The Family Justice Council Concurrent Planning Seminar

Thursday 8th November 2007

Introduction

The Family Justice Council held a seminar partly funded by Cafcass to discuss the benefits and potential drawbacks of concurrent planning for the small group of looked after children in care proceedings for whom this is an option.

This note provides a summary of the issues raised in the presentations at the seminar about the purpose of concurrent planning, the potential benefits and concerns and highlights some of the issues for operating a concurrent planning service which emerged during the seminar.

Presentations at the seminar in favour of concurrent planning were made by researcher Margaret Adcock and Brighton and Hove Children's Services solicitor Natasha Watson. The opposing view on concurrent planning was made by barrister James Presland.

Copies of the papers are available on Family Justice Council website

What is the purpose of concurrent planning?

Concurrent planning is designed to prevent the problems associated with delay in permanency planning for young children's development both before and after permanent placement. Research shows that poor /inadequate/abusive parental care can adversely effect brain development. Attachment difficulties, separation and loss are likely to result in developmental difficulties. The early nurturing environment and the amount of care given can fundamentally alter the expression of key genes involved in the stress response and the reward mechanisms that may underlie attachment and bonding.

So the response of concurrent planning is to work with both the possibility of returning home and adoption concurrently rather than sequentially. Concurrent planning places the needs and welfare of the child at the forefront of its activities but also aims to provide a high quality of service to the birth parents.

In concurrent planning the child is placed on a fostering basis with carers who are approved for both fostering and adoption. At the same time the birth parents are offered a service to establish what changes they would need to make within a few months to be able to meet their child's needs on a more permanent basis and appropriate services are arranged. If the birth parents cannot make sufficient change and no suitable carers from the extended family can be identified, the child remains with the concurrent carer and is adopted.

The concurrent planning process can dramatically reduce the number of placements a child might otherwise have and it enables the child to experience good uninterrupted and consistent care as soon as possible.

It is important to note that neither adoption nor long term fostering in these cases can be a guarantee of complete or trouble free recovery.

How is the concurrent care process made available?

Concurrent planning was imported from the US in the late 1990s. The Government gave pilot funding to the Goodman project in Manchester, Brighton and Hove council and the Coram Family in the mid 1990s. Currently there are four projects around the country offering concurrent planning and a fifth is about to be established. Of the projects so far two are provided in the voluntary sector and three (including the project yet to commence) are local authority projects.

Across the four projects approximately 147 children have so far been placed with concurrent carers, of this number 8 have returned to the birth families.

However, it is important to recognise that even if this service is expanded further, concurrent planning is not a process which is advocated for a large number of children. Concurrent planning can make a difference to the lives of a group of very vulnerable children in care proceedings whose needs are in conflict with their parents and should lead to a reduction in the difficulties they may experience in their later lives.

How does the process of selection of cases for concurrent planning operate?

Typically the social worker will consider a concurrent foster placement in those cases where parents are assessed as being very unlikely to be able resume there care. As researcher Margaret Adcock puts it:

"…..children, often very young babies, whose home situation is thought to be so damaging that they have at least a 60% chance of being placed for adoption"

A case will usually be selected when a parent has already previously had children taken into care and a social worker will often make this assessment pre-birth. There will typically be a discussion with other social workers and professionals involved and a second opinion will always be sought before it is referred to the concurrency team who then undertake their assessment. The social worker from the concurrency team will also complete an assessment prior to proceedings looking at the child's needs, risk and geographical proximity of carer to birth family, likelihood of drug rehabilitation etc and helps to identify an appropriate match. The social work judgement is based on the assessment that a care order is highly probable, the detail of family history, very little reasonable chance of rehabilitation within the child's timescales and no possibility of placement with the extended family.

The most commonly used poor prognosis indicators are:

- A parent has previously killed or seriously harmed another child
- A parent has repeatedly and with premeditation harmed a child
- A parent's only visible support system is a drug culture, with no significant effort to change over time
- A parent has significant, protracted, and untreated mental health issues
- A parent's rights to another child have been involuntarily terminated.

The case is then placed before the court for approval for concurrent planning, the experience of Brighton and Hove concurrency team is that 95% of the cases put before court are approved for the process.

Child Contact

Those delivering the concurrency service argue that it contributes to improved contact arrangements between the child and the birth parents. Experience of running the service indicates that the opportunity for prospective adopters to meet the birth parents can frequently break down the barriers and demonstrates the birth parents as the vulnerable adults they frequently are and removes the fears of the prospective adopters. In Brighton and Hove they achieve direct contact in one third of their cases and indirect contact in the other two thirds.

Tensions with concurrent planning

Those who are resistant to concurrent planning are uneasy about the quality of social work assessment rather than the principle itself. Concerns are raised that unless concurrent planning is implemented very carefully and appropriately resourced, the very fact of being in a concurrent planning process runs the risk of a negative impact on the prospects of a return for the child to the birth family.

It is questioned whether parents in concurrent planning are receiving better services than parents in other cases and it is questioned whether it would be better to put in place greater resources for families earlier on with a firm message as to what could happen if the help is not taken?

Critics of the process ask: *While outcomes for the children involved are monitored, is there research about the impact on birth parents of their ultimately unsuccessful experience of concurrent planning, and are their perceptions taken into account?*

Conclusions

There are inevitable tensions in the concurrent planning process where the needs of young children come into conflict with the needs of the birth parents.

The question raised at the end of the seminar was, who should hold that pain and pressure should it rest with the child or with the adults?

The President of the Family Division has acknowledged these tensions and suggests that all agencies working with families in this process need to be upfront and honest and not shy away from the fact. What is needed he suggests, is faith in the system, that the system will resolve these tensions.

Certainly the Government seems to follow this approach, earlier this summer in the Green Paper ***Care Matters: Time for Change,*** the Government set out its plans to promote and enable greater use of concurrent planning by increasing the availability of existing services and the learning from these projects. Plans have been established to ensure that social worker training includes a component on effective concurrent planning, and issue guidance on concurrency to those social workers with responsibility for permanence planning.

Chelsey Bonehill

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CONCURRENT PLANNING – A Service for Children in Care and theirParents.

By
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There is currently a serious problem for a group of young children in the care system, usually in care proceedings. Their welfare is not being made the paramount consideration. There is good evidence from clinical practice and research to show that they are suffering or at risk of suffering significant harm in their early years and, because of significant delays in decision making and in the legal system, they experience further harm before they are permanently placed. Either the children remain at home too long and/or they have several admissions to care, and /or they have several placements in care before a permanent placement is made.

The effects of these delays have a significant effect on the child's development both before and after permanent placement. Neither adoption nor long term fostering in these cases is a guarantee of complete or trouble free recovery. Moreover delay also has a significant effect in diminishing the likelihood of ultimately achieving a successful permanent placement.

The Concurrent Planning process is designed to prevent/ remedy these problems by providing early permanence for these children, often very young babies, whose home situation is thought to be so damaging that they have at least a 60% chance of being placed for adoption. Both the possibility of returning home and adoption are worked on concurrently not sequentially. Concurrent planning is a service that places the needs and welfare of children at the forefront of its activities but at the same time provides a very high quality service to assist birth parents.

How does Concurrent Planning work?
In Concurrent Planning the child is placed with a carer on a fostering basis whilst the birth parents are offered a service to establish what changes they would need to make within a very few months to be able to meet their child's needs on a permanent basis and appropriate services for this are arranged. If the birth parents cannot succeed, and no suitable carers from the extended family have been identified, the child remains with the concurrent carer/s and is adopted. The concurrent process can dramatically reduce the number of placements a child might otherwise have. It enables the child to experience really good quality, uninterrupted, consistent care as soon as possible and offers the best hope of diminishing future harm and promoting healthy development.

Four projects around the country now offer Concurrent Planning. Two projects are based in Local Authorities and two in Voluntary Agencies. A fifth project is being developed in a local authority social services department. Across the four projects approximately 147 children, since 1998, have been placed with concurrent carers. 8 have returned to birth parents or extended family members and 2 of these subsequently have come back into care. 17 parents signed their agreement to adoption and a further 29 did not oppose the Projects' final recommendation for adoption. Direct contact was planned for 46 birth parents and relatives and has continued for all but 3 children. 100 have a plan for indirect contact. Research on the projects (Monck

et al.2003) has established that carers can be recruited and that babies can achieve permanence (a final care order) within a few months.

In thinking about concurrent planning for children in care it is important to recognise that, even if expanded, this is not a process advocated for very large numbers of children. 3300 children left care to be adopted in the year ending 2007 (out of 46,000 in the care system) Concurrent Planning can, however, make a very significant improvement to the lives of a very vulnerable group of children and should lead to a reduction in the difficulties in their later lives and behaviour and subsequently to the outcomes for their own children.

Why do some children need Concurrent Planning?

In order to understand the important contribution Concurrent Planning can make, it is necessary to look at why and how some children become victims of delay and impermanence. Two research studies provide good evidence. Ward et al (2006) studied 42 babies who entered care before their first birthday and were still there 12 - 24 months later. The children had had 143 placements and a 101 moves between them in this period.

Selwyn et al (2006) retrospectively followed a group of 130 children, for between 6 and 11 years, for whom "the adoption in best interests decision" was taken in the 1990s. The children were all aged 4 or under at the time of the first referral to a SSD. Their family circumstances are discussed in detail later.(Page 11.)

The problem.

Selwyn reported the following findings:

Children remained too long at home with birth parents.

- Children remained at home on average 2.7 yrs from the date of first social work involvement, usually continuing to be abused and neglected. (see page 11). There were very significant problems for these children in their birth families which were then compounded by their experiences in care.
- Rehabilitation was planned for 73% of children after they came into care but only attempted for a quarter.
- The average cost of support services to the families at home was £13844, ranging from £120 - £49920.

Delays in Decision Making, which increased the likelihood of changes of placement, (ranging between 2 and 7 moves)

- the decision for permanency away from the birth family (adoption in best interests decision) was delayed for many children, initially by social workers and then by a time lag before the adoption panel.
- For 41% it was 2.7 years on average (range 12 months to 8 years later) before the social work decision.
- 31%of the children then experienced delay at the next stage - an average of 1.9 years (range 12 months to 5 years.) Most of the children were aged between 3 and 13 years old by the time they went to Panel although they had all been age 4 or under, at the time of the first referral to a SSD.
- 85% of the children were then linked to a family within a year. For the remaining 15% it took anything up to 4 years.

Reasons for the delay.

- In 53% of cases the delay in decision making was caused by lack of social work assessment, planning and action. The quality of social work action was said to be generally poor.

Condition of the children.

- By the time of the decision for permanent placement, 52% of children had multiple special needs. More than half, 55%, were described as having emotional and behavioural difficulties.

Permanent Placement

- Only 96 of the 130 children were eventually placed for adoption and 16 of these subsequently disrupted, 11 before an adoption order and 5 after it. Most of the placement disruptions occurred primarily because of the children's challenging behaviour and the impact of unregulated or problematic contact.
- 45 children were placed for long term fostering, of whom 46% disrupted.
- 50 children moved (often more than once) between adoption, long term fostering and no permanent placement.

Final permanent placement

	Number in placement at completion of research
Adoption	80
Long term fostering	34
No permanent placement	16
Total	130

Selwyn et al concluded that age at entry to care and the length of time between entering care and having a best interests decision were found to be significant predictors of not being adopted. The odds of not being adopted increased 1.8 fold for every extra year of age on entry into care.

Government recognition of the problem

For many years the government has recognised that children thrive best in a family. Official policy has sometimes advocated putting maximum effort into keeping children with their birth parents or rehabilitating them as soon as possible and sometimes recognising the need to plan permanent substitute care away from home for more children. Despite this a large number of children have spent many years in care without a permanent family.

In the late 1990s the Government made clear its concern about what was happening to children who came into care. In 1998 the Government published a paper "**Quality Protects**" which emphasised the right of the child to have a secure and permanent attachment to a carer. This was followed by the Prime Minister's **Review of Adoption** which proposed an increase in the number of children placed for adoption.

Despite this the Green Paper “**Care Matters**” recently stated “we are driven by the knowledge that these are our children and that the childhood we are giving them has not been good enough. ….The long term outcomes of children in care are devastating. They are over represented in a range of vulnerable groups including those not in education, employment, or training post 16, teenage parents, young offenders, drug users and prisoners.”

Solutions: Planning for permanence.

Planning for Permanence was adopted as policy in the late 1970s by a number of agencies as a way of trying to solve the problem. The agencies systematically reviewed children at an early stage in their care careers and sought to return them on a permanent basis either to their birth families or to adoptive families. The policy dwindled in popularity in the late 1980s and the 1990s, partly because of some poor social work practice, partly because of difficulties and delays in the court system and partly because of an increasing emphasis on rehabilitation to birth families even though this might mean “yo yo-ing” in and out of care. There continued to be concern about the number of moves that children experienced before achieving permanence.

Meanwhile in Seattle, USA, a voluntary agency, Lutheran Social Services, had devised a new form of planning for permanence which adopted a concurrent rather than a sequential process. Babies or children who were at risk of not being able to remain with their birth families were placed at an early stage with carers who would act as foster parents while time limited efforts were made at rehabilitation. The carers would then keep and adopt the child if rehabilitation was not possible. This dramatically reduced the number of placements a child might otherwise have had and enabled the child to experience really good quality care as soon as possible.

The first Concurrent Planning Project was established in the U.K in 1998 at the Goodman Project in Manchester following a visit to Seattle by Margaret Adcock and the Director of the Project, and was followed by three other projects in London (Coram) Brighton and Kent.

How do the Projects work.

The concurrent planning projects are all small with not more than four or five social workers and one or two family aides. These are dedicated specialist teams who, unlike local authority social workers in front line teams, do not have competing emergencies or numerous other demands on their time. The work with the birth families and the support for the carers are carried out in the same team, although not by the same workers. This minimises the opportunities for communication delays and failures.

The child is placed, following a direction by the court. on a fostering basis with carers who are approved both to foster and to adopt. The court time table and date of final hearing are also decided. Contact takes place regularly in a comfortable neutral setting. The birth parents usually meet the carers when they bring the child. The foster parents are committed to adopting the child if the plan to return home to the birth parents does not materialise. For those babies who cannot be rehabilitated, concurrent planning enables the child to retain the attachment relationships to their caregivers, without the experience of loss and disruption which inevitably happens with moves within foster care and between foster care and adoption.

Both the possibility of returning home and adoption are worked on concurrently not sequentially. The birth parents attend the project office for assessment and contact. They have their own worker although they usually know all the members of the small team. They are offered a high quality structured assessment by experienced specialist workers who are able to provide continuity, availability, time, care and respect. Extended family members who are willing to provide the child with a permanent home can also be assessed.

Contact is supervised, usually by a family aide who is able to offer advice and support in looking after the child. The parents often develop a strong relationship with the social worker and or the family aide and often feel they experience some good quality parenting for themselves that they have never had before. The research on the Projects (Monck 2003) showed that many birth parents in the projects valued being supported and treated with respect.

Most parents value the contact with the carers. In some cases the parent will say "if I can't have my baby, I want him to go to the person who has been looking after him and who I know loves him". One mother said "I wish I could be adopted by my baby's carer". In many cases parents have remained in touch with their workers and some have been able to care successfully for a subsequent child. (Monck et al.2003)

What Concurrent Planning does is to provide a process in which delays are kept to a minimum, including in the court process and in decision making. This is achieved by rapid, concentrated assessment and good support to parents, working closely with the courts, establishing a court timetable and deciding what expert reports are needed at the outset and then ensuring that assessments and reports are completed and submitted on time. At the same time the children (many of whom are very vulnerable infants, who may have been damaged in utero) are receiving a quality of care that enables them to flourish.

Friends and foes.

There has been considerable support but also quite strong opposition to Concurrent Planning. Concurrent planning is supported by the Prime Minister, the Government, the Judiciary and by leading child psychiatrists and paediatricians.

The President of the Family Division (2007) in a Conference Paper entitled "Achieving Best Outcomes for Babies in the Care System" made the following comments about concurrent planning;

> 1"S.1. of the Children Act 1989 makes clear that the welfare of the child is paramount. Children have human rights too and, while the rights of the parents must be balanced against them, S.1 is crystal clear and I see no real likelihood of that provision being held non compliant with the European Convention, or being overlooked by judges.
>
> 2.Concurrent planning has built into it the need for recognition by the parents that while the Local Authority is committed to trying to assist them in having their child returned to their care, failure by the parents to address the underlying problems leading to the conclusion of the assessment that the child cannot be returned home, means that the local authority will then recommend to the court that their child is placed permanently with concurrent carers. This

ensures that clear messages are given by professionals and reduces the temptation to fudge this difficult issue when explaining matters to parents.
3 .For babies at risk, concurrent planning and the work of the projects represent their best chance of a life in which their wants are realised."

As already stated, there is very good evidence from research and from clinical practice experience to support the idea that the development of children in the care system suffers from lack of early planning, impermanence, multiple placements, drift and delay. Nevertheless there is fierce opposition to concurrent planning from some lawyers and some social workers. They say it is unfair to birth parents and is merely a fast track to adoption. It is said by some to be an infringement of the parent's human rights.

Given that it should be accepted that the welfare of the child is the paramount consideration, subject only to proving significant harm or its likelihood, it is important to consider the reasons for the opposition to concurrent planning. Possible explanations might be that;

1. there is an assumption that placing children in concurrent placements will have a more detrimental effect on their attachment to birth parents than placement in regular foster care.
2. birth parents of children placed in concurrent placements will be denied the possibility of a permanent successful rehabilitation they might otherwise have achieved within the child's timescales.
3. research findings on child development are not well known. Delay, disruption, poor quality care and a number of placements may not be thought to be harmful to young children. It may be thought that children can be helped to recover.
4. research findings on the low likelihood of successful rehabilitation in these high risk situations are not well known

Points 1 and 2.

In relation to the first two points it is important to remember that most babies and young children who come into a concurrent placement will either not have an attachment to a birth parent at all because they are too young or they will have an insecure or a disorganised attachment. These children would not be in care proceedings if their parent had been able to provide a secure attachment. Most of the parents are themselves likely to have a disorganised attachment. For example, the parent with an addiction problem or enmeshed in a violent relationship cannot be consistently available to their child and is usually not able to provide another attachment figure to do this. Simply providing five days a week contact is unlikely in itself to deal with this problem.

One of the aims of the Concurrent Planning Service to birth parents is to see whether they can be helped to deal with their own attachment difficulties and the other problems which prevent them from offering their child a secure base. This may be through the provision of a different kind of relationship with a social worker or therapist and/or providing services to deal with addiction problems, mental health problems, domestic violence or other relationship problems.

There is no evidence from research to show that the concurrent process prevents a successful permanent rehabilitation that might otherwise have been achieved within the child's time scales. On the contrary, the birth parents are offered a dedicated, specialist service which it is usually impossible to provide in a busy SSD. They are provided with high quality support, and a structured assessment process to identify problem areas that are preventing good enough parenting and to suggest how changes can be achieved.

Points 3 and 4.

A key aspect of Concurrent Planning is its emphasis on the importance of meeting the needs of the child in the early months and years of life. Courts, Guardians, Lawyers, and Social Workers need to understand child development issues themselves and use their knowledge in the planning and legal process.. They also need to be very clear with parents, as the President said, and help them to understand what children need and the urgency for change. Children can not wait to have their needs met while their parents ignore the need for rapid change or hesitate to commit themselves to it.

Child Development Issues. The importance of nurturing resilient children.

Resiliency is the term applied to children exposed to severe risk factors, such as poverty, who nevertheless thrive and excel. It is the ability to spring back from and successfully adapt to adversity. Finding ways to enhance resiliency is a major task for child mental health professionals. (Leckman and Mayes.2007)

Writing about nurturing resilient children, Leckman and Mayes state " there is now compelling data for the presence of developmental windows during which the genetically determined micro-circuitry of key limbic- hypothalamic- midbrain structures are susceptible to early environmental influences and that these influences powerfully shape an individual's responsivity to psycho social stressors and their capacity to parent in the next generation. So, although our genetic endowment is important, the early nurturing environment and the amount of care can fundamentally alter the expression of key genes involved in stress response and the reward mechanisms that may underlie attachment and bonding.

There is now an increasing body of research which helps to clarify what children need from their parents/carers in order to develop as autonomous individuals capable of participating fully in the culture in which they live. Bentovim (1998) describes development as a series of stages and tasks that children have to accomplish. "Development is about progression, change, and reorganisation throughout life." He stresses that the way in which the stages and tasks of development in childhood are achieved has the potential to affect future outcome in the direction of good or less good states of adjustment. The successful resolution of early stage salient issues increases the possibility of subsequently successful adjustment and vice versa. The process is a compounding one, so that difficulties from one unresolved stage lay the foundations for the next in a "pile up" manner. Attention therefore has to be paid to all the aspects where children are experiencing or are at risk of significant harm. This includes the risks of changes in caregivers and delay in being able to develop a secure permanent attachment.

Some important stages in child development.

a. Pre-birth.

The child's development begins in the womb. It is now recognised that the way a pregnant woman cares for herself and the nature of her lifestyle can have a profound effect on the development of the foetus. In particular, drugs and alcohol affect the developing foetal brain and may cause irreversible damage.

Thus, babies who become eligible for concurrent planning may already be vulnerable and in need of optimal care with as few disruption as possible.

b. Birth and the early years.

At birth, Gerhard (2004) says;

> "There is a sense in which the human baby is incomplete, needing to be programmed by adult humans. The baby human organism has various systems ready to go but many more that are incomplete and will only be developed in response to other human input."

The first few months and years are a time of enormous growth and development. Well managed babies come to expect a world that is responsive to feelings and helps bring intense states back to a comfortable level; through the experience of having it done for them, they learn how to do it for themselves. However, even the growth of the brain itself, which is growing at its most rapid rate in the first year and a half may not progress adequately if the baby does not have the right conditions to develop.

c. Attachment.

Attachment is a biological instinct predicated on the infants need for survival. Similarly, adults are biased to engage in protective behaviour in response to infant signals. The attachment figure should provide a secure base from which the child can explore the world and to which s/he can return in times of stress.

The first attachment figure is usually the mother, but can be any individual who has been consistently responsive to the infant's signals. Children can have more than one attachment figure at the same time.

Except in very abnormal circumstances a child will form an attachment to an adult at about the age of 9 months but it will not automatically be a secure one. The child develops internal representations (working models) of these attachment figures based on the experience of the relationship, which is not necessarily a good one. The effects of these experiences persist but new learning is possible.

Four different attachment patterns have been described.

Secure	60-70% of the population
Avoidant and resistant/ambivalent	20-30% of the population
Disorganised/disorientated	10-20% of the population.

Although the avoidant and resistant/ambivalent patterns of attachment may not provide the child with as much comfort and satisfaction as a secure attachment they

are nevertheless predictable and enable the child to develop strategies for relating to the attachment figure. The child's development may however be compromised in some respects.
A disorganised attachment is associated with many later difficulties in relationships, in behaviour and in school. It has been estimated that up to 80% of abused children may have disorganised attachments.

What can go wrong in the parenting task.
In a longitudinal study of 180 children and their parents, Sroufe et al (2005) described an inadequate care group of mothers who showed some clear evidence of abuse or neglect of their child in physical or emotional areas. Sroufe stated that

> "maltreatment or grossly inadequate care giving evolves from the interaction of psychological characteristics of vulnerable at risk mothers in the context of environmental stress and lack of support. Isolation in the midst of challenging life events, as well as a history of unresolved, harsh care giving experiences may all contribute to feelings of powerlessness, suspicion and fear, and the inability to control hostile impulses that influence care giving ability."

Jones (1998) See Appendix 1. examined a range of studies from clinical practice and considered the characteristics of those families who did relatively well with interventions contrasted with those who did less well. Like Sroufe he looked at the interaction of various factors and his conclusions are remarkably similar.

How likely is rehabilitation on a permanent basis?
The likelihood of young children who are involved in care proceedings being successfully rehabilitated on a permanent basis does not seem to be high. Research following up 100 children after Care Proceedings (Harwin et al.2003) showed that 21 months later only 22 were living at home although the initial plan had been for 39 to do so. 33 children were in adoptive placements although this had been the initial plan for only 19. Another study which tracked 42 babies in the care system (Ward et al 2006) showed that very young children whose mothers have entrenched alcohol/and or drug problems are unlikely to be re-united permanently with them within a realistic time frame. Only one such child in the study was able to return home on a permanent basis. The authors commented that "while the majority of children are best cared for within their family of origin this not true for *all* children. A long history of social services involvement, child neglect and abuse, problems associated with alcohol, drugs, mental illness and domestic violence should alert practitioners to the increased likelihood of family breakdown. Our evidence suggests that many very young children with such experiences will ultimately require a permanent home from outside the immediate family."

Jones concluded that the research on the outcome of intervention in child abuse engenders realism about the general likelihood of success. Gough (1993) in a review of treatment interventions for the Department of Health came to the same conclusion-
"Treatment results are modest - the important outcome to measure must be the welfare of the child."

Why do things go wrong for the child?
Experience determines the pattern of brain development. (Glaser 2005)

There will be effects on the developing brain from:-

Extreme deprivation.
There are critical sensitive periods for different brain areas to remain open/ receptive to normal, expected and required experiences. If that experience does not happen during the long sensitive period, capacity for that function is lost

Distortion of normal experience.
a. extreme deprivation may lead to attachment difficulties
b. early child abuse and neglect - the consequences of distorted and inconsistent care may lead to attachment difficulties. It may also lead negative expectations of new relationships and negative views of self, lower self esteem and a proneness to depression, difficulties in peer relationships and later to high risk of failure in school. Neglected children have severe and variable school difficulties and are often described as anxious, inattentive, unable to understand their work and lacking in initiative (Bentovim.1998).
c. The child with a disorganised attachment experiences unpredictability when the carer becomes frightened or frightening. The care giver is likely themselves to have had an unresolved trauma or loss and may have a hostile/helpless state of mind which interferes with empathic ability. The child is left without a strategy for obtaining comfort or care.

Hoffman Judd (2005) described disorganised attachment in the following way

> "when a frightened child runs/signals to the care giver, the care giver is unable to read the child's intentions and responds in a manner which increases distress. A paradox is created when the caregiver is the direct source of alarm. Fright without solution creates a conflict situation for the child and a breakdown in behavioural strategies. The child is unable to develop a consistent strategy for regulation of emotion that is based in relationship. The child is unable to create a coherent model of how to get needs met."

This is very relevant to children of parents with addiction problems or who are involved in domestic violence. Sometimes they are available and can provide excellent care at other times they are emotionally and/or physically unavailable to meet the child's needs.

It has been estimated that up to 80% of abused children may have disorganised attachments.

A disorganised attachment is associated with many later difficulties in relationships, in behaviour and in school.

3.**Stress and trauma.**
Most harm is done by inappropriate early experiences which are incorporated into neural networks. According to Perry (1993) "the experience of the young child exposed to chronic violence or abuse (including before birth) is fear, threat, unpredictability, frustration, chaos, hunger and pain. Therefore the child's template for brain organisation is the stress response. The brain acts on information from the environment in order to maximise survival. In an unpredictable, chaotic, violent

environment, it is highly adaptable to have a hyper vigilant, hyper reactive arousal system; if primary relationships are characterised by violence, neglect and unreliability, intimacy becomes maladaptive. If a child is frequently assaulted, it becomes adaptive to over-interpret non- verbal cues, to act quickly on impulses and to strike out before being struck."

4.**Separation and loss.**
These are likely to be issues in connection with moving children both within and outside the care system. An enormous amount has been written about this topic.
The effects of separation and loss will be different depending on the age and stage of development. It is often argued that it is alright to have a temporary foster home before an adoption placement rather than concurrency because young babies will not yet have formed an attachment. However, Fahlberg (1991) says "that babies will be aware of changes in rhythm and routine. They will react to differences in temperature, noise, smell, touch and visual stimulation. Interruptions in parenting may hinder the child's progress in sorting out his perception of the world. Since precursors to logical thinking and basic cause and effect begin even at this young age, disturbances in this area may result. Children who have been abruptly exposed to different routines and environments in infancy may have their sense of security upset enough that they may become less flexible in the future."

Even a very young baby in the care system is unlikely to move from a temporary foster home to an adoptive placement before s/he is six months old. Research suggests that the child is more likely to be nearly a year old or more. By that time the child may already be suffering from the effects of several moves. If the child has remained in the same foster home they will suffer the loss of their attachment figure, without having the cognitive ability to make any sense of the move or the loss..

Fraiberg (1977) points out that for older babies and toddlers " in the early years the child's personality is essentially an "inter-personality", the self evolving in relation to human partners. Therefore when that bond is broken, the very structure of personality is endangered and the mending of the personality will be an arduous task for the new parents."

<u>Effects of harm on children.</u>
The study by Selwyn et al (2006) showed clearly the interaction of parental difficulties and the effects on the development of the children. At the beginning

- The children's birth parents had multiple overlapping problems with domestic violence, mental health problems and drug/alcohol abuse as common features.
- 63% of birth mothers had been in care when they were younger.
- Schedule 1 offenders were often present in households where the mother had learning difficulties
- 79% of children had been referred to SSDs before they were 12 months old.
- Many of the children were looked after by adults other than their parents: 39% had spent time in foster care and 34% had been looked after by kin.
- 74% of the families received family support services but these did not lead to sustained improvements.

- Most of the families were subsequently referred again at a later period; the average number of re-referrals was 4 but in one case it was16 times.
- 90% of children were abused while living at home with 68% experiencing multiple forms of abuse
- When the children subsequently entered care, 85% had recorded health problems, including developmental delay and emotional and behavioural problems which became more apparent as the children started school.

By follow up, (6-11 years later) the situation was as follows;-

- Adopted children's lives were more stable and suffered fewer disruptions than those in other kinds of placements. Nevertheless only a quarter of the children were free at follow up from difficulties that were interfering in their lives and development in some way. 19% had been involved with health, CAMHS, education and police services.; a quarter had received services from three of theses agencies and a fifth from two.
- A third of adoptive parents reported settled placements with few struggles and much rewards, a third reported both challenges and difficulties and a third, especially those facing attachment or conduct difficulties had problems in many areas of their lives. These included depression, couple relationship problems, financial stress. The work patterns of mothers were affected. Many families had foregone an anticipated second income and a quarter were in debt.
- The picture for children in foster care was very similar except that the foster group was significantly more likely to have poorer outcomes on attachment.
- The poorest outcomes were for children who had not achieved a permanent placement. None of the 16 had achieved any educational qualifications. 12 were exhibiting violent behaviour and had a diagnosis of conduct disorder. 10 were showing at least five overlapping difficulties at a moderate or severe level. Social workers were pessimistic about the likelihood of the majority remaining in the community as adults.

Selwyn et al stated that their analysis of the data confirmed the strong influences of conduct disorder, over activity and difficulties in attachment prior to placement on the functioning of children several years later regardless of the type of placement in which they end up.

<u>Conclusion.</u>

Current research and clinical experience demonstrates the vital importance of providing children with very good early care and describes what can go wrong if this does not happen. Selwyn et al concluded "our research underlines the importance of current policy efforts to achieve early and rigorous risk assessment and swifter decision making for children". There has been no published research to date other than Concurrent Planning to indicate that the situation has improved substantially in this respect since their study was undertaken.

The implications are surely that the needs of children for security, good quality care, timely decision making and permanence must be put at the forefront of professional and legal thinking. Concurrent planning can offer a solution that meets the needs of both children and parents. As the President of the Family Division said

"For babies (and young children) at risk, concurrent planning and the work of the projects represent their best chance of a life in which their wants are realised."

Margaret Adcock. September.2007.

Appendix 1.

Table 1. Factors Involved in Success or Failure. Jones D. 1998.

Factors	Rehabilitation more likely to fail	Rehabilitation more likely to succeed
Abuse	Severe physical abuse inc. burns/scalds Severe failure to thrive Mixed abuse Child sexual abuse with penetration or over long duration M.S.B.P. Sadistic abuse	Less severe forms of abuse If severe, yet compliance and lack of denial, success still possible
Child	Developmental delay with special needs Very young- requiring rapid parental change	Healthy child attributions (in sexual abuse) Later age of onset One good corrective relationship
Parent	Personality-Antisocial -Sadism -Aggressive Lack of compliance Denial of problems Learning difficulties plus mental illness Substance abuse Paranoid psychosis Abuse in childhood not recognised as a problem	Non abusive partner Compliance Acceptance of problem Responsibility taken Mental illness responsive to treatment Healthy adaptation
Parenting and parent/child interaction	Disordered attachment Lack of empathy for child Own needs before child	Normal attachment Empathy for child Competence in some areas
Family	Pervasive family violence Power problems: poor negotiation, autonomy and expression of affect	Absence of other forms of violence Non abusive partner Capable of change Supportive, cooperative extended family
Professional	Lack of resources Ineptitude	Therapeutic relationship with child Outreach to family Partnership with parents
Social setting	Social isolation Violent unsupportive	More local child care facilities Volunteer networks

	neighbourhood	Social support

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Summary.

There is currently a serious problem for a group of young children in the care system, usually in care proceedings. Their welfare is not being made the paramount consideration. There is good evidence from clinical practice and research to show that they are suffering or at risk of suffering significant harm in their early years and, because of significant delays in decision making and in the legal system, they experience further harm before they are permanently placed. Moreover the odds of not being adopted increased 1.8 fold for every extra year of age on entry into care.(Selwyn et al. 2006) The effects of delay have a

significant effect on the child's development both before and after permanent placement. Neither adoption nor long term fostering in these cases is a guarantee of complete or trouble free recovery.

The Concurrent Planning process is designed to prevent/ remedy these problems by providing early permanence for these children. Both the possibility of returning home and adoption are worked on concurrently not sequentially. Concurrent planning is a service that places the needs and welfare of children at the forefront of its activities but at the same time provides a very high quality service to assist birth parents.
In Concurrent Planning the child is placed, after a court direction, on a fostering basis with carers, approved for both fostering and adoption. At the same time the birth parents are offered a service to establish what changes they would need to make within a very few months to be able to meet their child's needs on a permanent basis and appropriate services for this are arranged. If the birth parents cannot succeed, and no suitable carers from the extended family have been identified, the child remains with the concurrent carer/s and is adopted.
The concurrent process can dramatically reduce the number of placements a child might otherwise have. It enables the child to experience really good quality, uninterrupted, consistent care as soon as possible and offers the best hope of diminishing future harm and promoting healthy development.

Four projects around the country now offer Concurrent Planning. Two projects are based in Local Authorities and two in Voluntary Agencies. A fifth project is being developed in a local authority social services department. Across the four projects, since 1998, approximately 147 children have so far been placed with concurrent carers. 8 have returned to birth parents or extended family members and 2 of these subsequently have come back into care. 17 parents signed their agreement to adoption and a further 29 did not oppose the Projects' final recommendation for adoption. Direct contact was planned for 46 birth parents and relatives and has continued for all but 3 children. 100 have a plan for indirect contact. Research on the projects (Monck et al.2003) has established that carers can be recruited and that babies can achieve permanence (a final care order) within a few months.

In thinking about concurrent planning for children in care it is important to recognise that, even if expanded, this is not a process advocated for very large numbers of children. Concurrent Planning can, however, make a very significant improvement to the lives of a very vulnerable group of children and should lead to a reduction in the difficulties in their later lives and behaviour and subsequently to the outcomes for their own children.

There has been considerable support but also quite strong opposition to Concurrent Planning. The President of the Family Division (2007) said;

> **1S.1. of the Children Act 1989 makes clear that the welfare of the child is paramount. Children have human rights too and, while the rights of the parents must be balanced against them, S.1 is crystal clear. He saw no real likelihood of that provision being held non compliant with the European Convention, or being overlooked by judges.**
> **2.Concurrent planning has built into it the need for recognition by the parents that failure by the parents to address their underlying problems means that the local authority will then recommend to the court that their child is placed permanently with concurrent carers. Clear messages to this effect must be given by professionals.**
> **3 .For babies at risk, concurrent planning and the work of the projects represent their best chance of a life in which their wants are realised.**

Possible explanations for opposition to concurrent planning maybe that research findings on child development and on the low likelihood of successful rehabilitation in these high risk situations are not well known. Delay, disruption, poor quality care and a number of placements may not be thought to be harmful to young children. It maybe thought that children can recover completely.

Research shows that poor /inadequate/abusive parental care can adversely affect brain development. Attachment difficulties, separation and loss are likely to result in developmental difficulties. Although our genetic endowment is important, the early nurturing environment and the amount of care can fundamentally alter the expression of key genes involved in stress response and the reward mechanisms that may underlie attachment and bonding.
Guardians, Lawyers, and Social Workers need to understand child development and the importance of achieving early and rigorous risk assessment and swifter decision making for children in order to meet the needs of the child in the early months and years of life. Concurrent planning can offer a solution that meets the needs of both children and parents.

Concurrent Planning - For the best?

JAMES PRESLAND
Barrister

In 2001, DJ Crichton described the Coram Family concurrent planning in these terms:

> "The project seeks to identify children under the age of two who cannot at present live with their birth parents and for whom there is a viable but not strong possibility that they may be rehabilitated with their birth parents. The Project also seeks to identify a very particular category of foster carer who will look after the child, work with the birth parents in order to maximise that possibility of rehabilitation, but who will adopt the child in the event that rehabilitation is not possible. The priority is to rehabilitate. Should that not prove possible, the next choice is for the child to be cared for by members of the extended family. Adoption by the foster carer is the last resort. In the event that the child is adopted, the benefit is that he/she will have received continuity of carer, and will not have suffered a change of carer and disruption of attachment."
> (*M v LB Islington and L*[2002] 1 FLR 95 at 98[8]

1. No-one would disagree that any child in care should not be moved from placement to placement avoidably. If a very young child cannot be brought up by his or her birth parents or in their wider birth family, no-one would disagree with the proposition that it is likely to be in their best interests to be cared for by one substitute family who are able to go on to adopt.

2. Concurrent planning aims to ensure as few changes as practicable, and to achieve an early move to permanence – either by an early rehabilitation or by an early adoption. But a great difficulty with putting these laudable goals into effect, and with some of their justification, is that they may be seen to work best with hindsight.

3. For example, one may judge a child has remained in their birth family "too long" only when family support has failed. But what about the cases where very positive social work leads to children remaining in their families?

4. Relationships between the concurrent carers, the birth family and agency workers are critical to the success of the implementation of Concurrent Planning. Birth families have to trust that the system is really committed to reunification and will help support them in becoming more effective parents. If not, it is understandable that many will perceive Concurrent Planning as a fast track to Adoption.

5. Does Concurrent Planning in practice give a priority to rehabilitation with the birth parents? Is placement in the wider family the next choice? Is adoption by the foster carer the last resort?

6. What do the statistics for children who have been the subject of concurrent planning so far in England and Wales tell us? Of 147 children placed with concurrent carers since 1998, just 8 have returned to birth parents or extended family, and 2 of those have returned to care

7. Does that reflect very great accuracy in the predictors used to select these children in the first place – or does it reflect a system which it is very difficult for the parent to navigate with success? Or both? Are the rights of the birth parents, and the rights of the child to be with them something which suffers along the way? If so, why?

In the background – "Family Life"

8. Article 8 gives the child a right to respect for his or her family life. And it gives the same right to the parents. But the interests of the child are paramount, and delay in decision –making is bad for children, so where the parents cannot put themselves in a position to care for the child without too much delay, the child's right becomes a right to respect for a family life with a different family.

9. But neither social serves nor the courts are there to achieve social engineering.

10. The grounds for a care order require that the parent is not able or likely to give that care which it would be reasonable to expect a parent to give. At the time proceedings begin, that may be clear with many of the families we are considering – the drug addicts, the mentally unwell, the feckless and immature.

11. But it is not quite so easy at the disposal stage, when the court has to determine what final orders should be made.

12. The Court of appeal in *Re D (Care: Natural Parent Presumption)* [1999] 1 FLR 134 held that where there was an issue as to whether a child should be brought up by a parent or another person, the question was whether it was demonstrated that the welfare of the child positively demanded the displacement of the parental right. Thus, the court should first consider the parent as a potential carer for the child and then ask itself whether there were any compelling factors which required it to override the prima facie right of a child to an upbringing by the parent. It was wrong to carry out a balancing exercise between two households.

13. If the parent can demonstrate by the time final orders come to be made in care proceedings that they could give "good enough" care, where do the best interests of the child lie?

    a) with arguably "good enough parenting" from the birth family (who have their problems or they would not be there); or

    b) with foster carers (who were very thoroughly vetted before they were allowed to put themselves forward as carers, who have provided a single

safe, secure home for the child from birth, and who have already shown themselves to be "very good", or they would not be there either)?

14. In considering the paramount interests of welfare of the child, the checklist for the court or adoption agency to consider under section 1(4) of the Adoption and Children Act 2002 includes:

> "(g) the relationship which the child has with relatives, and with any other person in relation to whom the court or agency considers the relationship to be relevant, including –
>
> (i) the likelihood of any such relationship continuing and the value to the child of its doing so,
>
> (ii) the ability and willingness of any of the child's relatives, or of any such person, to provide the child with a secure environment in which the child can develop, and otherwise to meet the child's needs,
>
> (iii) the wishes and feelings of any of the child's relatives, or of any such person, regarding the child."

15. Judges are human, and these cases no doubt present real dilemmas. *G v G* means it is rare for the judgment of an experienced tribunal to be appealable. In practice how many children are with their birth families at the end of the process to date?

Honesty and being a parent

16. A vital part of effective concurrent planning must be honesty with the birth family and the concurrent carers at every stage of the process. There are to be no surprises. But it must require a social worker with experience and confidence to deliver the necessary messages.

17. There is a real emotional difficulty for any parent who knows from the outset that another family are in effect competing for their baby, with the social workers' backing. Parents may understandably get the message that they have lost from the start. Concurrent planning can have the effect of raising barriers, hardening attitudes to the natural parents, and making it more difficult for them to get their baby back.

18. With the child apparently settled with foster parents who are potential adopters, how many parents will find morale, commitment and momentum to also address whatever chronic difficulties they brought to the table in the first place? Dealing with those problems in the timescale of care proceedings is already more than many parents can manage.

19. The Association for Improvements in Maternity Services made a number of observations in a submission in response to the *Care Matters* Green Paper proposals for an extension of concurrent planning, including:

> "Post-partum mothers are extremely vulnerable and find it difficult to access effective help quickly. Some we have worked with have been so devastated by separation from the baby that they are unable to read the necessary letters and documents, or to take in official communications, or instruct their solicitors properly. One solicitor told us that such a depressed mother (who is now doing very well caring for her children) would have been unlikely to keep her baby but for our support."

and

> "Since so much emphasis is placed on attachment disorder in this report, we must point out how often the importance of attachment with the birth mother has been disregarded by social workers. Their enthusiasm for placing a baby for early adoption takes over. Identifying and providing for the mother's needs to help her be a better parent fades into the background. This may seem far-fetched - but we have seen it at close quarters."

20. These are not uncommon impressions for those acting for parents in public law cases. Starting from that background, is it realistic to expect the parent to accept the feasibility, or even the desirability, of foster parents who are also prospective adopters acting as support to the birth parents and helping them meet the objectives of any rehabilitation plan? Contact may be difficult enough without the mother or father having to perform for people who they know want to keep their child forever.

21. Parents in that position may lash out. They may not want to cooperate.

22. It may be expecting a lot of a good social worker to expect them to turn the parent round without any ambivalence, when they have already judged they are unlikely to succeed. It is certainly expecting a lot of the concurrent carers to expect them to support the parent through the whole rehabilitation process.

23. In an Idaho State presentation on concurrent planning I found this quotation[1]:

> "I met Mama J. and the first thing she said was, 'I don't want your children to live with me forever, so you figure out how to get them back.' It made me laugh, and it was such a relief, you know, that she did not want to take them from me."

24. In an ideal world, all concurrent carers would be able to say that. But it must be exceptional to find a carer who can.

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[1] http://www.icwrtc.org/documents/Concurrent%20Planning%20Presentation%20for%20Feb%202005.pdf. There are many useful insights into US experience and improving practice.

Predictors of success - selection of cases for concurrent planning

25. Which children is it proposed should go into a concurrent foster placement? Those whose parents are assessed as being really unlikely to be able to resume their care. As Margaret Adcock puts it

> "…children, often very young babies, whose home situation is thought to be so damaging that they have at least a 60% chance of being placed for adoption."

26. Some cases may seem very clear cut indeed. For a lawyer representing a parent, or a wider family member, even assuming that the initial assessment of the prospects of success is accurate, a chance of up to 40% of the child not being adopted, and perhaps being rehabilitated is something to fight for.

27. But how does one identify for example which drug user is going to break from dependency and be there for the child at the end of the process?

28. Concurrent planning models frequently use some type of uniform assessment to identify families who have little chance for reunification. Many programs use strengths assessments and poor prognosis tools developed by Katz and her colleagues, but some have developed their own tools. The most commonly used poor prognosis indicators are the following (Lutz, 2000):

    - Parent has previously killed or seriously harmed another child.
    - Parent has repeatedly and with premeditation harmed a child
    - Parent's only visible support system is a drug culture, with no significant effort to change over time.
    - Parent has significant, protracted, and untreated mental health issues.
    - Parent's rights to another child have been involuntarily terminated.

29. But at least one study has found no relationship between poor prognosis indicators and the likelihood of family reunification[2] Therefore, poor prognosis indicators should only be used as one part of a comprehensive family assessment, along with other assessment tools such as strengths, risk, and safety indicators.

30. A range of pointers are commonly used in the United States, although there is some controversy as to how they should be applied (Kansas's is attached). If the decision relies on a gut feeling as to there being a real prospect of rehabilitation, but a real likelihood of adoption, then it leaves a lot or responsibility on the shoulders of social workers and their managers.

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[2] D'Andrade, Choice, Martin, & Berrick, 2001 (unpublished, cited in *Reunification Bypass and ASFA. Reasonable Efforts? Implementation of the Reunification Bypass Provision of ASFA*, Berrick, Choi, Chung-Ang and D'Andrade)

31. An American study of 366 children who underwent concurrent planning in Colorado, published in 2002[3], revealed that

- When substance abuse was identified in the family, the likelihood of achieving permanency within a year increased by 23 percent

- Each additional placement a child experienced reduced the odds of achieving permanency within a year by 32 per cent

- Each additional day of contact tripled the odds of permanent placement within a year

- **But** a single change of caseworker during the year reduced the likelihood of permanency **by 52 percent**

32. Quite aside from workers moving to new jobs (and agency workers moving on) it remains commonplace for local authorities to move the child to a different team once care proceedings are over, and adoption is embarked upon.

Wider family

33. Good practice requires careful consideration of potential kinship placements before any decision to seek permanence outside the birth family. Early family group conferences and kinship assessments are each emphasised by the Public Law Outline for care cases, now being trialled across selected localities across the jurisdiction, and London.

34. These cases may concern pregnancies which come to light only at a late stage. With the best will in the world it is not going to allow time to enquire and to plan. In such a case, a carefully planned match between the birth family and a potential foster-adopter is also going to be difficult to achieve. A placement which does not reflect the child's background is less likely to meet his or her needs.

35. Bearing in mind *P,C & S v UK* it is to be hoped that removals from hospital shortly after birth will be truly exceptional. A mother and baby placement ought to allow time to assess family resources – at least including any viability assessments, before a child may have to be placed.

36. Searches for wider family members need to be very thorough. Idaho's experience is that Relative searches should occur immediately, "looking for the child's kin as if you were searching for your own family members."

Contact

37. Of the 147 children placed

    a) direct contact was planned for 46, and has continued for all but 3

    b) 100 have a plan for indirect contact.

[3] Potter & Klein Rothschild

38. If that is right then it does suggest considerable progress. But still two thirds of these children will not know their parents *face to face* as they grow up – whatever the merits at first sight of the concurrent foster carers having got to know them through regular contact.

Planning for wider implementation

39. Concurrent planning has many positives for the children who are placed, unless it has undermined their prospects of growing up in their birth family.

40. Unless impeccably implemented, and thoroughly resourced, the very fact of being in the concurrent planning process risks a negative impact on the prospects of a return for the child to the birth family.

41. Are parents in concurrent planning receiving better and fuller services than parents in other care cases? Would steps to put in place greater resources for families earlier on, with a firm honest message as to what could happen if the help is not taken also be better? Would the resources be there?

42. The existing projects have funding allocated to them. As to a wider implementation, will children's services managers really want to concentrate limited resources on families necessarily judged most likely to fail, to the detriment of families deemed more likely to succeed?

43. Would limited resources be better deployed in encouraging social workers to remain in their posts long-term rather than adopting concurrent planning more widely? Changes in practice to minimise changes of social work team and practitioner are also likely to have a marked impact on delay. In a given local authority a single child may move from a family support and/or referral and assessment team to a child protection team, perhaps to a court team, and on to an adoption team. At each stage there will be a new worker. And there will be delay. And workers move on.

44. As the present cases are selected from families with a lower prospect of achieving rehabilitation it may be difficult to measure the outcomes against other cases. Margaret Adcock observes that "There is no evidence from research to show that the concurrent process prevents a successful permanent rehabilitation *that might otherwise have been achieved within the child's timescales*". As for Shrodinger's theoretical cat, which was killed by opening the box to see if it had been killed by the experiment it underwent in the box, this may be difficult to measure.

45. While outcomes seem carefully monitored for the children involved, is there research as to the impact on birth parents of an unsuccessful part in concurrent planning? Are their perceptions taken into account? Are resources in place to help them continue to focus on their underlying difficulties, or will the next child, and the next, see the same outcome?

46. If we are serious about changing long term outcomes for these children there has to be much greater commitment to the work with and on behalf of the birth parents, albeit within the very tight time frames dictated by the development of

the baby, to promote the possibilities for reunification. A perceived slant of much of the literature in support of Concurrent Planning is that it avoids delay for final placement. As presently implemented in England and Wales there are perhaps good reasons for birth parents to fear that the only permanence truly supported is permanence away from them.

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EARLY REUNIFICATION PROGNOSIS INDICATORS

Child's name:	

Parent/Child Relationship

☐ Parent shows empathy for child, has ability to put child's needs ahead of his/her own.
☐ Parent responds appropriately to the child's verbal and non-verbal signals.
☐ When they are together, the child shows comfort in the parent's presence.
☐ The parent has raised the child for a significant period of time.
☐ In the past, the parent has met the child's basic physical and emotional needs.
☐ Parent accepts some responsibility for the problems that brought the child into care or the attention of the authorities.

Support System

☐ Parent has a positive, significant relationship with other adult(s) who seem free of overt pathology (spouse, parents, friends, relatives).
☐ Parent has a meaningful support system that can help him/her now (church, job, counselor, neighbors).
☐ Extended family is nearby and capable of providing support.
☐ Extended family history shows family members are able to help appropriately when one member is not functioning well.
☐ Relatives came forward to offer help when the child needed placement and followed through on commitments in the past.
☐ There are significant other adults, not blood relatives, who have helped in the past and have followed through on commitments in the past.

Family History

☐ Parent's own history shows consistency of parental caregiver.
☐ Parent's history shows evidence of his/her childhood needs being met adequately.

Parent's Self-Care and Maturity

☐ Stable physical health.
☐ Parent's hygiene and grooming are consistently adequate.
☐ Parent has a history of stability in housing.
☐ Parent has a solid employment history.
☐ Parent has graduated from high school or possesses a GED.
☐ Parent has employment skills.

Child's Emotional, Cognitive, and Social Development

☐ Child shows age appropriate cognitive abilities.
☐ Child is able to attend to tasks at an age-appropriate level.
☐ Child shows evidence of conscience development.
☐ Child has appropriate social skills.
☐ Major behavioral problems are absent.

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