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Outcomes of Concurrent Planning:

Summary of Findings

October 2013

Coram Policy and Research Team

About Coram: Coram is the UK's first children's charity, established by Royal Charter as The Foundling Hospital in 1739. Today it is a leading organisation developing, delivering and promoting best practice in the care of vulnerable children and their families.

This report is intended for: Policy makers and a wide range of professionals and researchers whose interests relate to placement decision-making, adoption and fostering. It will also be of interest to those working in the many areas that interact with social work and children's services, including early intervention and legal teams. The report will also be informative to (prospective) foster carers and adopters, and their families.

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Outcomes of Concurrent Planning: Summary of Findings

In 2011, Coram began this exploratory study of the progress of children who had been placed by its concurrent planning service, inviting participation from families whose children had been in placement for two years or more.

The children

Overall, the service worked with 57 children between 2000 and 2011, and we report basic information from administrative records for all these children. For our more detailed study we contacted only the 46 families whose children had been in placement two years or more. After two reminders, 28 parents agreed to take part in the interview study, giving a response rate of 61 per cent. The children were aged between 3 years 7 months and 11 years 10 months, with ages spread evenly through this age range.

Methods

To undertake our research, we drew upon a range of sources:

- administrative records held at Coram;
- interviews with adopters or primary care givers for reunified children (mainly by telephone);
- children's case files held at Coram;
- Strengths and Difficulties Questionnaires (SDQ; Goodman et al 1997) completed by adopters/primary care givers and teachers; and
- school progress questionnaires completed by teachers.

Outcomes data focused on the children's health, wellbeing and educational engagement and attainment, as well as placement stability. In describing the children below, we have drawn on qualitative interview data, particularly parents' 'thumbnail sketches' of children at the time of the interview, and two widely-used scales that were included in our interviews. Where children were aged 3 years or more, we asked parents to complete the Strengths and Difficulties Questionnaire (SDQ) (Goodman et al. 1997). More details of measures used are at Appendix One.

Profile of birth parents and birth experiences

- Drug withdrawal and special neonatal care at birth: There were 16 children who received some special neonatal care (59%), of whom thirteen children (48%) were recorded as requiring treatment for withdrawal from drugs at birth. Twenty (74%) of mothers had serious drugs or alcohol misuse issues
- Six (22%) children had low birth weight (7% is the national average)

- Older siblings: The majority of the birth mothers (88%) in our file study sample had other children, but most of these were already in care. Only two birth mothers were parenting another child at the point of the new baby's referral to concurrent planning. Older siblings totalled 49 children for mothers and 24 for fathers.
- A third of mothers reported experiencing violence in pregnancy
- Mental illness diagnosed for half of the mothers and a quarter of the fathers
- Multiple problems – six had all of mental health issues, domestic violence and substance misuse.

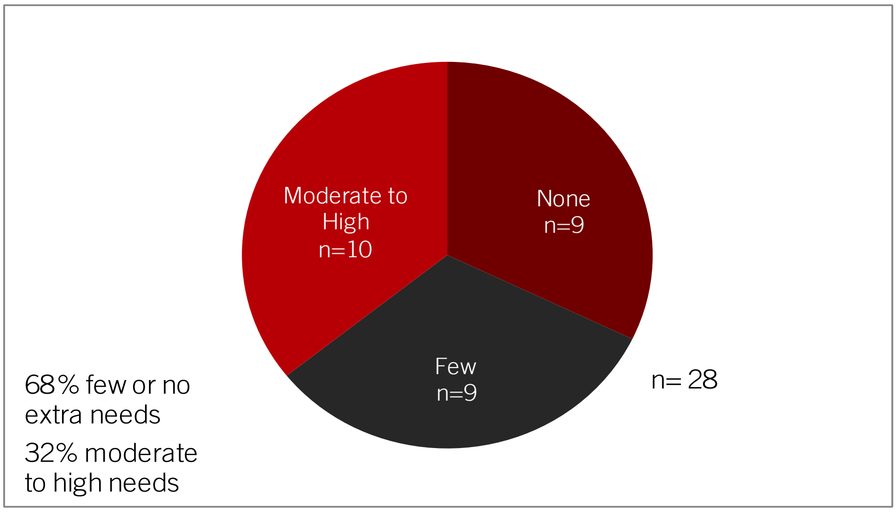
Children's overall progress

As already reported, all 57 children finally placed by the Coram concurrent planning scheme, whether with adopters or with birth family members, were still in placement in 2012-13. None have experienced post-placement disruptions, and none have been returned to care. Three of the 57 children for whom decisions have been made (5%) were reunified with birth families and 54 (95%) were adopted by their concurrent planning carers.

For three children, the outcome of their concurrent planning placement was to return to the birth family. Unfortunately it was only possible to complete an interview with one of these, who was placed with an aunt and grandmother. In the other two cases, one child returned to a birth mother, who had overcome her alcohol problems and the other was placed with an extended family member. All have remained in these placements.

Looking at the children's overall wellbeing (in terms of how they were faring in education, behaviour, peer relationships, and their physical and mental health), combined with the account by the parents of their own satisfaction with their relationship with the child, children were categorised into three groups. From parents' accounts, a number of the children have already moved between these groups, or are expected to as they grow up.

Figure 1. Concurrent planning: parent assessment of support needs



About one third of the children were well and needed no extra support and the majority (68%) required only minor or no support. Of the 28 children, 25 were attending mainstream schools and nurseries, one was home educated, and two were in special provision, one of these in a ‘resource base’ for children with autism, attached to a mainstream primary school.

Group 1: Children needing no extra support

Ten out of 28 children were receiving no extra support, and were reported to be happy and well.

For example: Harry, aged 9, was described as a *‘happy little boy, vibrant, loves life and lots of fun’. ‘A delight’ and ‘very bright’, he is in the top ten children in his class doing well in recent school exams. He is musical, playing drums and piano. ‘Easy going’, having ‘lots of empathy’, ‘confident’ and ‘charming’.*

For children in this group, their SDQ total difficulties scores ranged between 5 and 10, in the normal range, and similar to their peers in the general population. KPSS scores for parents in this group ranged between 17 and 21. These findings indicate this group of children have many strengths and very few difficulties and a high level of parental satisfaction.

Group 2: Children needing minor extra support

Nine of the children were receiving some extra support, five of them at ‘school action’ and one at ‘school action plus’ in terms of schools’ special educational needs framework, and with no specialist medical support. In two cases there had been some support given in the past but none at present. The kinds of support described included extra tuition at school; ‘nurture group’ on starting primary school, and music therapy from Coram in the past.

Jake was aged 5 years. He was described as follows:

> *‘He’s very fun-loving. This week he’s doing a drama course, a sort of holiday drama thing, he loves that sort of thing, dressing up, dancing, singing, performing shows,. Fun-loving, he’s quite sporty, very outdoorsy, quite a lot of energy. I would say that is his natural disposition anyway.’*

Jake had in that year been assessed by the school to require a ‘school action plus’ level of support, but the parent thought this was not needed:

> *‘In January, February - they got a behavioural special needs person to come and observe him... The behaviour person found him completely normal in every area and actually said if she had been invited into the class, she wouldn’t have spotted him as the person she needed to observe.’*

Rachel, aged 12, who returned to her birth family, is in this group because of some behavioural support at school over the last year, but is overall well with no major difficulties. She was in the top group at school and successful at sports.

For children in this group, their SDQ total difficulties scores ranged between 6 and 16. KPSS scores for parents in this group ranged between 12 and 18. These findings indicate that most children in this group have some difficulties and there is a moderate level of parental satisfaction.

Group 3: Children with moderate to high support needs

Nine children had moderate to high support needs. Five children had diagnoses of being on the autistic spectrum – one of these '*Aspergers with challenging behaviour, plus a hearing impairment'*. Another had emotional problems, with a diagnosis of *'attachment issues'* and had been receiving psychotherapy from CAMHS for several years. Two of the children on the autistic spectrum were in special education, one of these being a *'resource base'* for children with autism attached to a mainstream school. The rest were in mainstream education, and required significant support to meet their potential. Within this group there is a considerable range in terms of the extent to which the child's needs dominated family life. We therefore describe two children, firstly Elliott, whose parent gave the following reply when asked whether he had diagnosed difficulties:

> *'Elliott has physical problems he was born with and had to have surgery when he was a baby. He's on the autistic spectrum. He has ADHD, oppositional defiance disorder and a general anxiety disorder, a chromosome disorder, and severe learning difficulties.'*

However:

> '*His qualities are in the context of his medical and all the other issues that make him up. He's a wonderful, wonderful little boy. He's got a very good sense of humour. Very, very set in his ways. He can become quite obsessive about things and get carried away with particular things. He has very high emotional intelligence, and he's a very easy child to love and to like because he's highly communicative. .. He does bring a lot of joy into people's lives.'*

Elliott goes to a special school for children with moderate to severe learning difficulties that specialises in autism. Great difficulty in accessing services was described, partly due to distance, plus Elliott cannot readily be left with anyone, which adds a further major difficulty of access.

Harriet was aged 12 when interviews took place. She was described as follows:

> *'Adorable, autistic and adopted' her phrase. She has a hilarious aspect on life, should I say. She says exactly what she thinks at exactly the wrong time. She is incredibly loving, she is very sensitive. I'm very biased because she is the most adorable child that was ever born. She's blonde haired, blue eyed, big girl, she is very tall, very tomboyish just like I was - it's that nature-nurture - and I just feel incredibly lucky to have her. So, yeah, she's lovely.'*

Her lone parent describes herself as very satisfied in her relationship with Harriet and how since the first days of the placement, '*there has been this bond between us which is unbreakable*'. She describes the support she has received as of mixed value. Harriet was previously diagnosed with an attachment disorder by a paediatrician. '*Given lots to do, which did not work as she had autism.*' The misdiagnosis, missing autism, meant they '*lost five years'* in terms of coming to terms with it and getting her the right kind of strategies in place to help her.

Post adoption support

All adopted children are at some stage in their lives likely to require some support because of the nature of their circumstances – contact with birth families is often an issue, and children need to come to terms with their own story. As we have seen, some need much more extensive support because of their own difficulties.

Of the 28 families, parents most often received help from Coram's services (64%), CAHMS (36%), their Local Authority (32%), and other adoptive parents (32%). In addition, support from schools, other organisations, family members, and financial support were mentioned.

The 17 parents who made use of Coram post-adoption support engaged in one-to-one contact on the phone (61%) or at home (33%), and by seminars or workshops (including Coram's parenting skills programme; 61%). Support most often concerned life story work (50%), contact issues (44%) and parenting skills (39%). They valued personal relationships with team members, and the sense that Coram would respond if approached:

> *'But it was the fact that we'd had consistent support from the project team, that at that point, when... there were cracks starting to show, we were able to ask for help, and she referred us for more work.'*

CAMHS or other therapeutic services, including with the Tavistock and Portman NHS Foundation Trust and the South London and Maudsley NHS Foundation Trust was also accessed for support by ten parents (36%). Five parents added comments, of whom four noted that their support from CAMHS was valuable. One parent said their adoptive parent support group was '*wonderful*', another said she couldn't praise the Tavistock highly enough, and went on to say *'It was very helpful to go and hear other people's experiences... adoption at different stages of life, and what happened.'* The fifth said that it was not particularly helpful because of misdiagnosis.

Support from the local authority (LA) was received by nine (39%) of parents. Two parents had attended a range of courses and workshops from their Local Authority, including education, dangers of the internet and birth identity (one parent was aware of them but did not attend). Three families received financial support. One of the adopters said about the allowance they received: *'That has saved me, I'm deeply grateful for that.'*

Other parents talked of their difficulties in accessing support. One parent observed *'disparity [in the support] between different LAs'* in the level of support received. She said *'I have two nice later life letters from a social worker in [LA] – [I] had to push for those.'*

Support from school was particularly variable for this group of parents. Six parents (21% of total) reported that their children received support, whilst a further six discussed significant challenges to receiving support from schools. Three parents highly rated the support from their current schools, however, one also said that until two years ago the support was *'dreadful'*. Two parents suggested their children's schools were '*very unhelpful'*.

More broadly, many parents discussed the difficulties attached to knowing who to ask for help and what is available, and where can they access it. Some parents did not know who they should contact for post-adoption support. One parent said *'We should get in touch with the social worker and see if there's anything Coram could do. We could do with some help from someone.'*

Eight of the parents discussed practical obstructions to attending post adoption support (29%) both with Coram and local authorities. For parents who worked some workshops were not provided in hours when they could attend. *'I get letters from [LA] about really nice workshops which I'd love to go to in London, from 9-4, so I can't go.'* For other parents who have moved out of the area in which they adopted, the support they were being offered was now too far from their home. *'There's no way I can get up there and back on a school day.'* Generally parents who had moved areas received information from the LA that had placed a child with them, and would benefit from greater access to services in their present local area. A lack of provision of child care was a major barrier for others.

> *'That's the joke – they do these wonderful workshops but they never provide childcare. I've had this conversation with Coram. These workshops are wonderful and we'd love to attend them but if you can't provide us with childcare what are we supposed to do with our child.'*

Contact

Contact during proceedings: Five children had no contact with their birth family during care proceedings (19%)[1], and 2 had only a 'couple' of visits (7%).[2] It seems surprising that this happened in a concurrent planning placement, and will not have been the original plan made, but presumably the birth parent/s were not able to keep to the plan for contact. Contact took place for the remaining 20 children (one child had contact but their parent did not specify how often it was) during care proceedings, as described in the table below. The table shows two sets of information on the plan for contact that was set at the start of proceedings – what was on the file,

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[1] Although one child had some contact in the foster placement before she was in a concurrent placement

[2] The case where the child now lives with their uncle is not included here

and what the parent told us happened. We imagine the differences are due to the plan not happening exactly as expected.

Table 1: Contact during proceedings

Contact during proceedings (days per week)	File study	Parent interview
5 days a week	2 children	3 children
4 days a week	3 children	2 children
3 days a week	4 children	8 children
2 days a week	6 children	4 children
1 day a week or less	6 children	2 children
Total respondents where contact took place with data for this question	*21*	*19*

In most cases the amount of contact reduced over time up until the adoption placement.

From interview data, for six of these twenty children it was unclear how long contact lasted, but for the remaining 14 children contact lasted for between:

- 1 to 4 months for 4 children
- 5 to 8 months for 8 children
- 10 months and a year for 2 children.

The following description gives a picture of a high level of contact:

> *'We started with 5 days a week for three hours – for about two weeks. Then we went down to 4 days a week for 3 hours. Then after about 5 or 6 months we went down to 3 days a week. Then it went down to 2 days a week but we had a lot of contact. The care proceedings lasted 18 months. This was with birth mum, and every two weeks with grandmum and two half-siblings and that was cut down to every month. Initially there were security issues to do with birth father, so we were going to other secure venues in the borough. Then it slightly stabilised, and after about 6 months we started to go to Coram.'*

In a number of cases there was combined or separate contact with birth fathers. While many birth parents attended contact consistently, it was common for parents not to turn up or to be late, and when this happened repeatedly clear agreements would be set and if not complied with frequency of contact would reduce.

Post adoption contact: When the final order is made, if the child is adopted a voluntary agreement is put in place regarding future contact arrangements (which may involve some direct contact with parent/s or other relatives, or indirect contact such as letterbox with birth parents and other birth family members). As the legal parents, adoptive parents are then able to make their own decisions about contact if in their considered view the welfare needs of the child require a change to the original agreement. In the case of the child who returned to live with her aunt and grandmother, she currently has informal contact with her birth mother around once a month, as part of ordinary family life.

The case files showed that the plans made were for no contact for three children; direct contact for seven; letterbox 'one way' for three and letterbox 'two way' for 12 (data from file study for 25 children). Thus there was a plan for direct contact in place for about a quarter of the children. For 22 children (82%) contact was to be with the birth mother; eight (30%) with the birth father; seven (26%) with 'some siblings'; three (11%) with all siblings; five (19%) with other kin. Contact was planned either for once or twice per year. Of the seven with direct contact plans, this was arranged with the birth mother in at least five cases, plus birth father in two; siblings in two; aunt in one; plus grandmother in one. In one case direct contact was expected with grandfather and siblings only. As we will see there was a tendency for contact with birth parents to reduce over time, while in several cases there was increased contact with siblings, including younger siblings.

At the time of the interviews, ten children had no contact with their birth family. Of these, two had had letterbox contact, and one had had direct contact early on, but this did not continue. Ten further children had letterbox contact – for four this was two-way, and for the remaining five it was one-way and one did not specify this. Five further children had both direct and letterbox contact with birth family members and two only had direct contact. In only two cases was there ongoing direct contact with birth parents (one of these was with both birth parents) – most direct contact was with siblings, aunts, uncles and/or grandparents.

Two parents described positive contact with siblings, for example:

> *'We have face to face contact in Scotland with a half brother and a full sister and countless cousins. We go up and stay in Scotland; last year he stayed with his brother and sister for four nights. And a cousin another night.*
>
> *He treats it like a holiday. He wants to go, they want him. Very positive. We go along and drop him off. He has a whale of a time. Brother and sister are much older than him, in their 20s, they dote on him. He's going up next month. He said he wants his hair dyed pink, so his sister has got him pink hair dye! They phone up at Christmas and we try and call them before his birthday to remind them.'*

Sibling and extended family contact can be very positive for children, but the challenges for adoptive parents are considerable:

> *'Contact with maternal grandfather twice a year. Contact with his siblings once a year. His oldest sibling is 18 or older. His second two siblings are in long term foster care. The next two down were adopted together. And the next little girl is adopted separately. Then there's Andrew, and then the last little girl is adopted separately again. What we've done over the last four or five years is that we've had a big Christmas get together with everybody. And the little girl,*

> *who's one year older, we've seen on a separate occasion, on her own. And the youngest little girl, we've had contact between her and Andrew once separately. Contact itself has always been positive. Letterbox contact with his mother. But we don't know where she is and she has never made contact with us.'*

In addition for this family the child's understanding of his situation has also changed over time:

> *'Preparation for contact has shifted in the last couple of years, as he has become more aware, and understood better, who people are, in relation to him. When he was very little he didn't understand and just went along and was delighted. As he's got older he's not been that willing to accept that these children are his brothers and sisters. But when he sees them he always has a wonderful time with them. Last Christmas was quite difficult; he didn't want to go and he didn't want to accept that they were his brothers and sisters, 'they're not my brothers and sisters, [adopted brother] is my brother'.*

Letterbox contact was a more common experience for the children in this group, and for some this is a helpful process. However quite a few birth parents were not able to sustain their side of letterbox contact, so that the adoptive family were sending a letter but not receiving anything in return.

Reflections

Out of all of the 57 children placed through concurrent planning, whether adopted or returned to birth family care, there have been no breakdowns of placement and no children have returned to care. For the 28 children studied in more detail, then aged 3 to 12 years, about one third required no extra help, one third needed minor extra support, and one third had moderate to high needs. The children carried into their placements multiple serious risks (related to the reasons it was clear that they had a high likelihood of requiring adoption at or before birth). Despite this, two thirds needed little or no extra support, and those with high needs were receiving committed parental care. There are important implications for the provision of post placement support, whether to adoptive or birth families. It is to be expected that early-placed, as well as later-placed, children will face some difficulties, and their wellbeing throughout their lives will be improved by good quality accessible support in childhood.

The absence of breakdowns in placements or adoptions for any of the 57 children placed by Coram's concurrent planning team compares well with disruption rates reported for non-infant adoptions, which are found to occur in about 20% of placements, with a range of between 10 and 50% depending on the composition of the sample and rising with age of placement (Rushton 2003). These percentages include disruptions to placements before the adoption order, which are more common than those post-order, so not strictly comparable, but are the most relevant figures available.

On average, Coram concurrent planning children who went on to be adopted by concurrent planning carers were 17 months old at the date of adoption. Nationally, over the last five years, the average age when children are adopted is three years and 11 months. In terms of the very important issue of age at placement, of the 28 children we have studied in detail, 21 (75%) were placed below 3 months of age, of whom six were placed within their first month of life. The latest placed were four children placed at 10 to 16 months.

The information reported above on the children's wellbeing naturally leads us to ask questions about what may be the most important factors in determining the outcomes for the children. Our sample was small and we could not have confidence that any differences seen between groups of children within this sample were not the result of chance variations. Exploratory analysis has not shown any clear patterns – all the children suffered substantial early adversity, especially pre-birth, and for any specific risk factor, there appear to be children who are thriving as well as children with greater challenges. We looked at all the obvious possible factors which might correlate to different outcomes, including age at placement, exposure to different pre-birth factors, extent of contact experienced. There was an even spread of age in each of our categories for level of need.

From our findings, a greater proportion (68%) of the children placed through concurrent planning were free of major difficulties than the later placed children (53% in Selwyn et al 2006 study; 43% in Rushton and Dance 2006), as would have been predicted. However early placement has not prevented a significant minority of the children from experiencing considerable challenges. Later placement and greater instability in infancy could only have increased these difficulties. The fact that all placements have been sustained is very significant, and parents' accounts of their commitment to their children were impressive.

It is crucial that parents who undertake concurrent planning receive the best possible support both during the period while the child's final placement is under consideration and after a permanent order is made. Birth families whose children are returned to them also need support. It should be assumed that any family taking on the care of a child who has been looked after will need some (variable) support throughout the child's young life.

Many of the parents were committed to the thinking behind concurrent planning and had sought it out.

> *'We both really honed in on concurrent planning because it fitted with our views, from our professional lives, about what was best for children and it made complete sense to us that children would be placed in the place that might become permanent, and that it was the adults that bore the anxiety and the changes, and not the child.'*
>
> *'Hoped that it could give any child the best chance; it just does seem a really sensible idea that they're with their permanent family from an early point, while things are so unstable. Hopes that it would be excellent for her and help her to have a good life and develop well.'*

Asked whether their hopes for concurrent planning had been fulfilled, parents replied:

> *'Absolutely. There are certain aspects which are hard work, but other people have children who are hard work. They're in my heart. The moment Sam arrived he was adored. It was tough at the beginning but we absolutely adore him.'*
>
> *'I think obviously there is a pain in Emily, that she feels, there is a bit of sadness in her about the whole thing, which seems natural, but apart from that she seems very, very much part of our family and very stable, and it's been a very safe and easy transition for her.'*

The importance of having the child placed with them as a baby was emphasised by many:

> *'For all of us, just being there from... as early as you could have been… that offers stability, and you bond and you've got history together, and that's what families have, isn't it? Sam likes nothing better than saying 'look at my baby photos' and 'what did I do as a baby?' and I feel so blessed that we had them as babies and they've been part of our lives.'*

Key messages for local and national government

- Children placed through concurrent planning were (by definition) highly vulnerable at or before birth, bringing multiple risks from parental substance use, domestic violence and mental health issues in parents, with low birth weight and experience of neonatal drug withdrawal common
- Concurrent planning was effective in ensuring early security and ongoing parental commitment to very vulnerable children
- Relative to later placement, this evidence suggests a lower risk of placement breakdown (whether in adoptive or kin placement) and lower rates of emotional and behavioural difficulties in children
- Adoptive parents greatly valued having had care of the children as babies, and reported that their children valued their ability to recall their babyhood
- Post adoption support services should prioritise early as well as later-placed children
- The majority of children, at some point in their early lives, will require support in understanding their origins, and a minority will require focused support for families whose children experience major challenges including disabilities
- An improvement in timely accurate diagnosis of children's emotional and behavioural difficulties is needed
- Parents identified a need for greater assistance for the children with their challenges in education
- Complex birth family situations tended to create an ongoing need for support on post-adoption contact arrangements (whether direct or letterbox), including often with multiple siblings in different placements as well as birth parents and other birth relatives.

From our evidence, parents looked for the following characteristics in post-adoption services:

- Clear in explaining what support is available and offering it consistently but without pressure
- Responsive and staffed by people known to them
- Relevant to diverse needs
- Able to provide skilled support on contact arrangements and life story work
- Including parenting programmes tailored to adoptive families
- Also workshops on key topics
- Supportive of the wish to be seen as 'normal' families
- Able to provide or refer into appropriate expert support in relation to school issues and mental health needs.
- Group programmes should be provided:
    - Near to their homes, even when they move away from the placing agency
    - Provided at times they were available
    - Having suitable childcare support to enable them to take part, both parents where two parents are involved

Appendix One

The Strengths and Difficulties Questionnaire asks parents to respond to 25 statements in relation to the child. The statements relate to emotional symptoms; conduct problems; hyperactivity/inattention, peer relationship problems and pro-social behaviour. Responses from the first four categories are added together to generate a total difficulties score. Total difficulties scores range from 0 – 40 with 40 representing most difficulties. Twenty-one parents completed the SDQ.

Parents also completed the Kansas Parental Satisfaction Scale (KPSS), a simple assessment of the relationship between adoptive parents and their children (James *et al.* 1985). It is a three-item scale that measures parental satisfaction with child behaviour, with themselves as a parent, and with their relationship with their child. The measure is a seven-point Likert response scale ranging from *extremely dissatisfied* (1) to *extremely satisfied* (7). The three items are: (1) 'How satisfied are you with the behaviour of your child?'; (2) 'How satisfied are you with yourself as a parent?'; (3) 'How satisfied are you with your relationship with your child?'. Higher scores indicate greater parental satisfaction (i.e. 21 is the maximum possible score and indicates extremely high parental satisfaction). Twenty-seven parents completed the KPSS.

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