, no. I take that back. Was at the hospital. When my cousin lost her grandma. Um, didn't know, didn't say anything to me, didn't even look at me. Acted like I was a total stranger, which is fine by me. Last time she had contact with me she ripped up my birth certificate and mailed it to me. Yeah. My biological father is; he came up here two Christmas's ago from Mississippi.*

Overall, substance use has played a significant role in Courtney's life since she began using in high school. She has had many resources offered and mandated to her by child welfare, however she has only been able to remain in custody of one of her four children who currently has an active child protective services case. Courtney desires to stop using meth but will probably never stop utilizing cannabis.

Multigenerational Transmission of Substance Use

In this section I utilize methodological strategies to provide real life examples and lived experiences from nine interview participants. These themes and patterns are then presented utilizing the theoretical model lens proposed in this paper. Each box represents an influential life period that is explored below; beginning with childhood exposure from family of origin (box A), followed by the onset of substance exploration, use, and potentially abuse during late adolescence and emerging adulthood (box B), then exploring the creation of the individual's family of choice (box C), finally exploring the exposure to substances, trauma, and child welfare from family of choice (box D). Additionally, an examination of the described resources and treatment offered at critical timepoints are discussed.

Childhood Exposure from Family of Origin

Several themes emerged throughout the examination of data and coding each participant through the conceptual lens outlined in Figure 1. As illustrated in Table 2, each participant had some form of traumatic event or exposure in their childhood. This ranged from death of a close friend or family member to sexual assault and various other traumatic experiences. Not only did every individual experience trauma, six out of nine participants were exposed to substance use by a caregiver in their childhood. Many times, caregivers utilizing substances, and having them in the home, provided our participants with easier access to tobacco, alcohol, cannabis, or illicit drugs. Finally, six out of nine participants experienced child welfare involvement, of the three participants that did not describe child welfare involvement two out of three described experiences where requirements would have been satisfied for child welfare to be involved.

All of these experiences accumulate with beginning their lives in disadvantage. Many times, throughout childhood, these individuals witness domestic violence and unhealthy

relationship patterns, they watch their parents struggle financially resulting in housing instability and food insecurity, and sometimes are even removed from their primary caregivers in order to seek a safer and more stable environment. Unfortunately, this also leaves unresolved trauma and experiences that are carried into adulthood and oftentimes replicated later in life.

Table 2: Childhood Exposure from Family of Origin

	Substance Use	Child Removal/DHS	Trauma
Amy	Addiction runs in the family - her mom uses actively, and her brothers are in recovery. Her grandfather was an alcoholic.	When Amy was 10 her and her siblings were removed from their mom's care. Amy and her two brothers lived with their grandparents; her younger sister lived with her dad. Her grandma was a stay-at-home mom and her grandfather worked in construction. She believes she was better raised by her grandparents but also noted she feels she was adopted at a bad age because she just wanted to be with her mom.	Amy's childhood had high mobility and little supervision. Amy's mom had numerous boyfriends in and out of the home. Each of Amy's siblings have a different dad and none of them were involved with the kids. Amy has never met her dad.
Bill	Neither parent used drugs, but his dad's family included many drug addicts and alcoholics.	None discussed.	When Bill's dad died it was mentioned as the worst day of his life.
Sam	Sam's father, who has a history of substance use, made a reappearance in her life approximately 10 years ago and is now living with Sam and her family.	Sam was removed from her mother's home and recalls the best part of her childhood was when she lived with her grandparents before she was put into foster care. Sam was placed in various shelters and was placed in four different foster homes.	Sam's parents divorced when she was a baby and her dad left shortly after. Sam's mother had schizophrenia and passed away from cancer sometime in Sam's childhood/teenage years. Sam has some abandonment trauma related to her grandparents and father leaving when she was a child.

Table 2 Continued

	Substance Use	Child Removal/DHS	Trauma
Courtney	Courtney starting smoking cannabis when she was 14 and eventually started doing meth. Although her home life was traumatic and unstable there is no specific description of her mother/household members doing drugs.	Courtney describes that DHS was involved a lot, but her mother was having sexual relations with the DHS worker on multiple occasions which prevented them from being removed.	Courtney grew up in a very abusive and traumatic household. She lived with her mother and stepfather and was molested throughout her childhood (8-12 years old). Courtney's mother refused to allow communication between her and her biological father.
Jessica	Jessica's half-siblings started utilizing substances following the drowning of their mother.	DHS became involved due to her brother molesting her between the ages of 5 and 7	Jessica's childhood was extremely unstable. When Jessica was born her father was 70 years old. Her father had also been married three different times and had three sets of children with each parent. At 6 years old Jessica watched her home burn down, which was followed by severe housing instability. Between the ages of 5-7 she was molested by her older brother. At 13 years old Jessica's father was diagnosed with cancer and she watched him pass away when she was 16.
Melissa	Her dad used substances throughout her childhood and continues to use meth currently.	Melissa spent time in foster care before living with her grandparents.	Melissa's childhood included family sexual abuse, a parental split, and a child removal.
Bailey	Bailey's biological mother was unable to care for her when Bailey was born because of her own substance use.	Bailey was removed at a young age and was adopted into a family with 7 other children. She describes her childhood as pleasant.	Her adoptive mother passed away from cancer which she recalls as being a very traumatic experience in her adolescence
Vincent	After his dad went to jail for the first time, at 18, he learned his parents were using hard drugs. Vincent shared with them about his own use and the family began to use together.	Although Vincent did not experience child removal, had his sister not stepped up and met his basic needs throughout his adolescence his parent's substance use and absence would have more than met the requirements for child welfare involvement.	Around age 13 or 14, Vincent's dad lost his job and a year later his mom lost hers. Money got tight, and though he didn't know it yet, their use precipitated items disappearing around the house. Due to this, his older sister began to help ensure he had his school materials.

Table 2 Continued

	Substance Use	Child Removal/DHS	Trauma
Elizabeth	None discussed.	None discussed.	Elizabeth and her three sisters grew up in [location] in a trailer park with her mom and stepdad. They didn't spend much time with her mom's family but did spend time with her stepdad's family. It wasn't until about 11 or 12 that she learned that her stepdad wasn't her biological dad. At this time, she gained 4 siblings through this dad. Around this time, her mom split up with the stepdad and Elizabeth's life was marked by residential instability, abuse, and changing schools.

Individual's Substance Use in Late Adolescence and Emerging Adulthood

Table 3, below, addresses box B from the model presented in Figure 1. As we follow these individuals throughout their life, they begin to experiment with various substances throughout their adolescence and emerging adulthood. Eight out of nine individuals began their substance use in late adolescence or emerging adulthood. Occasionally, access to substances begins via availability of substances in the home like we see in Amy's life, starting with access to nicotine and increasing in severity from there. Sometimes substance use developed from teenagers attending parties where substances were present like was mentioned in Bill, Sam, Courtney, Jessica, and Melissa's stories, and occasionally there was minimal exposure to substances during adolescence and a pivotal traumatic event later in emerging adulthood triggered the need for relief, that the individual found in the use of substances like discussed in Bailey's story. It is worth noting that Bailey received the most significant intervention during her childhood by being adopted and her substance use did not commence until her adoptive mother passed away when Bailey was approximately 28 years old. This could be interpreted as a

successful intervention and the replicated choices did not occur until the intervention ended with her adoptive mother's death.

Finally, we also see that their substances of choice typically increase in severity as they proceed throughout their addictions oftentimes, beginning with alcohol, tobacco, or cannabis and increasing to substances like methamphetamine and prescription medications. It is important to note eight out of the nine individuals presented below, began some exploration of substance use during adolescence. This is pivotal when examining windows of time where treatment is offered or targeted to assist with recovery.

Table 3. Individual's Substance Use in Late Adolescence and Emerging Adulthood

Amy	Amy's had easy access to cigarettes at a young age due to her parents having them in the home. She started smoking cannabis at age 9. By 13 she was drinking and started smoking meth at 15.
Bill	Bill drank alcohol for the first time in the 6th grade and got in trouble when he was caught by his parents. Bill continued drinking until he was 16 years old.
Sam	Sam experimented with alcohol in her early teens when she was running away and while she was placed in foster care. When she was 17, she was introduced to meth and became an addict. She also utilized cannabis.
Courtney	Courtney started smoking cannabis when she was 14. She got access from her boyfriend at the time and meth when she was 18.
Jessica	Jessica began experimenting with alcohol at 13 years old. At 17 Jessica used crack for the first and then transitioned to meth by the age of 19 years old.
Melissa	Melissa was exposed to substance use from her parents during her childhood. Melissa started utilizing cannabis at 14 and drinking at 15 while she was still a minor.
Bailey	Aside from Bailey's exposure to substances with her biological mother prior to her adoption (age 2), it doesn't appear there was much, if any, exposure to substances from her family of adoption. Bailey did not begin using substances until the age of 28 following her adoptive mother's death
Vincent	Beginning at age 13 or 14, Vincent began drinking and partying with friends, which is a normalized timeline to him. He began to explore harder drugs at 17 beginning with hydrocodone and Vicodin pills
Elizabeth	By age 16, she started drinking, partying and spending a lot of time with college kids.

Individual Creates Family of Choice During Late Adolescence and Emerging Adulthood

It also became evident throughout the coding of these individuals' life trajectories that seven of the nine participants found cohabiting or marital partners during late adolescence or emerging adulthood. Eight of the nine individuals had a child during these same life stages. These results show that compared to national averages this sample of individuals tend to partner and have children at younger ages, which creates even further challenges and barriers for them to overcome. Finding ways to provide for a family when they have experienced a challenging childhood and are then caring for another human at a young age can pose unique challenges with employment, housing, transportation, and food security. Another common theme throughout these relationships was domestic violence incidents, even sometimes resulting in police involvement and incarceration. Considering that most participants experienced domestic violence of some form in their family of origin, the fact it is replicated in their own relationships and then their children are exposed to it is further solidifying the cyclical nature presented in these individuals' experiences.

Table 4. Individual Creates Family of Choice During Late Adolescence and Emerging Adulthood

	Partnering	Childbearing
Amy	Amy got married sometime before her second child was born and they were together for 11 years. It was an unhealthy relationship, and he was abusive and controlling. They met when she was 18. They had an 8-year time period where they were both sober following a DHS case.	Amy got pregnant at 16 and has a total of five children.
Bill	Bill had a marriage prior to his relationship with Sam. His marriage ended sometime around 1993/94. He has been in a long-term relationship with Sam that began about 5 years prior to the birth of their daughter.	Bill has one child with his long-term partner. They say they might as well be married they just never really prioritized getting married and don't see a reason to.

Table 4 Continued

Sam	Very little was discussed about Sam's oldest daughter's father. She is currently living with Bill another participant in this study and Bill is her youngest daughter's father.	Sam got pregnant with her oldest daughter when she was 17. This daughter is 25 years old at the time of the interview and Sam has minimal contact with her. Sam has another daughter with her current significant other and she is 9 years old.
Courtney	She had her first baby at 18, gave her up for adoption, got into trouble with an ex and spent three months in jail. Got out of jail and met her ex-husband got married and had 2 children with him while they were using on and off and then ended up divorced and married to the man she is currently with and they live with his ex-wife and her boyfriend. His ex-wife's daughter also happens to be her sister.	Courtney has four biological children and three stepchildren. Determining the fathers of each of these children was difficult because of the multiple partners Courtney was involved with. Courtney had her first child at the age of 18 and placed her for adoption (this was 21 years ago). She then had a son who is now 18 who was adopted with his sister who is 15. Her youngest child is three years old, when he was born, he tested positive for Opiates.
Jessica	Jessica entered an abusive relationship when she was 19 where she experienced domestic violence. Jessica's relationship with her partner was plagued with multiple instances of abuse, some of which were even while she was pregnant with their children. Six months after Jessica gave birth to their youngest child, their father was charged with child endangerment after being physically abusive.	She got pregnant with her first child at 21 one years old and had her second child with the same father in 2013.
Melissa	Melissa's boyfriend OD'd while she was pregnant and then went to jail.	The week Melissa's grandfather died she conceived her daughter. She immediately stopped using and stayed sober until her daughter was 9 months old.
Bailey	The father of her first child left when he found out she was pregnant. Father of her second child, which was planned pregnancy beat her and in front of her children, so she is not with him, but he raises their son.	Bailey had her daughter when she was 20 years old and her son when she was 24. The children have two different fathers. The oldest child was unplanned, but her father was excited about the pregnancy but ended up leaving. The second child was planned but his father was abusive, so Bailey left him.
Vincent	Vincent has three kids with his partner Elizabeth. These kids were able to stay with her as he cycled through treatment, and even with her in treatment. Vincent is happy to be with her because even when they weren't together (following the domestic charge) she always let him have contact with the kids. The kids are ages 7, 4, and 6 months.	Vincent has three kids with his partner Elizabeth. These kids were able to stay with her as he cycled through treatment, and even with her in treatment. Vincent is happy to be with her because even when he they weren't together (following the domestic charge) she always let him have contact with the kids. The kids are ages 7, 4, and 6 months.

Table 4 Continued

	Partnering	Childbearing
Elizabeth	Elizabeth has three children with her partner Vincent. These three children were able to stay with Elizabeth while Vincent was in treatment and even while Elizabeth attended treatment. Elizabeth seems content to stay with Vincent and their three children ages 7, 4, and six months.	About a year after Vincent graduated high school Elizabeth got pregnant with their first child who was unplanned. Vincent didn't want children and encouraged Elizabeth to get an abortion. Elizabeth told him she was having the child and he could choose to stay or leave. They went on to have 3 children together through a period of break ups and getting back together.

Substance Use and Trauma in One's Family of Choice

This portion of the thematic discussion is detailed in Table 4 and addresses box D from the Figure 1 model. Family of choice encompasses the current people the individual's immediate family is comprised of, typically their children and sometimes a partner. Every participant in this study had substance use history and a couple of participants were still currently using at the time the data were collected. Every participant in this sample had some form of child removal or child welfare involvement due to their substance use or inability to adequately meet the basic needs of their child/ren. Finally, every participant experienced some form of traumatic event in their adult lives.

Due to the high stress environment many of these individuals have children under, it oftentimes results in unhealthy patterns of coping mechanisms. For example, substance use, unhealthy or abusive partnerships, or struggling to provide for the basic needs of their child(ren). This then exposes their own child to substance use, child welfare involvement, and traumatic experiences/environments which can begin the cycle for another generation to follow similar patterns.

Table 5. Family of Choice Exposure and Experiences

	Substance Use	Child Removal/DHS	Trauma
Amy	Amy stopped using drugs from the time she got pregnant until her second child was born. At that point her and her husband were living together and began using drugs on the weekends, that developed into more consistent using, and then started selling drugs to fund their habit.	Amy's children were removed following the birth of her youngest child. Amy and her husband were using and selling drugs and the child tested positive for drugs at birth. They lost their home at this time as well. The children were removed for two months and placed in familial placements while Amy got into treatment and then the children joined her. From then on Amy says it has been "smooth sailing" and her DHS case closed within six months of leaving treatment.	Loss of housing, lots of moves, children removed and separated to different family members. The husband Amy was with for 11 years was abusive and controlling to Amy - which the children were exposed to.
Bill	In late adolescence Bill added to his alcohol use with trying cocaine and eventually beginning to use meth. Around the time Bill starting using meth he found his father dead, and this accelerated his coping mechanism.	Bill & Sam have two incidents with DHS with their daughter. The first incident occurred around 2010-2011 when their daughter was about 1 year old. They knew they needed to take her to a doctor, but Sam had used meth a couple of days before and had smoked a little cannabis that day while Bill had been drinking all day. Their daughter had a UTI and while they were in the hospital, they got stopped for a sobriety test and both failed. Their daughter was removed for 40 days, he recalls this was the longest 40 days of his life. Bill and Sam went through family treatment court and got her back. The second incident was around 2013-14. Bill and Sam had split up for a bit and relapsed on meth. They had a case for about 2 years and that was the last time he used meth because he realized it wasn't worth it, but he still drinks occasionally.	After finding his dad dead, Bill's marriage also ended so this furthered his drug use to cope with his grief.

Table 5 Continued

	Substance Use	Child Removal/DHS	Trauma
Sam	Sam utilized meth for the first 3 1/2 months of her pregnancy with her oldest. She stopped using until the baby was born and then began using again. Sam's meth usage continued throughout her lifespan and she has had two DHS involvements with her 9-year-old due to her meth use.	Sam's oldest was removed and custody was given to her father when the daughter was 2. Sam doesn't know her. Their youngest daughter has also had two DHS cases due to Sam's meth usage.	There was a raid on their home looking for drugs and Sam also mentioned her child abuse record but there was not much discussion of that.
Courtney	Courtney still smokes cannabis habitually and occasionally still uses meth. She does not ever plan on stopping using cannabis. She said she currently only uses meth when she has the money to pay for it. Courtney also admitted she has previously used sex as a way to get her drugs and once got pregnant from her dealer.	Courtney has had several DHS cases and is currently utilizing cannabis and meth. Whenever she was involved with treatment programs, she was sober for long enough to get her children back. Three out of four of Courtney's biological children have been adopted due to her drug use. Courtney stated that she had multiple charges with DHS within one year from neglect and failure to provide adequate shelter. She also has a current open case with her youngest biological son because they found cannabis in his system at birth.	Courtney was in a car robbery and was charged with conspiracy to commit a robbery in the first degree and extortion (two felony charges). Courtney states she is struggling financially and there is also issues related to unfaithfulness in her romantic relationships.
Bailey	Bailey started utilizing substances when her mother passed away from cancer when her son was 4. This would have made Bailey roughly 28 years old when her substance using began.	Bailey is currently involved with a DHS case. She said that someone suspected that she was using but she hasn't in a while. Her son was sent to live with his dad and her daughter was removed and placed with a family friend.	The children were exposed to domestic violence and substance use in their childhood.

Table 5 Continued

	Substance Use	Child Removal/DHS	Trauma
Jessica	Jessica began experimenting with alcohol and began drinking at 13 years old. At 17 years old, Jessica used crack cocaine for the first time, and then transitioned into methamphetamine use at 19 years old.	Jessica had an ongoing DHS investigation into her, but they weren't intending on removing her children from the home despite learning that she was actively using. It was later on during this process that Jessica made the decision herself to become honest with the investigator and voluntarily request for her kids be placed in foster care while she sought treatment to achiever sobriety.	Jessica's relationship with her partner was plagued with multiple instances of abuse, some of which were while she was pregnant with their children. Six months after Jessica had given birth to their youngest child, her partner was charged with child endangerment after being physically abusive to their son and following this incident Jessica ended her relationship with him. Jessica entered treatment in 2014 and then afterwards entered another relationship with a different man where she experienced the same type of physical abuse and it led to her using crack cocaine again & subsequently meth. After a particularly violent incident with him in 2017 where the police arrested him and her relationship with him ended.
Melissa	After starting college Melissa's substance use went beyond cannabis and alcohol and she tried meth. Her first experience, she smoked it and went to bed and stated that she woke up a full-blown addict. From this point forward Melissa was getting high daily. Melissa's grandpa received pain pills and wasn't using them, so she stole them and sold them for years. Melissa was able to stay sober for 9 months after her daughter was born before she relapsed.	After Melissa's relapse when her daughter was 9 months old. Her child's father and his girlfriend received custody briefly even though they were still using and had 8 drug charges. Melissa was not capable of taking care of her child and asked a friend to take her, but when DHS got involved, she was placed with Melissa's aunt. Melissa's aunt tried to adopt her. After Melissa completed 11 months at House of Mercy. Melissa worked on getting her rights back to her child which she now has, and the father is in prison. Even after having her child back Melissa feels as though she has PTSD about her experiences with DHS and fears future child removals.	When Melissa was 21 her nephew died of Leukemia and instead of being with her family, Melissa stayed with her boyfriend cooking meth. Shortly after that her grandfather passed away which accelerated Melissa's substance use.

Table 5 Continued

	Substance Use	Child Removal/DHS	Trauma
Vincent	Beginning at age 13 or 14, Vincent began drinking and partying with friends, which is a normalized timeline to him. He began to explore harder drugs at 17 beginning with hydrocodone and Vicodin pills (which was a decision based on access), which is when he learned his parents were using hard drugs. At this time, he began to use opiates (e.g., Oxycontin, Hydrocodone, Dilaudid) but mostly just on weekends. At age 22 he first tried meth and found it made the opiate withdrawals easier. He began to use daily. As expenses increased, he switched to using a needle because he realized he could get more of a high for less expense, and first used a needle for opiates.	Elizabeth got a DUI and attended outpatient. After this, she continued to drink and partake in meth. Elizabeth knew she needed more help so she went to treatment where she could take the kids with her rather than have them removed from her care. While in the treatment with the kids, she let their daughter be with Vincent who was still using, and she ended up having a DHS case. She found DHS to be helpful, and her kids weren't removed. She has no fear of the kids being removed, as she finds DHS to be helpful to parents.	After his first daughter was born, his mom died from an infected needle.
Elizabeth	By age 16, she started drinking, partying and spending a lot of time with college kids.	Elizabeth got a DUI and attended outpatient. After this, she continued to drink and partake in meth. Elizabeth knew she needed more help so she went to treatment where she could take the kids with her rather than have them removed from her care. While in the treatment with the kids, she let their daughter be with Vincent who was still using, and she ended up having a DHS case. She found DHS to be helpful, and her kids weren't removed. She has no fear of the kids being removed, as she finds DHS to be helpful to parents.	While in the treatment with the kids, she let their daughter be with Vincent who was still using, and she ended up getting a DHS case. She found DHS to be helpful, and her kids weren't removed. She has no fear of the kids being removed, as she finds DHS to be helpful to parents.

Treatment and Resources

Access to treatment and resources is another theme that emerged throughout the analysis. Three time points were identified as potential timepoints for intervention; box 1 in Figure 1 represents any resources or treatment that may have been offered/required during childhood while the individual is still nested within their family of origin, box 2 represents any resources or treatment that may have been offered/required following the beginning of substance use but prior to the creation of their family of choice, and box 3 represents any resources or treatment that may have been offered/required following the use of substances. It is important to note that there were not specific questions in the interview protocol targeted to ask what resources or treatment they have come in contact with throughout their lifespan, we only have the timepoints they discussed openly, and they felt important enough to share with us throughout their interviews. Six out of nine participants experienced some form of resources or intervention when they discussed child welfare involvement while living with their family of origin. Some individuals described periods in their lives when they lived with other family members or were placed out of the home. Bailey was the only individual who received significant intervention and discussed the fact that she was adopted at the age of two due to her mother's substance use (box 1). Although we cannot denote exactly what resources or treatment may have been offered to their family of origins, they openly discussed that they were removed and there was child welfare involvement. This would have meant that the opportunity for their biological caregivers to discontinue substances with the support of various resources would have been offered to the family. These resources primarily focused on inpatient and outpatient treatment options that individuals discussed throughout their interviews, however resources at each of these time points can include preventative programs like the nationwide DARE program in childhood, resources and programs

coordinated by case workers such as housing, childcare assistance, and food assistance, and also mandated programs like therapy, anger management, and parenting courses. All of these pieces weave together to assist individuals in achieving and maintain sobriety in addition to achieving and maintaining a safe and healthy living environment for their children.

Additionally, there were no participants that discussed treatment following their individual journey with substances beginning and prior to the creation of their family of choice (box 2). The ability to target this timepoint and assist individual's in receiving support with their substance use journey can potentially prevent the exposure of substances to their own children. Achieving sobriety prior to the creation of the individual's family of choice can also minimize any traumatic events that may be experienced due to substance use or child welfare involvement. Throughout these individuals' lives we see that they are more likely to obtain stable housing and employment during their periods of sobriety which also can assist them in meeting the basic needs of their children. Accessing treatment and resources prior to having children could greatly minimize exposure of substances, trauma, and child welfare involvement and create a potential break in the cyclical nature of these experiences. Unfortunately, none of that participants in this sample discuss this opportunity in their journey.

Finally, all nine participants in this study discussed treatment or resources following the creation and exposure of their family of choice (see Table 6 below; representative of box 3 in Figure 1). Several participants, like Bill and Sam, believed they were able to keep their substance use separate from their daughter and their parenting, however we see in their story that child welfare was involved at three different time points to ensure their daughter was protected. All of our participants had either attended substance treatment or had the access to attend treatment. Several of our participants were required by child welfare to attend treatment as part of their

children's case plan to ensure a safe environment if they wished to maintain custody. One of the most significant findings surrounding treatment was that the parents who were able to attend substance treatment with their children were more successful in completing their child welfare case and reflected more positively about their interactions with the child welfare agencies. This will be discussed further in chapter 6 for potential policy implications.

Table 6. Treatment and Resources

Amy	When Amy's youngest child was born, and they tested positive for cannabis and meth she was required to attend treatment as part of her case plan with DHS.
Bill	Bill attended treatment when DHS got involved, to make sure his daughter didn't get placed in foster care.
Sam	Sam discusses how long it took her to go to drug treatment court and that it took longer for her to go than Bill. But it is never specified which program she attended or when that occurred.
Courtney	Courtney attended treatment when DHS required it but only stayed sober for long enough to get her children back, until her rights were finally terminated. She currently has an open case and is still utilizing substances.
Jessica	Jessica entered treatment in 2014 for 7 months. After leaving her second abusive relationship, Jessica voluntarily gave up her children and went to an in-patient program for two months then transferred to YWCA. She also joined Narcotics Anonymous 12 step program.
Melissa	At one point Melissa discusses attending treatment for 10 days around the time of her daughter's birth but ended up completing 11 months once DHS was involved in their life. She has now been sober for 2 years and has been reunified with her daughter.
Bailey	Bailey told interviewers that she has a rehab place lined up and is making plans to get there.
Vincent	Vincent attended long-term treatment and has been sober for about a year at the time of the interview. He also utilizes Suboxone and methadone and finds them to be helpful in preventing his substance use.
Elizabeth	Elizabeth was able to attend treatment twice and take her children with her.

Concluding Findings

Although Bailey was fortunate to experience intervention in early childhood and ultimately adoption by the age of two, we still see a very consistent pattern across the lives of our participants following the cyclical model presented in Tables 2-6. Even when Bailey was removed from the exposure of trauma, substances, and child welfare involvement by the age of two she still ended up on this same pattern and trajectory as those who were not removed like Courtney. Courtney shared her childhood experiences with abuse and trauma and although child welfare was involved, she never experienced child removal because her mother was involved sexually with the case worker. Courtney began using substance in adolescence and is still using cannabis and meth when she can afford it. Three of her children have been removed and adopted and the child currently in her care has an open case due to a positive drug test on the child at birth. Although Courtney has been to substance treatment several times, she has only been able to maintain sobriety for short periods following the conclusion of treatment.

Amy and Courtney's stories also highlight that several participants voiced throughout their interviews, if individuals were not ready to achieve sobriety and give up their substance use, they would not ultimately be successful. Many of the participants that were interviewed for this study were able to experience sobriety, obtain stable housing and employment, and continue to parent their children with the resources and support child welfare offered to them. However, there were many examples that also displayed how vital it is for individuals to be ready to stop using substances before they can be successful. As described in Bailey's story, she had a treatment program set up and available to her when she is ready to go but she has yet to take advantage of it.

Another notable finding was the various ways children were removed from their homes. Some parents, like Courtney, chose to place their children for adoption when they realized they wouldn't be able to complete their case plans. Other parents exhibited some control prior to child welfare removing their children, by bringing them preemptively to a family member or friend prior to removal. There were also examples of children being forcibly removed against the parent's cooperation like in Bill's and Sam's cases. In some instances parents fought to remain in custody of some of their children. Finally, the manner in which each individual reflected on their experiences varied significantly; for example, some individuals viewed the choices their parents made as terrible for choosing drugs over their children but when they were faced with the same choices, they seemed at peace with how happy their children were at another caregiver's home.

The wide variety of resources, protocols, and approaches utilized across the different families studied for this dissertation highlights a key take away that the whole family system matters. In most cases, by the time child welfare becomes involved, exposure to trauma, child welfare, or substances has already occurred necessitating therapeutic recovery for the entire family system. In many of the individuals' stories resources are allocated towards recovery of the parent but little attention has been paid to the system as a whole. These results emphasize the importance of theory-driven practice; this study finds evidence that Family Systems Theory, Life Course Perspective, and 2-Gen approaches can be intermixed to create more ideal results for families.

When comparing the findings presented in this chapter to the total 40 participants in the original sample 36 out of 40 participants had biological children. Due to limitations in interview protocol not every participant discussed their exposure to substances and child welfare involvement, however each participant explained some form of trauma they experienced in their

childhood and twelve of the forty participants explicitly described child welfare involvement in their childhood. Thirty-six individuals were parents to at least one biological child and of those parents Thirty-two of them described experiences with child welfare involvement or child removal. Although the model was not tested in-depth, utilizing the full sample, there is evidence to suggest the model presented in this study would be well-supported with a larger sample, especially with tailored interview protocol asking about childhood exposures and events.

As presented throughout the tables we found that all nine individuals represented in this study experienced some combination of childhood exposure to trauma (nine of nine individuals), substances (six of nine individuals), and/or child welfare involvement (six of nine individuals; although each participant described circumstances that would have satisfied child welfare involvement only the people who explicitly stated involvement were included in this number). This then resulted in eight of nine participants beginning to experiment with substances during adolescence and emerging adulthood, which strongly supported the predicted pattern presented in the conceptual model. All seven out of nine participants then partnered in adolescence or emerging adulthood and eight out of the nine individuals had children by late adolescence and emerging adulthood. Many in these partnerships and relationships experienced domestic violence and unhealthy relationships with their partners. This resulted in 100 percent of this sample's (n=9) children being exposed to substance use, trauma, and child welfare involvement; directly supporting the theorized pattern in Figure 1. Finally, Figure 1 presents three possible timepoints for intervention of resources and treatment opportunities. In this sample, one participant experienced significant intervention with resources in early childhood through child welfare removal and adoption by the age of two, no participants received treatment after the onset of their individual substance use and prior to having children, and 100 percent of participants in this

study eight received treatment or and one individual had treatment offered and available following their childbearing. Overall, there is some variability present in the family of origin experiences, however when we consider the combination of substance use, trauma, and child welfare involvement cumulatively there is strong consistency supporting the multigenerational cycle.

CHAPTER 5. CHILD WELFARE INVOLVEMENT RESULTS

Child welfare involvement was a theme that unexpectedly presented itself throughout the collection of these interviews, so much so, that the entire focus of this chapter is on these interactions and experiences, with a particular focus on how child welfare involvement impacts the families with histories of substance use. This chapter aims to exploratively address research question 2: What are the experiences of families who had child welfare involvement? After reviewing the transcripts, the following questions arose to address the three emergent themes (1) How does the manner in which child welfare approaches families impact their experiences and success? (2) When temporary child removal occurs, how can trauma be minimized? (3) How do family-friendly treatment resources and programs help preserve families? If we can most effectively support families and provide resources, the state will be better able to efficiently allocate resources to maximize family impact of state funds, ultimately minimizing child removals and overall trauma.

The backbone of this process is the necessity of establishing trust between the case worker and the intake family, one of the foundational pillars of trauma informed care, and then empowering individuals to make decisions and be part of the solution. As you will see in the experiences and results presented throughout this chapter, if a trusting relationship can be established and if families view child welfare as helpful rather than focused on ‘taking’ their children, then there is a greater likelihood that parents and child welfare partners can work together to improve the conditions of the child’s life. Trusting relationships are also associated with a more positive overall reflection of the experience and resources in general.

Individuals reflected on the approach and overall interactions with child welfare, how traumatic child removal can be on families, and the importance of family friendly resources.

Each of these topics will be addressed individually with an introductory paragraph followed by the lived experiences of one or two participants' lives. Amy's story below will introduce the pattern, by sharing her interactions and reflections of how her life was impacted by child welfare involvement.

Family Experiences with Child Welfare

Amy's Story

Amy sat across from the interviewers wearing a black t-shirt, under a blue zipped up hoodie. Her two and three-year-old daughters sat nearby, playing with the recorder and babbling happily as the interview began. Amy smiled intermittently throughout telling her story while maintaining some eye contact, as she attempted to dodge the distractions of her small children being present. Her demeanor displayed openness and she always seemed to be engaged while detailing her life events. Amy's personality appeared to be more introverted, but she still openly and powerfully communicated throughout the interview. Amy's interview began like all of the others, with a request to 'tell me the story of your life'.

Amy has three siblings, two brothers and a sister. At an early age Amy and her siblings experienced a family life in flux, with a variety of living situations and transitions, most of which were a result of her mother moving in and out of relationships and homes with boyfriends. Amy's mother provided very little attention and supervision throughout their childhood, largely a result of her own substance use.

> *I was like nine and my mom's house got raided, or whatever, so we went to a foster care for a few months, and then after that we went, my grandparents got custody of us. And I don't I guess I was too young to be really involved in much, but, um, we just stayed with my grandparents after that for a while.*

Because Amy's mother used substances and created an unstable living environment throughout her early childhood, Amy transitioned to a more supportive environment living with her grandparents with the help of child welfare. Amy fondly recalls the beginning of her time with her grandparents highlighting that she was able to participate in many community and school activities for the first time in her life.

> *Um. Well, like when I was nine, before I got adopted, I was never in anything. We couldn't afford anything like that, but after I got adopted, I did volleyball and track. I did football. I was pretty involved in sports until probably like later into middle school, early high school.*

Prior to Amy being removed from her mother's care her family could never afford such extracurricular activities. While living with her grandparents, Amy's life got better, her and her siblings were well cared for. Despite this change in living situation, Amy admitted that when they were taken away from her mom, she really started to become rebellious. She attributed much of this rebellion to the age at which she was removed from her mother's care.

> *Well, like it was better. We were better taken care of, for sure, but I was, I was at a bad age, I think, to be taken away from my mom, but that's when I really started rebelling then. I really just wanted to go back with my mom.*

At approximately age nine, Amy began experimenting with smoking cigarettes and eventually began to smoke cannabis as well. *"Um, I started smokin' weed really young like when I was nine. Uh, I'd smoke weed and cigarettes and smoke a, or skipping school."*

By the age of thirteen, Amy started to socially drink alcohol and by fifteen she began experimenting with meth. She also mentioned that since her mom was deep in her own substance use she had easy access to both substances when she visited. *"Um, drinking probably around thirteen or so. Um, first time I did meth I was fifteen just hangin around friends."* Amy noted that because her friends/peer group was largely older than her and deeper in substance usage, it was easier to obtain items such as cigarettes, alcohol, and other such substances.

> *I hung out with a lot of older kids, so it was, and my parents smoked cigarettes so it was really easy to get my hands on stuff. I was very rebellious. If there was a rule that was made, I'd probably going to do the opposite.*

At the age of 15, she met her boyfriend, and they became sexually involved. They used substances together and further perpetuated Amy's rebellious path.

"And then when I was sixteen, I got pregnant with [child's name] and so I didn't do any drugs."

Amy began working for the first time in a plastic manufacturing company at the age of 18. Around the same time, she met her future husband and they got married. Amy and her husband got pregnant shortly after their marriage and were using together at the time. Amy was able to refrain from substance use until the birth of her second child, in fact they went a span of about eight years of sobriety together. After giving birth to her second child, her and her husband slowly started using meth again. It began with using it more recreationally on weekends, until they found themselves in full blown addiction again.

> *So, I didn't do any drugs again until after my second daughter was born. Um, we started, by then I was with my husband and um, we started slow. We'd use some on the weekends or whatever and gradually picked up to where he wanted to sell it to be able to um, afford our habit. And then, so we did that for a couple of years. Ended up losing our home and everything, we were living in hotels.*

At this point, child welfare was alerted to the parents' substance use and opened a case to address the unstable and potentially dangerous living environment for the children. Amy and her kids moved back in with her grandparents to prevent child protective services removal of the children. Amy went to treatment, met her sobriety goals, and completed her child welfare case requirements. Amy's husband took a little bit longer to come around and get help with their addiction but eventually joined her journey towards sobriety.

A couple of years later, her husband started to sell drugs again, and they ended up using again as well. When her husband went to jail on charges in connection to drug sales Amy decided that it was time to end the relationship. After the birth of her third child, the hospital found out that she was using drugs again through an infant drug panel. Child welfare was then notified per mandated reporting of the hospital and resulted in Amy's three children being removed. Amy was able to get into treatment and after displaying adequate effort, her children came back in her care.

> *It was because she [her daughter] was born like they knew at the hospital, it was pretty obvious, but, um, that time the kids were removed. They were gone for two months while I got into treatment and, um, once I got into treatment, it was like really smooth sailing from there. Once I got into treatment, it was like thirty days before they were back in my care and then I got out of treatment in January, my case closed in June.*

During the 11 years Amy was with her husband he was controlling and abusing her. She described times that she sold illegal substances just so she would have access to cash that he didn't know about so he could not control everything she did. Amy ended up in the hospital because of his physical abuse at one point. His need for control expanded so far that he put security cameras inside the house so could 'check' on Amy and see what she was doing whenever he was away.

> *And as far as relationships, I was with these guys' dad for eleven years and he was not good. He was pretty abusive, he was, he was always cheating, downgrading me. Um, he wouldn't let me work… 'cause he wanted me at home so that he knew what I was doing. He eventually ended up setting up cameras in the house so that he could see what I was doing while he was at work and then, after that it turned into he quit his job completely so that he could stay home and make sure I wasn't doing anything.*

While Amy was navigating her abusive and controlling relationship with her husband, their children were being exposed to trauma and substances in their environment. Child welfare were notified of the substance use occurring and they opened a subsequent case. Amy does not discuss if the abuse or overall environment were part of the reason for child welfare involvement,

but she focused heavily on the substance use being the reason. Amy reflected on her overall experiences with the child welfare system. She seemed to recall the experiences and circumstances as being fairly easy to navigate and resulted in her children being returned quickly during the second case where they were removed. She specifically noted that the child welfare system was helpful in allowing her to move in with her grandparents for supervision while receiving treatment rather than removing her kids for a third time.

> *The first time my grandma reported us and so they called and, um asked for drug tests and they were positive drug tests and so I just went home to my grandparents and that counted as a, like I was allowed to live there, the kids were never removed. That counted as enough supervision while I, ya know, got clean and did outpatient treatment whatever. The second time, it was because she was born like they knew at the hospital.*

Amy also had a positive outlook on her experiences with treatment. She was relieved her children could stay with her during treatment, because they were all in a safe environment away from her abuser. She did note, however, that her biggest struggle with treatment was not achieving sobriety itself, rather, she struggled to have a plan for after treatment when she was back in the real world. She noted that the stress of this process often drives people to relapse because it is too much for someone struggling with addiction to handle.

> *Um, it was good. It was, I mean there was a lot of rules, but I guess kind of have to be, but it definitely served its purpose and we lived there for three months. We lived there for three months and the only complaint I really had about it is they don't, they don't set you up with a good plan for afterwards. Like, you live there for three months, you have no job, no income or anything and like, when you leave, you're really, you don't, you know you can't get a place to live without a job and you just leave and then you're like well, now what? So, a lot of my peers have relapsed after leaving because it's a lot to deal with.*

Amy found support and accountability in a couple she met, who ultimately helped her to recover. This couple assisted her after treatment in securing a place to live and furnishing the place with needed items. The couple also helped connect her to the community who are all very supportive of her process and path to stability.

> *Um, well, I have like, um, I have a couple, they're in, [couple's name's], they're, um, they got clean probably ten years ago or so. They've been clean for a while. Um, and you know, they helped me when I got my house, get some furniture, and there was a lot of people in the community that were really supportive of what I was trying to do. And that was good, but I could also see all my tweeker friends with connections, so I had a pretty good balance of clean people out doing stuff so it wasn't, you know, dope, and having my familiar friends that I was really close with and knowing that I didn't want to do what they were doin.*

Amy completed high school and started college when she was younger but was never able to finish it. She was attempting to major in Early Childhood Education. Moving forward, Amy is recovering very well and is now 18 months sober. Amy is very happy with her progress and consistent lifestyle. She has a good relationship with her family now and noted that sometimes her mother comes over to her house. She also shared that she has a boyfriend who is supporting her through her journey. They were only renting their current place but are planning to buy another house. She is happy with her small community and has been working as a Department of Human Services Parent Partner for 6 months now. In this role Amy assists other families with open child welfare cases navigate the requirements of their case plan in addition to supporting them through personal understanding of the process. Amy is looking forward to getting an Associate degree and would ultimately like to work as a child welfare case manager to assist others through this process and helping them avoid mistakes she made.

> *"Um, well, the fact that I'm only eighteen months sober and that recovery is going very well. Um, I can only imagine that it will get better. The, you know, firmer I get in my sobriety, the more solid I feel living a clean lifestyle then.*

Amy's life story and experiences are a great holistic example of the significant role child welfare can play in an individual's life who is partaking in substances. Child welfare plays such a significant role in individual's life that they become part of the family system. In Amy's scenario she reflects fondly on how child welfare was able to provide treatment and resources to assist her in getting out of the abusive environment she was in, encouraging her to choose her

children and a safer environment. A key component of her success was the ability for her children to join her in the treatment facility after she was settled, and when the children had to be removed for a short time prior to joining her she was able to choose where they stayed, and it was with a family member. All of these components weaved together to help Amy in successfully achieving sobriety and reunification of her children.

Theme One: How does the manner in which Child Welfare Services approaches families impact their experiences and success?

Sam and Bill have faced many of the challenges that life has thrown at them. Although they have been together for many years, they don't view marriage as necessary to show their commitment to one another. Sam and Bill have one daughter together and Sam has a daughter from a previous relationship that was permanently removed from Sam's care at a young age. Sam's story illustrates that people have to be ready to embrace sobriety and willing and able to fight to keep their children in order to successfully maintain parenting rights. Sam chose not to contest her oldest daughter's removal because she knew she couldn't care for her and though she seems sad when she thinks about it, Sam discusses very little of this circumstance. Since Sam and Bill have been together, they have also came into contact with the child welfare system. They are jaded about the role of child protective services in telling them how to parent and they feel the system is 'out to get' parents rather than support them. In the case of this family, Bill and Sam were reported to the state when they were seeking medical help for their daughter. Sam and Bill exemplify how one's initial contact with the child welfare system can greatly impact the overall success of the case.

Bill and Sam's Story

Bill wore a red short-sleeve shirt, with the sleeves going down to his elbows, and black shorts with white ankle socks while Sam wore a white short-sleeve shirt with pink camo pants during the interview. Throughout the interview, Sam and Bill were happy and talkative, and the interview had a lot of laughter, smiling, and jokes. Bill and Sam were engaged and willing to answer every question that was asked, despite sharing that they generally are skeptical of other people.

The story of Sam and Bill's relationship has always centered around substance use. They met at the 'drug house' they both bought supplies from. After that, they started getting to know each other. As their drug addiction progressed so did their relationship.

> Bill: *I ran into her one day at a drug house. [Laughter] And, ah, actually, ah, a mutual friend of ours, I was out, and she had, she had lent her her car, and my car, my car was kind of hot from, ah, literally overheating, and I, ah, was broke so I didn't have money for coolant. So, ah, she was driving me around everywhere, you know? I was out looking for dope, for drugs." "Oh, God. And when we start, get together in '03 and we get a lot of, ah, she was in the halfway house in '04, the beginning of '04. In '03 we lived on the south side of [City Name], ah, in a house that my mom let us stay in just out of you know kindness.*

Sam and Bill described seasons where they struggled financially to pay their bills. There was a period of time where they did not have electricity, or running warm water, and no food. They ate at soup kitchens, couldn't pay for gas in their car, and ate packaged foods from the Hostess Bakery dumpsters. Their drug addictions placed them in social groups that resulted in Bill and Sam being taken advantage of, often resulting in even less money and fewer resources. The first five years of their relationship was mostly comprised of drug use together.

> Sam*: "And we had a lot, it wasn't always, you know, good. I mean we had, we had people come in between our relationship and, and you know just, I wasn't sure that I was where I wanted to be so I was out doing really dumb things and just you know, anything you know you can think of that involves that kind of a world. I mean we pretty much went through it."*

> Bill and Sam: *"[Laughs] Anyway so she ah we lived pretty poorly. And ah you know what you had to do sometimes to get food or whatever. We used to go dig in the dumpsters out behind fucking Hostess Bakery and get fucking. So, the first five years we were, we were pretty much high all the time. Pretty much. Um with relapses here and there since she's [their daughter] been born you know um. But the last nine years I think we've been more clean than we have high, haven't we?"*

Bill mentioned that after 5 years, Sam got pregnant with their first daughter. There have been a few relapses since, but Sam shared that she stopped using substances while she was pregnant with both of her children.

> Sam: *Well, wait. I had gotten pregnant with [oldest daughter] way back when I first got addicted to that crap, I didn't even do it then when I found out I was pregnant. It's just not something that, it's not humane. I don't know. I don't get it.*

Their daughter was unplanned as Sam never wanted another child after the removal of her first daughter. When they found out they were pregnant, they were living in a duplex and using substances regularly. They stopped using substances after they found out about the pregnancy. It is unclear how soon after the birth of their daughter the substance use resumed. However, Bill was driving to another town for work, so they moved after she was born to make it easier on him.

> Sam: *Yeah. We had a little duplex apartment you know, duplex apartment whatever. And um we were, we had some friends that used to come over all the time, But um when I found out I was pregnant with her you know of course it stopped and, My main thing back then when I found out I was pregnant with her was smoking pot. And we were, I don't think we were really doing meth that much. But he was drinking, and I was smoking a lot of pot.*

Bill said they have had two child welfare cases but three were mentioned throughout the interview process. The first instance occurred when Bill and Sam took their daughter to the emergency room to be treated for a possible urinary tract infection. The hospital noticed that Bill had been using alcohol and Sam was high from cannabis and meth. At this time, they claimed they had been doing good and were only using on the weekends. The emergency room contacted

child welfare and law enforcement and both Bill and Sam were unable to pass field sobriety tests. Their daughter was removed from their care while they attended treatment.

Sam*: "But she was only gone away from us for forty-four days, and we got her back.*"

Bill*: "It was the worst forty-four days of my life."*

The second case was opened when Sam relapsed and decided to leave Bill for eight months. When Sam left him, their child was placed with Bill. Bill had been using alcohol at the time they split up but he went straight to treatment and showed effort with child welfare services, so he was able to keep his daughter in his home.

> Sam: *Yeah. The second one was when we were split up for eight months. And then even though you were still getting away with what you were doing back, and she got to come home with you, and I had to stay where I was at.*
>
> Bill: *Fuck you. I went straight to treatment. That's why, that's why I got her because I went straight, my sister, my sister was in there helping me. I went straight to treatment and fucking found Treatment Court.*
>
> Sam: *Ok. He went to Family Treatment Court. I didn't for a long time.*

Sam and Bill showed little ownership of their behaviors and seemed to blame many of the things that occurred on child protective services. They described how the child welfare system oversteps when working with families. Sam and Bill were especially agitated that child welfare got involved when they took their daughter to the emergency room because they were attempting to be good parents by getting medical care for their daughter and instead it backfired. Their daughter's removal represented the worst 44 days of Bill's life and at the time he perceived child protective services as "cold-hearted" and self-righteous. Sam, though, knows she won't let what happened to her older daughter (loss of parental rights) happen to their younger daughter.

At times when they were using, Sam and Bill believe they have been able to keep their substance use separate from their parenting to the point that their daughter only thought they had

friends over but otherwise she has not questioned their behaviors. They even ensured that their daughter was in school when the interviews were scheduled for this study to protect her from hearing about their substance use. Bill feels strongly that it is their responsibility to protect her from their substance use choices. Their daughter has always been important enough for them to quit using and complete the child welfare case requirements.

> Sam: *We were like ok we'll just get our own place and take care of this while we're involved with DHS or whatever. Last few times they've been here, but it's almost over. It'll be over soon. They're going to close my case so, I'm just ready for it all to be over with cause I don't even like to admit that it happened. I'm still pissed off at myself. I still think about it every day.*

Both of the first two experiences with child protective services were described as long, but ultimately resulted in a closed case. More recently Bill and Sam experienced a third case when their home was raided by law enforcement for drug dealing. During the raid all that was found was some drug paraphernalia and an empty bag of cannabis, however it still resulted in child welfare involvement and some charges being brought forth. Sam has wrapped up her mandatory treatment and that case should be closed soon. The raid was conducted because of frequent people coming and going from their home and most of the people that were discussed in the warrant were their nephew's friends.

> Sam: *He rattled off like four or five different guys, kids his age you know from high school boys. And they were coming in and out of here all the time with him where they'd drop him off and pick him up. That traffic from them is what they based their search warrant on. I was at work and she called me at work and said you need to get home now. I said why? What's going on? She goes they're raiding the house. I said what the fuck for? And she said I don't know. I come home. They didn't find nothing. A few dumb ass odds and ends you know.*

They do not believe their daughter knows anything about their drug use and they seem to prefer that. They know that the DARE program is starting at school soon, and they aren't too happy about it. Bill and Sam would prefer their daughter not know substances in general, but

most specifically they feel strongly about her not knowing about their own substance use history. School programs can provide an opportunity to share the details and their opinions with their daughter and instill the values that they wish for her to have and believe.

> Sam: *So, she makes something out of her life. Honestly, there's kids that have never been in a, in a substance using family before and turn out to be druggies anyways. And there's also the kids that come in, come from addictive families such as ours, Who end up you know, doing the right, going the right way? You know I mean it can happen in so many different ways. I mean you don't have to be, you know, a child of an addict. And it, I mean, it's not like written in stone for her, that she's going to become an addict. But my thing is, I mean, I guess they say it's best if you educate 'em and tell 'em, tell 'em what to watch out for. You know, hey somebody offers you this. You know what do, you say stuff like that. But I mean, I'm thinking, well if I can, you know, and if I can keep her away from that kind of a person or let her.*
>
> Bill: *If you can keep her away from anybody. [Laughs]*
>
> Sam: *Yeah. But then there's that reality that that's not going to happen. So, I mean, I know I have to educate her, but I just think that right now is not the time, you know. She's still way too little, you know? I don't think that she needs to know about all that horrible stuff that life can bring right yet. You know, my substance abuse counselor says that there's nine-year-olds smoking pot right now, and I'm thinking I don't even want to hear that, you know? [Laughs]*

Sam thinks that cannabis needs to be legalized and she wishes meth was never invented though both of them think it'll never go away because people will always find ways to make it. They have found that quitting drugs comes down in large part to just wanting it and it's a choice that individuals have to make.

> Sam: *Cause I'm pro weed, I think they need to legalize.*
>
> Sam: *Meth needs to be, I wish it was never invented.*
>
> Bill: *To have this thing where you have to learn everything the fucking hard way, and that's the truth. That's the absolute gospel truth. It's got to be something effective about drug addicts because they have to learn everything the fucking hard way. Everything.*

Currently, Bill works about 60 hours a week and Sam is a stay-at-home mom who experiences a lot of loneliness. They seem to struggle trusting anyone in their community, and

this aspect of childcare is one big barrier to Sam thinking about getting a job. They don't find their neighborhood safe for their daughter and that is clearly a disappointment for them. Sam constantly feels out of place and that interferes with her ability to meet new people, but they view their move to a new city as a retreat from the people they knew (in the drug community). They also think their neighbors judge them for their home as it needs some repairs.

> Bill: *We have a big field you know. Should be able you know, a kid should be able to go out and play all summer without, Right here in this tiny little town you should be able to trust that our kids are ok right out there in the field. I can't. I can't trust it because there are pedophiles that live zero point two miles away which is pretty much down the block.*

Bill and Sam are confident in their ability to be great parents. They do not want their daughter to play outside because they are fearful that something bad might happen to her, they want to shield her from their history and lifestyle, and also would prefer she have no knowledge about illicit substances in general to protect her innocence. Bill and Sam's confidence in their parenting created a large amount of resistance when child welfare initially became involved with their family. Throughout their daughter's childhood they have had three child welfare cases, the first case was reflected on with the most frustration and animosity, the second case seemed to have a lot of guilt surrounding it from Sam, and the last case was portrayed as more of an annoyance. Although Sam had experience with the child welfare system with her first daughter who she chose not to work her case plan for, Bill had little experience with child welfare prior to their first case. Bill and Sam's first child welfare experience together occurred when they sought medical treatment for their daughter in the emergency room when she had a urinary tract infection. Both parents were under the influence of substances at this time which resulted in the immediate removal of their daughter. Because Bill and Sam are so passionate about being good parents this brought up feelings of betrayal; in their eyes they were just trying to care for their daughter. This bitterness has carried throughout their various cases with not wanting resources,

input, or parenting strategies from anyone. The most recent case was discussed with much less anxiety and they were confident it would close soon.

When child welfare has the opportunity to approach families with the intention of family preservation and are able to capitalize on family strengths while wrapping them in resources to encourage success, they are perceived in a much better light. In Bill and Sam's case they genuinely feel like they are great parents and care deeply about their daughter, and when she was removed while they were seeking medical care for her, they felt as though their ability to parent was being compromised. Iowa has currently enacted 911 Good Samaritan Laws which allows individuals to not be prosecuted for their own substance use when seeking medical assistance for another individual. This law, however, does not currently protect against any child endangerment or neglect/maltreatment that occurs while they are under the influence of substances, even if they are seeking medical treatment. In this specific scenario Bill and Sam had labeled child welfare as negative before they got a chance to build rapport. These scenarios and examples are pivotal when initially establishing relationships with families. It is essential that families feel supported and not attacked to begin navigating a case plan successfully with their child welfare worker.

Theme Two: When temporary child removal occurs, how can trauma be minimized?

Children being removed from an unsafe environment due to child welfare involvement or custody findings, results in parental stress. Many times, these stressful and traumatic experiences accelerate the parent/guardian's substance use which further exacerbates addiction and disadvantage. The following stories of Jessica and Melissa describe parents' reactions and responses to the removal of their child. Jessica was able to utilize and find benefits from the resource's child welfare offered her. Jessica achieved sobriety and was reunified with her

children. She speaks very highly of her interactions and involvement with child welfare and plans to continue partnering with her local child welfare agencies to help other families that have experienced similar things. Melissa was also able to achieve sobriety and was reunified with her child. She is proud of her progress and explains how her life is more stable than it has ever been. Melissa discusses at multiple points in her story how traumatic the child welfare involvement and removal of her daughter was. Although she was successful in closing her child welfare case, her experiences and reflection of the support that was given are important to reflect on when establishing ongoing protocols. One of the pivotal resources in Melissa achieving sobriety was the treatment program she was able to attend and that her child was able to reunify after she was settled in. This is a consistently praised resource that many participants note as critical to their successful recovery.

Jessica's Story

During the interview, Jessica wore glasses, a black t-shirt, and brown sweatpants. She was extremely engaged and open during the conversation, providing thoughtful responses and answering questions thoroughly and with as much pertinent information as she could. The only hesitations occurred when the topic turned to Jessica's own self-reported history of sexual abuse and regarding certain topics related to her past while her son was in the room. However, Jessica seemed very proud of how far she has come and was very willing to share her story.

Jessica's childhood was severely unstable in terms of numerous living arrangements and parental transitions due to her elderly father (who had custody of Jessica) having three marriages by the time she was 16 years old. As a result of these unions, her father had children with three different wives, giving Jessica a very large family, but not necessarily strong or consistent

supports to draw on in times of need. Jessica describes feeling like an outsider as a child because of her father's advanced age, which set her apart from other children.

> *When I was born, my father was seventy years old. So, it caused a lot of conflict when I was growing up between other kids, and stuff like that, because, you know, I'd tell em, Well, that's my dad, and they'd be like, are you sure that's your dad?*

The feelings of insecurity and isolation were compounded by a series of traumatic events at an early age, including Jessica being molested by her brother, watching her house burn down, and experiencing severe poverty after the family lost all they owned in the fire.

> *When I was six, I watched our house burn down, um, and then when I was seven, um, my, a little bit about yeah, so, uh, I told on my brother I was being sexually molested when I was, uh, between the ages of five and seven. So, I dealt with Department of Human Services for I think seven years because I had told which was good because it stopped and he got the necessary help that he needed to get so he could get better, um, which he is now part of my life, we talk and we're family obviously.*

At the age of 13, Jessica started experimenting with alcohol, cigarettes, and other drugs. Around the same time, her father was diagnosed with cancer. After multiple ineffective treatments, Jessica sat with her daughter while died, at the age of 16.

> *When I, when I was thirteen, I also found out that my dad, uh, had cancer. He had multiple myeloma which is, uh, multiple tumors in the bone marrow so there was nothing that they could do about it. He had tried various different, I can remember chemo, I don't know if he did any radiation, he was doing like a pill, um, experiment in there, um, but when I was sixteen, he, uh, he died in our living room and I watched him take, take his last breath.*

Jessica described herself as daddy's girl, so the death of her father had a strong negative impact on her choices moving forward. After her father's death, Jessica tried crack cocaine for the first time at age 17, followed by methamphetamine use at age 19. Jessica recalls that from there her substance use went from bad to worse, affecting her personal relationships and physical health.

During this period, Jessica was also trying to figure out what she wanted to do with her life. Her father's illness had brought her into close contact with the medical field, which interested her. When Jessica was 15 years old, she put herself through a trade school course to be a certified nurse's assistant, and six months before her father died, Jessica began working in a nursing home. After her father passed away, Jessica decided to leave high school at age 16 (around the same time her drug use began to escalate), and seven years later she completed her GED.

Jessica began her first serious romantic relationship at the age of 19. The relationship turned extremely abusive and was overshadowed by large amounts of substance use as a couple. At 21, Jessica and her partner got pregnant with their first child. During her first pregnancy the abuse continued but seemed to escalate during her second pregnancy, resulting in her partner's arrest and jail time. Upon his release, however, she took him back but soon after realized the relationship was still controlling in nature and the abuse would eventually continue. When her daughter (2nd child) was six months old, her partner got abusive with Jessica's son. The police got involved on multiple occasions, resulting in two child endangerment charges. At this point, Jessica decided to leave her husband for the safety of herself and her children.

> *Um, nineteen I got into a really bad, abusive relationship, um, there's a lot of domestic violence and a lot of drug use with methamphetamines. Um, I had my first child at twenty-one. Um, during pregnancy was rough, um, a lot of abuse. Um, and the main, the main thing that I remember is being choked out. Moving on from there um, the abuse just got worse and worse and worse and then I got pregnant with our daughter in 2013. [speaks to child] Um, so while I was pregnant with our daughter, um, I had been punched in the back around I was seven months pregnant and I'd had enough, I called the police and he was arrested. He went to jail for a few weeks and then I took him back, just controlling abusive relationships are hard, so, they are really really hard. So that, it still continued for up until [Daughter] was probably six months old and, um, he got abusive not with me this time but with her son and he was thrown clear across the room. The cops were called and he was charged with child endangerment not for the first time, but for the second time, um, so, and, that pretty much, that was it, that was it, I was done. I left.*

Jessica's substance use varied around her childbearing and the abusive environment she faced at home. She was able to 'stay clean' during her first pregnancy but used methamphetamine heavily during her second pregnancy to cope with the intimate partner violence she was facing. When her daughter (2nd child) was born, Jessica was surprised she never tested positive due to the extent of her substance use. She reflects that not getting caught was a problem, because her usage continued to spiral, putting her children at risk.

> *Um, so my methamphetamine use, it was spiraling, I was still using all in, I didn't use while I was pregnant with my son, um, I used a lot of methamphetamines while I was pregnant with our daughter. Um, so, and she never tested positive for methamphetamines when I had her, they didn't take her so things just kept gettin worse and worse and worse for me and I kept, um, you know neglecting. As you're using methamphetamines, you're not a good mom. I wasn't a good mom while I was usin' drugs, that's just that.*

In her late twenties Jessica got called in to child protective services due to methamphetamine use and she asked the state for help and support to seek recovery. CPS helped put Jessica in touch with a treatment facility, and she moved into a full-time center that provided 24-hour accountability and support. Even though she wanted to maintain her sobriety she started a cycle of treatment and relapse over the next several years that included two different inpatient facilities and a halfway house.

> *I, uh, had a DHS call on me of my methamphetamine use and I finally admitted to them that I had been using, um, and that I needed help. So, I had left, uh, my hometown and moved about an hour from there and uh, still, I, uh, had problems stopping. I still had not gained control over my use. Um, I ended up going to the [Treatment Facility] which is in [City Name]. I was there for seven months, um, I had to do inpatient and halfway house there.*

After her last round of inpatient treatment, she started dating a new man. Like before, she soon realized she was in an abusive relationship. Over time, her partner became more controlling and overbearing and Jessica describes starting to use crack cocaine once again as a coping mechanism for the domestic abuse that was happening. In the same pattern as before, the abuse

was tied to cocaine use which eventually led to methamphetamine use. Not long after Jessica began using methamphetamines regularly, there was another incident when her partner slapped and punched her. Jessica immediately called the police and had the partner arrested on domestic abuse charges. To ensure her safety, Jessica had a no contact order put into place, but her partner continued to break the order resulting in his arrest.

> *I got into another abusive, different relationship, became over controlling and overbearing and I started using, um crack cocaine while I was up there and then that stemmed from going from crack cocaine and methamphetamine use. And pretty soon before I knew it, you know, I was using again to numb them feelings because I was, yeah, being hurt and so…. It was a scary, scary, scary night and my two kids were in the home, they were asleep, um, and I can remember them waking up after all of this you know, cuz I was screamin and I was on the phone callin 911 and he was trying to get into my door and um, the cops came eventually I got him out of the house, locked him out, he still tried coming in the front door, but the police showed up and then they arrested him and took him away, um, and still even after that he broke the no contact order [loud gum chewing] twice but just by phone calls not by showing up or anything.*

Within six months of her second partner going to jail, Jessica hit a critical point in her substance use life course. Child protective services were called and asked Jessica to do a drug test. Jessica vacillated on how to engage, opting to both volunteer to do a highly sensitive drug test (assuming she would fail), and also trying to 'beat' the test by covering up her substance use.

> *Um, this time DHS was called again and I don't know why but I, uh, I volunteered to do a hair strand test even though, even though I was dirty and I knew I was dirty. So, I tried covering it up. I tried dying my hair, still didn't work. Um, I still came back positive, not enough though to where, they wouldn't remove my kids from the home."*

Getting 'caught' a second time by child welfare services proved to be a pivotal moment for Jessica. Realizing she needed extended help if she was going to maintain sobriety, Jessica told the child welfare investigator that she wasn't able to take care of her children and she recommended they be placed in foster care while she went through inpatient treatment once again.

> *I finally came to my senses that, uh, I needed to stop, I needed to tell somebody, um, I needed to become honest. Um, so, I went to the DHS investigator that was investigating my case and um, I became honest with him and told him that I could not take care of my kids and that we needed to do a placement. So, I voluntarily placed my children in foster care and eight days later I went to treatment again.*

Jessica then went to a women and children's facility for two and a half months to receive treatment. After that, Jessica transferred to a different treatment facility to continue receiving treatment. While she was there, two important things happened. First, she became a member of Narcotics Anonymous (NA) and found a sponsor that provided meaningful support for her recovery. Second, due to her significant progress, Jessica's children were reunited with her, and lived with her in the treatment facility for about ten weeks before she graduated from treatment and moved home.

Jessica reflected on how important the treatment resources were for her and her children moving forward with their lives. Both children and Jessica, received therapy, which Jessica describes as necessary for addressing the trauma she has been through as well as the trauma her children have been exposed to. She feels particularly grateful that her son was able to receive supports given the severity of the trauma he was exposed to by her abusive partner (both children receive CPS services and Behavioral Health Intervention Services (BHIS)).

> *But, I also had gotten some services set up not just for my children, but for myself because of all of the trauma that I've endured in my life and they have endured a lot of trauma, not just, um, not just from me, but from other people too because, uh, from the last domestic he was being very, he was very, it was very traumatic for [Child's Name]. Um, he would come up and smack him on his chest, he would, Yeah, and, uh, would make him get down and do um, uh, what do you call, push-ups. He would make him do push-ups. Not just always push- ups but sometimes he would make him, uh, sit in a push-up stand and not doing anything and just, he'd have to sit there for thirty minutes, um, so, but going back to treatment I, when I set up services, so I got both my kids in therapy, I got myself started on EMDR therapy which is, yeah. Um, I got my, both my children involved in BHIS behavioral health intervention services.*

In her life story, Jessica shares that at the time of the interview she is 14 months sober. She's pursuing a degree in Human Services and is currently training to become a DHS Parent Partner with Iowa's child welfare system. Once she has completed school and earned her degree, she said she would like to become a substance abuse counselor. Currently, she is living with her two children as well as her mother who provides a lot of help with caring for the children while she's in college. She also characterizes Narcotics Anonymous as being a very significant source of support for her in her recovery. Jessica is actively involved in NA meetings where she attends three-four times per week, and also spends some time with her children whether it's swimming at the rec-center or outdoors sledding in the snow. Jessica speaks very highly of the support she receives from different programs, where she says that Family Independence Program, food stamps, and state-provided healthcare have all been beneficial for her.

> *Um, I mean it's not any different than what I had with FSRP [Family Safety Risk & Permanency worker] 'cuz my DHS [Department of Human Services] case just closed out so they're pretty much just doing the same supports that she would do, um, that she's been doing. It's pretty much all the same thing, just coming and asking me what I need, if I need anything and hookin' me up with resources if I do need somethin' so.*

Jessica directly states that hitting rock bottom was the catalyst for her to decide that she needed to seek help for recovery. In her situation rock bottom was being an extensive meth user and having her children removed from her care. The time point and culmination of events in Jessica's individual lifespan may differ when comparing others' definitions of 'rock bottom', however this seemed to be a key piece propelling change in individuals' journeys to sobriety. Furthermore, she shared her belief that children cannot be the only reason a person has to get 'clean' and that it has to be a self-driven motivation to seek and maintain recovery.

> *The reason why I got clean is because I got, I, I just, I had hit my rock bottom and rock bottom is where I just came to a point in my usage where I couldn't do it no more. It was*

> *either, it was either continue using and die, or stop using and get help. That's where I was at, so.*

Jessica described that her children endured a significant amount of trauma from her previous abusive partners as well and that she has had them involved in therapy to help them process the trauma they experienced. As a result of her own path, Jessica wants to be involved in helping other families navigate through the struggles of addiction and is currently working to be involved in the Parent Partner program. She is proud of where she is and how far she has come in her substance use life course.

> *I'm in school. I am working, so right now, I accepted a position, so two months ago I accepted a position with an independent contractor, so I'm in the training right now to become a Parent Partner. A Parent Partner is someone who has had their children removed from their care, they have to have their children in the system, they have to have a CINA [Child in Need of Assistance case]. Um, and then either, had their rights terminated or they got their children back and they have to be clean for a whole year. So, um, so I get the opportunity to go out into the community here in the next month I'll be done with training, um, sub, it's kind of like subcontracted through the department of human services. Iowa's the only place that has parent partner. Wisconsin's getting ready to take on parent partner I believe 'cuz I just went through build a better future training. Um, so, like I said, I just get that opportunity to go out into the community.*

Jessica's story is promising because regardless of the trauma she experienced throughout her life, child welfare was able to step into her life, support her in achieving sobriety, and provide ongoing supports for Jessica and her children. Now Jessica is a partner with child welfare and supporting other families going through similar cases that she experienced. She has come full circle and embraced her recovery, while doing her best to care for her children.

Melissa's Story

Melissa wore casual clothing, she had jeans with a basic t-shirt. The interview was conducted at her current place of employment. During the interview, Melissa was engaged and displayed a willingness to share her stories. She was forthcoming throughout the interview and maintained strong eye contact.

Melissa's mom was born and raised in Germany and immigrated to the United States when she was twenty-one years old. Melissa's parents separated and their relationship didn't go well. When Melissa was only three weeks old, her mom was lacking resources and relatives to care for Melissa, so her mother gave her to her grandparents. During the time they were sorting custody out Melissa spent some time in foster care. Finally, when she was eight years old, her grandparents were granted sole guardianship of her.

> *My mom was born and raised in Germany. She came to the United States when she was twenty-one. She had met my older brother and sister's father in the army, he was over in Germany. So, she got pregnant, they came back to the United States. she got with my dad, um, and I was conceived, um, basically some not so good things went down with my family. So, she then, um, went to meet my dad, well since she was from Germany, she had no resources, no family here, didn't know anybody, um, didn't really have, you know, the means to take care of me, so, um, she gave me to my grandparents to raise me since I was about three weeks old. So, I spent some time in foster care, uh, while they were trying to get all that sorted out and what not. Um, about eight years old, um, my grandparents ordered the grandkids sole guardianship of me. It took, I remember going through court hearing, after court hearing, after court hearing, um,*

Melissa's childhood was riddled with instability and included familial sexual abuse, a parental split, and being placed with her grandparents. Each of her parents went on to remarry and each had two more kids; Melissa's older siblings lived with her mom. Her dad continues to use meth has always struggled with substance use and still uses meth to this day. Melissa was the middle child of four brothers and sisters, two of her siblings were from her mother's previous relationship and two of them were from her father's remarriage.

> *My adopted uncle basically ended up molesting my older brother and sister, and so my mom was no longer ok with being with my dad. So, she then, um, went to meet my dad, well since she was from Germany*

Melissa shared that when she was in High School, she was involved in sports like playing golf and she was also a cheerleader. She graduated high school early as expected and she was pretty good student that time. *"Oh, totally, I met Freshman year, I was in golf, I was a*

cheerleader, I was in track, I did cross country, I was very involved all of high school. Um, well not all of high school."

Melissa moved to another town to live with her boyfriend, she then went to Community College for one semester. When Melissa and her boyfriend broke up, she then moved about two blocks away from her grandparent's house and while she was staying there, her roommate offered her meth and she smoked it. At first, she didn't get high but the next thing she knew she woke up a full-blown addict.

> *I move to [City Name] to live with a boyfriend. Was going to [College Name] Community College for about a semester. I got all the money that I was supposed to get [laugh] and I just basically never went back. Um, me and my boyfriend broke up from [City Name], I moved back to [City Name] about two blocks away from my grandparents' house and um, my roommate, one night offered me Meth and I smoked, I didn't get high, went right to bed and then the next thing I know, I was a full, full up born addict.*

Melissa admitted that she was getting high every day. She was smoking weed, taking drugs, and drinking alcohol. She also shared that she did everything with drugs, but she never used a needle in her life. During those times, she moved in with her grandparents' house. By that time, Melissa found out that her grandfathers' doctor prescribed him drugs, but her grandfather wasn't taking them. Melissa decided to sell the prescribed pain medication to make money from it. By that time, her family found out what she was doing, her grandfather was basically dying. Melissa stopped selling his prescription medications and then the realization that the man who raised her was dying and hit her very hard.

> *I was stealing his Vicodin and stealing his Percocet. He was always the one that went to work. Doctor was prescribing pills and they would stay in the cupboard for years and years, know. I was stealing his pills, Yeah, I have and I've been selling 'em, as I walk up my grandpas got this huge brace around his back and they basically informed me that my grandpa was dying and they found a mass in his spine that they've seen for months prior and didn't follow up, this man raised me my entire life is now dying. I had been stealing his pills, so I felt this bottom of the earth, yeah, scum bag.*

At the age of 21, Melissa found out that her nephew was also dying from Leukemia. At that time, Melissa's grandfather had completely stopped treatment. Melissa's nephew and grandfather died within a short time of each other. The death of these family members shook Melissa and her family with grief. While her grandfather was dying, Melissa and her boyfriend were continuing to use and cook meth and the grief seemed to only push her further into substance use.

> *My nephew is dying of Leukemia. Um, seven years old, they went up to Mayo Clinic, I turned twenty-one. Um, six days before he died and I was supposed to go up to the Mayo Clinic with the, some family to go see him, right before all of this, like he had a bone marrow transplant. So, they were up at Mayo. I'm still getting high, missed the ride to go up and see him, so I basically didn't even get a call from family members saying that he had died. I got a call from a uh, a friend, that was like ok, you piece of shit, your nephew just died, basically. So, my grandpa went up to Mayo to spend that time up there about a month and a half, um, during that time my grandpa completely stopped the treatment, he wasn't doing anything because he wanted to be there. Well, then my nephew died, so that was really hard on the family. Um, and then when my grandpa died, well before he even died, um, me and my boyfriend were cooking Meth.*

After her grandfather died Melissa found out that she was pregnant with her daughter, she had conceived a week before her grandfather's death. When she discovered she was pregnant she stopped using drugs. Her boyfriend continued to use throughout her pregnancy and ended up in jail. Melissa's daughter ended up being a source of hope and positivity for her and her family as they recovered from their loss.

> *I found out a month to the day, later that I was pregnant and my daughter, so she was conceived the week, he died. And when I first found out I was pregnant I quit doing everything, me and my baby's daddy were together, I quit everything, didn't do anything, maybe eighteen months, nine months after she was born, that I, you know, was just mom, the mom things, as sober, didn't touch nothing, didn't do nothing. And then, my baby's dad was still getting high the whole time I was sober and he was shooting up in the hospital room and my daughter was, when she was born, she was born with a 101.7 temperature, which is not good for infants and we knew that staying in the hospital for two and one half weeks with a meningitis scare, the whole time he was just in and out getting high, doing coke, doing heroin, he overdosed while I was pregnant and ended up going to jail while I was pregnant.*

After giving birth, Melissa broke up with her daughter's dad. Upon the breakup, Melissa struggled to find housing and the means to care for her daughter which resulted in her relapsing with meth again. She decided to ask her Aunt for help, she went to rehab, during which time her aunt cared for her daughter. Melissa's aunt and uncle also helped them secure housing after they returned from rehab and once she had shown an effort to achieve sobriety.

> *More, I would have known that I was going to end up doing what you were doing and then go get high and I was going to relapse and then all that, well we went through two different places and then with him being a felon, we couldn't hard, it was really, really hard for us to find a place to live. So, my aunt and uncle, um, the one that had the son with Leukemia, they were landlords and they were renting out houses and stuff like that and they were kind of like, Ok, we'll give you guys an opportunity," that I've done this good. We, me and him had already gone to a thirty-day rehab. He made it the first thirty days, I didn't even make it past ten. [laugh] But, it wasn't hard for me to, once I walked in there, I was in there with the same reason when I walked out. I was there to get sober, I was there to be a mom, again*.

Melissa continued to engage in friendships with other drug users. With the constant exposure to substance use she ended up relapsing again at her friend's house when she found a meth pipe. Melissa ended up breaking up with her boyfriend around this time and also losing housing. She went to a homeless shelter with her daughter for two weeks, but she could not recall which one because she was so high at the time.

Her continued drug use and lack of care for her child started to catch up with her. She was arrested on eight different drug charges, which resulted in her going to jail. Her grandma and aunt tried to have Melissa's daughter placed into their care but initially the court chose to give her daughter to her father. Child welfare ended up stepping in and performing an investigation which resulted in finding out that her daughters' father was still using drugs. Melissa decided to give her daughter to her best friends' mom. Her daughter stayed there for a couple of months, but the child welfare system transitioned her daughter again because they felt it better for her child to stay with her family. Melissa's daughter was then placed with Melissa's Aunt. Melissa's

Aunt was working towards adopting her daughter because Melissa kept trying treatment programs and not staying. Finally, Melissa attended a program and was able to stay there for three months where her daughter was reunited with her in treatment while she finished the next eight months of her program.

> *I found a loaded Meth pipe, and I caved, and I relapsed. And, at that point I didn't have anywhere to go with meth. And, um, then, uh, and [Daughter], and um, I lived upstate in a homeless shelter for two and a half weeks with her and I was getting high, one thing after another, I end up getting arrested for eight different drug charges, all meanwhile, trying to get my daughter from his new girlfriend, huh, and she takes off to a police station, she's saying that they arrested me. They come up there, the cops ended up letting my daughter leave with my baby's daddy and girlfriend--which were also on drugs. And after that I mean, DHS was called and as soon as DHS knocked on my door I willingly was like. This is what I'm doing, this is what I have been doing and this is where I need help. she had already had my daughter for a little while, for like a couple days, or whatever. So, um, then DHS was involved. Obviously, the case was opened and um, they then decided it was best for my daughter to be with family. So, they gave my daughter to my aunt. there. I spent three months there before [Daughter] was finally, um, reunited with me. I spent, um, altogether eleven months in the [Treatment Facility].*

When Melissa was asked if she attends church, she said that she believes there is a higher power and she knows that there is something more to believe in, but she is not regularly attending or identifying with a given organized religion at this point. Recently, she has been attending Reiki classes, and she learns a lot from there.

> *There wasn't one, there wasn't one at all. Uh, I wouldn't even say that now, it's necessarily God based religion. It's higher power and knowing that there's something more to believe in at this point. Yes, and no, No, because I don't believe, like I said, the whole God thing, kind of throws me off. I don't understand how he could do that to a seven-year-old. Or, I don't understand his ways but, the whole like crystal religion or the Wiccan religion and like some universal things are more intriguing to me than God, I guess, I would say. The Wiccans, like, I go to Reiki classes, so it's just like learning to just be more here and be here now and like I've got a couple different phone c, I don't like the witchcraft part of it. I like the more universal side of it so I've got crystals at home. I've got crystals in my purse and not gonna lie, crystals in other places with crystals. We meditate, we hold on, we feel them, we just talk a lot more about the things we're feeling, rather than the things we believe in, if that makes any difference?*

Moving forward, Melissa is happy that it's been one year since she got her apartment keys, and she is excited about the stability and changes she has brought to her life. Her focus now is to move forward. She enjoys her current boss, because he understands her past experiences and is supportive. She also mentioned that her daughter spends time with her aunt Thursday to Sunday every other weekend so she can have "me time".

Melissa is also open in sharing her experiences with her daughter in the future. She plans to explain everything her daughter wants to know. Melissa is two years sober and more self-sufficient than she has ever been before. Since her child's father is in prison it has been harder for her financially than she would like to admit, but she is scraping by. She lacks a community and strong friendships, and this has been hard for her. She is unsure of what to look for in a dream job and struggles to think about this in light of her criminal history. She seems ready to date again but is at a loss for how to get started again. Melissa states she was never a drinker, but she is open to reintroducing alcohol into her life especially as her daughter ages and they share celebratory occasions.

She is regaining the trust of her family (specifically her aunt and uncle) after two years; it is a work in progress. They hold her to higher standards but are willing to try and work through the broken trust with Melissa. She reconnected with her mom, but they have not had contact in recent months due to a conflict over how they view Melissa's childhood.

> *Kind of why I do the whole meditation thing, it's like to be here now, I have it on my arm. So, it's just learning to be in the present and quit worrying about everything I've done wrong, worried about everything that could go wrong, it's just like being happy, playing with those Barbie's, even though I'm not going to play with Barbie's forever. You know what I mean, she's not going to want to play Barbie's forever. So, honestly ,not stressing about laundry that needs to be done and taking that ten minutes to play with her and to give her that one on one time.*

Although there are variations across both Jessica and Melissa's stories, they were both successful in achieving a sober lifestyle and reunifying with their children. Both of these mother's had their children removed and had vastly different experiences with this process. Jessica chose to voluntarily place her children in foster care while she attended treatment with confidence that they would be returned to her. Melissa, however, voiced her preferences of where her child would go when she was removed from her care, after several transitions she was placed with her aunt who pushed for adoption while she attended treatment. Jessica reflects on the experience as positive and has gone so far as to partner with child welfare moving forward, while Melissa describes herself as having Post Traumatic Stress Disorder from her time working with child welfare. Key results from these stories are when child removal is inevitable providing as much control to the parent experiencing the removal can minimize trauma. Additionally, although kinship is a preferred option for child placement for many reasons, ensuring the kinship placement is encouraging of the parent's success also provides for more promising outcomes of reunification.

Theme Three: How does family friendly treatment help preserve families?

The first priority of the child welfare system is to preserve families and prevent child removal when at all possible. Many times, child protective services can step in when a family is at risk of child removal and offer resources and support to preserve the family unit. The following story is a great example of how child removal was avoided by providing assistance for Elizabeth to attend treatment and get back on her feet with housing and providing for the basic needs of their children, while maintaining custody. Child welfare was also able to support the children's relationship with their father through visitation services while maintaining the

protective order between Vincent and Elizabeth following the domestic violence charges. You will see various ways Elizabeth and Vincent were provided many resources which has largely resulted in their success.

Vincent and Elizabeth's Story

Vincent and Elizabeth participated by completing individual interviews and then a follow up interview as a couple. All three interviews were conducted in the couples' apartment where they were warm and welcoming. Their apartment was lived in and had typical clutter of a home with young children, with toys scattered about. Sheets were used instead of blinds on the windows while several picture frames and wall décor hung around the living room. Initially Vincent and Elizabeth were a little cautious in their individual interviews but opened up fairly quickly and were definitely more comfortable during the interview they did as a couple after they had already met the team interviewing them.

Vincent's childhood was rather unstable, and he was raised a majority of his teen years by his older sister. His parents were around throughout his childhood and he recalls having a fairly good early childhood, his parents were married, they went on vacation, and he fondly recalls going hunting and fishing with his family members. Vincent's parent's substance use was occasional and recreational throughout this time until his father's mother passed away when Vincent was the age of 11. Vincent did not understand the extent of the substance use problem until his father was arrested when Vincent was the age of 18.

> Vincent*: "once I turned ah thirteen, fourteen you know like any other kid, you start getting into you know drinking and partying with your friends. And I really wasn't into anything that bad. I just kind of mainly would go to parties just to hang out with girls. Um, but my parents, I'm not exactly sure a hundred percent what started going on with them. But they started using at that time. You know, I mean at the time, I didn't know what was going on cause you know I'm just thirteen or fourteen, so I had no clue. But, um, so they, things kind of started falling apart with them. They, my dad lost his job first and then probably about a year later, my mom lost her job and so you know money*

> *was real tight. And of course, with them using on top of it, um, things kind of started to you know disappear around the house cause you know when you're an addict, you start to sell things that are valuable to get your fix. And then of course, you know I started to notice like hey how come we never have food or like you know what I mean? My sister at the time, she was, she, my sister is older than me, Ah, she was eight years older than me. So right about the time that, ah, you know things started falling apart at the house, she was going to college and had a job and stuff. And she ended up always having to buy my school supplies or my shoes or things like that. And then, about the time I was like eighteen, I realized you know my parents were actually doing hard drugs.*

Elizabeth grew up in a trailer park with her mom, stepdad, and sisters. When Elizabeth was around the age of 11, she found out her stepdad wasn't her biological father and shortly after her mother broke up with him. The period of time following the breakup was chalked with residential instability, abuse, and multiple boyfriends for her mother. Elizabeth ended up living with her father for her teenage years.

> Elizabeth*: My mom wasn't, I don't know. My mom wasn't very much mentally there so I didn't, She was just kind of like there but she would sleep or she would just like be talking to guys from the internet. Like she wasn't there.*

Vincent and Elizabeth began their journey with substance use during their high school years starting with alcohol and cannabis. By their late teens and early twenties, they were living together and experimenting with drugs like Adderall, hydrocodone, Vicodin, meth, mushrooms, and heroin.

> Elizabeth*: We had, we would have people over a lot and party, smoke weed, and we'd, uh, take Adderall and you know get all messed up. And then, um, at one point we had, I'll tell ya a story. We had this kid like everyone was drinking and partying. We had this kid drink too much and get all mad and angry, and he jumped out one of my windows. The cops were called and he ended up breaking the cop's leg. It was just, yeah. We were known for the like the party group. The crazy kids.*

When Elizabeth got pregnant, she stopped using, but following the birth of their first child Vincent's mother died and their substance use was exacerbated to cope with the grief.

> Elizabeth: *I wanted to be a better person. So, I made the choice to try to stop using drugs and stuff. I worked for a little while, then I had [son] and eventually it just went crazy. I spiraled and went crazy.*

Both Vincent and Elizabeth have been in trouble with the criminal justice system. Elizabeth received a DUI and Vincent received charges for minor in possession when he was younger and domestic abuse for trying to strangle Elizabeth which wound him up in jail for 70 days.

> Vincent*: Obviously, there's no drugs in jail so I was clean, but I went to my dad's and started using and I'm on probation. And by this time, you know my mindset is a full-blown addict so I can't do like I did before when I was on probation where I was able to drop clean when I needed to. So, you know what I mean? By two months in, um, my, I've already dropped dirty from my PO a couple of times. He sends me to my first ah thirty-day in-patient treatment which I learned a lot there, and I came back.*

Elizabeth and Vincent's relationship has overall been riddled with many break ups and time apart including an instance when a no-contact order was in place. Despite their relational instability all three of their children were planned.

> Elizabeth: *And I was staying home, and I was still, I was still using, and he was using. I think he was using meth maybe more then. I don't know. We were still doing drugs and that's when we got our domestic and he went to jail. So, we were split up then. We weren't really together.*

Due to their substance use and involvement with the criminal justice they came into contact with the child welfare system. The initial incident that placed them on child protective services radar was Elizabeth's DUI.

> Elizabeth: *I got my DUI right a little bit before the domestic, I got a DUI. And I had my kid in the car, so I had child endangerment and a DUI. So, then I had to go to outpatient. That's when I began getting help."*

Following outpatient treatment Elizabeth went through a season of doing okay for a season.

> Elizabeth*: And I was doing good for a little bit. I was still drinking. I drank and I wouldn't do anything else. Um, but, eventually I steered back. Vincent got out for a little bit and we were talking, and you know eventually I think my dad or someone ended up calling because we had a no contact order and someone ended up calling and he ended up going to jail cause he was with the kids and I wasn't there but he still wasn't supposed to be where I lived or something. I don't know. He went back to jail.*

During this time while Vincent was incarcerated, Elizabeth started to deepen her use of substances but was unhappy with where she was in her life and wanted to ensure her choices did not negatively impact their children. It was at this time that Elizabeth reached out for help and resources again.

> Elizabeth: *I was still using and seeing the counselor in [City] and eventually I told her that I needed more help, that I wasn't, the outpatient wasn't, I needed to like be in-patient somewhere, And I was, uh, in there for six months with my kids. I took my kids. At one point we didn't have a DHS case or nothing, so I pretty much put myself there.*

Due to the fact Elizabeth reached out for help and was able to keep her children with her at the treatment facility this was not ordered by a child welfare case. At some point during her time in treatment she allowed Vincent to take their children and visit with them and she did not know he was using substances at that time, which resulted in another open case. Elizabeth feels as though the child welfare system has been nothing but helpful and she never felt as though her children were going to be taken from her.

> Elizabeth: *So, then I ended up getting a DHS case when I was in the [Treatment Facility] which wasn't bad. Everyone was always like you know like saying bad things about DHS, but they just helped us. They didn't take my kids from me. And then, um, I, when I got out the [Treatment Facility], I had the crisis center helped me get an apartment. I lived there for a few months and then my section, I got Section Eight, and they helped me get this place. Um, then I got a job at McDonald's and I was working, going to meetings, and I was staying clean. I stayed clean for a year about. I did have a relapse in last January. A year ago, I relapsed, and I put myself back in the [Treatment Facility]. It was just three months this time. It was, it didn't take me as much you know cause I already knew what I had to do.*

Vincent and Elizabeth are now both in recovery and living together. Elizabeth has been sober slightly longer than Vincent and was able to secure stable housing and employment. Vincent is still working on finding work but is doing his best to help out with the children while Elizabeth is working. Moving forward Elizabeth said she is not worried about maintain sobriety because she knows how to get help if she needs resources.

> Elizabeth: *I know if I relapse, I can reach out and get help. I don't think people are there to take your kids away. I don't think they're there to make your kid's life and your life more worse. I mean, I've seen it like in DHS and I've seen the type of people they take their kids ya know. And I've seen people get their kids back. And I just tell the difference of the ones who's don't get their kids back and the ones who do get the kids back.*

Elizabeth was asked why she feels like some people are unsuccessful or feel so threatened by the child welfare system and she explained that how the parents respond to the case workers is a big part of problem.

> Elizabeth: *Uh, I don't know. They just, they come about things the wrong way. Like by yelling at DHS and thinking, they think that they're out to get them and, they're not. They hide things cause they're scared and, [sniffling] they're not honest. I feel like being honest really helps. I mean, I hope I don't relapse, that doesn't happen, but it's a possibility always.*

Elizabeth would eventually like to go to school and find a better job to help their family. Vincent is happy to be back with this family and is excited to start working again when he can find a job. Vincent and Elizabeth are another success story that reflect very fondly on their interactions with child welfare. One of the key components that contributed to, specifically Elizabeth's, journey to sobriety was her ability to take the children to a treatment facility with her. There were several mothers throughout these findings that achieved great success and were extremely grateful for their opportunity to have their children remain in their care. This family friendly resource assists with minimizing trauma across the family system and reinforces stability, while having the oversight of the treatment facility to ensure the children's safety.

Concluding Findings

There is ample supporting literature to express how highly correlated substance use and child welfare involvement are (Radel, Baldwin, Crouse, Ghertner, & Waters, 2018; Kim, Brook, & Akin, 2018). Although the interview protocol for this study did not address questions about

child welfare directly, by focusing on how these individuals' lives were impacted by substance use, the story of child welfare became central, given how intertwined child maltreatment and parents who use substances tend to be. The illustrative examples provided above give rich detail into how substance use influenced their lives, but also how significant of a role child welfare played in their lives as well.

When child welfare becomes involved with a family, they become a member of the family system for a season. Utilizing theoretical frameworks to consider the significant role child welfare plays when interacting with a family unit reinforces the crucial importance of trauma-informed practices to build trusting relationships. Additionally, the onset of a child welfare case is innately stressful and the addition of a component to the family system is also innately stressful, which further compounds the impact on a family. As child welfare moves in and out the family system careful and supportive transitions are necessary for success. The findings of how these transitions can be most supportive and overall accomplish the goal of successful parenting are described below.

There were three major discussions surrounding child welfare involvement with these families that were highlighted. The first was the manner in which child welfare approaches families has an impact on their experiences. Several stories, for example Vincent and Elizabeth, reflected very fondly on the resources they were able to receive, the substance use treatment they were able to access via their case worker, and noted that they didn't feel like child welfare had the intentions of taking their children. We also have families like Bill and Sam that reflect very negatively regarding their child welfare experiences. They didn't believe anyone should tell them how to parent or care for their children, they didn't believe their daughter should have been removed from their care, and they accessed only the required, minimum programs from their

case worker. The important take-aways from these examples is whether child welfare can approach investigations in a manner of surrounding the family in resources and ensure the families understand the first priority is to preserve the family in accordance with the national legislation, families will be more receptive and less fearful – ultimately resulting in more honesty and transparency from the families. When families are honest and transparent about the challenges they are facing, more resources or support can be offered, and families will see better outcomes.

Second, when child removal is unable to be avoided how can the trauma of that experience be minimized. Regardless of the amount of time a child is removed from their primary caregiver's care the experience will be traumatic, but it is important to use the illustrative examples as a blueprint for what scenarios were successful in reunifying and preserving the family unit and which were not. The two individuals that were able to attend a treatment center that allowed their children to live with them while receiving in-patient treatment reflected most positively about their treatment experience. Amy had her children removed for a short period of time (less than two months) and then was quickly reunified when they were able to join her at the treatment facility. Another key reflection was trauma seemed to be minimized when the parent experiencing the removal was allowed to choose where the children resided. Jessica chose a close friend, Amy chose her grandparents, and she was able to live there as well, these experiences seemed to lessen the stress and anxiety that came with removal. There was also Melissa who had her child placed with her aunt, who was not supportive of the mother's recovery and resulted in her attempting to adopt the child while she attended treatment. This is important to note because although kinship placements are always a priority to place a child with

familiar people, it is also important to select a kinship placement that is supportive of the parent's recovery.

Finally, how do we provide family-friendly treatment and resources to assist in family preservation. The most common success, as mentioned above, was the ability for families to access treatment without the removal of their children, or a very short removal for the parent to detox. Often, the availability of treatment is minimal and then finding programs that also allow the children to attend are fairly rare. Another family-friendly resource that was mentioned in Elizabeth's interview was classes surrounding parenting strategies. She talked about what she learned and how she was implementing them with her children. This was a great, successful option that should be highlighted as well.

Although this study does not provide the quantitative nature to solidify and test these proposed experiences, understanding how these child welfare interactions influenced different families is helpful for policy implications moving forward. Finding ways to present child welfare involvement as resources or as assistance that is preventative and connecting individuals with resources that can assist families in feeling more supported throughout their journey to sobriety. Finding ways to minimize trauma when children do need to be removed from a primary caregiver for their safety is imperative to the health of not only the children, but also the parent. Finally, finding ways to adjust currently provided resources to be more family friendly, can enhance the overall interaction and success with child welfare.

CHAPTER 6. CONCLUSION

In this study, I utilized ethnographic interviews with individuals who have children and have personally partaken in substance use activities at some timepoint in their lifespan. There is evidence to support two key objectives this paper seeks to explore (1) Utilizing the multigenerational model (Figure 1) as a framing device, is there a typical cycle of substance use and child removals among parents in the sample, and does it correspond with the model? (2) What are the experiences, interactions, and reflections of families with the child welfare system and what positive or negative consequences does that have on achieving the child welfare goal of family permanency?

When examining the theoretical model, it is clear there is evidence to support the prevalence of a multigenerational pattern of substance use, child welfare involvement, and traumatic experiences. There are examples presented throughout the literature that children who are exposed by caregivers to substances are more likely to also use substances in their adult lives. This dissertation concurred with these findings and also expanded this finding to include the multigenerational transmission of child welfare involvement and traumatic events. Although this pattern of replication was present across generations, I used a broad scope to explain how this occurs, taking into consideration that transmission can occur via disease, social learning, or epigenetic factors which all impact the translation of substance use, child maltreatment, and trauma replication patterns.

Holistically, the findings presented about the prevalence of the multigenerational cycle of choices and experiences replication, but this leaves a big question: Can the cycle can be broken? Utilizing an in-depth lens and understanding of these individuals' lives I believe that the answer to that questions is, yes, the cycle can be broken. In order to evaluate the cyclical pattern,

sometimes we have to zoom out and look at an individual's overall life trajectories and focus less on the backslides, small bumps, and stumbles along the way to see if overall their life is on the upward trajectory. Although there were several participants who were able to access and receive resources that resulted in significant life changes and the achievement of sobriety, the concern is that we may have broken the cycle in this particular generation, but the children have already been exposed to this lifestyle. Like we see with Bailey, she received intervention early and was adopted by the age of two and ended up in the same apartment complex as her biological mother and addicted to substances. I also found that very rarely were interventions and resources provided between the onset of substance use and the individual creating their family of choice. This often results in children being exposed to substance use because resources are not offered until child welfare involvement occurs. Although many times child welfare can be a positive catalyst for resources and change, it also can present its own set of traumatic experiences like fear of child removal or the occurrence of child removal.

To address research question two, I examined the interviews of the nine individuals for their interactions and experiences with child welfare. Three key findings emerged throughout the in-depth coding and examination. (1) **The manner in which child protective services approaches families impacts the families' experiences and successes.** When child welfare can approach families with a 2-Gen perspective and attempt to shower the family with resources and reinforce that the intent is to preserve the family unit and not to remove the child when at all possible. This study found that families tend to be more successful in achieving the goals of their case plan when trust is foundational. (2) **When temporary child removal is unavoidable there are things child welfare can do to ensure trauma be minimized**. This study also found that when children must be removed for their safety, families are most successful in reunifying when

the caregiver has input on the placement location (especially when kinship placements are an option). (3) **Family friendly treatment resources help preserve families**. When caregivers are able to attend treatment programs with their children, they were more successful in achieving sobriety, transitioning into living outside of treatment, and navigating the stressors of parenting without significant assistance while avoiding relapse.

Contribution to the Literature

There has been significant research conducted about children who are exposed to substance use being more likely to replicate those experiences in their own adult lives. This study expands these findings and builds on the sparse literature that has been conducted about a similar pattern being present with child welfare involvement and traumatic experiences. In this dissertation, I provide a theoretical model that can be applied, tested, and further verified across various studies addressing multigenerational patterns of substance use, child welfare involvement, and trauma (combined or independently examined). This theoretical model is rooted in literature and considers generational reoccurrence through environmental exposure, epigenetic transmission, and the nature of substance use being classified as a disease that can be passed across generations.

A confirmatory analysis was performed with qualitative interviews to verify the emergent and preliminary patterns contributing to the replication of these three key occurrences (substance use, trauma, and child welfare involvement) across generations. This model was studied in-depth with nine participants and then compared to a sample of forty substance-using individuals to explore how their exposure throughout the life span influenced their experiences. The findings were consistent across the samples and the multigenerational cycle exhibited strong applicability

throughout different life trajectories. This model was applied to a diverse sample and should be further utilized with other varying demographic populations. These contributions move the literature forward with a working model that can be applied to across cultures and disciplines.

This work heavily focuses on how child welfare interactions are impacted by theory. For this study, taking a Family Systems lens was crucial to understanding and rigorously examining how child welfare interactions heavily influence specific family systems. When child welfare becomes involved, they disrupt the current negotiated terms, causing disequilibrium while trying to navigate substances, parenting, and healing from trauma in many cases. All of these factors culminate and interact with the individual's current Life Course trajectory. It is also imperative to the analysis process to carefully consider the entire life trajectory of each individual and how that trajectory holistically applies to the specific timepoint child welfare intervention occurs. All of these theoretical considerations provided framework in understanding that the initial approach for child welfare is important, when preservation is not possible involving the caregiver in the placement encouraged success, and individuals were more successful in achieving and maintain sobriety when their children were able to attend treatment with them.

This study promotes the importance of Family Systems Theory principles with the necessity to consider an entire system when providing interventions of any kind to an individual. Carefully considering how that individual is nested within the system, the role that they play and the influences they have on others in the system to further extend interventions throughout the system is crucial for effective 2-Generational approaches. Jessica's children receiving therapeutic services following reunification was a great example of the importance for holistic family resources. Life Course Theory was also iteratively supportive and supported throughout our study in the consideration that events, exposures, substance use occurrence, and recovery

processes happen over time. Finally, strengths-based models utilized with family systems must obtain equilibrium and lessen trauma with trauma informed care practices. When working with families there is evidence of positive choices and occurrences but there are also times where negative choices and occurrences happen. Balancing strengths-based approaches with the acknowledgement and pre-emptive planning for when strengths cannot always be tapped into is essential for holistic family success.

Finally, this paper contributes to the body of literature about the 2-Generational lens and proposes that child welfare serves as a catalyst to multigenerational resources for families. The 2-Gen perspective is widely embedded in state agency and policy work, however further exploration and testing is needed in academic arenas. This study takes steps toward identifying the mechanisms through which 2-Gen can serve as a blueprint for moving research-based findings into hands-on programs and policy informed protocols. How child welfare carries out the foundational principles of 2-Gen should be more widely used in the literature to link families across generations and understand familial needs and intervention points. Finding ways for other agencies and programs to provide early intervention and more preventative avenues, but replicate child welfare in wrapping the family in holistic resources encourages success and aligns with the goals of the Family First legislation.

Policy Implications

Moving research into practice in a timely manner is pivotal when working with the ever-changing family unit. Several policy implications were derived from the results of this study. The findings from the multigenerational cycle highlighted a critical timepoint where potential resources could be allocated to at-risk individuals in an attempt to break the repetitive cycle. Out

of the nine participants, none of them described resources that they received following their initiation of partaking in substance use, but prior to having children. This creates a huge target window where sobriety resources and basic need resources can be provided with hopes of preventing exposure to children later in adulthood. With the recent policy change to the Families First legislation more of the federal funding allocated to family preservation and child welfare should be allocated towards preventative programs and resources. Advocacy efforts targeting this intervention timepoint would be crucial to breaking the cycle and preventing another generation of children being exposed to substances, thus commonly decreasing the necessity for child welfare involvement. Much of the trauma exposure described throughout these individuals' stories surrounded substance use or child welfare involvement, which would ultimately increase the likelihood of breaking the multigenerational cycle.

Many policy changes and efforts could be taken from chapter 5's child welfare involvement stories and analyses, however the following two implications were prioritized for the sake of this study. First, opportunities for parents who are trying to care for their children and make healthy parenting choices while still using substances need to have a safe outlet to ask for help without negative repercussions. Two key examples of scenarios where these protective factors could have prevented extended maltreatment, when parents seek medical care for their children that results in her short-term removal because they were under the influence at the medical facility, also when there were instances when the parents said they would have attended treatment and got help sooner if they knew they would not have their children removed.

This first example reinforces the fear countless parents have across the country that if they take their children to a medical facility for care, they will be blamed or investigated in some way. In many ways this is detrimental to children and their health to extend seeking medical

treatment as long as possible to prevent someone removing the children if they are under the influence. Iowa's current 911 Good Samaritan Law protects individuals who are under the influence of substances from being prosecuted for their own substance use if they are seeking medical attention for another individual. This law does not, however, protect from prosecution for any child maltreatment or endangerment that occurs due to an individual being under the influence and transporting or being unable to make sound decisions on behalf of the minor. If care has been prolonged this can also place the parents at risk for prosecution for medical maltreatment/neglect. Policy should consider and address this in a way to minimize repercussions to substance using individuals attempting to care for their children – similar to the preventative Safe Haven legislation, without the necessity of relinquishing the child.

The second example ties closely together with theme three from chapter 5 results. Avenues for parents to reach out for help when they are using substances and trying to prevent the removal of their children must be established without repercussions. This also leads to the evidence of success when children are able to attend treatment facilities with their parent. Having children attend treatment with their parent eliminates the trauma associated with the separation from each other on both parties, and also places the whole family in an environment where there is constant oversight to ensure the children are being properly cared for. Treatment facilities that offer therapeutic resources to children who are present helps to provide another intervention with the intention of attempting to break the multigenerational cycle of substance use. There is a great need for funding and expansion of treatment programs that welcome children with the caregiver seeking sobriety. How many more caregivers would reach out for help, and confidently commit to a treatment protocol if their children could remain in their care for the duration? Finally, one notable point an individual discussed, is the importance of transitional programs to help the

caregiver successfully exit inpatient treatment. Transitional living post-treatment, utilizing family-level recovery can be a more holistic and system-based approach, increasing the chances of a successful recovery journey. Resources that can assist in this transition include finding housing, employment, childcare, food assistance, and other needed resources to lessen stress and minimize risk of relapse. This model of holistic care and resources for the family can be informed by the 2-Generational perspective.

Future Directions

This body of literature has many opportunities for future work, though only three main areas are suggested here. The first recommendation for future directions is the application of the proposed Multigenerational Model to various other people. Overall, this dissertation provides evidence that the generational cycle is present with utilization of ethnographic qualitative interviews. The model could be more rigorously tested utilizing quantitative data representing a larger population of individuals who have experience substance use, child welfare involvement, or trauma. This model should also be applied to populations outside of Iowa to examine if the same patterns presented here are consistent across various states/countries/locations.

The second opportunity for future work is a closer look at the driving forces of the generational cycle. As noted throughout the paper this dissertation utilizes a broad definition of transmission, incorporating disease, social learning, or epigenetic factors that can influence this ongoing cycle. A closer look at how each of these components drive the cyclical force provides opportunity for interventions to be tailored more precisely.

Lastly, the current interview protocol explored the lives of individuals who had utilized substances. The themes that emerged surrounding child welfare involvement and the

generational cycle were unexpected and novel. There were some areas with a lack of clarity because these results were not the initial purpose of the protocol, for example history of substance exposure or extent of child welfare involvement in the participants childhood. Future work should tailor interview protocol to explicitly ask about individuals' exposure to substances and trauma and their experiences during childhood, with child welfare. Additionally, clear questions surrounding child custody and extent of child welfare resources and whether removal occurred will help contribute to moving this body of literature forward.

Conclusion

Nearly nine million American children have spent at least a part of their childhood living with a caregiver diagnosed with a substance use disorder (Lipari & Van Horn, 2017). The findings, contributions to literature, and policy implication presented in this paper seek to provide guidance and progress in identifying the needs of substance using families, pivoting to preventative resources and interventions when at all possible, and minimizing trauma for the family system across their lifespan.

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APPENDIX A: PARTICIPANT SELECTION TABLE

(Highlighted: Selected Participants)

Name	# children	DHS Involved?	Generational ?
Vincent	3	Yes	No
Bailey	2	Yes	Yes
Elizabeth	3	Yes	No
Virginia	6	Yes	No
Sam	2	Yes	Yes
Carrie	1	Yes	Yes
Mindy	2	Yes	No?
Bill	1	Yes	No
Lip	0	No	No
Jeanette	1	Yes	No?
Emily	4	Yes	No
Ashley	2	Yes	No
Lolly	2	Lost custody to dad	No
Jessica	2	Yes	Yes
Melissa	1	Yes	Yes
Michael	4	Yes	No
Josh	0	No	No
Tony Stark	1	No	No
Jessica	2	Yes	Yes
Peter	2	Limited Custody No DHS mention	No

Ashley	4	Yes	No
Diane	4	Yes	No
Lucy	3	Unclear - child does not reside with her	No
Courtney	6	Yes	Yes
Veronica	3	Yes	No
Amy	5	Yes	Yes
Ellie	1	No	Unclear
Maria	4	Yes	Yes
Lexy	1	No	No
Abby	2	Yes	No
Victoria	2	Yes	Yes
Rowan	2	No	Ran away
Cornelius	1	Yes	No
Nick	0	No	Removed from mom lived with dad
Jackson	0	No	Unclear
Tom	1	No	No
Elaine	4	Yes	Yes
Michelle	4	Yes	No
Maria	2	Yes	No
Kelli	3	Yes	No

APPENDIX B: PARTICIPANT SUMMARIES

1. Amy – Amy was raised by a mother who struggled with substance use and always had boyfriends in and out of the home. She was removed at some point in middle childhood by DHS and placed with her grandparents who raised her for the remainder of her childhood.
    a. Amy is a great example of generational substance use and generational DHS involvement – which supports the cyclical model. Amy's youngest child was born positive for meth and cannabis.
    b. Amy discusses her experiences with DHS and recalls working her case plan was easy to navigate.
    c. Amy also has a positive outlook on attending treatment and getting sober in order to get her children back.
    d. Since getting sober and successfully completing her DHS involvement she has become a parent partner and works with parents who are currently navigating DHS cases.
2. Bill & Sam – Bill & Sam are married and completed individual interviews as well as a couple interview. Both individuals have struggled with substance use throughout their life and seem to struggle to trust people around them. They do not like or trust their community, they don't trust medical professionals, or DHS.
    a. Although both individuals recall having challenges to overcome in their childhood, they mostly discussed exposure to alcoholism in their childhood and neither one mentioned being removed as a child.
    b. DHS involvement and reflection is a strength of this interview. This couple discusses detailed interactions with DHS and how they impacted their willingness to work with them to get their daughter back. They also discussed their mistrust of the system and anyone else telling them how to parent their child.
    c. Both individuals attended treatment programs, there could be some perspectives of the overall treatment process here that are helpful.
    d. This couple really wanted to get DHS out of their life rather than wanting to partner with them for future work or helping others.
3. Courtney – Courtney was exposed to substances and trauma from a very young age. She began using substances at 14 years old. Courtney is still actively using at the time of the interview and hopes to someday stop using meth but plans to always use cannabis.
    a. Courtney is another good example of being exposed to substances and also experienced DHS involvement as a child and then has experienced this as an adult with her own children as well.
    b. Courtney recalls interactions with DHS from her childhood and her mother sleeping with the DHS worker. She also mentions her own experiences with DHS.
    c. Courtney has not experienced recovery at the time of the interview so her story might not play well into the discussion of treatment programs.
    d. Courtney has been given the opportunity to partner with DHS or become a parent partner.
4. Jessica – Jessica reflects fondly of her childhood and was raised in healthy home with her mother and her step-father.
    a. There is not much evidence of the cyclical model in Jessica's story.

   b. Jessica became pregnant when she was 17 and had a baby. While she was pregnant she was using and DHS got involved and resulted in her experiencing DHS involvement. She discusses how DHS was willing to work with her and placed her daughter with her parents and she was eventually allowed to move in with her parents as well to help care for them. Overall, she seemed to reflect fairly positively about the resources and involvement of DHS.
   c. Jessica discusses in quite a bit of detail the treatment programs she attended and how they coincided with DHS involvement. This could be a helpful to discuss how imperative quality programs for detox and rehabilitation from substances are.
   d. No discussion of life after DHS or parent partnership.
5. Melissa – Melissa was in foster care as a child while her mother and her grandparents sorted out custody. She experienced a multitude of instability, divorce, and sexual abuse prior to being removed from her home.
   a. There is clear recollection of cyclical substance use that Melissa experienced when she was a child and now as an adult. Although Melissa experienced DHS involvement and removal as a child and has now experienced involvement with her own children.
   b. Melissa has a great examples of how DHS cooperated with Melissa with placing her daughter in an out of home scenario to keep her with family.
   c. Melissa describes how ultimately her successfully completing treatment was the key to getting her daughter back. She discusses how she tried multiple treatment programs – this depicts the importance of quality programs.
   d. No examples were given of life after DHS/ Parent partnerships.
6. Sam (Ottumwa) – Sam was adopted as an infant and was raised in a great family with many siblings. She was very involved in sports at her private school and performed well in school. At the age of 20 Sam ended up pregnant and was raising her daughter as a single mom. At 24 she became pregnant from another man and the relationship ended up abusive. Sam then experiencing her adoptive mother passing away from cancer and at this time her substance use increased drastically.
   a. There are examples of DHS and substance use involvement generationally with her biological mother and her own choices and experiences as an adult with her children.
   b. DHS removed her children due to her substance use. It doesn't appear she is working her case plan and she seems content with where her children are currently residing.
   c. No discussion of treatment except for substance monitoring by DHS with patches/hair samples.
   d. No discussion of life after DHS.
7. Vincent & Elizabeth – Vincent and Elizabeth have been together since high school, although were separated for a period of time. Both have struggled with substance use and have children together.
   a. There are examples of DHS involvement and interactions and generational exposure to substance use. Elizabeth and Vincent had a restraining order in place at one point and navigated both of them getting sober and getting their children back.

b. DHS opened a case plan and helped get both individuals through treatment and offered many resources to help them navigate their case plan. Vincent and Elizabeth both reflect positively on their time with an open case and working on making themselves better for their children.
c. Both individuals reflect on their time in treatment programs and how helpful they were. Both of them attended multiple treatment facilities/programs.

APPENDIX C: IRB APPROVAL

This study was determined as an exempt study by IRB Co-Chair and Human Subjects Lead at the Iowa State University IRB office. The criteria were met for this study to be exempt due to this study using only secondary data with completely deidentified transcripts and the data belonging to Iowa Department of Public Health. Therefore, this project does not involve “human subjects” as they would be federally defined. Protocol was reverified with the ISU IRB office via email on March 23rd, 2021 and this project remains in exempt status.