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Family Reunification of Youth in Foster Care with Complex Mental Health Needs: Barriers and Recommendations

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Abstract This study presents findings of a formative evaluation of an innovative pilot program designed to reunify and reintegrate foster youth with complex mental and behavioral needs in residential treatment centers or therapeutic foster care with their families in the community. Data collection methods included in-depth structured case file reviews and semi-structured interviews with the youth, as well as their caregivers, Child Protective Services caseworkers, and pilot program staff. The participants provided important insights regarding system, program, and case-level barriers to the successful reunification of these youth back into the community. Training, practice, and policy recommendations are discussed.

Keywords Child welfare · Reunification · Permanency · Foster care · Residential treatment

Introduction

The belief that every child deserves a safe and permanent family is a fundamental value that shapes and directs child welfare policy in the United States. Ideally, permanency provides children with a sense of belonging and personal assurance that

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their physical, emotional, and safety needs will be met. According to the latest data from the U.S. Children's Bureau, in 2009, approximately 424,000 children and youth were in the foster care system (U.S. Department of Health and Human Services 2010a). The numbers for children of color are particularly striking. In the Southwest state where this program takes place, African American children are 2.6 times more likely to be in out-of-home care than white children, while Latino children are just slightly overrepresented (U.S. Census Bureau 2000; U.S. Department of Health and Human Services 2009).

While over half of children exiting foster care return to the care of their birth parents or relatives (U.S. Department of Health and Human Services 2010a; Wulczyn 2004), the reunification process is not always successful. Delays in reunification and post-reunification re-entries are often the result of an overburdened system and lack of available support services to help families address and resolve problems that contributed to the initial removal from the home (Ahart et al. 1992; Jones 1998; The PEW Charitable Trusts 2007). Such supports are especially critical for youth with complex mental health and behavioral needs reunifying from out-of-home group care, given their tendency to re-enter care at a rate higher than children in other types of settings (Barth 2002; Kimberlin et al. 2009).

This paper presents results from an exploratory formative evaluation of a reintegration program in its pilot phase. The program was designed to reunify youth with complex mental health and behavioral needs who reside in residential treatment centers (RTCs) or therapeutic foster care. The pilot program responds directly to the need for family and kinship reunification supports. We use the terms reunification and reintegration broadly and interchangeably to refer to a return to the community in a family-setting. This qualitative formative evaluation provided an in-depth look at the experiences of youth and caregivers preparing for, undergoing, and attempting to sustain reunification, as well as the staff who supported them through the process. The results provided insights into what facilitates or hinders successful reunification for this especially vulnerable subpopulation of youth in group care settings. Furthermore, they provided real-time, concrete applications to help staff improve and further develop this program, as well as helped identify recommendations for other reunification efforts.

Youth in Residential Treatment Settings

The program evaluated in this study works with youth with complex mental and behavioral needs residing in intensive out-of-home placements, such as RTCs or therapeutic foster care. Of the 424,000 children in out-of-home care, 65,804 reside in group care settings (U.S. Census Bureau 2000; U.S. Department of Health and Human Services 2010a). Nationally, and in the Southwest state where this program was implemented, African Americans and whites are slightly overrepresented in group care settings compared to the foster care population more generally (U.S. Department of Health and Human Services 2009).

A growing body of literature documents the extent of mental health and behavioral disorders among youth in out-of-home placement. Analysis of the

National Survey of Child and Adolescent Well-Being found that almost half of children (age 2–14) with Child Protective Services (CPS) investigations for maltreatment had clinically significant emotional or behavioral problems (Stahmer et al. 2005). Youth in group care settings have particularly high rates of mental and behavioral disorders (Burns et al. 2004; James et al. 2006) and one-fourth of mental health expenditures for children serve youth in residential treatment settings (Lee et al. 2011). Children with mental health or behavioral challenges have lower rates of reunification in general (Snowden et al. 2008), but little research to date has specifically examined the reunification experiences of youth leaving RTCs.

While residential settings for children in out-of-home care typically provide therapeutic services, evidence of effectiveness is either mixed (Magellan Health Services Children's Services Task Force 2008; Barth 2002) or suggests worse outcomes for children in these settings (Annie E. Casey Foundation 2010; Lee et al. 2011). Coupled with the high cost of this type of care, the field has begun to focus more intently on community interventions and placements in the least restrictive settings possible (Annie E. Casey Foundation 2010; U.S. Department of Health and Human Services 1999). Reunification efforts are consistent with this goal.

Reunification and Re-entry Rates

Although existing research on reunification has focused on statistical correlates of successful and unsuccessful reunification (Bronson 2005), few studies have documented staff or families' experiences during the reunification process. Existing research shows that children with emotional and behavioral problems or a disability, children removed for neglect, as well as very young children and adolescents are less likely to be reunified with their birth families (Fraser et al. 1996; Taussig et al. 2001; Teare et al. 2001; Wells and Correia 2010). Family factors associated with a lower likelihood of reunification include extreme poverty, the presence of only one parent or caregiver in the home, younger caregivers, caregivers with less education, and the existence of parental mental illness or substance abuse issues (Bronson 2005; Fraser et al. 1996; Thomlison et al. 1996; Wells and Correia 2010). Ethnicity is also a factor, as recent data suggest that in some communities, African American children are less likely to be reunified than white children (Connell et al. 2006), and experience slower times to reunification when it does occur (Harris and Courtney 2003; Wells and Guo 1999) (see Wulczyn 2011 for data on county variability in racial disparity). Finally, children in group care settings are less likely to reunify (Wells and Correia 2010) and have an increased likelihood of re-entry into care, as do youth with emotional and behavior disorders (see Kimberlin et al. 2009, for a review).

Service Delivery for Reunification

Recent research has demonstrated that reunification is most likely to occur for families who have highly engaged caseworkers, received appropriately matched

services, and those who received support for basic needs (Cheng 2010). In addition, research has found that factors related to service delivery, such as the availability and intensity of support services for the family and child are negatively associated with re-entry into care (Bronson 2005). Because of the high rates of emotional, behavioral, developmental, and educational problems among children involved in the child welfare system (Halfon et al. 1992; Harman et al. 2000) and in RTCs more specifically (Burns et al. 2004; James et al. 2006), intensive support services for children and families are an essential component of successful reunifications (Fein and Staff 1993; Walton 1998). These support services for families need to involve multiple systems and address the many domains affecting family and child functioning, including the home, school, and the community (U.S. Department of Health and Human Services 2006). Services identified as particularly effective during the reunification process include intensive case management (Ryan et al. 2003); concrete help, such as food, housing, and utilities (Cheng 2010; Fraser et al. 1996; Wells and Fuller 2000); substance abuse treatment (Smokowski and Wodarski 1996); and, home-based services such as family preservation services (Walton 1998), parenting and life skills development, including family therapy (U.S. Department of Health and Human Services 2006). The following practice elements have been found to be predictive of reunification success: frequent pre-reunification parental visitation between children and their family of origin (Davis et al. 1996; Hess 1988; Leathers 2002); engagement of families in the reunification process (U.S. Department of Health and Human Services 2006); individualized assessment of parental circumstances and "family-centered" case planning with clearly articulated goals that are agreed upon by all parties involved (Macdonald 2001; U.S. Department of Health and Human Services 2006); and heavily involved caseworkers in the reunification process (Cheng 2010). A wraparound service model embodies many of the elements predictive of reunification success (Walker and Bruns 2006).

Study Purpose

The purpose of this study was to capture the experiences of caregivers and youth undergoing reunification as part of a pilot program that uses a wraparound service model. The principal objective was to provide data to inform the ongoing development and improve the effectiveness of the pilot program. A formative evaluation addressing barriers to reunification from the different perspectives of the families first involved in the program's inception makes the most sense for a program in its infancy, and can be "used to inform an ongoing cycle of reflection and innovation" (Patton 2008, p. 116). This qualitative descriptive approach to evaluation also facilitated other study objectives: (a) to contribute to the research literature on reunification by better understanding barriers to successful reunification from the multiple perspectives of those involved; and (b) to develop practice recommendations for the field on how best to support permanency for this special population of youth in foster care.

Methods

Intervention

The pilot program discussed in this article was designed to promote the successful transition of youth in the child welfare system from therapeutic group care and residential treatment settings to community-based services. The program utilizes a wraparound service model, which relies on case managers to partner with families to create child and family teams, access traditional and non-traditional services, and advocate within systems. The case manager (1) works with the family to develop a plan of care for the child based on the family's needs and strengths; (2) assists the family in problem solving; and (3) provides on-going support to the child and family prior to reunification during the planning phase, as well as once the child is reunified with the caregiver and reintegrated into the community.

The program is a collaboration between the state child welfare agency (CPS), a local health and human services agency, and a large national foundation. The pilot program is staffed by two case managers who use a flexible funding pool to purchase services, supports, and meet basic needs. Each case manager maintains a small caseload of no more than 10–12 youth and their families.

The pilot program serves children/youth between the ages of 5–17, who have a mental health diagnosis, are in therapeutic care through the public child welfare system, and have an approved caregiver.[1] The designated caregiver must reside in the local community, be willing to accept placement of the youth, and agree to work collaboratively with the pilot program to support the child/youth's transition back into the home and community.

The program has five phases of service: referral, screening, planning, integration and continuation of services. Table 1 identifies the key components of each stage of service. A significant factor in the design of the program is that service provision begins 90–120 days prior to the youth's reunification. During the screening and planning stage, the case manager for the youth works directly with the caregiver to prepare them for the return of the youth by addressing key areas, such as ensuring that they have the knowledge and ability to meet the needs of the youth; the resources to meet basic needs; plans for the day to day management of the youth; and, the identification and arrangement of supports or services required to sustain the placement. Also during the planning phase, the program works with the public child welfare system to develop an individualized transition plan for the youth which will, at minimum, include increased contact and visitation, family therapy, and the completion of a behavioral contract and crisis plan.

The network supporting this project has a diversity of providers, both traditional and non-traditional, that provide services including: respite care, therapeutic mentoring, tutoring, parent coaching, behavioral aid, and home-based individual and family therapy. Services also include occasional supports for basic needs (e.g.,

[1] A caregiver can be a biological parent, a biological parent whose rights have been terminated, an adoptive parent, a relative, a fictive kin, or anyone deemed appropriate by the child welfare system or the court of jurisdiction.

Table 1 Pilot program services summary

Stage of service	Focus of service	Length of service	Principals involved in service stage	Outcome
Referral stage	CPS staff identify and refer youth with complex mental health needs who reside in a therapeutic setting and who have an identified familial caregiver	Youth should be referred to the program 120 days prior to projected reunification date	CPS staff Pilot program staff	Establish child/youth eligibility for program. Receive all necessary documents to screen for enrollment
Screening stage	Pilot program staff review submitted documentation from the referral stage and meet with the potential caregiver to assess capacity and willingness to accept placement of the youth utilizing the program	30 days	Pilot program staff Potential caregiver CPS staff	Enrollment of youth and caregiver
Planning stage	Pilot program staff work with all principal parties to prepare for the reunification of the youth. Primary focus of the program is to ensure readiness of caregiver and support CPS staff to ensure that the youth is equally prepared for the reunification. Unique services and community resources are identified to support reunification. Extensive school transition plans are developed	90 days	Pilot program staff Caregiver Youth CPS staff Legal parties	Services are provided to the youth and caregiver and an individualized plan is developed to support reunification

Table 1 continued

Stage of service	Focus of service	Length of service	Principals involved in service stage	Outcome
Integration	Youth is returned to the caregiver and the services and supports identified in the planning stage are implemented and/or expanded. Community members are included as part of the Child and Family Team. Frequent contact to youth and family ensure appropriateness and effectiveness of services	6 months	Pilot program staff Caregiver Youth CPS staff Legal parties (until legal case is dismissed) Community members School personnel	Weekly Child and Family Team meetings for the first 30 days then less frequent meetings as warranted by the needs of the youth and family
Ongoing	Youth has remained in the community for 6 months, and CPS has closed their involvement with the family. Pilot program staff work with the youth and family to continue services to sustain progress and strengthen placement	6–12 months	Pilot program staff Caregiver Youth Community members School personnel	Family is transitioned to community supports and the pilot program services are discontinued

rent, utilities, clothing, food) through the flexible funding pool. Post-reunification, families are served for 6 months in collaboration with CPS, and then an additional 6–9 months after the child welfare system closes their involvement with the family. During this period, the youth and caregiver continue to access services through the provider network, hold child and family team meetings, and prepare to transition to community agencies for ongoing services.

Study Design

Yin (2008) suggests that case study design is well suited for describing and evaluating an intervention in a real-life context. Rather than focusing on a single case, we utilized a collective case study approach, defined as "studying several cases within the same project" (Stake 1995, p. 169), to conduct this exploratory, descriptive, and formative evaluation study of the infant pilot program. We employed the collective case study methodology in an instrumental manner (Stake 1995). In other words, each "case" in our study was instrumental to helping us develop a general understanding of a particular phenomenon—that is, barriers to successful reunification. By utilizing qualitative interviews and case record reviews, and through the inclusion of multiple perspectives (i.e., youth, the youths' caregivers, CPS caseworkers, and project staff), we were able to develop an in-depth and comprehensive understanding of each case in order to observe common patterns, triangulate experiences, and draw conclusions among them.

Sample

Youth and caregivers that were reunified during the first 10 months of the pilot program were invited to participate in the study. Six youth were reunified with their caregivers during this time frame. In addition to the youth and caregivers, the CPS caseworkers for the youth and the pilot program staff were also invited to participate. Therefore, the final sample for this study included youth ($n = 6$), their caregivers ($n = 6$), and CPS caseworkers and pilot program staff ($n = 11$). All were interviewed about their experiences with the reunification process.

Table 2 presents the demographics of the youth, caregivers, CPS caseworkers, and program staff included in our sample. All of the youth had been placed in at least one residential treatment setting while in foster care; three of the youth experienced multiple placements in different residential treatment settings. The range of time that youth spent in residential treatment ranged from 9 months to 6 years. All of the youth had at least one Axis I mental health diagnosis (DSM-IV) (e.g., bipolar disorder, major depressive disorder, anxiety disorder, ADHD, etc.). At least three of the youth were taking psychotropic medications at the time of reunification with their caregivers. Only three of the six caregivers with whom the youth was reunifying had custody of the youth at the time of their removal from the home.

Data Sources

Data for the analyses reported in this paper were collected from two primary sources. One source was the CPS case files from which data were gathered by the

Table 2 Demographics of study sample

	Youth (n = 6)	Caregivers (n = 6)	Program staff and CPS caseworkers (n = 11)
Gender			
Male	4 (66%)	0 (0%)	2 (18%)
Female	2 (33%)	6 (100%)	9 (82%)
Age			
Age at time of study (mean years)	13.5	50.1	28.3
Age at time of study (range)	10–17	33–67	22–49
Age at entry into care (mean years)	9.1		
Age at entry into care (range)	6–12		
Race/ethnicity			
African American	1 (17%)	3 (50%)	1 (9%)
Asian	0 (0%)	0 (0%)	1 (9%)
Biracial (African American/Latino)	2 (33%)	0 (0%)	0 (0%)
Latino	2 (33%)	2 (33%)	0 (0%)
Native American	0 (0%)	0 (0%)	1 (9%)
White	1 (17%)	1 (17%)	8 (73%)
Reason for youth's removal			
Neglect	3 (50%)		
Refusal to accept parental responsibility	3 (50%)		
Caregiver's relationship to youth			
Adoptive parent		1 (17%)	
Birth parent		2 (33%)	
Maternal/paternal grandparent		2 (33%)	
Fictive kin		1 (17%)	
Caregiver's income (range)		$10,000–$50,000	

evaluators using an in-depth case review structured instrument. The other source of data was face-to-face semi-structured interviews with the youth, their caregivers, CPS caseworkers assigned to work with the youth, and the pilot program staff.

Case File Reviews

In preparation of the study, a case-reading guide was created to compile and summarize the information on each case. The guide was designed to provide a comprehensive overview of each case from the time of the youth's removal from the home until after the youth's reunification. The guide included questions related to the youth's removal history and circumstances that contributed to their removal from the home, information about their birth parents and siblings, caregivers the youth had while in foster care, physical and mental health diagnoses, placement changes made while in foster care, as well as significant events that occurred while

the child was in foster care. The case-reading guide provided a structured and consistent format to compile and summarize information about each case.

Qualitative Interviews

A total of 31 face-to-face interviews were completed with study participants. The youth, their caregivers, and the program staff were all interviewed at least two times, while the CPS caseworkers were interviewed once. Interviews with youth and caregivers were conducted at 3 and 6 months post-reunification. Waiting 3 months to conduct the first interview allowed the youth to become settled with the caregivers, as some of the youth had been in foster care for quite some time and needed an opportunity to get reacquainted with their caregiver and adjust to the new placement. In addition, this timeframe allowed for the initial "honeymoon period" that often occurs when youth change placements and are becoming familiar with the rules of the home to pass. Interviews with CPS caseworkers and program staff were completed throughout the study.

Interviews with youth included open-ended questions regarding their experiences with and feelings about transitioning from foster care to their caregiver's home and reintegration into the community. Because the ages of participating youth ranged from 10 to 17 years, two interview guides were developed—one for youth age 12 and under, and another for youth age 13 and older. Interviews with caregivers included open-ended questions regarding their experiences with the reunification process and with receiving supportive services and training through the program. Interviews with referring CPS caseworkers focused on factors that contributed to their decisions to refer the youth to the program, as well as systemic and family barriers encountered or observed during the referral and reunification process. Interviews with program staff included questions about their perceptions of case, program, and system challenges encountered during the implementation of the program and barriers to the reunification of youth with their caregivers. All interviews were audiotaped and transcribed for the purposes of analysis.

Data Analysis

Case File Reviews

Using documents in the CPS case records for the youth and administrative data extracted from agency databases, a thorough case history was constructed for each child. A case-reading guide created for this study was used in order to compile and summarize the information on each case. The case file guide provided allowed us to organize and condense detailed information about the removal histories and circumstances that contributed to the removal of the youth from their homes, information about their birth parents and siblings, caregivers the youth had while in foster care, physical and mental health diagnoses, placement changes made while in foster care, as well as important events that occurred while in foster care.

Qualitative Interviews

A systematic qualitative method of coding similar to the method described in Sommer and Sommer (2002) was used to facilitate description and thematic analysis of transcripts from recorded interviews with the youth, their caregivers, the CPS caseworkers, and the program staff. Using this method, two of the evaluators read the interviews in their entirety. Potential themes and ideas were noted in the margins for each interview question to get an overall sense of the data without relying on a priori concepts or expectations. The evaluators then developed an agreed upon list of codes for each different type of interview (e.g., youth, caregiver) indicating common responses and reflecting the identified themes. Next, each person read all the interviews again, in full, and assigned a code or multiple codes to the interview content. Next, they relied on a consensus approach to obtain reliability. They met and discussed their interpretation and use of the codes as applied to the interview transcripts and reconciled any initial discrepancies. The codes were used to group and summarize the results. The data were analyzed for general themes as well as for individual variations in themes across all six cases. Information from the case-reading guides was used to supplement the interview data.

Results

System, Program, and Case-Level Barriers

Results of the cross-case analysis revealed several barriers that either delayed the reunification process or made the process more difficult once achieved.

System-Level Barriers

Collaboration with RTCs While all of the youth experienced at least one placement in a RTC, four of the six youth transitioned directly from a RTC to their caregivers' homes. The other two transitioned from therapeutic foster care group homes. Our findings show that the pilot program staff encountered problems in their attempts to work with RTCs to help plan for the youth's discharge from the facility. Program staff reported that RTC staff were often reluctant to identify specific discharge dates based on the youth's individual treatment goals. Some staff reported frustration that discharge planning seemed largely driven by reductions in youth's level of care, which are made by an independent agency contracted by CPS. The contracted agency bases level of care decisions on the youth's physical, psychological and social functioning during the youth's previous 30 days at the placement. Thus, decisions regarding discharge are not always based on whether or not the youth had actually met their treatment goals, rather they are often made following a reduction in the youth's level of care.

Program staff also reported a general reluctance of RTC staff to consider less conventional alternatives when discharging youth from residential care. The practice of discharging youth with severe mental and behavioral health needs

directly from residential treatment settings back into the community is relatively uncommon. Rather, the typical discharge plan calls for youth to first be placed in a therapeutic foster home before reunification into a less restrictive setting is considered. Program staff noted that some RTC staff questioned the overall wisdom of reunifying youth with complex and ongoing mental health needs directly back into the community directly from a residential treatment setting.

Some program staff also expressed frustration that youth, after achieving treatment goals, are not allowed to remain in the residential treatment setting for a period of time to see if they will be able to successfully maintain their behavior. One program staff member noted:

> This is very disconcerting because children need time to be successful and integrate the skill sets that they learn. As soon as the youth's behavioral manifestations are minimized or reduced, then their level of care is dropped and they have a 30-day window to discharge from the facility.

Program staff and CPS caseworkers both noted that this leaves very little time to ensure that the family is fully prepared for reunification, and that the child's family has realistic goals and expectations for the child's reunification into their home.

Finding Well-Qualified Service Providers An on-going concern voiced by program staff, CPS caseworkers, and some caregivers related to the difficulty in locating psychiatrists and therapists who accepted Medicaid and were also familiar with the needs of youth with complex mental health needs who have been in foster care. The lack of available service providers who used the most current evidence-based treatment methods was also cited as a concern. Program staff and CPS caseworkers expressed that the lack of available service providers in the community greatly limited their ability to individualize services for the youth and their families.

Facilitating Pre-reunification Contact Only two of the six youth in the study were able to maintain consistent face-to-face contact with their caregivers prior to reunification. Caregivers of youth placed in geographically close RTCs were more successful in visiting the youth on a consistent basis. However, youth placed out of the area did not have the benefit of consistent contact with their caregivers. High caseloads of the CPS caseworkers who referred the youth to the program, as well as CPS policies restricting caseworker travel outside their established regions resulted in inconsistent face-to-face contact between the youth and their caregivers. While some caregivers reported that they were satisfied with the amount of contact they had pre-reunification, others indicated that they would have liked to have more contact with the youth before the reunification occurred. In addition, several of the youth indicated that their visitation and phone privileges were often restricted by residential treatment staff when they exhibited poor behavior. Program staff and caregivers found this practice to be short-sighted, and stressed the importance of not withholding visitation as a negative consequence for poor behavior. One program staff suggested that residential treatment might be resistant to increased visitation because of concerns regarding the effect that the visits have on the youth's behavior. One program staff member noted:

> Kids don't always do well moving back and forth from home to the facility real easily. They tend to have more behavior problems leading up to the visits, and they have more behavioral problems upon return so that colors [residential treatment staff's] judgment about whether they should allow the visits.

Program-Level Barriers

Collaboration Between CPS and the Pilot Program Collaboration between CPS caseworkers and the program staff is an essential component of the program's process, particularly during the planning stage. However, effective communication and collaboration between the program staff and CPS did not always occur. Program staff, consisting of a case manager and a supervising program manager, reported experiencing difficulty in their efforts to collaborate with CPS caseworkers to determine the youth's projected reunification dates, to coordinate pre-reunification visits, and to work with the RTCs regarding discharge dates for the youth. During the first few months of the program, program staff observed that CPS caseworkers tended to step back from the case after the youth were accepted into the program. It was also noted that some of the CPS caseworkers did not appear to fully understand their role during the planning stage or after the youth reunified. CPS staff acknowledged that the responsibilities of the program's case manager and those of the child's CPS caseworker were not clearly outlined during the initial months of the program. However, CPS caseworkers and administrative staff reported that as the program evolved, the roles and responsibilities for CPS caseworkers were clarified by program staff and CPS administrators and, thus, became more defined.

Cultural Competency The majority of youth and caregivers involved in the program during the study period were Latino, African American, or biracial. Therefore, it is imperative that service providers involved in the youth's cases have a basic understanding of different cultural communities and how they can adapt their practices to the cultural context of the families that they serve. In some cases, efforts to be culturally appropriate appeared limited to individual CPS caseworker's personal understanding of the importance of culture. Despite their understanding of the importance of being culturally aware, there were also some instances in which professionals involved in the case failed to recognize situations when cultural issues may have been an important factor in the interpersonal dynamics of the families and how they dealt with stressful situations. For instance, program and CPS staff initially underestimated the severity of one African American caregiver's illness and were uncertain about how to best handle the family's unwillingness to discuss the caregiver's health condition or her long-term prognosis. The family's resistance was viewed by some staff as non-compliance. Awareness of cultural differences in health service utilization and sharing health information with others outside the family may have helped in this situation. In addition, program staff also recognized that there is a cultural component to assessing attachment between the caregivers and the youth that they found difficult to articulate and put into practice:

> There is something about how an Anglo person perceives attachment versus how an African American does—what does it look like and how is it different? There are some definite cultural pieces around expectations of behavior and [the child] shaming the family with misbehavior. All of that plays into this, but we have not been able to get a handle on it.

Case-Level Barriers

Youth Behaviors and Caregiver Ambivalence In some instances, the youth's aggressive and defiant behaviors served as a barrier to their reunification. Caregivers for these youth indicated they wanted the youth back in their homes; however, they were concerned about the safety and welfare of their other children. The caregivers reported some ambivalence about the timing of the reunification and whether the youth were ready to return to a less structured setting. The caregivers indicated that they were able to work through their anxiety; however, CPS caseworkers reported that some caregivers for other youth referred to the program opted not to pursue reunification because of their ongoing ambivalence about the youth's return to the home. In these instances the youth were unable to reunify until another suitable caregiver could be identified.

Assessing Readiness for Reunification Findings revealed the importance of ensuring youth and caregiver readiness for reunification. During interviews, it became clear that some of the caregivers underestimated how difficult it would be to care for the youth. Program staff reported that the caregivers for the first two youth reunified minimized the youth's behaviors, and seemed to feel that the youth would be fine after the reunification occurred. These two youth exhibited a number of problems, including general defiance towards authority figures, some episodes of running away, and violence towards others. Program staff learned from their experiences with these families and became more deliberate about assessing the caregivers' understanding of what they believe the reunification would look like and what they were expecting from the child. One program staff member reported that she has also focused on helping the caregivers understand that they may need to be flexible and willing to make adjustments for the youth:

> The bottom line key is a clear understanding and expectation of the amount of work and adjustments that [the caregiver] is going to have to make in caring for this child. There is clearly a misperception across many areas that somehow a child going into treatment will then come out a "fixed child," who will then no longer exhibit any challenging behavioral problems. That is just not true at all…

CPS caseworkers also did not have a uniform process for assessing either youth or caregiver readiness prior to referring the case to the program. In two of the cases, readiness was determined, in part, through discussions with the youth's therapists. However, in the remaining four cases, caseworkers were unable to provide specific criteria regarding how they determined the youth and caregivers' overall readiness. The most consistent answer provided by CPS caseworkers was that family reunification was the child's permanency plan.

Preparation for Reunification One of the greatest lessons learned was the absolute necessity for program staff to have an adequate amount of time to work with the caregiver prior to reunification. In working with the families, program staff found this to be of critical importance to the success of the placement and the family's level of engagement in services for their child. The planning process for the first two who reunified was accelerated in order to accommodate the youth's CPS case plans. However, program staff quickly recognized their error in expediting the placements without adequate preparation. They reported that the decision to expedite the placements compromised their ability to get to know the families better and effectively engage them in the pre-reunification planning process. One program staff member explained the consequences of their decision:

> None of the important conversations were discussed with the caregivers regarding the youth and their behaviors, the realities of caring for the child or how the caregivers would handle/manage situations that arise.

This staff person noted that the decision also hindered the ability to distinguish themselves from CPS and earn the families' trust.

Interviews with CPS caseworkers indicated that some felt unequipped to plan and prepare the families on their caseloads for reunification. One caseworker suggested that additional training on preparing families for reunification would be helpful for CPS staff:

> Many caseworkers don't understand what they should do after reunification or even during the process of reintegrating children back into the home. This is something that caseworkers should have a better understanding of—not just generally but specifically, step by step what the process should look like to be successful versus caseworkers just reintegrating and then getting out of the case. Reunification has to be a process.

Logistical Issues Some of the youth were inadequately prepared for the reunification, as program staff encountered logistical barriers during their efforts to prepare the youth. Program staff suggested that one of the greatest barriers to preparing youth for reunification was the physical distance of many of the youth's placements from their caregivers. All but two of the youth were placed at least 2 h away from their caregivers at the time of reunification. In addition to the placement distance, program staff had difficulty accessing residential treatment staff and records so that they might coordinate visits and monitor the youth's progress prior to discharge.

Financial Insecurity The program provided a much needed safety net for some of the families who experienced financial difficulties. While the amounts varied, all but one of the families in the study needed and received some form of financial assistance. Records indicate that families accessed funds for apartment deposits, rent, and the purchase of beds for the some of the youth. In addition, some caregivers received assistance to help cover basic necessities such as groceries and clothing for the youth. While program staff were able to provide assistance to the families, program staff and CPS caseworkers expressed concern regarding how these families would manage financially once discharged from the program.

Discussion

Five of the six youth in this pilot project were successfully reunified with their caregivers and reintegrated back into the community. Since that time, ongoing tracking of the outcomes of all enrolled youth have found that 50% of the 18 cases that have had their cases closed have successfully sustained their placement (Maher et al. 2011), which is striking, given the complex nature of the cases referred to the program and that only 44% of children age 5–17 in foster care, not all of whom have such complex needs, in the county where this project takes place are reunified with birth parents or primary caregivers (U.S. Department of Health and Human Services 2010b). Despite the small sample size, the findings can be useful to states as they develop strategies to comply with the Federal Child and Family Service Review requirements to improve efforts to preserve youth connections through visitation with families, engage families in case planning, and seek to achieve timely reunification and permanency goals earlier (U.S. Department of Health and Human Services 2008).

To address the previously identified systemic, program and case-level barriers identified in this study, specific changes in policy, practice and staff training are recommended. It will be important for roles, activities, and expectations of CPS personnel, program staff, and residential treatment providers to be clarified before, during, and after reunification. For example, more clarity is needed regarding the preparation and assessment process. Program staff relied on CPS to assess readiness for reunification; however, this was often left to the independent judgment of the youth's CPS caseworker. As part of the early preparation and assessment process to help determine overall family and youth's readiness for reunification, staff should use standardized instruments to assess caregiver and youth attachment and relationships. Used in conjunction with the CPS caseworker personal assessment, use of standardized instruments would provide program staff with a more well-rounded understanding of the youth and caregivers' overall readiness for reunification.

Moreover, since many of these youth returned to family caregivers after multiple placements and lengthy stays in residential treatment settings, attention must be placed on the reasons for multiple moves and the reasons for why reunification did not occur at an earlier point. Prevention as well as family preservation strategies are needed to reduce the number of children coming into care and reduce the time and number of moves in care.

For children who are being reunified following extended stays in care, pre-reunification visitation and contact are likely to facilitate the child's and family's adjustment, as well as their development and maintenance of relationships. Increased visitation between caregivers and children is more likely to occur if RTC staff are involved from the beginning and are supportive of pre-reunification visitation. In this pilot, many of the RTCs were located some distance from the caregivers' homes. Strategies for facilitating visitation, despite the distance, should be developed to aid in the transition from residential treatment to the caregiver's home.

In order to achieve the above mentioned goals to better prepare youth and families for reunification, program staff need to have adequate time to facilitate visitation and prepare the caregivers for reunification. While the current caseload for

this program is already low, caseloads may need to be further reduced to facilitate this intensive reunification work. In addition, as part of the preparation for reunification, program staff must have time to explore community resources and services and be sure that the services families will need are available.

All but one of the youth in this study were either African American, Latino, or biracial. This is not surprising given the overrepresentation of children of color in the foster care system (Green et al. 2011). It is essential that residential as well as CPS staff be trained to provide culturally competent services to these youth and their families. As is often the case, none of the CPS caseworkers were ethnic minority. It is essential that all staff not only be able to relate to the needs of youth from various minority backgrounds, but that they also be comfortable with and prepared to provide services to families living in diverse communities. Skills in building cross-racial relationships are essential, and knowledge of unique challenges and issues experienced by the youth and families being served are very important for effective service delivery.

The families in this pilot had limited financial resources and although, they received some financial assistance, it is essential that program staff work with the family to find additional resources prior to their discharge from the program. A full assessment of the family's ongoing financial needs must be undertaken. Since many may be eligible to receive kinship guardianship assistance payments, this option should be explored. Also, since caregivers will need to monitor the youth's needs for psychotropic medication, program staff should ensure that caregivers have an understanding of the types and uses of each medication. Additionally, caregivers should be given a protocol to follow and have access to professional consultation should changes in medication be needed. Moreover, supports should be given to encourage caregivers to fully participate in the program, including participation in the youth's monthly team meetings as well as services that will support and encourage development of the caregiver's and youth's relationship. Caseworkers must support the caregiver's involvement, if possible, by having flexible hours and locations for team meetings, assisting with transportation if needed, and establishing other practices and policies which will support the caregiver's involvement.

Finally, interviews with staff revealed a number of training needs that would have better equipped them to serve this population. CPS caseworkers and program staff expressed a desire for greater knowledge about the unique needs of children with severe mental health problems and strategies for assessing readiness of children and caregivers for reunification. Additionally, program staff may need additional training regarding best practice strategies for reintegrating children and youth with severe mental health needs back home, into school and community settings, as well as a better understanding of the essential steps and time frames needed for successful reunification. As states move towards trying to expand options and improve outcomes for youth with severe and complex mental health needs through reintegration, staff must receive adequate training in successful wrap around service models to achieve this goal.

This project provided new insights about the process of reunifying youth in foster care; however, the study had a number of limitations. The sample size of youth and caregivers for this pilot study was small, as is typical in case study methodology.

Consequently, the findings cannot be generalized to the experiences of all youth with severe mental and behavioral health needs who have reintegrated into the community or to the experiences of their caregivers. Future studies may want to collect less in-depth information on a larger number of cases of youth undergoing reunification in order to make comparisons between gender, ethnicity, and age groups and to enhance the generalizability of the findings. Our approach prioritized in-depth information on a few cases from multiple perspectives. In addition, future research should ideally include a larger sample of caseworkers to get a more complete picture of the different barriers that they encounter in their efforts to reunify youth with their caregivers.

Although there are methodological limitations to this study, the use of in-depth reviews of the youth's CPS case files strengthened the findings of the interviews with youth and caregivers, as the information provided in the case reviews validated and contextualized the findings. Future studies might include quantitative measures assessing overall attachment of the youth and their caregivers to each other, their readiness for reunification, and their long-term adjustment to the reunification following the youth's transition back into the community. The results of the current evaluation are promising and suggest that while youth with severe mental and behavioral disorders will encounter barriers to the reunification process, youth can successfully be reunited with their families, provided that they have agency commitment and appropriate services, a caregiver who is committed, and that the family has ongoing access to community supports.

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