The Reunification of Very Young Children from Foster Care

Family reunification is a central strategy for family preservation. Although child welfare services have arguably relied too heavily on family reunification to preserve families—and should more often prevent any separation of parent and child with in-home services—the incidence of children with a first entry into foster care has recently reached levels equivalent to those a decade earlier (Goerge, Wulczyn & Harden, 1994). The incidence rate for admissions to foster care among young children (ages 0-4) is now twice what it is for children 5-17 years of age, and infants now comprise nearly 25% of all entrances into foster care (Goerge, Wulczyn & Harden, 1994).

Child welfare commentators often consider family reunification a necessary evil, indicating that “family reunification and reconnection are often efforts to undo iatrogenic damage that has been done to families and children by a failing socio-economic system and by a child welfare system that has found it difficult to follow the principles of permanency planning” (Hartman, 1993; p. xxi). Most of the literature also addresses families with older children and explains ways to assist them in the transition back to living with their biological families (e.g., Folaron, 1993). This review will depart from earlier treatments in two ways: by not assuming that reunification is a strategy inherently second to in-home services in achieving permanency planning outcomes, and by focusing on very young children. This discussion is facilitated by the rapidly growing base of evidence about reunification of young children and the greater availability of administrative data that allows researchers to follow the movements of children in and out of care (e.g., Barth, Courtney, Berrick & Albert, 1994; Goerge, Wulczyn & Harden, 1995).

Although shorter stays in foster care are apparently consistent with permanency planning goals, they are more likely to be followed by reentry into foster care. Preliminary analyses of Chapin Hall's multi-state data archive show that about 30% of the children who were reunified since entering foster care in 1983 reentered foster care by the end of 1993. The analysis also found that the reentry rate was consistently higher for children who had been in foster care a short time (i.e., less than 3 months). These multi-state data are only descriptive, but are consistent with more sophisticated multivariate analyses of data from New York (Wulczyn, 1991) and California (Courtney, 1995), which indicate that children who stay in foster care a short time are far more likely to reenter foster care than children who have longer stays and are then reunified. Courtney’s analysis shows that this effect lasts.

Duration of Foster Care

A recent analysis of administrative data in five large states (California, Illinois, Michigan, New York and Texas) found that the duration of first spells in foster care lasted about as long in 1993 as they had in 1988 (Goerge, Wulczyn & Harden, 1995). Although the median length of time children remain in foster care had increased in 1990 and 1991, the recent trend has been toward shorter median stays. These shorter durations are particularly likely for white children. Foster care stays are also generally shorter in large urban regions than in outlying areas of the states. Infants have the longest spells, and African American children have median durations that are 40% greater than those for other children.

Reentry into Foster Care

Although shorter stays in foster care are apparently consistent with permanency planning goals, they are more likely to be followed by reentry into foster care. Preliminary analyses of Chapin Hall’s multi-state data archive show that about 30% of the children who were reunified since entering foster care in 1983 reentered foster care by the end of 1993. The analysis also found that the reentry rate was consistently greater for children who had been in foster care a short time (i.e., less than 3 months). These multi-state data are only descriptive, but are consistent with more sophisticated multivariate analyses of data from New York (Wulczyn, 1991) and California (Courtney, 1995), which indicate that children who stay in foster care a short time are far more likely to reenter foster care than children who have longer stays and are then reunified. Courtney’s analysis shows that this effect lasts.

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up to 6 months, after which the relationship between length of stay and reentry lessens.

A proportional hazards model of reentry in California looked at explanatory factors other than length of stay. The results indicate that children who were infants at exit from foster care (i.e., they entered and left care prior to one year of age) were 25% more likely to reenter care than older children (Barth, Needell, Berrick, Albert & Jonson-Reid, 1995). This was mitigated for children in kinship care and for Hispanic children. Children who reunified from kinship placements were one-third less likely to reenter care than other children. Caucasian children had lower foster care reentry rates than African-American children but higher reentry rates than Hispanic or "other" children. Children who were AFDC-eligible were more likely to reenter after reunification.

The timing of these foster care reentries is very instructive. In California, a recent analysis of 41,812 children ages 0-5 who had been reunified with their families showed that 23% reentered foster care within four years. (This figure is similar to that in other states.) The largest proportion of those children who did reenter did so by the end of two years (87%); however less than half of all those who reentered within four years did so within the six months after they returned home. This suggests that, since few post-reunification services last longer than six months, these reentries were not primarily a result of the ongoing supervision and heightened vigilance of the child welfare workers who oversaw the reunifications. The fact that the majority of children who reenter foster care typically do so after six months of being returned home suggests, instead, that they may be gradually reexposed to living conditions below the minimum standard of care. That nearly one-in-four young children reenter care after reunification is, alone, cause for considerable concern; the actual number of children who are exposed to marginal living conditions is likely to be even higher given the probability of underidentification and underreporting. Unfortunately, research now tells us little about the circumstances of reentry—that is, how much harm has befallen children who were in foster care prior to their reentry. It is plausible that the threshold of reentry is higher than the threshold of initial entry for children never before in foster care, and that children are coming back into care on the basis of relapsed parental behavior rather than actual harm to the children.

Family Preservation vs. Short-Term Foster Care

The finding of high reentry for very young foster children, especially those that stay a short time, is vexing. One critique of the child welfare system has been that family reunification programs too often serve families that could have been served with in-home services. That is, if a family’s problems can be resolved after only one to three months of foster care, why were temporary in-home services not provided to bridge the crises instead? On the other hand, the findings cited above suggest that short foster care episodes are often not resolving the crises either.

Another criticism is that foster care episodes, even short ones, may further destabilize families who might have remained together for a longer period of time had family preservation services been provided instead of foster care. This hypothesis may be tested, in part, with the advancement of family preservation programs. These programs should help to divert families that do not need foster care and, by so doing, could reduce the number of short foster care episodes. (In four of the five multi-state data archive states, more than one-in-five foster care stays commencing in 1993 was shorter than 3 months.) If the foster care entry rate among those who receive family preservation services is lower than the reentry rate for those who have short foster care stays, we would have evidence to suggest that short episodes of foster care are less helpful than family preservation services. Further study would then be needed to confirm this possibility. At this point, we do not know whether in-home services or reunification-focused foster care is ultimately more likely to result in family preservation.

Timing and Process of Reunification

Foster care placements occur because of a judgment that this is the best possible way to protect a child from harm. Very young children are placed into foster care following fewer child abuse reports than other children (Barth, Needell, Berrick, Albert & Jonson-Reid, 1995). This suggests that they are brought into foster care with some understanding of their age-based vulnerability. Yet, their high reentry rate into foster care after returning home suggests that their developmental vulnerabilities may not be considered as carefully at discharge as at intake.

The quandary is profound. Pressure to return infants and young children home comes from at least two child-centered concerns: (1) concern about multiple placement which may result when the foster care system acts to transition children out of the first, and more expensive, emergency foster care placements, and (2) concerns about disrupting the child’s relationship to the biological parent(s). Consequently, some children may be reunified too soon, which appears to place them at increased risk and result in excessive reunifications. Given the high reentry rates for very young children, the physical dangers of premature reunification seem to outweigh the psychological dangers of multiple placements and prolonged uncertainty. The evidence suggests that final decisions about reunification should be made between 6 and 12 months whenever possible.

Please see page 15...
It was Valentine’s Day, 1992 when Kathy Jackson moved in with Linda Stewart. Kathy had recently completed treatment for “crack” cocaine addiction. Her four children — a girl aged 7, twins age 4, and an infant — had been taken from her and placed in foster care. Two months earlier she had been desperate: tired of the structured living of residential treatment, no where to go after completing her program, and hopeless about getting her children back. She was skeptical when a counselor first suggested that she consider placing herself with a foster family. Kathy’s reaction quickly shifted as she learned that her children would join her in placement when she became ready.

This article is intended to inform readers about whole family foster care as a vehicle to reunite parents and children who have been separated due to substance addiction or other entrenched issues which put children at risk of abuse and neglect. The model poses particular promise (and challenges) for parents new in their recovery, needing to rebuild whole support systems, and vulnerable to relapse. The experiences of Kathy, her children, and Linda, with whom they lived for fourteen months, will illustrate how Whole Family Foster Care, as practiced by Human Service Associates in St. Paul, Minnesota, affected the lives of these individuals.

A family reunified through HSA’s Whole Family Foster Care

Background

Human Service Associates (HSA), a private, nonprofit child-placing agency located in Minnesota, South Carolina, and Texas, has provided treatment foster care for children and adolescents with special needs for fifteen years. The agency’s primary goal is the creation of community-based family resources as an alternative to inappropriate or premature institutional care for children. Treatment family foster care engages the healing elements involved in normal family living to ensure that children with therapeutic needs grow and change while in out-of-home placement. Goals are set and outcomes are evaluated with the hope that youth come out of placements with skills and strengths they can use in the world and with their own families. Whole Family Foster Care extends this mission and model to adults as well as children.

Whole Family Foster Care evolved as a program option at Minnesota HSA in 1991. During this time, family preservation programs were being funded nationally to prevent out of home placement of children by offering support to the entire family. HSA had always encouraged social work staff and foster care providers to involve families of children in their care, yet many providers felt that this was not enough. They believed that the parents needed the same intensive services and family support that their children received if reunification was to be successful. This was especially true of families involved in child protective systems due to “crack” cocaine abuse. HSA care provider Linda Stewart was among those concerned. She had just sent another foster daughter home and was struck by how painful the transition was for all involved: for the child’s mother who feared what her child had learned in another home, for the child who felt confusion (e.g., a need to separate from one family to be loyal to the first), and for herself who felt loss and pain from both the child’s and parent’s reactions to the placement.

Despite experiences like Linda’s, however, there seemed to be little connection between family preservation and foster care programs. The Whole Family Foster Care model grew in part out of HSA’s efforts to bridge this gap. It was developed for parents who are not able to consistently meet the physical and emotional needs of their children, but for whom family separation is not necessary in order to resolve child protective issues. The model uses components of standard family preservation programs (e.g., family life and parent education, respite, support, counseling, a team approach), which are delivered in the context of living with another family, true to treatment foster care.

Whole Family Foster Care has both foster and client families’ interests at heart. It was critical for Kathy, who needed a more constant and integrated approach in order to effectively identify and meet her children’s needs. At the same time, child foster care providers, like...
Linda, are attracted to the program as an opportunity to stop foster care drift for children and apply their energies where they will have most effect, i.e., with the parents. As households merge, the families can develop values mutually, resulting in less confusion for the children and more trust among the adult caregivers.

Program Components

At its core, Whole Family Foster Care uses a family setting, a foster care provider's special skills to examine the needs of both parent and child, and a community team approach to help families meet those needs. The foster provider's role is not to be the prime parent, but to share in the parenting tasks by modeling nurturing and discipline and enabling the parent to claim a rightful parental role in her or his family. The foster family becomes the basis of support for a stressed family by offering an environment in which healing can take place as client family members become reacquainted with each other and regain a sense of normalcy. Providers perform their role by offering direct and nonjudgmental feedback to parents about their parenting; acting as extended family to the children; setting clear family rules and boundaries; and helping the family to obtain community resources such as GED tutoring, job training, or aftercare counseling. To accomplish these tasks, the program model has four components: contracting, networking, peer support and mobilizing community resources.

Contracting

Parents and children referred for Whole Family Foster Care enter the program with an array of needs: developmental or emotional delays, recovery from chemical dependency or a physically abusive relationship, or discharge from incarceration. All personnel involved with the client family come together at the start of placement, and again at three month junctures, to develop a common understanding of the family's critical issues, the placement goals, and the steps needed to meet the goals. This process culminates in a written contract that outlines what each member of the team agrees to do. The team, which consists of a child protection worker, an HSA worker, and the foster family, and may include a parent educator from the community and/or the guardian ad litem for the children, becomes a resource for the client family. Team members communicate frequently to help the family in their movement toward agreed upon goals and to work through problems as they occur.

Two goals which made a difference for Kathy were budgeting=money management and parenting skills. She learned how to plan for a month of expenses after living day-to-day for the drug. She also had to redefine how she wanted to be as a parent.

"I didn't want to look at it and see that I could work with the kids differently. I had to start all over again. There was a time when all I could do for them was provide a bucket for a toilet, lock them in the apartment as I went to use, and return in time to get them to the shelter for something to eat. Now I can say 'no' to them — set real limits — not just say 'yes' out of guilt, wanting to please them anyway I could."

Networking

Adults in a shared household set the social and emotional environment in the home. The relationships among them is therefore critical to the success of the placement, as well as the follow-up support as a client family reestablishes its independence. The HSA worker, who is in the home at least twice monthly, assists families to maintain communication and work collaboratively toward placement goals. Additionally, the team often pulls in professional community resources, such as a mental or chemical health professional, for consultation or to help maintain the working relationship between foster and client parents. The agency also funds continued networking between foster and client families after client families have left placement. HSA reimburses foster families for up to three months for the childcare, advocacy, and peer support they provide as part of aftercare services.

Kathy, who trusted no one, felt she could trust Linda right away because she seemed genuine — put on no airs and meant what she said. "This woman didn't smoke, drink, or even keep pop in her house; she could set limits on herself and keep them." Kathy felt safe. Both women shared their African American culture and approximate age, and Kathy saw values of her childhood which she wanted for her children.

Linda saw in Kathy the stubborn desire to make it — willing to do anything to get her kids back — without which Linda was unwilling to go forward. As opposed to laying everything up front, Linda chose instead to let Kathy do things her way, but was always there to redirect her when Kathy burned out. "What Linda said stuck. I'd not talk to her for awhile until the kids said something, and I realized I couldn't keep this up for the kids' sake. I'd then see maybe she did have my best interest at heart. With the drugs, my focus was always outside of myself and so it took me away from everyday stuff. Linda's comments brought me back to what was real, like needing to turn off a burner after you're done cooking. She told me to my face that she was scared stiff that I'd burn the house down with all of us in it. That motivated me to change."

Today Kathy and her children count on seeing Linda at least monthly and still call her weekly two years after the placement ended. Linda has the pleasure of seeing for herself the result of their work in placement. The two women joke about how hot Kathy used to try to keep Linda's place, and how cool her apartment is now that she is paying the heat bill.

Peer Support System

Fostering and parenting are difficult and emotionally draining activities, frequently made more difficult by a sense of isolation and/or lack of group support. A peer group can give members support, encouragement, and concrete help to cope with whatever arises when families live together. Foster care providers who work with whole families need particular support. They are paid at minimum $31/day per person in placement, receive $200/year training funds and monthly respite benefits, and have access twenty four hours a day to an HSA social worker. Yet peer support from other care providers in
similar situations seems to be key to keeping people going. Care providers attend a monthly support group. New providers are matched with experienced families through a "buddy" system. Phone consultation is frequent. Fourteen families currently have whole family placements, out of two hundred care providers statewide. This group is culturally and geographically diverse. Single women and female heads-of-house hold the majority, though increasingly male/female partners are taking on whole family fostering despite the more complex family dynamics involved.

Client families also need peer support to build new support systems which do not endanger their children. Parents range in age from fifteen to forty with up to four children, infants to adolescents. The majority are young women with small children who are seeking parental mentorship as a way to end their involvement with child protective services. All families are asked to attend at least one community support/education group in order to minimize dependence on the foster family and gain opportunities to develop friendships. Several care providers with the program intentionally foster two or three families at a time to create a small community of parents within the foster home.

Mobilizing Community Resources

Client families facing issues such as recovery from chemical addiction or chronic mental illness require special services beyond what foster families are able to offer. Identifying local resources such as a Cocaine Anonymous group, a therapist, or a public health nurse before and during placement is a critical responsibility of all placement team members. Ideally, families are connected to resources that they can continue to use once placements have ended.

Kathy only knew the old using haunts. She needed to learn from Linda and new places to shop and play. Nine months into the placement during the stressful holidays, Kathy had a relapse and her placement was in potential jeopardy. It was time that she begin to truly address painful past issues that fed the desire to use. Linda could no longer be her sole confidante, so the placement team assisted her in finding the right therapist. The HSA social worker also put her in contact with an older African American woman and found an apartment complex which would give Kathy a break in rent because of her program involvements. Kathy moved out of her placement with all four children two months later and has not had a relapse since. Now that the children and she are more settled, she is starting GED classes and hair stylist training which she could only talk about two years ago.

Program Outcomes and Challenges

County child protection and probation staff refer families to Whole Family Foster Care to prevent placement of children away from their parents, to reunite parents with children who have been in foster care and need a gradual, supervised reunification process, and to determine if a parent can make changes before termination of parental rights is explored. Successful program completion implies that parents have the ability to assess and understand their parenting abilities, that children will move on to permanency (with their biological family or another family), and that no new reports of child abuse/neglect are received up to six months after families leave placements. Goals set in placement to achieve these outcomes include the development of parents’ self-care skills and parenting skills to identify and meet children’s needs, and links to community resources which can serve as regular sources of support for once isolated families. HSA is also in the process of selecting a parent-child inventory to evaluate program effectiveness for individual families. Client parents would complete the instrument before and during placement to document change over time in key variables which indicate abuse or neglect potential. The placement plan itself serves as a type of self-anchored scale for all team members to discuss and document change on individualized goals.

Between 1992 and 1994, forty-six families participated in whole family care through Minnesota HSA. Twenty-three of those families moved as a family unit to independent housing after completing the program and ended involvement with child protective services. Eight families left their children in foster care. Of this group, five children achieved permanency through adoption after termination of parental rights. Fifteen families continued in placement into 1995. Placements have ranged in duration from one month to several years, depending on family needs and county funds available.

Despite the program’s potential, most in and outside the child welfare system approach the concept of fostering whole families with awe and great skepticism, with good reason. Extreme care should be made in both the selection of care providers and clients to include families who might thrive with this kind of model. To open one’s home to another adult, to supervise parenting that is often too harsh or ineffective, to see children want something from parents which they are not now able to give, takes tremendous resiliency, flexibility, and commitment in a foster care provider. Client families need to accept loss of independence, financial control, intense scrutiny, and vulnerability to forming relationships with unknown adults with whom they will be living. Children’s needs must be considered to ensure that placement with their parent is in their best interest at this time. Abuse and neglect risks must always be evaluated and protocol established for how foster families might intervene if they fear for a child’s well-being. Client parents need to be fiercely motivated to keep their children with them and be willing to engage in weekly reflection as to how their actions affect their children as they receive support, personally and in parenting tasks.

This is especially true in working with parents with “crack” cocaine addiction. Relapse rates among cocaine addicts remain high, especially among those who leave residential care with a false sense of security, having been temporarily insulated from triggers and stressors. The majority of disrupted placements in this program have involved return to drug use by parents and abandonment of their children in foster care. Because incidents of relapse are almost a given among addicted parents, HSA staff are now urged to contract with all placement team members regarding agreed upon relapse consequences.
Through the federally funded Abandonment Prevention and Treatment Project, Society for Seamen's Children established the Intensive Permanency Planning (IPP) program designed to reunite children in foster care with their families much sooner than traditional foster care. The concept of the program is that through extra funds, intensive interventions with families and creative program planning, more timely permanency can be achieved for children in care. Permanency may involve children returning to their birth parents or being placed with an adoptive family.

During the first year of the program, few referrals were made. This was largely because there were fewer children coming into care and, of those coming in, few families met the intake criteria initially established by the program. The criteria was thus amended to include birth parents living in areas of Manhattan and Brooklyn near Staten Island, parents of low mental functioning who are not severely mentally ill or developmentally disabled, and parents whose children may have been in care for some time. Since the new intake criteria was established, referrals have been plentiful and the program is functioning at full capacity.

**Service Components**

The service components of IPP vary from traditional foster care. They include lower caseloads, a bio-parent advocate, frequent visitation, flex fund usage, and drug treatment. The IPP social worker serves no more than five or six families at any given time, compared with twenty or more children on a typical foster care caseload. The IPP social worker is assisted by a biological parent advocate (BPA) who acts as a role model for birth parents, assisting with parenting skills, escorting parents to appointments, and engaging them in visits with their children. In order to maintain the bond between parent and child, parents in the program visit with their children twice per week rather than twice per month. The quality of the visits is enhanced because they usually take place in a more comfortable setting for the parent and child, e.g., a park, a restaurant, the bowling alley or the parent’s home.

We have also found that early engagement and assessment are crucial to the success of IPP cases. IPP workers attempt to establish contact with the birth parent within the first twenty-four hours of referral. After meeting with the parent, conducting a home visit and setting up parent/child visits, the IPP social worker draws up a written contract with the birth parent within 14 days of intake. This contract outlines agreed upon goals the parent is to achieve before her/his child is returned, and describes what parents may expect from the IPP program. The contract is reviewed with the parent at quarterly case conferences, and parents may opt out of the program at any time.

Birth parents served by IPP receive tremendous support through almost daily face-to-face or phone contact with their social worker or the BPA, who help them remain focused on their goals. The social worker is accessible to birth parents through a beeper 24 hours a day, seven days a week. The social worker also provides individual counseling to birth parents once per week to discuss issues and areas of concern for reunification.

The IPP program addresses whatever presenting problems and issues the parent has and makes a determination to request a trial discharge from the New York City Child Welfare Administration once a parent has been drug free for at least six months, has secured suitable housing, and is assessed by the IPP team as being capable of caring for her/his child’s basic needs. Once the three month trial discharge has occurred, IPP continues to work with the family during the adjustment period, providing counseling, assisting with home management and budgeting and helping the parent to negotiate other social service systems.

**Intake Criteria**

Criteria for acceptance into the program are important. When the program first began two years ago, the established intake criteria was Staten Island residency, voluntary participation by the parent, and an assessment that the child(ren) could return home within six months to one year.

Most of the birth parents referred to the program have a substance abuse problem and require treatment to which they are referred upon intake. A unique feature of
Outcomes

Birth parents involved with the program have been very willing to participate and have generally been very pleased with the program. Primarily, they appreciate that they may visit with their children twice per week rather than twice per month in “regular” foster care. The parents also enjoy having their visits in their homes and in settings outside the agency. In addition, they appreciate the incentives and recognition (e.g., birthday and Christmas gifts, parties celebrating their achievements, dinner and a movie with their child on special occasions, and a hair cut and new dress for a court appearance) that IPP provides birth parents through extra funds. Finally, birth parents understand that with IPP their children may return to them in as little as six months rather than the traditional 18 months.

Since the program’s inception in October 1992, thirteen families have been served by IPP. Of the seven families served in the first year, permanency was achieved for four of them (three were reunified and one surrendered her child for adoption). Not all birth parents who entered the program the first year were prepared for the intensive services they received. Decisions were made to transfer three of the families to regular foster care units because the parents were not complying with their goals. They expressed to the IPP team that they felt too overwhelmed by the intensive services and needed more time to rehabilitate. Of the seven families currently being served by IPP, one was recently reunified, one is making plans for adoption, two recently entered the program and are engaged in planning for their children, and three have nearly reached their discharge goals.

Aside from drug abuse problems, birth parents served by IPP have a range of other issues preventing them from having their children returned. Two parents are low functioning and require assistance with basic child care, house keeping and home management skills. Several other parents have no appropriate housing and require assistance in securing housing and subsidizing rent.

Conclusion

As states begin to explore more creative and effective ways of working with families toward achieving permanency expeditiously for children in care, intervention strategies such as those employed by IPP can serve as a model. Some states, e.g., New York, that are considering managed care models for foster care may find service components such as early assessment, flexible funds, a bio-parent advocate, lower caseloads, quality enhanced visitation and collaboration with other service providers to be effective approaches to reducing the time children spend in foster care. Those of us who have participated in the IPP program find that this approach, as opposed to traditional foster care, makes for greater satisfaction and a better experience for service providers as well as birth parents.

Testimony from Marianne, a Birth Mother in the Society for Seamen’s Children’s Intensive Permanency Planning (IPP) Program

Marianne, whose son was born with a positive toxicology to cocaine in June 1994, had a long history of substance abuse. Her son was returned to her from foster care after she participated in the IPP program and an intensive drug treatment program for six months. IPP continues to monitor her progress as she receives ongoing drug treatment services.

“This program definitely helped me get my son back from foster care a lot sooner that I would have. They kept in constant contact with myself and my child and they also appeared in court with me.”

“The part of the program that I like best was having more time with my child. The part that was most useful for me as a mother was the counseling sessions I was given by my social worker.”

“This program helped me obtain extra money to help me pay my rent so I could live normally. I got my child every other weekend for a month, then every weekend for the following month, then he was home for good. My son is a special gift to me. I live for him and love being close to him while he grows up. I would definitely recommend this program to others. This program helps you and your child to bond together and have a closer relationship.”

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Susan Maher, MSW, Supervisor, IPP
Kim Marie Allen, Social Worker, IPP
Adrianna Caffaros, Bio-Parent Advocate, IPP

*Society for Seamen’s Children is a non-profit, child and family multi-service agency located in Staten Island and Brooklyn, NY. Along with foster care and adoption services to families and children, the Society provides drug treatment, bio-advocacy and prevention services.*
Family Reunification: Ready or Not, Here I Come

Mika is three years old. He has been living in a long term foster care arrangement since his discharge from the hospital. Mika’s mother had a heavy heroin habit along with alcohol addiction and “whatever drug” she could get. At the time of his birth, Mika’s mother also had twin girls one year older and a daughter aged 12. Mother, who entered drug treatment shortly after Mika was born, remained in contact with the older children but has never had any contact with Mika. She has recently completed a three month residential program following numerous other attempts at getting sober, and she is being awarded full custody of all four children. Her oldest daughter, who is now 15 and has a six month old infant of her own, lives with her. The four-year old twin girls are aggressive and have been acting out. Mika has become quiet and clingy since plans were announced. Yet, there will be no transitional period, no preparation, and no contact between foster family and Mother to prepare the children and educate her about their schedules, likes, dislikes, medical needs and other necessities. Mother insists she does not need any help or information from the foster family.

Supporting Reunification Through Better Decision Making

An estimated 25 percent of children reunified with biological parents eventually return to foster care. What are we doing wrong? How might we deal better with situations like Mika’s to prevent repeated separations? Improved planning and preparation might insure higher success rates as well as better decision making about terminating parental rights. In assessing a family’s readiness for reunification, the following primary factors must be considered: (1) When is the biological mother ready? (2) When is the child ready? (3) How have both been prepared and (4) What transitional services and ongoing supports are planned to ease the way? Appropriate planning must consider age(s) of the child(ren), size of the sibling group, length of time outside the home, amount of contact with biological parents, reason for the original separation and improvement in the circumstances which caused the separation. Is there support to continue the process of positive change? Does the parent really want this child returned or is she ambivalent or negative about the child? If neglect occurred in the past, was it due to a lack of resources, a lack of understanding of the child’s needs or the parent’s personal problems such as substance abuse? Have these conditions changed?

Assessing Maternal Readiness

One of the first steps we can take is to assess parenting skills; child rearing history, and access to appropriate services and support from family, neighbors, friends and professionals. Parenting is not an easy task for anyone. Even mothers without extraordinary crises in their lives experience parenting stress and frustration. Most women are able to draw upon their own positive experiences in being raised and to call upon a variety of external resources (e.g., baby-sitters, family members and friends) to provide them with respite and advice. Women who have been separated from their children by the courts, on the other hand, were frequently not parented appropriately themselves. They have had no role models for good parenting and may not know how to deal with the frustration which is a normal part of parenting. In addition, they may be reluctant to admit their frustration and difficulty to others and may therefore not have access to information and advice used by many other families. Mothers who have been separated from their children due to drugs, child abuse and neglect, hospitalizations or mental illness are often unprepared to handle many of the basic tasks of parenting and may have never had the experience. This does not mean that they are not capable of parenting.

Most women could benefit from a basic series of classes in child development and parenting techniques appropriate to their child’s developmental stage. In addition, it is important to provide individual consultation and problem solving training specific to challenging children, and to address a mother’s guilt and fear that she will never be “good enough” as a parent and that her child will never love her, forgive her, or want her. Only by ensuring that parents have the support they need, and by working with them individually, emphasizing their strengths, encouraging success, and modifying techniques which are not working, can we expect them to be effective parents.”
following reunification. We must emphasize reunification as a process, not an end point, and address a child's need for continuity. Despite the pain to the adults, a child's emotional health would be enhanced by allowing ongoing contact (even by phone) with the previous caregiver until the child has adjusted to the new situation. This is particularly important if the child has lived in the foster setting for a long period of time. Adhering to routines and rituals (e.g., bedtime sequences; favorite blanket) in both homes is important as new routines are established.

Also, in order to prevent further separation, ongoing support services must be provided for the family beyond the initial reunification. For mothers, this should include ongoing counseling related to her own issues, assistance with schedules and time management, parenting support, and assistance in understanding and managing child behavior and sibling issues. Children should receive ongoing assessment of their adjustment and behavior (e.g., regression in developmental milestones) and age-appropriate counseling when necessary. Inappropriate child behavior, parenting stresses and parent relapse into old habits are all important signals of problems that can be addressed through transitional services before the problems escalate. Ongoing individual and family counseling for both mother and child will help them cope with problems as they occur.

We must, however, allow time for the process to unfold and for parent and child to relax with each other. Reunification is a complex process which requires assessment of family strengths and needs before, during and after it occurs. The intensity and duration of service during the reunification process must be assessed case-by-case to reflect the varying needs of families. After a decision is made to terminate services following reunification, it is helpful to continue monitoring the family by phone, or to provide a "resource contact" for families to call in times of stress and for help solving problems.

Is Reunification Always the Best Goal?

We also must be realistic about families for whom there is no hope of reunification and provide an earlier plan for permanent placement of their children. Although there are no hard and fast rules for determining when reunification is not in the best interests of parent and child, attention to a list of risk factors for failure of reunification may help guide the decision. Learning to look beyond the adult investment towards child needs will help inform it.

Researchers such as Turner (1984) and Hess and colleagues (1992) have found a number of factors relevant to the issue of returns to foster care. Importantly, children classified as "recidivists" had the most problems and received the least department of social service case management and fewer services both during foster care and after their return home. In addition, parents classified as "ambivalent" about their children had similar risk characteristics: requested original child placement, refused at least one service offered to them, and had inconsistent attendance at court, in visits with their children and in service participation. One might expect, based on these characteristics, an inconsistent parenting style with their children. It is important to keep in mind that even by providing the best of all services, not all parents can be successfully reunited with their offspring (nor do all have this desire). Perhaps it would be less damaging in the long run to both child and parent to recognize this and terminate rights in such cases, allowing children to be placed in a secure, long term situation be it foster care or adoption.

Summary

Most children are better off remaining with their biologic families. It would make much better sense to invest a portion of the dollars spent on foster and group homes to improve a family's chance of successfully meeting the child's needs than to continue tearing families apart. If families have been separated, we must assist them in addressing counseling, housing, employment and day care issues while children are in foster care, not after they have been returned. It is essential that policies be developed reflecting long term gain over short term cost savings. Funding levels and service provision must reflect the belief that a family is the best place for a child to be raised. If we want to insure long term success and prevent repeated foster placements due to "failed" reunification, we need to commit more time and money to the process the first time around. If we are going to mandate policies such as reunification, we must provide the mechanisms for success within reunified families. Let's envision a different scenario for Mika . . .

Mika's mother is first reunited with her twin daughters, who are working with a child and family counselor to deal with their aggressive behavior. Mika's mother sees the counselor along with the children so she can learn more appropriate responses to their behavior and talk about her parenting difficulties. Her 15 year-old daughter is referred to a community program for teenage mothers. Mika's mother begins weekly visits with Mika's foster family so that she can become acquainted with Mika, learn his routines, and become comfortable with the foster family. The twin girls' counselor schedules several sessions with Mika and his foster family to help them prepare for the upcoming changes. After several months, Mika's mother and her case manager determine that she is ready for weekends with Mika. Nine months after the twin girls have been reunified, the case manager, family counselor and mother jointly determine that she is ready for reunification with Mika. Despite care is arranged weekly for the next six months, and all three children are enrolled in daily half-day school programs. Mika continues to visit his foster family and talk to them on the phone. The family receives ongoing case management and counseling services until it is determined no longer necessary.

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before a placement begins. HSA would prefer to view relapse not as failure but as a signal that treatment is not complete, and to capitalize on parents’ post relapse motivation to change their behavior and thinking, as Kathy was able to do. Unfortunately, Whole Family Foster Care is not used by counties as often for prevention, but as a last resort with parents for whom they are considering termination of parental rights. This pressure, where one false move means loss of one’s children, the very force which motivates change, can truly set all up for placement failure.

The full promise of Whole Family Foster Care as a vehicle to reunite addicts in recovery with their children has yet to be realized. Arnold Washington wrote in Cocaine Addiction: Treatment, Recovery, and Relapse Prevention, that the major goals of the recovery period are to prevent relapse and lay a foundation for lasting recovery. This involves changes in attitude and perception, developing improved coping skills to deal with addiction-related and other personal stressors, and movement to a deeper experiential acceptance of the problem and the need for personal change (Washington, 1989). What this program offers are the key elements of continued structure and accountability for those newly in recovery, the opportunity to be with one’s children, and connection to a daily source of support, all located in the context of everyday life in the community. For Kathy Jackson, this combination allowed her to take on the experiential acceptance and change of which Washington speaks. The power behind the connection developed between foster and client parents in the “living together” experience cannot be duplicated through other counselor/patient means. The Whole Family Foster Care approach warrants consideration elsewhere, by treatment programs and child protective entities, to bring more families like Kathy’s together again, for good.

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possible, with full reunification services continued for at least 12 months. Brief foster care spells for children younger than 3 should be discouraged. Also, while in care, effort should be made to limit a child's placements to one home — ideally one that is committed to becoming an adoptive home if reunification fails after no longer than six months.

Perhaps more intensive family reunification services can yield more lasting reunifications. Two recent evaluations have considered the use of intensive services to reunify children from foster care: Illinois (Rzepnicki, Schuerman & Johnson, in press) and Utah (Walton, Fraser, Lewis, Pecora & Walton, 1993). The models and findings are similar. Services were akin to those in family preservation programs, although they were provided for a longer period of time than some family preservation services. Still, they were intended only for 90 days in Utah and about 180 days in Illinois. In Utah, significantly more children returned home if they received intensive services. In both settings, approximately 20% of cases reentered foster care within about one year. These results do not suggest that more durable reunifications will result from more intensive reunification services.

Colorado has adopted legislation which enhances reunification services and shortens the review period for young children so that a facilitated, early permanency planning decision can be made. They cite as their rationale the "numerous studies establishing that children undergo a critical bonding and attachment process prior to reaching the age of six" (Colorado Revised Statute, 1994, B19-1-102; p. 1). In the Colorado demonstration in Jefferson County, they will conduct permanency planning hearings at 3 months after the dispositional decree, at which time the court may ask the county to show cause why it should not file a motion to terminate the parent-child legal relationship. A child is to be returned home or placed in a permanent home no later than 12 months after placement (unless the court determines that a permanent placement is not in the best interests of the child at that time).

The Need for Extended Post-Reunification Services

The reunification process needs to be conceptualized as one that extends well beyond the time that a child returns home. Conventional "trial visits" were initially developed in order to integrate the older child back into the home. This involved helping the child gradually sort out the roles of the biological family, and supporting and supervising the biological family's transition back to the parenting role. For younger children, and families involved with substance abuse and neglect as the primary reason for removal of their children, these are necessary but not sufficient post-placement services. Additionally, families need continued contact and treatment to identify the reemergence of self-destructive and child endangering behavior patterns.

Reunification of very young children also requires that the social worker or provider of post-reunification services be knowledgeable about the developmental status and needs of small children. The practitioner must be comfortable holding the baby, checking the baby for bruises and infections, interviewing the families, and understanding signs of parental relapse. If young children are involved with early intervention (e.g., PL 99-457) services, the link needs to be made between the intervenor (who would previously have worked with the child and foster parents) and the biological parent. If there have been no early intervention services, assessment for and enrollment in them should be pursued prior to ending reunification services. Additionally, given the high recidivism rate, no child should be returned home without establishing a relationship between the child, family and outside agencies in order to ensure ongoing support and surveillance.

Another option is to bring biological parents into foster care. In such arrangements, families have the opportunity to reestablish living arrangements with the support and mentoring of foster families. (This model is discussed in "Shared Foster Family Care" in the Spring 1994 issue of The Source and the Nelson article on p. 3 of this issue.) Another innovation which appears to be getting increasing attention is one that involves using the foster family as a respite family during the transition to reunification (see Barth, 1991). All means of connections between the reunified family and supportive services provide children and their families with protection from the calamity of further disruption.

A Longer Vision

Our understanding of the perils of short foster care episodes combined with short post-reunification services calls for a longer vision of services. Besharov (1994) argues that brief services are not sufficient for many child welfare families and that we must think long-term. He concludes that the greatest barrier to that is not budgetary, but conceptual. New York, among other municipalities, encourages reunification and allows agencies to provide necessary aftercare services without incurring new costs by paying a fixed rate per case (Wulczyn, in press). Even if the use of a capitated rate is not feasible, local funds, along with new funds available under the Family Preservation and Support Program, could be used to provide post-reunification services. We should aim to establish a minimum length of combined out-of-home and in-home aftercare. Since, each year in the U.S., as many as 25,000 children are reunified from foster care after stays of less than six months, however, IV-B funds would not be sufficient to substantially extend post-placement services without supplanting nearly all other uses of IV-B (i.e., placement preservation). Clearly IV-E funds must also be brought to bear if we are to routinely provide in-home post-reunification services. Support for these very needed services could be enabled by allowing title IV-E funds to pay for case management for up to one year after reunification of children younger than five at the time of exit from care. Failing that, states may want to experiment with extended post-placement services under the new I-VE waiver provisions.

Programs that guarantee extended periods of case management have been developed in lean fiscal times and have been shown to be cost-effective. In general, a dose-response relationship does exist.
for services, and longer services are better (Barth, 1993). Child welfare’s current clientele are younger and more vulnerable than ever before. Their child protection needs are extensive and so must be the services they receive.

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Hutto Patterson Professor and Principal Investigator
AIA Resource Center, Berkeley, CA

REFERENCES


We are very pleased to welcome two new members to the AIA Resource Center staff and celebrate the continuation of a valued staff member.

Gwen Edgar-Miles brings 13 years of experience in the public health and social service fields to her new position as Research Associate. She has served as a case manager, health educator, counselor, and child protective services worker with families affected by chemical addiction and HIV infection. Additionally, she has developed programs at a San Francisco public housing project for residents who are crack addicted, and has been a consultant to a residential treatment facility for pregnant women and their infants. Gwen also developed and managed an HIV community health outreach program, where she directed a staff of peer workers. Gwen’s areas of expertise include: perinatal substance abuse, detoxification, HIV/AIDS, homelessness, forensic services, sexually transmitted diseases, and dual diagnosis. Her educational background includes a bachelors degree in sociology, certification in HIV Pre- and Post-Test Counseling, and coursework towards a Masters in Counseling and Mental Health. Gwen’s duties at the Resource Center will include: organizing and staffing technical expert groups; developing educational resources and materials; planning and hosting telephone roundtables and seminars; helping to plan AIA Resource Center conferences; tracking pertinent legislation and funding; and training. Gwen has a wealth and breadth of knowledge and experience combined with an infectious enthusiasm — we are very fortunate to have found her.

Sheryl Goldberg, who will be working half-time on the Evaluation Team, has a background in health and social work, with experience in research, program administration and grant making in the public and nonprofit sectors. As part of a team of researchers at the Institute for Health & Aging at the University of California, San Francisco, Sheryl was involved in all phases of a study of health policy, organizational behavior and the elderly. She also served as Research Coordinator for a national study on the lifestyles of older women conducted at San Francisco State University. Presently, she is President and Co-Founder of the Institute on Women’s Health, a nonprofit that conducts, translates and disseminates applied research on women’s health issues. Her credentials include a Masters degree in Social Work and a Ph.D. in Medical Sociology. At the Resource Center, Sheryl will: complete annual studies of AIA programs which describe client and service characteristics; provide technical assistance to program evaluators; coordinate a Monograph on AIA Project Outcomes; and help determine the feasibility of an AIA cross-cutting evaluation. Sheryl is also working part-time as Research Coordinator with the Bay Area Social Services Consortium at the UC Berkeley School of Social Welfare. We are delighted to have someone on board with Sheryl’s skills, expertise, and commitment.

We are also delighted to announce that Amy Price will continue in her position as Senior Research Associate at the AIA Resource Center. With the drive and stamina of an army, Amy will continue to edit this national newsletter; organize and staff technical expert groups; develop educational resources and materials; plan and host telephone seminars; assist in the planning of Resource Center conferences; and conduct training. We could not be more pleased that she has chosen to stay on with us and give us the benefit of her fine work.

Additionally, we are very grateful for a bright, capable and ambitious team of social work students who work at the AIA Resource Center. We would be hard pressed to provide our services and produce our materials without their excellent contributions.

Rick Barth, Principal Investigator, and I continue to oversee the operation of the Resource Center.

— Jeanne Pietrzak, MSW
Director, AIA Resource Center
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