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Family Reunion Services: An Examination of a Process Used to Successfully Reunite Families

Lois Pierce and Vince Geremia

Family Reunion Services, an intensive-home-based service for families whose children are unlikely to return home without additional services, was evaluated. The 196 children who received FRS services and remained home had fewer previous placements, were more likely to be black and to come from families where the FRS worker intervened in the areas of parenting skills or communication. FRS workers' activities are described.

Although we have always believed that the best place for children is in their own homes (Kadushin, 1980), and, in spite of federal policy to ensure that children are placed only when necessary, the use of foster care has grown during the past decade (Ahart, Bruer, Rutsch, Schmidt & Zaro, 1992). While many children who enter care return home and remain at home, a relatively large number either never exit alternative care or re-enter care (Maluccio, Krieger & Pine, 1988; Rzepnicki, 1987; Tatara, 1992). Children may remain in care because the child welfare system is overloaded and unable to respond to families with multiple problems. Other studies suggest children may re-enter care because there are few services available once families are reunified (Ahart et al.), because parents have not resolved ambivalence about the child's return home (Hess & Folaron, 1991), or because the child's problems have not been resolved (Fraser, 1991). When there are few services offered, families often revert to the problems that caused children to enter care initially.

A number of family reunification programs have been developed using intensive, family-centered, home-based services (Frankel, 1988; Hodges & Blythe, 1992) as a way to respond to the lack of services available to families with multiple problems. In 1992, Ahart et al. described 9 programs they had reviewed for the Office of the Assistant Secretary for Planning and Evaluation of the U.S. Department of Health and Human Services as part of an exploratory study on intensive family reunification programs. One of the major problems found by the team was no common definition of family reunification, which makes it difficult to compare and evaluate programs. In fact, the team found a wide range of reunification success rates—38% after 2 years to 74% after the first year.

Even more difficult is trying to compare families that have experienced more than one placement with families whose children remain home after the first placement. As Ahart et

al. (1992) and Rzepnicki (1987) point out, foster care places additional stress on families, and families who have children placed more than once are likely to be those with the most serious problems and the most difficult to work with.

Few programs have published results of their family reunification services. Fewer still have provided a process evaluation or analyzed how the program worked. One of these is the process analysis described by Lewis, Walton, & Fraser (1995) in which the Utah State Department of Human Services used the Homebuilders™ model of brief intensive family preservation services to reunite families after a child had been removed from the home. At the time of the 12-month follow-up, 77% of the children in the family reunification program had returned home compared to 49% in a control group. Lewis et al. conclude that, while the process of family reunification services is similar to that of family preservation, it may be more efficient in changing foster care utilization.

Efficient foster care utilization has been mandated by the Adoption and Safe Families Act (H.R. 867), which reemphasizes the philosophy that foster care is a temporary, not permanent, solution to care for children whose families are unable to provide a safe environment. The ASFA allows states to provide concurrent planning for reunification and adoption and requires that a child's case plan must include steps being taken to achieve permanence. The ASFA ensures that foster care will be temporary by requiring, in most cases, that states file for termination of parental rights after a child has been in care for 15 of the last 22 months.

Although the program described in this article was developed before passage of the ASFA, the program provided resources and services to families of children who had been in foster care for longer than six months and who were judged unlikely to return home in the near future. Children who remained out of care after the program are compared to those who reentered care to see which components of the program contribute to its effectiveness.

The Family Reunification Services Program

In an attempt to respond to increasing numbers of children residing in out-of-home care, the Missouri Division of Family Services (DFS) developed a family reunification program in 1994. Family Reunion Services (FRS) is based on the use of intensive preservation services with families whose children were unlikely to return home within six months without intensive intervention. This article describes the process used to implement the program.

FRS, as structured by Missouri, is a short-term, intensive, family-based program designed to reunify with their family children who are in out-of-home care and who, as mentioned

earlier, are unlikely to return home in six months. The goals of FRS are to assist a family in removing barriers to the return of their children, assist in the transition of returning the children to the family, and develop a plan with the family that will maintain the children safely in the home for at least one year following the intervention.

The families targeted for FRS are those for whom reunification is unlikely if the family receives traditional alternative care services. The decision to focus on this population is based on the finding that the likelihood for reunification decreases and the likelihood for more restrictive placements increases the longer children remain in care.

FRS provides intensive case services for 60 days (with the possibility of a 30-day extension) to families and children. Family reunification specialists are available to the family 24 hours a day seven days a week. Hours of direct face-to-face service intervention average 13 hours a week over the course of the intervention. Services are home-based and focus on the family. To allow specialists to provide the intensive services associated with FRS, caseloads are limited to three families.

Families are selected for FRS after being referred by their DFS worker and screened by an FRS team that includes representatives from DFS, FRS, and in some counties, the court. The safety of the child must be ensured, and parents who are abusing substances must participate in a treatment program before being eligible for FRS. Within the first two weeks after FRS begins, children return home and the FRS specialist works with the family to make changes necessary for the child to remain home.

Methodology

All Family Reunion Services cases opened in St. Louis City and County and Jackson County (Kansas City) between July 1, 1994 and January 31, 1996 were included in the evaluation—312 children from 169 families. Children who exited care were followed for 16 months following their exit date, the time within which almost all children in Missouri who reenter care have reentered care. Those who subsequently reentered care were compared to those who didn't.

In addition, the FRS children were compared to a group of children in traditional alternative care who were matched to them on age, race, gender, and date of first entry into care. Information on the number of previous placements and length of time in care prior to the start of FRS indicated the FRS group had been in care for a longer time and had significantly more placements than the traditional care group. The emphasis of this article

though will be on the comparison of the FRS children and their families before and after FRS.

Evaluation data were collected from FRS records (assessment and process information), and interviews with FRS specialists and FRS parents. In addition, three instruments were used to collect information on the family and children: the Walmyr Index of Parental Attitudes (IPA) and Index of Family Relations (IFR) (Hudson, 1982), and the Piers-Harris (Piers & Harris, 1964). These instruments were administered by the FRS specialists, and informed consent was explained to the families and signed consent forms obtained before any questionnaires were completed. Specialists indicated that 6 families refused to participate. The analysis for this study was based on two data sets. One, which included only the FRS children, merged information from two forms developed for the project, from the specialist's narrative, and from the scores on the research instruments. The second data set, from the Missouri Department of Social Services Research and Evaluation unit, included information on all placements of the FRS children and the children in the traditional care comparison group. When examining family variables, only one child from each family was used.

Description of FRS Children and Their Families

The families served by FRS can be described as poorly educated and as having little income (see Table 1). The majority of the parents (61%) had less than a high school education. Sixty-four percent of the families had a monthly income of less than \$800 a month, with 23% of those families receiving less than \$400. Sixty-five percent of the parents did not have a partner living with them, and the majority of families had one (36%) or two (23%) children in care.

In addition to the usual demographics, workers were asked to list up to five family characteristics or barriers that prevented the child's return home. Although there were 40 possible categories, the following were listed most frequently—poor parenting skills (62%), stress (46%), lack of problem-solving skills (37%), communication problems (37%), substance abuse (34%), employment (31%), and housing (27%).

The FRS children (see Table 2) were more likely to be female (56%) and to be African-American (77%). The average age of FRS children was 8.2 years with participants averaging 5.8 placements overall—5 placements before FRS and 1.4 placements for the 115 children (37%) who were placed after FRS.

Table 1. Description of Family Reunion Services Families*
(N=169)

	N	%
Education		
No high school diploma	96	61
High school graduate	41	19
GED	9	6
Some college	22	14
Income Level		
Less than \$400/month	28	23
\$401-\$800/month	50	41
\$801-\$1200/month	24	20
Over \$1201/month	19	16
Children in Care		
One child	63	37
Two children	41	24
Three children	35	21
Four children in care	18	11
More than four	12	7
Family Characteristics (Barriers) Keeping Children from Returning Home (5 Possible Responses/Family)		
Poor parenting skills	105	62
Stress	78	46
Lack of problem-solving skills	63	37
Communication problems	63	37
Substance abuse	57	34
Employment	52	31
Housing	46	27
Parent-child conflict	41	24

*Some totals are less than 169 because of missing data.

The FRS children were more likely than those in the comparison group to be in care because of physical abuse (27% compared to 21%), parent abandonment (17% compared to 9%) and sexual abuse (14% to 13%), and less likely to be in care because of physical neglect (22% compared to 32%). Other reasons for enter into care include the parent's request and incorrigible behavior.

Results

For those children who returned home after FRS, 63% did not re-enter care.

Comparison of Children Who Returned to Care with Those Who Didn't

Discriminant analysis, which allowed us to determine which variables contribute the most to the difference between two groups, was used to compare those children who returned to placement with those who didn't. The variables examined, number of placements before FRS, length of time in placement before FRS, and the child's race and age, were able to significantly differentiate between the two groups ($X^2=14.11$, $df=4$, $p=.007$). Children who returned to care after FRS were more likely to have more placements before FRS, to be white and to be older. Interestingly, length of time in care contributed little to the difference.

Barriers to Return Home

When the barriers checked most often by DFS workers—stress, parenting skills, lack of problem solving skills, and communication problems—were combined in a discriminant analysis, they were able to significantly differentiate between those children who returned home and those who didn't ($X^2=28.75$, $df=4$, $p=.000$). Lack of problem solving skills and parental stress contributed the most to the difference, with children whose parents have poor parenting skills and who are experiencing stress being most likely to return to care. But when the barriers to return to care were combined with the child variables, the child variables—the number of prior placements, the child's race, and the child's age—remained the most important in differentiating between the two groups ($X^2=16.99$, $df=5$, $p=.005$).

Table 2. Comparison of FRS Children Who Reenter Care Post-FRS and Their Families to Those Who Don't and Their Families

Child Variables (N=312)	Remain Home (N=196)	Placed (N=115)	Total (N=312)*
Mean number of times placed	4.7	7.9	5.8
Mean days in care overall	864	1263	1010
Mean number of times placed prior to FRS**	4.7	5.9	5.0
Mean days in care prior to FRS	864	955	902
Mean number of times placed post-FRS		1.4	1.4
Mean length of time in care post-FRS		81	81
Age (in years)**	7.7	9.9	8.2
Race**	85%	65%	
African American	15%	35%	
White			
Sex	47%	43%	
Male	53%	57%	
Female			
Family Variables (N=169)			
Family barriers to return home***	N	%	N %
Communication	73	38	
Poor parenting skills	51	27	
Lack problem solving skills	46	24	
Stress	45	23	
Housing			31 30
Parent/child conflict			26 25
Child unmanageable			22 21
Areas of intervention***			
Communication	60		
Poor parenting skills	41		
Lack problem solving skills	43		
Stress	41		
Housing			24 30
Parent/child conflict			20 25
Child unmanageable			18 23
Had specialist goals	57	77	17 23
Achieved goals	40	54	14 19

Process Analysis

To better understand how the program obtained the results it did, we examined more closely how the components of the FRS program operated. The first step for families to become involved in FRS was referral to the program by their DFS case manager. Each case was reviewed by a team of DFS staff and representatives of the reunification staff from the four family services agencies that had contracted with the state to provide family reunification services. After the review team agreed that the family met the guidelines for participating in the program, the family was assigned to one of the agencies' family reunion specialists. The specialist met with the family to conduct an assessment and set goals. During the time the family was in the program, the specialist worked with the DFS worker on a regular basis to ensure coordination between the two organizations.

Case Manager Goals

As part of the referral process, DFS case managers listed their goals for the family. Not surprisingly, the most frequently listed case manager goals were closely related to barriers preventing the child's return home. This was especially true for poor parenting skills, ($X^2=6.4$, $df=1$, $p=.011$) and housing ($X^2=33.64$, $df=1$, $p=.000$). However, manager's goals were not related to whether or not a child reentered foster care after FRS.

Specialists' Approach

Family reunification specialists had at least a bachelor's degree in social work or a related area, and most had experience in family preservation services. They were trained using a modified Homebuilders™ curriculum, which had been changed to include increased emphasis on safety and separation and attachment issues. Specialists were enthusiastic about the program. They believed they were making progress with the most difficult families seen by DFS.

To find out more about how the specialists saw their role in the program, they were interviewed by the evaluation team 6 to 12 months after FRS started.

Initial problems: Initially, specialists were concerned because they spent a great deal of time on housing and other concrete services instead of therapy. They believed safety was an issue in some cases and wanted to be able to accept cases when the safety of a child could be ensured. However, the primary problem facing specialists was inappropriate referrals. They believed workers didn't understand the program or their families well enough to make

the kinds of referrals that could be successful—those families who were interested in making some change.

In response to these concerns, a number of changes were made by the case managers and specialists after the beginning of the program. Specialists became more flexible, lowered their expectations, and built necessary networks of referral sources. DFS case managers became more willing to work with specialists and to trust specialists to work "outside the box." In fact, trust was a major issue at the beginning of the project at both sites. In Jackson County, where specialists met often with court representatives, specialists felt their opinions about families were ignored when decisions were made. As these issues became apparent, relationships with the court and with DFS workers improved.

Because poor communication often contributed to the other problems, several modifications were made to improve the exchange of information. Specialists and DFS workers began to meet on a regular basis to work with the family, and the specialists' supervisors were placed on the screening team. The latter resulted in more appropriate referrals. These changes improved the coordination of services and also increased the mutual trust between DFS workers and FRS specialists.

Successful cases: Specialists felt they were most successful with families who wanted to change, where goals were well-defined, where DFS continued to provide support, and where they could provide something different from therapy. They emphasized that families should have already begun visitation with their child and should have sought treatment for substance abuse, if indicated, before starting FRS. As one specialist said, "we work better with cases that are from the middle of the barrel."

Specialists believed FRS was somewhat easier than family preservation services because children were out of the home and not at risk or in crisis when services started. They could concentrate on providing services, because the safety of the child was less likely to be a problem. They were committed to helping families and were excited about their successes, particularly as they believed they were working with a group for whom success has been elusive.

Specialist Activities

In addition to participating in interviews with the evaluator and administering evaluation instruments, FRS specialists were also asked to keep track of the services they provided each week. To do this, specialists were asked to complete a three-page form that listed all the activities that might be included under clinical and concrete services. Clinical services

were divided into child management, emotion management, interpersonal skills, advocacy, and miscellaneous clinical categories. In all, there were 78 possible services listed.

Specialists were asked to indicate for each week, those ten services they used most often, starting with the service used most often (1) and ending with that used least often (10). While there were changes from week to week, listening or active listening were listed as one of the three most frequently used services every week of the ten weeks that were tracked. During the first four weeks, specialists concentrated on establishing treatment goals and relationship building. In week four, referral to counseling appears as one of the most frequent services offered. After that, specialists are likely to spend more time on concrete services, such as housing and transportation.

Another way to look at specialists' activities is to examine the average use of activities during 10 weeks. Because there were fewer cases open during the end of the period, the scores for each week were weighted to prevent the activities in the later weeks from receiving higher averages.

Table 3 lists those activities used with more than 20% of the families at least once during the 10-week period. As can be seen, a combination of clinical (i.e., providing support and hope and listening) and concrete (i.e., transportation) services are used throughout the intervention. Building self-esteem and handling frustration also remain relatively high throughout the service period. As would be expected, setting treatment goals was high during the first two weeks. Although it's a somewhat crude measure of comparison, an average score for all 10 weeks shows that in their work with families, specialists use listening, transportation, and support most frequently.

Specialist Goals

As was true for DFS case managers, the specialists' goals closely matched the barriers to the children's return home, particularly in the areas of parenting skills, stress reduction, and family communication, the three most frequently used goals. Using one child in each family, we found therapy (which included improving communication and substance abuse treatment) was more likely to be a specialist goal for families who had a child return to care after FRS, although this relationship only approached statistical significance ($X^2=5.28$, $df=2$, $p=.07$). And, although not statistically significant, children who returned to care were more likely to come from families where the specialist's goals were not achieved.

Areas of Intervention

In most cases, those areas described as barriers to the child's return home and those areas where specialists intervened were similar. Stress, one of the most frequently mentioned areas of intervention, was likely to be related to the specialist goals of individual therapy or problem-solving. When the areas of intervention used most often by specialists—communication, poor parenting skills, housing, and parent-child conflict—were included in a discriminant analysis, these areas were able to significantly differentiate ($X^2=12.80$, $df=4$, $p=.01$) between the children who remained home and those who returned to care. Children who lived in families where the specialist worked on communication, poor parenting skills and parent-child conflict were more likely to remain home after FRS. When the areas of intervention were combined with the times a child was placed previously, the child's race, and the child's age, the areas of intervention contributed less to the difference between the groups although the combination still significantly differentiated among the groups ($X^2=23.97$, $df=6$, $p=.001$). Children who had fewer placements, were younger, were black, and had specialists who intervened in the area of parenting skills were more likely to remain home.

Although not statistically significant, those children who returned to care were more likely to come from families where the areas of intervention included parent-child conflict and where the child was described as unmanageable. They were also more likely to live in families where physical abuse was described as a barrier to return home and where housing was an issue.

When Returned to Care

There appeared to be no pattern of when children returned to care with half of the children who returned to care, returning within 167 days.

Family Well-Being

We used the Walmyr Index of Parental Attitudes (IPA) and Index of Family Relations (IFR) to examine family relationships. The specialists administered the forms to family members early in the FRS intervention and then shortly before termination. Both forms have a clinical cut-off score of 30, with those scoring higher than 30 having a problem in that area. Because the forms ask parents the extent to which they agree or disagree with statements on how they feel about their children and families, it is possible that parents put what they believed was the acceptable answer rather than the way they felt. Specialists were trained to emphasize that there were no right or wrong answers and used a code for the parent's name.

Table 3. Services Used During 10 Weeks of Family Reunion Services (%)

Week	1	2	3	4	5	6	7	8	9	10	\bar{x}
Clinical Services											
Support/Understanding	20	15	12	22	8	24	18	22	8	25	17
"I" Statements	2	10	12	10	14	12	23	19	12	10	11
Active Listening	18	20	28	26	24	14	30	24	12	20	22
Time Out	10	13	18	12	6	20	5	12	8	5	11
Natural/Logical Consequences	10	23	20	24	6	18	7	14	0	0	12
Emotion Management											
Building Self-Esteem	24	32	20	24	18	20	30	26	36	30	26
Handling Frustration	28	27	32	30	28	22	30	22	16	35	27
Interpersonal Skills											
Problem Solving	28	27	24	22	20	16	14	28	20	15	21
Advocacy											
Social Services	24	8	14	12	12	8	9	17	8	10	12
Miscellaneous Clinical											
Relationship Building	36	36	28	16	18	16	16	14	12	15	21
Clarifying Family Roles	26	21	24	12	18	10	7	10	4	5	14
Family Rules	16	27	24	10	12	12	9	10	4	5	13
Treatment Goals	52	36	16	14	14	8	5	17	4	10	18
Support/Hope	38	46	46	28	32	40	37	36	28	35	37
Providing Literature	16	13	26	16	8	20	16	12	12	0	14
Listening	56	49	44	40	40	46	44	36	36	40	43
Concrete Services											
Transportation	26	34	44	44	30	44	38	43	36	30	37
Household Goods/Furniture	6	23	12	10	12	14	9	22	12	30	14

The first IPA was completed by 54 people, with 49 scoring below 30 and 5 scoring above. The follow-up IPA was completed by 25 people. Of those who scored above 30 originally, 2 had follow-up scores below 30, one still had a score above 30 and two did not have

follow-up scores. Fifty-three people completed the IFR the first time, with 35 scoring below 30 and 8 scoring above. When the IFR was repeated, 29 people completed the scale with 4 still scoring above 30. Because the number of parents for whom we have completed forms is so small, it is difficult to make any assumptions about the relationship between these scores, the specialist's activities and a child's reentry into care, but at this point, there appears to be little correlation between the two.

Because specialists were asked to indicate if a family refused to participate, and few did, the low completion rate is more likely to reflect the fact that the specialists placed a low priority on the evaluation when they had a limited amount of time to work with families. In fact, one questionnaire was discontinued because specialists felt it took too long to administer.

Child Self-Esteem

Children over 10 were asked to complete the Piers-Harris. Only 17 completed questionnaires were available for analysis with 12 of those scoring in the 7th stanine or above. The children who returned to care (4) scored in the 6th stanine or below, but the numbers are so small, it is difficult to make any assumptions about the relationship between a child's self esteem and the success of FRS.

Interviews with Clients

Interviews were held with 10 randomly selected FRS clients, and a follow-up survey was sent to families from Jackson County by DFS. Of the families visited, one had a child remain in care, another had a child return to care. Attempts were made to visit several other families, but they either were not at home at the time of the appointment or did not respond to a request to interview them. Many parents didn't have phones or had moved by the time we tried to contact them. Because information is from a small number of reachable parents, the information may not reflect the thoughts of all FRS families.

The interviews and surveys indicated families were pleased with the program, even those families where children either remained in care or returned to care. In those families, parents understood that either they or their child had problems that would make it difficult for their child to live with them, and they were comfortable with the arrangements made for their child.

Families liked FRS because specialists were available to them and knew them. "More intense" was the phrase used most often to describe the difference between FRS and traditional services. Parents said they were able to understand their children's behavior

better and were taught how to relate actions to consequences. Parents also learned how to structure time and set limits.

Skills learned during FRS were used after the specialist terminated, but most of the parents said they could have used more follow-up and additional services. Several parents wanted information on how to apply skills they learned as their child got older. Families continued to need services after FRS. Housing, transportation, and family counseling were those most requested. Although it was not a question asked, it does appear that FRS clients had more of a family focus after receiving the services. That is, they are more able to understand how they function as a unit rather than as individuals living in the same house.

Limitations of Study

Initially we believed that specialists would be able to use the Walmyr IPA and IFR in their work with clients. It soon became apparent that the collection of research information was low on their list of priorities, and data were missing for more than half of the families. It is not clear how those families for which we have completed instruments differ from those for whom the instruments are missing. We have been cautious in interpreting these data. Data were also missing from some records at the time of review. Attempts were made to return to records that had missing data, but in some cases, the FRS case was completed before the missing data were added. This was true in the case of some specialist goals and some specialist activities forms. On the other hand, specialists provided information on areas of intervention to the state database, and these data were used whenever possible.

Records from one of the sites were complete, while records from the other site had more missing data. Because there was no difference between the sites on the number of children returning to care and the specialists received the same training and had the same resources, we assume that information on specialists' activities are generalizable from site to site. However, because the sites are both large cities, it is not clear how the process described here will generalize to smaller cities and rural areas. The majority of the children in this study were African-American, and it is also not clear how these findings will apply to other groups.

Discussion

Although FRS appeared to meet some initial resistance from DFS workers, changes made during the 18 months the project was being followed improved the workers' willingness to refer to the program. Lines of communication, and therefore trust, improved and more appropriate referrals were made.

Specialists engaged in a range of behaviors, but much of their time was spent listening to clients or on concrete services like housing and transportation. Specialists did not see themselves as therapists and emphasized that their role was to supplement therapy. In fact, therapy was the service being used most often by parents when they began FRS. But, those children who returned to care were more likely to have therapy as a goal. If we assume that those are the families who had not yet started therapy, it would suggest that specialists are correct when they define themselves as providing services in addition to therapy. It also implies that FRS works best if families have been in therapy prior to referral to FRS. Specialists can be more effective in changing behaviors if parents are working on understanding themselves and their families. And families may be more amenable to change if they have already begun the therapy process.

The use of services also underscores the ways in which specialists differ from therapists and, to some extent, DFS workers. The specialists spend most of their time listening, providing support or transporting clients. At first, specialists were concerned because they spent so much time transporting parents. They soon learned that they could do some of their best listening and intervention in the car and in waiting rooms. On the other hand, DFS case managers, who have much larger caseloads, need to focus on obtaining services for clients.

Overall, specialists liked FRS because they felt they were accomplishing changes that otherwise would not occur. They believed it was less stressful than family preservation services, because children were out of the home and not at risk when intervention began. This allowed them to focus on the family interaction.

Families appeared to be pleased with the services they received. They appreciated the specialists' concern and willingness to advocate for them. They often expressed regret that the specialist could not continue working with them after FRS ended. Several families believed that even though the outcome was not what they originally hoped for (the return of their child), the outcome was the best for everyone.

Summary

The use of intensive family preservation services to reunite families who otherwise would be unlikely to reunify can be considered successful when compared to other studies (Fein & Staff, 1991; Fraser, Walton, Lewis, Pecora & Walton, 1996) and to DFS' traditional foster care. Children accepted into FRS are children who, when compared to children in traditional alternative care, have experienced significantly more placements in the 16 months prior to FRS and have fewer reentries in the 16 months after exit from FRS.

When the FRS children who subsequently re-entered care were compared with those who didn't, children who remained home had fewer prior placements, were younger, were black, and were more likely to have specialists intervene in the areas of parenting skills and communication problems. Successful families are those where changes within the family environment (e.g., communication, improved parenting skills) occur. Specialists' activities suggest they are most effective providing services that supplement therapy and that they are able to provide a unique combination of clinical and concrete services that, when achieved, contribute to children remaining home.

These findings indicate that intensive services work not only when families are in crisis, but also when traditional approaches don't. Specialists who spend several hours a day with families are able to quickly identify problems in communication, and in the use of discipline and other parenting skills. By modeling new behaviors and encouraging parents, they are able to help parents change behaviors, or when change doesn't occur, to help parents support other permanency plans. Moving quickly to other permanency plans has become even more important since the passage of the Adoption and Safe Families Act.

FRS is less successful with families where housing is an issue and who have children with behavior problems. Housing should not prevent the permanent reunification of families. It makes little sense for children to remain in the foster care system for long periods of time because housing is unavailable. Although this may be more of a problem for urban families than for others, it does indicate that the foster care system must be able to provide a range of concrete services for families. In most cases this is done, but these findings suggest there should be closer links between child protective services and local housing authorities.

This study also suggests that when a child has been described as unmanageable, intensive clinical services must be used early on to supplement the work of the specialist. If substance abuse is a problem, parents must receive treatment before participating in FRS. It follows that a child who exhibits severe behavior problems and his or her family should receive therapy and show improvement before they are accepted for FRS.

Although this study found that parents who have at least started therapy are more amenable to treatment and more likely to respond to family reunification, the number of placements prior to FRS appears to contribute the most to children returning to care. It is important to consider the use of FRS or other family preservation programs earlier in a child's alternative care career as a positive step toward preventing additional placements.

One of the difficulties we continue to have is predicting which families can benefit most from FRS services, although it does appear that for the majority of families judged unlikely

to reunify with their child in the near future, FRS provides the extra support needed for reunification. However, there is a need for studies that follow families over time and more closely examine the interaction between family problems and the use of services. Additional studies will help determine more specifically which services are most appropriate for which families. This will allow us to be more responsive to the requirements of the Adoption and Safe Families Act.

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