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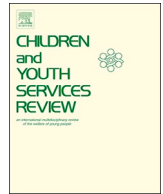
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To preserve or not to preserve: That is the question. Decision-making about family preservation among families in multi-problem situations

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ABSTRACT

High rates of failed reunification indicate that family preservation (FP) does not necessarily lead to permanency for children. It could be argued that, in such failed cases, the decision-making process leading to the preservation of the family was inadequate. In order to gain insight into the role that decision-making plays in family preservation practice, we studied decision-making within an FP-intervention program provided by the Expertise Center. The Expertise Center explicitly combines treatment and decision-making in an assessment-based intervention that is provided to families seeking either to be reunited with their young child (0–2) or to avoid an out-of-home placement of the child. In addition, at least one of the parents has psychiatric problems. We hereby attempted to a) map decision-making trajectories in practice and b) provide feedback about Expertise Center decision-making based on evidence regarding the – sometimes evolving – quality of parental behavior as observed in the participants. We have used a descriptive design ($n = 100$) as well as a one-group repeated measures design ($n = 28$) to examine parental behavior using the Atypical Maternal Behavior Instrument for Assessment and Classification (AMBIANCE). We hypothesized that a negative recommendation regarding family preservation would manifest itself in the display of more frequent and more severe atypical parental behavior. Our results indicate that the Expertise Center succeeded in contributing broadly to timely decision-making in the context of permanency planning, and that implementation of the Decision-making Continuum potentially improved the quality of clinical decision-making. Furthermore, our hypothesis was confirmed by four out of five measurements of parental behavior that have been proven to be significant for children's attachment security. Since these are promising results, the Expertise Center program could serve as an inspiration for the practice field.

1. Introduction

Once families become involved with child protection, a continuous process of professional decision-making begins (Baumann, Fluke, Dagleish, & Kern, 2014; Taylor, 2010). Decisions concerning the out-of-home placement of a child in the context of *permanency planning* are exceptionally high-stake decisions, since the consequences are far-reaching and the impact on the lives of the families involved is enormous (Davidson-Arad & Benbenishty, 2008; Lindsey, 1994). Ever since a *family preservation* prototype arose in the field of child welfare in the 1970s (Tully, 2008) – which can be viewed as both a philosophy and a service delivery model (McCroskey, 2001) – the prevention of out-of-home placement or the reunification of the child with the birth family have been considered the most favorable outcomes in the context of this ideal. However, in terms of reunification, family preservation does not necessarily lead to permanency (Kimberlin, Anthony, & Austin, 2009; Maluccio, Abramczyk, & Thomlison, 1996).

Although accurate rates of re-entry into care after reunification are lacking (Festinger, 1996; Lee, Jonson-Reid, & Drake, 2012; Mc Grath-Lone, Dearden, Harron, Nasim, & Gilbert, 2017; Taussig, Clyman, & Landsverk, 2001), studies generally report high percentages of failed reunification. For example, Wulczyn, Chen, Collins, and Ernst (2011) explored data from 14 states in the U.S., from 2000 through 2008, and found that approximately one in three infants re-entered family foster care following reunification. It could be argued that, in these cases, the decision-making process leading to preservation of the family was inadequate, since it appeared not to last. Indeed, inadequate assessment – where decision-making plays an important role – has been associated with reunification breakdown (Donald & Jureidini, 2004; Wilkins & Farmer, 2015).

Another current issue of concern in this context is the delay involved in the decision-making process (Brown & Ward, 2013; Masson, Pearce, & Bader, 2008), resulting in long periods of uncertainty for both children and parents (Choy & Schulze, 2009; Farmer & Lutman, 2010).

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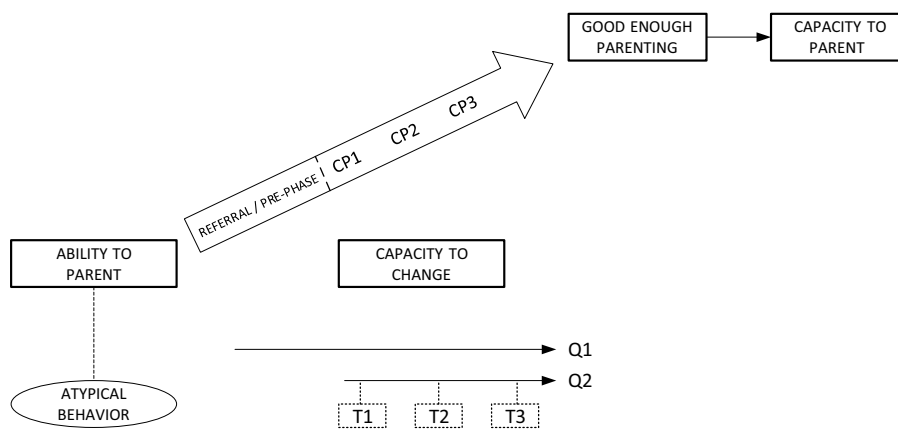


Fig. 1. Overview of the study. Research question 1 (Q1) is about the complete intervention from referral through to the end of the clinical phase; question two (Q2) is about the clinical phase.

From an attachment perspective, timely decision-making regarding permanent placements is especially significant for infants and toddlers, given the importance of forming a secure attachment bond in early life. The period suggested for making a permanency decision for infants and toddlers is preferably within six months and at most within a year following out-of-home placement (De Baat, Van den Bergh, & De Lange, 2014; Juffer, 2010). So to summarize, it is vital for decisions concerning family preservation to be well timed and effective, and for them to lead to desirable outcomes such as permanency for the child. However, there is repeated evidence that this is not being achieved in current practice. How to reverse this and succeed in family preservation is a challenging issue in the field of child welfare, since the decision-making involved is a highly complex process (O’Sullivan, 2011).

The complexity of the decision-making process in these cases is caused by the many interconnecting factors influencing the situation on the individual level (decision-maker), the case level (characteristics of the family involved), and the contextual level (organizational and external context) as indicated in *The Decision Making Ecology* (Baumann et al., 2014, p. 28). This general model emphasizes the context in which decisions are made and considers decision-making as a *continuous process*. In child welfare, this continuum – referred to as the Decision-making Continuum – begins with the decision to invite a family for an intake and ends at case closure (Baumann et al., 2014, p. 29). In between, the decision-making process involves a large number of disparate (smaller) decisions, all of which influence the outcome of key decisions such as, for instance, the out-of-home placement of a child.

1.1. Aim and research questions

In order to understand the role of decision-making in reunification and to come up with strategies for improvement, it is useful to study in depth the context and quality of current practices in which placement decisions arise. We therefore studied the outcomes of a family preservation intervention program that is used in the Netherlands, the Expertise Center for Treatment and Assessment of Parenting and Psychiatry (in short, Expertise Center), by doing a program evaluation study (cf. Harinck, Smit, & Knorth, 1997). The Expertise Center explicitly combines treatment and decision-making in an assessment-based intervention that is provided to families with infants and toddlers during a maximum 16-week period of admission in a clinic. The inpatient phase of the intervention includes three instances of evaluation (week 4, week 10, and week 14), in which the trajectories of parents who do not seem to be taking sufficient advantage of the program will end up being terminated with a negative recommendation concerning family preservation. In the study, we are investigating the treatment component as well as the decision-making component. In this particular paper, we will be reporting on the latter topic.

Our aim is twofold: 1) mapping decision-making trajectories in practice for the purpose of improving the awareness and quality of professional decision-making, and 2) providing feedback regarding the decision-making of the Expertise Center that includes evidence about the quality of parental behavior with the participants.

The first research question is: “what are the characteristics of the decision-making processes in the Expertise Center in terms of duration, reasons, and decision-makers?”. The second question refers to the quality of parental behavior during the inpatient part of the program, just before the decision about family preservation is made; more specifically, whether there is a difference in “atypical parental behavior” between families that were given a negative recommendation concerning family preservation by the professionals of the Expertise Center (group “No FP”) and families whose decision was positive (group “FP”). “Atypical parental behavior” is defined as behavior of the parent that disrupts the interaction with the child and is associated with infant disorganization (Bronfman, Madigan, & Lyons-Ruth, 2014). It is hypothesized that the first group of parents will show more and more severe atypical parental behavior, since the team of the Expertise Center considers the quality of parenting in such cases as too marginal to grant family preservation. Confirmation of this assumption will yield an initial empirical provision for the family preservation decisions made by the professionals of the Expertise Center during the clinical phase of their program. In Fig. 1, an overview of the study is presented. The main concepts are displayed in boxes and the studied concept related to the ability to parent in the oval. The large arrow represents the intervention, including the three evaluation points during the clinical phase (CP). This figure will be further explained in the method section.

2. Method

2.1. Intervention

The Expertise Center for Treatment and Assessment of Parenting and Psychiatry was set up in the Netherlands as part of Mental Health Care Drenthe (in Dutch, GGZ Drenthe). The objective of the program is to support parents with infants and toddlers towards achieving *good enough parenting*, to assess their *capacity to change*, and to evaluate whether family preservation is in the best interests of the child. The program was developed based on the assumption that a timely placement decision and the consent of the parents were crucial factors in the prevention of (further) harm to the child through disruptions in early relationships with primary caregivers, along with inadequate parenting. The families referred to the Expertise Center (for the most part by their family guardian, case manager or another CP professional) can be regarded as families living in a chronically problematic situation (Tausendfreund, Knot-Dickscheit, Schulze, Knorth, & Grietens, 2016),

characterized in the literature by various terms such as *high risk families*, *multi-problem families*, *multi-stressed families*, and *troubled families*. Families are eligible for the program in case they either aim to achieve reunification with their young child (age 0–2) or to prevent out-of-home placement of their young child; if at least one of the parents has psychiatric problems; and if a CP professional such as a case manager or family guardian is involved in the family. The children that are placed before the program usually stay in foster families. The children that are still living in the family of origin are mostly staying with their parents under strict supervision of the network of the family, explicated in a safety plan.

The program consists of several phases including a (predominantly outpatient) pre-phase, a residential phase, and an aftercare phase. The intervention is based upon various principles, theories, and methods regarding parenting, family-system therapy, attachment, and trauma recovery. Building a trustful and positive working alliance with families is at the heart of the working methods, using techniques from De Shazer's *Solution-Focused Brief Therapy* (SFBT) (1985). In order to tailor the program to the unique needs and characteristics of the families, a broad range of methods, techniques, and interventions is offered during the program. The Expertise Center facilitates shared decision-making through set evaluation points, from intake through to the end of the program, in which the three parties involved (family, professional responsible for the referral of the family, and the team of the Expertise Center) together assess the parenting situation, explicate the treatment goals, and monitor the process of the family in the program (see Vischer, Grietens, Knorth, & Mulder, 2017 for a more extensive description of the intervention program).

2.2. Parenting

In Fig. 1, the upward arrow represents the intervention and its primary aim: improvement in the *ability to parent* (assessed as inadequate before intervention) so as to reach a “good enough” level (which is the indispensable condition for *good enough parenting*). “Ability to parent” refers, in this study, to the fundamental element of parenting: the ability of parents to take care of their child at a basic level (thus showing sensitivity and responsivity) in direct interaction with their child at a certain point in time. Therefore, the “ability to parent” is not a feature of the individual parent but a characteristic of the relationship between the parent and the specific child, since parenting is an interaction (Crittenden, 2005).

We operationalized this concept through an examination of atypical parental behavior using the Atypical Maternal Behavior Instrument for Assessment and Classification (AMBIANCE; Bronfman, Parsons, & Lyons-Ruth, 1992; Lyons-Ruth, Bronfman, & Parsons, 1999). AMBIANCE is a coding system to assess parental behaviors that have been associated with disorganized attachment. It is based upon the paradigm that parental behavior towards children is the key determinant for the quality of infant attachment. Since the behaviors mapped with the AMBIANCE are the opposite of the essential parenting qualities *sensitivity* and *responsivity* (basic principles include for instance responding adequately and promptly to infant cues, and providing affection and protection), this instrument is suitable to examine the ability to parent. In addition, taking into consideration the age of the children of the target population of the Expertise Center, it is appropriate to study parental behavior that is evidently linked to attachment quality.

Providing a good enough quality of parenting (ability to parent) on a *continuous* basis in the long term can be considered as the *capacity to parent* (cf. Vischer et al., 2017; Conley, 2003). Using Fig. 1, decision-making regarding family preservation during the clinical phase of the program can be depicted as continuously determining whether parents are still moving the arrow upwards, in other words, improving their parenting and showing *capacity to change*. If so, a “go” decision can be made to continue the program towards the next phase. If not, change is considered as coming too slowly, and the trajectory will be terminated

with a negative recommendation about family preservation resulting in a “no go” decision.

2.3. Design

The two research questions reported in this paper are part of a broader evaluation study, they specifically focus on the decision-making component of the program. When answering question 1 (“trajectories”), we used a descriptive research design including all phases of the intervention: *referral, intake, two-week trial stay in the clinic, clinical phase 1, clinical phase 2, clinical phase 3, and aftercare*. Exclusively administrative data were used.

Regarding question 2 (“parenting and decision-making”), we used the data of a study on the quality of parental behavior using a one-group repeated measures design obtained by inviting parents to participate to our study. Data were collected during the residential phase of the intervention in week 2 (T1), in weeks 6 or 7 (T2), and just before the final evaluation in weeks 13 or 14 (T3). The data were analyzed from two perspectives: a) focusing on changes in the quality of parental behavior during the clinical phase (reported in another paper) and b) decision-making (this paper). This study can be considered exploratory, since no other research evaluating an intervention that explicitly incorporates decision-making on family preservation is known by the authors.

2.4. Participants

The administrative data of all families referred to the Expertise Center from May 2013 through April 2015 were included in the trajectory analysis ($N = 100$). The available background data for families included in the trajectory analysis are displayed in Table 1. The administrative data of seven families could no longer be retrieved at the analysis phase. The remaining 93 families included a total number of 145 referred parents and 113 children, some of which were as yet unborn.

With reference to research question 2, the study regarding the

Table 1
Participant characteristics trajectory analysis upon referral.

	<i>M</i>	<i>SD</i>	Range
Number of referred family members ^a	3.4	0.83	2–6
Parent age at referral ^b	28.8	7.6	18–59
Child age in months at referral ^c	11.3	10.1	0–40
	<i>N</i>	%	Missing
Parent gender			0
Female	82	56.6	
Male	63	43.4	
Child gender			0
Female	53	51.9	
Male	49	48.1	
Family type			8
Two-parent household	59	69.4	
Two-parent household (blended)	5	5.9	
Single-parent household	21	24.7	
Parent ethnicity			4
Dutch origin	123	87.2	
Immigrant background	18	12.8	
Child ethnicity			5
Dutch origin	78	72.2	
Immigrant background	30	27.8	

Note. For seven families there were no administrative data available in the Electronic Client File program of the Expertise Center. Missing observations are the result of children born after referral and are due to missing administrative data.

^a $n = 93$.

^b $n = 145$.

^c $n = 89$.

Table 2
Parenting and decision-making study – Participant characteristics at referral.

	M	SD	Range
Parent age at T1 ^a	25.9	5.5	18–44
Child age in months at T1 ^a	15.6	10.5	1–32
	n	%	
Child age groups			
0–12 months	12	40.0	
13–24 months	9	31.0	
25–32 months	9	31.0	
Parent gender			
Female	27	90	
Male	3	10	
Child gender			
Female	15	50	
Male	15	50	
Family type			
Two-parent household	16	53.3	
Two-parent household (blended)	4	13.3	
Single-parent household	10	33.3	
Number of children in family			
One child under age of 3	23	76.7	
Two children under age of 3	7	23.3	
At least one child above age of 2	8	26.7	
Parent ethnicity			
Dutch origin	21	70.0	
Immigrant background	9	30.0	
Child ethnicity			
Native Dutch	21	70.0	
Immigrant background	9	30.0	

^a n = 30.

quality of parental behavior was designed to include all families who have been admitted into the clinic of the Expertise Center for the inpatient part of the intervention from March 2014 onwards. Inclusion continued until the target number of 30 parent-child dyads (one dyad per family) was reached in February 2016. The participation rate was 91% with three families declining to participate. The parents of these families all stated that they were not comfortable with the idea to be filmed. Written informed consent was obtained from all participants.

There is an overlap in the two samples of the sub-studies reported here, since some of the families included in the trajectory analysis were admitted to the clinic of the Expertise Center within the inclusion period for research question 2 and thus decided to participate in this sub-study as well (n = 22). The remaining families (n = 8) were referred to the Expertise Center after April 2015 and are therefore not included in the trajectory analysis. Background data of the 30 participants are shown in Table 2.

2.5. Measurements and instruments

2.5.1. Trajectories

The following variables were registered for each phase of the program: *start* and *end date* (to calculate “duration”); *outcome per phase* (“go/no go” to the next phase); and in case of trajectory termination: *decision-makers*, and *arguments for trajectory ending*.

2.5.2. Parenting and decision-making

The ability to parent was measured using the Atypical Maternal Behavior Instrument for Assessment and Classification (AMBIANCE; Bronfman et al., 1992; Lyons-Ruth et al., 1999).

This instrument consists of five dimensions: (1) *affective communication errors* (e.g., contradictory signaling to infant or failure to respond to infant cues), (2) *role/boundary confusion* (e.g., treating infant as spousal partner or role reversal), (3) *fearful/disoriented behavior* (e.g., appears frightened in interaction with infant or generally disoriented), (4) *intrusiveness/negativity* (e.g., verbally or physically intrusive behavior, inappropriately attributes negative feelings to child), and (5)

withdrawal (avoidant, maintaining distance from the child). Each dimension consists of two up to four codes (items) and each of these codes is constructed upon a number of concrete and observable parental behaviors (between 4 and 19 descriptions). Haltigan et al. (2017) provide item descriptions for each dimension. The system demonstrated to have good reliability, validity and stability over time (Madigan et al., 2006).

Coding using AMBIANCE is performed on the transcript of a five-minute videotaped parent-child interaction and results in: a *frequency score* for each dimension (the number of observed atypical behaviors); a *rating score* for each dimension (rating of the severity on a scale from one to seven, where one is low severity and seven is high severity, based upon the number and severity of the assigned codes); and a score of the overall *parental level of disrupted communication*, which classifies the behavior of the parent as *disrupted* (a score of five or above) or *not disrupted* (a score of below five).

2.6. Procedure

2.6.1. Trajectories

The analysis of the trajectories (research question 1) is descriptive. The trajectories were monitored with help from the administrative Electronic Client File program of the Expertise Center and several other administrative overviews, mostly Excel spreadsheets, to manage new referrals and the flow of families through the stages of the program. The main researcher (first author) checked new referrals and shifts of families through the phases of the program on a weekly basis. In addition, the records of weekly team meetings and evaluations were scanned for relevant data in the context of the trajectory analysis. In cases of missing data, an attempt was made to collect this information from the Expertise Center team. The information about each family was filled in on a trajectory form, and, after case closure, the quantitative data were entered into a database.

2.6.2. Parenting and decision-making

The ability to parent is measured by naturalistic observation of the following core parenting tasks: feeding the child, physically caring for the child (e.g., changing diapers, dressing), and putting the child to bed. Parents were asked to notify the main researcher (located in an office at the clinic on data collection days) each time they carried out one of the core parenting tasks. This way, data collection was fitted into the daily structure of the family in order to respect their planning. Parents were asked to “act as usual” and as if there was no camera. Each parenting task was filmed for a minimum of ten minutes. The parents received a coupon for a local supermarket and a digital copy of the videos after each measurement. If parents desired, the family coaches were provided with the videos to use for video-feedback sessions with parents, which is one of the regular methods used in the Expertise Center.

The first author is a certified AMBIANCE coder (having completed the training and reliability test) and thus coded the videotapes. AMBIANCE requires a minimum of five-minute fragments of parent-child interactions; therefore, a selection procedure was applied to select six minutes from all the video material. From the “feeding” and “care-taking” situation, the final 2.5 min were selected and from the “putting-to-bed” situation, the first minute was selected from the exact moment the parent put the child to bed onward. The coder strictly followed the AMBIANCE coding protocol, and the trainer was contacted on a regular basis for consultation, specifically in cases of fearful/disoriented behaviors, since the ICC of the rating on this dimension was low (ICC = 0.49) in the reliability test. Efforts were made to blind the main author to the time (T1, T2, or T3) of the measurement during the coding of the video fragments through a) renaming all fragments with a new id number and b) coding the video's in a random order (both organized by a research assistant). The analysis phase started over two years after the final video registration in the clinic (which was done by the main author as well).

All procedures were based upon the Ethical Guidelines of the

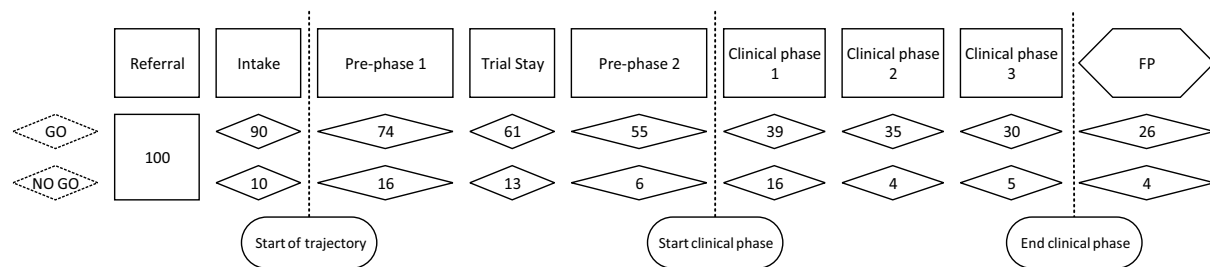


Fig. 2. Flow of families referred to the Expertise Center in the Decision-making Continuum. The “no go” applies to the decision to discontinue the program, not strictly to the decision about family preservation (with the exception of the final box). Note: FP = Family Preservation.

department of Pedagogy and Educational Sciences of the University of Groningen. The Medical Ethical Board of the University Medical Center Groningen concluded that further assessment of the medical ethical protocol was not needed.

2.7. Data analysis

2.7.1. Trajectories

The quantitative data were analyzed with descriptive statistics using IBM SPSS, version 25. The qualitative data, which concerned the variable “arguments for trajectory ending,” were first explored for the purpose of defining categories and developing a codebook under the supervision of the first author. Consequently, all data were coded by a Master’s student and the first author, while the first author reviewed all final coding in order to ensure all fragments of text were coded under the relevant category.

2.7.2. Parenting and decision-making

First, we calculated the means, standard deviations, and maximum scores for both the frequency and rating scores of each AMBIANCE scale, including the overall level of the disruption scale at the last measurement before the decision about family preservation was made (TL), for both groups “No FP” and “FP.” Furthermore, we calculated the percentages of families with a rating score in the disrupted range for both groups.

Moreover, using the Mann Whitney *U* test, the differences in rank means for the dimensions that differed in means between the groups “FP” and “No FP” were tested. Due to the small sample and the exploratory nature of the study, a level of statistical significance of $p \leq .10$ was employed here (Cohen, 1990).

Finally, we conducted a Chi-square test to test the relationship between the decision about FP (positive/negative) and the classification of the overall parental behavior (disturbed/not disturbed).

3. Results

3.1. Trajectories

3.1.1. Decision-making continuum

Exactly 100 families were referred to the Expertise Center over a period of two years. For 74 families, an actual trajectory was started as a result of a positive decision (“go”) after intake. In the pre-phase, the trajectory of 35 families was terminated, resulting in 39 families starting with the inpatient part of the program. Nine of these families “dropped out” during the clinical phase, with a negative recommendation about family preservation; most of the remaining 30 families received a positive recommendation about family preservation ($n = 26$). Four families were given a negative recommendation concerning family preservation following a complete clinical trajectory of a minimum of 16 weeks. Fig. 2 shows the flow of the population of the Expertise Center through the Decision-making Continuum. The two layers below the program phasing represent the set decision times,

where the upper layer presents the number of families continuing towards the next level (receiving a “go” decision) and the lower layer the number of families with terminated trajectories (receiving a “no go” decision).

3.1.2. Duration

The duration of the decisions about family preservation was calculated for families with a trajectory ending before the clinical phase ($n = 35$), and for those who started the clinical phase ($n = 39$) with intake as the starting point. Considering the first group, the number of weeks between intake and termination of the trajectory ranged from one to 72 weeks ($M = 21.5$, $SD = 16.7$). For 75% of the 35 families who ended the trajectory before the clinical phase, the trajectory ended within half a year (26 weeks), and for 91.4% within a year. The trajectories of families who were admitted into the clinic ($n = 39$) lasted between 20 and 77 weeks ($M = 41.2$, $SD = 12.8$). For three families (7.7%), a decision about family preservation was made within half a year of intake. Three quarters of the families (74%) followed the program between 26 and 52 weeks ($n = 29$), which means that the decision-making process lasted between half a year and one year. For seven families (17.9%), the trajectory ranged between 57 and 77 weeks.

3.1.3. Arguments

From the qualitative data, six categories of reasons for ending the trajectory emerged. The trajectories of the families who did not enter the clinical phase ($n = 35$) were, for the most part, terminated due to the *unwillingness of parents* to be admitted into the clinic (31%, $n = 11$), even though in most cases this decision on the part of the parents led to permanent out-of-home placement for the child. For 23% of the families, it was reported that the professionals of the Expertise Center had assessed the problems as *too severe* for clinical treatment. This same percentage was found for the family guardian considering the *chance to achieve family preservation* with clinical treatment as *too minimal*. Other reasons mentioned were not fulfilling the *required criteria* for the clinical phase (for instance, regarding housing, financial stability, not using drugs and/or alcohol), and a *misfit* between specific needs of the family and the service provision of the Expertise Center. Conversely, for five families who did not enter the clinical phase (14%), the parenting situation was assessed as “good enough” during the pre-phase, and a positive decision about family preservation was made by the case manager.¹ For some families, more than one reason for termination of the trajectory was reported.

3.1.4. Decision-makers

When the trajectory was ended in the pre-phase of the program, the decision was, for the most part, made by the case manager ($n = 26$,

¹ By the “case manager,” we are referring to the professional responsible for the referral of the family to the Expertise Center. This is the child protection worker responsible for the safeguarding of the children. In the Netherlands this professional is called a “family guardian” in involuntarily cases and “case manager” in involuntarily cases.

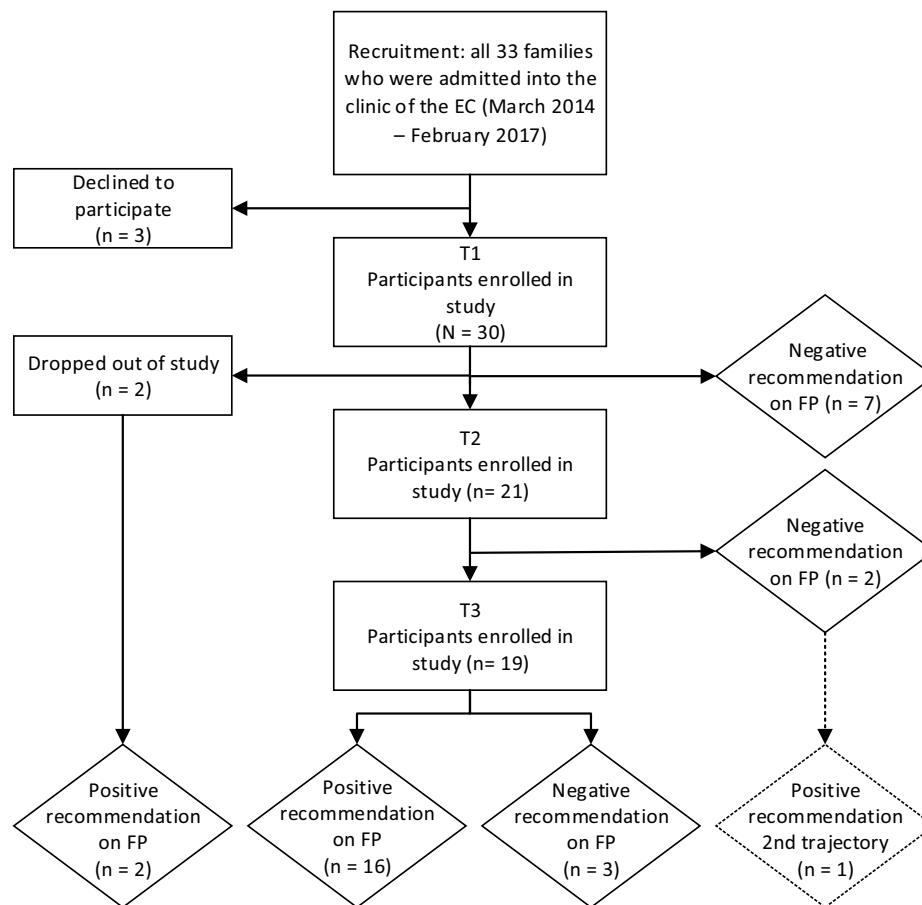


Fig. 3. Participant flow through measurement periods. Note: FP = Family Preservation.

74.2%). In seven cases (20%), the parents themselves were the decision-makers, and the same percentage applies to the team of the Expertise Center. In some cases ($n = 5$), there was more than one decision-maker.

3.2. Parenting and decision-making

The flow of participants through the sub-study that includes those families that were admitted into the clinic is presented in Fig. 3: here, the “no go” decisions are displayed on the right-hand side and the “go” decisions in the middle. As shown, the trajectories of seven families were terminated with a negative recommendation at the time of the first evaluation of the clinical phase (week 4). In the first evaluation, one strict criterion was assessed: that there should be no safety concerns regarding the children returning home with the birth family during the weekend. Over the first four weekends, the children usually returned to their foster families. In the second period of the clinical phase, the trajectories of two families were ended.² After the final evaluation, three families received a negative recommendation (following a clinical trajectory of 16, 20, and 20 weeks, respectively), and, for the remaining families ($n = 16$), a positive decision about family preservation was made.

Eleven of these trajectories lasted between 16 and 18 weeks, six trajectories between 19 and 22 weeks, and one trajectory lasted for 29 weeks. One of these families was preserved, on the condition that the

²One of these families was admitted into the clinic for a second trajectory (after data collection for this study), in which the other parent was then assessed as the main caregiver, resulting in a positive recommendation. In this study, we included this family in the “No FP” group, since we were examining the behavior of the other parent at that point.

family would live together with (an) approved extended family member (s). Two families dropped out of the study after the first measurement. In addition, also one of these families was preserved on the condition that the family would live together with extended family.

3.2.1. Frequency scores

Our hypothesis was that parents for whom the clinical phase was terminated with a positive recommendation about family preservation (“FP”) would display less atypical parental behaviors in comparison to families that were not preserved (“No FP”). An examination of the scores (see Table 3 for the descriptive statistics) revealed that, for all scales except one (*intrusiveness/negativity*), the mean scores were indeed lower in the family preservation group. Comparing both groups with respect to the rank mean frequency scores of the four scales showed a significant difference regarding *affective communication errors* ($Z = -2.656$; $p = .008$), *fearful/disoriented behavior* ($Z = -3.160$; $p = .002$), and *withdrawal* ($Z = -1.758$; $p = .079$).

3.2.2. Rating scores

It was hypothesized that the “No FP” group would display more severe atypical parental behavior in comparison with the “FP” group. Consideration of the mean rating scores per scale level (Table 2) showed that the means within the group “FP” were lower, indicating less severe atypical behavior, for all AMBIANCE scales including the *overall level of disruption* compared to the “No FP” group. In addition, all mean scores of the FP families fell within the *non-disrupted* range. Within the “No FP” group, the mean of *affective communication* and the *overall level of disruption* scores fell into the *disrupted* range.

Examination of the percentages of parents who were rated with a dimension score in the *disrupted* range showed a similar trend: the

Table 3

Frequency and rating scores of atypical parental behavior scales at the last measurement (TL) before the decision on family preservation was taken per recommendation about family preservation.

Recommendation about FP	FP (n = 16)				No FP (n = 12)			
	% ^a	M	SD	Max	% ^a	M	SD	Max
Atypical parental behavior Scales								
Affective communication errors ^c								
FR		6.9	5.1	17		12.9	5.0	19
RAT	25.0	3.0	1.8		41.7	5.1	1.6	
Role/boundary confusion ^c								
FR		4.3	4.8	18		7.3	7.2	26
RAT	6.2	2.4	1.6		25.0	3.3	1.6	
Fearful/disoriented behavior ^c								
FR		3.6	5.1	21		10.5	6.7	22
RAT	0.0	2.0	1.1		25.0	3.8	1.0	
Intrusiveness/negativity								
FR		7.0	7.0	20		6.7	4.4	12
RAT	31.2	2.6	1.9		33.3	3.2	2.0	
Withdrawal ^c								
FR		2.4	1.9	6		4.9	4.3	14
RAT	0.0	1.9	1.1		25.0	3.3	1.9	
Overall level disruptive behavior ^c	31.2	3.1	2.0		75.0	5.1	1.5	

Note. Higher mean and maximum scores are more unfavorable. FP = family preservation, FR = frequency score, RAT = rating score.

^a Percentage with a rating score in the disrupted range.

^c $p < .10$.

percentages of the “FP” group were lower for most dimensions compared to the ratings in the “No FP” group, including two scales (*fearful/disoriented behavior* and *withdrawal*) in which none of the “FP” families scored in the *disrupted* range. The single dimension, on which the percentages of the “FP” and “No FP” families were alike, was in line with the frequency scores: *intrusiveness/negativity*. Mean ranks of the two groups were compared, resulting in significant differences on the *affective communication* ($Z = -2.796$; $p = .006$), *role/boundary confusion* ($Z = -1.698$; $p = .089$), *fearful/disoriented behavior* ($Z = -3.409$; $p = .001$), *withdrawal* ($Z = -2.065$; $p = .039$), and *overall level of disruption* ($Z = -2.544$; $p = .011$) scales.

3.2.3. Classification of parental behavior

Using a Chi-square test, the association between the type of recommendation about family preservation (positive/negative) and the range (disrupted/not disrupted) of the *overall level of disruption* was tested and rendered a significant relationship ($\chi^2(1) = 5.25$; $p = .022$). Most of the parents with a positive family preservation decision were assessed as *not disrupted* (69%), and most of the parents with a negative recommendation about family preservation were assessed as *disrupted* (75%). However, in five cases, the parental behavior was classified as *disrupted* and the recommendation of the professionals of the Expertise Center on family preservation was positive.³ In three cases, the parents were classified as *not disrupted*, even though they received a negative recommendation about family preservation.

4. Discussion

To the best of our knowledge, this is the first study in which decision-making in the context of permanency planning for infants and toddlers has been evaluated. Using decision-making theory, we analyzed the trajectories of the target population of the Expertise Center, and we linked actual clinical conclusions with parenting quality, thus

aiming to provide feedback about decision-making within the Expertise Center.

4.1. Trajectories

To begin with, the study provided insight into some characteristics of the decisions of the Expertise Center, namely duration, parties involved, and main arguments. Several conclusions can be drawn here.

First, the team of the Expertise Center seems to succeed in contributing to placement decisions within the suggested period of half a year up to a maximum of one year for a large portion of the target population. This is specifically the case when a trajectory ends before the clinical phase of the intervention program, which generally implies a negative decision about family preservation, although there were a few exceptions. In contrast, positive decisions about family preservation tend to be made a little slower. The difference in timing between negative and positive decisions can be explained by the fact that completing the in-patient intensive treatment phase, which lasts four months, seems necessary for achieving good enough parenting. Despite this, a substantial part of in-patient trajectories were terminated or completed within a year of intake.

Yet, it should be mentioned that the duration of the decision in the study was calculated starting from the intake, and not from the exact date of the (potential) out-of-home placement. Therefore, the actual duration of the placement decisions is more extensive. Given this fact and our findings that a proportion of trajectories lasts for over a year, it is recommended that the actual start date of the decision-making period – and the remaining time – be included as an essential factor each time “go”/“no go” decisions are made during the program. The remaining length of time should be based upon a prior determined timeframe for decision-making, suitable for the specific child involved, and thus taking into account age and well-being, for instance. Formally determining a time frame a priori, along with close monitoring of the remaining duration, is likely to promote timely decision-making. In this context, implementation of the Decision-making Continuum could be helpful, since it shows, for example, which phases of the program are still ahead in the assessment procedure and what the minimum term is for completing the program. If, for any reason, the pre-phase lasts a long time, it is more or less likely that timely decision-making will not be feasible.

Another factor that needs to be mentioned with reference to duration is our interpretation that trajectory termination represented a decision about family preservation. This assumption was based upon the Expertise Center being a “last resort” for families aiming for family preservation. However, clear information about the placement of the child after closure of the trajectory at the Expertise Center in the pre-phase was not always available. Therefore, the results for that topic need to be interpreted with caution. Likewise, the data collection with reference to the arguments and the parties involved in decision-making was made complicated due to unclear and/or missing reports concerning the conclusions which were arrived at.

The second conclusion, based upon the information that was available on these topics, is that the residential part of the program was considered highly undesirable for some of the referred families, since some of them refused admission to the clinic, even though they were aware of the fact that this was their last chance for family preservation. Other reasons noted can be considered as information about the family situation needed for a decision about family preservation that became available during and/or through the pre-phase of the program. The arguments that the professionals of the Expertise Center assessed *the problems as too severe*, the family guardian considered *the chance to achieve family preservation as too minimal*, and *the required criteria* for the clinical phase were not attained can be considered as evidence that there was not enough capacity to change within the family. This can be seen as a ratification of the choice to terminate the trajectory (implying a negative decision about family preservation). On the other hand,

³ In one case this applied to a family with an extended trajectory.

when parenting was assessed as *good enough* during the pre-phase, there seemed to be evidence that the family showed enough capacity to change without clinical treatment, thereby legitimizing a positive decision about family preservation.

Third, it can be concluded that the Expertise Center program facilitates shared decision-making – a method that has been recommended by Bartelink, Van Yperen, and Ten Berge (2015); see also Bartelink, Van Yperen, Ten Berge, and Knorth (2019) – and one that is to be utilized in practice in combination with other methods. However, since most of the trajectories are mandatory, it is expected that the influence on decisions is not equal among the parties.

Fourth, the use of the Decision-making Continuum (Baumann et al., 2014) in this study demonstrated several potential advantages. We have shown that “drop out” during the program is not necessarily an undesirable outcome. Instead, it could imply timely decision-making. Furthermore, in order to improve clinical decision-making, it is fundamental for the professionals involved to be aware that they are constantly making decisions, and that these decisions influence the key decision about family preservation. It is essential to carefully report on each important decision along the trajectory in order to improve communication between all parties and to work towards transparent decision-making. This is likely to be of great value for families, since it might enhance a better understanding and expectation with regard to the assessment procedure, the specifics of each phase (for instance, the criteria to continue to a subsequent phase), and the potential consequences. Moreover, it is likely to be helpful in coming to an understanding about the assessment process and making the final decision about family preservation (both for parents and children, when they are older). The Decision-making Continuum could be utilized as a format in practice to achieve this.

4.2. Parenting and decision-making

We also examined the link between the ability to parent and the decision about family preservation made by the team of the Expertise Center, thus attempting to underpin their conclusions with empirical evidence. In this regard, we can draw some conclusions as well. First, we hypothesized that a negative recommendation regarding family preservation would feature the display of more frequent and more severe atypical parental behavior. All of the results, except the outcomes on the *intrusiveness/negativity* scale, supported our assumption. The most evidence was found in reference to the behaviors coded under the *affective communication* and *fearful/disoriented* scale. It appears that the Expertise Center team considers these types of behaviors vital in terms of good enough parenting. On the contrary, this does not seem to apply to *intrusiveness/negativity* behaviors, since a similar proportion of the “FP” group to the “No FP” group display these behaviors. We recommend investigating this issue within the Expertise Center and targeting these behaviors, as well as the other types of atypical behavior, during the intervention.

Second, a connection between the overall classification of *disrupted/not disrupted* and the decision about family preservation was found, which thus further supports our assumption. An examination showed, however, that in five of the 28 cases, the parental behavior was classified as *disrupted*, while the professionals of the Expertise Center arrived at a positive decision about family preservation, raising the question of whether the inadequate parental behavior went unnoticed by the Expertise Center team or whether there were other factors that influenced their positive decision-making. For instance, one possible explanation is that there might be another primary caregiver involved in the family who counterbalanced the compromised parenting of the parent included in this study. However, this hypothetical situation still reflects a fragile situation since it would implicate that adequate caregiving in those cases depends on the availability of this other caregiver, and continuous support will be needed after the trajectory of the Expertise Center. It can be concluded that, in order to further underpin

the decision of the team of the Expertise Center in these families, evidence about the availability of another primary caregiver is needed including their ability to parent. The opposite combination, a *not disrupted* classification with a negative decision, was also found in the study and presumably illustrates the distinction between the ability to parent and the capacity to parent. The decision is likely to be influenced by factors causing the parents not to be able to provide for the child on a continuous basis with *good enough parenting* for the long term, for instance, due to severe domestic partner violence. In these specific cases empirical evidence on the capacity to parent would be necessary, in addition to the evidence on the ability to parent, in order to further underscore the clinical decisions to preserve these families. This also applies to families with a *not disrupted* classification using the AMBIANCE and for whom was decided that family preservation is in the best interest in the child.

4.3. Strengths and limitations

With this study we succeeded in conducting research in an involuntary and emotionally burdensome context with an inclusion rate of 91%, which was far above our expectations. The design of the study, in which the parents were minimally burdened (since naturalistic parenting situations were filmed in accordance with the family's organization), is likely to be an important factor in achieving this result, coupled with the dual use (research and treatment) of the recorded videos.

As far as we know, this is the first study in which actual clinical decisions (in contrast to, for example, decision-making research that uses vignettes) were linked to (improved) parental behaviors during intensive treatment in order to evaluate the quality of placement decision-making regarding infants and toddlers, which occurs in everyday practice. This methodology could well prove useful in future evaluation research about decision-making.

A limitation of this study is that the trajectory analysis was generally based on administrative data. The databases within the Expertise Center were found to not always be up to date, and reports of trajectory decisions were, in general, very brief. We would recommend including observations of clinical decision-making in further research in order to improve the accuracy of the research data.

Second, the match between how parenting is being assessed within the Expertise Center and how this was done within our study using the AMBIANCE is not ideal, due to the fact that study measures and daily practices were separated in order to prevent interference. The decisions of the professionals of the Expertise Center are based upon a broader examination of parenting (capacity to parent) in comparison to the AMBIANCE measure which reflects the ability to parent. An implication of this is that in some cases, as mentioned, evidence on the capacity to parent is lacking while this would be necessary in further underlining the decisions of the Expertise Center team. However, measuring parenting quality as a whole in an accurate and reliable way is complex and some even argue impossible (Cann, 2004; White, 2005).

Third, it is complex to predict future parental behavior, and there are numerous other factors that impact on the outcomes of the decisions made. Consequently, research into clinical decision-making will never inform us with a hundred percent accuracy whether in practice ‘the right decisions’ are being taken. However, it can provide us with indications on this matter and valuable feedback on *process aspects* and indications of the accuracy of decision-making as to improve decision-making practices.

Fourth, some of the clinical trajectories were extended after 16 weeks of assessment (although the policy of the Expertise Center states that a clinical trajectory is 16 weeks at the most), even though the last measurement took place after 14/15 weeks of clinical assessment (T3). Due to these extensions, not all decisions about family preservation were made in a limited period of time (one or two weeks) after our last measurement (TL), as intended. This implies that these families did

receive further clinical treatment, which may have then influenced the level of their ability to parent and the final decision about family preservation. In order to be transparent concerning the duration of the program phases for families, case managers, and the health insurance company, and in relation to working towards a timely decision, we would recommend providing the program in accordance with the guidelines. We noted that extensions resulted in the waiting list for the clinical phase growing longer. Consequently, extending the clinical phase has both an impact on the family involved as well as on families on the waiting list.

Our lack of a comparison group was another limitation of this study. The greatest practical challenge was to find a control group, since our target group consisted mainly of families with a child who had been placed in out-of-home care, meaning that it was not possible to assess parenting among families in a similar situation, since parents typically no longer care for their children following out-of-home placement. Although the sample was rather small ($n = 28$), due to our data collection being limited to two years, we were able to find significant and relevant differences between the group of parents receiving a positive recommendation about family preservation and the group of families for whom it was decided that family preservation was not in the best interest of the child.

4.4. Conclusion

To summarize, this study was designed to contribute towards finding an answer to the question of how reunification breakdown among infants and toddlers can be prevented. We assumed, based upon evidence regarding an association between poor assessment and reunification failure, that knowledge about current clinical decision-making practice would be useful in this context. Our examination of the decision-making component of the Expertise Center yielded new insights and illustrated the advantages of putting decision-making theory into practice. Furthermore, the Expertise Center was shown to contribute greatly to timely decision-making in the context of permanency planning, and the clinical decisions of the Expertise Center professionals were most of the time confirmed by measurements of parental behavior that have been proven to be significant for children's attachment security. Since these are promising conclusions, the program of the Expertise Center could well serve as an inspiration for the practice field.

Further research is needed to study the outcomes of the program in the long term, for instance, in terms of the sustainability of reunifications following positive decisions and separations as a result of negative decisions. In addition, factors other than the decision-making process could be the cause of placement breakup, for instance, insufficient provision of services after reunification or unforeseen events. Further research is needed to understand the role of decision-making in the issue of breakdowns and to test whether improved decision-making (explicit, careful, transparent, and timely) will lead to improved rates of permanency after reunification.

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Declarations of interests

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