Connections
child, youth and family services



Connections Out of Home Care

Submission to Community Affairs References Committee

Submission

Connections UnitingCare

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1 Introduction to Connections UnitingCare

Connections UnitingCare ('Connections') is a community organisation with a long and proud history of supporting marginalised and disadvantaged children, young people and families. Connections has a vision of empowered children, young people and families whom enjoy wholeness and fullness of life within social inclusive communities. As an agency, Connections boldly and sensitively seek out and actively engage children, young people and families experiencing marginalisation and disadvantage to create opportunities for safe and nurtured living. Connections work contributes to the overall National work undertaken by the agency's founding body, the Uniting Church in Australia and the UnitingCare Victoria and Tasmania network. Connections offers a broad range of support programs and services to help children, young people, families and individuals in need that live in south-east Melbourne, Victoria. Out of Home Care programs offered by Connections include Local Adoption, Permanent Care, Concurrent Care Project, Adoption Information Service and the Enhanced Therapeutic Contact Service. On a weekly basis Connections provides services to 2000 clients and annually 23,000 children, young people and families are supported. Connections is considered a strong leader in the sector and is well renowned for the delivery of quality, trauma informed services.

2 Community Affairs References Committee into Out of Home Care

The following submission specifically pertains to the following sub-divisions of the Terms of Reference outlined by the Community Affairs References Committee:

C. Current models for out of home care, including kinship care, foster care and residential care
G. Best practice in out of home care in Australia and internationally
I. Extent of children in out of home care remaining connected to their family of origin
J. Best practice solutions for supporting children in vulnerable family situations including early intervention

This report will specifically provide details of two Connections lead initiatives; the Enhanced Therapeutic Contact Service and Concurrent Care Project. These two programs provide innovative, evidence based and child focused services to children in out of home care and their families.

3 Enhanced Therapeutic Contact Service

In June 2013, Connections implemented the Enhanced Therapeutic Contact Service (ETCS), funded by Department of Human Services (DHS), to deliver therapeutic contact and transportation services to children in Out of Home Care and their families. The program services clients in the Southern Melbourne and Bayside Peninsula regions of Southern Division. ETCS is staffed by a qualified and trained team of allied health professionals and support staff. The program differs from traditional models of 'supervision' and 'monitoring' based contact, where contact is observed with minimal support. Instead ETCS dynamically transforms the contact environment into a physically and psychologically safe, child-centred environment for children, young people and families to connect using a coaching and empowerment based therapeutic approach. Contacts are tailored around the individual needs of children and families. The contact environment is either structured, semi-structured or free play based on input from children and families to achieve their goals, within the context of DHS requirements. Contacts may occur at Connections purpose built centre in Doveton called 'Connections Family Centre', in the community or in the family home. The program is designed to complement other specialist services servicing the child, young person and family including home based care, Child Protection, reunification and other therapeutic services.

The program has had a positive impact on children's social, emotional and psychological development, the quality of contact has supported reunification of children to home care (along with input from other specialist supports), has empowered families through goal setting and planning activities, and finally has involved the community to support children, young people and families.

3.1 Conceptual Framework

From a theoretical perspective, the program is grounded in attachment, trauma, neurobiology, child development, identity and systems theories. The program is also underpinned by the Best Interest framework and principals, within a strengths and empowerment based model.

US based research by Johnston and Straus (1999) has influenced ETCS in grounding contact services in a model that not only promotes the physical safety of children, but also their emotional and psychological safety and wellbeing. The research emphasises that helping a child gain a sense of control and predictability in the contact setting can help build their trust and decrease anxiety (Johnston and Straus, 1999). Johnston and Straus (1999) also highlight the importance of supporting children to build positive, non-destructive relationships with their parents. In accordance with the literature, traumatised children may learn that they cannot rely on adults when feeling stressed, so may exhibit adaptive coping skills such as aggressive outburst, uncontrollable crying, oppositional behaviour or emotional introversion. As such, the contact supervisor's role is to recognise and intervene when a child is not coping by either supporting the family member to respond, or if this is not possible, directly supporting the child (Johnston and Straus, 1999). The research suggests families should also be provided with opportunities to reflect on these situations between contact sessions with a trained professional to promote learning and development (Johnston and Straus, 1999).

The ETCS model is also influenced by the work of Beyer (2008) who pioneered 'visit coaching'. Visit coaching involves more than just watching the family in contact, and transforms the contact environment into a space where an appropriately qualified and trained worker plays the role of coach and therapist using principals of *empowerment, empathy, responsiveness and active parenting*. Contact coaching contributes to increased physical, emotional and psychological wellbeing of children (Johnston & Straus 1999; Beyer 2008). It also supports parents in coping with their own feelings and to respond to their children's needs (Johnston & Straus 1999; Beyer 2008).

Visit coaching involves:

- Supporting family to take charge of visits, making them as homelike as possible and normalising experience of contact;
- Visits become a celebration of the family by taking pictures, making a family scrapbook and family storytelling;
- Coaching families to stand in the child's shoes;
- Creating opportunities for each child to have "just you and me time" with the parent in every visit;
- Supporting parent with the effects their circumstances may have on their wellbeing, e.g. experience of grief and loss due to being separated from the child or impacts of protective concerns;
- Supporting parent to have 'adult conversations' outside contact so contact is all about spending time with their child;
- Visits being an anger-free, depression-free zone: where families learn how their anger, sadness or feelings of injustice may negatively affect their ability to meet child's needs;
- A contact environment where play is led by the child, and activities like singing, dancing, reading, and crafts are opportunities to give 100% attention to the child during visits;

- Families being supported to improve the fit between the parent's limit-setting and the child's temperament and behaviour; and
- An inclusive approach, where families are involved in the child's school, activities, and medical appointments.

The impacts of a therapeutic approach to contact for children include:

- Improved mental health, resolution of issues of loss and trauma, a stronger sense of identity and family connectedness (Neil and Howe, 2004);
- Enhancing the child's emotional, behavioural and intellectual development (Sen and Broadhurst, 2010). For example greater emotional stability and fewer externalised behaviours;
- Regular, quality contact time between children in Out of Home Care and their families has been correlated with timely reunification and shorter foster care placements (Beyer, 2008; Sen & Broadhurst, 2011); and
- An avenue to develop or maintain positive relationships with family.

Not only are there benefits on an individual case level, more broadly well supported contact services consequently have advantages from a cost-benefit perspective by promoting timely reunification.

Research has reported that traditional contact practices can alienate children and families unintentionally, for example through non-family friendly spaces or a lack of toys, games and activities (Beyer, 2008). Beyer (2008) noted that traditional contact services can also leave parents feeling embarrassed engaging in imaginary play, singing nursery rhymes or playing dress ups so the ETCS program is intentionally set up to be a supportive, child centred environment. ETCS tailors contacts around the individual needs of children, young people and families using a goal focused approach. Children and families are encouraged to participate in planning activities to build on their strengths and reach their goals. The program aims to create a relaxed and 'normalised' environment in which children and their families can interact.

When the case plan is reunification, the staff encourage positive interactions and connections, as well as attachment and bonding between children and their families. The service also promotes quality time and positive contact experiences for all involved. Contact is an opportunity to feed into Life Story Work. Depending on therapeutic goals and progress against those goals, the environment is set up with activities and games to encourage families to have fun and to enjoy spending time together. Beyer (2008) noted that in traditional contact services parents may feel embarrassed engaging in imaginary play, singing nursery rhymes or playing dress ups so the ETCS program is intentionally set up to be a supportive, child centred environment to allow family members to tap into their natural parenting abilities, or if required to learn age appropriate skills to follow their child's lead in play, to be curious about their child's development and to strengthen relationships through play or activities. The ETCS program also supports family members to appropriately respond to children's behaviours and emotions, and provides support to develop parenting skills such as identifying and responding to cues, or developing routines, boundaries and disciplinary skills which may support the child's reunification home. The program also supports children or family members with additional needs, such as developmental delay, to be more engaged in play or interactions within the contact.

Children in Out of Home Care, including those in Permanent Care, may also struggle with issues of loss, grief, separation, identity, belonging and genealogy (Barnados, 2013; Neil and Howe, 2004). In a small number of cases, the program works with children on a permanent care case plan to promote positive contact and quality time between children and their family of origin, and encourage children's positive understanding of their history and identity. The program also supports birth and permanent care families to develop independent relationships.

Research supports that contact services are most effective when they are complemented by other therapeutic programs and have mechanisms for referral pathways into other services (Oehme and Stern, 2014; Thoennes and Pearson, 1999). ETCS is designed to work together with other specialist programs providing support to the children and/or their families. The program is also offered within an agency that delivers a wide range of services targeted at vulnerable children and families currently in or exiting Out of Home Care; such as Placement Prevention and Reunification Services, Clinical Services, Early Childhood Services including NewPin and Permanent Care Services, which offers options for a continuum of client care. ETCS also communicates with the child's caregiver or placement provider to discuss the child's progress and support needs and adjustment before and after contact. This work may also be complemented by sessions with the child's family either by phone or face to face to help them reflect on the child's needs and their responses during the previous contact.

3.2 Role of Program Staff

ETCS staff members have a multi-faceted role. This role includes contact and transportation services, however as a therapeutically grounded program is much more than this. The below provides a brief summary of the activities undertaken by program staff.

- **Intake services:** Facilitating intake meeting with the family, DHS and care provider to explain the program, explore expectations and begin exploring the family's therapeutic goals (within the context of DHS bottom lines). This phase includes meeting children in placement before contact commences, or inviting the child and their carer to the centre so they are familiar with the worker/environment to support a smooth transition.
- **Contact:** coaching and therapeutic work during contact with children and families.
- **Transportation:** mobility services to enable children and on occasion parents/family members to travel to and from contact.
- **Goal planning and regular reviews:** Supporting children and families to develop therapeutic goals and regularly reviewing progress against these goals.
- **Therapeutic case work:** Therapeutic work with family members between contacts to create a reflective space and promote change. Contact with family members also occurs to plan for future sessions.
- **Session planning:** Joint consultation sessions with other ETCS staff to plan future sessions, particularly if the case is co-allocated. Session planning also includes researching future contact activities in line with the child's and family's therapeutic goal plan. If centre based, the environment is individually tailored for each contact. Staff may also provide child friendly resources for use during community or home based contacts.
- **Communication with other professionals:** Professionals including DHS, Foster Care and other services aimed to support the child's needs or address protective concerns.
- **Active participation in case plan, care team, professional meetings:** A fundamental part of the ETCS role is to participate in meetings to ensure that contact does not occur in a silo (disconnected from the child's support network and services that may be providing therapy/interventions related to protective concerns, e.g. AOD, Mental Health, Family Violence services). Participation also seeks to ensure that the child's contact experience is reflected in their case plan.
- **Referrals:** ETCS staff may support self-referrals to other services or with consent, may make referrals on the parent's behalf. ETCS staff may also advocate to DHS for referrals to specialist services e.g. reunification programs or Early Childhood Services.
- **Support and consultation regarding the child's needs before and after contact:** Communication with the carer and/or placement provider regarding child's needs before and after contact to support the child's adjustment.

- **Groupwork:** It is hoped in future that the program will deliver playgroup services within an educative and supportive model to carefully selected infants and their parents.
- **Supervision and Professional Development:** Staff receive regular formal and informal supervision and have opportunities to participate in professional development.

3.3 Client Feedback and Outcomes

A limited number of young people and adult clients have elected to participate in client feedback processes. To date, one young person and/or seven adult clients have provided client feedback through formalised feedback channels. Client feedback will also be extended to children under twelve in the future.

Of this small sample, client feedback has demonstrated that families usually had a consistent worker and that the contact environment enabled them to enjoy time with their child. Most families noted the physical space felt comfortable and the environment was child and family friendly. From an outcome perspective the majority of parents or family members observed that since involvement with ETCS; 1) their relationships with their children had improved, 2) they were more aware of their children's needs, 3) they had more skills for relating to their children, 4) contact was a better experience for their children and 5) that they enjoyed spending time with their children.

Qualitative feedback provided to Connections Quality and Service Enhancement Unit has included:

- I was given a lot of positive feedback. I was given a listening ear.
- [ETCS] help[ed] me in different ways in understanding things better. Very honest and forthcoming. Lovely. Practical support makes sense to me. My worker is very good.
- Just the best worker I could ever have. So helpful, kind and supportive. Really understand the kids and help me heaps.
- [I] thought everything was perfect after a few visits with my 4 month old, because staff made it baby friendly with accessories.
- [Our situation is] better - my daughter is now in the habit of seeing me and my ETCS worker. She relates well to me because the conditions are stable and unchanging.
- We have learnt a lot and I think things are getting better.
- [ETCS] helped me to get on better with my son and environment for us to interact is better.
- [The best thing about being involved in ETCS is] kindness and support. [ETCS] treat you like a real person. [They] really understand the kids.
- The kids enjoy the environment and activities they do, the cooking, play dough. Things are good at the Doveton centre.

Two case studies from the ETCS Program were *published in the Good Practice: A State-Wide Snapshot 2014.* Please refer to this publication should you wish to review examples of programmatic outcomes.

3.4 Summary

The ETCS program is an innovative, evidence based approach to the delivery of contact services in the Southern Division of Melbourne. ETCS is ground breaking in the Out of Home Care sector and has enormous potential to improve the quality of contact services for children across Australia. It is hoped that the program will pave the way for higher minimum standards in contact services and that the program will inspire therapeutically grounded contact programs to be rolled out, employing qualified and experienced multi-disciplinary staff. ETCS provides an inclusive model of servicing children residing in Out of Home Care and their families. The program is transforming the direction of contact

services in Australia and provides an innovative, flexible and therapeutically grounded service to children and their families. It is hoped that ETCS plays a part towards timely reunification of children back into family care, or where this is not possible, children maintaining a connection to their family origin, and developing a solid understanding of their birth history and identity.

4 Concurrent Planning

"Concurrent planning involves considering all reasonable options for permanency at the earliest possible point following a child's entry into foster care and concurrently pursuing those options that will best serve the child's needs" (Department of Health and Human Services, Child Welfare Information Gateway, 2012).

Concurrent Planning was first developed as a placement option in North America in the 1970's and is now used as a third stream of out of home care (with foster care and kinship care) in several countries world-wide. Concurrent care is considered a strong option for the timely delivery of permanency and stability driven outcomes for children and young people.

"Concurrent permanency planning is a process of working towards a primary permanent plan, such as family reunification, while developing at least one alternative permanency plan at the same time (in line with a dual case plan). It is a case management method effective in reducing the length of time a child spends in foster care placement" (North Carolina DHHS, 2014).

Historically, when the decision to place a child in an out of home care placement is made the primary goal is reunification with the family of origin. A placement is made with an appropriate home based carer who can provide care in a short to medium term capacity. Permanent care becomes a placement option once the child has been residing in home based care for a period of time and efforts to address the protective concerns have been exhausted. Potentially, a child or young person may experience multiple placements, unsuccessful reunifications and an extended period of indecision.

Concurrent Caring provides an alternative where a child or young person is placed in a potentially permanent placement as early as possible in their out of home care experience, when there are strong early indicators that the child may require long term permanent care. The primary goal of reunification is supported through intensive work addressing the protective concerns with the family of origin, but with full awareness and disclosure to all parties that permanency is also being considered and planned, with a decision reached within a designated timeframe of typically six months.

Concurrent planning is considered to be a preferred placement option, especially for children under three years of age, where indicators suggest a high probability of permanent placement outside of the home.

Characteristics of Concurrent Care include:

Child-centred: Children need safety and permanency to form secure attachments with adults who are able to provide for their needs. Home Based Care by its definition is impermanent and temporary in nature.

"Every move in foster care causes grief to a child and damages a child's ability to develop secure attachments, which are vital to healthy growth and development. Concurrent planning meets the child's needs for a home that is safe, nurturing and permanent and that is achieved as quickly as possible." (North Carolina DHHS, 2014)

"Permanent or long term foster care is a contradiction in terms. Foster care is, by definition a temporary living arrangement. The foster parent has no legal commitment to the child, since the agency maintains custody of the child. The living arrangement is always subject to change based on the request of the foster parent or the decision by the agency. There is no assurance that the child will continue to have access to the foster parent as a living or emotional resource after they reach the age of majority (maturity). Such a situation does not encourage trust." (North Carolina DHHS, 2014)

Family-focused: Concurrent care plans are developed with the parents and caretakers of the child or young person entering placement. Parents are fully informed about the concurrent plan and are given the opportunity to fully participate in the process. They are provided with the support, guidance and avenues for contribution to achieve reunification with their child and if this is not possible, to participate in facilitating and supporting the transition to permanent care. The parent and carer of the child are supported to establish a relationship, which may help facilitate positive contact and contributions to the child's life moving forward regardless of the outcome of reunification or non-reunification.

"Parents need to know all of their alternatives from the beginning if they are truly to be empowered to choose the future that is best for themselves and their children" (North Carolina DHHS, 2014).

Case planners have increased options for supporting positive outcomes for children and young people. Concurrent Planning allows practitioners to actively avoid home based care drift and advocate for a timely and permanent outcome by providing a highly supported and structured decision making tool (North Carolina DHHS, 2014).

The North Carolina Department of Health and Human Services (2014) identifies some of the specific potential benefits of concurrent planning to be:

- A reduction in the length of time children spend in foster care;
- A decrease in the number of moves and relationship disruptions while in foster care;
- The support of a child's developmental needs for continuity and stability in family relationships;
- The involvement of parents and family members early in the case planning process;
- A potential for the reduction of adversarial relationships between birth families, home based care families and agency workers;
- The potential to turn a crisis into an opportunity for change and growth;
- It can lead to increased safety and early reunification, as well as voluntary relinquishments;
- Identification of potential permanency planning resources from the commencement of agency involvement with the family;
- A reduction in the likelihood of permanency disruptions because of the younger age of placement into care;
- Allows for the recruitment of families accepting of the primary objective of reunification and if this is not possible, open to making a long-term commitment to the child; and
- Potential cost reduction for services which can be reinvested in other programs.

4.1 United Kingdom (U.K.) Models

"It is for adults to overcome the hurdles when they can and not to expect the burden of uncertainty and waiting and more waiting is carried by the child" (Coram Centre for Early Performance, 2013).

Concurrent planning was first introduced into the United Kingdom (U.K.) in 1998 from North America when the Goodman Project was launched by the Manchester Adoption Agency. The Coram program was established in 1999 and is currently the only dedicated team working nationally with this approach.

"Concurrent planning depends on front-line social workers being equipped to identify and refer on cases where concurrent planning may be appropriate. It places significant demands on the social workers and carers involved. They must work intensively with the birth family to give them the best chance of resolving the issues that led to the child coming into care. They must manage regular and appropriate contact between the child

and the birth family to minimise disruption if the child does return home. Above all, the carers must be well-trained and be able to cope emotionally and practically with the possibility that they may not go on to adopt the child in their care" (Department of Education, 2012).

The Coram Concurrent Planning Program was established in several municipalities in the London area in 1999 to meet the out of home care needs of a relatively small group of very young children aged from birth to 2 years with a heavy emphasis on screening, thorough accrediting and considered matching of children and their families and carers.

"The current system of balancing the rights and needs of the child and those of the birth parents is fundamental to a humane, fair and just society, but at the heart of the system is a vulnerable child who will carry the longer term consequences of this complex balancing act" (British Association for Adoption & Fostering, 2013).

In 2012, a review of the Concurrent Planning program was commenced and an interim report with preliminary findings released in July of that year. These findings show that the Coram program placed 59 children in concurrent placements from 2000 – 2011 and data was available on 57 of those children. The final outcomes report was released in March 2014 (Coram Centre for Early Performance, 2013), which reiterates and confirms the interim report and adds an exploratory study of outcomes relating to 28 children who have been in concurrent care placements for greater than two years.

Summary of preliminary findings:

About the children:

- 31 of children were girls and 28 boys.
- Five sibling groups were placed – two sets of twins, one sibling pair placed at the same time and two cases where subsequent children joined a child or children already placed in concurrent care (one pair and one set of three siblings).

About the birth parents:

- 74% of mothers had serious drug and alcohol issues.
- 88% of mothers had other children. Most were already in out of home care placements. Only two mothers were parenting another child at the time of the new baby's referral to concurrent care.
- 50% of mothers were diagnosed with a mental illness and 25% of fathers.
- 33% of mothers reported violence during pregnancy.

The children's birth experiences:

- 59% of the children received some neonatal care post birth – 48% of these required treatment for drug withdrawal.
- 22% of children recorded a low birth weight.

Permanency outcomes:

- Three of the 57 children were reunified with their birth families (one to his birth mother and two to kin placements).
- 54 children (95%) were permanently cared for by their concurrent carers. Two additional cases were currently going through proceedings at the time of the report.
- The average age of a child permanently cared for through the concurrent planning program was 17 months.

Placement stability:

- All 57 children remained with their concurrent carers until a final decision on permanency was made.
- There were no pre or post placement disruptions and no children returned to care post-adoption order or post-reunification with their birth family.

Children's overall progress:

To determine the progress of the 28 children included in the exploratory study, the overall wellbeing of the child was reviewed, including educational outcomes, behaviour, peer relationships and physical and mental health and this information was combined with accounts from parents around their overall satisfaction with their relationship with the child. The combination of this information was used to determine an overall support needs rating of moderate to high, none or few. A total of 68% of the children were considered to have few or no extra needs, while the remaining 32% were considered to have moderate to high needs.

Referral pathways:

- 33 referrals that progressed to placement were made during pregnancy and almost all placements were made before the child's first birthday.
- Referrals made during pregnancy generally occurred during the third trimester, with three children referred during the mother's second trimester.
- The oldest child placed in concurrent care was three years and three months with a younger sibling.
- 20 children were placed with concurrent carers directly from hospital following birth.
- 39 children (58%) spent some time with foster carers or relatives before being placed with concurrent carers.
- Of the 28 children included in the exploratory study, 21 (75%) were placed below three months of age, with six placed within their first month of life. The eldest four were aged between 10 – 16 months at the time of placement.

Average timescales for children who progressed to a permanent order through concurrent care:

- On average children and infants placed through the program took 14 months from entry to care to adoption. In comparison the U.K. national average at the time for adoption of under one year old children was two years and three months.
- The average age of a child at the time of an adoption order was 17 months compared to a national average age of three years and eleven months.

Contact experiences were reviewed for the 28 children included in the exploratory study:

- Contact during proceedings:
- 20 children had regular contact with their parent(s)
- Five children (19%) had no contact with their family
- Two children (7%) had a 'couple of visits'
- One child had contact, but regularity was not known
- File data on 21 of the children indicated that:
- Two children had five day per week contact
- Three children had four per week contact
- Four children had three day per week contact
- Six children had two day per week contact
- Six children had one day per week or less contact
- Post adoption contact:
- File data on 25 of the children indicated that:
- There were plans for direct contact for 25% of the children, including:
- A no contact plan for three children
- Direct contact was recommended for seven children:
- At least five of these included the birth mother
- Two including the birth father

- Two including siblings
- One including an aunt
- One including a grandmother
- One way written contact was recommended for three children
- Two way written contact was recommended for twelve children
- At the time of interview:
- Ten children had no contact with their birth family. Of these three had contact previously, but this did not continue.
- Ten children had written contact with their birth family. Of these five were two-way and five were one way.
- Five children had both direct and written contact with their birth family members (siblings, aunts, uncles, grandparent(s)) and two of these were with birth parent(s).

The review also considered the key aspects of good practice in relation to concurrent caring and identified five key areas:

1. *Strong partnership arrangements with local authorities and the courts* demonstrated through an advisory group, which facilitates ongoing communication and problem solving.
2. *Local authority social workers and local courts understanding concurrent planning* fostered through ongoing training aimed at facilitating a concurrent caring approach.
3. *Local authorities identify cases early* through a monthly permanency tracking panel and consistent senior management tracking of children who might be suitable (with a specific focus on babies).
4. *Recruitment of prospective concurrent carers* through intensive publicity, including positive action to recruit carers from all culturally diverse backgrounds.
5. *Adequate financial support during the fostering phase* to allow single parents and lower income families to apply to become carers.

Despite children carrying multiple serious risks into the placements due to the reasons they required placement, none of the placements have broken down and none of the children have been returned to care. Further, of the 28 children studied in greater depth 68% had none or only minor support needs.

It is considered crucial that parents (birth and adoptive) are offered the best possible support through both the pre- and post-order phases.

4.2 Children, Youth and Families Act 2005

Concurrent care aligns with section 10 of the Victorian Children, Youth and Families Act 2005 (CYFA 2005) which outlines the Best Interest Principles, in particular:

(b) the need to strength, preserve and promote positive relationships between the child's parent, family members and persons significant to the child.

(h) if the child is to be removed from the care of his or her parent, that consideration is to be given first to the child being placed with an appropriate family member or other appropriate person significant to the child, before any other placement option is considered.

(f) the desirability of continuity and stability in the child's care.

(g) the child is only to be removed from the care of his or her parent if there is an unacceptable risk of harm to the child.

(i) the desirability, when removed from the care of his or her parent, to plan the reunification of the child with his or her parent.

(j) the capacity of each parent or other adult relative or potential caregiver to provide for the child's needs and any action taken by the parent to give effect to the goals set out in the case plan relating to the child.

(k) contact arrangements between the child and the child's parent, siblings, family members and other persons significant to the child.

(p) the possible harmful effect of delay in making the decision or taking the action.

Concurrent care is congruent with recent changes to the Victorian CYFA 2005 which emphasises permanency and timely decision making for children subject to Children's Court Orders.

4.3 The Connections / MacKillop Concurrent Care Program: *'Breaking Down the Silos'*

Connections and MacKillop Family Services (MacKillop) have partnered to develop and deliver a concurrent care program of integrated carer recruitment, training and support. This Connections led initiative was funded by the philanthropic Phyllis Connor Memorial Trust. The aim of the program is to enhance and expand the existing continuum of care for infants and toddlers under three years old residing in out of home care in the Southern Division. The process draws on learnings from existing concurrent planning programs internationally, which have been adapted and refined to the local context. This new process has introduced an additional avenue of home based care. The process is importantly coupled with intensive parental support towards a primary goal of reunification, while also planning for the possibility of the foster placement becoming a permanent care outcome, with the carer being dually trained and accredited for both potential outcomes.

Concurrent planning has been chosen as a viable addition to the current continuum of out of home care due to demonstrated long term benefits and positive outcomes, specifically that:

- All parties involved in the process including birth parents, carers, DHS, the Court and Community Service Organisation practitioners, have realistic, well defined and clearly communicated expectations and understandings around roles, responsibilities, timeframes and potential outcomes.
- All parties maintain a focus on the child and achieving a positive and timely outcome that supports their development and establishes a solid foundation through stability and permanency for their future.
- The birth parent(s) is an active member of the care team with the concurrent carer and together work towards achieving the best outcome for the child.
- All program areas provide advice and input into each placement and are equally consulted on the best way to support and advocate for a long term positive outcome for that individual child.
- Concurrent carers are provided with appropriate support to ensure stability for the child while in care.

The training and assessment process clearly outlines to prospective carers that up until the point that a Permanent Care Order is finalised, there is a chance that the child's Case Plan may be contested and the child could be returned home, or the Custody to the Secretary Order/Guardianship Order could be extended. Accordingly, prospective carers are assessed regarding their preparedness for uncertainty over an extended period and if suitable for Concurrent Care and matched with a child, carers are supported to cope with this uncertainty.

4.3.1 Child Eligibility

The Breaking down the Silo's program will be targeted at the early identification of children from birth until three years of age:

- Who are entering care for the first time or have experienced only one previous out of home care placement;
- Who are unlikely to remain in or be reunified to their birth parent(s) care;
- Where there is no suitable familial placement available;
- Who do not already have a permanent care case plan;

The decision to introduce an age limit is based on evaluation research which has found that younger children are more likely than older children to benefit from concurrent planning. The Potter and Klein Rothschild study (2002) showed concurrent planning was most successful for children placed before aged three.

4.3.2 Case Eligibility

Most existing Concurrent Planning models use a probability model of 80% or greater likelihood that a child will be permanently removed from their parent(s) care as the eligibility criteria for inclusion in the program. The determination of 80% is made through a combination of professional judgment, consultation and the employment of assessment tools.

A 2012 review of Concurrent Planning recommended that "agencies should use poor prognosis indicators as only one part of a comprehensive family assessment, along with other assessment tools such a strengths, risk and safety indicators. A different diagnosis that includes all these tools may be more effective in helping caseworkers gather and assess all relevant information to determine services and concurrent planning needs".

The most commonly used poor prognosis indicators for concurrent care include:

- Parent has previously killed or seriously harmed another child;
- Parent has repeatedly and with premeditation harmed a child;
- Parent's has serious, entrenched drug and alcohol issues, with no significant effort to change over time;
- Parent has significant, protracted, and untreated mental health issues; and
- Parent's rights to another child have been involuntarily terminated.

These indicators may be used in conjunction with existing organisational assessment tools, in particular the Best Interests Case Practice Model, to reach a final determination of eligibility. For the most effective use of the Concurrent Planning Model identification of these cases would occur at the earliest point of involvement with Child Protection, either at Intake or Response / Investigation.

4.4 Concurrent Carers

"(Concurrent carers)… must be willing to make a permanent commitment to a child placed in their home before the child is available for [permanent care], while at the same time work cooperatively with the agency and family of origin to effect reunification" (Department of Health and Human Services, Child Welfare Information Gateway, 2012)

4.4.1 Concurrent Caregiver Eligibility

To be considered as appropriate for accreditation as a concurrent carers applicants will need to demonstrate characteristics and lifestyle practices currently considered necessary for both foster care and permanent care, including:

- Demonstrating an understanding of the realities of the out of home care that they are applying to provide.
- Being able to provide stable home for the child and that this environment be free of abuse.
- Being able to support themselves financially without a dependence on carer reimbursements.
- Demonstrating an ability to be child focused and to make child centred decisions.

- That all household members are supportive of this change to their family and aware and understanding of what this will mean for them.
- That applicants are able to discuss their life experiences in a way that is reflective and balanced and that impactful experiences have been resolved to a level that all household members are able to provide care to a child or young person.
- That the applicants are able to work as a part of a team to meet the needs of the child in their care and on to reunification (if applicable), including as a couple and with organisations.
- A willingness to commit to using no physical discipline within their family.
- A willingness to provide a safe and appropriate living situation for a child, including a smoke free home that meets safety check requirements.

Additionally, they will also need to demonstrate characteristics specific to the needs of concurrent caring, including:

- An ability to manage high levels of legal risk and uncertainty and to reflect on and manage their responses to this without impacting on the child in their care.
- Demonstrate child centred values that align with concurrent care principles, including an understanding of the importance of reunification and a willingness to support and participate in efforts to achieve this.
- Promoting positive attachment between the child and their parent(s) by being willing and able to facilitate potentially high levels of contact as directed by the court by taking the child to and from these visits, making efforts to build a relationship with the parent(s) and, if appropriate, participate in contact visits in a supportive way.
- Demonstrate a capacity to manage potentially high levels of contact between the child and their parent(s) as directed by the courts and to be able to manage the complexities of contact and any personal responses to this without impacting and on the child in their care.
- Giving priority to the child in their care by:
- No further fostering until a permanent care order is issued or reunification occurs.
- Being financially able to sustain without reliance on carer reimbursements, one parent being home with the child full time for one year from the date of placement. At the end of the twelve months a return to work would be negotiated with the program and would be dependent on the needs of the child at that time.
- Practising conception control and undertaking no fertility treatment or surrogacy for one year from the date of placement.

4.4.2 Concurrent Carer Assessment and Accreditation

At the core of every out of home care program is a determination to find the best quality care for children and young people who are unable to live with their family of origin for a period of time ranging from weeks, to months, to permanently. Accordingly, the process of finding, training and assessing carers to provide safe, stable and child focused placements is paramount. All programs, home based temporary care or permanent ongoing care, utilise thorough and rigorous recruitment, training and assessment processes, focused on understanding an applicant's skills, knowledge and experiences, to achieve this goal.

Competency based assessment has been the state-wide endorsed methodology for the assessment of out of home carers in Victoria for over ten years. Concurrent carer assessment competencies will take the existing competencies in the Step By Step package as the foundation, have been expanded and developed further rather than replaced. In Victoria, competency based assessment has not previously been introduced to the permanent care context.

4.5 Post-placement support

The primary aim of concurrent care is to achieve a timely permanency outcome for a very young child living in out of home care. Primacy is given to reunification to their parent(s) with the secondary outcome potentially being a permanent care placement with their concurrent carer(s). As part of achieving a permanency decision that recommends reunification at the six month case direction decision making meeting, parents will be supported and encouraged to take significant and sustainable steps towards addressing protective concerns and meeting any conditions on the court order.

Parent(s) and families of origin will be at the centre of decision making regarding how they will resolve protective issues with clear bottom lines set by DHS. A care team approach will be adopted inclusive of the parents, DHS, Connections and MacKillop in order to promote transparency and active engagement. In conjunction with any specified conditions on the court order, all organisations involved in the concurrent care case will be required to contribute to the development of child and family plans. As per current practice, Child Protection will hold primary responsibility for coordinating work with the parents in order to promote reunification.

4.6 Summary

International evidence supports the benefits of a concurrent care stream in out of home care. Concurrent care is vital when it has been identified at an early stage that reunification may not be possible due to the significance of the protective pattern and history. In this approach primacy is given to supporting parents with intensive support to address protective concerns and to provide the best possible opportunity for reunification. However, concurrent care consecutively provides children with a consistent, stable home environment with carers who are accepting of the potential that children may return to family care, or that the child may alternatively transition to permanent care. The model is strongly grounded in the best interests of the child and seeks to reduce the number of placement moves this cohort of young children endure before potentially transitioning to a final permanent placement. Recent amendments to the CFYA 2005 are congruent with concurrent care principles. Concurrent care is not currently an option within the Australian context and this is a significant gap for the small number of highly vulnerable children who may benefit from this stream of out of home care.

5 Conclusion

In conclusion, this paper has presented two best practice models. The first is Connections Enhanced Therapeutic Contact Service, which is transforming contact environments between children in out of home care and their families from a transactional based model to a dynamic therapeutic environment. The service aims to provide a tailored, outcome focused approach family contact.

The second model is Concurrent Care, which is a part of the “Breaking Down the Silos” Project. The project seeks to collapse systemic barriers where it has been identified early in Child Protection involvement that there is a high probability of non-reunification.

Each of these programs are ground breaking within the Australian context and highly focused on the best interests of children in out of home care, with an emphasis on improving outcomes for children.

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