

Travis County, Texas, Child Protective Services Reintegration Pilot Project

Final Evaluation Report

Prepared for Casey Family Programs by

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Executive Summary

According to the latest data from the U.S. Children's Bureau, in 2007 approximately 496,000 children and youth were in the foster care system. Family reunification and placement with relatives are typically the preferred permanency options for children in care. However, child welfare agencies often lack the necessary resources and staff expertise to provide ongoing community based services for families of youth with severe emotional and behavioral health problems. The availability of comprehensive community-based services for children in the foster care system is essential to the successful reintegration of these youth back into the community.

To facilitate reintegration of youth into the community, the Children's Protective Services (CPS) Reintegration Pilot Project was implemented in Travis County, Texas. This program provides home and community-based services to a small number of youth involved in the Texas foster care system who have complex mental and behavioral health needs. The program is a collaborative partnership between Casey Family Programs, Travis County Health and Human Services and Veterans Services (HHS&VS), and Texas Child Protective Services (CPS), which is designed to help youth successfully transition back into the community from intensive out-of-home placements, such as residential treatment centers or therapeutic foster homes, and to empower families to safely care for their youth.

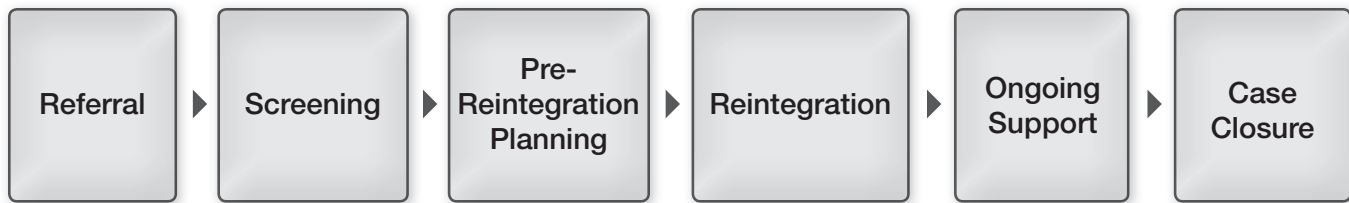
Consistent with the research on successful reunification practices, the CPS Reintegration Pilot Project uses a wraparound service model to assist youth and their caregivers in meeting this goal. Under this model, services are coordinated and managed through a Care Coordinator in partnership with the child's family. Services are individualized to the specific strengths and needs of the youth and their families. Available services include care coordination, team meetings, youth mentoring, parent coaching, after school care, tutoring, respite care, psychiatric services, outpatient therapy, and 24-hour crisis intervention/support for caregivers.

Eligibility criteria for the program were developed specifically to target youth with severe emotional and behavioral health needs who CPS believed could safely reintegrate into the community. During the course of the evaluation, 51 youth were referred to the program. Of these 51 youth, 30 were declined because the child or the caregiver did not meet the minimum eligibility criteria for the program or because the Court or CPS sent the child home earlier than the reintegration date projected by CPS when the initial referral was made. The remaining youth had "active" cases, meaning that they met the minimum eligibility criteria for the program and were either on the program's waiting list, in various phases of the referral and screening process, planning for reintegration, or had already achieved reintegration. A full description of each phase in the reintegration process is provided in Figure 1.

Casey Family Programs contracted with the University of Texas at Austin Center for Social Work Research to conduct a qualitative, descriptive evaluation of youth and caregivers who accessed services through the CPS Reintegration Pilot Project. A multiple case study evaluation design was used to explore two research questions:

1. What are the experiences of youth in care with complex mental and behavioral health needs who have reunified with their parents or other caregivers and reintegrated into the community?
2. What are the barriers that delay or prevent the reunification of youth in care with complex mental and behavioral health needs with their caregivers?

Figure 1. Phases of the Reintegration Process



Referral Phase – During the referral phase of the process, the CPS caseworkers are asked to complete a one-page pre-screening tool prior to making a formal referral. Youth who do not meet the minimum criteria do not enter the program. CPS caseworkers for youth who meet the minimum criteria for the project are then asked to complete a more in-depth formal referral form. CPS caseworkers are given 45 days to complete this form and return it to the Care Coordinator.

Screening Phase – During the screening phase of the process, the Care Coordinator meets with the identified caregiver for the referred child to discuss the CPS Reintegration Pilot Project and to determine the caregiver’s overall interest in participating in the program. In addition, the Care Coordinator obtains additional documentation and information needed to assess the child and caregiver’s appropriateness for the program. A child might be declined at this stage of the process if the program staff determine that he or she is not in need of services through the program in order to maintain the reintegration or if the caregiver declines to participate in services through the program.

Pre-Reintegration Planning Phase – During the pre-reintegration planning phase of the process, the Care Coordinator begins the process of working with the caregiver to identify and coordinate services that the child and family will need to prepare for and sustain the reintegration once he or she is placed with the caregiver. In addition, the Care Coordinator obtains additional documentation, such as educational records for the child or an FBI background check, if the caregiver has resided outside Texas within the last three years. The Care Coordinator also arranges to meet the child at his or her current placement and assists CPS in facilitating pre-reintegration visits between him or her and the caregiver. While the length of the pre-reintegration planning phase varies for each child, ideally the Care Coordinator will have a minimum of two full months following the child’s acceptance into the program to develop a plan with the family and ensure that services are in place prior to the child’s return to the caregiver.

Reintegration and Ongoing Support Phases – The reintegration phase of the process begins when the child is placed in the caregiver’s home. During this phase of the process, the Care Coordinator facilitates meetings with the child, caregiver, and wraparound team at least once a month. The frequency of wraparound team meetings varies for each child, depending on the child or caregiver’s level of need and the complexity of services involved. Following reintegration, families are provided with ongoing case management services. The Care Coordinator is actively involved with the caregiver and child and continues to assist the family in identifying needs. The Care Coordinator arranges services to address the needs identified by the caregiver and assists the family and wraparound team in assessing progress.

Case-Closure Phase – Case closure typically occurs under two circumstances: 1) when the caregiver and wraparound team determine that they are able to maintain the reintegration of the child in the home without further assistance from the Care Coordinator and the wraparound team; or 2) in the event that the caregiver determines that he or she is no longer able or willing to care for the child and he or she requests that CPS intervene and locate a new placement for the child.

This report outlines the findings of the project's evaluation. Detailed case studies of the six youth and their caregivers who transitioned from intensive out-of-home placements back into the community during the evaluation period are included.

Case Studies

The evaluation included a sample of six youth, their family caregivers, CPS caseworkers, and program staff, who were interviewed about their experiences with the reintegration process. Data collection methods included in-depth structured case file reviews and semi-structured interviews with youth who reintegrated back into the community, as well as their caregivers, CPS caseworkers, and program staff. Interviews were conducted with participants between January 2008 and January 2009 at 3 months and 6 months post-reintegration.

The six youth in the study ranged in age from 10 to 18 years, while caregiver ages ranged from 33 to 67 years old. Two of the youth were Hispanic, one was African American, one Caucasian, and two were biracial (African American and Hispanic). Three of the youth were originally removed from their homes because of neglect, while the remaining three were removed due to refusal of the caregivers to accept parental responsibility for their care. All of the youth were placed in at least one residential treatment setting while in foster care.

Birth parents and grandparents comprised most of the caregivers in the study; however, one caregiver was the adoptive parent of one of the youth while another was the youth's fictive kin. All of the caregivers were female. Three of the six caregivers were African American, two were Hispanic, and one was Caucasian. Five of the caregivers were in their 40s or older (range 33-67 years).

Summary of Case Study Findings

Several themes emerged from the case study analysis of the six youth and their caregivers. Although interviews with the youth's caregivers suggested that they were excited about their child's return to the home and greatly relieved to have him or her out of the foster care system, they also seemed to display varying levels of attachment and commitment to the youth and to the reintegration experience. Prior to the reintegration, some caregivers minimized the youth's behavior problems and the difficulties they might experience once the youth reintegrated. Because of this, some caregivers were caught off guard when problems emerged during the placement. Despite some problems adjusting to the youth's reintegration, all but one of the caregivers interviewed indicated that they did not regret their decision to have the youth placed with them and wanted the youth to remain in their homes. Overall, caregivers were very satisfied with the program and with the level of support the program provided them prior to and following the reintegration.

Youth interviewed for the study indicated that they were relieved to be out of foster care and home with their family. Some of the youth experienced difficulty adjusting to a less structured environment; however, all of the youth interviewed indicated that they were generally happy with their placement and wanted to remain with their family. When asked what they liked best about living with their caregivers, the youth's most common responses included "being a family again" and "having more freedom." Of the six interviewed youth who reintegrated into the community during the evaluation period, only one disrupted from his or her placement and returned to the foster care system.

The reintegration experiences of the six youth in the study highlighted the importance of program staff

allowing time prior to the reintegration to become fully engaged with the family in order to develop a full understanding of each family's needs. In addition, program staff learned the necessity of determining the youth and caregivers' readiness for reintegration and ensuring that both youth and caregivers were adequately prepared for problems that might emerge.

Barriers to Reintegration: Lessons Learned

Interviews with the youth, their caregivers, CPS caseworkers, and CPS Reintegration Pilot Project staff revealed several barriers that either delayed the reintegration process or made the process more difficult once achieved.

System-Level

Insufficient Collaboration with Residential Treatment Centers

Program staff encountered problems in their attempts to work with residential treatment centers (RTCs) to help plan for the youth's discharge from the facility. Residential treatment staff were often reluctant to identify specific discharge dates based on the youth's individual treatment goals. Rather, discharge planning was largely driven by reductions in youth's assigned level of care.

Lack of Well-Qualified Service Providers

Program staff and CPS caseworkers experienced difficulty locating well-qualified psychiatrists and therapists who accepted Medicaid and were familiar with the needs of youth with complex mental health needs who have been in foster care. Program staff also noted the lack of available service providers who used the most current evidence-based treatment methods.

Insufficient Pre-Reintegration Contact

High caseloads and agency policies restricting caseworker travel outside their established regions resulted in inconsistent face-to-face contact between the youth and their caregivers. While some caregivers were satisfied with the amount of contact they had pre-reintegration, others indicated that they would have liked to have more contact with the youth before the reintegration occurred. In addition, several of the youth indicated that their visitation and phone privileges were often restricted by RTC 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.

Program-Level

Lack of Collaboration between CPS and the CPS Reintegration Pilot Project

Collaboration between CPS caseworkers and the CPS Reintegration Pilot Project staff is an essential component of the wraparound process, particularly during the planning stage. However, effective communication and collaboration between the program staff and CPS did not always occur. Program staff experienced difficulty in their efforts to collaborate with CPS caseworkers to determine the youth's projected reintegration dates, to coordinate pre-reintegration visits, and to work with the RTCs regarding discharge dates for the youth. Some of the CPS caseworkers did not appear to fully understand their role during the planning stage or after the youth reintegrated into the community. CPS caseworkers might have benefitted from some training by program staff regarding reintegration and the role of each party in the process.

Cultural Competency

Efforts to be culturally appropriate appeared limited to individual CPS caseworker's personal understanding

of the importance of culture. The caseworkers demonstrated an awareness of the importance of culturally competent practice but did not seem confident about how to translate their understanding into day-to-day practice with clients. Despite their understanding of the importance of being culturally aware, there were instances in which professionals working with the families failed to recognize situations when cultural issues might have been an influencing factor in the interpersonal dynamics of how family members related to each other and dealt with stressful situations.

Proper Utilization of CPS Reintegration Project Service Model

Program staff varied from the program model during the first two reintegration placements. The program model specified that program staff take at least two to three months to fully engage with the family and ensure that services are in place prior to the child's reintegration into the caregiver's home. Because program staff did not do this, they experienced difficulty engaging the caregivers and the youth in the wraparound process. In addition, the program staff experienced difficulty communicating with the caregivers regarding the youth's needs and progress following the youth's reintegration. Program staff learned the importance of assessing the caregiver's attachment to the child as well as the caregiver's expectations about the reintegration and what the caregiver was willing to tolerate from the child.

Case-Level

Youth Behaviors and Caregiver Ambivalence

In some instances, the youth's aggressive and defiant behaviors served as a barrier to their reintegration back into the community. Caregivers for these youth indicated that 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 reintegration and whether the youth were ready to return to a less structured setting. While some caregivers were able to work through their anxiety, other caregivers opted not to pursue reintegration because of their ongoing ambivalence concerning the youth's return to the home.

Assessing Readiness for Reintegration

Evaluation findings suggest the importance of ensuring youth and caregiver readiness for the reintegration. CPS caseworkers did not have a uniform process for assessing either youth or caregiver readiness prior to referring the case to the CPS Reintegration Pilot Project. In some cases, readiness was determined, in part, through discussions with the youth's therapists. However, in most of the cases, caseworkers were unable to provide specific criteria regarding how they determined the youth's overall readiness. The most consistent answer provided by CPS caseworkers was that family reunification was the child's permanency plan.

Preparation for Reintegration

Program staff encountered logistical barriers during their efforts to prepare the youth for reintegration. Perhaps the greatest barrier program staff reported was the physical distance of many of the youth's placements from Travis County. All but two of the youth were placed at least two hours away from Travis County at the time of reintegration. In addition to the placement distance, 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 during the evaluation period. 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. There is concern regarding how these families will manage financially once they are discharged from the program.

Recommendations for Practice

System-Level

- Improve services for youth and families by providing caseworker training on services to youth with severe mental health needs and implications for transitioning back home.
- Increase the amount of pre-reintegration visitation/contact between youth and caregivers.
- Increase communication with residential treatment centers to increase likelihood of visitation between youth and their family members and residential staff's involvement in preparing the youth and their families for reintegration.
- Provide training for CPS caseworkers on how best to help families address both the short-term and long-term challenges associated with the reintegration process.
- Ensure that professionals involved with the youth's cases receive training in culturally competent practice in order to develop a better understanding of different racial and ethnic backgrounds, as well as ways professionals can adapt their practices to the cultural context of the families that they serve.
- Provide families with access to qualified and experienced providers who understand the unique needs of youth with complex emotional and behavioral health needs.
- Educate the court as well as attorneys and CASAs regarding the essential steps and time frames necessary for successful reintegration.

Program-Level

- Provide program staff with adequate time to prepare youth and caregivers for reintegration and engage with the caregivers and ensure that the necessary services are in place.
- Clarify with CPS caseworkers what their role will be in the reintegration process and how they can help prepare the youth and caregivers for reintegration.
- Ensure that there is open dialogue with CPS staff regarding the cultural relevance of services provided to families in the program.
- Continue efforts to engage and educate CPS administrators and caseworkers about the program, what constitutes an appropriate referral, and proactive case planning.
- Assess and refine program policies based on evaluation results.
- Formalize policies by creating a handbook of policies and practices for future program staff to use.

Case-Level

- Assess needs of caregivers and youth prior to reintegration and assess resources in the community to meet those needs. If resources are not available in the community, identify other services outside of the community that can address their needs.
- Assess the caregiver's willingness to engage in therapeutic services as well as the child's wraparound plan of service.
- Use a standardized instrument to assess caregiver and youth attachment during the screening phase of the process to help determine their overall readiness for reintegration.

- Prepare youth's siblings for the youth's reintegration back into the home.
- Work with caregivers to monitor the youth's needs for psychotropic medication. Develop a protocol for families to follow when they are considering the discontinuation of medication for the child in their care.
- Require identified caregivers to participate in Parent Engagement and Self-Advocacy training classes.
- Identify and implement policies for caregivers to encourage the full participation of caregivers in the program, such as a requirement that caregivers attend the youth's monthly team meetings.
- Ensure the availability of funding for families' basic and enrichment needs.
- Conduct and document a full assessment of each family's ongoing financial, health, and support needs prior to discharging youth from the program.

Conclusions

The primary purpose of this study was to provide descriptive information about the experiences of youth in foster care who are reintegrating from intensive-out-of-home placements back into the community. This study also captured information that can contribute to the dialogue about how child welfare agencies conceptualize reintegration and the circumstances under which reintegration can successfully be achieved. The findings suggest that youth with severe mental and behavioral problems can successfully be reunited with their families and return to their communities, provided that they have agency commitment and appropriate services, a caregiver who is committed, and that the family has ongoing access to community supports.

Longitudinal follow-up of the youth and caregivers in this study could reveal important insights about the long-term outcomes of the placements.

Introduction

The CPS Reintegration Pilot Project provides home and community-based services to a small number of youth involved in the Child Protective Services (CPS) system who have complex mental health needs.¹ The goal of the program is to help youth successfully transition back into the community from intensive out-of-home placements, such as residential treatment centers or therapeutic foster homes. Reintegration refers to the exit of youth from intensive out-of-home placements to the care of their birth parents or other relatives and caregivers. In this report, the term “reintegration” is used interchangeably with “reunification.”

The CPS Reintegration Pilot Project is a collaborative partnership between Casey Family Programs, Travis County Health and Human Services and Veterans Services (HHS&VS), and Texas Child Protective Services (CPS). The program receives funding from each of the three agencies to provide services to youth and families who participate in the program.

In August 2007, Casey Family Programs contracted with the University of Texas at Austin Center for Social Work Research to conduct a descriptive evaluation study of youth and caregivers who accessed services through the CPS Reintegration Pilot Project. The primary purpose of this study was to develop a comprehensive understanding of the experiences of youth in foster care who have reunified with their parents or other caregivers and reintegrated into the community. Although the CPS Reintegration Pilot Project was initiated in October 2007, the program experienced several delays during the initial months of the program that impeded the efforts of staff to identify, screen, and prepare youth and caregivers for reintegration. To better understand the problems that program staff encountered in their efforts to identify eligible youth and caregivers for the program, an additional evaluation component was added to the study in December 2007. The new component was designed to explore barriers to the reintegration of youth who have severe mental health needs with their caregivers.

The evaluation was designed to explore two research questions:

1. What are the experiences of youth in care with complex mental health needs who have reunified with their parents or other caregivers and reintegrated into the community?
2. What are the barriers that delay or prevent the reunification of youth in care with complex mental health needs with their caregivers?

Focus of Report

The primary focus of this report is to present in-depth case studies that describe the characteristics, circumstances, and experiences of youth who received services through the CPS Reintegration Pilot Project between October 2007 and January 2009. In addition, this report identifies a number of systemic, program, and case-level barriers that were found to delay the reintegration of youth back into the community. This report presents findings from qualitative interviews with participating youth and caregivers, CPS caseworkers who referred youth to the program, and CPS Reintegration Pilot Project staff. Data obtained from in-depth case reviews of the youth’s CPS files are also presented to further contextualize the experiences of these youth and their caregivers during the reintegration process.

This report contains five chapters. Chapter 1 includes a brief review of pertinent child welfare legislation,

¹ The term “complex mental health needs” refers to a diagnosed emotional, behavioral, or substance problem that substantially disrupts a child’s ability to function socially, academically, and emotionally. The term is used by states and at the federal level to identify children and youth who experience significant functional impairment due to mental, emotional, and/or behavioral problems (U.S. Department of Health and Human Services, 1999).

research on reunification, challenges in meeting the needs of youth with severe mental and behavioral health needs, and a description of the wraparound service model. Chapter 2 offers an overview of the CPS Reintegration Pilot Project, issues encountered during implementation of the program, and a description of the 51 youth referred to the program by CPS. In addition, selected characteristics of the youth, their caregivers, CPS Reintegration Pilot Project staff, and referring CPS caseworkers are presented. Chapter 3 summarizes study methods, including a description of the evaluation design, study sample, and qualitative measures employed in this study. Chapter 4 presents case study findings for the six families in the study, including the perspectives of program staff and referring CPS caseworkers about the youth and families involved in the project. Chapter 5 concludes with a discussion of the study's findings, limitations, implications for research and practice, and program recommendations.

Chapter 1: Literature Review

Scope of the Problem

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 their physical, emotional, and safety needs will be met. Although reunification of children with their birth parents is generally regarded as the preferred permanency option (Maluccio, 2000), children can also experience permanency with relatives, adoptive families, and other adults who are committed to care and provide for their needs.

According to the Adoption and Foster Care Analysis Reporting System (AFCARS), the data reporting system for children in foster care, preliminary estimates indicate that as of September 30, 2007 approximately 496,000 children and youth were in the child welfare system (U.S. Department of Health and Human Services, 2009). While the majority of these children will eventually return to the care of their birth parents or relatives, the reunification process is frequently delayed for children and families. Delays in reunification are often the result of an overburdened system and a lack of available support services to help families address and resolve problems that contributed to the initial removal from the home (Ahart, Bruer, Rutsch, Schmidt, & Zaro, 1992; Jones, 1998).

A disproportionate number of children in the U.S. foster care system are children of color (U.S. Department of Health and Human Services, 2006). In 2006, children of color represented over half (58%) of all children in the U.S. foster care system. Research suggests that African American children represent the greatest disproportion of children in care; however, there is evidence that a disproportionate number of children in the foster care system are also Native American. Hill (2006) reported that although Hispanic, Asian, and Pacific Islander children are underrepresented in the child welfare system on a national level, they are overrepresented in several states and in many counties. In addition, a disproportionate number of children in foster care are removed from families with multiple and complex problems, such as substance abuse, mental illness, domestic violence, and extreme poverty. Thus, many parents have inadequate economic, social, and emotional resources to address the child welfare agencies' concerns without a substantial amount of support and encouragement from the child welfare system.

Legislative Background

During the last three decades, Congress has enacted several pieces of federal legislation to promote permanency for children in the public child welfare system. The Adoption Assistance and Child Welfare Act of 1980 (AACWA), also known as the "Family Reunification Act," was the first federal piece of child welfare legislation to emphasize permanency planning and family reunification. This legislation was passed in order to help facilitate the permanent placement of children, either by means of family reunification with the birth parents or, in cases where this was not possible, placement with relatives or an adoptive family. In order to establish permanency for children more quickly, AACWA required child welfare agencies to develop comprehensive case plans and reviews for each child in foster care (U.S. Department of Health and Human Services, 2005). Despite these efforts, the legislation had little effect on slowing the entry of children into the foster care system. Between 1983 and 1995, the foster care population more than doubled, rising from 242,000 to 507,000 (Maza, 2000).

In response to the growing number of children in the child welfare system, Congress enacted the Adoption and Safe Families Act of 1997 (ASFA). Hoping to accelerate the placement of children into permanent

homes, Congress included more stringent timelines for parents with children in foster care by requiring states to pursue termination of parental rights for children who have been in foster care for 15 out of the most recent 22 months. While ASFA stipulated that reasonable efforts should be made to preserve and reunify families, the legislation clarified that reunification services for birth parents should not be provided indefinitely. Rather, Congress emphasized that reunification services should be time-limited and dependent on the parents' willingness and ability to demonstrate progress in alleviating safety concerns. In order to expedite permanency for children, ASFA encouraged states to concurrently plan for adoption or placement with relatives while working toward the goal of family reunification. In addition, ASFA provided a financial incentive to states to increase their yearly baseline adoption rate (U.S. Department of Health and Human Services, 2004). However, the legislation did not include incentives to encourage permanency by other means, such as kinship care or family reunification. More recently, the Fostering Connections to Success Act of 2008 was enacted to promote permanency for youth in foster care through relative guardianship and adoption. In addition, the legislation provides additional supports to families and youth and extended federal support for youth in the U.S. foster care system to age 21 (Center for Law and Social Policy, 2009).

Family Reunification

The overall body of empirical knowledge regarding reunification is somewhat limited (Maluccio, Fein, & Davis, 1994). Studies on reunification have largely been non-experimental and have centered on child, family, and systemic factors associated with re-entry of children into the foster care system (Bronson, 2005). Furthermore, Maluccio et al. (1994) cited a number of methodological limitations of existing studies on reunification, including lack of comparison groups and small sample sizes as well as differences in operational definitions and measurements.

A number of studies have been conducted in the last two decades to identify child and family factors associated with decreased likelihood of reunification as well as factors that are predictive of re-entry into foster care. Children with emotional and behavioral problems, children removed for neglect, as well as very young children and adolescents are less likely to be reunified with their birth families (Taussig, Clyman, & Landsverk, 2001; Teare, 2001). Family factors associated with a lower likelihood of reunification include extreme poverty, the presence of only one parent or caregiver in the home, and the existence of parental mental illness or substance abuse issues (Bronson, 2005; Thomlison, Maluccio, & Abramczyk, 1996).

Research has found that slightly more than one-fourth (28%) of reunified children will eventually re-enter the foster care system. Approximately 40% of these children will re-enter care within 90 days of reunification with their family (Wulczyn, 2004). Factors associated with re-entry into foster care include financial strain, parental problems such as substance abuse, noncompliance with service plans, and parental hostility toward the child (Festinger, 1996; Jones, 1998). Studies have also found that factors related to service delivery, such as the availability and intensity of support services for the family and child are also associated with re-entry into care (Bronson, 2005). In recent years, several studies have documented high rates of emotional, behavioral, developmental, and educational problems and delays among children involved in the child welfare system (Halfon, Berkowitz, & Klee, 1992; Harman, Childs, & Kelleher, 2000). Thus, intensive support services for children and families are an essential component of successful reunifications (Fein & Staff, 1993).

Factors Associated with Reunification Success

Some researchers have identified characteristics of reunification interventions that are helpful when reintegrating children who have been involved with the child welfare system with their families (U.S.

Department of Health and Human Services, 2006). Frequent parental visitation has been shown to be positively associated with reunification success (Davis, Landsverk, Newton, & Ganger, 1996; Hess, 1988; Leathers, 2002). Studies have consistently demonstrated that children in foster care benefit from frequent parental visitation because it contributes positively to the child's physical, emotional, and psychological adjustment by providing the security and stability that the child needs to continue to maintain a bond with his or her family. McWey and Muillis (2004) found that children with frequent parental visitation were more likely to exhibit higher levels of attachment to their family and fewer behavioral problems than children who did not participate in frequent visitations.

One characteristic of successful reunification programs is engagement of families in the reunification process (U.S. Department of Health and Human Services, 2006). Caseworkers can promote family engagement by developing an open and honest rapport with the family and by facilitating frequent parent-child visitations (U.S. Department of Health and Human Services; Yatchmenoff, 2001). Other components of successful reunification strategies include individualized assessment of parental circumstances and "family-centered" case planning with clearly articulated goals that are agreeable to all parties involved (Macdonald, 2001; U.S. Department of Health and Human Services). Finally, broad utilization of multi-systemic support services is essential. Services should address multiple domains affecting family and child functioning, including the home, school, and the community (U.S. Department of Health and Human Services). Services that have been identified by researchers as particularly effective during the reunification process include intensive case management (Ryan, Marsh, Testa, & Louderman, 2003); concrete services, such as food, housing, and utilities (Wells & Fuller, 2000); substance abuse treatment (Smokowski & Wodarski, 1996); and home-based services, such as parenting and life skills development, and family therapy (U.S. Department of Health and Human Services).

Challenges in Meeting the Needs of Youth with Severe Mental and Behavioral Health Needs

According to the U.S. Surgeon General, approximately one in ten American children experience a mental illness that is severe enough to cause significant functional impairment (U.S. Department of Health and Human Services, 1999, 2000). However, there is evidence that the prevalence of mental health problems in youth in foster care is much higher than in the general population of children in the U.S. (Duchnowski, Hall, Kutash, & Friedman, 1998; Quinn & Epstein, 1998). Research has shown that children in the public child welfare system have higher rates of chronic medical, mental health, and developmental problems than other children from similar socioeconomic backgrounds (American Academy of Pediatrics, 1994).

Studies conducted in the last two decades have suggested that children in foster care have a rate of mental health service utilization up to 15 times higher than other children enrolled in the Medicaid system (dosReis, Zito, Safer, & Soeken, 2001; Halfon, Mendonca, & Berkowitz, 1995; Harman et al., 2000). Furthermore, there is research to suggest that, in general, African American and Hispanic children in the foster care system are less likely to receive mental health services than their Caucasian counterparts (James, Landsverk, Slymen, & Leslie, 2004).

A recent report issued by the U.S. Government Accountability Office (2009) suggests that the realities of foster care present a number of challenges to meeting the needs of youth who have severe mental and behavioral health care needs. The report noted that many youth entering foster care may have experienced disruptions in care, changes in providers, and/or have missing or incomplete medical records. Child welfare agencies often experience difficulty obtaining information from parents or guardians regarding the child's history of physical and mental health problems. In addition, youth in foster care often lack continuity of

care by physical and mental health care providers due to frequent placement changes during their stay in foster care. Changes in placement can pose significant challenges for agencies and providers with regard to providing continuity of services and maintaining current and accurate information on children's medical needs and course of treatment (U.S. Government Accountability Office, 2009).

Another challenge to meeting the needs of children with severe emotional and behavioral health needs is the lack of authorized providers available to treat children with Medicaid coverage. Medicaid providers are often in short supply or difficult to access because of low reimbursement rates and long waiting lists. Locating Medicaid providers in rural areas, as well as providers for some specialties such as psychiatry, can be particularly difficult for child welfare agencies (U.S. Government Accountability Office, 2009).

Wraparound Service Model

Several studies have shown that the utilization of post-discharge community-based services, such as wraparound services, can contribute to positive outcomes for youth transitioning from intensive out-of-home placements into the community (Frensch & Cameron, 2002; Hoagwood & Cunningham, 1992; Nickerson, Colby, Brooks, Rickert, & Salamone, 2007; Wells, Wyatt, & Hobfoll, 1991). The wraparound model is described as a planning process that uses the individual strengths of the youth and the caregivers to identify services and supports the family will need in order to successfully maintain the child in the home (Bruns, Burchard, & Yoe, 1995; VanDenBerg & Grealish, 1996). The goal of this model is to provide intensive, individualized services and supports to families that will allow youth experiencing ongoing emotional problems to live in a safe and stable family environment in their own community (Evans, Armstrong, & Kuppinger, 1996). Although elements of the wraparound model were used as early as the 1960s, the model became more popular in the 1990s as an innovative alternative to costly inpatient residential treatment services for youth with severe emotional and behavioral problems (Bruns et al., 1995).

VanDenBerg and Grealish (1996) identified eight core principles that serve as a philosophical foundation for the wraparound process: 1) wraparound services must be community-based; 2) services and supports provided must be individualized and based on the specific strengths and needs of the family and youth being served; 3) services should be provided in a culturally competent manner and in a way that addresses the values, preferences, and racial makeup of each family; 4) families should be full and active partners in the development of service plans and in all decisions concerning the youth's treatment; 5) agencies providing wraparound services must have access to flexible, non-categorical funding; 6) community agencies should collaborate and coordinate resources to provide services to youth and families; 7) services provided to youth and families must be unconditional and flexible to the needs of the family; and 8) outcomes of the wraparound process should be empirically measured.

Several studies have been conducted in recent years to gain insight about the effectiveness of the wraparound service model. Bickman, Smith, Lambert, and Andrade (2003) conducted a comparison study of a congressionally mandated wraparound demonstration project. They found that children who participated in the demonstration project received more services than those in the comparison group and experienced fewer days in residential treatment. However, no differences between groups were noted regarding the number of days youth were hospitalized. One of the more frequently cited studies involving children in foster care was conducted by Clark, Lee, Prange, and McDonald (1996). The authors conducted a randomized comparison study (n=132) of children who received traditional foster care services and children in the Fostering Individualized Assistance Program, a wraparound service program offered to children at risk of being lost in the foster care system. Findings of the study were mixed; however, the

authors noted that the wraparound model holds some promise for improving placement outcomes for children and youth with severe emotional and behavioral needs who are involved in the foster care system. (See also Walker and Bruns, 2006.)

Chapter 2: Background and Overview

Program Description

The CPS Reintegration Pilot Project was initiated in Fall 2007. The program is designed to provide home and community-based services to youth with complex emotional and behavioral needs who are involved in the CPS system in Travis County, Texas. The goal of the program is to help youth successfully reintegrate into the community from intensive out-of-home placements, such as residential treatment centers or therapeutic foster homes, and empower families to safely care for their youth. Consistent with the research on successful reunification practices, the CPS Reintegration Pilot Project uses a wraparound service model to assist youth and their caregivers in meeting this goal. Under this model, services are coordinated and managed through a Care Coordinator in partnership with the child's family and CPS. Services are individualized to the specific strengths and needs of the child and his or her family.

As part of the CPS Reintegration Pilot Project, a range of traditional and non-traditional services are offered through the provider network, which is supported and managed by Austin Travis County Mental Health and Mental Retardation Center (ATCMHMR). These services and supports are youth-centered, family-focused, and strength-based. Services available to youth and caregivers participating in the CPS Reintegration Pilot Project are described below:

Care Coordination – Service provided by a Care Coordinator who works in partnership with the family to develop a plan of care for the child based on the family's needs and strengths. In addition, the Care Coordinator facilitates monthly team meetings with the child's wraparound team and coordinates/monitors services provided to the child and his or her family. The Care Coordinator also assists the family in problem solving and provides on-going support to the child and family during the pre-reintegration planning phase, as well as once the child is reunified with the caregiver and reintegrated into the community. The Care Coordinator position is funded by Travis County HHS&VS, as well as Casey Family Programs.

Team Meetings – Scheduled face-to-face meetings held between the child, the caregiver, and members of the child's wraparound team for the purpose of coordinating services, developing service delivery strategies, and assessing the child's response to services. Wraparound team members typically include the caregiver and other significant adults involved in the child's life, as well as representatives of agencies that provide services to the family, such as mentoring, therapy, etc.

Individual Mentoring – Service provided to the child by a positive adult role model in order to provide the child with guidance and on-going support on a particular issue or challenge identified by the child and his or her family, such as peer relations, anger management, or socialization in community settings.

Family Mentoring – Service provided to the child and members of the child's family, such as a sibling, to facilitate successful family relationships and improve the child's ability to function in the home.

Parent Coaching – Service provided to the child's caregiver(s) to assist in the acquisition and development of effective parenting skills and techniques for management of the child's behavior or symptoms. In addition, parent coaches assist caregivers in accessing needed services in the community. Parent coaches are selected based on their overall compatibility with the caregiver and family.

Psychiatric Assessment/Evaluation Services – A scheduled face-to-face evaluation of the child by a licensed psychiatrist to determine mental, emotional, or behavioral capabilities from a medical perspective and to prescribe and monitor psychotropic medications.

Outpatient Counseling – The assessment, evaluation, and treatment of a child or family member through a combination of mental health, psychotherapeutic, and human development principles, methods, and techniques. Counseling may focus on a wide range of issues including lack of trust, anger, depression, anxiety, fear, family interactions, trauma, and attachment.

After School Care – A structured program that provides care for youth whose after-school care needs cannot be met in a generic community after-school program due to their behavioral or emotional needs. Youth participate in activities that promote the development of appropriate socialization, recreation, communication, problem solving, and life skills in a safe and supervised environment.

Tutoring – Educational training, support, and remedial assistance provided to youth during non-school hours by an individual with knowledge or expertise in the academic subject area.

Respite Care – Service that provides for the planned or emergency short-term, non-routine relief of the child’s caregiver. Respite services provide supervision of the child to ensure his or her health, safety, security, nutritional, social, and recreational needs are being met while the caregiver is absent.

Crisis Intervention and Support – Non-clinical activities, interventions, and supports provided to the child and family during a crisis situation. Crisis intervention and support includes the coordination of emergency services, preventative measures, and problem solving before, during, or after the crisis event.

Assistance with Basic Needs – Financial assistance provided to youth and their families in order to help them secure items and services that are needed to sustain the family in the course of everyday life, such as clothing, food, housing, utilities, assistance with transportation, etc.

Parent Engagement and Self-Advocacy (PESA) Training Classes – A six-week strengths-based parent education program designed to improve caregivers’ advocacy skills. The PESA curriculum was developed by the REACH Institute, Casey Family Programs, and the Annie E. Casey Foundation.

The CPS Reintegration Pilot Project relies on CPS caseworkers to identify youth who are in need of the program’s services, as the youth’s CPS caseworkers are most familiar with their needs and whether reintegration is an appropriate permanency plan. The initial referral process is brief and requires information that caseworkers can readily provide. Once it is determined by program staff that the child and the identified caregiver meet the minimum eligibility criteria for the program, caseworkers are asked to provide additional information and documentation that will allow program staff to determine the child and identified caregiver’s overall readiness for reintegration and willingness to participate in services offered through the program.

Eligibility criteria for the program were developed specifically to target youth with severe mental health needs who CPS believes can safely reintegrate into the community. In addition, the criteria were designed to “screen out” youth and caregivers who might otherwise be eligible for and potentially benefit from less intensive community programs and supports. Youth and their identified caregivers who met all of the following criteria were eligible for participation in the CPS Reintegration Pilot Project:

- Child’s case must originate from Travis County.
- Caregiver must reside in Travis County.

- Child must have an Axis I mental health diagnosis (DSM-IV) (e.g., bipolar disorder, major depressive disorder, anxiety disorder, ADHD, etc.).
- Child must be between the ages of 7-17.
- Child is not considered an immediate danger to self or others.
- Child has willingness/desire to reintegrate into his or her parent/caregiver's home.
- Caregiver wants to reintegrate the child into the home.
- Child and caregiver are willing to participate in services provided.
- Caregiver is reasonably physically and mentally healthy.
- Reintegration is projected to occur in less than six months but no sooner than two months.

Program Implementation and Recruitment

As previously mentioned, the program experienced a number of unanticipated delays during the initial months following implementation. The original timeline for the program projected that the first three to four youth would be referred, screened, and approved during the first month of the program. This timeline would have allowed the Care Coordinator a minimum of two to three months to prepare the youth and caregivers for reintegration. However, during the initial months of the program, program staff received a number of referrals from CPS who did not meet the minimum eligibility criteria for the program. Of the 19 youth referred during the first six months of the program, 13 did not meet eligibility criteria for the program and were subsequently declined by program staff. In addition to referrals of youth who were inappropriate for the program, the referral and screening process for youth and caregivers took longer than program staff expected due to paperwork delays and problems communicating/coordinating with CPS caseworkers and caregivers. Despite the program's slow start, referrals increased as awareness of and support for the program grew among CPS caseworkers. Between October 2007 and January 2009, the CPS Reintegration Pilot Project received referrals for 51 youth. A total of 20 of those referrals met the criteria and were accepted to receive services through the program.

Chapter 3: Study Methods

Overview of Evaluation

A multiple case study approach that incorporated different qualitative methods and multiple perspectives from participants was used in this evaluation. Case study research allows for the holistic inquiry of a “bounded system” (e.g., activity, event, process, or individuals) over time, through in-depth data collection from information sources rich in content as well as context (Creswell, 1998). In addition, case study research is particularly suited for describing and evaluating an intervention in a real-life context and making complex causal links between aspects of an intervention and outcomes (Yin, 2008). In this study, we examined the success of each case in terms of reintegration and the factors that led or failed to lead to a successful outcome. By relying on multiple perspectives and using multiple qualitative approaches for collecting data, we enhanced the case study design and developed an in-depth, comprehensive approach to understanding each case.

Data collection methods included in-depth structured case file reviews and semi-structured interviews with youth, caregivers, CPS caseworkers, and CPS Reintegration Pilot Project staff. The study was designed to include two distinct components:

Component I – The first component of this study describes the characteristics, circumstances, and experiences of youth and caregivers who received services through the CPS Reintegration Pilot Project. Specifically, this component sought insight regarding the experiences of the youth and their feelings about transitioning from foster care to their caregivers’ homes and reintegrating into the community. This component also explored the caregivers’ experiences with the reunification process as well as their experience receiving supportive services and training through the CPS Reintegration Pilot Project. All youth and caregivers accepted by the CPS Reintegration Pilot Project during the study time period were eligible to participate in this component of the study.

Component II – The second component of this study identifies barriers to the reunification of youth in foster care with their caregivers, from the perspective of referring CPS caseworkers and CPS Reintegration Pilot Project staff. The CPS caseworkers and program staff who participated in the study were interviewed about their perceptions of systemic, program, and case-level factors that impeded the process of reunification or prevented reunification of youth with their caregivers from occurring. Program staff affiliated with the CPS Reintegration Pilot Project as well as all CPS caseworkers who referred youth to the project were eligible for participation in this component of the study.

Although the evaluation was contracted by Casey Family Programs to begin in August 2007, formal evaluation efforts did not commence until late December 2007 when the program staff facilitated their first reintegration. The initial months of the evaluation were used to design the study and to establish protocols that would be used with youth and caregivers who elected to participate. The University of Texas at Austin Institutional Review Board (IRB) approved the evaluation design and data collection instruments in early November 2007.

Recruitment of Participants

Recruitment of youth and caregivers for the evaluation began in mid-November 2007. We recruited from all families enrolled in the CPS Reintegration Pilot Project during the evaluation time period and all CPS caseworkers involved in the referral process, as well as CPS Reintegration Pilot Project staff. Recruitment of CPS caseworkers and CPS Reintegration Pilot Project staff began in early February 2008. A total of 24

CPS caseworkers who referred youth to the program were contacted to participate in the study, and they were contacted an average of three times each by phone. Messages were left on the caseworker's voicemail when he or she could not be reached directly. Nine CPS caseworkers responded affirmatively to requests to participate in the study.

The process of obtaining consent from families was more complex. For youth, the process involved gaining the consent of both the CPS caseworker (legal guardian) and the caregiver for the child to participate in the study. We contacted referring CPS caseworkers directly to obtain their consent to participate in the study. This meeting typically provided an opportunity to request consent for the youth to participate. At the first arranged meeting with the child, his or her consent was obtained.

For the caregivers, a collaborative approach was used to introduce the study and obtain caregiver consent and consent for the youth to participate. In order to protect the privacy of youth and caregivers participating in the program, the Care Coordinator for the program was asked to distribute a flyer to caregivers that described the study. Caregivers who expressed an interest in participating in the study were asked by the Care Coordinator to sign a release of information authorizing her to provide the caregiver's contact information to evaluation staff. We then contacted the caregiver and scheduled a face-to-face meeting to discuss the study and obtain written consent from him or her. We also used this meeting to discuss the child's participation in the study and obtain the written consent of the caregiver for the child. Once consent for the child to participate was obtained from his or her CPS caseworker and caregiver, we then met with the child to discuss the study and to obtain his or her written assent. All of the caregivers and youth who were contacted agreed to participate in the study.

Demographics

Demographics of All Referred Youth

Descriptive statistics regarding the 51 youth referred to the CPS Reintegration Pilot Project between October 2007 and January 2009 are presented in Table 1. More than half of the youth referred to the program were male (61%). Almost three-fourths (73%) of the referred youth were ethnic minorities (Hispanic 33%, African American 26%, biracial 12%, Asian 2%). The majority of youth referred (61%) were between the age of 13-17 years at the time of referral. The average age of youth referred to the program at the time of this report was 13.8 years old. Although several of the youth had entered the foster care system more than once, the two most common reasons for the youth's most recent entry into care included neglect (45%) and "refusal to accept parental responsibility" (41%).¹ Youth referred to the program had been in foster care an average of 2.7 years (range of 7 months to 11.5 years).²

Of the 51 youth referred to the program, 20 had "active" cases at the conclusion of the evaluation, meaning that they were either on the program's waiting list, in various phases of the referral and screening process, planning for reintegration, or had already achieved reintegration. A full description of each phase of the reintegration process is provided in Figure 1.

Between October 2007 and January 2009, 30 of the 51 youth referred were formally declined by the program. See Table 2 for a detailed description of the reasons youth were declined by the program staff. Of the 30 youth who were not chosen to participate in the program, the majority (43%) were declined because either the child

¹ The term "refusal to accept parental responsibility" is defined as the failure of a caregiver to permit the child to return to the child's home without arranging for the necessary care for the child after the child has been absent from the home for any reason, including having been in juvenile detention, residential placement or having run away.

² This represents the mean length of time child have been in care during his or her most recent stay in care and does not account for any prior removals.

or the identified caregiver did not meet the minimum eligibility criteria for the program. Twenty percent of the youth were declined by the program staff because either the court or CPS sent the child home earlier than the reintegration date projected by CPS when the initial referral was made. Program guidelines require that staff be given a minimum of two to three months to prepare youth and caregivers for reintegration. Therefore, youth who either reintegrated or were projected to reintegrate in less than two months were declined and referred by program staff to other community services and supports. Twenty percent of the 30 youth were declined for this reason. A small percentage of youth were declined because their identified caregivers expressed unwillingness to care for the youth and/or were unwilling to participate in reintegration services through the program.

Table 1. Demographics for Referred Youth

	All Youth (n=51)	Active (n=20)	Declined (n=30)	Discharged (n=1)
Gender				
Male	31 (61%)	13 (65%)	17 (57%)	1 (100%)
Female	20 (39%)	7 (35%)	13 (43%)	0 (0%)
Age (range)				
0-6 years	4 (8%)	1 (5%)	3 (10%)	0 (0%)
7-12 years	15 (29.4%)	6 (30%)	8 (27%)	1 (100%)
13-17 years	31 (61%)	13 (65%)	18 (60%)	0 (0%)
Unknown	1 (2%)	0 (0%)	1 (3%)	0 (0%)
Race/Ethnicity				
African American	13 (26%)	6 (30%)	7 (23%)	0 (0%)
Caucasian	14 (27%)	4 (20%)	10 (33%)	0 (0%)
Hispanic	17 (33%)	7 (35%)	10 (33%)	0 (0%)
Biracial ³	6 (12%)	3 (15%)	2 (7%)	1 (100%)
Asian	1 (2%)	0 (0%)	1 (3%)	0 (0%)
Reason for Removal				
Neglect	23 (45%)	7 (35%)	15 (50%)	1 (100%)
Physical abuse	5 (10%)	2 (10%)	3 (10%)	0 (0%)
Refusal to accept parental responsibility	21 (41%)	10 (50%)	11 (37%)	0 (0%)
Sexual abuse	1 (2%)	1 (5%)	0 (0%)	0 (0%)
Lack of mental health resources	1 (2%)	0 (0%)	1 (3%)	0 (0%)

Note: Percentages may not equal 100% due to rounding.

³ The six youth who identified their ethnicity as biracial included three youth who were African American/Caucasian and three youth who were African American/Hispanic.

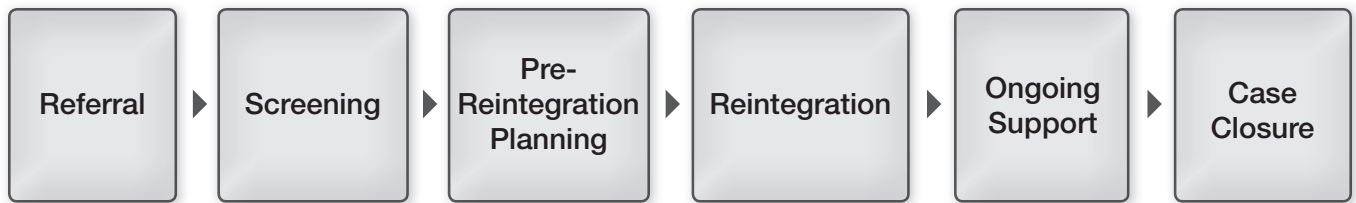
Table 2. Reasons Youth Were Declined

Reason	Declined Youth (n=30)
Child or caregiver ineligible for the program (e.g., no mental health diagnosis or behavioral health needs, not a resident of Travis County, etc.)	13 (43%)
Child sent home early by CPS or court	6 (20%)
Reintegration timeline greater than six months or less than three months	6 (20%)
Caregiver unwilling to accept child and/or unwilling to participate in the program	4 (13%)
No significant need for program support	1 (3%)

Note: Percentages may not equal 100% due to rounding.

To date, only one child has been discharged from the program. The child was discharged from the program following a disrupted placement (post-reintegration) and subsequent re-entry into the foster care system.

Figure 1. Phases of the Reintegration Process



Referral Phase – During the referral phase of the process, the CPS caseworkers are asked to complete a one-page pre-screening tool prior to making a formal referral. Youth who do not meet the minimum criteria do not enter the program. CPS caseworkers for youth who meet the minimum criteria for the project are then asked to complete a more in-depth formal referral form. CPS caseworkers are given 45 days to complete this form and return it to the Care Coordinator.

Screening Phase – During the screening phase of the process, the Care Coordinator meets with the identified caregiver for the referred child to discuss the CPS Reintegration Pilot Project and to determine the caregiver’s overall interest in participating in the program. In addition, the Care Coordinator obtains additional documentation and information needed to assess the child and caregiver’s appropriateness for the program. A child might be declined at this stage of the process if the program staff determine that he or she is not in need of services through the program in order to maintain the reintegration or if the caregiver declines to participate in services through the program.

Pre-Reintegration Planning Phase – During the pre-reintegration planning phase of the process, the Care Coordinator begins the process of working with the caregiver to identify and coordinate services that the child and family will need to prepare for and sustain the reintegration once he or she is placed with the caregiver. In addition, the Care Coordinator obtains additional documentation, such as educational records for the child or an FBI background check, if the caregiver has resided outside Texas within the last three years. The Care Coordinator also arranges to meet the child at his or her current placement and assists CPS in facilitating pre-reintegration visits between him or her and the caregiver. While the length of the pre-reintegration planning phase varies for each child, ideally the Care Coordinator will have a minimum of two full months following the child’s acceptance into the program to develop a plan with the family and ensure that services are in place prior to the child’s return to the caregiver.

Reintegration and Ongoing Support Phases – The reintegration phase of the process begins when the child is placed in the caregiver’s home. During this phase of the process, the Care Coordinator facilitates meetings with the child, caregiver, and wraparound team at least once a month. The frequency of wraparound team meetings varies for each child, depending on the child or caregiver’s level of need and the complexity of services involved. Following reintegration, families are provided with ongoing case management services. The Care Coordinator is actively involved with the caregiver and child and continues to assist the family in identifying needs. The Care Coordinator arranges services to address the needs identified by the caregiver and assists the family and wraparound team in assessing progress.

Case-Closure Phase – Case closure typically occurs under two circumstances: 1) when the caregiver and wraparound team determine that they are able to maintain the reintegration of the child in the home without further assistance from the Care Coordinator and the wraparound team; or 2) in the event that the caregiver determines that he or she is no longer able or willing to care for the child and he or she requests that CPS intervene and locate a new placement for the child.

Demographics of Caregivers

Selected descriptive statistics regarding the identified caregivers of youth referred to the CPS Reintegration Pilot Project are available in Table 3. The majority of the identified caregivers for referred youth were female (73%). As with youth referred to the study, the majority of caregivers (61%) were an ethnic minority (Hispanic 29%, African American 28%, biracial 2%, and Asian 2%). Over two-thirds of the caregivers identified themselves as either a birth parent (57%) or adoptive parent (14%) of the youth, with the remaining caregivers identifying themselves as the child’s paternal or maternal grandparent(s) (8%), paternal or maternal aunt and/or uncle (6%), “other relative” (4%), or fictive kin (8%).

Table 3. Demographics of Referred Youth’s Caregivers

	All Caregivers (n=51)	Active (n=20)	Declined (n=30)	Discharged (n=1)
Gender				
Male	2 (4%)	1 (5%)	2 (7%)	0 (0%)
Female	37 (73%)	16 (80%)	20 (67%)	1 (100%)
Male/Female (couple)	8 (16%)	3 (15%)	5 (17%)	0 (0%)
Unknown	3 (6%)	0 (0%)	3 (10%)	0 (0%)
Race/Ethnicity⁴				
African American	14 (28%)	8 (40%)	5 (17%)	1 (100%)
Caucasian	16 (31%)	4 (20%)	12 (40%)	0 (0%)
Hispanic	15 (29%)	7 (35%)	8 (27%)	0 (0%)
Biracial ⁵	1 (2%)	1 (5%)	0 (0%)	0 (0%)
Asian	1 (2%)	0 (0%)	1 (3%)	0 (0%)
Unknown	4 (8%)	0 (0%)	4 (13%)	0 (0%)
Caregiver’s Relationship to Child				
Adoptive parent	7 (14%)	3 (15%)	4 (13%)	0 (0%)
Birth parent	29 (57%)	9 (45%)	20 (67%)	0 (0%)
Maternal/Paternal grandparent	4 (8%)	4 (20%)	0 (0%)	0 (0%)
Maternal/Paternal aunt or uncle	3 (6%)	2 (10%)	1 (3%)	0 (0%)
Other relative	2 (4%)	1 (5%)	1 (3%)	0 (0%)
Fictive kin	4 (8%)	1 (5%)	2 (7%)	1 (100%)
Unknown	2 (4%)	0 (0%)	2 (7%)	0 (0%)

Note: Percentages may not equal 100% due to rounding.

⁴ Race/ethnicities of caregivers were identified by the Texas CPS database, IMPACT.

⁵ The caregiver identified herself as African American/Caucasian.

Demographics of Program Staff and CPS Caseworkers

Program staff and CPS caseworkers who referred youth to the program were eligible for participation in the study. From October 2007 to January 2009, 24 caseworkers referred a total of 51 youth to the program; 14 of the 24 CPS caseworkers referred more than one youth to the program. In addition to the 24 CPS caseworkers who made referrals, two CPS Reintegration Pilot Project staff were also invited to participate in the study. Selected descriptive statistics regarding program staff and referring CPS caseworkers (n=26) are presented in Table 4.

Over three-fourths (77%) of program staff and referring CPS caseworkers were female. The majority of program staff and CPS caseworkers were Caucasian (69%) with the remaining caseworkers and staff (19%) identifying themselves as African American, Asian, or Native American. Given the proportion of Hispanic youth referred to the program (33%), it is interesting to note that none of the program staff or CPS caseworkers were Hispanic. The average age of program staff and CPS caseworkers was 29.5 years. In addition, CPS caseworkers who made referrals to the program had been employed with CPS an average of 3.1 years. However, the majority of CPS caseworkers who referred youth had been with the agency for less than two years (62%) at the conclusion of the evaluation period.

Table 4. Demographics of Program Staff and CPS Caseworkers

Program Staff & CPS Caseworkers (n=26)	
Gender	
Male	4 (15%)
Female	20 (77%)
Unknown	2 (8%)
Age (average)	29.5 years
Race/Ethnicity⁶	
African American	2 (8%)
Caucasian	18 (69%)
Hispanic	0 (0%)
Asian	2 (8%)
Native American	1 (4%)
Unknown	3 (12%)
Tenure at CPS (average)	3.1 years

Note: Percentages may not equal 100% due to rounding.

Note: Only applies to the 24 CPS caseworkers.

⁶ Race/ethnicities of CPS caseworkers were identified by the Texas CPS database, IMPACT, and self-identified by program staff.

Study Sample

Study Sample - Component I

Although the goal of the program was to reintegrate 12 youth within the first year of the program, only 7 youth reintegrated during this time. This limited the number of participants in the study, as the evaluation was designed to include youth and their caregivers only after reintegration occurred. Due to funding and timeline constraints, recruitment for the study ended in late July 2008 in order to allow for enough time to conduct a final interview with each child and caregiver before the completion of the study in January 2009. Therefore, the final sample of youth and caregivers in this evaluation includes six youth (n=6) and their caregivers (n=6).

All six youth and six caregivers varied in their level of participation in the study. Four of the youth and their caregivers participated in each of the two interviews; however, two of the youth and caregivers were unable to fully participate in the study due to extenuating circumstances the two families experienced while the study was in progress. Of these two families, one caregiver and child discontinued with the study following the child's disruption from the home and the other caregiver and child discontinued following the death of a close family member. Because the study contains different methods of data collection and different types of participants, we chose to include these two youth and their caregivers in the final sample and have noted in each of the youth's case studies the components in which the youth and caregivers were able to fully participate.

Table 5 presents the demographics of the youth in the final study sample. Four of the youth were male and two were female. Half of the youth were between the ages of 7 and 12, and the other half were between the ages of 13 and 17. The majority (83%) of the youth participants were ethnic minority. Half of the youth were originally removed from their homes because of neglect, while the remaining three were removed due to refusal of the caregivers to accept parental responsibility for their care. The demographics of youth in this study are consistent with those of the other 45 youth who were referred to the study (See Table 1).

Table 5. Demographics of Youth in Study Sample

Youth (n=6)	
Gender	
Male	4 (67%)
Female	2 (33%)
Age	
7-12 years	3 (50%)
13-17 years	3 (50%)
Race/Ethnicity⁷	
African American	1 (17%)
Caucasian	1 (17%)
Hispanic	2 (33%)
Biracial (African American/Hispanic)	2 (33%)
Reason for Removal	
Neglect	3 (50%)
Refusal to accept parental responsibility	3 (50%)

⁷ Race/ethnicities of CPS caseworkers were identified by the Texas CPS database, IMPACT, and self-identified by program staff.

Table 6 presents selected characteristics of the caregivers in the final study sample. All of the caregivers for the youth were female. Five of the caregivers were in their 40s or older (range 33-67 years). Five of the caregivers in the final sample were African American or Hispanic and one was Caucasian. Birth parents and grandparents comprised most of the caregivers in the study; however, one caregiver was the adoptive parent of one of the youth while another was the child's fictive kin.

Table 6. Demographics of Caregivers in Study Sample

Caregivers (n=6)	
Gender	
Male	0 (0%)
Female	6 (100%)
Age	
Average	50.1 years
Range	33-67 years
Race/Ethnicity⁸	
African American	3 (50%)
Caucasian	1 (17%)
Hispanic	2 (33%)
Caregiver's Relationship to Youth	
Adoptive parent	1 (17%)
Birth parent	2 (33%)
Maternal/Paternal grandparent	2 (33%)
Fictive kin	1 (17%)

⁸ Race/ethnicities of CPS caseworkers were identified by the Texas CPS database, IMPACT, and self-identified by program staff.

Study Sample - Component II

Of the 24 CPS caseworkers whom we attempted to contact regarding the study, 9 consented to participate in the study. In addition, 2 CPS Reintegration Pilot Project staff agreed to participate in the study. Selected demographic characteristics of the 11 program staff and CPS caseworkers who participated are presented in Table 7. The majority of program staff and CPS caseworkers were Caucasian females. The average age of program staff and CPS caseworkers was 28.3 years. CPS caseworkers interviewed for the study had been with the agency an average of 2.5 years at the conclusion of the evaluation period.

Table 7. Demographics of Program Staff and CPS Caseworkers in Study Sample

Program Staff & CPS Caseworkers (n=11)	
Gender	
Male	2 (18%)
Female	9 (82%)
Age	
Average	28.3 years
Race/Ethnicity	
African American	1 (9%)
Caucasian	8 (73%)
Asian	1 (9%)
Native American	1 (9%)
Tenure at CPS* (average)	2.5 years

* Only applies to the tenure of the 9 CPS caseworkers.

Data Sources

Data sources for the two components of the study included semi-structured qualitative interviews with youth, caregivers, referring CPS caseworkers, and CPS Reintegration Pilot Project staff, and in-depth structured reviews of the youth's CPS case files.

Qualitative Interviews

A total of 30 interviews were conducted with study participants between February 2008 and January 2009. Face-to-face interviews were conducted with five of the six caregivers and four of the six youth who participated in the study. Two of the youth were unable to participate in interviews due to extenuating circumstances that their families experienced while the study was in progress. In addition, nine face-to-face interviews were conducted with CPS caseworkers who referred youth to the program and four interviews were conducted with program staff. Table 8 provides an overview of the interviews that were conducted with study participants during the evaluation period.

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 participating youth's ages 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 the youth's caregivers included open-ended questions regarding the caregivers' experiences with the reunification process as well as their experience in receiving supportive services and training through the CPS Reintegration Pilot Project. Interviews with youth and caregivers were conducted at 3 and 6 months post-reintegration. This timeframe 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 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 that they encountered or observed during the referral and reunification process. Interviews with program staff included questions regarding challenges and delays encountered during the implementation of the program and barriers to the reintegration of youth with their caregivers. All interviews were audio taped and transcribed for the purposes of analysis.

Table 8. Interviews with Study Participants

	1st Interview	2nd Interview	3rd Interview	Total
Youth	4	4	0	8
Caregivers	5	4	0	9
CPS caseworkers	9	0	0	9
Program staff	2	1	1	4
Total	20	9	1	30

Youth

Interviews with youth began in May 2008 and concluded in January 2009. Youth who assented to be in the study were invited to participate in two brief semi-structured face-to-face interviews that were conducted 3 months post-reunification and again at 6 months post-reunification. All interviews were conducted by a research assistant who was a Licensed Master Social Worker (LMSW) and who had had extensive training and experience working with children in foster care and their families. Interviews with youth were conducted separately from the caregivers in order to help ensure confidentiality. In addition, structured case file reviews for youth who participated in the study were completed following each child's reunification. Table 9 provides a timeline of data collection efforts for youth who participated in the study.

Table 9. Timeline for Data Collection for Youth

Data Source	1st Interview	2nd Interview	Structured Case File Review
Time	3 Months Post-Reunification	6 Months Post-Reunification	Post-Reunification

Caregivers

Interviews with caregivers began in January 2008 and concluded in January 2009. Caregivers were asked to participate in two face-to-face interviews. As with the youth, interviews with caregivers were conducted 3 months post-reunification and again 6 months post-reunification. Interviews with caregivers were conducted separately from the youth. To minimize the inconvenience to the caregivers, the interviews were completed at the caregiver's residence. See Table 10 for a timeline of data collection efforts for caregivers who participated in the study.

Table 10. Timeline for Data Collection for Caregivers

Data Source	1st Interview	2nd Interview
Time	3 Months Post-Reunification	6 Months Post-Reunification

Program Staff and CPS Caseworkers

Two CPS Reintegration Pilot Project staff members and nine CPS caseworkers who referred youth to the program consented to participation in brief semi-structured interviews. Interviews with the caseworkers and program staff began in January 2008 and concluded in October 2008. As mentioned, interviews with CPS caseworkers focused on factors that contributed to their decisions to refer the youth to the CPS Reintegration Pilot Project, as well as systemic, program, and case-level barriers that they encountered or observed during the referral and reunification process. Interviews with CPS Reintegration Pilot Project staff focused on problems and delays encountered during the implementation of the program and barriers to the reunification of youth with their caregivers.

Structured Case File Reviews

CPS case files for each of the six participating youth were reviewed. Using documents in the case record and agency databases, a case history was reconstructed for each child. The reviews were recorded on a structured case-reading guide developed for this study (approximately 15 pages) and included narrative information related to the child's removal history, birth parents and siblings, current and former caregivers, as well as important events that occurred while the child was in foster care.

Data Analysis

Thematic Analysis of Qualitative Interviews

Interviews with participants in the study produced a large amount of data of great richness and depth. To facilitate description and thematic analysis of the data, a systematic qualitative method of coding similar to the method described in Sommer and Sommer (2002) was used. Using this method, open coding was completed on each interview in order to get an overall sense of the data without relying on a priori concepts or expectations. Transcripts were read in full, and potential themes and ideas were noted in the margins for each interview question. Themes and responses to each question that were common across interviews were organized into a codebook in which every interview question was listed, followed by a numeric list of common responses to each question. Code numbers served as a nominal level of measurement in that they represented different ideas or themes identified in the interviews rather than quantitative information. Transcripts were independently coded by two coders using the codebook and numeric codes. Differences between coders were then reconciled to increase the reliability of the analysis.

Chapter 4: Findings

Component I Findings: Perspectives of Youth and Caregivers

As previously mentioned, the purpose of Component I of the evaluation was to gain a comprehensive understanding of the experiences of the youth and caregivers with reintegration. With this goal in mind, we developed six detailed case studies of youth and their families who accessed community-based reintegration services through the CPS Reintegration Pilot Project. Data sources for these case studies included the following: interviews with the youth, the caregivers, CPS Reintegration Pilot Project staff, and the youth's CPS caseworkers. Additional information was extracted from a structured case review of each child's CPS case file. Because the families had varying degrees of participation in the study, we have noted what sources were used in the analysis of each case. Some demographic details and all names have been changed to protect the identity of the youth and their families. Finally, it is important to note that this material is based on a very small pilot sample, and, for this reason, we have not conducted any statistical analyses. However, based upon the in-depth case studies, practice issues were identified and are presented below; observations are presented that were developed based upon the in-depth case studies.

Case History: Marcus

Marcus is an 11-year old male of African-American and Hispanic heritage who is in the 5th grade. He has been in foster care for nearly half of his life. After as many as nine CPS investigations, Marcus and his five siblings were removed from their mother when she was 34 years old. She was a known drug user and suspected prostitute. The reason for removal was neglectful supervision and refusal to accept parental responsibilities. There is little information about Marcus's father in the case record, other than that he was not living with the family at the time of removal and has not had contact with Marcus in several years.

Marcus has been diagnosed with Bipolar Disorder and Attention Deficit Hyperactivity Disorder (ADHD). While in the foster care system, Marcus was prescribed medication for mood swings, aggression, and depression. Marcus scores in the borderline range of intelligence and performs below grade level in all areas of achievement. His CPS case record noted that Marcus sometimes experiences feelings of inadequacy about his inability to keep up with his classmates. This, combined with the difficulty he has maintaining concentration, has made school a frustrating environment for Marcus. School is the place where he has most often acted out. Although Marcus generally gets along well with his peers and possesses good social and leadership skills, he has attacked teachers and other school personnel on several occasions. Marcus also has a history of self-mutilation and has exhibited suicidal ideation. On at least two occasions, he has attempted to run away from placements.

Despite his young age, Marcus's placement history is long and varied. During a five-year period, Marcus experienced 20 placements and attended 11 different elementary schools. When first removed, Marcus was placed in an emergency shelter for approximately two months before being moved into a therapeutic foster home. This placement lasted only two months. Marcus was then placed in another therapeutic foster home. Although reportedly a fun-loving, personable, and good-

natured child who displayed no serious behavioral problems prior to removal, while in care, Marcus began exhibiting signs of depression and behavioral disturbances. After approximately nine months in the therapeutic foster home, Marcus experienced the first of five psychiatric hospitalizations. He was then moved to two different residential treatment settings in a little over a year. Upon discharge from the second residential treatment center (RTC), Marcus was placed with his fictive kin, Margaret Johnson, 32. Ms. Johnson was the adoptive mother of Marcus's two older siblings. This arrangement disrupted within two months after Ms. Johnson determined that she could no longer manage his behavior.

After his placement with Ms. Johnson disrupted, Marcus spent additional time in RTCs and psychiatric hospitals in different cities throughout Texas. During this two-year period, Marcus was physically separated from his siblings; however, he maintained some contact with them by phone. As Marcus had a history of having a close relationship with his older siblings, the lack of contact was very difficult. Despite the separation, Marcus maintained a relationship with his former caregiver, Ms. Johnson, and her mother, Patricia Thompson, 57. Although Marcus was not biologically related to Ms. Thompson, he viewed her as family because she was the paternal grandmother to Marcus's three younger half-siblings. Marcus was the only one of the six siblings not placed with family (his two older siblings remained in their adoptive home with Ms. Thompson's adult daughter, Ms. Johnson). Records indicate that Marcus missed being with his brothers and sisters and had a strong desire to regain a normal family environment.

Ms. Thompson also felt strongly that 11-year-old Marcus should be with his siblings and out of foster care. She contacted CPS and indicated that she was willing to care for him. Her advocacy, coupled with the improvements in Marcus's behavior while in his last RTC (including managing without medication for 11 months), led CPS to recommend him for placement in the Thompson home, provided the family had the support of the CPS Reintegration Pilot Project. The process of reunifying Marcus with Ms. Thompson was expedited despite the fact that she had a tense working relationship with CPS, and her visits with Marcus had been somewhat sporadic over the years. An additional concern was her history of intolerance for Marcus's poor behavior. Records suggested that while Marcus was placed in an RTC, Ms. Thompson threatened to stop having contact with him because of his behavior.

Although the program guidelines call for two to three months to plan for reintegration, staff made an exception to this policy so that Marcus could reintegrate to Ms. Thompson's home during the Christmas holidays. Both Marcus and Ms. Thompson were excited about the prospect of being together. Marcus's CPS caseworker and the Care Coordinator for the program worked together to quickly put services in place, given the truncated timeline. Ultimately, no formal assessments of individual readiness for reintegration were completed, nor did Marcus and Ms. Thompson participate in any form of family therapy together to help them prepare for the transition. However, records in the CPS case file indicate that Marcus discussed the reintegration in his individual therapy sessions at the RTC. In addition, Marcus was able to have one weekend visit at Ms. Thompson's home prior to the reintegration. Because Ms. Thompson was unavailable to meet with program staff until several weeks after the initial referral was made, only four planning meetings were held between the Care Coordinator and Ms. Thompson prior to the reintegration. Program

staff expressed concerns about whether her expectations of Marcus were realistic; however, despite their concerns, Marcus was reintegrated with Ms. Thompson and his younger half-siblings.

At first, Marcus did well in the placement. Despite his history of being on prescribed medication, Marcus did not require medication at the time of the reintegration. After a few weeks, he experienced some difficulty controlling his behavior at school, but Ms. Thompson insisted his behavior at home was not a problem. Despite the school’s efforts to address Marcus’s behavioral problems, his behavior continued to escalate and became a significant source of stress for the family. In response, Marcus’s wraparound team attempted to step up their level of contact with the family, but Marcus’s behavior at school did not change. Four months after Marcus was placed with Ms. Thompson, she requested that CPS remove him from her home. The request was precipitated by an incident that occurred at Marcus’s school in which he attacked a school employee. Marcus was subsequently moved to an emergency shelter and then placed in a therapeutic foster home. CPS Reintegration Pilot Project staff closed Marcus’s case shortly after his placement with Ms. Thompson disrupted and he re-entered foster care.

CPS Reintegration Pilot Project: Services Received

In the four months that Marcus was placed with Ms. Thompson, the family accessed the following services: individual youth mentoring, individual therapy for Marcus, after-school care, and financial assistance. In addition, the Care Coordinator for the program provided ongoing case management and service coordination for Marcus’s wraparound team. Ms. Thompson also used non-emergency weekend respite care services in the weeks preceding the disruption of the placement. While the family used several services, the majority were specifically designed to support Marcus rather than the caregiver. Table 11 provides a complete list of services the family accessed through the CPS Reintegration Pilot Project pre- and post-reintegration.

Table 11. Services Received—Marcus

Services	Date Initiated	Date Ended
Case management & service coordination	November 2007	May 2008
Financial assistance	December 2007	May 2008
Youth mentoring	January 2008	May 2008
After-school care	January 2008	May 2008
Individual therapy—youth	January 2008	May 2008
Non-emergency respite	March 2008	May 2008

Sources of Data

As Marcus’s placement disrupted within a few months of his reintegration, we did not have an opportunity to interview him or to conduct a second interview with his fictive grandmother, Ms. Thompson. Therefore, the themes noted in Marcus’s case were extracted from the one interview with Ms. Thompson, an interview with the CPS caseworker assigned to Marcus’s case, interviews

with CPS Reintegration Pilot Project staff, and information extracted from a structured case review of the child’s CPS file.

Table 12. Sources of Data for Case Study—Marcus

Source of Data
1 Interview with the caregiver
1 interview with CPS caseworker
2 interviews with CPS Reintegration Pilot Project staff
Structured case review of the child’s CPS file

Case Themes: Marcus

Caregiver and Youth Attachment

Throughout the reintegration process, the CPS caseworker and CPS Reintegration Pilot Project staff expressed concerns regarding Ms. Thompson’s overall level of attachment to Marcus. Statements made by Ms. Thompson suggested that she cared for him and wanted him placed in her home; however, it appeared that she was more attached to the idea of Marcus being placed in her home rather than Marcus as an individual. During the interview, Ms. Thompson indicated that she wanted Marcus out of the foster care system so that he could have a relationship with his two older siblings and his three younger half-siblings. Although Marcus’s siblings were in two different homes, it was important to Ms. Thompson that the children were all out of foster care and able to maintain contact with each other: “I just want the kids to stay in his life...I don’t want to have him have to be on some talk show saying I haven’t seen my brothers and sisters in these many years.’ I don’t want that.”

Feelings about the Reintegration

Ms. Thompson advocated for over a year to have Marcus placed in her care. Therefore, she was happy when she was told by the CPS caseworker that Marcus would be placed in her home. Despite the fact that Ms. Thompson wanted the reintegration to occur, she resented CPS’s ongoing involvement in the case. She had a particularly strained relationship with Marcus’s CPS caseworker and felt that the caseworker was unresponsive to her as a person or her efforts to advocate for Marcus’s best interest. However, the caseworker’s assessment of the relationship was very different. The caseworker reported that the relationship was not strained, and Ms. Thompson was friendly and welcoming during visits to the home. Furthermore, the caseworker indicated that CPS was very involved with Marcus’s case, stating: “I don’t feel like we could’ve possibly been more supportive or offered more services to this family. Ms. Thompson never demonstrated that she was willing to put her full effort into the reintegration. It was more about her stress than the welfare of Marcus.”

The CPS caseworker reported that Marcus was excited about the prospect of living with Ms. Thompson, as the placement would enable him to live with his younger half-siblings and have

frequent contact with his two older siblings who resided with Ms. Thompson's adult daughter, Ms. Johnson, in the Travis County area. In addition, Marcus was relieved to be moving to a less restrictive setting than the residential treatment center.

Readiness for Reintegration

Although Ms. Thompson was persistent in her desire to have him placed in her care, it is clear that she was unprepared for the challenges that arose following the reintegration. Following the reintegration, program staff and the CPS caseworker expressed concerns that Ms. Thompson had unrealistic expectations regarding Marcus's behavior and about the reintegration experience in general. After the placement disrupted, Ms. Thompson reflected, "I didn't know it was going to be a challenge. I thought like he was just going to come and he was going to live with me, he's going to fit in and we're going to make him comfortable and it was going to be fine."

In addition, Ms. Thompson was under the impression that Marcus's behavioral and emotional problems would no longer be an issue once he was placed in her care. Ms. Thompson expressed surprise that he continued to have anger problems following his discharge from the RTC.

"I was thinking things were okay when I talked to him on the phone, but it wasn't...I didn't hear anything about the anger, that he still had his anger problems because if he had it, then he wasn't ready to come back out."

Program staff suggested the importance of helping caregivers, such as Ms. Thompson, avoid these situations by helping them to set realistic expectations regarding the child's behavior so that they can adjust the manner in which they provide the child with the necessary structure and support. One program staff member stated:

"It is important to help the caregiver understand that they are not receiving a "fixed child" and that children with mental health challenges are not ever "fixed;" they are just more successfully supported and managed in their environment. As the caregivers, they need to adjust their parenting style to meet the needs of the child. This message then needs to be broken down into more practical realities and help the caregivers problem solve how they will manage different scenarios, such as if the child is suspended from school, if the child destroys furniture in the home, or if the child cusses the caregiver out."

Preparation for Reintegration

Marcus was formally referred to the program approximately two months prior to his reintegration into the home. While the number of meetings between caregivers and the Care Coordinator is determined on a case-by-case basis, records indicate that four face-to-face meetings between the Care Coordinator and Ms. Thompson were held during a three-week period to prepare for the reintegration. The four meetings were enough for the Care Coordinator to determine which services would benefit the family but not enough to fully engage with Ms. Thompson. In addition, because program staff were unable to have more contact with Ms. Thompson prior to the reintegration, they were unable to adequately assess her overall attachment to Marcus and her commitment to fully participate in the wraparound process. Program staff and the CPS caseworker reported that Ms.

Thompson was difficult to engage during the brief period that they worked with her to develop the reintegration plan.

After the disruption of the placement, staff reported that there were a number of red flags that emerged during the planning phase that should have been addressed, such as Ms. Thompson's unrealistic expectations of Marcus's behavior and her unwillingness to engage with the Care Coordinator and other members of the wraparound team.

Placement Disruption

Program staff also indicated that they believed that an additional contributing factor to the placement disruption was Ms. Thompson's belief that Marcus had some element of control over his anger problems and was choosing to not control his behavior. One program staff noted:

"For a child with a mental health disorder, this is the 'kiss of death' because the [caregiver's] perception is that the youth is choosing to be the way that they are, as opposed to the perception and understanding that the behavior is a manifestation of their mental health disorder."

During the interview with Ms. Thompson, it was clear that she had very different ideas from others involved in the case regarding what led to the disruption of the placement. She appeared to believe that increased involvement by CPS in the case would have made a difference in the success of the placement: "I feel like it would have worked if CPS had been a little bit more involved in it." She expressed concern on a number of occasions that CPS was not engaged in the case and was unresponsive to her or Marcus's needs. Many of her frustrations related to her perception of CPS's inattention to Marcus's poor academic performance at school:

"If it was music, PE, or lunch he had a perfect day and life would be easy for him, but when it came to math and reading and all that...that was overwhelming...they told me that this was under control and that's what upset me more with CPS because like I said, CPS had him since 2003 until now. Out of all those five years, he has been out [of the CPS system] 5 ½ months... why have they not noticed his education? He's in [the CPS] system. Where's the caseworker to check and see, 'Okay let me go to the school and see how Marcus is doing in school?'"

The caseworker reported that several attempts were made by CPS to engage Ms. Thompson and Marcus's education team; however, Ms. Thompson was unresponsive. The caseworker recounted that several meetings were held at the school with Marcus's education team, the school principal, and various CPS staff overseeing the case. The caseworker reported that Ms. Thompson did not attend these meetings.

Though she never reported problematic behavior in her home, Ms. Thompson expressed concern that CPS would remove Marcus's three younger half-siblings from her care if he were to become violent and hurt one of them. Ms. Thompson was concerned that CPS might claim that she was not protective of the children and remove them from her care. Her anxiety about the possibility of losing the other children appeared to be a factor in her decision to have Marcus removed from her home:

"I was so scared about keeping Marcus with the problem that he had, because in the papers they gave me to sign, if they removed this child for this, it is a possibility that any other child in the home can be removed. I worked and cried and lost and been without so much to get my other three [children] that I was too scared to chance it, because CPS don't...you know they are like the law. So if they come in here and say "take them" then they are just going to take my children."

Miscommunication between the program staff and Ms. Thompson may have also played a role in the disruption of the placement. As Marcus's behavior began to escalate, program staff and other members of the wraparound team increased their efforts to support the family. CPS and program staff indicated that they experienced a great deal of frustration trying to engage Ms. Thompson in services and in their efforts to work with her to address Marcus's behavior at school. It appears that there was some miscommunication during this time regarding her willingness to participate in services that might have aided in stabilizing the situation, such as family therapy. The program staff and other members of the wraparound team were under the impression that Ms. Thompson was adamantly opposed to participating in joint counseling sessions with Marcus. However, when asked about services that might have been helpful, she expressed frustration that she was not offered therapy for her and Marcus to address his anger problems together. Ms. Thompson noted that she thought that Marcus would be more open with a therapist if she were present during the sessions. Despite Ms. Thompson's assertion that she would like to participate in therapy with Marcus, when the CPS worker discussed this with her, she indicated that she was too busy.

Satisfaction with the CPS Reintegration Pilot Project

Despite the outcome of the reintegration, Ms. Thompson was very complimentary about the program: "I have nothing, absolutely nothing bad to say about the wraparound program. Because if it wasn't for the wraparound program, I don't think Marcus would have lasted as long as he lasted." She reported that the program Care Coordinator and other members of Marcus's wraparound team provided the support that she needed throughout the placement: "I would not have been able to make it without them...they were there for me, and they were truly, truly there for me." Ms. Thompson was particularly complimentary of the program's Care Coordinator. When asked about the services that the Care Coordinator provided, she commented: "She made me feel very comfortable that I could tell her anything."

Summary of Case Findings: Marcus

Although Ms. Thompson felt that the CPS Reintegration Pilot Project was helpful, her concern about the other children in her home and anxiety about CPS's ongoing involvement in the case ultimately proved too stressful and the placement failed. While the outcome of the case was disappointing to all involved, this case provides valuable lessons for the program staff, such as 1) the need for adequate time to assess and screen families to ensure that both the child and caregiver are ready for the reintegration and have realistic expectations regarding the child's abilities and limitations; 2) the importance of assessing and addressing with the caregiver the impact of the reintegration on siblings living in the home; and 3) the importance of assessing the caregiver's willingness and ability to engage and fully participate in the wraparound process.

Case History: Anthony

Anthony is a 14-year-old African American male in the 9th grade. He was referred to the CPS Reintegration Pilot Project by his CPS caseworker in November 2007. Anthony reports that he likes to read poetry and enjoys writing short stories. His CPS caseworker describes him as bright and polite. However, in his less quiet moments, Anthony sometimes has problems controlling his anger and aggression. In recent years, he has been in several fights at school, and he has frequently displayed a lack of respect for authority figures. Anthony's behavior in class has resulted in multiple suspensions from school. Case records indicate that he also has a history of involvement with the juvenile justice system. Prior to entering care, Anthony was referred at least five different times to juvenile authorities and was placed on probation.

In the fall of 2006, Anthony violated the terms of his probation by assaulting a teacher and was arrested and placed in juvenile detention. Anthony's mother, Tracy Tucker, 34, refused to pick her son up from juvenile detention, citing that she could no longer care for him because of his behavior. CPS was contacted at this time. The family had no history of CPS involvement prior to this event. Ms. Tucker's inability to care for him was primarily due to her poor health that, unbeknownst to CPS at the time, was quite serious and resulted in frequent hospitalizations. Although Ms. Tucker, Anthony, and Anthony's younger half-brother had been living for some time with Anthony's maternal grandmother, Joyce Miller, 56, Ms. Miller determined that she was not in a position to take primary responsibility for her grandson. In the weeks following his arrest, Ms. Miller attempted to secure a placement for her grandson at the Texas Baptist Children's Home in an effort to keep him out of the foster care system. However, her attempt was unsuccessful due to Anthony's history of aggressive behavior. With no alternative placement options available, Anthony remained in juvenile detention for a month before CPS located an RTC placement in a community approximately two hours outside of Travis County.

During a psychological evaluation that was administered shortly after his arrest, Anthony indicated that he did not really have a relationship with his mother or grandmother—or with any other family members or adults. There was no indication that Anthony has had much contact with his father, as the father was incarcerated in another state. In addition, there was no indication that Anthony has had contact with his father's extended family. Anthony was diagnosed during this evaluation with Child or Adolescent Antisocial Behavior and Parent-Child Relational Problem. In addition, documents in the case record suggested that Anthony may not be developmentally on target. While at the RTC, Anthony received individual counseling and was placed on five different medications in an effort to address his emotional and behavioral problems. Records indicate that Anthony was opposed to taking the medications and that the medications were changed several times during the eight months he was placed at the RTC.

Anthony's family attempted to maintain a good relationship with him by calling him and visiting him while he was in the RTC. This was no small feat given the seriousness of his mother's illness. Despite the family's efforts to maintain contact, records suggested that the RTC made minimal efforts to accommodate contact between Anthony and his family. Case records indicate that Ms. Tucker expressed frustration to RTC staff and Anthony's CPS caseworker regarding the difficulty

she was experiencing trying to reach Anthony by phone during designated visitation hours. Records suggest that little effort was made by the CPS caseworker or RTC staff to help facilitate consistent communication between Anthony and Ms. Tucker.

Anthony's behavior improved considerably during the eight months he was placed at the RTC. However, RTC staff reported a noticeable decline around the time that he was told he would be leaving the RTC. Following his stay at the RTC, Anthony was placed in a therapeutic foster home in another community for another eight months. Although the family was allowed unlimited phone calls and visits with Anthony while he was placed at the foster home, the family was only able to visit him on two occasions.

Anthony enjoyed living in the foster home, a two-parent African American family located in an affluent community. Initially, Anthony did a good job of controlling his behavior. Because of the progress he displayed during this time and Ms. Tucker and Miller's desire to have him return home, Anthony was referred to the CPS Reintegration Pilot Project. Following his referral to the program, Anthony's behavior declined, perhaps in response to the news that he would soon be going home. The CPS caseworker assigned to the case noted that Anthony expressed some ambivalence about returning to his family as he enjoyed the foster home and felt conflicted about leaving them.

Prior to the reintegration, the family was minimally involved in the planning process. Records indicate that Ms. Tucker and Ms. Miller met with the Care Coordinator for the program just three times prior to the reintegration. The family's lack of involvement was interpreted as the family's disinterest in the program, as program staff and the CPS caseworker did not understand the true seriousness of Ms. Tucker's illness and the amount of stress the family was facing. This misunderstanding proved to be an ongoing barrier to serving the family and a source of frustration for all involved.

Within three months of Anthony's referral to the program, he was reunified with his family. Anthony's transition from foster care back into the home was not without incident. In the weeks following the reintegration, CPS received a report that Anthony was physically aggressive toward his younger brother. In addition, it appears that Anthony did not fully understand or accept the extent of his mother's illness. His behavior became increasingly defiant with her. Ms. Tucker reported that Anthony refused to go to school on several occasions when Ms. Miller was out of town and away from the home.

In the months following the reintegration, the family became increasingly difficult to reach. That the family did not seem to be fully engaged in the wraparound process and did not take advantage of services to the extent that was originally planned was a source of frustration for the program staff working with the family. Again, this was partly a lack of understanding by CPS and program staff concerning the seriousness of Ms. Tucker's illness and the amount of stress that it placed on the other members of the family.

Anthony's mother passed away three months after his return to the home. In the months following her death, Anthony demonstrated an immense amount of strength as he coped with the loss of his mother. At the conclusion of the evaluation period, Anthony had been placed in Ms. Miller's

home for almost a year. While he still displays several behavior problems, Ms. Miller has remained committed to him and has initiated efforts to formally adopt him, as well as his younger brother.

CPS Reintegration Pilot Project: Services Received

Several services were offered through the CPS Reintegration Pilot Project. These services included ongoing case management and support services for the family, mentoring for Anthony, financial assistance, as well as emergency and planned respite services. After-school care was initially provided by the program; however, Anthony only used this service a few times and chose to stop participating. Psychiatric and individual counseling services were also discontinued shortly after the reintegration, because Ms. Miller felt Anthony was not benefiting from the services.

Ms. Miller requested relatively few services through the CPS Reintegration Pilot Project. Services that Ms. Miller requested primarily related to the family's need to provide Anthony with activities to keep him active and his mind off of his mother's illness. The following services were provided to the family during the evaluation period: individual youth mentoring, non-emergency respite care, and ongoing case management and service coordination for Anthony's wraparound team. The family accessed other services; however, these services were provided on a limited basis immediately following the reintegration and were discontinued shortly thereafter. These other services include psychiatric services, individual therapy, after-school care, and financial assistance. Table 13 provides a complete list of services the family accessed through the CPS Reintegration Pilot Project pre- and post-reintegration.

Table 13. Services Received—Anthony

Services	Date Initiated	Date Ended
Case management & service coordination	February 2008	Ongoing
Youth mentoring	February 2008	Ongoing
Individual therapy—youth	March 2008	April 2008
Psychiatric services (medication)	March 2008	April 2008
Non-emergency respite	March 2008	As Needed
Financial assistance	March 2008	As Needed
After-school care	April 2008	April 2008

Sources of Data

Although Anthony and Ms. Miller initially participated in the study, the family declined to participate in the interviews, as they were still grieving Ms. Tucker's death. Therefore, the themes noted in Anthony's case were extracted from an interview with the CPS caseworker assigned to Anthony's case, interviews with CPS Reintegration Pilot Project staff, and information extracted from structured case reviews of the child's CPS file.

Table 14. Sources of Data for Case Study—Anthony

Source of Data
1 interview with CPS caseworker
2 interviews with CPS Reintegration Pilot Project staff
Structured case review of the child’s CPS file

Case Themes: Anthony

Caregiver and Youth Attachment

In the months following Anthony’s reintegration, concerns were voiced by the CPS Reintegration Pilot Project staff and Anthony’s CPS caseworker that Ms. Miller and Ms. Tucker were not fully invested in the reintegration and did not seem very attached to Anthony. Their concerns primarily stemmed from the amount of time Anthony was spending outside the home and away from his family in respite care and in the care of other family members. Without a full understanding of the extent of Ms. Tucker’s illness, the CPS caseworker and program staff were left with the impression that the family did not want to care for Anthony. At the time, program staff acknowledged that their concern might be an inaccurate interpretation of the situation and could be the result of cultural differences or general differences in parenting styles; nonetheless, the family’s behavior was confusing for those involved in the case.

Prior to understanding the seriousness of the mother’s illness, the CPS caseworker indicated that she felt that the family needed to “step up” and start using the services that they requested for Anthony. The CPS caseworker noted: “Everyone has to make an effort...it can’t just be CPS and the Reintegration Project setting up the services. The family has to be willing to utilize the services too.”

Although the extent of Ms. Miller’s attachment to Anthony was unclear, it would be unfair and perhaps misleading to attempt to assess the level of attachment between the two given the extraordinary amount of stress that Ms. Miller experienced caring for her sick daughter while maintaining two jobs. Ms. Miller’s actions following the death of her daughter are perhaps the best indication of the level of commitment that she has for her grandson. Program staff report that Ms. Miller is fully committed to adopting Anthony and ensuring that he has a permanent placement with his family.

Feelings about the Reintegration

Interviews with the CPS caseworker and program staff suggested that Ms. Miller and Ms. Tucker were happy when they were informed that the reintegration would occur. However, the CPS caseworker and program staff both felt that the family had unrealistic expectations about the reintegration and of how Anthony would respond. One program staff member noted that the family seemed to feel that most of Anthony’s behavioral problems and anger stemmed from him being in foster care. The program staff member stated that she had the impression that the family believed that being out of care and with family who loved him was what Anthony needed most and that this

would be the solution to his behavioral problems. Despite these concerns, the family was approved to receive services through the CPS Reintegration Pilot Project and efforts were made to quickly put services in place to support Anthony's return to his family's care.

Anthony's feelings about the reintegration were mixed. Anthony's CPS caseworker reported that Anthony felt some ambivalence about coming home: "Before the reintegration, Anthony was really torn between wanting to come home and be with his mom and wanting to stay with his foster family." In addition, Anthony expressed concerns about leaving his foster family during the middle of the school year and indicated that he wanted to stay with them until he finished the academic semester. The timing of the reintegration was necessitated by the legal deadline for the case; however, it resulted in Anthony having to withdraw early from his school so that he could return to Travis County.

Readiness for Reintegration

There is no indication in the case record that Anthony was formally assessed for readiness. The Care Coordinator for the program met with Ms. Miller and Ms. Tucker on three occasions to assess their readiness for the program and develop a plan for the youth's reintegration. Program staff reported that they were frustrated by the family's lack of engagement but ignored their own concerns:

"We felt pressure that we put on ourselves and we allowed ourselves to fall into it because we needed to get kids enrolled. So we agreed to pick up kids even though the engagement was not there, either because of time or just because of the individual presentation of the caregiver. In hindsight, that was poor decision making. We should not have done that because the [wraparound] model clearly indicated that we needed that time [to engage with the family] and now we cannot get it back."

Anthony's CPS caseworker reported that she also had reservations about the reintegration. She noted that her primary concern was Anthony's behavior and his family's ability to manage his behavior. The caseworker stated: "Even though Anthony's behavior was improving, he still had angry outbursts and aggressive episodes at times." The caseworker expressed that Ms. Tucker's illness was another serious concern for CPS. Although the caseworker did not know the mother's long-term prognosis, she reported that she was aware that Ms. Tucker was not doing well and that she had been recently hospitalized. The caseworker noted that the family was very private regarding Ms. Tucker's medical condition, stating: "Even when I attempted to get information about Ms. Tucker's prognosis, the family was not forthcoming." The caseworker indicated that she had several conversations with Ms. Miller about her daughter's illness but Ms. Miller was unwilling to provide details about her condition and long-term prognosis. The caseworker noted that she did not press the conversation further with Ms. Miller, as she felt that it would have been "culturally inappropriate to continue to solicit sensitive information that the family obviously did not wish to share."

It appears that Anthony's concern about leaving during the middle of the school year and his ambivalence about returning home were minimized by the CPS. Anthony's feelings suggest that he may not have been emotionally ready for the reintegration and might have benefited from additional time to process the idea of returning to his family's care.

Preparation for Reintegration

Anthony was referred to the CPS Reintegration Pilot Project three months prior to reintegrating into his family's home. The Care Coordinator used this time to meet with the family to discuss their needs and help them identify which services would provide them with the support they needed to ensure the success of the reintegration. However, program staff reported that the family was particularly difficult to engage and frequently did not return phone calls.

Program staff and the CPS caseworker both reported that the family minimized the extent of Anthony's behavioral problems and did not seem to believe he would have problems after he returned to their care. Although program staff and the CPS caseworker were concerned that the family had unrealistic expectations of the placement, the decision was made to proceed with the reintegration. Program staff later expressed regret that they did not insist on additional time to properly engage with the family and demonstrate their willingness to fully support the placement, as the staff member did not feel that the family viewed them as an ally in the situation:

"The caregivers did not perceive the Care Coordinator as an ally or as an asset to promoting a sustained placement. They saw her more as an adjunct to CPS, or in some cases as another CPS worker or something along those lines."

There is no evidence that Anthony was formally prepared for reintegration. This is particularly problematic, as CPS Reintegration Pilot Project staff relies on CPS caseworkers to determine the child's overall readiness for reunification prior to making the referral. The case record indicates that Anthony was seeing a therapist while at the foster home, but it is unknown whether this time was used to prepare Anthony for the reintegration. Anthony spent a week at home prior to the reintegration to help him transition home; however, given the concerns that he voiced about the reintegration to his caseworker, he might have benefited from additional pre-reintegration visits to help him adjust to the idea of returning home. Additional visits would have also given the Care Coordinator more time to get to know Anthony and assess whether the reintegration was premature and should be delayed.

Residential Treatment Center

The residential treatment center that Anthony stayed in prior to moving to a therapeutic foster home did not make an effort to accommodate Ms. Tucker's efforts to maintain contact with the youth. The case notes suggested that residential staff were inflexible and did not follow their own policies regarding phone contact. The difficulty that the family experienced in their attempts to maintain contact underscores the RTC's lack of understanding or acceptance of the importance of visitation and helping the youth maintain connections with their families.

Barriers to Reintegration

This case proved to be an important learning tool for program staff as the circumstances that emerged following the child's reintegration highlighted the need for program staff to be fully engaged with the family and have an adequate understanding of the family's needs and how the program could support the family. Engagement did not occur between program staff and the

family until after Mrs. Tucker's death. The family's behavior prior to and in the months following the reintegration was confusing to those involved in the case, as Anthony's CPS caseworker, the Care Coordinator, and the members of Anthony's wraparound team each struggled to understand how they could best support the family and help maintain his placement. The family's lack of involvement in wraparound team meetings made this difficult.

It is clear that CPS and program staff were unsuccessful in their efforts to communicate with the family and with each other in the months following the reintegration. Ms. Tucker's illness created an awkward situation for the CPS caseworker and for the Care Coordinator, as neither had a clear sense of the extent of the mother's illness or how the illness was impacting the family. The family's lack of engagement in the wraparound process and program staff's and the CPS caseworker's own discomfort with addressing the issue directly with the family prevented those involved in the case from being able to accurately assess the problem and work towards a solution.

The CPS caseworker and the Care Coordinator for the program both reported that they had good communication with each other prior to Anthony's reintegration back into his family's care. However, program staff reported that communication was less frequent following the reintegration. Once Anthony returned to the home, the CPS caseworker disengaged from the case in many respects. It is important to note that this behavior was also observed with other CPS caseworkers for other youth referred to the program and was not an isolated incident. Nevertheless, the caseworker's disengagement from the case contributed to program staff's frustrations about the case and the family's lack of involvement. Although the CPS caseworker reported that she made more than one home visit each month to the home to speak with the family, the CPS caseworker reported that she was not involved in the case to the extent that she would have liked and felt that the size of her caseload was a barrier to her becoming more involved.

Ms. Tucker's death was sobering and put the family's behavior and lack of engagement in perspective. In the months following Ms. Tucker's death, program staff reached out to the family. Ms. Miller was reluctant to ask for assistance but accepted a limited amount of financial assistance and asked that the limited services provided by the program continue. Program staff learned through this experience that Ms. Miller was uncomfortable seeking assistance from "outsiders" but was willing to accept help when it was offered. It was only after the mother's death that program staff understood this dynamic. Despite her discomfort in involving others in a very private situation, Ms. Miller was grateful for the help that the program provided in the months following her daughter's death. This time period allowed the Care Coordinator to forge a more trusting relationship with the family.

Summary of Case Findings: Anthony

Although Ms. Miller's overall attachment to Anthony was not readily apparent, her actions during the last year have demonstrated her commitment to keeping Anthony in the home and out of the foster care system. The amount of strain that the family endured in the months following Anthony's reintegration to the home were not fully understood until after his mother's death. However, program staff now understand that the family's minimal involvement in the wraparound process

likely had more to do with the stress of Ms. Tucker's illness than their unwillingness to participate in services. In hindsight, it is impressive that the family was able to shoulder the stresses of the reintegration process along with the overwhelming pressures associated with Ms. Tucker's illness.

Although CPS and program staff agreed that it was important to understand the extent of Ms. Tucker's illness for case planning purposes, CPS and program staff were clearly uncomfortable with addressing Ms. Tucker's illness, as both parties expressed discomfort with asking the family about her prognosis. This discomfort stemmed from uncertainty about how the family would react to the question and whether the family would disclose this information to "outsiders."

Program staff reported that they learned a great deal from this experience. Perhaps the most important lesson learned from this experience is the absolute necessity of engaging with families so that caregivers view the program as a source of support during difficult times. This case highlighted the need for program staff to spend an adequate amount of time prior to reintegration getting to know the family and understanding how the family copes in stressful times and how the family communicates with each other and with individuals outside of the family.

Case History: Maria

Maria is a 17-year-old Hispanic female who was referred to the CPS Reintegration Pilot Project by her caseworker in 2007. Maria and her three younger siblings were removed from their mother's care when Maria was eight due to neglectful supervision and physical neglect. Case reports describe that the children were often outside without supervision, crossing busy streets and inappropriately dressed for the climate. Maria's birth father left the family when Maria was three. He now lives in Mexico and has not had contact with her since 2000.

According to the records, the family had a long history of CPS involvement prior to the removal. In fact, CPS received more than 10 reports on the family from the time that Maria was 3 until she was removed from the home. Several of the reports were substantiated, including an allegation that Maria was sexually abused by her mother's boyfriend at the age of four. Following the allegation of sexual abuse, Maria's mother, Rosa Acosta, age 34, was protective and ended her relationship with the man.

Upon removal, Maria and her siblings were placed together in foster care. Once parental rights were terminated by the Court in 2000, Maria's siblings were adopted by their foster family. Prior to the adoption, however, Maria had been removed from this foster family due to her ongoing anger and aggressive behavior with others in the home. She continued to have a strained relationship with both foster parents and vowed to continue acting out until she was reunited with her mother. However, the official permanency plan for Maria was adoption by this foster family once her behavior stabilized.

True to her word, Maria spent the bulk of her childhood and teen years acting out. During this time, she was placed in a series of foster homes, group residential treatment centers, and a psychiatric hospital. Maria experienced 19 different placements in all, most of which disrupted due to her behavioral problems, including physically assaulting other youth in care and throwing objects at staff. In the last nine years, Maria attended 14 different schools and was placed in special education and resource classes during that time. Maria is developmentally on target and has no special medical, physical, or disability needs. However, she has been diagnosed with a Mood Disorder (non-specified), Attention Deficit Hyperactivity Disorder, and Oppositional Defiant Disorder. In addition, Maria was on several different medications while in foster care—so many that, at one point, the court ordered that her medications be reviewed and the number be reduced if possible.

Despite these challenges, the caseworkers assigned to Maria over the years report that they enjoyed working with her and appreciated her great sense of humor and resiliency. Staff members from the CPS Reintegration Pilot Project also noted that they found Maria to be a smart and clever girl who is very much in touch with her needs and good at expressing them and advocating for herself.

During the nine years that Maria was in foster care, her birth family remained important to her and she held on to those relationships. For several years, Maria was able to maintain contact with her younger siblings through monthly visits. However, those visits ended abruptly when Maria's siblings' adoptive family discovered that she had resumed contact with her biological mother, as the family

was concerned that Maria might be negatively influenced by her mother and, in turn, that this might have a negative effect on Maria's siblings.

Two years prior to returning to her mother's care, Maria was asked to choose between seeing her siblings and keeping in contact with her mother. Maria chose the latter. In terms of other significant relationships with adults, Maria has maintained a good relationship with the CASA volunteer who was assigned to her case when she first came into foster care.

Maria remained steadfastly unwilling to be adopted and, at the age of 17, was no longer as vulnerable as she was when removed from her mother's care. Maria's CASA volunteer began to recognize that reunification with Ms. Acosta might provide the best opportunity to have a support system in place as Maria matured into young adulthood. Despite the fact that parental rights were terminated, Maria's CPS caseworker referred her to the CPS Reintegration Pilot Project to explore the possibility of reunification. This decision was also supported by the fact that Ms. Acosta had made significant changes to turn her life around over the years and was viewed as a more stable and appropriate parent. The Care Coordinator for the Reintegration Project documented many family strengths, including Ms. Acosta's honesty about past mistakes and her desire to take responsibility for her children. In addition, Ms. Acosta was employed part-time at a local school, was in a committed relationship, and had successfully parented Maria's little half-brother, Daniel, for seven years. Although Ms. Acosta had a history of depression, her mental health status was noted as "good" in the CPS case record.

Ms. Acosta was excited at the prospect of reunifying with her daughter and readily engaged with CPS and the CRP Care Coordinator to bring her daughter home. Approximately four months prior to reintegration, Ms. Acosta began meeting with the Care Coordinator for support and guidance as she prepared both emotionally and logistically to reintegrate Maria back into her home. Although Maria's mother was provided extensive support during the months prior to reintegration, it appears that the same level of support was not available for Maria. The process of determining Maria's overall readiness for reintegration was informal and did not involve the use of a structured assessment. As Maria's RTC was more than three hours away from Travis County, only two visits between Maria and her mother were arranged prior to reintegration.

Just three months after Maria was reintegrated, the court dismissed CPS from the case and awarded Permanent Managing Conservatorship to Ms. Acosta. Maria has been home for nearly a year now and has done extremely well. She is enrolled in high school and has been making all A's and B's. Her teachers agreed that she is no longer in need of Special Education Program services due to her immense progress. Ms. Acosta takes great pride in Maria for doing so well in school and marvels at her potential to go to college. Currently, Maria is preparing to graduate from high school and is in the process of applying to community colleges. In addition, she is looking for part-time employment.

CPS Reintegration Pilot Project: Services Received

As Maria and her mother were separated for over nine years, Ms. Acosta was concerned about easing her daughter's transition into the home. She was interested in accessing services that would provide

Maria with emotional support as well as opportunities to experience different activities in the community. During the evaluation period, Ms. Acosta accessed the following services for her family: individual mentoring services, summer camp activities, individual therapy for Maria, and family mentoring services for Maria and her younger brother. In addition, Ms. Acosta accessed psychiatric services for a few months to monitor Maria's medication. Ms. Acosta also accessed services to provide additional support for herself, including pre-reintegration counseling, parent coaching, PESA classes, and family therapy. Ms. Acosta also received some financial assistance to help with the deposit and first two months of rent on a larger apartment, as well as with groceries and utility bills. In addition to these services, the Care Coordinator for the program provided on-going case management and service coordination for Maria's wraparound team. Because Ms. Acosta's first language was Spanish, program staff located a bilingual parenting coach familiar with Hispanic culture so that Ms. Acosta might have the option to communicate in either language and share her concerns with someone who had an understanding of her own cultural beliefs and values. Table 15 provides a complete list of services the family accessed through the CPS Reintegration Pilot Project both pre- and post-reintegration.

Table 15. Services Received—Maria

Services	Date Initiated	Date Ended
Case management & service coordination	October 2007	Ongoing
Parent Engagement & Self-Advocacy (PESA) classes	November 2007	December 2007
Pre-reintegration counseling	January 2008	February 2008
Financial assistance	February 2008	As Needed
Youth mentoring	March 2008	Ongoing
Family mentoring	March 2008	Ongoing
Individual therapy—child	March 2008	Ongoing
Psychiatric services (medication)	March 2008	June 2008
Parent coaching	March 2008	Ongoing
Family therapy	April 2008	As Needed
Summer camp activities	June 2008	June 2008

Sources of Data

Themes noted in Maria's case study were extracted from two interviews with Maria and two interviews with Ms. Acosta. Interviews with both clients were conducted at three months post-reintegration and again at six months post-reintegration. In addition, information was extracted from an interview with Maria's CPS caseworker, a structured case review of the Maria's CPS case file, and interviews with CPS Reintegration Pilot Project staff.

Table 16. Sources of Data for Case Study—Maria

Source of Data
2 Interviews with the child
2 Interviews with the caregiver
2 interviews with CPS Reintegration Pilot Project staff
1 interview with CPS caseworker
Structured case review of the child's CPS file

Case Themes: Maria

Caregiver and Youth Attachment

As with other youth, no formal assessment of attachment was made for Maria and her mother. However, it was apparent to those involved in the case that Maria and Ms. Acosta remained deeply attached to each other despite their nine year separation. One program staff member noted the importance of attachment in ensuring that the placement is successful: "It is important that the youth have a desire to be home. In Maria's case it was her dream to go home. And when you are able to get your dream then that is a pretty strong motivating factor." After being removed from her mother's care as a child, Maria had a difficult time adjusting to the loss of her mother from her life and developed behavioral problems as a result of the anger and grief that she felt about the separation. Maria continued to act out, spending six out of the nine years that she was in the foster care system placed in various residential treatment centers. Maria noted that she developed a pattern of RTC placements after her mother's rights were terminated:

"The first time I went was because of how I was acting when my mom's rights got terminated, and then I guess I stayed there too long and moved to the next one. At that one, I was behaving so badly that they moved me to a next one...that was the pattern."

Feelings about the Reintegration

The family's feelings about the reintegration were very positive, as both mother and daughter had never given up the hope of being with each other. Ms. Acosta expressed excitement about the prospect of Maria coming home but admitted that she was a little nervous about the reintegration. She reported that she was concerned that she might not meet Maria's expectations, and that she would not know how to parent her daughter after so many years of separation. Ms. Acosta feared that because her son was only seven, she was not experienced in parenting an adolescent and uncertain about what challenges this might present. In addition, Ms. Acosta reported some anxiety about how her son, who had lived as an only child his whole life, would adjust to having a new sister in the house. Despite her concerns, she was committed to the reintegration and demonstrated to the CPS caseworker and the Care Coordinator that she wanted to make Maria's transition home as smooth as possible.

When interviewed after the reunification, Ms. Acosta commented that the transition had gone well and that she was enjoying spending time with Maria, just being a family: “It’s really good because I get to see her come in, from school and everything, and when we sit down and watch TV, we’re all together.”

Although Maria’s CPS caseworker was assigned to the case after Maria was referred to the program, the caseworker noted that it was obvious that Maria wanted to be with her mother. Interviews with Maria following the reintegration indicated that she was happy with the outcome of the reunification and was enjoying living with her mother for the first time in nine years. Maria reported that she was happy because “I don’t have to make an appointment to visit [my mother].” When asked what the best thing about living with her mother was, Maria reported, “Just being with her, since it has been so long.” This was found to be a recurring theme throughout the interviews that were conducted with Maria and her mother following the reunification. Both indicated that they were just happy to finally be together.

In addition to being with her mother again, Maria reported that she enjoyed having more freedom and privacy than she had at the different RTCs:

“I’m more free to do things, even though I’m not free enough to do like whatever, but free enough to do other things like move around the house, use the bathroom without asking, go to my room without having someone in there to watch me. I mean, sometimes I would say, ‘Ma, can I use the bathroom?’ I did that a couple of times.”

Maria remarked that even though she has not liked some of the household chores her mother has asked her to do, she has appreciated having more responsibility. She recalled that the only responsibilities she had at the RTCs were “staying in my room and out of trouble.” She has also discovered that she enjoys cooking and being able to make breakfast for herself in the mornings. Maria reported that she has enjoyed her school and has been making friends with her classmates. Maria seemed somewhat surprised that other youth her age wanted to get to know her better, stating, “I was secluded at other schools, but not here. I mean, everybody wants to know me.”

Maria remarked that one of the hardest parts about being home has been the realization of many lost childhood memories. She commented that her mother remembers many things about her childhood that she has forgotten. She indicated that this has been frustrating because she is not able to share these memories with her mother:

“There are a lot of things that I don’t remember that my mom does about me. Like I didn’t even know I had broken a wrist and when I was younger with—I don’t remember, but it was snowing. I don’t ever remember seeing snow. But my mom does.”

Both Maria and Ms. Acosta noted that they felt a great deal of sorrow that they missed so much time together and felt that they needed to make “new memories” to make up for the ones that they lost during the years that they were separated. Maria appeared to be the most affected by this loss. Maria expressed that despite her age and plans to attend college she wanted to live with her mother for a few more years because “I’ve missed too many years of her life, and she’s missed—she’s missed too many years of mine.”

Readiness for Reintegration

As with other youth in the reintegration project, there is no indication in the case record that Maria was formally assessed for readiness. While Maria participated in individual therapy sessions, there is no evidence that the therapist was consulted about the decision to refer Maria to the CPS Reintegration Pilot Project. Rather, according to a review of the case notes from the month in which Maria was scheduled to go home, a CPS caseworker who was not assigned to the case spoke with the RTC staff, and the RTC staff reported that they were unaware that CPS planned to move Maria later that month. While this could have been a miscommunication between the CPS caseworker and residential staff, input from the youth's therapist would likely have been helpful in establishing that Maria was genuinely ready for the reintegration and would benefit from being returned to her mother's home.

The case record indicated that CPS and CASA recommended that Maria be placed with her mother because she had made so little progress in residential treatment settings and continued to act out despite several years of intensive treatment. Their hope was that Maria would respond positively to the change, as Maria continued to express that she wanted to be placed with her mother and had maintained a close bond with Ms. Acosta throughout their long separation. As much of Maria's anger stemmed from her feelings about being separated from her mother, CPS and the CASA volunteer believed that it would be in Maria's best interest to at least try to reintegrate Maria into the community and into her mother's care.

It appears that Ms. Acosta participated in a few sessions of pre-reintegration therapy to help her prepare for the reintegration; however, these sessions occurred after the referral was made to the CPS Reintegration Pilot Project. Regardless, these sessions helped establish that Ms. Acosta was ready for the reintegration and gave her an opportunity to discuss her concerns with a neutral third party.

Preparation for Reintegration

By the time that Maria was ready to reintegrate, program staff had already learned from the experiences of the first two youth in the reintegration program. Reintegration program staff recognized the necessity of not rushing the reintegration process and instead taking time to fully engage with the caregiver prior to transitioning the youth to the home. Therefore, program staff proceeded with more caution and were more deliberate about preparations with the caregivers referred to the program.

Ms. Acosta's openness to the wraparound model during the planning phase also made a tremendous difference during preparations, as she recognized the need to access services that would help her emotionally and logistically prepare for Maria's transition home. She accessed every resource available to her to prepare for the reintegration, including meeting with the Care Coordinator eight times over the course of four months, participating in reintegration counseling, attending PESA classes, as well as using the financial assistance available from the program to help her move to a bigger apartment that could better meet the family's needs. In addition to these services, Maria and her mother also participated in a weekend pre-reintegration visit a month before the reintegration

and one face-to-face visit at Maria's placement. Ms. Acosta reported that it was important to her that they be able to visit prior to the reintegration so that they could get to know each other again.

"I figure it would have been better if we had a little bit more time to see each other because the time was very valuable. And visiting with each other, talking about a lot of things and catching up, it helps. It really does help."

Ms. Acosta spent over three months preparing for her daughter's reintegration. Because of the effort she made and the support and resources that were made available through the CPS Reintegration Pilot Project, program staff felt very positively about her overall readiness for the reintegration.

As mentioned, residential treatment staff indicated that they were unaware of CPS's plans to place her with her mother. The Care Coordinator met Maria on at least two occasions prior to the reintegration; however, there was little opportunity to work with Maria to help her emotionally prepare for the reintegration. Although the reintegration was what Maria wanted to have occur, she would have benefited from having an opportunity to process the idea of returning to her mother's care. Maria indicated that, in particular, she would have liked to work with her therapist to establish realistic expectations for the placement.

Residential Treatment Center

Maria reported that she spent much of her time in residential care reading and trying to stay out of trouble. The CPS case notes indicated that some residential staff felt that Maria used reading as an escape and a means of withdrawing from others. Maria indicated that while she liked some of the residential care staff, she found the RTC environment to be a threatening environment in which she felt forced to defend herself: Maria shared some insights regarding her time in residential care:

"I was always picked on 'cause of the way I am. I'm just shy and don't like to fight. So I'm an easy target. If you don't like to fight, they're going to fight you. I had to at the last RTC. The people who fought me also encouraged me to fight back...they wanted to see me defend myself."

Although Maria did not indicate that she was unhappy with the amount of contact permitted by the RTC with her mother, she did express some frustration with the inconsistency and unfairness of residential staff's decisions regarding youth being allowed to contact their families: "Well, the RTCs, depending on how the staff feels, they won't let you call if they—if they think that you've been bad, even though it's your phone privilege."

Satisfaction with the CPS Reintegration Pilot Project

Ms. Acosta was very positive about the CPS Reintegration Pilot Project's role in preparing her for the reintegration and helping her after Maria transitioned home. She was particularly grateful for the support that Maria's wraparound team provided, noting that the team was available to help when she encountered problems:

"They're very accessible...I wouldn't change [the wraparound team] because it has all the combinations to it. And it's pretty good having the Care Coordinator around and then having the parenting coach as a support. And the CPS caseworker...when I ask for things that I need for her...he's there."

Ms. Acosta expressed that she liked having people from the wraparound team who were willing to listen to her concerns and help her think through potential solutions: “I know we're going to miss them because they're there. You know, they have the time to take out to go and, you know, hear our problems and see how we can resolve it.”

Future Concerns

Perhaps one of the greatest concerns is Maria's future. Ms. Acosta has indicated a strong desire for Maria to live up to her full potential: “I just want to make sure she's on the rise and she's settled. I can see that she's already ready to be responsible, have her own apartment, you know, have her own good career that she wants to do.” Maria indicated that she is not ready to leave her mother just yet; however, she reported that she is committed to graduating from high school and noted that she would like to enroll at a local community college after graduation. Because of her love of animals, Maria is interested in studying to be a veterinary technician.

The family's finances are another major concern. Ms. Acosta is currently employed part-time at a local school. Although her position appears to be stable, Ms. Acosta earns less than \$10,000 a year in this position and has required financial assistance from the program on several occasions to help make ends meet. Maria's CPS caseworker and the Care Coordinator have expressed concerns about the family's ability to be financially independent once they are discharged from the program.

Although Maria would like to continue her studies, she also feels a great deal of responsibility to help her mother out financially. She is aware that her mother is struggling financially and stated during the interview that she has found this frustrating because “we don't have as much money as we really need—for things we need.”

Ms. Acosta has made it very clear that Maria's education should be her primary focus and has discouraged her from getting a job during the school year. However, Maria remains adamant that she would like to find a part-time position so that she can help her mother out financially and so that they will have extra money to do activities together that they enjoy, such as going to the movies or to local events. Maria has applied for several positions in establishments within walking distance of her home but has been unable to secure a position. It is likely that the recent decline in the economy is responsible for the shortage of available positions but nonetheless, Maria has been frustrated that she has not been able to find work.

While Maria's job search has not gone as well as she would have liked, she is excited about the prospect of going to college. Program staff were successful in their efforts to advocate for Maria to receive educational benefits through the State of Texas. Prior to CPS's dismissal from the case, Maria was granted a tuition waiver that will exempt her from the payment of tuition and fees provided she is willing to attend a state-supported community college, technical institute, college, or university in Texas. The flexibility demonstrated by CPS in this case not only eliminated a potential barrier to reintegration for this family but also will be instrumental in helping Maria achieve the goals she has set for herself in life.

Summary of Case Findings: Maria

The outcome of this case is particularly encouraging as it is uncommon for youth to return to the care of a parent whose parental rights were once terminated. The decision to reunify Maria with her mother after nine years has proven to be positive for Maria and her family. Reunification was strongly desired by Maria and her mother. Because of this, Ms. Acosta took full advantage of the support that was made available by the program and members of the wraparound team. Maria has done exceptionally well in Ms. Acosta's care and has demonstrated a great amount of maturity during the last year. While the family will likely continue to encounter financial challenges in the coming years, the commitment that they have shown to each other will be their greatest asset as they address challenges that come their way.

Case History: Michael

Michael is a 12-year-old Caucasian male who is in the 6th grade. He was formally placed in CPS care during the summer of 2007. However, this was not his first stay in foster care. Prior to his most recent entry into the foster care system, Michael experienced a great deal of instability as he was passed from relative to relative. Although CPS was not formally involved with the family on an ongoing basis during this time, the agency received a series of referrals from the time Michael was one until his first entry into the foster care system when he was seven.

When Michael was one, his biological parents placed him and his older brother with their maternal uncle following an allegation of physical abuse by the children's father. Michael and his half-brother remained with this relative for approximately a year until CPS received a referral alleging that the children were abandoned by their uncle. CPS did not validate the allegation of abandonment; however, the uncle determined that he could no longer care for the children and placed them with their paternal aunt and her husband. Michael's biological parents relinquished their parental rights within a year of the children's placement with their paternal aunt and her husband. Although the children were placed with relatives, the children had little contact with their parents following the relinquishment of their parental rights.

The children remained with their paternal aunt and her husband for approximately three and a half years until CPS received a referral alleging neglectful supervision and physical and emotional abuse of Michael by the children's uncle. Following this referral, Michael was placed with another paternal aunt, Kathy Pearson, age 45. Records are not clear regarding where Michael's older brother was subsequently placed. However, Michael remained with his aunt and uncle for approximately two months until Ms. Pearson requested that CPS remove him from her home. Michael was briefly placed in an emergency shelter and then was placed in a therapeutic foster home for seven months. During the time that Michael was placed in foster care, his paternal aunt separated from her husband and filed for divorce. Shortly after the divorce, Michael's paternal aunt requested that she be allowed to pursue adoption of Michael. CPS granted this request and placed Michael back in her home. A year later, his paternal aunt formally adopted Michael. Since the adoption, Michael no longer has contact with his biological mother but occasionally has supervised contact with his father.

Despite the fact that Michael now had a stable home and committed caregiver, he struggled emotionally and continued to exhibit a number of behavioral problems, including verbal and physical aggression, stealing, and displaying sexually inappropriate behavior. During this time, Michael's post-adoption caseworker described him as anxious, noncompliant, and easily angered. In an effort to address Michael's rapidly declining behavior and emotional state, Ms. Pearson used post-adoption services to admit Michael into a local residential treatment program. Within three months, Michael's medical benefits for residential treatment were depleted. Ms. Pearson made a good salary, earning approximately \$60,000 a year; however, she was unprepared to cover the cost of residential treatment for Michael. Because of this, Ms. Pearson was forced to reach out to CPS for assistance. CPS petitioned the court and was awarded shared custody of Michael with his adoptive mother. This arrangement allowed Michael to remain at the RTC and continue to receive treatment. While admitted at the RTC, Michael was diagnosed with Depressive Disorder, Attention

Deficit Hyperactivity Disorder (ADHD), Impulse Control Disorder, Post Traumatic Stress Disorder (PTSD), and Reactive Attachment Disorder (RAD). In addition, Michael was provisionally diagnosed with a learning disorder.

Although it was not known at the time, Michael was sexually abused by another child in the therapeutic foster home where he resided prior to being adopted. Michael carried this secret for two and a half years until the child who abused Michael confessed to his own therapist and a formal report was made to CPS. This revelation occurred while Michael was placed at the RTC. The CPS caseworker assigned to Michael's case described the abuse as Michael's "deepest darkest secret." She noted that the timing of the allegation allowed Michael to process the abuse in therapy at the RTC and begin to address the tremendous pain and shame that he felt regarding the abuse.

While Michael was at the RTC, the permanency plan was family reunification. Ms. Pearson remained committed to him and visited two to three times a week throughout his stay. Approximately 10 months after Michael was placed at the RTC, he was reunified with Ms. Pearson. Following the reunification, CPS continued to monitor the case for 3 months before requesting that the court dismiss the agency from the case. Services provided by the CPS Reintegration Pilot Project wraparound team provided Michael's adopted mother with the level of support that she needed to meet Michael's therapeutic and behavioral needs on an ongoing basis. At the conclusion of the evaluation, Michael had been home for almost a year and by comparison was doing much better at home and at school than before he was placed in residential treatment.

CPS Reintegration Pilot Project: Services Received

During the evaluation period, Ms. Pearson accessed a range of services to support Michael's reintegration home, including individual mentoring services, after-school care, summer camp activities, non-emergency weekend respite care, and parent coaching. In addition to these services, the Care Coordinator for the program provided ongoing case management and service coordination for Michael's wraparound team.

As a single parent, Ms. Pearson expressed an interest in accessing services that would provide age-appropriate activities and care for her son in a structured and supervised environment. Because Michael responded very well to the structured environment provided by the RTC, Ms. Pearson also requested the assistance of a parenting coach to help her create a daily schedule for Michael and to identify consequences that could effectively be used in a less structured home environment. Table 17 provides a complete list of services the family accessed through the CPS Reintegration Pilot Project pre- and post-reintegration.

Table 17. Services Received—Michael

Services	Date Initiated	Date Ended
Case management & service coordination	October 2007	Ongoing
Parent Engagement & Self-Advocacy (PESA) classes	November 2008	December 2008
Non-emergency respite	April 2008	April 2008
Youth mentoring	April 2008	Ongoing
After-school care	April 2008	Ongoing
Parent coaching	April 2008	Ongoing
Summer camp activities	June 2008	July 2008

Sources of Data

Themes noted in Michael’s case study were extracted from two interviews with Michael and two interviews conducted with his adoptive mother, Ms. Pearson. Interviews were conducted with both clients at three months post-reintegration and again at six months post-reintegration. In addition, information was extracted from an interview with Michael’s CPS caseworker, a structured case review of the Michael’s CPS case file, and interviews with CPS Reintegration Pilot Project staff.

Table 18. Sources of Data for Case Study—Michael

Source of Data
2 Interviews with the child
2 Interviews with the caregiver
2 interviews with CPS Reintegration Pilot Project staff
1 interview with CPS caseworker
Structured case review of the child’s CPS file

Case Themes: Michael

Caregiver and Youth Attachment

Despite Michael’s diagnosis of Reactive Attachment Disorder (RAD), there was a strong bond between Michael and his adoptive mother. This bond was perhaps aided by the contact that the two were able to maintain while Michael was in the RTC. During this time, Ms. Pearson visited him frequently, seeing him as often as two to three times a week. When asked about his time at the RTC, Michael noted that it was difficult to be separated from his adoptive mother, stating

“Most of the time, I missed my mom there. Every time I went to bed I was crying.” Although the separation was difficult, she believed that it was of paramount importance to get Michael the help he needed. His adoptive mother’s commitment to helping him was rewarded, as Michael thrived in the structured environment that the RTC provided and was able to make great strides in improving his behavior.

Feelings about the Reintegration

In the months prior to Michael’s reintegration into the home, Ms. Pearson experienced mixed emotions about the reunification. The behavior that Michael displayed prior to entering the RTC made it difficult and emotionally taxing for Ms. Pearson to care for him, as few others in her support system were equipped to help her with the stress of Michael’s day-to-day care. Michael’s admission into the RTC not only provided him with the structured environment that he needed but also allowed her to “recover” from the emotional exhaustion she experienced when caring for him. By all accounts, Ms. Pearson remained adamant that she wanted Michael to return to her care. Nevertheless, she was initially apprehensive about the reunification. Her anxiety stemmed from the concern that Michael might revert to old behaviors once he returned to her home. To address this concern, the Care Coordinator and parenting coach worked with Ms. Pearson to develop a plan that would provide the level of emotional and logistical support that she would need to care for Michael.

While Ms. Pearson had mixed feelings about the reintegration initially, her concerns subsided once Michael returned to her home. Six months following the reunification, Ms. Pearson noted that she felt that in some ways the reunification went better than she expected. She also commented on the change in Michael’s behavior following his return from the RTC and the effect that this had on her: “It’s a pleasure to be around him now. It’s not constant work and turmoil like it was before.” Because Michael’s behavior stabilized, she felt that she would now have the opportunity to nurture Michael as a parent and play a more active role in helping him realize his potential: “I feel like I have the chance to help him succeed and for him to be a part of the family and to be successful in this life and do what parents are supposed to do.”

Michael’s CPS caseworker reported that Michael was excited about the prospect of returning home. However, it appears that he experienced a great amount of anxiety about whether the reunification would actually occur. The CPS caseworker commented, “Michael did not think it was for real for a while.” Following the reintegration, Michael also expressed happiness about being with his mother. He seemed relieved to have a stable home life again with a single caregiver. When asked what the best thing was about living with his adopted mother again, Michael replied, “She’s my only mom now.”

Preparation for Reintegration

Notes from the CPS case file indicated that the RTC made a concerted effort to prepare Michael for the reintegration during individual therapy as well as during family therapy sessions held with Ms. Pearson. In addition, the RTC staff permitted Michael to go home on weekends in the months immediately prior to the reintegration, provided he demonstrate appropriate behavior at the RTC

during the week. It appears that visitations were treated as a reward for good behavior. Case records suggested that on at least one occasion, Ms. Pearson and the RTC staff denied Michael visitation because of his poor behavior. In addition, records indicated that on a few other occasions, the length of his visitation was reduced as a result of his behavior. Michael's CPS caseworker noted that Michael was well prepared to return home and that the reintegration coincided with the RTC's discharge plans for Michael.

Preparation efforts for Ms. Pearson included the family therapy sessions with Michael at his RTC and approximately seven meetings with the Care Coordinator. She and the Care Coordinator developed a reintegration plan and identified the various service providers who would participate in Michael's wraparound team. As noted previously, Ms. Pearson's primary concern was locating resources that would provide age-appropriate activities and care for her son in a structured and supervised environment. In addition to meeting with the Care Coordinator, she began meeting with a parenting coach several months before Michael came home. With the assistance of the parenting coach, Ms. Pearson was able to begin to identify the changes that she needed to make to ensure the success of the reunification.

Readiness for Reintegration

Although Ms. Pearson was initially uncertain about the timing of the reintegration and whether she was emotionally ready for it, the length of the preparation phase (over four months) allowed her to work through her ambivalence. During this time, Michael's CPS caseworker, as well as the program staff, had many discussions with Ms. Pearson regarding her readiness to have Michael return to her home. Her confidence in the timing of the reintegration grew as services were put in place and as she and Michael worked through their expectations of the reintegration in family therapy.

According to the CPS case record, Michael's reintegration home coincided with the RTC's original discharge plans for him. However, there is very little documentation concerning how the RTC determined that Michael was ready for reintegration.

Satisfaction with the CPS Reintegration Pilot Project

Michael's CPS caseworker noted that she was relieved to have the CPS Reintegration Pilot Project assist with Michael's reintegration. The caseworker indicated that she felt that the wraparound team would provide Ms. Pearson with the support that she needed to ensure that the reintegration was a success.

Feedback provided by Ms. Pearson about the program was extremely positive. She indicated that the wraparound team was a tremendous source of support for her prior to and during the reintegration. When asked about services the program provided the family, Ms. Pearson reported that participation in the PESA training classes for parents was one of the more helpful aspects of the program for her. The classes helped her better understand the CPS system and how she could be the best advocate for her son:

"PESA training gives you an overall view of how the CPS system works and how to get benefits for your kids and how to change your kid's treatment plan and what power you have to do that

as a parent. [PESA training] should be mandatory to participate in the program. It's invaluable as a parent, and it empowers you to know that if you don't know the answer, or you feel unsure, you have the information to go to get it."

In addition to the PESA classes, Ms. Pearson noted that the parenting coach that she worked with helped her prepare for Michael's return to the home and provided her with a great deal of support. She also reported that the parenting coach was extremely helpful in working with her to "implement structures and procedures that were working for him in treatment and modify them for him at home, so that he can continue to have that secure feeling and the confidence that he knows what his expectations are."

Ms. Pearson indicated that she was particularly pleased with the services provided by the CPS Reintegration Pilot Project and with the Care Coordinator's efforts to ensure that Michael's needs were met and that members of the wraparound team were on the same page: "It has all worked. [The Care Coordinator] has done a very good job of keeping everybody in the loop about everything, especially Michael's day-to-day behaviors."

Future Concerns

At the end of the evaluation, Michael had been home for almost a year. Depending on each family's unique circumstances, youth and caregivers involved in the program typically begin transitioning from paid program services to other community services after they have been with the program for a year. At the time of the last interview, Ms. Pearson had begun thinking about transitioning from the program to other community supports. She indicated that she was anxious to begin the process early so that she would have everything in place and could be assured that the new services would provide the support that Michael required: "I'm really trying to wean us off of the services that the program offers because I want to see if I can function by myself before the Reintegration Project is over. I want to make sure that we're okay."

One of Ms. Pearson's primary concerns about the future related to the availability of age-appropriate services in the community that are able to meet Michael's therapeutic and behavioral needs. Ms. Pearson reported that they had problems during the summer locating activities that were age-appropriate and would not be over-stimulating and overwhelm her son. In addition, the family experienced difficulty locating resources that provided the level of supervision that Michael required:

"He's outgrowing the system...[it is difficult] finding something in that middle ground where he has the supervision and direction that he needs to be successful and to stay in control and to be redirected in a positive way, but still has access to normal activities."

Summary of Case Findings: Michael

Michael's reintegration was a success. Factors that contributed to the success of the placement include 1) the length of the preparation phase (over four months), 2) Ms. Pearson's willingness to take full advantage of services available through the program, and 3) Ms. Pearson's commitment to maintaining frequent contact with Michael, through visitation and phone calls, while he was placed

at the RTC. The extended preparation period allowed the CPS Reintegration Pilot Project staff to engage with the family and understand their needs. The RTC's close proximity to Ms. Pearson's home allowed her to maintain frequent and consistent contact with her son. Ms. Pearson was a full participant in the wraparound process. With the wraparound team's assistance, Ms. Pearson was able to simulate the structured environment that Michael needed to maintain the placement.

Case History: Cristina

Cristina is a 15-year-old Hispanic female in the 8th grade. Her family has an extensive history of CPS involvement. Between 1997 and 2008, CPS received a total of 13 referrals of abuse and/or neglect involving Cristina and her three older siblings. Four of the 13 referrals alleged sexual abuse of Cristina by various family members, including her older brother and her stepfather. CPS records suggest that Cristina's biological father, 44, has been incarcerated since 2002 when he was convicted of sexually assaulting Cristina's older sister. Cristina's mother, Gloria Saucedo, eventually remarried.

Cristina has been in foster care on two different occasions. In total, Cristina has spent close to three years in the Texas foster care system. While in foster care, Cristina experienced a great deal of instability. She first entered foster care when she was eight after Ms. Saucedo, 44, stopped cooperating with family preservation services. During this stay, Cristina experienced four different foster homes, one emergency shelter, and one psychiatric hospital, all in an 18-month period. Additionally, Cristina attended at least four different schools before returning to her mother's care.

Cristina was removed again at age 12 after Ms. Saucedo contacted CPS and notified the agency that she could no longer care for Cristina because of her aggressive, self-injurious, and sexually promiscuous behaviors. During her most recent stay in foster care, Cristina was placed in two residential treatment centers, two emergency shelters, and experienced two psychiatric hospitalizations during a 17-month period. She attended four different schools during this time as well. Cristina is enrolled in special education classes and has been diagnosed with Borderline Intellectual Functioning. In addition, she has been diagnosed with a Mood Disorder (non-specified) and Attention Deficit Hyperactivity Disorder (combined type). Cristina can be strong-willed at times, but those who know her report that she can be loving and has shown a great amount of resiliency in her life.

Cristina's CPS case record indicated that she has a history of seeking negative attention from authority figures and aggressive behavior with her peers. The case record also indicated that she has a history of making outcries of sexual abuse and then later recanting and stating that she lied. Ms. Saucedo reported that Cristina became sexually active at a young age and in the past has engaged in inappropriate sexual acts at school with her peers. In addition, prior to Cristina's most recent entry into care, Cristina was the victim of statutory rape with a man in his 30s. At the time, Cristina was just 12. Cristina's behavior is indicative of someone who has experienced sexual abuse as a younger child.

Ms. Saucedo has a history of depression and anxiety and often requires a great deal of reassurance from those around her regarding her daughter's care. CPS case records suggested that much of the instability Cristina experienced in foster care was the result of Ms. Saucedo's treatment of residential treatment staff. The case records suggested that Ms. Saucedo's behavior was a contributing reason for the breakdown of at least two of Cristina's placements during her most recent stay in foster care. One placement reportedly asked that Cristina be moved from the RTC after Ms. Saucedo threatened to contact the media regarding her daughter's care. Ms. Saucedo and Cristina have a complex relationship. They have a genuine desire to be with each other but have a great amount of difficulty communicating with each other at times.

During the first few months of the program's implementation in Fall 2007, Cristina's caseworker referred her to the CPS Reintegration Pilot Project. The complicated family dynamics between Ms. Saucedo and Cristina combined with Cristina's lack of progress in residential treatment settings were important contributing factors to CPS's decision to recommend that Cristina return to her mother's care. There was concern that Cristina would not succeed in a placement independent of Ms. Saucedo's involvement. The Care Coordinator for the CPS Reintegration Pilot Project screened the family and began preparing Ms. Saucedo for her daughter's reintegration into the home. Shortly after the referral was made, Cristina alleged prior sexual abuse by her stepfather. Because Cristina's stepfather resided in the home that she was to return to, CPS was forced to suspend efforts to reunify Cristina with her mother while they investigated the allegations. CPS investigated the allegations and concluded that they were false. Although the allegations were ruled out, there was concern that Cristina was not emotionally ready for the reintegration. In late Spring 2008, the court ordered those involved in the case to participate in mediation. During the mediation, it was agreed that Cristina would be re-referred to the CPS Reintegration Pilot Project in order to prepare for reintegration back into Ms. Saucedo's home. The mediation agreement was accepted by the court with the stipulation that the reintegration would not occur if it was later determined by Cristina's therapist or psychiatrist that she could not safely return to the community because she was a danger to herself or others.

The Care Coordinator resumed preparation efforts and worked with Ms. Saucedo to determine what services the family would need in order to successfully manage Cristina's ongoing emotional and behavioral health issues. Ms. Saucedo initially was impatient for her daughter's return to the home but ultimately cooperated with program staff during the planning phase. During preparations for the reintegration, Ms. Saucedo kept in contact with her daughter by phone. Cristina was able to comply with the court's stipulation that she remain out of trouble during the remainder of her stay at the emergency shelter where she was temporarily placed. Two months after being referred for the second time to the CPS Reintegration Pilot Project, Cristina was returned to her mother's care.

The family reported that the initial months following the reintegration were particularly difficult. Ms. Saucedo lost her job and Cristina's stepfather was deported. In addition, one of Cristina's older brothers was diagnosed with cancer during this time. Cristina and Ms. Saucedo experienced difficulty communicating and argued frequently. Two months after she reintegrated back into her mother's home, Cristina physically assaulted her mother during an argument. Ms. Saucedo was not injured; however, the assault further complicated what was already a tense situation. Cristina was arrested and placed on probation for the incident.

Although Cristina and Ms. Saucedo experienced difficulty adjusting to the transition, they both reported that their relationship eventually improved. Finding the correct balance of medications to help Cristina cope with her ongoing feelings of depression and anxiety contributed to their ability to improve their relationship. Concerned about the effects of psychotropic medications, Ms. Saucedo initially took Cristina off of her medication; however, after a few weeks Cristina's depression and anxiety increased. Program staff were able to locate a psychiatrist that the family felt comfortable with to reassess Cristina's medications. The psychiatrist was able to prescribe the correct balance of psychotropic medications that Cristina needed to help alleviate her symptoms.

Ms. Saucedo and Cristina also determined that they might benefit from family therapy to help resolve their communication problems and learn to listen to each other. At the conclusion of the evaluation, Cristina had been living with her mother for six months. She was reportedly doing well in school and had made some new friends at school. Both Ms. Saucedo and Cristina reported that they were communicating better and were enjoying being a family again.

CPS Reintegration Pilot Project: Services Received

Because Ms. Saucedo felt that her daughter required a great deal of supervision, she was concerned about finding age-appropriate activities for Cristina in a supervised environment. Ms. Saucedo was also interested in accessing services that would provide her daughter with emotional and logistical support following the reintegration. During the evaluation period, Ms. Saucedo accessed the following services for Cristina: individual mentoring services, individual therapy, summer camp activities, and psychiatric services to obtain a more thorough assessment of Cristina's capabilities (neuropsychological evaluation) and to monitor her psychotropic medication. Ms. Saucedo also accessed services to provide herself with the emotional and logistical support she needed to sustain the placement, including parent coaching, PESA training classes, and occasional financial assistance. In addition to these services, the Care Coordinator for the program provided ongoing case management and service coordination for Cristina's wraparound team. As in other cases, program staff located a bilingual parenting coach so that Ms. Acosta might have the option of communicating in Spanish or English. At the conclusion of the evaluation, Cristina and her mother were planning to begin family therapy to help improve their communication skills. Table 19 provides a complete list of services the family accessed through the CPS Reintegration Pilot Project pre- and post-reintegration.

Table 19. Services Received—Cristina

Services	Date Initiated	Date Ended
Case management & service coordination	December 2007	Ongoing
Financial assistance	July 2008	As Needed
Parent coaching	July 2008	December 2008
Youth mentoring	July 2008	Ongoing
Summer camp activities	July 2008	July 2008
Individual therapy—youth	August 2008	Ongoing
Parent Engagement & Self-Advocacy (PESA) classes	September 2008	October 2008
Psychiatric services (medication & evaluation)	October 2008	Ongoing
Family therapy	February 2009	Ongoing

Sources of Data

Themes noted in Michael’s case study were extracted from two interviews with Michael and two interviews conducted with his adoptive mother, Ms. Pearson. Interviews were conducted with both clients at three months post-reintegration and again at six months post-reintegration. In addition, information was extracted from an interview with Michael’s CPS caseworker, a structured case review of the Michael’s CPS case file, and interviews with CPS Reintegration Pilot Project staff.

Table 20. Sources of Data for Case Study—Cristina

Source of Data
2 Interviews with the child
2 Interviews with the caregiver
2 interviews with CPS Reintegration Pilot Project staff
1 interview with CPS caseworker
Structured case review of the child’s CPS file

Case Themes: Cristina

Caregiver and Youth Attachment

No formal assessment of attachment was completed for Ms. Saucedo and Cristina. Ms. Saucedo and Cristina have a complicated and sometimes contentious relationship. However, different professionals involved in the case acknowledged that the mother and daughter seem to have a strong attachment to each other that is not easily understood by others. Cristina’s behavior has been a point of contention for the family for the last two years, as Ms. Saucedo is devoutly religious and has high expectations of how Cristina should conduct herself. Cristina’s rebellious and defiant behavior has been stressful and difficult for her mother to accept. Like many teenagers, Cristina is frequently moody and irritable. Ms. Saucedo reported that her daughter’s irritability makes communication difficult:

"We’re having a lot of problems with communication because I could tell you that in a day, we can only say two or three words but not a complete sentence because she’s always angry, grouchy, depressed and I’m trying to avoid for us to have a fight. So it’s like what I’m trying to do is not to push her to talk or do things she don’t want to do because I don’t want us to end up fighting or having a fight like we did before."

Ms. Saucedo observed that her daughter’s reactions to her attempts to communicate have been frustrating; however, she knows there are limitations to what she can do to help her daughter:

"Sometimes I do get frustrated in a way that I don’t know what to do to help her better. I mean, she’s not wanting to open up. And I can’t push it...that’s why I’m taking it slow. But I don’t want to—I don’t want time to pass by and then she’s growing up and then we’re not having any communication."

Cristina also expressed that they have experienced difficulty communicating. She explained one reason for their difficulty thus: "I just really don't like talking that much, I guess." She reported that this was not always the case and has been true only in the last few years. The change in Cristina's feelings about communicating with her mother is a normal response for adolescents her age; however, Ms. Saucedo does not attribute their problems to normal adolescent changes. Rather, she believes that her daughter is depressed and that this is the primary reason for their communication problems. Although Cristina has not been clinically diagnosed with Major Depression, a recent neuropsychological evaluation confirmed that Cristina displays depressive personality traits and symptoms.

Ms. Saucedo has been very honest about the difficulties that she and her daughter have experienced since the reintegration. She noted that although there have been times since Cristina returned home that she wanted to give up, she knows that the frustration is temporary and not indicative of how she truly feels: "Sometimes, I just tell her that 'if you're going to keep it up like that, I'm just going to have to let you go,' but it's coming just from my mouth. But it's not coming from my heart." When asked if there has been a time when she has questioned her decision to have her daughter return home, Ms. Saucedo stated:

"I had my moments when I said, 'Oh, man. I can't do it.' But you know, it's not like I can just give my daughter away to some strangers...I'm going to have to do whatever it takes for me to—for both of us to stay together."

Ms. Saucedo reported that while it has been difficult to care for her daughter at times, she is committed to continue trying to make the reintegration work for Cristina's sake:

"I'm willing to take whatever it is, to put up with it because she's my daughter and I don't want her away from me because I'm afraid what she's going to become if she's taken back up there. I'm real worried about her future, about her safety, about [the RTC] employees. With everything's that going on over there, I don't trust those places. And I [would] rather overcome it. I know it's not going to be easy, but I pray for it and we take it day by day."

Feelings about the Reintegration

Although Ms. Saucedo advocated strongly for her daughter to be returned to her care, she experienced some reservations about the reintegration after Cristina made an outcry alleging that her step-father sexually abused her. Ms. Saucedo's concerns were eased when the allegation was investigated by CPS, and Cristina reported that the allegation were false. After the allegation was resolved, Ms. Saucedo indicated that she was anxious to have her daughter returned to her care as soon as possible. However, CPS and Cristina's guardian ad litem expressed concerns about whether Cristina was emotionally ready to reintegrate. Cristina's case was referred by the court to mediation to help resolve differences and reach a consensus about what would be in Cristina's best interest. The mediation was successful and it was agreed that CPS would move forward with plans to reunify Cristina with her mother. Following the mediation, the case was referred for a second time to the CPS Reintegration Pilot Project. Cristina's caseworker reported that Ms. Saucedo was receptive to the involvement of the reintegration program and recognized that she would need additional

support to help ensure that the reintegration would be a success.

Cristina also indicated that she wanted the reintegration to occur. During an interview, Cristina offered the following advice to other youth who want to come home: “The youth also have to work in order to come home, if they really want to go home...basically, I would stay in my room to stay out of trouble. And I did it. I’m home!” Cristina’s response demonstrated some level of maturity and acceptance that she played an important role in allowing the reintegration to occur.

Ms. Saucedá’s anxiety and frustration with Cristina’s behavior and their lack of communication appeared to dissipate between the first and second interviews. By the second interview (conducted six months post-reintegration), Ms. Saucedá had a pragmatic assessment of the reintegration: “So having Cristina here, it’s also been a challenge, you know. Even though I have had hard times with her, but I’m the parent. And who said it was going to be easy, you know?” During the second interview Ms. Saucedá acknowledged that the reintegration was initially difficult for the family, but things were getting better. “It’s getting better. Slowly, but it’s getting better—and I enjoy her company.”

The interviews with Cristina indicated that she is relieved to be home with her family. She agreed with her mother’s assessment that things were getting better and expressed that it was important to her to be able to remain with her family: “I just want to stay here ‘cause I just want to be with my family.” In addition, Cristina expressed throughout the two interviews that she was happy to be able to spend time with her pets. Cristina’s interaction with her pets and comments during the interviews suggested that they have been an important source of comfort for her and have brought joy to her life.

Barriers to Reintegration

Cristina’s behavior was a considerable barrier to the reintegration, as she began acting out and making allegations of abuse by her step-father after she was first notified that she might transition home. Her response to the news resulted in concerns by her mother regarding her readiness to reintegrate home. While Cristina’s reaction was not atypical of youth in residential treatment who are informed of an impending change, Ms. Saucedá did not understand her daughter’s response. The allegations combined with Cristina’s ongoing behavioral problems caused Ms. Saucedá to lose trust in her daughter. This was a point of contention between Cristina and her mother following the reintegration: “With everything that happened with her, I mean, she gets upset because she wants me to trust her just like that. And I said, un-uh, that’s not going to happen.”

Ms. Saucedá’s strict expectations of her daughter’s behavior and lack of understanding about the dynamics of mental illness and sexual abuse also served as a barrier to the reintegration. Following the reintegration, Ms. Saucedá reported that it took several months for her to realize that her expectations were unrealistic. She suggested that many of the problems that the family experienced during the early months of the reintegration might have been avoided if she had participated in the PESA training classes sooner. Ms. Saucedá expressed that the classes were instrumental in helping her understanding of the effects of her daughter’s diagnoses and what she could do to create a supportive environment for Cristina:

"After I got that PESA training and everything, I said, my God. I mean, I think I was—at first, I was asking too much from her like—or expecting too much from her like following my rules just right at the moment she walked in my door and be organized and clean and all that stuff, you know. I didn't have in mind—or I forgot that she picked up a lot of bad manners over there."

In addition, Cristina's caseworker reported she believed that Ms. Saucedo would benefit from education on the effects of sexual abuse considering that Cristina's behavior was indicative of sexual abuse and Cristina's older sister was known to have been sexually abused by their biological father.

Readiness for Reintegration

As with the other youth, a formal assessment was not conducted to assess Cristina or her mother's readiness for reintegration. However, the allegations that Cristina made about her step-father forced CPS and program staff to evaluate more carefully whether Cristina was emotionally and behaviorally ready to return home. In addition, CPS and program staff considered whether Ms. Saucedo would be capable of meeting her daughter's needs in a less structured environment. Cristina's CPS caseworker reported that she was concerned about Ms. Saucedo's ability to follow through with consequences should Cristina resort to old behaviors.

As there was some disagreement between Ms. Saucedo, CPS, and Cristina's guardian ad litem regarding whether Cristina could successfully reintegrate back into her mother's home, a mediation was facilitated. The mediation provided a much needed forum for the different parties involved in Cristina's case to discuss and resolve concerns regarding the family's readiness for reintegration.

As previously mentioned, CPS's decision to recommend that Cristina be reunified with her mother was largely based on the agency's concern that Cristina could not be successful in a therapeutic placement, as she experienced multiple placement changes during her time in care and made very little progress in the different treatment settings. Though Cristina was not making substantial progress in the various treatment settings, she consistently maintained that she wanted to return home to her mother's care.

Preparation for Reintegration

Cristina was referred by her CPS caseworker in December 2007 and again in May 2008 after the mediation was held. Even though preparation efforts were stopped while CPS investigated Cristina's allegations of sexual abuse, the Care Coordinator was able to work closely with the family over the course of five months to assess their needs and coordinate services for the family. During this time, the Care Coordinator met with Ms. Saucedo at least 15 times and held numerous phone conferences with her to plan the reintegration. In addition, Cristina's wraparound team met prior to the reintegration to help prepare Ms. Saucedo for the transition.

Despite the extensive effort that was put forward to plan for the reintegration, Ms. Saucedo later noted that she underestimated how difficult the reintegration would be for her and her daughter. She reported that she was unprepared for how much attention and structure her daughter required: "I thought it was going to be easy when she first came home, but I never thought that she needed that much of attention and structure until time went by."

During the planning stage, Ms. Saucedo also stayed in frequent contact with the CPS caseworker. The CPS caseworker noted that Ms. Saucedo liked to be kept “in the loop” and informed of what to expect during each stage of the reintegration process. Despite the CPS caseworker’s and Care Coordinator’s efforts to keep her informed, Ms. Saucedo reported that during the planning phase she was frustrated because she did not understand why preparations were taking so long: “At first, you know. I was so upset, you know. I was so angry at them. I didn’t understand until everything fell into place.”

Ms. Saucedo visited Cristina at least two times in the months leading up to the reintegration. Although program staff worked with Ms. Saucedo extensively to prepare for the reintegration, little information was found in the case record regarding efforts made by the CPS caseworker, program staff, or Cristina’s last placement to prepare Cristina for the reintegration. It is known that Cristina met weekly with an individual therapist at her placement; however, it is unclear whether these sessions were used to prepare Cristina to return to her mother’s home.

***Satisfaction with the CPS Reintegration Pilot Project**

Ms. Saucedo indicated that overall, she was satisfied with the program and the support that was provided to help ease her daughter’s transition back home. She reported that the parenting coach was not as responsive as she would have liked; however, she was highly complementary of the Care Coordinator and other members of her daughter’s wraparound team. Ms. Saucedo expressed that while she did not always appreciate the involvement of the various agencies in her life at the time, she eventually realized that everything that was done had a purpose and helped bring her daughter home:

"I complied with everything that they asked me. I mean, I know there were a lot of things I needed to work on, and I really appreciate that I had all those people involved...especially, I appreciate [Cristina’s CPS caseworker and the Care Coordinator], I mean, the way they organized everything. And you know, they took everything step-by-step for me to do. And I’m glad I complied with it...I can understand people getting upset when people get involved in their lives, but I would suggest that they look at it differently, you know. It’s for their own good. And it helps a lot...you know, after you succeeded with everything and get your child at home, you say, 'man, they’re good!'"

Ms. Saucedo indicated that the most helpful services provided by the CPS Reintegration Pilot Project were the PESA training classes and the ongoing case management services provided by the program’s Care Coordinator:

"The PESA classes helped a lot. And plus, [the Care Coordinator], you know, she’s been a lot of help, a lot of support. And I also learned a lot from her...I learned how to be more organized with my appointments and all that kind of stuff because I wanted to keep everything up here in my brain...it was a lot of appointments every single day...but no, I mean, thank God that you know, she was able to help me with some of the appointments I had."

Future Concerns

Cristina's transition from residential treatment back into the community required a great deal of coordination and support from the CPS Reintegration Pilot Project, CPS, and other members of Cristina's wraparound team. Ms. Saucedo reported that she has a fairly good relationship with her adult children; however, she has a limited amount of support in the Travis County area. Ms. Saucedo reported that she does not expect her husband (Cristina's stepfather) to return to live with her, and that she is planning to file for a divorce. In addition, Ms. Saucedo's extended family has not been a consistent source of emotional or logistical support for the family:

"I don't have any support. I just have four children, and my family is not like, kinda like a support family, you know...we kinda like don't see each other that much and my family was taught to deal with their own problems without even asking for help from anybody else. I mean, we have to deal with our own stuff. So it's kinda like basically, with my divorce and everything, I've been on my own all the time with no help from nobody."

The family's lack of external support from friends and family may pose a challenge to the wraparound team as they prepare to discharge Cristina from the program in the coming months. The Care Coordinator will work with Ms. Saucedo before the family is discharged from the program to ensure that she has access to services in the community that will help her meet Cristina's ongoing needs. Medicaid and non-educational funds available through the school district can be used to cover the costs of many of the services that Cristina has received through the program, such as counseling and mentoring services. However, as a single parent, Ms. Saucedo will be the one to shoulder the day-to-day logistical challenges of caring for a child with severe mental health issues. Ms. Saucedo indicated that she is somewhat concerned about how she will be able to meet her daughter's needs as a single mother who is the sole wage earner in the family:

She needs a lot of structure, a lot of supervision, you know. It's hard. I can understand those mothers who are struggling right now out there and taking care of their kids and then trying to hold a job and making it to all these appointments and everything.

Historically, Ms. Saucedo has derived a great deal of comfort from her church community. Program staff have encouraged Ms. Saucedo's involvement so that she might develop a source of ongoing emotional support when her involvement in the program ends.

Summary of Case Findings: Cristina

The reintegration was a difficult adjustment for the family; however, Ms. Saucedo and Cristina were able to work through many of the problems that emerged during the initial months of the reintegration. Ms. Saucedo initially underestimated her daughter's need for a structured and stable environment and had unrealistic expectations of her daughter's behavior. However, Ms. Saucedo was open to change and took full advantage of the support and services available to her through the CPS Reintegration Pilot Project. Her participation in the PESA training classes provided her with a better understanding of her daughter's mental health issues and helped equip her with the knowledge of how to be a more effective advocate for her daughter. In addition, the training helped

her understand adjustments she needed to make in her expectations of her daughter and how she could provide her with a more structured and consistent environment. While her commitment to Cristina was tested on a number of occasions, Ms. Saucedo has consistently demonstrated a desire to care for her daughter and remain a family.

Case History: David

David is a 12-year-old male of African American and Hispanic heritage. He was referred to the CPS Reintegration Pilot Project in late February 2008 by his CPS caseworker. David and his younger brother, Justin, were removed from their mother's care in early 2007 following several allegations of neglectful supervision and of physical abuse. In addition to these allegations, concerns were also raised regarding their mother's ongoing drug use, after she tested positive for cocaine at a local hospital.

Records indicated that the family has a history of CPS involvement. Prior to these allegations, CPS had received at least three other referrals between 2002 and 2006 that also alleged neglect and physical abuse of the children. Although David was living with his mother, Teresa Jackson, 37, at the time of his removal, he spent much of his early childhood in the care of his maternal grandmother, Sara Dixon, 67, and her common-law husband, George Arnold, 73. Little information is known about David's father; however, CPS records indicated that David's mother reported to a CPS investigator that David's father was physically abusive to her and that she left him because of this reason. Records suggested that David has not had contact with his father in several years.

The week preceding David's removal from the home, a series of incidents occurred that contributed to CPS's decision that David and his younger brother could not safely remain in their mother's care. Although David was only 10 at the time, he stole the family car and attempted to drive the car to the home of a family friend. David ran into some trees and totaled the car. Fortunately, he sustained only minor injuries from the crash. Four days later, he reportedly injured a teacher at his school when the teacher attempted to stop him from leaving the classroom. David was subsequently arrested, charged with felony assault, and placed in juvenile detention. CPS considered placing both David and his brother Justin with Ms. Dixon and her common-law husband; however, CPS caseworkers expressed concern to the court regarding the couple's ability to care for the children, as Ms. Dixon had just been released from the hospital and her husband, Mr. Arnold, had serious ongoing health concerns as well. The court agreed with the agency's assessment and placed the brothers in foster care. Justin was placed in a foster home in Travis County, and David was transferred from juvenile detention to a residential treatment center (RTC) near Travis County. Following the children's removal, the court ordered that weekly supervised visitations be facilitated for David and Justin to see their mother. David's mother frequently missed visitations with the children; however, Ms. Dixon and Mr. Arnold faithfully visited the children each week.

During the 16 months that David was in foster care, the CPS caseworker worked with his mother to try to reunify the family. But after nine months of attempting to work with her, it became clear that she was not making enough progress in addressing CPS's concerns regarding her ongoing drug use. During a mediation, David's mother made the decision to relinquish her rights so that the children might be permanently placed with Ms. Dixon and Mr. Arnold, as the couple's health had stabilized and they were now capable of caring for the children.

Following his admission into the RTC, a psychological evaluation was completed. David was diagnosed with an Adjustment Disorder with Mixed Disturbances of Emotions and Conduct but

was not placed on medication. Results of the psychological evaluation indicated that he is of average intelligence but can be socially immature and impulsive at times. David experiences some difficulty relating to other youth his age and is frequently the subject of ridicule by other students because of his social immaturity. Despite a history of being bullied by other youth his age, David does not have a history of physical aggression with his peers.

While at the RTC, David's behavior declined and he became depressed. During this time, RTC staff reported that David was defiant and uncooperative and that he was frequently restrained because of his behavior. As a result, the RTC staff recommended that David not be allowed to attend visits with his family, as the treatment center staff felt that visits would reward David for his poor behavior. It is unclear how many visits David missed. During his stay at the RTC, David participated in weekly individual therapy, group therapy, and peer-based groups to address issues of past abuse and neglect. He also attended classes on behavioral management techniques, chemical dependency, and anger management.

David was an ideal candidate for the program, as Ms. Dixon and Mr. Arnold both recognized that the program could potentially be helpful in ensuring that the reunification would be a success. The Care Coordinator worked with Ms. Dixon and Mr. Arnold for over four months to prepare for the reintegration. David's CPS caseworker and the Care Coordinator for the program both reported that David's family was very motivated during this time to do whatever was needed to have him placed in their home. The CPS caseworker indicated that she felt that David could safely be returned to his family's care provided the family would have access to support services to advocate for David at school and to help them access other resources. Although David has experienced difficulties with his peers since returning home, Ms. Dixon reported that he has been doing well at home and that the couple's only concerns are finding activities to keep David and Justin busy and locating a new home so that the children will have a yard.

After 16 months of treatment at the RTC, David was placed with Ms. Dixon and Mr. Arnold. In addition, David's younger brother, Justin, was reunified with Ms. Dixon shortly before David was placed back in the home. Both David and Justin reported that they were happy to be with their family again; however, the reintegration has been a difficult transition in some respects. Ms. Dixon reported that although David does not wish to live with his mother anymore, he would like to be able to visit with her. He has had a difficult time understanding that he can no longer have contact with his mother.

Although Ms. Dixon and Mr. Arnold consider themselves to be in a common-law marriage and the couple intended to raise the children together, it was determined that Ms. Dixon would pursue adoption of David and Justin alone. Ms. Dixon recently reported that adoption plans for the children are on track and should be finalized by May 2009.

CPS Reintegration Pilot Project: Services Received

During the evaluation period, Ms. Dixon accessed the following services for the family: individual mentoring services, family mentoring services, summer camp activities, financial assistance, parent coaching, and PESA training classes. In addition, the Care Coordinator for the program provided

ongoing case management and service coordination for David’s wraparound team. In developing a reintegration plan for David’s return to the home, Ms. Dixon’s primary interest was in identifying services that would provide activities to help keep David occupied, as well as strong role models to help him improve his ability to interact appropriately with others. Additional mentoring services were authorized when it became clear that David and his brother might benefit from family mentoring services to help strengthen their relationship and learn how to interact with each other without fighting. Individual mentoring services for Justin were also authorized after he expressed concern that David was receiving an unfair amount of attention from the family and outside service providers. The family later determined that individual mentoring for Justin was not necessary, as the brothers’ relationship had improved. The availability of flexible funds allowed the CPS Reintegration Pilot Project staff to accommodate this need despite the fact that Justin was not the “focal child” served by the program. Table 21 provides a complete list of services the family accessed through the CPS Reintegration Pilot Project pre- and post-reintegration.

Table 21. Services Received—David

Services	Date Initiated	Date Ended
Case management & service coordination	March 2008	Ongoing
Parent Engagement & Self-Advocacy (PESA) classes	June 2008	July 2008
Financial assistance	July 2008	As Needed
Youth mentoring—David	July 2008	Ongoing
Summer camp activities	July 2008	July 2008
Parent coaching	December 2008	Ongoing
Family mentoring	January 2009	Ongoing

Sources of Data

Themes noted in David’s case were extracted from the two interviews with David and the two interviews conducted with his grandmother, Ms. Dixon. Interviews were conducted with both clients at three months post-reintegration and again at six months post-reintegration. In addition, some information was extracted from a structured case review of David’s CPS case file and from interviews with CPS Reintegration Pilot Project staff.

Table 22. Sources of Data for Case Study—David

Source of Data
2 Interviews with the child
2 Interviews with the caregiver
2 interviews with CPS Reintegration Pilot Project staff
Structured case review of the child's CPS file

Case Themes: David

Caregiver and Youth Attachment

A particularly strong attachment and bond was observed between Ms. Dixon and David. When asked what she liked best about David's return to the home, Ms. Dixon noted, "He's sort of my inspiration. He's keeping me going because I know that I gotta keep him going." In addition, Ms. Dixon expressed appreciation for David's caring nature and desire to help. Ms. Dixon stated, "Anything I want, he'll bring...if he hears me coughing, he'll run from [his room] to get to the kitchen just to get me a cup of water." Although David's statements concerning his grandmother were largely superficial in nature (e.g., "she will protect me if any harm comes," "listen to your grandma...because she won't tell you wrong"), nonetheless, his comments consistently conveyed the general sense of trust and security that he felt about their relationship.

Unlike many other adult figures in his life, Ms. Dixon appears to have a general understanding and acceptance of who David is as a person. Referring to his personality, Ms. Dixon reported that "David is the type that's got to be heard...got to fix the biggest burger, grab the biggest ball. That's just David and we know it's just David. And you know, we don't expect no different." She noted that she sometimes feels that others, including David's mother, do not understand him the way that she does. Despite her affinity for her grandson, Ms. Dixon displayed some frustration that he does not act as seriously as he should at times and that he may not be living up to his full potential:

"His potential is so high...I want him to dig down deep and bring it on out. But he won't. He'll sit there and he'll just act silly. But when he gets to school—as long as he is doing good, let him act silly at home. I can handle him. As long as he is doing good at school, I'm proud of that. I tell him every day that I'm proud of him and for him to keep on."

Feelings about the Reintegration

Ms. Dixon expressed great relief and happiness in having David out of foster care and back home with his family. She indicated that the separation from him was difficult and that she felt somewhat helpless while he was at the RTC:

"Every time I'd see him, I'd hate to leave him, because I was feeling what he was feeling...I

know he was feeling bad because I was feeling bad for him. But there wasn't nothing I could do but say, "David, be good," so he could come home. And I kept writing him and letting him know that I cared, that I really wanted him home."

During the initial interview, Ms. Dixon indicated that she felt that David had been through a lot in his 12 years and that she wished to make things better for him. She was clear that her feelings have not changed regarding her decision to have David return to her home. While she has had moments of frustration and irritation with David, she has not ever seriously questioned her decision to have him return to her care.

David also expressed happiness about leaving the RTC and living with his family. In addition to the comfort of being with his own family after 16 months in foster care, David indicated that he has appreciated the additional space and freedom that he has at his grandmother's home. In particular, David noted that he has enjoyed having his own room and being able to watch TV more often. He also reported that he has enjoyed simple things that he used to take for granted, such as having second (and third) helpings at meals, being allowed to set the alarm clock at night to the radio station of his choice, and being able to play with his brother.

Barriers to Reunification

When evaluating information obtained from the CPS case file and from interviews with CPS Reintegration Pilot Project staff, no obvious barriers or delays were noted regarding the timing of David's reintegration from the RTC to Ms. Dixon's home. However, Ms. Dixon noted that she believed that the RTC "stalled" the reunification and credited the CPS Reintegration Pilot Project and the CPS caseworker with helping David get home:

"If there hadn't been somebody here pulling for him, he would have never made it. They would still have kept him down there...the way that it worked, [the program] had everybody pulling for him and trying to get him [home]. Other than that, I believe that he'd have been right down there until he was 18. I really do."

Readiness for Reintegration

As with the other cases, there was little information in the case record or in interviews with Ms. Dixon or David regarding specific efforts that were made by CPS or David's RTC to assess the family's readiness for reintegration. Despite the apparent lack of targeted efforts by CPS or the RTC to assess the family's readiness, Ms. Dixon reported that she felt very prepared for his return to the home and, in fact, had been prepared since the children were initially placed in foster care. Ms. Dixon remained adamant that despite her poor health when her grandsons were initially removed, she was capable of caring for their needs: "I was prepared for them when they left." She expressed frustration with the court's decision to place David and his younger brother in foster care in the first place:

"They didn't think I was able to take care of him. But I could have...and that's why I made myself better. With the help of the good Lord, I prayed that I'd get better so I could get him... because he didn't need to be [at the RTC]."

Preparation for Reintegration

David was referred to the project approximately four months prior to his reintegration into the home. This allowed the Care Coordinator ample time to engage the family and work with them to develop a reintegration plan. According to the CPS case file, David, Ms. Dixon, and Mr. Arnold began participating in family therapy at the RTC in order to prepare for the reintegration. In addition to family therapy, Ms. Dixon and Mr. Arnold maintained weekly contact with David while he was at the RTC.

Residential Treatment Center

Although David's recollection of his time at the RTC was generally positive, the case record indicated that David became depressed while at the RTC and his behavior declined during his stay. Ms. Dixon also noted changes in his demeanor while he was at the RTC: "They changed him. He was doing good...but to me it seemed like he was more afraid of the [staff]." When asked about his stay at the RTC, David's responses tended to focus on the freedoms he felt he lost and the general feeling of boredom he experienced during his stay. It was also noted that David did not comment about how he felt about being separated from his family or fears that he may have had during his time at the RTC.

Satisfaction with the CPS Reintegration Pilot Project

As with many of the other caregivers, Ms. Dixon was thankful for the support that the CPS Reintegration Pilot Project provided her family. She was particularly touched by the voucher that the Care Coordinator was able to provide to help her purchase new clothes for David and his younger brother: "We were so happy...I let them go to the store, let them pick out their pants and their shirts. And they were just overjoyed. They were so happy." Ms. Dixon reported that this meant so much to the family because her grandsons lost or outgrew much of their clothing while they were in foster care.

Ms. Dixon also felt that the Care Coordinator personally cared about the family and was willing to help them in whatever ways the family needed:

"She seems like she cares...you know, I've never been through anything like this before, and it makes me feel good to know that there is somebody you can talk to...I can tell her anything. And if I ask her about something, she'll try to help me."

Future Concerns

Although the reintegration has been very positive for the family, it has become clear that their current living situation is not ideal. The family resides in a small three-bedroom mobile home; however, the home does not have a yard in which David or his younger brother can play. In addition, the property manager has voiced complaints about David and Justin's presence in the home because of previous complaints from several years ago about David and Justin's behavior on the property grounds. This has created a stressful situation for the family, as David and Justin do not have a place to play outside and must remain in the house after school unless Ms. Dixon or

Mr. Arnold can take them to the park to play. Given the couple's history of health problems, this becomes a particularly burdensome task during the summer months. In response to the family's housing concerns, the Care Coordinator for the CPS Reintegration Pilot Project referred Ms. Dixon to a local non-profit organization to assist the family in locating alternative housing. At the conclusion of the evaluation, Ms. Dixon was enrolled in a class through the agency to gain more information on home ownership.

David's experience with bullying and harassment by other youth at school presented an additional concern for the family. Prior to the conclusion of the study, the family attempted to address the situation by meeting with school officials and the program Care Coordinator to discuss the problem and to identify potential solutions. In addition, Ms. Dixon enrolled David in an after-school program in order to prevent him from having to ride the bus home with some of the youth who contributed to the problem.

Summary of Case Findings: David

Overall, both Ms. Dixon and David indicated that the reintegration has been a very positive experience for the family. Although David experienced some problems interacting with peers at school, both Ms. Dixon and David believe that the reunification has been a success. At the conclusion of the evaluation, David was reportedly doing exceptionally well in the home and was not displaying any significant behavior problems at home or at school. Although Ms. Dixon did not use as many support services as some of the other caregivers in the program, she remained open to the wraparound process and to the assistance of the Care Coordinator.

Component II: Findings

The purpose of Component II of the evaluation was to identify barriers that can potentially delay or prevent reunification of youth with severe mental health needs with their caregivers. To gather these data, we asked the CPS caseworkers and program staff who participated in the study about their perceptions of systemic, program, and case-level factors that impeded the process of reunification or prevented reunification of youth with their caregivers. Program staff affiliated with the CPS Reintegration Pilot Project, as well as all CPS caseworkers who referred youth to the project, were eligible for participation in this component of the study. This section of the report details findings that emerged from the interviews with CPS caseworkers and CPS Reintegration Pilot Project staff.

System-Level Barriers

Insufficient Collaboration with Residential Treatment Centers

During the initial months of the evaluation, program staff encountered several unanticipated barriers to the reintegration of youth referred to the program. One barrier identified by program staff related to the difficulties working with residential treatment centers (RTCs) to determine projected discharge dates for youth referred to the program. Program staff expressed surprise at the amount of resistance from residential treatment staff during this process, as the RTC staff were reluctant to identify specific discharge dates for youth based on the youth's individual treatment goals. Program staff reported frustration that discharge planning seemed largely driven by reductions in youth's level of care rather than whether the youth had actually met their treatment goals.

Another barrier related to the reluctance of RTCs to consider less conventional alternatives when discharging youth from residential care. The current service model used by the CPS Reintegration Pilot Project requires that CPS and RTC staff make a philosophical shift in how they address permanency planning for youth in intensive out-of-home placements. The practice of discharging youth with severe mental and behavioral health needs directly from residential treatment settings back into the community is relatively uncommon in Texas. Rather, the typical discharge plan calls for youth to first be placed in a therapeutic foster home before reintegration into a less restrictive setting is considered. Program staff noted that some residential treatment staff questioned the overall wisdom of reintegrating youth with complex and ongoing mental health needs directly back into the community from a residential treatment setting.

In addition, program staff expressed frustration that the child welfare system does not allow youth, after achieving treatment goals, to remain in the residential treatment setting for a period of time to see if youth 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."

This practice leaves program staff and CPS caseworkers with very little time to ensure that the family is fully prepared for the reintegration and that the child's family has realistic goals for the child's reintegration into their home. In addition, this practice has created situations in which the child must first transition to an emergency shelter or therapeutic foster home until preparation efforts for the reintegration are complete. Although temporary, the additional placement changes result in unnecessary stress for the child that might prompt his or her behavior to regress.

Continuity in Medicaid Coverage

Program staff reported several barriers relating to the provision of mental health services for youth who reintegrate back into the community. Texas recently launched a new health care program, STAR Health, for children in foster care. While the intention of STAR Health is to improve access to health services for children in the foster care system, program staff have experienced problems as a result of the new program. Because CPS retains conservatorship of youth who receive services through the CPS Reintegration Pilot Project for at least three months following the youth's reintegration, many of the services coordinated by program staff must be contracted through approved STAR Health providers. Program staff found that youth may not have access to some providers after CPS is dismissed from the case, as STAR Health is designed to provide coverage for youth in the foster care system rather than youth in the general public. Once the youth are no longer in CPS's care, they will no longer be covered by STAR Health. This could potentially lead to a disruption in therapeutic services that were previously covered under the STAR Health plan.

In order to regain health coverage, the youth's caregivers must apply for traditional Medicaid for the youth and will be required to meet eligibility guidelines unless the youth is adopted and Medicaid is provided as part of the adoption subsidy package. There is concern that not all providers will accept both forms of coverage, that is, coverage by the STAR Health program and traditional Medicaid. It appears that program staff are committed to maintaining continuity of services for youth after CPS is dismissed; however, this may result in additional expenses for the program and will not address the problems that caregivers will face once the family is discharged from the program.

Lack of Well-Qualified Service Providers

Another concern voiced by program staff and CPS caseworkers was the lack of quality service providers in the community who accepted the newly implemented STAR Health program or traditional Medicaid coverage. Program staff reported that for some services, such as psychiatrists to monitor the child's medications, respite care, and parent coaching, there are only a handful of providers in the community who accept STAR Health or traditional Medicaid coverage. According to program staff, not having enough service providers to choose from has inhibited their ability to individualize services for the youth and their families.

Program staff reported that they had the most difficulty locating quality providers who accepted STAR Health and traditional Medicaid coverage for non-traditional services such as art and music therapy.

"Our kids have been in therapy so much that things like art and music therapy, and recreational therapy, and just utilizing a therapeutic mentor who takes the child into the community to do activities and reinforce positive social behavior...we find that sometimes those are much more effective than the traditional therapeutic outlets but those aren't the services that are necessarily available under Medicaid or under a STAR Health provider. So we are having to go outside of [the approved providers list] to provide those services."

In addition, program staff and CPS caseworkers reported difficulty locating well-qualified psychiatrists and therapists familiar with the needs of youth with complex mental health needs who have been in foster care. Program staff also noted the lack of available service providers who are using the most current evidence-based treatment methods:

"We have to deal with the quality of the service provision and whether or not the providers are using evidence-based treatment methods...what we are learning is that using evidenced-based treatment is clearly indicated for all populations and particularly for this population. And what is even more strongly urged is the use of trauma-based therapy since these kids have been traumatized. It seems so obvious, and yet we are not using trauma-based techniques when working with these kids."

Some judges who preside over child protection cases in Travis County have prohibited CPS caseworkers from using certain psychiatrists who are known to have a history of over-prescribing psychotropic medications to youth in foster care. This has proven to be an additional barrier to providing services to youth in a timely manner. Project staff attempted to address the problem by accessing program funds to pay providers directly. This allowed the staff to circumvent the need for Medicaid. However, this was an additional unanticipated expense that the program had to bear and one that the program would likely be unable to sustain in the long run.

Insufficient Pre-Reintegration Contact between Youth and Caregivers

Only two of the six youth in the study were able to maintain consistent face-to-face contact with their caregivers prior to the reintegration. Caregivers of youth placed in the Travis County area were more successful in visiting the youth on a consistent basis. However, youth placed out of the Travis County area did not have the benefit of consistent contact with their caregivers. Program staff and CPS caseworkers acknowledged the importance of pre-reintegration visitations; it appears that minimal efforts were made by CPS to facilitate visitations: "The idea of visitation prior to reintegration is not one that CPS has really embraced." Research on the importance of visitation in promoting a healthy relationship between the youth and their families is very clear. It appears, however, that high caseloads and agency policies restricting caseworker travel outside their established regions resulted in inconsistent face-to-face contact between the youth and their caregivers. CPS administration later reported that they have worked to educate CPS caseworkers on the importance of these visits; however, it is unclear whether this has been effective in increasing the number of pre-reintegration visits for other youth receiving services through the program.

Program staff suggested that RTC staff 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 [RTC staff's] judgment about whether they should allow the visits."

Interviews with program staff and the youth revealed another problematic practice. Several of the youth indicated that their visitation and phone privileges were frequently restricted when they exhibited poor behavior. Although program staff advocated for increased visitation for the youth, they suggested that CPS might be more effective in changing this practice: "Having to push up against that is hard when we are not the CPS staff member, so then we have to convince the CPS staff to advocate against the facility [withholding visits]."

Program-Level Barriers

Lack of Collaboration between CPS and the CPS Reintegration Pilot Project

Collaboration between CPS caseworkers and the CPS Reintegration Pilot Project staff is an essential component of the wraparound process, particularly during the planning stage. During this stage of the reintegration process, CPS Reintegration Pilot Project staff collaborate with CPS caseworkers to set a projected reintegration date, coordinate pre-reintegration visits and work with the RTCs regarding a child's discharge. However, effective communication and collaboration between the program staff and CPS did not always occur during this process. One program staff member noted the importance of effective collaboration:

"What we have found is that we can't do our best work without them. We need them to be a continuing collaborative force that is fully engaged in the process...these are extremely challenging and complex situations, and it requires everybody to be 'hands on deck' for it to work. Everybody has a role and a responsibility."

Need for Clarification of Roles

There seemed to be an overall lack of clarity among CPS caseworkers regarding their role. Interviews with CPS caseworkers and program staff revealed that initially caseworkers did not fully understand their role in the reintegration process during the planning stages or after the youth reintegrated into the community. During the first few months of the program, it was noted that CPS caseworkers tended to step back from the case following a child's acceptance into the program. Furthermore, program staff felt that some caseworkers became overly reliant on the Care Coordinator to complete some tasks that she lacked the authority to complete, such as scheduling pre-reintegration visits and coordinating the child's travel for the visits. These tasks were necessary to adequately prepare the youth and caregivers for reintegration; however, program staff expressed frustration that CPS caseworkers did not take a more active role in coordinating the logistics of the visits.

Program staff noted that there seemed to be a general lack of ownership by CPS caseworkers of the youth's cases once youth were referred to the program and the Care Coordinator began working with the families. One program staff attributed this to the fact that CPS's work with families and youth tends to be limited to resources within their own system, and therefore collaboration with an outside entity to support the family's reintegration falls outside of their comfort zone: "There is the idea that once the youth is returned to a caregiver, then CPS's role diminishes significantly and their need for involvement, collaboration, and ownership of the situation is greatly reduced."

CPS staff acknowledged that the responsibilities of the Case Coordinator and those of the 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.

CPS caseworkers indicated that the size of their caseloads was perhaps the biggest hurdle to their remaining more involved in the youth's cases following reintegration. Although some caseworkers participated in their child's monthly team meetings, not all of them consistently attended these meetings.

Cultural Competency

To date, the majority of youth referred to the CPS Reintegration Pilot Project have been Hispanic, 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.

CPS Reintegration Pilot Project staff have made efforts to consider the role of culture in their work with families referred to the program. Program staff reported that they have learned to be flexible and to pay closer attention to how the families communicate and express their needs. For example, program staff reported that they have found that some families are particularly reluctant to ask for help while others are more open to doing so. One program staff member reported that she has learned to be more assertive in offering assistance to the families who have been less willing to directly ask for her assistance. The staff noted that she has learned to become a better listener and to take cues from these caregivers:

"Generally, the way that I work with families is that I try to make it clear that [the caregiver] can ask for anything—if they need anything then just ask me; that is exactly what I am here for and that it is not a burden or a problem. I do a lot of that at the beginning in hope that they will call me or email me when they need something...but [with some of the caregivers], I've learned that they are not going to ask for help and that I have to ask them and I have to take cues. I have to really listen closely when they are telling me how things are going...It is just better listening, listening more closely to what they are saying."

Among CPS caseworkers interviewed for the study, it was noted that efforts to be culturally appropriate appeared limited to individual CPS caseworkers' personal understanding of the importance of culture. The caseworkers demonstrated an awareness of the importance of culturally competent practice but did not seem confident about how to translate their understanding into day-to-day practice with clients. One CPS caseworker expressed her frustration: "People try to use a cookie-cutter approach and say 'this is a Hispanic family so we should handle it a certain way' but I know that it doesn't work like that." 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.

Case-Level Barriers

Assessing Attachment

During the initial months of the program, program staff began to recognize the importance of attachment between the youth and the caregivers as a necessary component to a successful reintegration. As a result, program staff have considered the use of a standardized instrument to assess attachment between the caregivers and the youth. The instrument would be used during the screening phase of the reintegration process. However, program staff also recognize that there is a cultural component to assessing attachment that they must consider:

"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."

Assessing Readiness for Reintegration

Several caregivers underestimated how difficult it would be to care for the youth. Program staff reported that the first two caregivers presented in the case studies above minimized the youth's behaviors and seemed to feel that the youth would be fine after the reintegration occurred. Program staff learned from their experiences with these families and became more deliberate about assessing the caregivers' understanding of what they believe the reintegration will look like and what they are expecting from the child. One program staff member reported that he or 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..."

Preparation for Reintegration

One of the greatest lessons learned during the past five months is the absolute necessity for program staff to have an adequate amount of time to work with the caregiver prior to reintegration. 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 reintegrated was accelerated in order to accommodate the youth's CPS case plans. However, program staff quickly recognized their error in expediting the placements. 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-reintegration 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.

The other part of this that was more subtle is that these two particular caregivers did not perceive [the Care Coordinator] as an ally or as an asset to promoting a sustained placement. They saw her more as an adjunct to CPS, or in some cases as another CPS worker or something along those lines.

Conversely, some of the youth were inadequately prepared for the reintegration. Many of the youth were placed several hours away from Travis County. The distance created a logistical barrier to ensuring the youth were adequately prepared for the reintegration, as program staff had limited contact with the youth prior to the reintegration. One CPS caseworker reported that the child she referred to the program was given only two days notice that he would be returning to his family’s care. The CPS caseworker expressed regret that more was not done by CPS or the program to prepare the child for the reintegration. The boy’s location made preparation efforts logistically difficult; however, his CPS caseworker reported that lack of preparation may have played a role in the difficulty that he experienced making the transition back into his family’s care.

Because of the limited amount of access that the Care Coordinator has with some youth who are placed outside of the Travis County area, it is particularly important that program staff are able to collaborate more effectively in preparing the youth for the reintegration. However, one CPS caseworker reported that she felt unequipped to plan and prepare families on her caseload for reunification. The 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.

Psychotropic Medications

Four of the six youth in the study were prescribed at least one psychotropic medication at the time of discharge from the RTC. At the end of the evaluation period, only two of the youth were still taking medication. Of the two youth still taking medication at the end of the evaluation period, one was taken off of the medication by the caregiver but was soon placed back on the medication after she began experiencing auditory hallucinations.

Caregivers of the youth who discontinued medication reported that this was done without the involvement of a psychiatrist either because the youth refused to take the medication or the caregiver decided not to refill the child’s prescription. In most cases, program staff supported the caregivers’ decisions to take their youth off medication but recommended that the caregivers do this under the supervision of a psychiatrist. Although program staff experienced difficulty locating psychiatrists to evaluate the youth and monitor their medication, this did not appear to be a factor in the caregivers’ decisions. It was not clear whether the youth’s CPS caseworkers were supportive of the caregivers’ decisions to discontinue use of psychotropic medications.

Interviews with program staff and the youth’s caregivers suggest that the caregivers’ feelings or biases about the use of psychotropic medication were the primary reasons that the youth were taken off their medication. Program staff indicated that some of the caregivers explained to them that they were unconvinced that their youth truly required medication and/or had reservations about the long-term effects.

Financial Insecurity

Financial insecurity was another theme that was consistently present in interviews with caregivers and program staff. While the amounts varied, all but one of the families in the study needed and received some form of financial assistance during the evaluation period. Some of the caregivers required assistance to help prepare for the reintegration. Records indicated that families accessed funds for apartment deposits, rent, and the purchase of beds for some of the youth. In addition, some caregivers received assistance to help cover basic necessities such as groceries and clothing for the youth.

The Care Coordinator noted that she has seen an increase in the amount of financial assistance some of the families need. She explained that some of the caregivers lost their jobs or had to seek positions that would provide more flexibility so that they could be more available for the youth. One caregiver reported that she lost her job because she missed several days of work taking her daughter to various appointments. She was able to locate another position fairly quickly but was concerned about how she would be able to work a full-time job and provide her daughter with the supervision and structure that she believed her daughter required.

The program has provided a much needed safety net for some of the families who experience financial difficulties; however, there is concern regarding how the families will manage once discharged from the program.

Summary

Interviews with the CPS Reintegration Pilot Project staff and CPS caseworkers who referred youth to the project revealed several barriers to the reintegration of youth with complex emotional and behavioral health needs. Systemic-level barriers identified include 1) insufficient collaboration with residential treatment centers regarding discharge planning, 2) continuity in Medicaid coverage following the youth's reintegration back into the community, 3) lack of well-qualified service providers in the community who accept STAR Health or traditional Medicaid, and 4) an insufficient amount of pre-reintegration contact between youth and their caregivers.

Program-level barriers identified in interviews with the program staff and CPS caseworkers include 1) lack of collaboration between CPS and the CPS Reintegration Pilot Project staff during the planning phase of the reintegration process, 2) need for increased clarification of the roles of CPS caseworkers and program staff regarding case tasks and monitoring the placement, and 3) need for increased culturally competency practice when working with the youth and caregivers.

Case-level barriers identified in the interviews include 1) insufficient assessment of attachment between the youth and the caregivers, 2) inadequate assessment of the child and/or caregiver's readiness for reintegration, 3) need for greater preparation of youth and their caregivers prior to the reintegration, 4) need for increased education for caregivers regarding the use of psychotropic medication, and 5) on-going financial insecurity of many families who participated in the CPS Reintegration Pilot Project.

Chapter 5: Discussion and Conclusions

The results provide a glimpse of the characteristics, circumstances, and experiences of youth and caregivers who received services through the CPS Reintegration Pilot Project from October 2007 through January 2009. The results also provide important insights on how families use the services, as well as barriers that CPS caseworkers and program staff encountered to the successful reintegration of youth with severe mental health needs into their families and into the community. Although a causal relationship between participation in the program and successful reintegration cannot be established with such a small sample and by using qualitative methodology, the results of the study are encouraging.

Summary of Results

Several themes emerged from interviews with the six youth and their caregivers, CPS caseworkers, and CPS Reintegration Pilot Project staff. Interviews with the caregivers suggested that they were excited about their child's reintegration and greatly relieved to have him or her out of the foster care system. Caregivers displayed varying levels of attachment and commitment to the child and to the reintegration experience in general. Program staff reported that prior to the reintegration, some caregivers minimized their child's behavior problems and the difficulties he or she might experience once the child reintegrated into the home. Because of this, some caregivers were emotionally unprepared when problems emerged during the placement.

Preparation for Reintegration

The findings of the study suggest the importance of ensuring youth and caregivers' readiness and adequate preparation for the reintegration. During the interviews, it became clear that CPS caseworkers did not have a uniform process for assessing the youth or caregivers' readiness prior to referring the case to the CPS Reintegration Pilot Project. In some cases, readiness was determined, in part, through discussions with the youth's therapists. However, in most of the cases, caseworkers were unable to provide specific criteria regarding how they determined the youth's overall readiness. The most consistent answer provided by CPS caseworkers was that family reunification was the child's permanency plan.

Utilization of Wraparound Service Model

CPS Reintegration Pilot Project staff reported that they strayed from the service model during the first two reintegration placements. The CPS Reintegration Pilot Project service model specifies that program staff be given at least two to three months to fully engage with the family and ensure that services are in place prior to the child's reintegration into the caregiver's home. Program staff quickly learned the error of this decision, as they experienced difficulty engaging the caregivers and the youth in the wraparound process. In addition, program staff reported that they also experienced difficulty communicating with the caregivers regarding the youth's needs and progress. While difficult for all involved, the first two reintegration experiences became a necessary learning experience for program staff. The Care Coordinator for the program later reported that they learned the importance of more closely examining the caregiver's attachment to the child, as well as the caregiver's expectations about the reintegration and what kind of behavior the caregiver was willing to tolerate from the child. Following their experiences with these youth, program staff began declining youth whose reintegration plans did not allow them a full two to three months to meet with and prepare the family to receive the child.

Insufficient Pre-Reintegration Contact

Interviews with the caregivers and youth in the study suggested that pre-reintegration contact between the child

and caregiver was limited for most families. While some of the youth's caregivers were satisfied with the amount of contact they had pre-reintegration, other caregivers indicated that they would have liked to have more contact with the youth before the reintegration occurred. In addition, some caregivers stressed the importance of not using the youth's behavior as a reason for withholding visitation. While policies vary by individual residential facility, Friesen, Kruzich, Robinson, Jivanjee, Pullman et al. (2001) confirmed that RTCs often use points and level systems as a therapeutic technique that is intended to provide youth with an incentive to demonstrate positive behavior. Under these systems, youth earn privileges when they earn a specified number of points or reach a certain level. The authors noted that some RTCs view visitation as a "privilege" that can be revoked at any time.

Youth's Behaviors and Caregivers' Ambivalence

Interviews with the participants in the study suggested that the primary barriers to reintegration of the youth who were referred to the program were the youth's behaviors and the caregivers' ambivalence about the timing of the reintegration. Program staff also noted that they initially encountered resistance from CPS caseworkers regarding placement of youth with severe mental and behavioral health problems directly back into the community. However, staff noted that as awareness and support for the program grew within CPS and among other legal parties, CPS caseworkers embraced the idea that youth could successfully transition from residential care back into the community, provided the youth and their families received the support that was necessary to maintain the child in the home. Evidence of this support for the program is in the number of referrals made to the program, as well as the number of caseworkers who made multiple referrals.

Preparing Youth for Reintegration

Program staff reported that they also encountered some logistical barriers as they collaborated with the CPS caseworkers to prepare the youth for reintegration. Perhaps the greatest barrier program staff reported was the physical distance of some of the placements from Travis County. All but two of the youth were placed at least two hours away from Travis County at the time of reintegration. This presented a challenge in assessing the youth's readiness for reintegration and in developing rapport prior to the reintegration. In addition to the distance of the youth's placements, staff expressed their difficulty accessing residential treatment staff and records to coordinate visits and monitor the youth's progress in treatment prior to discharge. They also noted that they sometimes had problems gaining access to the youth at RTCs, which created additional difficulty in assessing the youth's readiness for reintegration and developing rapport prior to the reintegration.

Establishing a Date for Reintegration

An additional barrier was the difficulty that program staff encountered in their attempts to identify a specific date for the child to transition from the RTC to their caregiver's home. Program staff reported that residential treatment staff were unwilling to commit to a specific date unless the child's service level dropped, as this provided an economic incentive to discharge the child from their care. For youth placed in foster homes, program staff faced challenges with setting a reintegration date because the legal parties often disagreed about when the youth should reintegrate home. Many of the youth's therapists indicated that they did not feel comfortable determining a specific date. In these cases, mediation settlement agreements or the legal dismissal date for the case were the deciding factor. Other barriers program staff encountered that were eventually resolved included difficulties getting complete referral paperwork for youth from the referring CPS caseworkers and problems communicating with the CPS caseworkers regarding the youth's progress.

Caregivers' Assessment of Reintegration Program

Overall, caregivers were very satisfied with the program and with the level of support the program provided them

prior to and following the child's reintegration into the home. The caregivers were particularly complimentary of the Care Coordinator for the program. They reported that the Care Coordinator provided them with the emotional and logistical support that they needed. All of the caregivers who were interviewed noted that they appreciated the Care Coordinator's availability and willingness to help them access various community and contracted services as their needs changed.

All four of the caregivers who participated in the PESA training classes reported that the classes were extremely beneficial and helped them develop a better understanding of mental illness and how they could more effectively advocate for their child in the mental health, educational, and child welfare systems. Caregivers explained that the classes helped them reevaluate their expectations of the youth and of the reintegration experience as a whole. Several of the caregivers believed that the classes should be mandatory for all caregivers participating in the CPS Reintegration Pilot Project. Program staff reported that they have considered making the classes a condition of participating in the program; however, they have been reluctant to impose services on families. Other helpful services mentioned included youth mentoring services and financial assistance provided by the program.

Limitations

This study provided a tremendous amount of insight about the reintegration of youth in foster care; however, the study had a number of limitations. Because of the small number of youth who transitioned home during the evaluation period, the sample size of youth and caregivers interviewed for this study was relatively small. Therefore, 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. Decisions about the scope of the study's recruitment efforts and one-time interviews with CPS caseworkers were dictated primarily by time and resource constraints. Ideally, the sample of CPS caseworkers interviewed for this study would have been much larger in order to gain a more complete picture of the different barriers that they encountered 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 further validated the responses of participants and helped contextualized the findings. However, the study would have been further strengthened by the inclusion of quantitative measures assessing the youth's and caregivers overall attachment to each other, their readiness for reintegration, and their adjustment to the reintegration following the youth's transition back into the community.

Implications for Practice and Further Research and Recommendations

Our data suggest that the reintegration process is a highly individualized process; however, some practices were found to be important to the success of the reintegration. This study has begun to document the strengths of the youth and their caregivers in the program and the challenges they encounter during the reintegration process. Because the reintegration process relies heavily on the cooperation and support of those involved in the youth's cases, we suggest the following recommendations be made to further improve outcomes for youth and caregivers who receive services through the program:

System-Level Recommendations

- Improve services for youth and families by providing caseworker training on services to youth with severe mental health needs and implications for transitioning back home.

- Increase the amount of pre-reintegration visitation/contact between youth and caregivers.
- Increase communication with residential treatment centers to increase likelihood of visitation between youth and their family members, and residential staff's involvement in preparing the youth and their families for reintegration.
- Provide training for CPS caseworkers on how best to help families address both the short-term and long-term challenges associated with the reintegration process.
- Ensure that professionals involved with the youth's cases receive training in culturally competent practices in order to develop a better understanding of different racial and ethnic backgrounds, as well as the ways professionals can adapt their practices to the cultural context of the families that they serve.
- Provide families with access to qualified and experienced providers who understand the unique needs of youth with complex emotional and behavioral health needs.
- Educate the court as well as attorneys and CASA regarding the essential steps and timeframes necessary for successful reintegration.

Program-Level Recommendations

- Provide program staff with adequate time to prepare youth and caregivers for reintegration and engage with the caregivers and ensure that the necessary services are in place.
- Clarify with CPS caseworkers what their role will be in the reintegration process and how they can help prepare the youth and caregivers for reintegration.
- Ensure that there is open dialogue with CPS staff regarding the cultural relevance of services provided to families in the program.
- Continue efforts to engage and educate CPS administrators and caseworkers about the program, what constitutes an appropriate referral, and proactive case planning.
- Assess and refine program policies based on evaluation results.
- Formalize policies by creating a handbook of policies and practices for future program staff to use.

Case-Level Recommendations

- Assess needs of caregivers and youth prior to reintegration and assess resources in the community to meet those needs. If resources are not available in the community, identify other services outside of the community that can address their needs.
- Assess the caregiver's willingness to engage in therapeutic services as well as the child's wraparound plan of service.
- Use a standardized instrument to assess caregiver and youth attachment during the screening phase of the process to help determine their overall readiness for reintegration.
- Prepare youth's siblings for the youth's reintegration back into the home.
- Work with caregivers to monitor the youth's needs for psychotropic medication. Develop a protocol for families to follow when they are considering the discontinuation of medication for the child in their care.
- Require identified caregivers to participate in Parent Engagement and Self-Advocacy training classes.
- Identify and implement policies for caregivers to encourage the full participation of caregivers in the program, such as a requirement that caregivers attend the youth's monthly team meetings.
- Ensure the availability of funding for families' basic and enrichment needs.

- Conduct and document a full assessment of each family's ongoing financial, health, and support needs prior to discharging youth from the program.

Conclusions

This pilot study has generated both answers and additional questions. Unanswered questions pertain largely to the long-term sustainability of the youth's placements and how the families will fare once discharged from the CPS Reintegration Pilot Project. Longitudinal follow-up of the youth and caregivers in the study will reveal important insights about the long-term outcomes of the placements. The primary purpose of this study was to provide descriptive information about the experiences of youth in foster care who are reintegrating from intensive-out-of-home placements into the community. Yet this study also captured information that can contribute to the dialogue about how child welfare agencies conceptualize reintegration and the circumstances under which reintegration can successfully be achieved. The findings suggest that youth with severe mental and behavioral problems can successfully be reunited with their families and returned to their communities, provided that they have agency commitment and appropriate services, a caregiver who is committed, and that the family has access to community supports.

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