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To cite this article: Sarah Carnochan , Daniel Rizik-Baer & Michael J. Austin (2013) Preventing Re-Entry to Foster Care, Journal of Evidence-Based Social Work, 10:3, 196-209, DOI: [10.1080/15433714.2013.788949](https://doi.org/10.1080/15433714.2013.788949)

To link to this article: <http://dx.doi.org/10.1080/15433714.2013.788949>



Published online: 24 May 2013.



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## Preventing Re-Entry to Foster Care

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Re-entry to foster care generally refers to circumstances in which children who have been discharged from foster care to be reunified with their family of origin, adopted, or provided kinship guardianship are returned to foster care. In the context of the federal performance measurement system, re-entry refers specifically to a return to foster care following an unsuccessful reunification. The federal Children and Family Services Review measures re-entry to foster care with a single indicator, called the permanency of reunification indicator, one of four indicators comprising the reunification composite measure. This review focuses on research related to the re-entry indicator, including the characteristics of children, caregivers and families, as well as case and child welfare services that are associated with a higher or lower risk of re-entry to foster care. Promising post-reunification services designed to prevent re-entry to foster care are described.

*Keywords:* Child welfare, re-entry, outcome, policy

### INTRODUCTION

Re-entry to foster care generally refers to circumstances in which children who have been discharged from foster care to be reunified with their family of origin, adopted, or provided kinship guardianship are returned to foster care. Re-entry is often the result of an unsuccessful reunification with the family of origin or an adoptive or permanent kinship placement. In the context of the federal performance measurement system, re-entry refers specifically to a return to foster care following an unsuccessful reunification.

When children re-enter the foster care system because abuse or neglect has recurred, they suffer the direct consequences of the repeat maltreatment as well as disruption to their relationship with their caregiver. Although child welfare agencies typically seek to return re-entering children to a former kin or foster placement, in many cases they must enter unfamiliar households. Re-entry into foster care may be particularly harmful to very young children, for whom attachment to a consistent and responsive primary caregiver is central to healthy development. Children who experience multiple changes in caregiver relationships during the first few years of life may experience long-term impairment in their ability to form meaningful interpersonal relationships (Berrick, Needell, Barth, & Jonson-Reid, 1998; Kimberlin, Anthony, & Austin, 2009).

A 2008 federal report from the Department of Health and Human Services found that state child welfare case plans were in line with federal policies, giving priority to permanency either in the

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form of reunifying children in foster care (49%) or adoption (23%; U.S. DHHS, 2008). This report also indicated that the majority of children (53%) exiting foster care were ultimately reunified with their parent or primary caregiver (U.S. DHHS, 2008). It is more difficult to establish a common re-entry rate, as a number of factors contribute to local variation in re-entry rates, including geographical area, population demographics, and time elapsed after reunification (Festinger, 1996). For example, in 2007, foster care re-entry in the California Bay Area counties ranged from 3.3% to 20.3% (Needell et al., 2007), while in other states, the re-entry rate has been as high as 28% (Wulczyn, 2004). Re-entry rates also differ depending on the length of time that children remain in foster care, with shorter stays in foster care associated with higher re-entry rates (Wulczyn, 2004).

### CFSR PERMANENCY OF REUNIFICATION INDICATOR

In the federal Children and Family Services Review (CFSR) evaluation process, re-entry to foster care is measured with a single indicator, called the *permanency of reunification* indicator, one of four indicators comprising the reunification composite measure (the first three indicators relate to the timeliness of reunification). This review focuses on the re-entry indicator of the larger composite, defined as follows:

- **CI.4:** Of all children who were discharged from foster care to reunification in the 12-month period prior to the target 12-month period, what percent re-entered foster care in less than 12 months from the date of discharge?

The re-entry indicator is the most heavily-weighted component of the reunification measure, comprising 46% of the total reunification composite score. While there is no national standard for scores on this indicator, it weighs heavily in the composite score for reunification. In the first round of the CFSR, the re-entry indicator was separate from the reunification indicator. In the second round of the CFSR process however, this indicator was placed in the reunification composite under the permanency outcome goal (U.S. DHHS-ACF, 2007). By counting failed reunifications against the reunification score, ACF sought to ensure that the federal performance measures did not create an incentive for states to reunify families too quickly. Explaining this decision, ACF stated: “Although ACF believes that it is important to reunify children with their families as quickly as possible, we also believe that children should not be reunified until sufficient changes are made to prevent the child being removed from the home again” (U.S. DHHS-ACF, 2007).

### FACTORS ASSOCIATED WITH RE-ENTRY TO FOSTER CARE

The researchers examine the characteristics of children, caregivers and families, as well as case and child welfare services that are associated with a higher or lower risk of re-entry to foster care. Many of the risk factors associated with re-entry to the foster care system are also associated with recurrence of maltreatment. This is a logical overlap; most children who re-enter the foster care system do so because of the recurrence of maltreatment (Kimberlin et al., 2009). Awareness of these risk factors helps child welfare workers to develop appropriate case plans and service goals. However, it is important to note that the presence of risk factors does not mean that re-entry will necessarily occur. This discussion draws primarily on the risk factors for foster care re-entry identified by Kimberlin et al. (2009).

### Child Characteristics

Researchers in several studies have examined the characteristics of children that place them at a higher risk for foster care re-entry. For example, children with special needs (e.g., health, mental health, and behavioral problems) are at a higher risk for foster care re-entry (Courtney, 1995; Courtney, Piliavin, & Wright, 1997; Jones, 1998). In addition, children who experienced prenatal substance exposure have been found to be more likely to re-enter foster care (Frame, 2002). African American children (Courtney, 1995; Shaw, 2006; Wells & Guo, 1999) and infants, pre-teens, and teenagers (Courtney, 1995; Shaw, 2006; Wells & Guo, 1999; Wulczyn, 1991) are at a greater risk of re-entry than children in other ethnic or age groups. Finally, children with a sibling in foster care are also more likely to re-enter foster care (Shaw, 2006).

### Caregiver/Family Characteristics

Researchers in studies of caregivers have identified the following issues that are associated with an increased risk of re-entry to foster care: (1) parental ambivalence about parenting role (Festinger, 1996; Hess & Folaron, 1991; Turner, 1984); (2) lack of parenting skills and social support (Festinger, 1996; Terling, 1999); and (3) the total number of parent problems (Festinger, 1996; Terling, 1999; Turner, 1986). These researchers do not, however, provide conclusive findings and further research is needed. Looking more broadly at family characteristics, the following have all been found to be associated with an elevated risk for foster care re-entry: (1) poverty or AFDC receipt (Courtney, 1995; Jones, 1998; Jonson-Reid, 2003; Shaw, 2006); (2) substance abuse or related services (Brook & McDonald, 2009; Shaw, 2006; Terling, 1999); and (3) a higher number of children living at home (Barth, Weigensberg, Fisher, Fetrow, & Green, 2008).

### Case and Service Characteristics

Research indicates that several factors related to previous involvement in the child welfare system may predict re-entry to foster care. First, the type of maltreatment is significant, as neglect has been associated with foster care re-entry (Terling, 1999). Factors related to prior involvement with the child welfare system have also been shown to be associated with re-entry to foster care (Barth, Guo, & Caplick, 2007; Terling, 1999). There is strong evidence that short initial stays in foster care (less than three months) are highly correlated with re-entry (Courtney, 1995; Courtney et al., 1997; Jonson-Reid, 2003; Shaw, 2006; Wells & Guo, 1999; Wulczyn, 1991). One explanation for this finding is that the short time period does not provide sufficient time to address the problems that led to the initial removal (Fuller, 2005). This view is supported by researchers in studies that find that unmet service needs and unresolved family problems are associated with foster care re-entry (Festinger, 1996; Turner, 1986). However, others suggest that longer stays in foster care may be associated with lower re-entry rates due to another mediating factor; namely, the ability to sustain a parent-child relationship through a difficult period (Wulczyn, 2004).

A large number of foster placements have also been associated with high rates of foster care re-entry (Courtney, 1995; Courtney et al., 1997; Jonson-Reid, 2003; Koh, 2007; Wells & Guo, 1999). This may be due to child behavioral problems that resulted in multiple placements in foster care and, subsequently, present a challenge to caregivers in relationship to the reunification process (Courtney, 1995). In addition, children placed in group foster care have been shown to be at risk for re-entering foster care (Wells & Guo, 1999). Finally, the period of time after a child returns home is crucial. Wulczyn (2004) found that almost 70% of children who re-entered foster care did so within one year of returning home, with almost 40% doing so after just three months.

## PROMISING PRACTICES TO PREVENT RE-ENTRY TO FOSTER CARE

Re-entry to foster care may occur following adoption, placement in kinship care, or family reunification (Freundlich & Wright, 2003). However, the federal standards focus specifically on re-entry following reunification. The National Family Preservation Network (2003) suggests that family reunification practices incorporate the following three stage model: (1) preparing the family for reunification; (2) providing intensive services after the child is returned home; and (3) engaging in a follow-up process of less intensive services. Post reunification practices occur *after* a child is returned home and help to support a family in maintaining a successful reunification (Freundlich & Wright, 2003). Recommended services include: (1) housing assistance or respite care; (2) “soft” services such as counseling; and (3) social worker assistance throughout the process of reunification and after (Wulczyn, 2004). Other post-permanency services include educational and informational services, clinical and treatment services, material services such as financial support, and supportive networks and other forms of informal and formal support for children and families (Freundlich & Wright, 2003). However, post-reunification services are usually not adequately funded and may be the least developed of child welfare prevention and intervention strategies (Wulczyn, 2004).

Promising post-reunification services designed to prevent re-entry to foster care include strategies that have been broadly linked to preventing foster care re-entry but the absence of rigorous research evidence makes it difficult to conclusively establish their impact.

### Intensive Family Preservation Services

Intensive Family Preservation Services (IFPS) are designed to serve families that are at “imminent” risk for out-of-home placement and feature time-limited, intensive interventions for up to 90 days (Washington State Department of Social and Health Services, 2007; Ryan & Sheurman, 2004; Kirk & Griffith, 2004). The goals of IFPS programs include: (1) ensuring child safety; (2) preventing placement (if appropriate); (3) facilitating safe reunification (as requested and appropriate); (4) reducing risk factors for children, families, and caregivers; (5) strengthening family units and avoiding new referrals; and (6) connecting families with community resources (Washington State Department of Social and Health Services, 2007).

Homebuilders is an example of an IFPS program (developed by the Institute for Family Development [IFD]) for use in populations served by the child welfare and juvenile justice system or in need of mental health services (IFD, 2009). Homebuilders provides “intensive, in-home crisis intervention, counseling, and life-skills education for families who have children at imminent risk of placement in state-funded care” (IFD, 2009; [http://institutefamily.org/programs\\_IFPS.asp](http://institutefamily.org/programs_IFPS.asp)). Homebuilders also works with families that have been referred by the state and face difficult post-adoption situations, or have children returning home from out-of-home care (IFD, 2009). Ryan and Sheurman (2004) describe Homebuilders as the “pre-eminent model” of family preservation services.

The program provides emotional support services (e.g., counseling and anger management classes to address psychological and emotional issues and needs of parents) as well as material support services to families in need (Ryan & Sheurman, 2004). The core elements of the program are noted below (<http://institutefamily.org/pdf/HOMEBUILDERS-Standards-2.2.pdf>):

- **Intervention at the crisis point:** Professional therapists see families when they are in crisis, within 24 hours of referral.
- **Treatment in the natural setting:** Almost all services take place in the client’s home or the community where the problems are occurring.

- **Accessibility and responsiveness:** Therapists are on call to their clients 24 hours a day, 7 days a week. Families are given as much time as they need, when they need it.
- **Intensity:** Services are time-limited and concentrated in a period targeted at 4 weeks. The service is designed to resolve the immediate crisis, and teach the skills necessary for the family to remain together. Each family receives an average of 40 to 50 hours of direct service.
- **Low caseloads:** Therapists carry only 2 to 3 cases at a time. This enables them to be accessible and provide intensive services. Low caseloads also allow therapists the time to work on specific psycho-educational interventions, as well as the basic hard service needs of the family.
- **Research-based interventions:** Therapists utilize a range of research-based interventions, including crisis intervention, motivational interviewing, parent education, skill building, and cognitive/behavioral therapy.
- **Flexibility:** Services are provided when and where the clients wish. Therapists provide a wide range of services, from helping clients meet basic needs, to sophisticated therapeutic techniques. Therapists teach families basic skills such as using public transportation systems, budgeting, and where necessary, dealing with the social services system. They also educate families in areas more commonly associated with counseling, such as child development, parenting skills, anger management, other mood management skills, communications, and assertiveness.

*Effectiveness.* There is some debate about the general efficacy of family preservation services in preventing foster care re-entry. Several studies have found that intensive family preservation services may not be effective at preventing foster care re-entry (Fraser, Walton, Lewis, Pecora & Walton, 1996). However, Blythe and Jayaratne (2002) found that after 12 months, 93% of children in the IFPS program remained in their home compared to 43% of children in the control group. In a study of the specific program components that make up the Homebuilders program, Ryan and Sheurman (2004) found that cash assistance decreased the risk of subsequent placement in foster care.

*Implementation.* The IFD uses a “Quality Enhancement System” (Quest) to design and implement its Homebuilders program. Quest activities and assistance include (IFD, 2009):

- Infrastructure development in the public agency/funding agency;
- Assistance in hiring program staff;
- Workshop training for program managers, supervisors, and therapists;
- Clinical consultation and home visits with therapists and supervisors;
- Technical assistance for program managers, supervisors, and support staff;
- Review of case record documentation;
- Review of agency and individual performance on fidelity measures;
- Review of program outcomes.

The following resources are typically needed for implementation (California Evidence-Based Clearinghouse for Child Welfare, 2009):

- Team of 3–5 therapists, 1 supervisor (carries a partial caseload), and 1 secretary/support staff;
- Small amount of staff work/office space, supplies, telephone, copier, etc.;
- Pagers and/or cell phones;

- Clinical staff use their own vehicles for home visits, mileage is paid for all client and program related travel;
- Access to a computer and Internet for client records and data collection.

For additional information on Homebuilders contact: <http://www.institutefamily.org>

### Respite and Crisis Care

The Child Abuse Prevention and Treatment Act (as amended by the Keeping Children and Families Safe Act of 2003) provides a federal mandate that respite care be included in grants to community-based services in an effort to prevent child abuse and neglect. The Act defines respite care as:

[S]hort term care services provided in the temporary absence of the regular caregiver (parent, other relative, foster parent, adoptive parent, or guardian) to children who—(A) are in danger of abuse or neglect; (B) have experienced abuse or neglect; or (C) have disabilities, chronic, or terminal illnesses. Such services shall be provided within or outside the home of the child, be short-term care (ranging from a few hours to a few weeks of time, per year), and be intended to enable the family to stay together and to keep the child living in the home and community of the child. (42 U.S.C. 5116, Section 209 (5))

Most respite care services view the family in an ecological context and include an array of family support services designed to support families at risk or already cited for child maltreatment (ARCH, 2007; FRIENDS, 2006; Jerve, 2008). The family-centered service model may include counseling (individual and group), substance abuse treatment, case management, parenting classes, and more (Cowen, 1998; FRIENDS, 2006; Jerve, 2008). Services may be in-home, out-of-home, periodic, therapeutic, in summer camps or after school programs, and may involve child care and mentors (FRIENDS, 2007; Jerve, 2008). In a study of four crisis care programs (ARCH, 2007) researchers identified the following major service components:

- Overnight care for children ages 0–5,
- Minimum 24-hour stay,
- Maximum stay of 30 days,
- Volunteers who interact with the children and provide additional supervision,
- Parent support/case management services, and
- Parent visitation.

*Effectiveness.* In an ARCH study (2007) examining outcomes of families in four crisis care programs researchers found that families reported lower stress after respite care was provided. Although families that had a prior history of CPS involvement were referred more often than those without, their substantiation rate was lower. An earlier study found that counties implementing crisis care services noted a 2% reduction in the reported incidence of child maltreatment, although it was not established that crisis care was directly responsible for the reduction (Cowen, 1998).

*Implementation.* The FRIENDS National Resource Center (2006) estimates the annual cost of one episode of respite for a family is approximately \$1,500.

### Parent Child Interaction Therapy

Parent Child Interaction Therapy (PCIT) is a parent training program based on attachment and social learning theory (Herschell, Calzada, Eyberg, & McNeil, 2002; Chaffin et al., 2004). It is

designed for families who experience problems with young children (2–6 years old) exhibiting emotional and behavioral problems (Herschell et al., 2002). PCIT aims to teach parents specific skills to establish a nurturing and safe relationship with their child (e.g., effective non-violent discipline) while increasing their child's prosocial behavior and decreasing negative behavior (Chaffin et al., 2004). PCIT provides a manual that guides coaches in the training of individual parent–child dyads (Chaffin et al., 2004; Herschell et al., 2002). Although most families complete PCIT in 10–16 one-hour weekly sessions, PCIT is assessment driven and therefore has no predetermined time limit (Herschell et al., 2002).

PCIT takes place in two successive phases: (1) Child-Directed Interaction (CDI) and (2) Parent-Directed Interaction (PDI). When playing with their child during the CDI phase, parents are taught to frequently use the PRIDE skills (Praise, Reflection, Imitation, Descriptions, and Enthusiasm) and to avoid questions, commands, and criticism (Herschell et al., 2002). Children choose their own toy and parents must follow their child's lead. Parents are continuously assessed during CDI and begin PDI when they are determined to be ready. PDI helps parents to acquire skills in issuing commands appropriately as well as providing consistent consequences for both positive and negative behavior. Treatment is completed when parents have attained the necessary skills and children achieve behavioral goals (Herschell et al., 2002).

At the beginning of each phase, the therapist describes the skills involved in the interaction and why they are used. After the initial explanation, therapists model the specific interactions so that parents and children can role-play the skills and practice what they have learned. Parents and children then attend weekly coaching sessions in which the therapist uses a one-way mirror to observe parent–child interactions and speaks to parents using a radio earpiece to inform them how to implement specific behavioral skills with their children (Chaffin et al., 2004).

*Effectiveness.* PCIT is considered to be an evidence-based, empirically supported program (Chaffin et al., 2004; Herschell et al., 2002; California Evidence-Based Clearinghouse: CEBC, 2009a). In a meta-analysis of PCIT studies, Thomas & Zimmer-Gemlock (2007) found that PCIT was effective in reducing child behavior problems and improving parenting outcomes. Chaffin et al. (2004) report that PCIT reduced recurrence of maltreatment among a population of physically abusive parents. Other studies have suggested that PCIT can reduce child conduct problems (Nixon, Sweeney, Erickson, & Touyz, 2004), mothers' stress (Nixon et al., 2004; Bagner & Eyberg, 2007), and coercive discipline techniques (Nixon et al., 2004). However, Thomas & Zimmer-Gemlock (2007) report that findings cannot necessarily be generalized to those with low socio-economic status or those in high-risk groups.

*Implementation.* Resources needed to implement PCIT include: (1) two connected rooms with a one-way mirror on the adjoining wall; (2) wireless communications set consisting of a head set with microphone and an ear receiver; and (3) VCR and television monitor to tape record sessions for supervision, training, and research (CEBC, 2009). PCIT requires a comprehensive training program where the cost of a five day workshop is \$3,000 and includes: (1) 40-hours of face-to-face contact with a PCIT trainer; (2) advanced live training; (3) case experience; and (4) skill review. For additional information, contact [pcit@phhp.ufl.edu](mailto:pcit@phhp.ufl.edu).

## The Incredible Years

The Incredible Years is a program providing child, parent, and teacher training designed to prevent and reduce conduct and behavior problems in young children, increase emotional and social competence, and promote positive parenting practices. While the program does not directly attempt to prevent foster care re-entry, it aims to prevent factors that may contribute to re-entry.



The Incredible Years is used primarily in outpatient clinics, community agencies, and schools (CEBC, 2009b). Incredible Years parenting programs focus on improving parenting skills and increasing school involvement for parents of children ages 0–12. Training occurs in a series of weekly two-hour sessions (9–20, depending on the program). The BASIC program contains a home visiting component for parents mandated to enroll in the program due to child abuse or neglect. The CEBC (2009) provides the following description of competencies for the parent components:

The Incredible Years BASIC Parent Training Program:

- How to build strong relationships with children through child-directed play interactions
- How to be a social, emotional, and academic coach for children
- How to provide praise and incentives to build social and academic competency
- How to set limits and establish household rules
- How to handle misbehavior

The Incredible Years ADVANCE Parent Training Program:

- How to handle stress, anger and depression management issues
- How to problem solve between adults
- How to help children learn to problem solve
- How to provide and receive support
- How to effectively communicate with your children and other adults

The child training components include guides for facilitating small group therapy and for teachers in the classroom seeking to “strengthen children’s emotional, social, and academic competencies” (The Incredible Years, 2013: <http://www.incredibleyears.com/program/child.asp>). Small group therapy is conducted in two hour sessions over the course of 20–22 weeks. Program materials include a therapist manual, DVDs, workbooks for home activities, problem solving books, and case vignettes (The Incredible Years, 2013). Facilitators may also purchase extra program materials (e.g., puppets and magnets; The Incredible Years, 2013). Ideally, the therapeutic version is facilitated in conjunction with the parent component. The CEBC (2009) provides the following description of the competencies for the child components (The Incredible Years, 2013):

Emotion Management:

- How to talk about feelings
- How to understand and detect feelings in others
- How to self-regulate and manage upsetting feelings

Social Skills:

- How to talk to and make friends
- How to work in teams
- How to cooperate and help others
- How to effectively communicate
- How to follow rules
- How to play with others and enter groups

**Classroom Behavior:**

- How to listen
- How to follow school rules
- How to stop–look–think–check

**Problem Solving:**

- How to deal with anger
- How to solve problems step-by-step
- How to be friendly

**Effectiveness.** The Incredible Years program is one of the few child welfare interventions evaluated in multiple randomized control trials (Baydar, Reid, & Stratton-Webster, 2003; Reid, Webster-Stratton, & Baydar, 2004; Reid, Webster-Stratton, & Beauchaine, 2001; Webster-Stratton, Reid, & Hammond, 2001a, 2001b, 2004). It has been found to improve positive parenting and decrease child conduct problems at home and school (Baydar, Reid, & Stratton-Webster, 2003; Webster-Stratton, Reid, & Hammond 2001a, 2001b, 2004). The program has been shown to: (1) increase in effectiveness as program engagement increases (Baydar, Reid, & Stratton-Webster, 2003; Reid, Webster-Stratton, & Baydar, 2004), and (2) serve the needs of low income families (Reid, Webster-Stratton, & Baydar, 2004). A California Department of Social Services annual report found that children whose parents completed the Incredible Years program experienced a rate of maltreatment recurrence of 5.7%, which was two to six percentage points lower than that of children whose parents did not complete the program (California Department of Social Services, 2007).

**Implementation.** The Incredible Years can range in cost from \$1,300 for the SCHOOL AGE Parent training program to \$4,795 for the entire program package (Baby/Toddler + Preschool Basic + Advance + School Age Programs). Although the *Incredible Years* recommends that group leaders get certified, it is not required, however, an agency must purchase the program materials. For more information, contact [incredibleyears@incredibleyears.com](mailto:incredibleyears@incredibleyears.com).

**Shared Family Care**

In an effort to achieve permanency for children and self-sufficiency for the family, Shared Family Care is a program that provides an alternative to traditional post-reunification services and parent training in order to improve parenting and living skills, gain connections to community resources, and deal with personal issues (Barth & Price, 1999; The National Abandoned Infants Assistance Resource Center [AIA], 2002). Shared Family Care provides an alternative to home visiting, therapy, or case management and is based on the following principles:

- Every child deserves a safe, healthy, nurturing environment in which to grow;
- Most children are better off in a family setting;
- Families should remain together if at all possible;
- In order to support a child, it is necessary to support the child's parent(s);
- Parents' basic needs (e.g., food and housing) must be met in order for them to effectively address psychosocial, emotional, or parenting issues;
- Families learn best from each other;
- Families should be placed in homes in which they are culturally comfortable, and in communities in which they can feasibly transition to independent living;

- Compatibility between mentor and participant families is important and is achieved through comprehensive, individualized assessment and careful matching; and
- Relevant and accessible services and support may be needed to help families move toward independent living in the community (AIA, 2003).

In Shared Family Care “whole families are placed in the homes of community members who mentor the families and work with a team of professionals to help the families obtain the skills and resources they need to achieve these goals” (AIA, 2002, p. 1). The placements, lasting 6–12 months, provide families with the benefits of both out-of-home placement and in-home services (Barth & Price, 1999; AIA, 2002). Although Shared Family Care can be implemented differently across different locations, it contains several core components (AIA, 2002, 2003; Price & Wichterman, 2003):

- **Mentors:** While the biological family maintains primary responsibility for their children, living in a mentor’s home provides a role model from which to model positive parenting skills and receive feedback in a natural environment (Barth & Price, 1999). Mentors are screened and trained to provide adequate support for clients and their families. Mentors may teach parents anything from positive parenting skills to budgeting, and may provide links to resources, transportation, and childcare help.
- **Matching of mentors and clients:** An important piece of a successful placement is a positive relationship between clients and mentors (Clovis, Price, & Wichterman, 2002). Mentors and clients are matched through a “comprehensive, individualized assessment” (AIA, 2003, p. 1) to ensure assignments are culturally appropriate and meet clients’ needs.
- **Rights and responsibilities agreement:** Both parties (client and mentor) must create and sign an agreement that details each party’s rights and responsibilities.
- **Family support team:** Many families in Shared Family Care face multiple challenges that require a variety of services. A team of professionals provides additional support to help families achieve successful reunification and reduce the need for ongoing services. The team and family jointly develop an individualized plan that outlines realistic goals for the family. The team: (1) helps to identify goals, complete court plans, and plan for goal achievement; (2) provides intensive case management and links to community resources; (3) monitors progress; (4) provides 24 hour crisis intervention; and (5) completes home visits at least once per week.
- **Wraparound services:** Wraparound services can include parenting training, clinical treatment, counseling, and access to community resources.
- **Aftercare services:** Aftercare services are “critical to the ultimate success of SFC placements.” Programs usually contain aftercare services for 6 months or more. These services provide ongoing support as a family moves out of the mentor home and toward self-sufficiency. Services may include, but are not limited to, crisis intervention, case management, and housing assistance.

Clients of Shared Family Care tend to be single women with young children (with an average age of 28 years and an average of two children) who are often very poor, isolated, lack stable housing, have little education and typically have a history of substance abuse (AIA, 2002). Barth and Price (1999) caution that not all parents are good candidates for Shared Family Care. Parents must want to change and actively participate in improving parenting skills (Barth & Price, 1999; Clovis et al., 2002; Price & Wichterman, 2003)

**Effectiveness.** In a study of Shared Family Care in Contra Costa County researchers followed 87 families over a four year period and found that average income doubled from \$500 to \$1,099

after graduation and, with the help of a housing specialist, all families found permanent housing (Price & Wichterman, 2003). The program's effect on foster care re-entry is also promising; in one study researchers found that families that graduated from the program had a lower percentage of children re-enter foster care compared to the national average and to families that did not graduate (Clovis et al., 2002; Price & Wichterman, 2003).

*Implementation.* As Price and Wichterman (2003) note, the implementation of a Shared Family Care program is a complex process. Preliminary steps include community and agency needs assessments and an exploration of funding sources. Multiple funding streams are necessary to provide comprehensive services and often require private, local, state, and federal (Title IV-E, TANF, and Medicaid) funds. Program development can take 12–18 months and the staffing needs include: (1) Case manager (with a caseload of no more than 6 families); (2) Program coordinator/supervisor; (3) Mentor recruiter/trainer; and (4) Housing specialist (if needed).

It can cost approximately \$200,000 to set up and implement the program, including costs for administration, mentor recruitment and training, family placement, case management, and additional services. The cost of providing a Shared Family Care placement, close to \$18,000 for one year, tends to be slightly higher than traditional foster care, but lower than treatment foster care (AIA, 2002; Price & Wichterman, 2003; Clovis et al., 2002). The monthly cost for each family is approximately \$3,000 based on: (1) Mentor's monthly stipend (\$1,200); (2) Case management services (\$533); and (3) Other administrative expenses (\$1,225; AIA, 2002).

While costs appear high, Clovis, Price, and Wichterman (2002) and Price and Wichterman (2003) note that the program houses families and parents that would be homeless without it, thereby avoiding the costs of placement in a homeless shelter. They also point to the fact that the success of the program means fewer families will subsequently require child welfare services. Moreover, program outcome data indicate that families will raise their monthly income through successful program completion. For additional information on training contact amyprice@berkeley.edu. For information on services see <http://www.familiesfirstinc.org/>.

### Motivational Interviewing

Caregiver substance abuse has been identified as a factor associated with a higher risk of re-entry to foster care. Although not specifically designed as an intervention for child welfare populations, Motivational Interviewing (MI) is a relatively brief intervention for adolescents and parents with substance abuse issues (CEBC, 2009b). Rollnick and Miller (1995) describe MI as a directive, client-centered approach to counseling designed to elicit behavior change by helping clients to examine and resolve feelings of ambivalence. Elements of MI include: (1) developing rapport through an interpersonal relationship built on therapist empathy; (2) engaging in reflective listening; (3) asking open-ended questions that explore client motivation; (4) eliciting and affirming client discussion of change; (5) focusing on differences between client values and actions; (6) encouraging confidence and self-efficacy for change; (7) asking permission before giving advice and information; (8) responding to resistance in a non-confrontational manner; and (9) developing and committing to an action plan (Burke, Arkowitz & Menchola, 2003; CEBC, 2009a; Moyers, Martin, Manuel, Hendrickson, & Miller, 2005; National Registry of Evidence Based Practices: NREBP, 2009; Rollnick & Miller, 1995).

Rollnick and Miller (1995) describe the "spirit" of MI as follows:

- Motivation to change is elicited from the client, and not externally imposed.
- It is the client's task, not the counselor's, to articulate and resolve his or her ambivalence.
- Direct persuasion is not an effective method for resolving ambivalence.
- The counseling style is generally a quiet and eliciting one.

- The counselor is directive in helping the client to examine and resolve ambivalence.
- Readiness to change is not a client trait, but a fluctuating product of interpersonal interaction.
- The therapeutic relationship is more like a partnership or companionship than expert/recipient roles.

*Effectiveness.* The CEBC and the NREBP report that MI is a rigorously tested practice for treating substance abuse, however, no known studies have examined its effects on the reduction of child maltreatment or foster care re-entry.

*Implementation.* MI does not need to be implemented as an agency wide practice. Practitioners can use MI training approaches to build relationships based on the spirit of MI. Trainings and training resources can be found at the following website: <http://motivationalinterview.org/training/index.html>.

## CONCLUSION

In this review of the literature we focus on the CFSR outcome indicator related to re-entry to foster care. In addition to examining the indicator itself, this review describes research findings on factors associated with re-entry to foster care and promising practices linked to improvement in performance on this measure. The following discussion questions are offered as a way to promote dialogue among practitioners related to applying the available research to practice in order to improve outcomes on re-entry:

- How well are support services to parents and children following reunification being maximized to increase the chances of sustaining successful reunification?
- How well is respite care being utilized to assist reunified families?
- How well are behavior problems in foster children being addressed to support successful permanency plans?
- Given the re-entry risks facing children with substance-abusing parents, how well are community resources being utilized to address substance abuse problems in the reunification plans?

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