Northern California Training Academy

Preventing Re-entry into the Child Welfare System

A Literature Review of Promising Practices

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TABLE OF CONTENTS

Foreword

What is the Northern California Training Academy?

The Northern California Training Academy is funded and supported by the California Department of Social Services. The Northern California Training Academy offers training programs that are designed to develop a uniformly high-level of competence in services for families and children.

Purpose of this guide

This *Resource Guide* is a partial response to the needs of Child Welfare Services by summarizing a systematic review of the evidence based and promising practices relevant to providers of children and youth in the foster care system and contending with issues related to re-entry. While there are comprehensive reviews addressing re-entry in foster care (e.g., see Kimberlin, Anthony, & Austin, 2008, for a recent review of the literature), there are few resources that offer a range of effective practice tools, interventions and comprehensive models to address issues and concerns related to re-entry practices in child welfare.

Due to the limited studies examining the effectiveness of particular strategies and programs working toward preventing re-entry into foster care/child welfare, this paper identifies promising or acceptable practices that may be useful in preventing (either directly or indirectly) re-entry after children are reunified with their families.

Introduction

Re-entry to foster care, also referred to as recidivism, has been and continues to be a perpetual problem for foster care services. One statistic related that re-entry

rates for individual states ranged from 21% to 38% (Wulczyn, Hislop, & Goerge, 2000).

Most importantly, re-entry into foster care can have many adverse consequences for the children and families. Re-entry into foster care also may indicate that issues and problems were not adequately addressed prior to children being reunified with their families.

While reunification with a child's family of origin is the most common permanency plan for children in foster care (U.S. Department of Health and Human Services, 2006), often reunification does not result in long term safety or stability for the child. For some children, they are again removed from their homes due to subsequent child abuse and neglect and re-enter the foster care system.

While preventing re-entry is a common goal of child welfare, there is limited research attesting to the effectiveness of practices that are believed to be important components of reunification programs. Most research has examined the characteristics of families and children that either support or deter reunification (Wulczyn, 2004) and are less concerned with the programs and practices that mitigate re-entry.

Method

Information for this resource guide was collected from academic literature and general and target searches using the World Wide Web. The following search terms were used: "foster and re-entry," "promising practices and re-entry into foster care," "child welfare services and re-entry," "foster care and reunification" and "child welfare services and reunification."

The academic literature searches included the following: Social Services Abstracts (CSA/Illumina), Social Work Abstracts, PsycARTICLES, PsycINFO, Sociological Abstracts and Family and Society Studies Worldwide. Additionally, in using the World Wide Web, primarily Google, the following Child Welfare Research and Policy Organization websites were searched: Child Welfare Research Center (CWRC) (http://cssr.berkely.edu), Child Welfare Information

Gateway (www.childwelfare.gov), and American Humane Association (www.americanhumane.org).

Review of the Literature

What does research tell us about re-entry to foster care?

"Re-entry into care in its extreme form means that children have no secure home base whatsoever; all placements are temporary, including periodic stays with birth parents" (Wilson, 2000, p. 26).

As mentioned previously in this resource guide, there are few rigorously evaluated studies examining methods and factors related to preventing re-entry into foster care. However, many studies have been conducted that identify factors which may increase the likelihood of re-entry to foster care. While a complete review of these factors is outside the scope of this resource guide, there are several areas found to relate to successful or unsuccessful reunification and re-entry into foster care. These key factors associated with re-entry include the following: (See Table 1 and Appendix A for a quick reference and checklist of these factors.)

- Placement instability
- Children placed with non-relative foster care
- Parental mental illness, substance abuse or poverty
- Previous failed reunification attempts
- Parental ambivalence about reunification
- Children with behavioral or health difficulties
- Predominant placement

While the ADSFA says that states must meet particular standards based on child welfare outcomes, such as a child being reunified within 12 months of being removed from the home, the factors listed above and in Table 1 are intended to highlight some of the complex factors that can contribute to re-entry. It is hoped that attention to these factors will assist child welfare workers in determining if reunification will result in success.

One study using data from Child Welfare Supervised Foster Care in California (1998-2001) examined the possibility that there were differences between children re-entering care within 12 months and those re-entering care from 12 to 24 months. There analyses revealed that African-American children were more likely to re-enter foster care within 12 months and between 12-24 months as compared to White children. Additionally, children who remained in care for 9 months or more had significantly lower odds of re-entry for re-entries that occurred between 12 and 24 months. A very telling finding from this study was that if drug/alcohol services are indicated, there was two times the odds of re-entry within 12 months, and these odds increased when looking at re-entry rates between 12 and 24 months (increased odds by 2.55). For children with health and behavioral issues, there are increased odds of re-entering foster care in the 12 to 24 month group

The findings discussed above highlight the importance of looking at associated factors and re-entry within the timing that re-entry occurs. As will be reiterated throughout this guide, there is limited research in understanding why these associations exist. However, there are some promising and best practices that work to promote the protective (strength-based) factors in families preventing re-entry in child welfare. These promising practices are discussed in the other sections of this resource guide.

Important Areas Related to Increased Risk for Re-entry into the Child Welfare System **(*Note: not all of these factors have been empirically shown to directly relate to re-entry but have shown to be indirectly associated.)**	**Risk Factors**	**Protective Factors**
Child Characteristics	Poor mental health	Emotional resiliency ▪ Strong internal locus of control ▪ Sense of belonging
	Behavioral problems	Prosocial skills with peers and adults Academically successful
	African-American race	Hispanic ethnicity
	Infant age or pre/teen teenager age ▪ Adolescent girls are more at risk than adolescent boys	Adolescent females
	Poor health problems	
	Parental substance abuse ▪ Shaw (2006) ▪ MacManon (1997)	English not the primary language spoken in the home

Family Characteristics	Low SES (poverty status--e.g., AFDC-eligible, Title IV-E eligible) ▪ Shaw (2006) ▪ Courtney (1995) ▪ Jones (1998)	Stable employment (post-reunification service)
	Type of maltreatment (neglect or dependency) ▪ Barth, Guo, & Caplick (2007)	
	Parental ambivalence (e.g., child returning home, conflicted feelings about parenting role) ▪ Hess & Folaron (1991)	
	Poor parenting skills ▪ Festinger (1996)	Increased confidence in parenting abilities
	Lack of social support	Extended family supports
	Inadequate housing	Stable housing
	Poor mental health ▪ Festinger (1996)	Decreased depressive symptoms
	African-American ethnicity	Hispanic ethnicity

Child Welfare Service Characteristics	Short initial stays in foster care o Koh (2007) ▪ Shaw (2006) ▪ McDonald, Bryson, & Poertner (2006)	Children had resided in kinship foster care (one study, Berrick et al., 1998, found it was kinship care not receiving federal foster care funds)
	More foster care placements ▪ Koh (2007) ▪ Courtney (1995)	▪ Regular home visits prior to reunification ▪ Being placed in kinship care for infants
	Type of placement (i.e., group home) ▪ Wells & Guo, (1999)	Continuous child welfare staffing
	Continuing need for services when reunification takes place	Providing adolescents with special education services
	Prior involvement with child welfare services	Parental involvement in six-month progress meetings

Directions for Future Research: Identifying Protective/Resiliency Factors

While empirically the following factors have not been found to mitigate re-entry into foster care or Child Welfare Services, previous research has found these factors and characteristics to be importantly related to family resiliency. (See Thomas, Chenot & Reifel, 2005, for a review and more in depth discussion for their proposed resiliency-based model.) The usefulness in applying the theoretical concepts behind the resiliency model is that it highlights how families respond to major stressors and crises using a strength-based approach. Specifically, "families in crisis" are defined as:

> The system's fundamental inability to achieve balance and harmony along four interrelated dimensions of family life: (a) interpersonal communication and emotional relationships; (b) individual member and family development, well-being and spirituality; (c) family structure and function; (d) community relationships and nature. (McCubbin, McCubbin & Thompson, p.31)

The resiliency-model as it applies to protection against re-entry is broken into child/youth characteristics, family level characteristics and community level characteristics (Rutter, 1997). Identifying factors impacting families and the adaptation process to experiencing significant family stressors can provide valuable insights and information in the provision of family-centered

services. Again, it must be acknowledged that not all of these factors are related directly to re-entry in child welfare/foster care; however, most it not all are importantly related in to re-entry in some way.

- Child characteristics
    - Easy going temperament
    - Young female child
    - Male adolescent
    - Prosocial with peers and adults
    - Being personally aware of own strengths and limitations
    - Empathetic of others
    - Believing that one's efforts make a difference
    - Can effectively manage feelings of anxiety

- Family characteristics
    - Positive and healthy inter-parental relationships
    - Having a close supportive relationship with one parent when there is discord between both parents
    - A sense of belonging in the family
    - Warm supportive caregivers

- The Community/Environment
    - Having supportive extended family/caregivers for support
    - Being a member of a religious faith or community
    - Being involved in extracurricular activities
    - Contributing to community (volunteering, a job)
    - Achieving successfully in school

Understanding these resiliency factors is important because it promotes a more strength-based approach in providing services to prevent re-entry into foster care

and the child welfare system and it highlights attributes or skills that lead to more successful outcomes. The following promising practices/programs work to support and promote these resiliency factors in families.

Promising Practices

What services or supports are needed to reduce the likelihood that children will re-enter foster care? There are many financial and psychosocial costs associated with a continuing cycle of placement instability and children's re-entry into the child welfare system. Thus, identifying and implementing promising practices and programs to increase the chances of permanency and mitigate the risk of children and family's re-entering CWS is a meaningful and important goal.

AGENCY PRACTICES

- **Pre-Planning Post Placement Services**

Post reunification services and pre-planning these services to ensure that they are available and accessible is noted as being essential for preventing re-entry into foster care (Dogherty, 2004). Aptly, Dogherty (2004) states, "reunification is the preferred permanency 'outcome,' but that doesn't mean it is an event; like other forms of permanence, it is a process that needs to be sustained with post-permanency services" (pg.5).

- **Setting up formal and informal services**

Formal	Informal
Respite care	Extended family
Professional Mentor	Food planning/meals
In-home counseling	Budgeting/shopping
Parenting supports	Babysitting
Financial programs	Homework

Transportation	Family assistance
Child care	

- **Useful resources related to post-reunification services**

  Freundlich, M., & Wright, L. (2003). *Post-permanency services*. Washington, DC: Casey Family Programs. Available from: http://www.casey.org/Resources/Publications/PostPermanency.htm

- **Decision-Making Practices during Placements**

The process in which placement decisions are made can contribute to successful reunifications and diminish the possibilities that children/youth will re-enter child welfare. These practices can also be useful when making decisions concerning services and visitations. Some of these placement practices follow:

- *Participatory Case Planning Practices:* Involve families and important community partners in placement decisions so that the child and family can maximize their strengths and resources. Most importantly, these types of placement making practices that involve the child/youth can empower the family to find solutions in collaboration with child welfare that should contribute to successful family reunification. While most of the research to date is qualitative rather than quantitative, the promising results show that families typically are more interested in the case plan, family relationships improve, worker-client relationships improve and placement outcomes are improved. All of these positive results are believed to contribute to the prevention of re-entry in to the child welfare system. Participatory case planning practices include *Family Team Conferencing, Family Group Decision Making (e.g., Family Group Conferencing, Family Unity Meetings), Family Team Meetings and Team Decision Making*.

One pilot program in Washington State involved having *legal representation* of the birth parents at these participatory case planning meetings (Oetjen, 2003). Examining results from an archival review of court records comparing cases that provided birth parents with attorney

representation evidenced greater reunification rates for those families receiving legal representation (36.8% no legal representation versus 56.4% with legal representation). While this pilot evaluation did not look at impact of having legal representation on re-entry rates, it appears that having legal representation is beneficial to families and may lead to great compliance with the case plan and thus prevent and/or reduce the rates of re-entry into child welfare.

- Useful resources related to the use of participatory case planning practices
    - *Family Group Decision Making*
        - National Center on Family Group Decision Making, http://www.americanhumane.org/site/DocServer/FGDM_Statements.pdf?docID=6781
        - National Resource Center for Family-Centered Practice and Permanency Planning, http://www.hunter.cuny.edu/socwork/nrcfcpp/info_services/family-group-conferencing.html
        - Family group conference / New Zealand Youth Court: http://www.justice.govt.nz/youth/fgc.htmlFamil
        - Family Group Conference home page / Winchester Local Education Office, UK: http://www.hants.gov.uk/TC/edews/fgchome.html
        - Family group conference: information for parents, extended families and friends / British Columbia Ministry of Children & Family Development: http://www.mcf.gov.bc.ca/child_protection/pdf/brochure_parents_2
        - RealJustice: http://www.realjustice.org/
    - *Family Team Meetings (FTM)*
        - More information about these practices can be found at: http://www.americanhumane.org/site/DocServer/FTM_Report_111605.pdf?docID=3401
    - *Team Decision Making*

- Additional information on TDM is available at: http://www.aecf.org/Home/MajorInitiatives/Family%20to%20Family.aspx

- *Assessing Family Readiness to Reunify Children:* Hess and Folaron (1991) state that it is useful and beneficial to assess the parent's level of ambivalence concerning reunification so that children are not returned too soon and then reenter the system. Specifically, they say that a, "Worker must be willing to identify and explore, initially and ongoing, the parent's feelings about each child, about parenting generally, and about all options for each child's permanent care" (p.15).

  Parental ambivalence is defined as, "A pattern of verbal statements that reflect conflicting feelings about parenting, about a particular child, and/or about a child's return home, or a pattern of behaviors that is inconsistent with the parents stated interest in the child's return (visitation, court attendance, and service use" (Hess & Foloran, 1991, p.2). Addressing these concerns during the case plan and prior to the children returning home can assist in knowing why a parent is unsure or ambivalent about their child reunifying. What is extremely important is to not use such assessments against the parents but rather as a tool for attaining more supports for the parents.

  Some ways to assess parental ambivalence concerning reunification are to look at the following indicators:

  - Parent responds appropriately to the child both verbally and nonverbally;
  - Parent is receptive and responsive to services that are essential for bringing the parent and child closer;
  - The parent acknowledges responsibility for their role in contributing to family difficulties that contributed the removal of their child.

A useful assessment tool that is specifically designed for assessing parental ambivalence, family safety, child well-being, family interactions, and readiness for reunification. The tool is termed, the "North Carolina Family Assessment Scale for Reunification (NCFAS-R)" (Kirk, 2001). The tool can be

accessed at: http://www.nfpn.org/tools-a-training-mainmenu-6/86-training-resources.html

- **Effective Parent-Child Visitation**

One of the greatest predictors of successful family reunification, and in some cases preventing re-entry into child welfare, is ensuring quality visits between the parent and child. While the present policy is to have at least one visit per month between parent and child, greater benefits are rendered when infants receive daily visits and older children receive weekly visits that are *consistent.* Research finds that consistent weekly visits increases the likelihood of successful reunification, reduces the time in out-of-home care and promotes healthy secure attachments (Smariga, 2007).

The important components that contribute to meaningful parent-child visitations (Burke & Pine, 1999) are having the visits serve as opportunities for parents to practice and enhance their parenting skills: scheduling visits at the foster family's home during challenging times such as bedtime, scheduling visits that allow the parent to be apart of the child's life (e.g., doctor appointments) and encouraging the foster parents to have a healthy and supportive relationship with the birth parents.

One population that can be extremely difficult to maintain contact with is incarcerated parents. Approximately 10% of children with an incarcerated mother are in foster care, and 6% of children with an incarcerated father are in foster care (Wright & Seymour, 2000). The most common reasons for children being removed and entering child welfare who have incarcerated parents is 1) there was abuse and/or neglect prior to the parent being incarcerated, 2) due to the parent's arrest, or 3) disruption in the living arrangements that were made during the parent's incarceration. Problems that make contact difficult or impossible include the too often great geographic distance between the child/youth's placement and prison facilities, the time-consuming nature of visits and the lack of conducive environments for having visits. However, maintaining contact with family members during incarceration is hugely important as it can reduce the negative impacts of being separated and has shown to increase the likelihood for successful reunification (Women's Prison Association, 1996).

One promising program in Florida termed "Reading and Family Ties-Face to Face," facilitates parent-child interaction for mothers who are incarcerated by transmitting live video recordings via the Internet. The video session takes place once a week for a period of an hour and is provided to families at no cost. Mothers (caregivers) who are incarcerated often lose contact with their child, experience difficulty establishing healthy relationships with their child. While there is no strong empirical evidence indicating that this method reduces re-entry into child welfare, there is some anecdotal evidence that such strategies promote great confidence in being a parent and support positive attachments between mothers and their children. Research finds that children who are in foster care need family contact with their incarcerated parent for "bolstering children's well-being and healthy development, reducing the trauma of separation and assisting families to reunify after a parent's release" (Brennan Center for Justice at NYU School of Law, 2006).

- A useful resource that addresses children and families involved with child welfare services who have an incarcerated caregiver is the following:
    - Wright & Seymour (2000). *Working with children and families and separated by incarceration: A handbook for child welfare agencies*.

Enhancing caregiver skills and competencies

Parent-Education Classes and Psycho-education

Most biological caregivers and foster parents are required to attend some form of parent education class. However, many standard parent education classes have not shown to be successful in combating re-entry into foster care since some of these parenting education classes do no improve a caregiver's (e.g., biological parents) ability to care for their child (Gray, Ellison, Almeida, 2008). This is because many of these caregivers contend with multiple stressors and do not learn well in a traditional classroom environment where the teacher lectures and expects the caregivers to read the hand outs and fully understand and implement the class content. However, there are some parent education programs that are successful in enhancing the parent-child relationship that is related to reducing the probability of re-entering child welfare. Research finds that key components for successful parent education programs include the following (Child Welfare Information Gateway, 2008):

- Strength based focus
- Family-centered practice
- Individual and group approaches
- Qualified staff
- Targeted service groups
- Program has clearly stated goals and continuous evaluation

Additionally, strategies that have shown parenting programs to be more effective in increasing parent knowledge and enhancing parenting skills include this list:

- Providing opportunities to practice new skills
- Using interactive training techniques (Brown, 2005)
- Involving fathers increases cooperation and better outcomes for families (Lundahl, Tollefson, Risser, & Lovejoy, 2007)

The following lists some of the more commonly used parent education programs that are evidenced-based or evidenced-informed. This is not an exhaustive list. Additionally, these parent education programs are intended

for different populations and may differ in their theoretical contents and program aims and objectives.

- **The Incredible Years**

The *Incredible Years* is a program intended to work with *children ages 2-12 years* and is intended *to decrease child behavior problems*, increase parenting competencies, decrease maternal stress, and strengthen the parent-child and parent-caregiver relationship. The *Incredible Years* consists of three developmentally appropriate curricula designed for parents, teachers and young children. Groups typically meet weekly (12-24 sessions) and last about 2 hours. They can take place in schools, a community agency or an outpatient clinic.

Evidence: In a recent evaluation examining the effectiveness of using *The Incredible Years* curriculum with both biological and foster parents (see Figure 1), the results indicated that after participating in parent education groups, both biological and foster parents increased their self-reports of positive parenting practices (e.g., social praise, hugs, smiles, positive verbal statements, clear expectations and collaborative co-parenting (Linares, Montalto, Li, & Oza, 2006). While this study relied primarily on parent self-report measures, future studies are underway that include observational data. Also, *The Incredible Years* is being modified to address some of the specific issues common to parents involved with child welfare, such as the development of trauma-focused interventions.

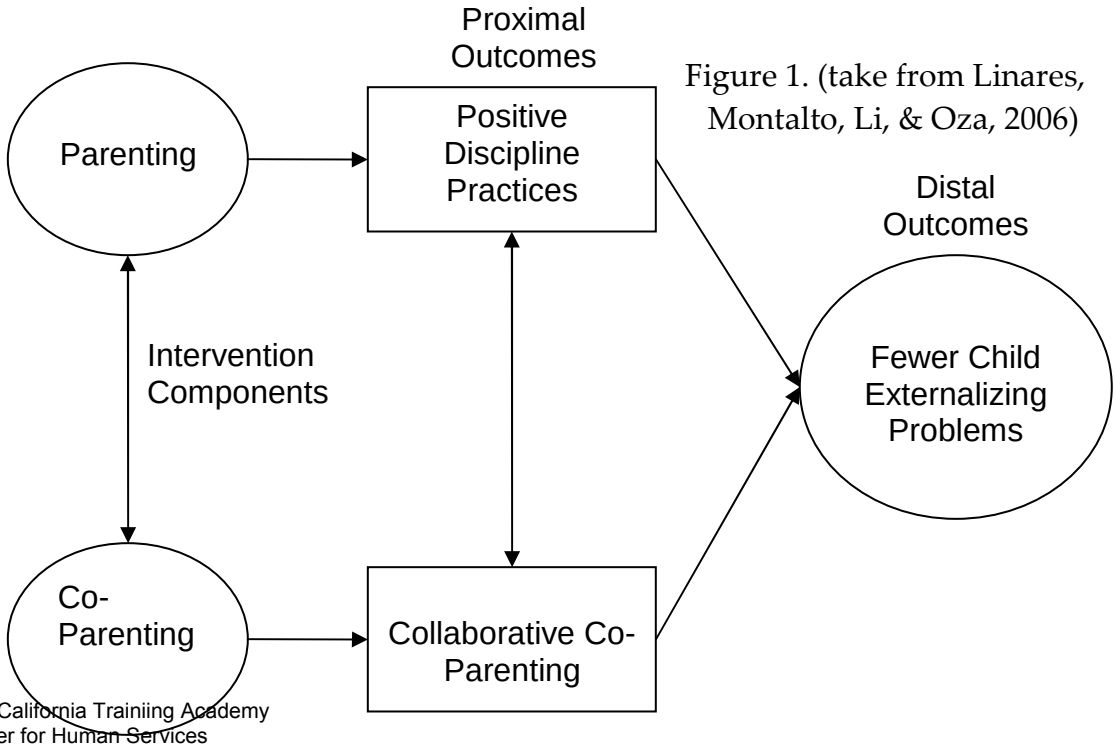


Figure 1. (take from Linares, Montalto, Li, & Oza, 2006)

Future research/extensions: Future research can extend the figure in identifying how parenting curricula such as *The Incredible Years* can prevent re-entry into child welfare and foster care system. Improving parenting knowledge and skills leads to actual improved parenting practices promoting positive child development (e.g., reduced behavioral problems) and leading to greater harmony in the parent-child relationship, which contributes to reduced probabilities of re-entry. Of course, future studies are needed to determine how parent education courses for caregivers involved in child welfare lead to actual observed behavioral changes and promotes healthy parent-child relationships. Finally, it would be beneficial to include both primary caregivers when relevant (e.g., biological mother and father) to promote greater harmony in the family and hence prevent re-entry.

More information can be attained from:

Website: www.incredibleyears.com

- **Nurturing Parenting Program**

The *Nurturing Parenting Program* is intended to prevent abusive and neglectful parenting by enhancing and building nurturing parenting skills for parents of children birth to five, 5-11 years old and 12-18 years old. Different curricula are designed to address the prevention of recidivism in families in child welfare, prevent the intergenerational cycle of abuse, reduce the rate of juvenile delinquency and substance abuse and lower the rate for teenage pregnancies. The *Nurturing Parenting Program* classes can be offered in diverse settings and some of the curricula incorporates the children by having them meet in separate groups followed by having the parent and child come together.

Evidence: In employing pre/post-data designs, the results indicate that caregivers who participate in the *Nurturing Parenting Program* evidence a significant ($p < .05$) decrease in the use of corporeal punishment and in family conflict. There are also increased positive changes in empathy, appropriate developmental expectations and improvements in family expressiveness and family cohesion (Camp & Finkelstein, 1997). What is one of the more

promising findings is that these effects continue to show one year after caregivers participated in the program.

Website: www.nurturingparenting.com

- **Triple P Parenting**

Triple P Parenting is an evidenced-based curriculum used with caregivers of children ages 0-16 and is designed to improve parenting skills, decrease parenting stress and depression, improve coping skills, decrease severe behavior problems, improve partner support, improve parent anger management skills and decrease social isolation for parents (caregivers) of children with severe behavioral and emotional problems. This curriculum has been delivered in many different settings (e.g., the birth family's home, community agencies, outpatient clinics, adoptive homes, etc.) and follows a strength-based approach by enhancing family protective factors.

Evidence: Though not specific to parents involved with child welfare, a meta-analysis found that the *Triple P* program reduced dysfunctional parenting behaviors and improved parent competency for high risk families (Graaf, I., Speetjens, P., Smit, F., Wolff, M., & Tavecchio, L. (2008). Further research is needed (as with most of the parenting education curricula) to determine if and HOW *Triple P* reduces or prevents re-entry.

Website: www.TripleP-America.com

Models/intensive family services

- **Parent-Child Interaction Therapy**

One such approach is implementing the live coaching method, *Parent-Child Interaction Therapy*. The reasoning behind the effectiveness of PCIT as a promising practice is that upon reunification, children have a greater likelihood of exhibiting emotional and behavioral problems toward their biological parents associated with insecure attachments. Therefore, providing parents (caregivers) with useful techniques and skills to better equip them to effectively support their children when they are reunified should reduce parental stress and hence prevent re-entry into foster care/child welfare

services. PCIT has found to be useful for children who have following characteristics:

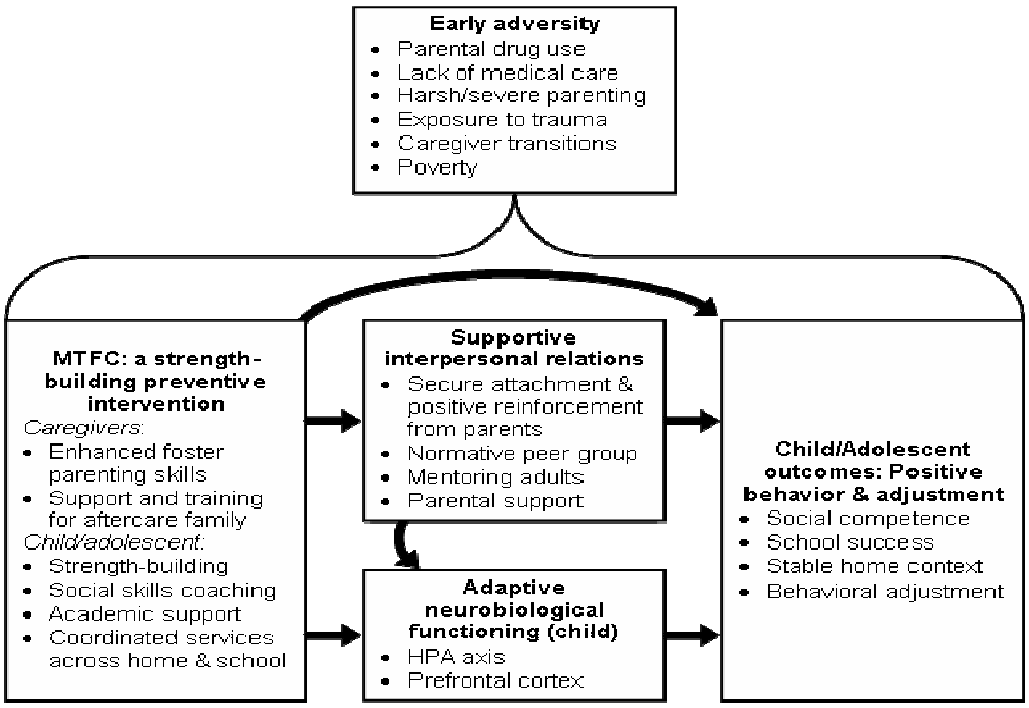
- Children with short attention spans
- Children with aggressive behaviors who hit and throw things out of anger
- Children experiencing adjustment difficulties
- Children who cry or whine easily
- Children who have frequent temper tantrums
- Children who have significant difficulty behaving in school, preschool and/or daycare

There is strong evidence supporting the effectiveness of *Parent Child Interaction Therapy* in decreasing corporeal punishment and physically coercive parental behaviors (Chaffin et al., 2004), decreasing parental stress (Timmer, Urquiza, Zebell, & McGrath, 2005) and improving positive parenting behaviors (Hembree-Kigin & McNeil, 1995). In 30 randomized clinical outcome studies, PCIT has been found to be effective and beneficial for at-risk families such as families involved with child welfare services. The challenges in implementing and providing PCIT are the intensive nature of the service and the high costs involved for the audio and visual equipment. Presently, agencies are working to modify the way in which PCIT is provided, such as providing it in the home with foster parents.

For more details, website: www.pcit.org

- **Multidimensional Treatment Foster Care (MTFC)**

MTFC is based on Social Learning Theory and aims to decrease problem behavior and increase developmentally appropriate and prosocial behaviors in children and adolescents who are in need of out-of-home placements. Treatment is provided for the child/youth and his/her biological family. Additionally, MTFC is a resiliency-based model promoting and enhancing family strengths:



Source: Chamberlain, P. Multidimensional Treatment Foster Care (MTFC): Outcomes, mechanisms & implementation.

Evidence: MTFC has evidenced promising results. For teenage youth who are living in or at-risk of living in a group home and who participated in MTFC, there has been a lower rate of re-entry into foster care or the juvenile system. Thus far, evaluation results find that MTFC, when compared to residential treatment models, is more cost-effective and leads to promising outcomes for children and families such as placement stability and reduced re-entry.

- *Early Intervention Foster Care:* This MTFC type model works with preschool age children who are in foster care. The purpose of Early Invention Foster Care is to increase foster parent competencies, serve as a strong support system for foster parents, decrease child behavior problems, improve parenting competencies, decrease parental stress and depression, increase social support, and promote reunification (Fisher, Burraston, & Pears, 2005) which are all believed to contribute to preventing re-entry in child welfare. This study found that among 177 preschool-aged children (of whom 117 were in foster care), those

preschoolers who are assigned to the MTFC group (N=57), and who were compared to regular foster care preschoolers (N=60), had significant reductions in reunification failures and increased secure attachment-related behaviors (Fisher et al., 2005).

For more details, website: (www.mtfc.com)

- **Functional Family Therapy**

Functional Family Therapy is designed for caregivers of youth (ages 11-18 years of age) and is intended to decrease the need for out of home placement and family negativity and hostility, decrease child behavior problems and increase parenting competencies. The model for *Functional Family Therapy* is for practitioners to provide individual family sessions (12-14) and employ an individual approach by tailoring the content of the sessions to the needs of the families.

For more details: www.fftinc.com

- **Trauma-Focused Cognitive Behavioral Therapy**

Trauma-Focused Cognitive Behavioral Therapy (TFCB) is designed for children between the ages of 4-18 years. The goals of TFCB are to decrease Post Traumatic Stress Disorder symptoms, decrease externalizing behavior problems, decrease negative attributes about the traumatic event, decrease parental depression and improve parenting. TFCB therapy is administered by trained therapists who provide individual sessions (typically once a week) with the child and jointly with the parent (caregiver) and child. These sessions usually range from 12-16 sessions. The topics addressed during therapy are establishing a trusting therapeutic relationship, providing psycho-education, learning effective ways to regulate emotions, connecting thoughts, feelings and behaviors, learning effective strategies for stress management, receiving personal safety and skills training and engaging in affective and cognitive processing of trauma experiences.

Evidence: Many children who enter the child welfare system can contend with significant traumas and loss. In randomized controlled trials, TFCB therapy was found to be effective in improving systems of depression, anxiety, feelings of shame and mistrust and has also been related to decreased depression in parents and their own emotional distress over their child being abused and is associated with increased positive parenting practices (Deblinger, Stauffer, & Steer, 2001).

For more information: http://tfcbt.musc.edu/

- **Shared Family Care**

Several counties in California and Colorado have developed and implemented Shared Family projects. The idea behind *Shared Family Care* is to have children and their families placed together in a home of a mentor family (Simmel & Price, 2002) with the ultimate goal of preserving families and reducing rates of re-entry of reunified children. The host family who serves as mentors are families from the community who receive extensive training in child welfare issues and safety, child development, parenting, conflict resolution, community resources and other important issues related to family preservation.

One evaluation of Contra Cost County, CA conducted by the National Abandoned Infants Assistance Resource Center (2002) found that three children from one graduated family (out of a total of 36 children) who participated in SFC re-entered the child welfare system. This represented an 8% re-entry rate in comparison to a re-entry rate of 15% of children in Contra Costa County who re-entered care within 12 months of being reunified after regular foster care.

Promising outcomes of SFCs: Presently there are few scholarly articles that have examined the effectiveness and specific benefits of using *Share Family Care* and there are no scholarly articles that address the long term outcomes and benefits of implementing SFCs.

- Effectiveness of SFC in keeping families together and developing safe plans for children
- What works? Implementation successes and needed improvements
- What is the cost effectiveness of Shared Family Care?
- Who benefits from SFC?
    - Presently no long term outcomes have been rigorously evaluated. It is expected that later evaluation studies of SFCs will take place. The proposed benefits of implementing SFCs include the following:
        - Parenting skills will improve
        - There will be reduced recurrence of abuse and neglect
        - In the long term, SFC will be no more expensive than traditional child welfare programs.

          This will be measured by looking at the following indicator, "if, after 6-9 month placement, SFC is successful at keeping families together and preventing subsequent out-of-home placements, the long-term cost of the program will be significantly less than traditional foster care options?"

- *Promising results*: Currently federal Family Preservation programs are found to be the most viable source of funds for SFC. Examining the results of three families, found that the average monthly cost of a SFC placement in Contra Costa County, CA, is approximately $3,000.00, which is more than basic foster care but costs less than treatment foster care.
    - Children/families will receive continuity of care
    - Families will meet the goals identified in the Individualized Family Plan

  An evaluation of SFC in Contra Costa County, CA found that for 25 clients, their median monthly income increased by about $600.00, with an increased number of families (40%) becoming employed from placement intake to graduation.

Summary of Interventions to Mitigate Re-entry

Prior to any one parenting program/service being chosen, a match against family needs must be made in order to successfully prevent re-entry into the child welfare system. As was evident in the above descriptions, many of these parenting programs/services are tailored for specific populations or groups and/or have not been validated with other groups. As is common with all programs/services, one size does not fit all.

Many of these programs/services related above show promising evidence that parenting and family skill building programs significantly improve parental attitudes, skills, parent-child interactions, child behavior--all of which are related to reduced re-entry in child welfare. However, to make these programs/services the most successful and more rigorously mitigate re-entry, it is important to ensure that ancillary services are also provided (e.g., community services, concrete needs, etc) (Forehand & Kotchick, 2002). Finally and most importantly, these are promising practices and great empirical work is needed to generate the most informative information in identifying how and for whom these parent services are effective.

Service Gaps

While there are some available promising practices and programs to mitigate children and family's re-entry into the foster care system, the greatest gap exists in the areas of treatment and services for the mental health, substance abuse and domestic violence problems that are often the factors that bring children to the attention of the foster care system and often is what leads to re-entry into the child welfare system.

The issue of substance use/abuse has and continues to be an immense issue and contributes to a great many cases re-entering the child welfare system. In fact, an estimated 60 to 75 percent of child welfare cases are involved with substance abuse issues in some way (Young, Gardner, & Dennis, 1998). What has been a large contributor to unsuccessful reunification and re-entry into child welfare are the incompatible timelines between those specified in the Adoption and Safe Families Act of 1997 and those needed for alcohol and other drug (AOD) recovery (CWLA, 2002; Young et al., 1998). Often, a caregiver who is in AOD recovery requires more time than 12 months in order to provide a safe and stable home for his/her child.

In a recent study comparing successful reunification and re-entry rates for participants in AOD recovery, the results revealed that the caregivers who participated in a comprehensive service-delivery program had significantly higher re-entry rates as compared to caregivers who did not receive the comprehensive services (Brook & McDonald, 2007). Two proposed reasons for this unexpected finding was that the group of caregivers receiving comprehensive services had more "eyes" and people ensuring that they did not relapse and/or the amount of services given were overwhelming and exerted too much stress and pressure on the family contributing to a relapse. Further understanding as to why those families receiving the comprehensive services and who were in substance abuse treatment evidenced greater re-entry rates is an important future goal. Such an understanding may aid in the endeavor of better supporting families and ensuring stability and healthy environments for children.

A useful tool for getting an idea of whether or not a client has a substance abuse problem includes the following:

- Index of Drug Involvement (Hudson, 1996; see Appendix B): Using such a tool to gauge a parent's ability to effectively parent and their level of involvement with substances is useful in identifying whether or not a parent is ready for reunification.

CONCLUSIONS

Presently there are some promising practices that are lending to positive consequences in mitigating re-entry in child welfare services. However, as is common with a great deal of prevention and intervention research, further empirical evidence is needed that is more rigorous, comprehensive and longitudinal. Furthermore, while there are some specific practices/programs that empirically evaluated whether or not their services prevented re-entry into child welfare (e.g., Shared Family Care), most of these services/programs have not directly tested this outcome. Thus, most of the evidence presented in this resource guide relates those outcomes that previous research has found to be associated with re-entry, such as positive parent-child relationships.

A great deal of research and many reviews have found those factors that associate with re-entry into foster care/child welfare services, but the research is extremely limited in understanding why these associations exist. For example, there is conclusive evidence that children who are placed with relatives are significantly less likely to re-enter care (in one study these children were 80% less likely, Child Welfare League of America, 2000).

Whatever service or program is chosen to support families in providing safe and stable home for their children, tapering off of services should be based on individual family needs and not on an arbitrary time frame (Kirk, 2001). Presently, it appears that the most promising and best practices are those that focus services toward improving and enhancing the parent-child relationships and, when possible, include both caregivers. Preventing re-entry into child welfare is a complex issue that requires greater empirical scrutiny in order to understand why and how specific factors are effective or not effective for

families. Such research endeavors will greatly advance the field and improve services provided to families involved with child welfare.

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APPENDICES

APPENDIX A

Some Quick Terminology Related to Re-entry in Foster Care

Concurrent planning: puts into place a secondary plan for a permanent home should family reunification prove to be impossible.

Re-entry*:* A child enters foster care within 12 months of a previous discharge from an out-of-home placement. The federal measure of re-entry is stated as follows, "Of all children discharged from foster care to reunification in the year prior to the one shown, what percent re-entered foster care in less than 12 months from the date of discharge?"

Promising practice: shows some positive research evidence, typically quasi-experimental, of success and/or expert consensus.

Effective evidence: achieves child/family outcomes based on controlled research (using random assignment) with independent replication in usual care settings.

APPENDIX B

Risks for Re-entry Checklist: How At Risk is Your Client?

(Source: Terling, T. (1999). The efficacy of family reunification practices: Re-entry rates and correlates of re-entry for abused and neglected children reunited with their families. *Child Abuse and Neglect, 23*, 12, 1359-1370.

Below is a quick reference for factors associated with children/youth re-entering child welfare following reunification:

- *Factors related to child-specific concerns/issues*

  ☐ Physical health of the child

  ☐ Delinquency

  ☐ Psychological problems

  ☐ Substance use/abuse

  ☐ Status offences

- *Factors related to parent-specific concerns/issues*

  ☐ There continues to be the presence of substance abuse and not enough time was allotted for recovery

  ☐ Involvement in criminal behavior

  ☐ Inadequate/poor parenting skills

  ☐ Have a history of domestic violence

  ☐ Difficulty with cognitive processing (difficulties with making decisions and processing information)

  ☐ Mental health issues

- *Family Characteristics*

  ☐ Economic stress

- ☐ Single parenthood
- ☐ Poor/inadequate housing
- ☐ Lack of social support
- ☐ Prior history with Child Welfare Services

- *Child Welfare Service Characteristics*
  - ☐ Not adequately assessing and addressing the risk factors that contributed to the child originally entering foster care
  - ☐ Absence of services and supports following reunification
  - ☐ Insufficient services for children and parents during the child's stay in foster care
  - ☐ Services are terminated immediately when child/youth is returned to the family

APPENDIX C

Index of Drug Involvement (IDI)

(Hudson, 1996 available for purchase from Walmyr Publishing Company)

Name: _____ Today's Date:_____

This questionnaire is designed to measure your use of drugs. It is not a test, so there are no right or wrong answers. Answer each item as carefully and as accurately as you can by placing a number beside each one as follows.

1 = None of the time

2 = Very rarely

3 = A little of the time

4 = Some of the time

5 = A good part of the time

6 = Most of the time

7 = All of the time

---

1. _____ When I do drugs with friends, I usually have more than they do.
2. _____ My family or friends tell me I take too many drugs or too much.
3. _____ I feel that I use drugs too much.
4. _____ After I've begun using drugs, it is difficult for me to stop.
5. _____ I do not use drugs.
6. _____ I feel guilty about my use of drugs.
7. _____ When I do drugs, I get into fights.
8. _____ My drug use causes problems with my family or friends.
9. _____ My drug use causes problems with my work.
10. _____ After I have been using drugs, I cannot remember things that happened.
11. _____ After I have been using drugs, I get the shakes.

12. _____ My friends think I have a drug problem.
13. _____ I do drugs to calm my nerves or make me feel better.
14. _____ I do drugs when I am alone.
15. _____ I do drugs so much that I pass out.
16. _____ My drug use interferes with obligations to my family and friends.
17. _____ I do drugs when things are not going well for me.
18. _____ I can stop using drugs whenever I want to.
19. _____ I do drugs before noon.
20. _____ My friends think my level of drug use is acceptable.
21. _____ I get mean and angry when I do drugs.
22. _____ My friends avoid me when I am using drugs.
23. _____ I avoid excessive use of drugs.
24. _____ My personal life gets very troublesome when I do drugs.
25. _____ I use drugs several times a week.

APPENDIX D

Adolescent Drug Involvement Scale: ADIS

Moberg, D.P., Hahn, L. The Adolescent Drug Involvement Scale. Journal of Adolescent Chemical Dependency, 2(1), 75-88, (1991).

THESE QUESTIONS REFER TO YOUR USE OF DRUGS OTHER THAN ALCOHOL. PLEASE CIRCLE THE LETTERS OF THE ANSWERS WHICH BEST DESCRIBE YOUR USE OF THE DRUG (S) YOU USE MOST. EVEN IF NONE OF THE ANSWERS SEEMS EXACTLY RIGHT, PLEASE PICK THE ONES THAT COME CLOSEST TO BEING TRUE. IF A QUESTION DOESN'T APPLY TO YOU, LEAVE IT BLANK.

1. How often do you use drugs?

(0) a. never

(2) b. once or twice a year

(3) c.. once or twice a month

(4) d. every weekend

(5) e. several times a week

(6) f every day

(7) g. several times a day

2. When did you last use drugs?

(0) a. never used drugs

(2) b. not for over a year

(3) c.. between 6 months and 1 year ago

(4) d. several weeks ago

(5) e. last week

(6) f. yesterday

(7) g. today

3. I usually start to use drugs because:

(CIRCLE ALL THAT ARE TRUE OF YOU)

(1) a. I like the feeling

(2) b. to be like my friends

(3) c. to feel like an adult

(4) d. I feel nervous, tense, full of worries or problems

(5) e. I feel sad, lonely, sorry for myself

4. How do you get your drugs?

(CIRCLE ALL THAT YOU DO)

(1) a. use at parties

(2) b. from friends

(3) c. from parents

(4) d. buy my own

e other (please explain) _____

5. When did you first use drugs?

(0) a. never

(1) b. recently

(2) c. after age 15

(3) d. at ages 14 or 15

(4) c. between ages 10-13

(5) f. before age 10

6. What time of day do you use drugs? (CIRCLE ALL THAT APPLY TO YOU)

(1) a. at night

(2) b. afternoon

(3) c. before or during school or work

(4) d. In the morning or when I first awake

(5) e. I often get up during my sleep to use drugs

7. Why did you first use drugs? (CIRCLE ALL THAT APPLY)

(1) a. curiosity

(2) b. parents or relatives offered

(3) c. friends encouraged me

(4) d. to feel more like an adult

(5) e. to get high

8. Who do you use drugs with? (CIRCLE ALL THAT ARE TRUE OF YOU)

(1) a. parents or relatives

(2) b. with brothers or sisters

(3) c. with friends own age

(4) d. with older friends

(5) e. alone

9. What effects have you had from drugs? (CIRCLE ALL THAT APPLY TO YOU)

(1) a. got high

(2) b. got wasted

(3) c. became ill

(4) d. passed out

(5) e. overdosed

(6) f. freaked out

(7) g. used a lot and next day didn't remember

10. What effect has using drugs had on your life? (CIRCLE ALL THAT APPLY)

(0) a. none

(2) b. has interfered with talking to someone

(3) c. has prevented me from having a good time

(4) d. has interfered with my school work

(5) e. have lost friends because of drug use

(6) f. has gotten me into trouble at home

(7) g. was in a fight or destroyed property

(8) h. has resulted in an accident, an injury, arrest, or being

punished at school for using drugs

11. How do you feel about your use of drugs? (CIRCLE ALL THAT APPLY)

(0) a. no problem at all

(0) b. I can control it and set limits on myself

(3) c. I can control myself, but my friends easily influence me

(4) d. I often feel bad about my drug use

(5) e. I need help to control myself

[6) f. I have had professional help to control my drug use.

12. How do others see you in relation to your drug use? (CIRCLE ALL THAT APPLY TO YOU)

(0) a. can't say or no problem with drug use

(2) b. when I use drugs I tend to neglect my family or friends

(3) c. my family or friends advise me to control or cut down on my drug use

(4) d. my family or friends tell me to get help for my drug use

(5) c. my family or friends have already gone for help for my drug use

Scoring of ADIS: Only items 1-12 are scored. For each item 1-12, add the highest weight circled. If more than one answer is circled, use the highest. (Do not put the weights indicated in square brackets above, on the actual questionnaires.) The higher the total score, the more serious the level of drug involvement.