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Reunification of children in out-of-home care to birth parents or relatives: A synthesis of the evidence on processes, practice and outcomes

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REUNIFICATION OF CHILDREN IN OUT-OF-HOME CARE TO BIRTH PARENTS OR RELATIVES: A SYNTHESIS OF THE EVIDENCE ON PROCESSES, PRACTICE AND OUTCOMES

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1. Introduction

This report scopes and synthesises the evidence available to those who seek to improve services to children returning from public out-of-home care to their birth parents or relatives. It draws on a study of data on children in care in 14 'developed' countries with comparatively well-developed child welfare systems (Thoburn, 2006, Thoburn, 2009), as well as reviewing the (mainly) English language practice and research literature. This review is more comprehensive with respect to research conducted in the USA and UK[1]. but includes some research from other European countries published in English.

Out-of-home care is an essential part of the child welfare services in all countries. The characteristics of the service (and the frequency with which it is used) vary according to social and political context. In some countries (including Germany and most mainland European and Nordic countries) it is viewed more positively as part of a service to help parents and children under stress or otherwise vulnerable to adversity than in other (mainly Anglo-phone) countries, where it is more often viewed as a service of last resort. However in all countries, the aim is to return children to the care of their families as soon as this can be done whilst ensuring their well-being and development are safeguarded. Yet, as will be shown in what follows, once children have been away from home for more than a few weeks, and especially if they entered care because of maltreatment or neglect, return to one or both parents with whom the child was living before entering care is (using a range of measures) the least successful placement option. It is of some concern, therefore, that this aspect of child welfare practice is one about which there is least robust evidence on policy and practice effectiveness. As one of the major commentators puts it, referring to research in the USA where most of the programmes specifically aimed at reunifying children have been developed and evaluated:

> Of all the child welfare services studied over the past few decades, reunification services have rarely attracted the kind of attention dedicated to other child welfare services, such as family preservation. Thus the evidence base for successful reunification programs and practices is especially thin, even by child welfare standards. Wulczin (2004) p 108.

Before examining the evidence on rates, processes and outcomes in more detail, it is essential to make two points:

[1] Data are now reported separately for England, Northern Ireland, Scotland and Wales. In this paper 'UK' will be used with respect to general policy and 'England' when data refer only to England.

- The needs of children in care are complex and highly variable (varying with age, disability and mental health status, reasons for entering care, whether they did so on a voluntary basis or under court mandate, the type of placement in care and the quality of the care experience, the length of stay in care and age at returning home). Consequently a wide range of services will be needed, often provided concurrently as well as consecutively. Hence, research is unlikely to be able, with so many intervening variables about the child and the services, to come up with clear answers about 'what works' even for a specific group of children (eg young children entering care because of neglect), much less for 'children in care' as an undifferentiated group.

- Evidence from a particular jurisdiction and social and welfare policy context, produced at a specific time, may not be relevant to a different jurisdiction or time, or at the very least, will need to be contextualised if it is to inform policy and practice in another jurisdiction.

- The outcomes of reunification are at least to some extent, and often to a large extent, influenced by what has happened before children entered care, and whilst in care, and on the services provided to parents and carers as well as to the children themselves. Consequently, even though evaluations specifically focusing on programmes and interventions to achieve the successful placement of children back home are few, the relevant literature is extensive, encompassing general 'in care' literature as well as literature focusing on aspects of general child welfare services when children return home.

- Although there are specific short-term programmes to assist with a particular problem (anger management for a parent or cognitive behavioural work with a child) that can be evaluated using experimental methodologies, reporting on longer term outcomes requires a range of research approaches, if the processes and practices associated with different outcomes are to be understood. Such studies are expensive, since they require the collection of data over long periods if (for example) accurate baseline data are to be available on a child entering care at the age of two, reunified at the age of eight. Because of the known vulnerability of such a child to the impact of past experience and future stress, reliable outcome measures can not be arrived at (and compared with similar children who remained in care) until the child is a young adult.

For all these reasons, this review of the available evidence on processes, practice and outcomes takes a broad approach to the types of research to be included. Pine et al (2002, p91), in their article on devising programme objectives as an essential first step towards evaluating family reunification programmes, stress that process evaluations (what is in the intervention 'black box'?) are as essential as outcome evaluations. They warn against the dangers of overly simplistic research methodologies:

> such as considering as successful outcomes only those cases in which children return to live full time with their parents. An expanded view of family reunification emphasises the importance of family ties and a more flexible

definition of success that aims at "helping each child and family to achieve or maintain, at any given time, their optimal level of reconnection – from full reentry of the child into the family system to other forms of contact, such as visiting, that affirm the child's membership of the family" (Warsh, Maluccio & Pine (1994).

It comes as no surprise therefore that there are only a very small number of experimental design studies that specifically set out to evaluate services aiming to reunify children from care with birth parents or relatives, and none which provide data on long term outcomes as well as details of interventions and services provided. There are a larger number of prospective or cross-sectional cohort studies (re-analysing routinely collected administrative data or using survey methodologies or case records). Some of these are mixed methods studies which use detailed interview or survey data on a smaller sub-sample to expand on the limited data available on the whole cohort.

Smaller scale studies, using a range of quantitative and qualitative methods (including action research undertaken in partnership with agency staff) complement these larger scale cohort or experimental studies. They often provide detailed data on processes and outcomes (using standardised scales on a range of outcome measures), and importantly, report on the views of parents and children about what they find helpful. These can be helpful to practitioners and service planners but (taken alone) no conclusions can be drawn about variables associated with successful outcomes. However, a high degree of agreement between the findings from larger scale studies and the conclusions of these smaller studies means that they make an important contribution to the body of knowledge. (See Biehal's (2006) and Farmer's (2009) literature reviews for a more detailed appraisal of research methodologies used when evaluating reunification services in the USA and UK and the 1996 special issue of *Children and Youth Services Review* Vol 18: 4/5 for scholarly analyses of both practice and research issues.)

2. Reunification as part of a total care process: the impact of 'permanence' or 'stability' policies' on practice and research in different jurisdictions

As indicated above, out-of-home care is used differently in different countries. Whilst in some countries (such as USA and Canada and some States in Australia) it is almost exclusively a response to child maltreatment, and usually court-mandated, in others it is also provided following a request for service of parents struggling with their own difficulties or a child's developmental, behavioural or mental health problems.

Reunification from planned short-term or respite care

This service is usually short term or may be provided on a regular basis for 'support' 'respite' 'educative'[2] or 'therapy' purposes. It may be provided in a kinship

[2] It is important at this stage to make the point that the Anglo-phone nations (where most of the research referred to in this paper was conducted) do not have the European profession of social pedagogue/ éducateur specialisé. The tasks undertaken by these professionals may be undertaken by social workers, health visitors, psychologists, special educational needs teachers, family therapists, play therapists, youth workers, residential child care workers, clinical or educational psychologists, and para-professional social care or family support workers, who usually work under the supervision of

or non-kin foster family, a health service/ mental health establishment, a children's home or a residential school. When used in this way, the child's return to the parental home, the nature of contact arrangements and the division of parental responsibility whilst the child is away, are usually incorporated into the original service agreement. The arrangement is essentially a 'shared care' arrangement and 'reunification' other than in the physical sense, is not a necessary additional service[3].

Although in other European countries such arrangements tend not to be so precisely formulated, short term care with parental agreement in emergencies, and planned short or intermediate term care to assist families under stress are fairly frequent, and many children entering care return home within a few weeks. Because reunification plans are included from the start, such 'short term' 'shared care' arrangements are not covered in this review, except in-so-far as they become long term because the child does not return home as planned. However, some of what follows is relevant to these arrangements.

Reunification from indeterminate or longer term care

As family support services improve, the need for short term emergency placements or voluntary family support-type placements (other than respite care for families with disabled children) diminishes. Across Europe, in North America and Australasia, increasing proportions of children enter care because of maltreatment or (for older children) mental health or severe behaviour problems. In such cases, plans for reunification are not clear when the child enters care, often for a period of assessment, and it is for these children, whose stays in care are indeterminate or for planned longer term periods, that reunification polices and practice have been developed.

Drawing on research, commentators have concluded that for children who enter care for agreed longer periods, or in respect of whom the length of time in care is not known when the child leaves home, care practice and planning have to be seen as a process, with the possibility of reunification being part of the planning at the time the child leaves home. Key sources here are USA writers on 'permanence policies' (for example Maluccio et al, 1986). Although 'permanence policies' are discussed more explicitly in North America, Australia and the UK as the guiding principle for out-of-home care services, in essence they underpin child welfare policy in other jurisdictions. Put simply, the aim is to secure stability and family membership for all children who need to enter the care system. In accordance with the UN Convention on the Rights of the Child, the first 'permanence' option in all jurisdictions is return to a stable and loving birth parent. At the same time, for all countries, research on the importance of attachments and of providing stability and a 'secure base' for the child

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social workers. The terms 'educator' or 'pedagogue' are usually taken as synonymous with 'teacher' and do not have the broader meaning they have in other European countries.

[3] In the UK, this type of regular out-of-home care is provided (usually in the same foster family or group care setting) under a separate legislative section of the Children Act 1989. It is referred to as 'provided under a series of short term placements' and data on these placements are reported separately from data on other children entering care or in care on a given date. It is provided mainly for children with disabilities but also for parents with chronic problems or disabilities or families under acute stress (Aldgate, 2002). In England, in 2004-5, 10 children per 10,000 in the general population started on a 'series of short term breaks' placements, in addition to the 23 per 10,000 who entered out-of-home care for other reasons and unspecified periods

in long term care have resulted in attempts to decrease the amount of movement between placements, thus avoiding not only the harmful impact of multiple carers, but also changes of school and disrupted friendships.

Despite these similarities of long term objectives, the way in which these aims have been operationalised in North America and the UK has resulted in marked differences in practice between these jurisdictions and other European countries, Australia and New Zealand. In the USA, Canada and the UK, if young children can not return home within 6 to 12 month of entry to care, severance of legal links with the birth family via legal adoption is considered the next preferred option. (In cases of maltreatment, broadly defined, this can be without parental consent.) The more coercive nature of practice, in order to achieve rapid decision making and exit from care, can impact on the nature of social work with birth parents and children (and the likelihood of successful return to the birth family) in both positive and negative ways. Parents may be more likely to work co-operatively with social workers if overt coercion is not being used. On the other hand, the power of the courts to require parents and older children to engage in treatment plans may contribute to engagement and the success of those plans, especially if one possible consequence of non-co-operation is the loss or limitation of parental rights or the severing or restriction of contact with the child. In most other countries, and in the UK for children over the age of four or five or sibling groups, the most usual long term options are kinship foster care and foster family care. Group care or residential education are also favoured as long term 'shared care' options in some European countries including Germany.

For most jurisdictions in Europe, because there is no legal or policy imperative to decide within a short time frame whether return home is a feasible and appropriate goal, there has been less impetus to develop 'reunification policies'. This is one explanation for the fact that much of the more focused research referred to in this report comes from the USA. In the UK, from the mid 1970s to the last few years, the emphasis was heavily on permanence achieved via adoption, and it was in that direction (rather than towards reunification) that most practice writing and research was directed. Thus, in the UK as in Europe (but for different reasons) the importance of planning for reunification from the time serious consideration was given to a child entering care, was not incorporated into every-day practice. UK policy for the last 20 years or so (as in the USA, Australia and Canada) has been based around keeping children out of care if at all possible, and if they do come into care, getting them out of care as soon as possible). But unlike in the USA, there has been no corresponding move towards improving practice around the time of return home, and supporting the family once the child has returned. In the UK there have been only three major studies and four small scale ones specifically on reunification compared to very many more on adoption and foster care. In, Australia and New Zealand, whilst I have been able to find only one MA thesis specifically on reunification, there is a growing body of literature on the role of kinship and agency foster carers in helping parents to resume care of their children (see especially Fernandez, 2006; Thomson and Thorpe, 2003, 2004; Thorpe et al, 2005; Thorpe, 2007; Lovett, 2008, and the research review by Panozzo et al, 2007). Much of this (as with Canadian research and practice literature) relates to aboriginal children who are greatly over-represented amongst children in care (Tilbury, 2009).

Although European longitudinal studies and cohort studies have recorded when children return home, I have not identified any studies from countries other than USA and UK that specifically report on reunification policies and practice in general terms, although there are some studies of planned care and therapy for offenders or adolescents with challenging behaviour (Grietens et al, 2007: Tillard and Rurka, 2009).

3. The impact of children's characteristics on reunification policy and practice

Children entering care (the flow data), and children in care at a given date who may return home (the stock data) have different characteristics, and these vary between countries. Robust research that can contribute to improvements in policy and practice might be expected to take on board these differences. This is often not the case, although some of the cohort studies have large enough numbers for these variables to be held constant for purposes of statistical analysis.

Comparisons on the 'flow' and 'stock' of children entering care[4]

Most countries have reasonably sound data on children in care at a given date and these show considerable variation (74 per 10,000 under 18s in Germany compared with 102 in Denmark, 102 in France, 66 in USA, 55 in England and 58 in Australia (Thoburn, 2006, 2009). However, 'flow' data on entrants to care in a given year are more variable in availability and reliability, and sometimes are provided separately for children entering foster family care and group care. In some cases data are provided for each care episode so children entering twice or more in a year inflate the figures. (In other words there are problems when comparing information and policies for jurisdictions that use 'care episode as unit of return' rather then 'child as unit of return' and these differences are not always clear in published data.)

Table 1 shows that the country with the highest rate of children entering care in a given year is the USA (42 per 10,000 in 2004-5, although this hides considerable differences between States). If this is compared with the below average 'stock' rate, it can be seen that the pattern in the USA is for a heavy use of the care system, but with shorter stays in care- perhaps explained by and explaining the interest in reunification practice and research. Although the Nordic countries, from which robust data are available, have many similarities, there are also differences (Grinde, 2007). For example, Sweden and Denmark have very different pattern of 'stock' and 'flow' (32 per 10,000 entering care in Sweden – a high rate when compared to the average 'in care' rate, whereas Denmark has an average 'flow' rate of 30 per 10,000 but a high in care rate, indicating that children entering care in Denmark tend to stay longer than their counterparts in most other jurisdictions. The rate for England is 23 per 10,000 but around 30 per 10,000 if those starting on a series of short term placements are included. The tables below show that, although the rate in care at any one time in Germany is on the high end of the spectrum, it is not as high as for some Scandinavian countries.

Age differences

When considering reunification policies, 'flow' data on recent entrants are more helpful than 'in care' (stock) data since a strong argument can be made (with some support from research and administrative data) that practice at the point of entry to care impacts on the possibility of successful reunification. However, since children may return successfully to birth families after being in care for periods of years the 'stock' data are also relevant to considering reunification policies.

Table 1 Children in out-of-home care at a given date and rates in care per 10,000 children under 18*

COUNTRY/STATE (year of data)	0-17 IN CARE POPULATION	RATE PER 10,000 <18** IN CARE	RATE PER 10,000<18 ENTRANTS
Australia (2005)	23,695	49	26
Denmark (2005)	12,408	102	30
France (2003)	137,085	102	N/A
Germany (2006)	99,372	67	22
New Zealand (2005)	4,962	49	24
Norway (2004)	8,037	68	13
Sweden (2004)	12,161	63	32
UK/England (2005)	60,900	55	23
USA (2005)	489,003	66	42

* See Thoburn (2006) for detailed notes on sources.

** For comparability between countries (because in most countries children leave care on reaching the age of 18) where possible 0-17 figures are used in this table and young people still in care when aged 18 or over are not included. (For Denmark, around 1,500 were aged 18+ i.e 11% of the 'in care' population; for France 17,755 were aged over 18+ (11% of the 'in care' population); for Germany, 12,798 were aged 18+ (11% of the total 'in care' population); for Norway , 1297 (14% of the total in care) were aged 18+; 10,321 children in care in USA were aged 18+ (2%); for Sweden, 2,765 were aged 18+ (18% of the 'in care' population).

As with rates in care and entering care, there are marked differences in the ages of children in care, which have to be born in mind when considering the relevance of research conducted in different jurisdictions. Age is also a 'proxy variable' for the other dimensions considered below, such as reasons for entering care, problems of the children when entering care, and, obviously, impacts on length of stay in care since those entering as infants can potentially stay longer than those entering in their late teens. Broadly speaking higher proportions of those entering care in 'Anglo-phone' jurisdictions are aged 0-4 (38% in Australia, 34% in New Zealand, 35% in England 38% in USA compared to 20% aged 0-5 in Germany; 12% in Denmark; 23% (0-5) in Norway; 12% (0-3) in Sweden[5]. Although these differences are repeated to some extent with respect to children entering care when aged between 5 and 15 (54% in Australia; 58% in England; 41% (5-14) in Denmark; 39% in Sweden; 43% aged 6-14 in Germany) the biggest difference is with those who have high rates entering care when 16 or over (8% in Australia, 7% in England compared

[5] Note that these are percentages and not rates, and a more careful inter-country comparison would need to consider rates in the different age bands, as well as percentages. Data are not readily available for most jurisdictions for this to be done.

with 45% aged 15+ in Germany; 49% over 16 in Sweden (including 15% over 18); 45% over 15 in Denmark (including 4% over 18). In other words, care entrants in Germany, Denmark and New Zealand have a more balanced age distribution whilst in USA and Australia more are younger; in England they are 'bunched' in the under 5s and 10-15 age groups and in Sweden a larger proportion is over 16.

Table 2 Age at entry to out-of-home care- % of children in each age group*

COUNTRY/ STATE	<12 mths	0-4	5-9	10-15	16-17	18+
Australia	13%	24%	27%	27%	8%	
Denmark	5%	8%	12%	31% (10-14)	41% (15-17)	4%
Germany	6%	14% (1-5)	21% (6-11)	22% (12-14)	32% (15-17	6%
New Zealand	14%	29%	19%	47% were	aged 10-17	
Norway		23%(0-5)	18%(6-12)		51%(13-17)	8%
Sweden		12% (0-3)	15% (4-9)	24%	34%	15%
UK/England	17%	18%	18%	40%	7%	
USA	15%	23%	20%	23%	20%	

* In this table and table 3 those over 18 are also included

Data on children in care on a particular date (Table 3) demonstrate some of these differences, although to a lesser extent since children entering care in the Anglophone jurisdictions when under the age of 5 tend to leave more quickly through reunification or adoption than those entering when over 5. In England 19% were aged 0-4 in 2005 and 18% were aged 16 and 17; the proportions for the USA were 28% aged 0-5 and 29% 16-21. For Australia, which makes little use of adoption as a route out of care and is therefore a better 'Anglophone' comparator for mainland European countries, 24% were aged 0-4, 63% were 5-14 but only 13% were aged 15 or older, indicating that a larger proportion leave care before they reach the age of 16 than is the case in other jurisdictions. In Denmark, where children tend to remain in care for longer periods, 6% were aged 0-4; 16% aged 5-9; 43% 10-15; 25% 16 or 17 and 10% aged 18 or over. In Germany, as with other European countries, because data include young people who can remain 'in care' as young adults, 42% of the 'in care' population was aged 15 or over. Only 12% were aged 0-5 compared to over 19% in England, and 28% in the USA.

Table 3 Children in care on a given date- % in each age group

COUNTRY/ STATE	0-4	5-9	10-15	16-17	18+
Australia	24%	31%	32% (10-14)	13% (15-17)	
Denmark	6%	16%	43%	25%	10%
France	16% (0-5)	22% (6-10)	32% (11-15)	16%	14%
Germany	12% (0-5)	24% (6-11)	21% (12-14)	31% (15-17)	11%
New Zealand	22%	27%	41% (10-15)	8% (16+)	
Norway	12%(0-5)	31% (6-12)		43% (13-17)	14%
Sweden	6% (0-3)	16% (4-9)	28% (10-14)	32% (15-17)	18%
UK/England	19%	20%	44%	18%	
USA	28% (0-5)	20% (6-10)	24% (11-15)	24%(16-18)	5% (19+)

These data are relevant when considering reunification research, since European countries including Germany will be considering reunification for larger proportions of children who enter care when aged 5 or over than is the case for the USA, where most of the research specifically focused on reunification has been conducted. Those studies need to be carefully scrutinised with respect to the age at entry of the sample of children in the study when their applicability to a specific care population is being considered.

Reasons for entering care and legislative differences which may impact on reunification practice and research

Alongside difference with respect to age groups, perhaps the most important factor to be understood in developing reunification policy and practice is the reasons why children enter care. Unfortunately routinely collected administrative data are inadequate for sound international comparisons. In the USA and UK data collection systems ask for only the main reason for entering care (as opposed to any of a list of the circumstances that are known to be associated with children needing to come into care). Particularly in the USA where almost all children enter care via the courts, the reason most frequently given in the statistics is 'child abuse or neglect' (in more than 90% of cases). In the UK and Australia, although other reasons are options on the data entry instruments, because only 'main reason' is asked for and thresholds for entering even voluntary care are high, the main reason tends to be 'abuse or neglect' (48% in England and 42% in Australia). Other main reasons given were parental illness or disability (8% in Australia and England) relationship problems in the family (43% in Australia and 24% in England, and problems and difficulties of the child (9% in England – not given as a reason in Australia). In Sweden the pattern is very different. Abuse or neglect is not available as a main reason, and data show that 50% enter care mainly because of the behaviour or other problems of the child and approximately 50% because of family or relationship problems. Denmark has recently revised its data collection system and is the best source of data for all main and additional reasons why children enter care. When the main reason is considered 56% entered care because of problems or disabilities of the child; 27% because of relationship- or other problems in the family; 6% because of abuse or neglect, 6% because of parental illness or disability and 5% because the child had been abandoned or had no parent[6].

Clearly, since resolving the difficulties that resulted in the child needing out of home care (not necessarily just the main reason) are related to successful reunification, the lack of good data on this in evaluations of reunification policies and programmes makes it difficult to weigh up the relevance of these research studies for policy and practice development in other jurisdictions. Such data are more likely to be provided in publications reporting on smaller scale, qualitative or mixed methods research. These descriptive studies indicate that the family and relationship difficulties resulting in child maltreatment and/or entry to care are similar in different countries. Addictions and mental health problems of parents and intimate partner violence are present in the histories of many of these families. However, with respect

[6] I have not been able to identify similar data for care entrants in Germany, but the data on age and marital status and help received before entry to care indicate that the pattern will be similar to Denmark and Sweden

to problems of the children, it is difficult to know how comparable are the populations in care in different countries. In some countries (eg France) most children needing longer term out-of-home care because of physical or cognitive disability are in a different system of care. In the USA some children with mental health and challenging behaviour receive residential therapy through an insurance-based mental health care system. There are also big differences in the extent that young offenders are cared for within the child welfare system- almost all who need out-of-home care in Sweden and almost none in the USA and UK (this is one of the major explanations for differences in the rates entering care in the older age groups).

Age and reasons for entering care are to some extent over-lapping variables. However, legal status is to a greater extent country specific. In Denmark and Sweden 92% and 85% of children respectively enter care at the request of the parents and older children (or at least without the need for court or administrative order) and that is the case for 67% of those entering care in England. In contrast, in the USA more than 95% enter care via a court order. These data are only available for most countries with respect to children in care on a particular date. However for these 'stock' data, proportions in 'voluntary care' in Denmark (91%) and Sweden (66%) are still high. In Germany in 2004 85% of those in residential care and 71% of those in foster family care were there under voluntary arrangements. For longer stay children, the position in the UK is more similar to that in the USA, since the practice is to apply for more control of the case through the courts (and limit parental responsibility and rights) if children remain in care for longer than a few weeks (69% of those in care in England in March 2006 were the subject of Court Orders and only 31% in care under voluntary arrangements. The position is similar in Australia with 86% in care under a court order. France also makes more use of court orders than do most European countries.

From their detailed recent study of over 7,000 children in the care of English local authorities, Sinclair et al (2007, p66) devised a typology that combines these demographics and family problems. These authors found this a helpful way of considering the different policies and practices that may be needed for different groups:

- 'young entrants' - children who started this episode of care before the age of 11 and are still under 11 (43% of their cross sectional sample)
- 'adolescent graduates'- children starting this care episode when under 11 but are now over 11 (29%)
- 'adolescent entrants' – children who entered care when aged 11 or over for reasons other than maltreatment (14% of the sample)
- 'abused adolescents' those who entered care when aged 11 or over mainly because of parental abuse or neglect (9% of the sample)
- children across the age ranges who entered care mainly because of a disability (4% of the sample);
- unaccompanied asylum seekers under 18 (5% of the sample).

Some in each of these groups might need reunification services, but the characteristics of those services will need to be different to meet their different needs.

Length of time in care and placement in care

These variables interact, and impact on the length of time the child is in care and the placement options when the child is away from home, which, in turn, have an

impact on the rates of children returning to birth parents and the methods to secure their safe return and stability after return.

Table 4 Length of time in care*

COUNTRY/ STATE	Average (sometimes median) time in care of those leaving care	% in care who have spent longer periods in care
Australia		48%: <2 yrs; 26%: 5+ yrs
Denmark	3.4 years	66%: 2+yrs; 37%: 5+yrs
France (Paris only)		3%:10+yrs
Germany (foster children)	4 years	
New Zealand	2.8 yrs	46%: 2+yrs
Sweden	9mths vol care: 17mths compulsory care	
UK/England	2.1 yrs	33%: 4+yrs
USA	1.8yrs	30%: 2+ yrs

*In countries/ states where young people can remain in care beyond the age of 18 the average length of time in care is likely to be longer. The average figure conceals wide variations with those leaving care at 18+ having longer stays. In Denmark, for example, the average length of stay of those leaving care between the ages of 0 and 17 was 2.3 years but for those aged 18+ it was 4.3 years and 30% of the care leavers in this age group had spend 5 or more years in care.

Table 5 shows that there are also marked differences in placement patterns, with larger proportions in Anglophone jurisdictions being in either in 'kinship' or non-kin foster family placements[7] and more in mainland Europe being in group care. This is to some extent explained by differences in age profiles and differences in reasons for entering care, but also by different views about the ability of group care to have a positive impact. It is also linked with the profession of 'social pedagogue' which, in most countries in Europe, provides a pool of well-educated professionals whose training provides them with supervised experience in working in group care settings. In the UK, some professionally qualified social workers and other professionals are employed in these settings, but most are para-professionals who often start on their careers with no relevant training and 'train on the job'.

Clearly, there will be differences in reunification practice when children are placed as foster children with members of family and friends, than will be the case when they return home from group care or from non-kin foster families recruited by the agencies and not previously known to the child or parents.

[7] A note of warning on terminology is needed here. When used in the USA, 'foster care' usually includes children in all types of out-of-home care, including children's homes or other forms of 'group care'. The term 'foster family care' is used when referring to placement with families (who may be kinship carers supported financially and in other ways by the agency, or non-kin foster carers recruited by the agency). In most other countries foster care is only used for family placements. This tends to leave out 'privately fostered' children (whether with kin or non-kin families) - private arrangements in which the state does not play a part and the children are not 'in care' although universal welfare benefits may be available, and the state may have a regulation/monitoring function.

Table 5 Placements of children in out-of-home care

COUNTRY/ STATE	Kinship care	Un-related foster care	Group care	With adopters	In care but placed with parents	Other *
Australia	40%	54%	4%			1%
Denmark		48%	41%			11%
France	7%	46%	40%			7%
Germany	8%	40%	47%			5%
New Zealand	35%	40%				25%
Norway	17%	61%	19%			3%
Sweden	12%	65%	21%		1%	1%
UK/England	18%	47%	13%	5%	10%	7%
USA	23%	46%	19%	5%	4%	3%

* (eg 'foyer', hostels, independent living, custody, missing)

4. The knowledge base on reunification from care

As noted in the introduction, the evidence linking outcomes for children returning to birth families from care with the services, methods and programmes provided to assist reunification is weak. This is to some extent inevitable, given the large number of variables about the child and family as well as the complexity of the interventions. . What follows is a synthesis of findings from a range of studies, mainly about children in care more generally, with only a small number of researchers specifically focusing on practice aiming to achieve reunification. Biehal (2006 p 59) warns, with respect to these studies:

> different studies have different follow-up periods, making it difficult to compare results across studies. To compound the difficulty, some studies follow up children over varying periods of time. . Also, comparison becomes meaningless when it is between studies with very different samples, comparing, for example, rates of re-entry for abused infants with those for a sample of all ages who were admitted for a variety of reasons.

Also, comparing data from different jurisdictions and different research studies is problematic as 'reunification' is defined differently. In some countries it refers only to children who return to the birth family home before the age of 16 and in others, it refers to those who return at any point, including when they leave care as young adults. In some research, children returning to relatives are included, and in others, only those returning to birth parents. This paper concentrates on the research and practice literature on children who return to parents or relatives whilst still of an age to be dependent on good parenting. It does not cover in detail the important studies that have focused only on children leaving care as young adults, who will often return to their home communities. (See the edited volume of 'leaving care' studies from several countries of Munro and Stein (2008) and the report of the longitudinal research of Courtney et al 2005).

Most useful to an understanding of rates of children returning to the parental home are those studies which follow up a cohort of children entering care when under the age of 16 until they return to birth parents or relatives, or at least for a period of several years (eg Wulczyn's (2004) ten year follow up study; the longitudinal studies reported by Barth and colleagues (1987) and Courtney and colleagues (1994, 1995, 1997) in the USA; the Bullock et al (1993, 1998) and Farmer et al (2008) cohort studies in the UK and Fernandez's (1996); Delfabbro et al (2003) in Australia).

Important sources are the major USA and UK longitudinal studies that reanalyse administrative data and sometimes supplement them with more detailed interview data. A minority (some involving evaluations of demonstration projects) focus specifically on reunification (Davis et al, 1996; Festinger, 1996; Fraser et al 1996; Landsverk et al, 1996; Wells and Guo, 2004; Wulczyn, 2004; Cordero, 2004; Webster et al, 2005; Ryan et al, 2006; Pine et al 2007; Brook and McDonald, 2008 in the USA. In the UK the larger scale studies are those of Farmer and Parker, 1991; Bullock et al, 1993, 1998; and Farmer et al, 2008 and there are four small scale ones (Thoburn, 1980; Stevenson and Smith, 1983; Trent, 1989; Pinkerton, 1994). I am aware of only one very small scale Australian MA thesis (Jackson, 1997) and no others in the English language from Europe. Most of these provide data on outcomes, mostly in terms of whether the placement with parents broke down and the child returned to care. Some also provide time series data demonstrating changes over time in response to organisational, legislative or practice changes (for example Wells and Guo, 2004, on the impact of changes in welfare payments on rates of reunification and the Meezan and McBeith, 2008, study on the impact of changes in the way reunification services are commissioned and paid for.)

However, as noted in the earlier section, country context, and the different characteristics of the 'flow' and 'stock' populations in different countries have to be born in mind when looking at reunification rates reported in these studies.

Rates of children returning from care to live with birth parents or relatives

Because leaving care and returning to birth parents or relatives is the main outcome for children in care in any given year, some reasonably reliable evidence on percentages of those who leave care to return home is available from administrative data.[8] Data are more readily available for the percentage of children leaving care over a twelve month period who go to live with parents or relatives than for the rates of children entering care who are reunified at any point in their care careers. For some large data sets and research samples, those going home in any one year and those returning home within a given time of entering care are analysed by a range of fairly basic variables (usually age of child at entry and exit, placement in care[9] and exit 'destination'.

[8] This is only the case where, as in New Zealand, UK, USA, and most Scandinavian countries and Germany this is collected with the individual child as the 'unit of return'. Where data are collected with 'placement' or 'entry to care' as the unit of return, or only as aggregated data- administrative data are not available on a national basis, though they may be available for individual municipalities or states.

[9] A note of warning on terminology is needed here. When used in North America 'foster care' usually includes children in all types of out-of-home care, including children's homes or other forms of 'group care'. The term foster family care is sued when referring to placement with families (who may be kinship carers supported financially and in other ways by the agency, or non-kin foster carers recruited

Some examples of percentages of those leaving care in a given year who return to parents or relatives are[10]:

- England 42%
- Sweden 56%
- USA 64%
- Western Australia 63%
- Germany 40% (of those leaving foster family care)

Some possible explanations for these differences are explored in the sections which follow. The USA high percentage returning home is a factor of the young age of children entering care and the generally short stays. More in other countries stay longer and 'age out' of care as young adults.

A different pattern emerges if the percentage of those entering care in a given year who eventually return home is the focus of analysis. In both the UK and the USA, the trend in recent years is towards an increase in exits from care via adoption and a decrease in the rates exiting through family reunification, although the larger proportion still exit through reunification (around 50% in Wulczyn's 10 year follow up study (with around another 10% leaving care to join relatives). This compares with between 25% and 30% leaving care via adoption over a 10 year time scale in the USA (Wulczyn, 2004) and around 10% in the UK.

The consensus from USA studies is that around a third of children entering care will have returned to birth parents within three years (eg Meezan and McBeith, 2004) and just under half of children entering care will have returned to birth parents ten years later (Wulczyn, 2004) (though some, as discussed later, will have gone back into care, sometimes more than once). As might be anticipated given the broader range of children entering care in the UK, a larger proportion eventually return to birth parents. Just under 70% of those entering care will have left within two years (Millham et al, 1986; Rowe et al, 1989; Dickens et al, 2005: Sinclair et al, 2007) although some will have moved on to adoptive families or to independent living arrangements. Excluding those placed for adoption or going to independent living (not with a relative) somewhere between 55% and 58% will have left care to live with a birth parent or relative within 2 years. Taking a wider time frame, Bullock et al found that 87% of over 800 children entering care in the 1980s had returned to the birth family within 5 years, although some had come back into care. As with the USA, this does not include those still in care and living with a relative. Around 10% of English care entrants will be living with parents whilst still in care under a care order and others will be living with relatives as foster carers.

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by the agency. In most other countries foster care is only used for family placements. Kinship care tends to be used for family care by a family previously known to the child or family (not necessarily a blood relative) for children who are formally 'in care' and who are monitored and usually financially supported by the agency. This tends to leave out 'privately fostered' children (whether with kin or non-kin families_- private arrangements in which the state does not play a part and the children are not 'in care' although universal welfare benefits may be available.

[10] The other main 'exit destination' is 'ageing out' or 'moving to independent living' or in some USA reports 'emancipation'.

In mainland Europe and the Nordic countries, as with Australia and New Zealand, most children either return to parents or relatives (sometimes with a guardianship order) or 'age out' of care. Legislation requires efforts to be made to ensure that (wherever possible) links are retained between birth relatives and children in care and most will return to their home communities, as young adults if not before. Some in these countries 'age out' of care with well established links with their foster carers and sometimes also their birth parents. Germany, along with Denmark and Norway has comparatively low rates of children entering care, but high rates in care, indicating that children remain for longer periods and are more likely to put down roots with their foster families, than is the case with the USA with high entry rates, comparatively low average length of stay, and comparatively low 'in care' rates.

Of particular relevance to Germany are the population and administrative data studies available from Sweden (Vinnerljung and colleagues (2005, 2006) at the Social Statistics Institute (*Socialstyrelsen);* from Denmark (Egelund and Vitus, 2009, and the Danish Ministry of Social Affairs website: www.ast.dk) and Norway (Grinde and http://www.ssb.no/barneverng_en/ and the Norwgian Social Research Institute http://www.nova.no/ the Norwegian Social Research Institute. Most countries in Europe produce annual statistics of children in care, although for France and Italy detailed statistics are only available at administrative district level and can not be amalgamated.

Characteristics of children who return home

Despite differences between countries, the data are broadly consistent in terms of the characteristics of the children most likely to return home. Most children who return to their birth parents do so within the first six months, and beyond this time the probability of return to birth parents declines rapidly. This applies especially to children entering care when under the age of one. Examples of percentages of children in different jurisdictions or research projects returning home in a recent year in the different age bands are:

Germany: 0- 3 15%; 3-5 13%; 6-8 12%; 9-11 16%; 12-14 14%; 15-17 20% (including 14% who left care to live with relatives)
Sweden: 0- 3 13%; 4-6 10%; 7-9 10%;10-12 14%; 13- 14 14%; 15-17 40%
England 0 -4 19%; 5-9 18%; 10-15 45%; 16+ 9%
USA (Festinger, 1996) <1 7%; 1-2 24%; 3-10 46%; 11-14 23%
USA (Fraser et al 1996) <6 25% 13-17 50%

These profiles show that all the countries in which the research has been undertaken are seeking to return children home across the age ranges, (though with more teenagers returning home in Germany and Sweden) indicating that the available research is likely to be relevant across national boundaries.
Several studies in the UK and USA have identified variables in the children, the families, the placements in care and the social work or social welfare arrangements that are associated with a higher likelihood of return home. Looking beyond age and the reasons for entering care, researchers have identifies a wide range of variables about the child, the family and the services that interact to determine whether the child returns home and the timing of the return. Packman et al (1998) identified different care careers, and different patterns of return home for three groups whom

they characterise as 'the volunteered' (for whom out-of-home care is part of a family support service for families experiencing stress, mainly with young children); 'the victims' (taken into care in response to an allegation of maltreatment); and the 'villains' (entering care because of parental or societal concern about their behaviour).

Looking specifically at those who entered care on care orders, Farmer and Parker (1991) looked separately at two groups who returned home: 'the protected' (mainly young children under the age of 10 who entering care because of concerns about abuse or neglect) and the 'disaffected' (mainly children over the age of 10, though some were younger, who entered care largely because of challenging behaviour or emotional problems, including delinquency).

Variables about the children

- Gender does not appear to be a significant variable impacting on rates of reunification, when reason for entering care and age are held constant.
- A consistent finding is that, amongst young children entering care because of maltreatment, those who enter care because of allegations of physical, sexual or psychological maltreatment are more likely to be reunified within the first 12 to 18 months than is the case for those who enter care primarily because of neglect. However, young children who have been severely injured, or whose sibling has been seriously injured, are less likely to return to parents if the abuser is still in the home (Barth and Berry, 1987; Barth et al, 1987).
- Children with learning disabilities and physical disabilities are less likely to return to birth families within the first year or so (McMurtrie and Lie (1992); Cleaver 2000; Sinclair et al, 2007; Landsverrk et al, 1996; Davis et al, 1997).
- UK, USA and Australian studies have found that (leaving aside unaccompanied asylum seekers) children of African, African Caribbean, and Indigenous heritage, and children or mixed ethnicity are less likely to return to birth families within a fairly short time scale (Lu et al, 2004; Bullock et al, 1998; Farmer, 2009; Tilbury, 2009). East and South Asian children and recent immigrant children are less likely to come into care, and more likely to return quickly to birth families. There is a correlation here with placement type and also with poverty and housing problems.
- Children who have already had one return home and been readmitted (other than where this is part of planned family support) are less likely to return home (Sinclair et al, 2007).
- The pattern is less clear for those who enter care when past infancy and for reasons of challenging behaviour or behavioural or mental health problems. (Goerge, 1990; Bullock et al, 1993, 1998). Wells and Guo (2003) found that children aged between 12 and 16 at entry to care were reunified at a slower rate than was the case for children entering when aged 8-11. Sinclair et al (2007) identified 'intermediate returners' (who returned to parents or relatives between 6 and 12 months after entering care) who were mostly adolescents when they entered care, often as a result of behavioural difficulties. Those returning to parents or relatives after two years in care are a more mixed group. Some are adolescents with behavioural problems, who return to the family home because they or their parents are dissatisfied with the care provided or because a long term placement breaks down (Fisher et al, 1986; Farmer and Parker, 1991; Schofield et al, 2007).

- Tausig et al (2007) found that children with behavioural and emotional problems and challenging behaviour were more likely to return to parents or relatives than children without these difficulties. Older returners experienced more problems at school and were more likely to take drugs and be involved in risky behaviour. Landsverk et al (2006) however found that children with emotional and behavioural problems were less likely than those who did not have such problems to return home within 18 months of entering care. This variable is correlated with age at entering care and reason for entering care.
- Children who have had multiple changes of placement in care are less likely to return home, although Wulczyn et al (2003) call attention to the fact that the stage in the child's 'care career' when placement changes happen has a differential impact on whether the child is reunited with a parent
- Children are more likely to return home if they are determined to do so (and consequently do not settle in placement or possibly run away from the placement) (Thoburn, 1984; Pinkerton, 1994; Farmer and Parker, 1991)

Variables about the birth family

- Early returners are more frequently those who enter care at the request of parents (most often single parents) to tide them over a period of stress or an unexpected emergency (Millham et al, 1984; Packman and Hall, 1996; Bullock et al, 1993, Cleaver, 2000).
- Apart from very temporary care, children from single parents are less likely to return home, and less likely to return home quickly, than those returning to two parent families. There is a higher likelihood that children (especially African American and Indigenous children) will come into care from poor families with housing problems and that these children will return home at a lower rate and more slowly. (Goerge 1990; Courtney et al, 2004; Rzepniki et al, 1997; Wells and Guo, 2004).
- Children whose parents have multiple and long standing problems are less likely to return home (Goerge et al, 1990; Rzepniki et al, 1997; Sinclair et al, 20070.
- Children whose parents are addicted to alcohol and drugs. Increasing numbers of children, across jurisdictions, are entering care because of parental addictions, combined with neglect and other forms of maltreatment. Rzepniki et al (1997) and Jones et al (1985) found that there was a lower likelihood of children being reunified within a short time scale if this was the reason for admission, but others have not found this to be the case. Smith (2003) found that children whose parents complete drug treatment programmes are more likely than the generality of children entering care to return to parents.
- Children whose parents (and especially mothers) have chronic mental health problems are also less likely to return to birth parents before they reach adulthood.
- Children are more likely to return within a reasonable time scale if their parents are motivated to care for them and accept help to remedy the problems that led to care, or (with older children) are dissatisfied with the care they are receiving away from home (Thoburn, 1984; Cleaver, 2000; Farmer and Parker, 1991; Farmer, 2009).

Variables about the foster carers

- Children placed with relatives (other than for short periods of respite or emergencies) are less likely to return to birth parents than those in other types of placement (Wulczyn and Goerge, 1991; Geen, 2004; Rowe et al, 1989; Farmer and Moyers, 2008). Farmer and Moyers found that children were placed with relatives when there was very little chance of them returning home, though they also give instances when negative interactions between the paternal and maternal sides of the family result in reunification plans not being achieved. Some USA writers conclude that another factor is that parents are less motivated to complete treatment plans because they are not opposed to the child remaining with relatives. Brandon and Thoburn (2008) however, found that these considerations applied in some cases, but in other cases relatives, especially grandparents, played an important role in providing short term, respite and emergency care.
- Children are less likely to return home if foster carers would really like them to stay with them on a long term basis or adopt them (Fanshel and Shinn, 1979; Thoburn, 1980; Rowe et al, 1984; Aldgate, 1980; Thorpe, 1980). Conversely, return is more likely if foster carers and residential workers encourage the parents to visit, take steps to make the visit as comfortable as possible for all concerned, and find arrangements to help the child retain 'currency' so that they still have things in common with the birth family (Fanshel and Shinn, 1979; Millham et al, 1986; Cleaver, 2000; Thomson and Thorpe, 2003; Thorpe et al 2005, Thorpe, 2007).

Contact arrangement and legislation and organisational issues

- In the USA and Canada, and to a lesser extent the UK and Australia, legislation, performance management and targets and funding streams push towards early reunification prior to plans being made to terminate or limit parental rights and contact and placement with permanent substitute families (see especially Wells and Guo, 2004; Wulczyn, 2004; Meezan and McBeith, 2008). This may result in different patters of return in European countries where these policies are less in evidence (see Thoburn, 2006, 2009, for a discussion of the different attitudes in different jurisdictions towards care services a part of family support or a service response to be avoided if at all possible).
- Studies going back over several years report an association between frequent and 'comfortable' contact between the parents and the child whilst the child is in care and the child returning home (Fanshel and Shinn, 1979; Rowe et al, 1984; Millham et al, 1986; Davis et al, 1996; Farmer and Parker, 1991 (especially for older children). The relationship between the child returning home and aspects of practice, including contact arrangements, will be discussed below. However, when multivariate analysis techniques have been used, it is not clear that contact is in itself a causative factor since it is correlated with other variables that predict return home including whether the social worker worked with the parents to encourage contact, the easing of problems in the home, and the child's retaining a role and place within the family.

Knowledge on outcomes when children are reunified with birth parents or leave care to live with relatives on an informal basis or guardianship order

The main sources of information on the likelihood of reunified children remaining with their birth families are summarised by Wulczyn (2004) in the USA and Biehal (2006) and Farmer (2009) in the UK. Several researchers provide information on stability and other outcome measures. Geen, (2004) and Hunt (2009) summarise the data on children placed with relatives, some of whom left formal care but remained with their relatives as legal guardians. The data on outcomes need to be considered separately for four groups:

- children entering care in their early years and returning from care within around 12 months of entry (the subjects of much of the USA research and some of the UK studies);
- children entering care when still quite young but returning to parents after several years, including some returning home as teenagers;
- children entering care when over the age of 10 and returning home within a period of months;
- children entering care when aged 10 or over and remaining for two or more years but returning to the family home when still of an age to need 'parenting'.

Those who leave care as young adults are the fifth group which tend not to be included as part of studies of 'reunification'. The UK studies and those from other European countries and Australia tend to include some in all four groups and differentiate for purposes of analysis either by reason for entering care and the placement plan at that time (Farmer and Parker, 1991, Hunt and Macleod, 1999); by length in care (Bullock et al, 1998) or a combination of these (Sinclair et al, 2007; Farmer et al, 2008).

Outcomes measured by child's re-entry to care

Biehal (2006), reviewing the USA and UK research on re-entry to care from placement at home, reports that approximately 20% will enter care again within two years of returning to birth parents. From his 10 year follow up of children who came into care in 12 States in the USA in 1990, Wulczyn (2004) reported that almost 30% of those who left care to return to birth families were re-admitted to care during the 10 year time-scale of the research. Re-entry to care is most likely to happen within a year of returning home. (From an overview of the USA literature Wulczyn (2004) concluded that around 70% of the re-unified children who went back into care did so within a year of returning home and 57% of these did so within three months.)

The 1980s UK cohort study of Rowe et al (1989) found that 18% of children reunified from care were readmitted to care during the following two year (including 7% readmitted twice). (This cohort would be more similar to a cohort in Germany in that it included children received into care on a voluntary basis as part of a family support service.) The studies by Bullock et al (1993 and 1998) found that 28% of those who returned home went back into care and did not go back home during the five year follow up period. Focusing on those who left care to return to birth families as adolescents, these authors concluded that just under 30% of these placements back home of older children had been unsuccessful. Bullock et al and Rowe et al identify a group of 'oscillators' who move in an unplanned way (ie not including planned

respite) three or more times between the family and care. Figures from the Farmer and Parker (1991) study, including only children on court orders, are at or above the USA rates (38% of the 'protected' and 50% of the 'disaffected' children who returned to birth parents re-entered care between 2 and 14 years after returning home- in part explained by a longer time frame than the USA studies).

More recent information is available from Sinclair et al's (2008) reanalysis of administrative data on over 7,000 children in care in England, supplemented by survey and interview data. They found that at least 23% of children entering care had had a previous admission to care. The Dickens et al (2007) data analysis and survey found that 12% of the children who had returned home within a year of entering care (including voluntary admissions as well as those on care orders) had gone back into care by the end of the year. Failure rates for reunification are higher for cross-sectional studies of children returning home from care, since they include more 'long-stayers'. Sinclair et al (2007) found that 37% of children who returned home from care had re-entered care within two years.

Hunt and Macleod (1999) report on a detailed study of a consecutive cohort of 131 children (most under the age of 5) on which a court order was applied for because of concerns about maltreatment (which resembles the cohorts described in USA and Australian research).

The recently published Farmer et al (2008) study explored in detail the care and post-care experiences of a consecutive sample of 180 children who had been in care in England for at least six weeks and returned home to at least one parent in 2004-5. They were followed up for two years. A third were under five when they returned home, a fifth were between 5 and 10 and half were aged 10-14. 60% were admitted at the request of their parents (or without a court order being necessary) and these were mainly older. Whilst 71% returned home from non-kin foster care, 8% returned home from kinship foster care and 13% from residential care. The age range and the inclusion of parental agreement admissions to care and the range of placements whilst in care make the sample more similar to those from Germany and other European countries that the USA samples. This study found a higher rate of 'unsuccessful' returns home, with 47% having returned to care at least once within 2 years. As with the Sinclair et al study, this higher rate than for some USA studies is in part explained by the fact that this is a 'cross-sectional' sample, including more children who had been in care for several years and fewer recent entrants than in some of the USA studies. As with other researchers Farmer et al identified 'oscillators' (around a third of the sample) who returned to care more than once.

Other outcome measures

Looking at measures other than stability/ placement breakdown, there is agreement amongst USA and UK researchers that, for children entering care because of maltreatment or because of their own emotional or behavioural problems:

> returning to birth parents is the placement that carries the greatest risk of poor outcomes. This is so whether placement stability, remaining safe from further maltreatment, or a range of well-being measures, are used as outcome indicators. The only outcome indicator on which reunification scores best

(alongside placement with kin) is having a sense of identity and personal history (Thoburn, 2009, p44).

The Swedish studies conducted by the *Socialstyrelsen* research institute are particularly important sources on long term outcomes, as data are available on all children in the population, including whether any entered care. Vinnerljung,et al (2005) and Vinnerljung et al (2006) provide data on long term outcomes for children born in the 1970s who had ever been in care, and compare them with cohorts receiving services in the family home; with those in the general population not recorded as having received a public child welfare service; and with those adopted from overseas. The first study focuses on educational attainment as the outcome measure and the second on suicide attempts or severe psychiatric problems. Although they do not specifically focus on children reunified with parents, they report on sub groups in short term and intermediate length care for whom one can infer that most of these will have returned to the family home. In the second study 9,418 were in short term care (totalling less than 24 months before their 13th birthday, in either residential care or foster care or both) and 2534 in 'intermediate care' (25-60 months, mostly in foster care). When socio-economic and psycho-social status of parents were controlled for, all who had spent any time in care were at greater risk of psychiatric illness and suicide attempts than the general population, the risk being highest for those who remained in long term care and were not reunified Those in short term care were at slightly lower risk than those in intermediate or long term care The risks for those in short term care were not dissimilar to the risks for similar children receiving a child welfare service in the family home. Boys were particularly vulnerable. In the first study a different large scale sample was used to consider educational achievement (measured in terms of completion of secondary and post secondary education). The worst results were for those who had been in care during their teens, and also for those who had received a child welfare service in the family home in their teens. Those who experienced short or intermediate length care before their teens; those who received care in the family home and those who were in long-term stable care were statistically more likely to complete secondary or higher education than the first two groups, but still 'had a more than two-fold risk of being less educated young adults, compared with normal population peers with less-educated mothers' (Vinnerljung, 2005b p 271).

Looking at re-abuse or experiencing further neglect after returning home as outcome measures, Farmer et al (2008) found that of the 52% of placements home that had not broken down, a third were assessed by the researchers to be of poor quality in terms of the quality of parenting and the risks to health, development and safety. They found the children who had not been the subject of care orders, as well as those who were known to have been maltreated, were at risk of neglect and poor parenting when they returned home. Brandon and Thoburn (2008) in an 8 year follow up of a consecutive cohort of 105 English children suffering 'significant harm' found that more of those who remained at home throughout, and of those who had a brief stay in care and returned home and remained there, had poor outcomes (in terms of being again maltreated and being assessed as of poor wellbeing) than was the case for those who remained in care, or returned home briefly and were then placed in long term care.

Thoburn (1980), Lahti (1982); Barth et al, 1987; Pinkerton (1994), Farmer and Parker (1991), Bullock et al (1993 and 1998), Festinger (1996), Jones, 1998, Packman and Hall (1998), Hunt and Macleod, (1999), Harwin et al (2001), Taussig et al (2001), Fuller (2005), Sinclair et al (2007), Brandon and Thoburn (2008) and Farmer et al (2008) all identify cases when children were re-abused, or exposed to continuing serious neglect, after returning home, some of whom did not return to care and remained in a neglectful or abusive family. For example, Jones (1998) found that 20% of 445 children returned home from care (average age 4 years) suffered neglect and 9% physical abuse after return home. Taussig et al (2001) reported that 21% of children returning to birth families had serious school attendance problems compared to 9% who remained in care. The respective proportions involved in crime were 49% compared with 30%.

Most UK and USA writers tend to equate re-entry to care as placement failure. However, in their USA research, Fein et al (1983) found that some children who returned home and went back into long-term care subsequently had successful outcomes in adoptive or foster families. Packman and Hall found that when children (including a majority about whom there were child protection concerns) were received into care at the request of parents (or at least without their active opposition if care was recommended by professionals), most of their parents found this helpful. These researchers reported that, two years after entering care, for the majority of those who returned home and stayed there and those who returned for very brief periods to care (62% of their sample of 177 children who entered care) 'positive outcomes in parenting, parent child relations, material circumstances, risk factors, parental health, and the child's schooling, behaviour and health outweighed the negatives' (Packman and Hall, 1989, p 147).

Two other small scale European longitudinal studies are of interest. Andersson (2005) followed up at intervals over 20 years a small sample of 20 children placed initially in residential care and then in long term foster care. She found that moves between foster care and birth family care can be associated with good long term outcomes. Sixteen were reunified with a parent or relative and half of these remained there until adulthood. Ten were rated as of good wellbeing (five of these had returned to a parent and remained there till adulthood); two were reunified with a parent but then returned to foster care until adulthood and three remained with the same foster family as adults. Nine were in the 'moderate social adjustment' group (four of these were reunified and remained till adulthood, two were reunified and returned to care and three remained in stable foster care). Seven were in the 'poor social adjustment' group (four had been reunified and returned to care; one had remained in the same foster home; and two had had multiple placements in care). This study is particularly interesting because of the detail provided about the arrangements for contact between the birth and foster families, and the young adults' reflections on their attachments with their birth and foster families. .

The Dumaret et al (1997) French study is similar, although the data on outcomes are more positive. They followed up 59 children who had spent at least five years in foster care and were aged 23 or over. Records were scrutinised and most were interviewed. 27% went home before the age of 15 and 21% when they were aged 16 or 17. As with Andersson, they found that the young adults primarily identified with their foster families or their birth families with only four having good links as adults

with both (17 had good links with their birth families and 22 with their foster families).

Variables associated with more or less successful return home

There is some consistency amongst researchers in terms of the factors associated with unsuccessful return to parents, especially if those entering care when young for reasons of maltreatment and those entering care when older because of developmental problems, behavioural difficulties or delinquency, are considered separately. The majority of studies (most of the USA ones) concentrate on the first group whereas the UK studies cover a broader age spectrum. Most researchers use cohort studies to compare stability/placement breakdown for children who returned home with placement stability for children in the same cohort who remained in care (Sinclair et al 2005; Hunt and Macleod, 1999; Taussig, 2001; Wulczyn, 2004, Pine et al, 2007). Some (including the experimental or quasi experimental design studies of Jones (1998); Festinger (1996), Fuller (2005), Farmer et al, (2008). Some factors identified by a majority of researchers associated with a greater likelihood of re-entry to care are similar to those that predict that the child is unlikely to return home. However others, such as the child's disturbed behaviour in care (which may result in return home due to placement breakdown) are associated with a greater likelihood of return to care.

(It should be noted that most of these variables are also associated with placement breakdown when children remain in care or are adopted.)

Child variables associated with greater risk of returning to care

- Young children taken into care because of neglect are more likely to re-enter care than children who first entered care because of concerns about physical or sexual abuse.
- The child is in an older age group.
- Children with emotional and behavioural problems before and/or during care.
- Young people who abuse drugs or alcohol before and/or during care.
- Young people involved in crime when in care
- Some groups of ethnic minority children (in UK, African Caribbean and of mixed Caribbean/white heritage, in USA African American; indigenous children in Canada, Australia and USA).
- Children who have been in care for three years or more.
- The child returning home from care alone- children who return home with at least one sibling are less likely to re-enter care
- Children who have had several placements in care.

Family variables associated with higher risk of return failure

- Child originally entered care because of parental addiction problems.
- Child originally entered care because of parental mental illness.
- Parents had poor parenting skills after the return.
- Serious parental problems (eg intimate partner violence) had not been resolved when the child went home.
- Parental hostility towards the child or ambivalence about the return home.

- The child returning to a single parent, if compounded by poverty and poor housing.
- Serious financial or housing problems.
- Lack of support from extended family or neighbours.
- Changed family composition (but only if linked with adverse consequences for the child in terms of conflictual child/ step parent relationships).
- Conflict between siblings, especially step and half siblings.
- Non-compliance of parents with service plans when the child was in care and/or after return.
- 'False compliance' with plans and/or hostility to caseworker.

Family variables associated with the return home being successful

- Parents were strongly motivated to resume care of the child.
- Parents' willingness to change and taking steps to do so (provided this is not 'false compliance'.
- No unresolved family problems when the child returned.

Organisational/ service variables

- Abused or neglected infants and toddlers who return home within a few weeks or months of entering care are more likely to re-enter care and to experience abuse and neglect whilst at home than those who return after a longer period in care (but less that 3 years). Wulczun (2004) reports that around 25% of those who returned home after 18-35 months experienced breakdown compared with 30% who returned home after between 1 and 2 months in care. Wulczun and Wells and Guo (2004), commenting on changes in USA legislation and policy, note that children in recent years return more quickly from care, and suggest that children may be moved back home before sufficient change has been brought about in the family's material and emotional circumstances. There are similar policies in Australia, Canada and the UK for children to return quickly from care to parents or relatives and trends towards a higher proportion returning to care.
- Poor quality practice and poor prior planning (Packman and Hall, 1989; Block and Libowitz (1983).
- Ryan et al (2006) and Brook and Mcdonald (2007) found *no association* between children who entered care because of parental addictions returning successfully from care, and their parents being mandated by the specialist 'addictions courts' to attend combined addictions treatment and child welfare services.

These service and practice variables will be considered in detail in the next section.

5. Research on services and on practice approaches and methods

There is, therefore, a body of evidence that return to birth families from care breaks down in an important minority of cases, and is often problematic when it does not break down. Yet in all countries, backed by the United Nations Convention on the Rights of the Child, and the wishes of the majority of children and parents themselves, the first 'permanence' option for all children who have to come into care is that they should return safely to a birth parent or, if that is not possible, to a member of the birth family.

It is all the more surprising, and to be regretted, that, so much less effort and resources (in practice developments as well as research) have been put into providing and evaluating high quality services to children who return home and their families, than into services for children who remain in care

Alongside their attempts to identify the characteristics of the children, the families, and the in care experiences that appear to be associated with more or less successful return home, most of the studies cited above have something to say about the characteristics of the decision making and practice of social workers and their professional colleagues that appear to be associated with successful return home. Some report on intensive interview samples which explore in detail the nature of practice and provide insights which help to explain the quantitative results.

This section also draws on a wider range of smaller scale studies that provide more detailed information on practice, although the sample numbers may be too small for observations to be made about the relationships between variables and outcomes. These small-scale studies (for example Aldgate, 1980; Thoburn, 1980; Thorpe, 1980; Trent, 1989; Fisher et al, 1986; Hess et al, 1992; Frame et al, 2000; Pinkerton, 1994; Ellaway et al, 2004) provide more detailed information on process and outcomes. Most report the views of the children and their parents or relatives about what they found helpful or unhelpful. Some studies of children in care, though not focusing specifically on reunification, provide detailed information on the in care services that contribute to successful reunification (Millham et al, 1986; Hess and Proch, 1988; Cleaver, 2000; Beek and Schofield, 2004; Pecora et al, 2005; Thorpe et al, 2005, Lovett, 2008). In Europe, more research has looked at the role of residential child care workers and social pedagogues in working with the parents of older, troubled children in group care (see especially the papers in Chakrabarti and Hill (2000); Grietens et al (2007) and Tillard and Rurka (2009). Increasingly important sources of information in the UK are the overview reports commissioned by the government that bring together lessons from cases where children have died or been seriously injured (including some killed by parents after being returned home from care) (Brandon et al, 2008).

A small number of the researchers seek to identify models or aspects of practice or decision-making resulting in more successful outcomes through the use of experimental or quasi-experimental research designs, sometimes using an action research methodology. These seek to control for some family variables by selecting children assessed as likely to need care, being in a specific age band, having a particular problem such as alcohol abuse, or having a case plan for reunification within a particular time frame. Children are then randomly allocated to agencies using different models of decision making or practice and to a ‘service as usual group’ (for example Jones et al. 1985); or to a single intervention model group and a ‘service as usual’ group (Stein and Gambrill, 1977; Lahti, 1982; Fraser et al. 1996; Swenson et al, 2000; Lewandowski and Pierce, 2002; Pine et al, 2007). Others use ‘naturally occurring experimental conditions, by comparing those who receive services before and after a policy change. For example, Wells and Guo (2004) consider the impact of welfare reform and different income maintenance systems on children of poor families entering care and returning home; Ryan et al (2006) and Brook and McDonald (2007) report on the impact of the introduction of addiction courts and

court mandated treatment models; and Meezan and McBeith (2008) consider the impact on reunification rates and outcomes of the introduction of market-based service funding models.

A challenge these researchers seek to overcome is to clearly describe and maintain consistency of the interventions being evaluated and maintain 'programme fidelity' in the different agencies where the model of practice is being used. The complexity of practice in these high need and complex cases means that this is not an area where 'manualised' programmes have been developed and evaluated, although parent training programmes (see Barlow et al, 2006 and McMillan et al, 2009 for reviews of the effectiveness of these programmes) or evaluated interventions for groups of children with specific problems (such as multi-systemic therapy, Littell et al, 2005) are sometimes used as one part of a package of services. There are however detailed guidelines on reunification practice, some developed by researchers (Maluccio et al, 1986; Pine et al, 1988; Hess et al, 1992; Marsh and Triseliotis, 1993; Thoburn, 1994; Festinger, 1996; Pine et al, 2007) or tools to aid decision making (Bullock et al, 1998). Drawing on his small scale study in Northern Ireland and other research, Pinkerton (1994) provides a 'model' for understanding the reunification process.

What follows is a synthesis of the conclusions about effective practice drawn from these studies, which in broad terms reach similar conclusions.

Practice can be considered in terms of:

- assessment, decision making, and case planning;
- services;
- casework, support, training and therapy with children, parents, relatives and foster carers at the different stages of the care and reunification process.

The other dimension when considering reports of reunification practice is the age of the child on returning home. Some literature specifically addresses the issues for young children returning home after an assessment following the reporting of abuse or neglect, and some focuses on helping older children to return home. Sinclair's categorisation of six groups of children in care may be helpful in planning reunification policy and practice (listed in Section 3 above).

Assessment and decision making

Wulczyn (2004, p 98) comments:

> Although family reunification is the most common exit type for children in care, relatively little is known about reunification decision making and the process of reintegrating children with their families.

The key decisions are:

Before care is provided
Has the time come to plan for the child to have a period in out-of-home care, and if so, can this be negotiated with the parents or will a court order be needed?

- What sort of care experience (or 'care career') is most likely to be of benefit to this child and family? Rowe et al (1989) listed the purposes of care, the proportions of children in each, and the success in achieving these aims with respect to 397 placements of English children. Whilst 15% of placements were for 'care and upbringing' outside the family, 85% had short or intermediate term aims. The list is relevant to the placements being made currently, but the proportions are likely to be different with more children having a planned placement for 'care and upbringing. 52% of the placements studied by Sinclair et al (2007) (in a study with many similarities with that of Rowe et al) were for 'care and upbringing' (including 13% that were placements prior to adoption by the current carers). If these care and upbringing placements are removed the placement aims and percentages used by Rowe and by Sinclair are:

Table 6 Placement aims in 2 large scale UK studies
% of placements with this aim

	Sinclair	Rowe	Rated as successful (Rowe et al)
Temporary care	22%	46%	88%
Emergency	3%	14%	83%
Preparation for long-term placement	29%	14%	79%
Assessment	10%	13%	57%
Treatment	2%	9%	46%
Bridge to independence	23%	4%	53%
Remand (offender)	1%		
Other	10%		

Table adapted from Rowe et al, 1989, p90; Sinclair et al, 2007, p162; Sellick et al, 2005 p38

The main difference over time is the increased use of placements that are unlikely to prepare for return home (although this change is partly explained by the inclusion in the Rowe study of 'respite' type short term placements whilst planned short term placements with the same carer are excluded from the Sinclair et al study).

- What practical arrangements for the child's move into care will be least traumatic (for the child but also for the parents) and most likely to facilitate that good practice that will lead to return home?
- What placement would be most appropriate- kinship foster care; non-kin foster care; children's home; a secure children's home; a health care facility (including mental health); a residential school?
- What sort of contact arrangements between the child and members of the birth family are likely to be appropriate and how are these going to be arranged so that reunification is facilitated?

When in care

- Can this child go safely home and is there a good chance that the placement will last and meet the child's needs? Will a court decision be needed to sanction this and will any specific protective measures such as court-mandated supervision be needed?
- If further assessment demonstrates this is the 'permanence' option most likely to meet the child's needs, what 'packages of care' (practical and financial help,

emotional support, therapy) are needed by the different birth family members, the child and the carers to ensure successful reunification can be achieved ?

When reunification work starts and in the early stages when the child is back home

- What services will be needed and 'packages of support and therapy' including any financial and practical assistance?
- What are the short and longer term 'contingency plans' if return home proves not to be in the child's interest?
- What supervision and monitoring arrangements are needed if there are still concerns about safety?
- What are the different roles to be played by those involved in supporting the child and family?
- Who is the 'lead professional' accountable for ensuring the services are provided and the plans adhered to or appropriate changes agreed?
- If the child is going to live with one parent who is separated from the other, or if the child is to live with relatives, what assistance is needed with contact arrangements to ensure that the child benefits and remains safe during contact?

Once the child is at home,

- At any point decisions may have to be taken that the child is at serious risk of harm, or that his or her needs are not being met. The specialist USA reunification studies listed above, and, in the UK, Thoburn (1980), Farmer and Parker, (1991) Farmer (2008), Bullock et al (1989) Hunt and Macleod (1999) Brandon and Thoburn (2008); Farmer et al (2008) and reviews of child death cases (Brandon et al, 2008) have all identified that once the child is back home, decision-makers are reluctant to decide to remove a child. In the absence of incontrovertible evidence of a serious physical or sexual assault, some children remain in the parents' or relatives' home in adverse and damaging circumstances, sometimes for periods of years, until they are old enough to take the decision to leave home.

There is a great deal of research and practice literature on effective decision making systems, assessment, case reviews which can not be considered in detail here. One model of decision making practice which is particularly relevant to reunification decisions, developed in New Zealand but now used widely across the continents, is the Family Group Conference. There have been several descriptive studies and a small number of attempts at more experimental models of evaluation but it still remains a 'promising practice', which is generally viewed favourably by family members and workers. The model of 'family group conference' or 'family group decision-making' is adapted for use in different jurisdictions, and this makes comparative evaluations difficult because of lack of 'programme integrity'(Marsh and Crow, 1998; Vesneski, 2009). Several studies (for example Packman and Hall, 1998, Thoburn et al (1995) provide data on the multi-disciplinary child protection conference (to which, in the UK, parents are invited). Hunt et al (1999) and Harwin et al (2001) provide detailed accounts of the role of courts. These and several of the USA researchers (including Stein and Gambrill, 1977; Lewandowski and Pierce, 2002; Ryan et al 2006) report on whether detailed treatment plans made by courts or case review systems are achieved or not.

One conclusion reached by UK researcher (Department of Health, 2001) which has fed into practice guidance (Department of Health, 2000) is that it is essential that assessment and services should be provided concurrently, with the nature of the assistance reviewed and changed as appropriate as the assessment provides more detailed information. Parents and children interviewed by researchers have asserted that a good assessment is 'therapeutic' even though it precedes 'therapy' in the narrower definition of the word.

Research on social work approaches methods and therapy when the plan is reunification from care

Given the complexity of both practice and research in this field, it is unsurprising that there is no systematic review of research on programmes and services designed to return children home from care (Cambbell Collaboration http://www.campbellcollaboration.org/). Indeed a 'programme' approach to interventions, that tends to figure highly in systematic reviews, does not fit well with the complexity of the cases for which reunification from care may be attempted. Almost always, there will be a range of services and casework and therapeutic approaches, provided concurrently as well as sequentially to the different members of the family, often over several years. Brandon and Thoburn (2008) found most of the children who were reunified from care with parents or relatives had received a service for the majority of the eight years of their longitudinal study, and that many different services were provided and casework methods used during that time. It would be impossible to say, given so many variables, whether any particular intervention was 'effective' in achieving successful return home.

A further problem for those seeking to use experimental research methods to evaluate practice in this field is that a key element in achieving success is the casework relationship (the therapeutic alliance) and researchers have not yet found a way of building this as a variable into a scientific evaluation model. There is not an easy 'fit' between a 'programme' approach to helping (which is usually time-limited) and longer term relationship-based psycho-social casework and support that involves putting together changing 'packages of care' (which characterises the child welfare approach in much of Europe). The commissioned programme approach to welfare services most in evidence in North America is one explanation for the fact that more research specifically on reunification has been undertaken in the USA.

Having said that, although there are differences in the legal and social contexts in different jurisdictions, and the profiles of cohorts of children in care may differ, when it comes to individual children and their families, there are many similarities in service delivery models and practice methods. As we saw above, poverty, intimate partner violence, addictions, neglect alongside specific acts of abuse, figure strongly in all countries in the lives of the children entering care. The family backgrounds of children who enter care when older because of their own behaviour and problems tend to be more varied.

Across all jurisdictions, a child's entry into care and the period before return are in the majority of cases marked by changes in the parental household, the loss of a parent, the arrival of a step-parent and step-siblings, and, more frequently than for the average child, the death or a seriously disabling condition of a parent. Millham et al

(1986) describe graphically how children react to finding that their bed and their toys have been taken over by an unknown child who has moved into their mother's home with a new man the child is expected to call 'dad'. Farmer (2008) reports that a quarter of the children returned to a different family form, either a single parent after the other parent had left, or a new step parent.

As Wulczyn (2004, p14) puts it:

> Reunifying a child is not a one-time event, it is a process involving the reintegration of the child into a family environment that may have changed significantly from the environment the child left.

The researchers all agree that practice and services have to be specific to the constellation of problems that led to the need for each child to enter care. As was seen from the outcome studies, the most likely reason for reunification being unsuccessful is that the child returned to a parent or household whose problems remained unchanged. The detailed reunification studies indicate that many children return to families who still have serious problems. Some of the research-based practice literature is specific to the tasks involved in getting children safely home and ensuring that the placement lasts and meets their needs. However, there is a much larger body of research-based practice literature on how to help the different groups of children and families. Thus the practice literature on working with parents with addiction problems, or mental ill health, poverty or housing problems, or marital problems including intimate partner violence are all relevant to practice when children return from care. Literature on therapy for children with attachment problems, low self esteem, post-traumatic stress disorder, addictions, delinquency and a range of behavioural problems is also relevant. This will only be cited if the literature specifically refers to reunification.

There is much common ground amongst researchers who have evaluated the specialist reunification programmes in the USA and reunification practice in the UK and Australia. All emphasise very active case management, often backed by court directions.

In Australia, Canada and the USA much use is made of formal written agreements with the parents and older children which spell out and regularly review the problems to be tackled and what needs to change within defined time scales (Stein and Gambrill, 1977; Fraser et al, 1996; Walton, 1998). These specialist projects emphasise high intensity and short duration of services and services based on a cognitive behavioural approach. Others, whilst emphasising the contractual nature of the work, place more emphasis on parental participation and a strengths based, ecological approach, using cognitive behavioural approaches alongside relationship-based psycho-social casework (Lewandowski and Pierce, 2002; Jones, 1985; Maluccio et al, 1986; Thoburn, 1994; Pine et al 1998; Pine et al, 2007). These approaches tend to be more flexible about time scales for the completion of the work and case closure. This approach also emphasises the importance of practical help alongside casework and therapy (Rezpnicki et al, 1997 and Courtney et al, 2004, who emphasise the importance of providing assistance in securing decent housing).

The research does not clearly point to any one approach or method being more successful in either returning children home or maintaining them there. The studies all point to the importance of the parent/social worker and child/social worker relationship and to the very high level of skill needed to maintain an empathic, professional relationship in which the family members can develop trust, whilst at the same time, monitoring the care and being willing, if necessary, to decide against return home, or remove a child who has been returned. The detailed reunification research and the UK serious case reviews (Brandon et al, 2008) report on those cases where a worker has become too enmeshed in the problems of the parents and failed to recognise that children were being maltreated and needed to be removed back into care to ensure their physical safety and/or psychological wellbeing.

All the research emphasises the importance of small caseloads and good and available professional supervision.

Practice at the point of entry to care

The quality of practice at this stage can make a difference to whether later reunification will be successful. Much of the practice and evaluation literature crosses over with 'family preservation' literature, and some studies evaluating attempts to avoid the need for children to come into care continued to study the children when they entered care and returned home (see Schuerman et al, 1994, Courtney, 1997 for reviews of this body of research). It can also pave the way for effective longer-term care if further assessment demonstrates that this is necessary.

Packman and Hall (1989) and Thoburn (1994) argue that a careful assessment when serious problems emerge can lead to a shared decision that a placement in care is necessary. Joint plans can then start to be made about the work to be done in order to reduce the difficulties (of the family or the child or both) even before the child enters care. A well planned entry to care, with the parent and child visiting the placement beforehand, or the carer visiting the child and parents in the family home, can avoid the trauma of an emergency admission, usually to an inappropriate placement and necessitating a further move. A planned placement can also avoid a move of school and loss of friendships. Thoburn (1994) refers to this as a 'changing gear' stage of the service, when the focus of practice switches from maintaining the child on a full time basis in the family, to planning for a successful and minimally harmful separation, a more positive care experience and a better chance of return home at a time that is right for child and family.

Packman et al (1986) and Packman and Hall (1989) report that this often does not happen in the UK, where the dominant policy direction is to avoid taking a child into care. They found that results were more satisfactory (as seen by the parents and measured in terms of child welfare and reduction of parental problems) in the agency that saw reception into care as a supportive measure than in the 'care averse' agency, which she describes as an area where:

> A 'rule of pessimism' operated about the care system, which meant that admission was sometimes almost unthinkable until it became too late to think at all. 'Last resorts' are, after all, seldom desirable or constructive places to be. (Packman et al, 1986, p197)

These authors identified a small number of cases where an emergency unplanned admission to care could not be avoided, but a larger number of 'predictable emergency' cases, in which it was clear that the child would enter care, but the social workers refused to discuss the possibility and a traumatic entry happened which could have been avoided

In the USA, Jones (1985) found that the 'experimental project' children were less likely to enter care, and to return home more quickly, although at the end of the five year follow up there was no statistically significant differences between the two groups. Within the intervention group, those who received a lower intensity longer duration service, combining practical help and a casework relationship did better than those receiving a higher intensity, shorter duration service (although the 'lower intensity' service in the experimental group was still much higher intensity than for the 'service as usual' group). This finding differs from that of some other USA researchers who have studied reunification (Stein and Gambrill, 1979; Pierce and Geremia 1999) who found more positive results from short term intensive services. Jones and colleagues recommend, for families with complex and multiple problems, a model of service that has 'permeable boundaries' so that parents can easily renter the service if problems recur, without having to be reassessed by a different worker, or wait until a report of maltreatment is made. The UK research on family centres (Tunstill et al, 2007) is relevant to an understanding of effective services before and after children have been in care. These participatory approaches to supporting families that involve the provision of emotional support, therapy and practical help fit within the broad 'empowerment' 'strengths based' or 'ecological' approaches to family reunification practice advocated by Maluccio et al (1986) and more recent writers on social work practice.

This period of planning for the move into care provides an opportunity for a placement agreement, involving the child if old enough, the parents and the carers to be discussed, and in particular for preliminary arrangements to be made about contact with birth family members. Researchers on kinship placements have identified that careful planning at this stage can result in the child moving directly to a kinship placement rather than having to move first to an agency foster family and then having to move again.

At this stage of the work, a discussion can be held as to whether a respite care service with regular stays with the same foster family or residential setting would be appropriate, or an admission to care for a planned period or for an assessment is needed before long term plans can be made. The skills of negotiation are central to checking whether a voluntary move into care can be achieved or whether a court order will be required. Where voluntary arrangements can be made, the parents are likely to be less hostile and it is possible for the move into care to be achieved in a less damaging way, by making introductions of the child and parents to the placement. On the other hand, Farmer et al (2008) found that cases scrutinised by the court were more likely to receive a good service, especially when the child returned home. The specialist 'addiction courts' (now a feature in some states in the USA and being piloted in UK) may require a period in care accompanied by a mandated programme for the parents which spells out the steps to be taken prior to return home, although, as

noted above, the research to date on the impact of such services on child outcomes is mixed.

For children with challenging behaviour or convicted of offences, or mental health problems, multi-systemic foster care has been evaluated as an effective approach to the provision of short term intensive assistance (Chamberlain and Smith, 2003). Because it is an intensive intervention intended to last only for a few months, it is most effective if parents or relatives are committed to the plan and the reunification strategy is planned for before the child enters care. This programme is being piloted and evaluated in Sweden and in the UK.

Practice when the child is in care

Although not specifically focusing on reunification, the reports of therapeutic interventions for troubled and troublesome young people entering residential care in France, the Netherlands and Flanders reported in Grietens et al, (2007) and Tillard (2009) are relevant to understanding reunification practice in residential care, and especially the role of social pedagogues and psychologists in undertaking therapeutic work with older children and their parents. These studies evaluate practice when the plan is for short term care, or for a longer term 'shared care' arrangement (as when older children have a residential school placement with continuing parental links and some time spent at home). Accounts of these evaluations are available in the languages of these countries and referenced in these publications.

When reunification is planned at this early stage, the nature of the service to be provided when the child is away from home should already have been agreed. For younger children, the emphasis of practice will be on securing comfortable contact arrangements so that relationships are maintained and the child retains his or her place in the family home. For older children whose own behaviour is the precipitating reason for care, the emphasis is on a targeted service to improve the behaviour of the young person, improve parental understanding and parenting skills and improve relationships within the family. The research suggests that it is important for trained and well supported foster or residential workers to work alongside social workers, therapists and family support workers as key members of the 'team around the child', modelling good parenting practice to the parents. In Europe the social pedagogue working both with children in care, the French model of salaried and trained foster carers, and the Swedish 'contact family service' (Andersson, 2003) have had promising evaluations.

However, research across continents indicates that a proportion of foster carers (sometimes a large proportion) and some residential workers lack empathy for the birth parents and do not have either the attitudes or the skills to help with the reunification process. There are examples in the detailed research studies that when children are placed with such carers (who would really like the child to remain with them long term) or who have a 'child rescue' approach to their work, the reunification efforts of the social workers and therapists are made ineffective. Thorpe et al, (2007) found that only 37 of the kin and non-kin foster carers in their study in Queensland, Australia had empathy for the child's right for identity and continuing kin family membership and only 22 had empathy with the natural parents and were able to 'walk

in their shoes'. Forty had predominantly mixed attitudes to the birth parents and 36 were predominantly negative about them. This was despite the Queensland government policy of encouraging reunification (Queensland Department of Child Safety, 2000).

Practice when the initial plan is assessment of whether early return home is likely to be in the child's interest

Since most of the specific reunification programmes and evaluations have been conducted in the USA, it is important to note, that they, and some of the UK research which concerns younger children, are conducted in the context of 'concurrent planning' policies. This involves working concurrently to reunify the child quickly with birth parents or relatives, and preparing a 'contingency plan' of removing parental rights and restricting or terminating contact if the child does not return home within a timescale of 6 to 12 months. Contingency plans (usually for permanent placement with an adoptive or foster family) are often in place when a child returns home from care in case the placement fails. Children entering care via the courts following allegations of maltreatment tend to return home more quickly in these jurisdictions than in most countries of Europe. Often the nature of the service provided, the requirements on the parents to take up services, and the contact/ visitation requirements are court mandated. As noted above, some researchers have found that maltreated children returning early are more likely to return to care or to be again abused. This suggests that the policy of early return can become more important than the need to work with the parents and child to find sound solutions to the problems that led to the need for care.

In the UK literature, more attention is paid to assessment of whether the child can return home. However, the practice of completing the assessment before providing help, which used to be common, is no longer seen as best practice. This is in part because of earlier research which demonstrated that the 'gap' left by the child can all too easily close up, depression and lack of self worth sets in, visiting becomes painful to the parents and drops off. Jenkins and Norman (1972) coined the term 'filial deprivation' to explain this phenomenon which mirrors Bowlby's (1971) 'maternal deprivation' theories for understanding the post-separation behaviour of young children. This work has been followed up in England (Aldgate, 1980; Thoburn, 1980; Thorpe, 1980; Rowe et al, 1984) and helps to explain the finding from some small scale studies that parents who are angry are more likely to have children return quickly to them than those who feel guilty at letting their children down, resigned or depressed.

Researchers who have explored in detail either cases where children returned home unsuccessfully (Festinger,1996; Farmer et al, 2008), or were seriously re-abused or killed (Brandon et al, 2008) stress the importance of social workers taking a full psycho-social history of the parents and children, including the child's patterns of attachment, and also a history of the interventions- what has been tried and been effective or not in the past- before a decision is taken to work towards a child returning home. The motivation and wishes of the parents and children are also central at this stage. Farmer et al (2008) found that in 42% of cases children returned to parents who were ambivalent about whether they wished the child to return home (mainly older children who had entered care because of behavioural difficulties). A

majority of the children interviewed for that study had concerns about whether their return would be successful, or were ambivalent about leaving foster families, residential workers and friends to whom they had become attached.

Some agencies have developed multi-disciplinary day care programmes to observe parents and children together over a longer period than is possible during contact visits. These tend to use strengths based, observational methods alongside parenting modelling and training, anger management, addictions and other programmes. If the assessment proves positive, the same programme can switch towards preparation for the return and provide support and continuing therapy after the child returns. Farmer et al (2008) include within their sample children who were placed with their birth parents in a residential assessment centre, and Zeira et al, (2008) describe the Swedish model of the 'assessment flat' which can be used on a day care or residential basis.

However, some writers (Stevenson, 2007; Brandon et al 2008; Thoburn, 2009) warn of the risks of 'false compliance' especially by parents of young children who entered care because of neglect or abuse. Determination on the part of some parents (especially those who deny having harmed their child and those with personality problems and controlling personalities) to recover custody of their children and 'get the interfering social workers out of our lives', can result in them apparently doing all the right things before the child returns home. Once the child is back home they become falsely compliant, or refuse access to those attempting to monitor the child's wellbeing and safety. It is therefore essential that a detailed psycho-social and relationship history is part of the assessment, alongside any strengths based approaches focusing on parenting in the present. Observed competence during contact meetings, or complying with court or social services requirements (eg in attending parenting, addiction, anger management of marital relationship or domestic abuse treatment programmes) can be an important indictor that the parents have made changes. However this sort of progress when the child is living elsewhere and spends only limited time with the parents does not, on its own, provide sufficient evidence that reunification will be successful. Brandon et al (2008) identified from their research on child deaths a 'start again syndrome' amongst workers who were too willing to look at the here and now and evidence of apparent change, and failed to pay sufficient attention to the full psycho-social and mental health history of the parents, and the reasons why admission to care was originally considered necessary.

A further point emerging from the research is that, once work is started on returning the child home, usually by increasing contact and home visits and telling the child and parents the planned timetable, it is very rare for the return not to happen, even if there are warning signs that it may not work out. In cases where there are serious doubts about whether the child should return, or whether a longer period in care is needed, it may sometimes be necessary to have a full court hearing, or multi-agency decision making meeting or review, at which the positives and negatives are fully reviewed and analysed, before the decision on reunification is taken. Several research studies have been able to identify, from the data available at the time that the reunification decision was taken, that the placement was unlikely to succeed. Awareness of the variables listed above as associated with placement breakdown might, for some children, lead to more time in care but a more successful return. This

is particularly relevant in the light of the finding from the USA research that, amongst maltreated children, those who returned early were more likely to experience breakdown than those who stayed longer.

Special issues when children have been long in care

The research indicates that children who have been in care for longer than two or three years are at greatest risk of unsatisfactory returns home. Schofield et al (2007) describe a cohort of 1,002 children who were in care in England for at least three years, 17% of whom were living with parents but still under conditions imposed by a court care order.[11] Sometimes these returns happen because placements in care have broken down, and the child refuses to settle in any other placement. Sometimes they happen because of changed parental circumstances, for example the mother or father have a new partner and successfully parenting children of the new relationship.

Whilst the practice issues already referred to are relevant, there are additional issues. Young children returning from care after this length of time will usually have formed attachments to their foster carers. Parents or relatives will need help in understanding that a child's difficult behaviour is a reaction to the loss of loved foster parents and not hostility to the parents. Parents who can not be helped to understand this behaviour may react adversely, and may punish the child for a perceived 'lack of gratitude' or 'lack of love' (Thoburn, 1980; Trent, 1989). Where a child has had a less positive stay in care, including several moves, his or her behaviour difficulties may have become more marked than when they entered care, making them more vulnerable to re-abuse or further rejection.

Effective social work practice can sometimes overcome these problems by bringing them into the open during the period before the child returns, and devising packages of therapy, support and monitoring that provide safety for the child, but are not so threatening to the parents that raised anxiety adds to their difficulties. Whilst 'wrap around' services, or multi-systemic therapy can be helpful, the involvement of too many workers, especially if the work is poorly co-ordinated or roles are not clear, can actually contribute to re-abuse (Brandon et al, 2008).

In some agencies the foster carers take a major part in 'bridging' the child between the placement and the parents' or relatives' home (Thorpe, 2003; Thompson and Thorpe, 2003; 2004; Thorpe et al, 2005; Marchenko et al, 2005), and, if a good relationship is established when the child is in care, they may provide respite care, or provide support in the home. (See also Andersson, 2003 on the Contact Parent service in Sweden and Zeira et al, 2008). This is especially a feature of multi-systemic foster care (to date evaluated mainly with older children (Chamberlain and Smith, 2003). Trent (1989) describes a small action research study using the methods (including 'life story work') and support arrangements that have proved successful in introducing children to adoptive families, to help children moving back to birth parents or to relatives they have not previously lived with.

[11] Living with parents but still being formally 'in care' (under 'Placement with Parents Regulations') is currently used for around 10% of English children in care, but rarely used in other countries other than for short visits.

With respect to older children who have been long in care, researchers on children leaving care in late adolescence or as young adults (Stein and Munro, 2008) point to the advantages of social workers acting as bridge builders and mediators between young people and birth relatives so that they 'leave care in partnership' and have birth family support even if they do not actually live with relatives (Marsh and Peel, 1999).

Contact with parents and relatives whilst the child is in care

This is the area of practice about which there has been most research. Early studies (Jenkins and Norman, 1972; Fanshel and Shinn, 1978; Maluccio et al (1986); Hess and Proch, 1988 in the USA: and Aldgate, 1980; Thorpe, 1980; Thoburn, 1980; Millham et al, 1986 in UK report on whether, how often and where meetings between parents, relatives and children take place, and provide accounts of contact from the perspective of the parents, children and carers. More recent studies in the UK, have reported on contact arrangements following legislation which strengthens the child's right to contact (Cleaver, 2000; Sinclair et al, 2005 Farmer et al, 2008). These have concentrated on the quality of contact and also on the desirability of encouraging contact with some family members but not others. They conclude that careful assessment is needed as to whether and how contact should be arranged with a parent or relative who has severely harmed the child (see chapters in Neil and Howe, 2004 and Sinclair, 2005).

Most studies find an association between regular contact between the child and birth family members and return home. Biehal (2006) points out that this is not necessarily a causative relationship since there are many overlapping variables which impact on contact. Children and families in some studies (Cleaver, 2000) have a preference for meeting up in the family home, but this happens infrequently in the USA and UK, especially when there has been an issue of maltreatment. Increasingly in the UK and USA, contact happens in specialist 'supervised contact centres'. Though this is sometimes necessary to ensure safety of child and carers, this appears to be more frequently a matter of convenience, or because foster families do not wish to have the parents visit their home, rather than according with the preferences of the child or the parents. Farmer et al (2008) report that 82% of the children who returned home saw a parent at least weekly and that most parents complied with the agreed contact arrangements, although around a fifth were unreliable. For most, the amount of contact increased in the weeks before the children returned home, often involving overnight stays. Given the fairly high number of unsuccessful returns home reported by these researchers, this is a warning that, although there is an association between contact and return, a clear association has not been established between the existence or frequency of contact and *successful* return home.

Meetings between parents and children can also be specially arranged, as an opportunity to work with social workers and therapists to improve relationships between parents and older children, or to work on problematic attachment patterns with younger children. If, as is so often the case, there will be a new parental figure, or new siblings in the home, these meetings can help with the formation of new attachments.

Several studies have identified that a key variable associated with whether contact happens, whether it is a positive experience, and whether the child goes home is purposive social work practice with the parents, and also with the carers, to ensure that they encourage contact. The Jenkins and Norman (1972) and Rowe et al (1984) research importantly identified that the approach to arranging contact (common at the time) of waiting for the parents or relatives to initiate the first meeting is likely to be counter-productive. This 'let's wait and see if the parents or relatives are really interested' approach is still common in some countries and amongst some practitioners. Thorpe's research on foster care in Australia is particularly relevant to practice in Europe (Thorpe et al, 2005; Thorpe, 2007), where the details of contact and visits home are less likely to be court mandated than in the USA and UK, and where the duration of foster care, especially for school age children, tends to be longer.

Services, social work practice and therapy when children are back with parents

All the elements of good practice previously described are relevant to the service when the child is back home on a full-time basis and will not be repeated here. Particular emphasis is placed by researchers, reporting on the views of parents and children, on the importance of services providing combinations of support, well targeted therapy and practical and financial assistance, including assistance in securing adequate housing and appropriate physical and mental health care for parents as well as young people. .

The research from the USA and the UK indicates that the quality of practice frequently deteriorates, or intensive services end too soon, to be replaced by a form of monitoring with no clear purpose. Short term programmes, however intensive, have been shown to be inadequate in the face of the many and complex difficulties of many of the families to whom children return. Some researchers describe the benefits of informal support, provided either by enlisting the assistance of relatives and community members or faith groups or through volunteer home visiting schemes. Lower intensity 'drop in groups' have been found by parents, relatives and children to be a helpful form of support after the completion of therapeutic or educative group programmes. These are particularly valued by single parents.

The most effective practitioners tailor the packages of care and support to the reasons why the child entered care, or vulnerabilities identified during care and the return process. Given the high incidence of children returning to families with addictions, this is increasingly a focus for the work (Maluccio and Ainsworth, 2003; Ryan et al, 2006; Brook and McDonald, 2007). The lack of clearly demonstrably positive outcomes even when high intensity services are provided highlights the difficulties to be overcome when children who enter care largely because of parental addiction return to their families. Farmer et al (2008) point to the fact that routine health checks are especially important when young children who enter care because of neglect return home.

Given the importance of relationships of trust, but also the risk of becoming enmeshed, some researchers point to the benefits of child and family having separate workers. However, risks have been identified by serious case reviews of too many workers and too much monitoring which increases the stress on the family.

Practice issues when children are placed from care with relatives

Most of the research described above does not differentiate between children leaving care to live with birth parents and with relatives. The position is complex, as many children remain in care with relatives as foster carers, whilst others are cared for under informal or 'guardianship' arrangements outside the care systems. The literature on kinship foster family care is growing, and much of it is relevant to children who leave care to live with relatives, or who leave care because their kinship foster parents take over legal guardianship. The research on the outcomes for children placed in kinship care is generally positive, especially when the opinions of the children and young people are included as an outcome measure. Most of the cohort studies listed earlier reach this conclusion, and see especially LeProhn (1994); Berrick et al (1994); Geen (2004) in the USA, and Aldgate and McIntosh (2006); Farmer and Moyers (2008); Hunt et al (2008) in the UK. However Hunt et al report, over an 8 year follow-up period, that 28% of the maltreated children placed via the courts with relatives (whether within or outside the formal care system) experienced placement breakdown. The rate for under 5s was 11% but that for those aged between 5 and 12 when placed with relatives was 43%. Best practice guidance is to be found in the above studies and also in Doolan et al (2004) (drawing on evidence in New Zealand and the UK); Broad and Skinner (2005); Ebtehaj et al (2006) and Jordan and Lindley (2006).

The researchers almost all report that the socio-economic position of kinship carers is more disadvantaged that that of non-kin foster carers. This is the case even when children are in the care system, but even more-so when children are cared for informally or under guardianship arrangements. Relatives interviewed by researchers stress the need for practical and financial help, emotional support and advice on parenting emotionally disturbed children for themselves, and therapy and educational support for children with learning, emotional or behavioural difficulties. Almost all studies report that kinship carers receive less professional, financial and practical assistance than do non-kin carers, and that cases are often closed too quickly and whilst serious practical and emotional problems remain un-attended to. The research and practice literature does however give examples of positive practice, including systems for providing adequate finance, and also practical help in arranging safe contact for the children with their birth parents; negotiation, mediation and counselling to assist with intra-familial tensions; and self-help or support groups where they can share experiences with other relative carers.

6. Some concluding comments

It is impossible to summarise the findings of research on such a complex question. Taking the population-based Swedish studies of Vinnerljung et al (2005, 2006) as 'best evidence' it can be said that, if groups of children living in disadvantaged circumstances are compared, those who 1) remain at home or experience a short period of care as family support, and 2) remain in long term stable care or are adopted, on average do better than those who 3) enter care for more than a few weeks and return to parents. (The situation is less clear for those who leave care to live with relatives.) But the reasons underlying this are complex, and are different for different groups of children and families. Despite the apparent similarities in terms of demography and socio-economic factors, these three groups of disadvantaged

children are different in ways that can not be easily measured and entered into a scientific model as independent variables. Children whose families can not be supported without the need for them to enter care are an especially vulnerable group. They then suffer separation and loss and for older children (especially if siblings remain at home) a strong sense of rejection - experiences that set them apart from most who remain at home, even with less than adequate parents. Their parents, too, may be especially vulnerable in ways that can not be easily quantified, and their distress will be increased by the loss of their children and this very public 'proof' of failure as parents. When the children return home, as graphically described by the researchers (most recently by Farmer et al, 2008) they will usually be anxious that it won't work out (especially if an earlier placement home has failed), low in self esteem and often angry, or jealous of a sibling who has remained at home, or a step-sibling or new born half-sibling. Children of all ages returning home, especially after a long period of care, can often not stop themselves from behaving in unacceptable ways and 'testing out' their parents to see if they 'really love them'. Some will be missing foster carers and siblings to whom they have become attached and will go through stages of grief before they can settle again. Almost all will find their standard of living has dropped substantially.

When all these factors are considered, it is not surprising that the outcomes are not so positive as for children who remain in stable foster family, kinship or good quality residential care. Children who return from care need, if anything, better services than do foster families, yet the research is clear that generally they receive an inferior service. The research is consistent in pointing to the attributes of good quality services, The increased number of evaluations of these service over the last year or so may be an indication that the services needed by these children and families are at last getting the attention that their known vulnerability has long called for.

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