Practice Paper
Permanency Planning
October 2018
Introduction

She needs love, she needs a sense of belonging, a sense of worth as well and she needs to know that this isn’t just a phase. (Foster carer in Osmond & Tilbury, 2012)

For children to grow up successfully they need to feel consistently safe, loved and nurtured. Children who become subject to and involved in the child protection system are a particularly vulnerable group where this may not be assured. Given the number of children involved in out-of-home care and the recognition that all children should have stable and positive living arrangements, securing permanency for children in a timely manner is seen as critical (Child Welfare Information Gateway, 2018). Three main permanency options exist: reunification, long-term out-of-home care or adoption.

Amendments were made to the Child Protection Act 1999 (Qld) and implemented in 2018 with a focus on permanency, transition to adulthood and the safe care and connection of Aboriginal and Torres Strait Islander children. The Act’s paramount principle has been amended to refer to safety, wellbeing and best interests of a child both throughout childhood and for the rest of a child’s life, making an understanding of permanency and permanency planning even more important to child protection practice.

Concurrent planning which sees the development of primary and alternative case plan goals has been embedded into the Act. Legislatively a departmental case plan must include a primary goal for best achieving permanency and the actions to be taken to achieve this goal. In most cases, reunification will be identified as the primary goal for achieving permanency. An alternative permanency goal must also be developed, in the event that the timely return of the child to the care of a parent is not possible. The aim of concurrent planning is to achieve timely permanence for children and young people.

The Act provides a hierarchy for long term care options. When deciding permanency options for children and young people the first preference is for the child to be cared for by family, the second preference is for the child to be cared for under the guardianship of a family member with the third preference being for guardianship to the Chief Executive.

When considering permanency options the right to self-determination and the child placement principle elements of prevention, partnership, placement, participation, and connection in the Act are to be applied when working with Aboriginal and Torres Strait Islander children, young people and their families. Family Led Decision making processes are used to ensure maximum involvement of families in planning for children and are key to making permanency decisions.

In order to provide quality permanency planning, practitioners will understand: what concurrent permanency planning is; why it is important; what to consider when making permanency plans; and what practices to employ to optimise the likelihood of quality permanency planning outcomes.

What is permanency planning?

Although no common definitions of permanency planning exist, permanency planning is generally regarded as “a systematic, goal-directed and timely approach to case planning for all children subject to child
protection intervention, aimed at promoting stability and continuity (Maluccio, Fein & Olmstead 1986; Marsh & Triseliotis 1993; Thoburn 1994; Tilbury & Osmond, 2006, p.266).

**PERMANENCY**
- **Goal directed**
- **Systematic**
- **Timely**
- **Much more than placement**
- **Relational, physical and legal**

No definitions of ‘timely’ permanency planning exist in the literature however the Child Protection Act 1999 stipulates that consecutive short term child protection orders should not exceed a two year period unless exceptional circumstances exist and permanency planning must commence from the beginning of intervention, that is, at initial case planning embedded within permanency planning and the Child Protection Act 1999 are three different dimensions of permanence: relational, physical and legal (Sanchez, 2004 cited in Tilbury & Osmond, 2006; Stott & Gustavsson, 2010). **Relational** permanence refers to the experience of having positive, loving, trusting and nurturing relationships with significant others (e.g. parents, friends, siblings, family, carers); **physical** permanence is stable living arrangements and connections within a community; and **legal** permanence refers the legal arrangements associated with permanency, such as who has guardianship (Stott & Gustavsson, 2010).

Appreciation of these dimensions highlights that permanency planning is much more than placement (Tilbury & Osmond, 2006). It recognises that children need: consistent, predictable and loving relationships; a sense of connectedness and belonging to families/communities (particularly for Aboriginal and Torres Strait Islander children); and a stable place which they call ‘home’ (Brydon 2004; Fein & Maluccio 1992; Lahti 1982; Sanchez 2004 cited in Tilbury & Osmond, 2006). Failure to recognise the multifaceted nature of permanency planning can lead to children feeling a sense of impermanence (Stott & Gustavsson, 2010). This indicates that all permanency dimensions must be actively considered by practitioners.

**Why is permanency planning important?**

Permanency planning is based on a number of research-supported rationales (Tilbury & Osmond, 2006). **Attachment theory** underpins permanency planning. Attachment theory holds that early childhood relationship experiences with significant caregivers can have positive or negative psychosocial outcomes. Although there may be cultural variations, the nature and quality of the interactions between child and carer can lead to different attachment relationships: secure, avoidant, ambivalent or disorganised (Bowlby, 1969; 1982, Howe, Dooley & Hinings, 2000; Main & Solomon, 1986; Jordon & Sketchley, 2009; Ainsworth, Blehar, Waters & Wall, 1978). Children who receive consistent, loving, responsive and nurturing caregiving are more likely to develop a secure attachment. This experience for a child creates an internal representational model (a cognitive schema) that adults are trustworthy and that they in turn, are worthy and valuable (Bowlby, 1969; Berk, 2000).
WHY IS PERMANENCY IMPORTANT?

- Attachment Brain development
- Stability and continuity
- Identity formation

Children who have been maltreated have been recognised as particularly vulnerable for developing insecure attachment. “Children in care are at very high risk of attachment insecurity (Marcus, 1991) and of attachment disturbances (Minnis, Everett, Pelosi, Dunn, & Knapp, 2006), given their common experience of emotional deprivation, loss, and inconsistent caregiving” (Tarren-Sweeney, 2008, p. 2). The links between attachment and permanency are therefore important. Children need opportunities to develop positive and secure attachments with significant others. If this cannot be afforded by birth parents opportunities to develop positive relationships with others is crucial. Responsive and sensitive caregiving, can assist in repairing attachment difficulties with time and due care.

Another rationale for permanency planning is research on brain development. Maltreatment can have neurobiological impacts on a child’s brain functioning with lifelong consequences for learning capacity, mental health and wellbeing (Twardosz & Lutzker, 2010; Teicher, Andersen, Polcari, Anderson, Navalta & Kim, 2003).

The first three years of a child’s life are particularly critical to brain development and functioning (Harden, 2004). The impact of trauma (which includes maltreatment) can create physiologic changes to hormone levels and neurotransmitters “that render them susceptible to heightened arousal and an incapacity to adapt emotions to an appropriate level (DeBellis, 2001; Perry, 1995; Perry, Pollard, Blakely et al, 1995; cited in Harden, 2004, p. 36).

Children who experience trauma are likely to be stressed. Highly stressed children may have unusual cortisol levels (the stress hormone) compared to non-stressed children which can impact on brain functioning (Harden, 2004). This has been described as “toxic stress” because, if prolonged, may have significant impact on the brain’s architecture and stress regulation mechanisms (Shonkoff & Phillips, 2001; cited in Bromfield, Gillingham & Higgins, 2007, p. 35). However, stress effects can be buffered by positive relationships with parents or significant others (Harden, 2004).
The importance of *stability and continuity* also underpins permanency planning. Children need stability in order to thrive. Family stability has been recognised as an important factor in enhancing the developmental outcomes of children in health, academic, scholastic achievement and interpersonal skills (Harden, 2004). Children who experience instability or constant change (some children in out-of-home care system) can have compromised wellbeing, attachment, self-esteem, identity and access to education and health care (Ward, 2009).

Related to stability is the concept of continuity. Children need the opportunity to experience continuity in the activities and systems they are involved with. For example, it can be beneficial for a child in out-of-home care to enjoy continued attendance at the same school, or sporting club and have opportunity for contact with significant others such as aunts, grandparents, friends and pets. Maintenance of existing positive connections and activities can assist children manage transitions (McIntosh, 1999).

*Identity formation* is also a rationale for the promotion of permanency planning. A child’s sense of self is intimately connected to the ‘nature of’ the interactions with significant others. Positive interactional messages can lead to a positive sense of self and identity (Tilbury & Osmond, 2006).

Separation from family, grandparents, friends and community can impact on a child’s sense of ‘who they are’. Children often learn about themselves from these sources. Children in the child protection system are at risk in this regard. “For instance, such children may have a partial or confusing picture of how they came to be where they are and where they belong” (Tilbury & Osmond, 2006, p. 267). This can be particularly so for Aboriginal and Torres Strait Islander children in care who may not have opportunity to develop understandings of their spirituality, cultural heritage, connections and Aboriginality (Tilbury & Osmond, 2006).

**Aims of permanency planning**

Given the above, quality permanency planning practice should aim to:

- prevent protracted, unnecessary placements for children by timely decision-making
- create a sense of relational, physical and legal permanence for children
- facilitate a child’s opportunity to develop a positive attachment to a caregiver (Wise, 2000, p. 5)
- maintain positive connections and continuity with important social systems in a child’s life
- maintain and strengthen a child’s identity, with particular emphasis on cultural, biological and racial identity
- facilitate the establishment of a solid base that a child/youth or adult can connect to throughout life for “redirection, refueling, a sounding board” (Charles & Nelson, 2000, p. 18)
- create arrangements that assist a child to reach his/her full potential and maximize child safety and wellbeing (Courtney, 2009)
- provide living situations which assist children to recover from harm.

**Permanency planning options**

Permanency planning involves achieving living arrangements for children that are positive and optimal for their emotional, psychological and physical development. Three options in order of preference exist: family reunification, long term out-of-home care and adoption. There is no known evidence that one option is better than another¹. Each option has its place if responsibly matched to child and family needs/circumstances, and maybe considered sequentially or concurrently.
Reunification

Reunification denotes the return of a child from out-of-home care to their birth parents (Farmer, 2009). Reunification is based on the assumption that birth family is optimal for children if safe and nurturing. As many children in out-of-home care do reunify with their families, evidence on how to optimise successful reunification is imperative.

Identifying which children in what circumstances should or should not be reunified with their parents is a key professional task. Three questions that practitioners need to consider are:

1. Are the issues that prompted the child’s removal under control?
2. If secondary issues have developed during the child’s stay in... [out-of-home] care, are they under control?
3. Will these issues remain under control if the child is reintroduced in the home environment? (Fuller, 2005, p. 1303).

Research areas which aid decision making are:

1. research that identifies factors that heighten the likelihood of return;
2. research on maltreatment following reunification and return breakdown and predictors of re-maltreatment following child protection service involvement (see Appendix 1). This literature provisionally shows who might be best suited for reunification and who might need additional support to maximize positive reunification outcomes.

Factors influencing reunification

A number of factors are related to the success or otherwise of reunification (Farmer, 2009; Bullock, Gooch & Little, 1998). Families who have less complex problems and more personal resources are more likely to experience reunification (Farmer, 2009). Particular difficulties for families such as: poverty, chronic mental illness, substance abuse (parents ingrained in a drug culture) and housing can lower the chances of reunification (Fraser et al, 1996; Goerge, 1990; Rzepnicki et al, 1997; cited in Farmer, 2009; Hayward & DePanfilis, 2007; Jordon & Sketchley, 2009).

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1. Notably, there is limited Australian research on permanency planning. A majority of the research comes from the UK and US. Policy importation from the UK and US needs careful analysis because of different demographic, social, cultural, welfare and funding systems that exist (Tilbury & Thoburn, 2008). What is effective in one jurisdiction will not necessarily be effective in another. Although the evidence is building it is not conclusive.
Parents that are motivated to care for their children and change their behaviour can lead to reunification success (Cleaver, 2000; Sinclair et al, 2005; cited in Farmer, 2009). Parental ambivalence has also been reported as linked to reunification failure (Farmer, 2008; cited in Farmer, 2009).

Foster carers who are willing to mentor parents, support and facilitate family contact and provide assistance following reunification may heighten the likelihood of successful reunification. They also play a vital role in preparing children for reunification (Child Welfare Information Gateway, 2005; Farmer et al, 2008; cited in Farmer, 2009).

The timing of return has been reported as relevant to reunification. Research indicates that reunification is most likely immediately following placement in out-of-home care. Research also suggests that the longer a child is in out-of-home care the less likely reunification will occur (Farmer, 2009; Hayward & DePanfilis, 2007). However, passage of time in care is not the sole cause of failure to reunify. Many factors may contribute to why children are not reunified with their parents across time (e.g. acceptance of situation, changes in parental/child motivation and wishes) (Biehal, 2007).

REUNIFICATION

Reunification is highly desirable for children and families if safe.

Reunification practice involves critically considering issues that prompted a placement out of the home and whether these have been satisfactorily resolved.

Critically consider the factors that can influence reunification outcomes.

Remember your attitude and way of working with a family can impact on reunification success.

Reunification does require quality pre and post support.

Reunification practice does take considerable time and effort – children and families are worth it!

Research suggests that children who suffer from sexual and physical abuse tend to reunify with family quicker than those children who have been neglected. However, severity of any type of abuse may lead to a non return home (Farmer, 2009). For example, parents who have previously killed or significantly harmed a child (with or without pre-meditation) may have a poorer prognosis for reunification (National Clearinghouse on Child Abuse and Neglect Information and National Adoption Clearinghouse, 2006, cited in Jordon & Sketchley, 2009, p. 20).

Parental contact and visitation has been reported as positively associated to reunification with regular contact suggested as the main cause. However, some argue that contact per se does not lead to reunification, but rather other factors such as casework planning (Sinclair et al, 2005b cited in Biehal, 2007). However, assessment of contact remains vital because it provides insight into the quality and attachment of the parent/child relationship. If positive, contact can be an important component of reunification practice (Biehal, 2007).

Child characteristics related to reunification difficulties or longer time in care are: children who have physical health problems, disabilities (particularly a learning disability) and who have had several
placement moves (Farmer, 2009). Age of child has also been linked. “The middle childhood years (after infancy, prior to adolescence) seem to be the time when children are more likely to return home (Courtney, 1994; Harris & Courtney, 2003; Wulczyn, 2004)” (Hayward & DePanfils, 2007, p. 1322-1323).

**Family characteristics** influencing slower reunification are: sole parent families, parents experiencing financial problems, parent-child attachment difficulties, and maternal mental health problems (Farmer, 2009; Bullock, 1998). However, positive family relationships can increase reunification success. Commitment by a family to retaining a child’s ‘role’ or ‘territory’ within the family while the child is not living at home is also more likely to result in a successful return (Bullock et al, 1998, p. 200).

Parents’ perception of their **relationship with their caseworker** can impact on reunification success. If parents do not perceive and experience the casework relationship as empathetic, empowering, deeply engaged and family focused they may lose incentive to persist with reunification efforts (Alpert, 2005; Farmer, 2009; Cheng, 2010). Inclusive and participatory practice approaches are necessitated. Caseworker skills and engagement can improve the likelihood of reunification (Bullock et al, 1998; Cheng, 2010).

**Maltreatment following reunification**

Limited research has been undertaken on maltreatment following reunification and of that, results are mixed. However, the benefit of cautiously considering this research is that it highlights what child and family situations may be at higher risk for unsuccessful reunification. Additional support and monitoring can then be better targeted to promote child safety and permanency (Connell, Vanderploeg, Katz, Caron, Saunders & Tebes, 2009). Factors linked with maltreatment following reunification include:

Children who have been **previously neglected or abused** are more likely to be maltreated following reunification. “Compared to children placed in foster care for non-maltreatment reasons, risk nearly doubled for children placed in foster care as a result of physical abuse and more than tripled for children placed in foster care as a result of neglect” (Connell et al, 2009, p. 225). **Neglect** in family situations may warrant particular consideration and targeted intervention (Connell et al, 2009).

Children with a **history of repeated foster care** episodes (Connell et al, 2009, p. 227) are a higher risk for re-maltreatment following reunification. Likewise, children who are **reunified from non-relative** placements have been identified as higher risk (Connell et al, 2009, p. 227).

**Parental stress** may lead to re-maltreatment following reunification. When children are being reunified with their parents, particular child, carer and household factors may either heighten stress or conversely mitigate it (e.g. presence of support, whether carer is able to manage supervising infants and preschoolers compared to school aged children) (Fuller, 2005, p.1303).

Length of time in out-of-home care is identified as relevant to re-maltreatment following reunification. Two findings have been reported. Children who are in out-of-home care **longer than 3 years or more** are at higher risk for recurrence. However, children who are in out-of-home care for very **short periods** (i.e. less than 90 days) are also at higher risk because insufficient changes may have occurred in the family environment to facilitate successful reunification or errors made by decision makers that reunification was safe (Fuller, 2005; Jonson-Reid, 2003 cited in Fuller, 2005; McDonald, Bryson & Poertner, 2006).

Reunification is highly desirable for those children who can return home safely. However, reunification does have risks. Reunification when family situations are not resolved sufficiently, or families have not received effective pre and post reunification support may lead to unsuccessful reunification attempts. Children who return home too quickly or have repeated reunification attempts can have compromised
There are benefits and risks specific to kinship care that should be considered

However, other research reports concerns or risks associated with kinship care. Concerns raised include: poorer standard of care expected compared to non-kin placements; risk of unsupervised contact between child and parent; kin may have similar problems to birth parents; difficult family dynamics, and difficulties of working with carers (Hunt, 2009, p. 104; Rubin et al, 2009, p. 551). “Children in kinship care are [also] known to face additional hardships because their caregivers tend to be single, older, of poorer health, of lower economic status, have more mental health problems, receive less assistance and services from child welfare agencies, and have fewer supportive resources than foster parents” (Rubin et al, 2009, p. 551).

Although the evidence on the effectiveness of kinship care is not conclusive, it is a viable placement option for many children. Hunt et al (2009) report that successful kinship placements are more likely if:

- the child is younger at the time of placement
- the child has minimal problems
- the child has resided with the kin previously
- the kin initiated the placement
- the kin is a grandparent
- the kin is a sole carer
- there were no other siblings living in the household (cited in Hunt, 2009, p.109; see also Lutman, Hunt & Waterhouse, 2009).
Long-term foster care

Although no universal definitions of long-term foster care exist, long term foster care can denote care for children until they are 18 years of age “being part of a family into adulthood or a family for life” (Schofield, 2009, p. 142). But which children are most suitable for long-term foster care?

A number of child factors (age, history of abuse, existing emotional and behavioral problems) have been recognised as reasons for why foster care may be a better permanency option for some children. Children with significant emotional/behavioural problems may be better placed in long-term foster care than for example, adoption. These children may be more effectively cared for by foster parents who are trained and highly skilled at responding to the effects of harm.

Children who have strong family relationships such as sibling relationships may also be better served by long-term foster care. Keeping siblings together may be more easily achieved with foster care (or kinship care) as compared to other permanency options. Siblings provide a number of important benefits to each other and sibling separation has been identified as a possible risk factor for placement breakdown (Gustavsson & MacEachron, 2010, p. 44; Drapeau et al., 2000; Leathers, 2005; cited in Kane & Darlington, 2009).

Cultural and ethnic issues are also reasons why foster care may be most desirable. Other permanency options (e.g. adoption) may not be recognised or endorsed by particular cultural and religious groups (Schofield, 2009).

However, some research does suggest that long-term foster care may not be suitable for all maltreated children. These children are generally older, have very serious behavioural problems and a significant placement history (Strikker, Knorth and Knot-Dickscheit, 2008). This does not mean that long-term foster care cannot be used, but they are higher risk for placement breakdown. These placements may require substantial support and resourcing to reduce the incidence of breakdown.

Research clearly identifies that foster care can be beneficial to children and provide them with a loving and secure family environment. Benefits include: less likely to be re-abused, reduction in challenging behaviour, improved school performance, and an environment that can offer a child developmental recovery (Selwyn & Quinton, 2004, p. 7) However, they can be at risk of instability due to: placement moves, not having sufficient attention given to their needs as they develop across the lifespan; missing out on a ‘family for life’ or not developing a sense of belonging, and a lack of sensitive support post 18 years of age (Schofield, 2009; Selwyn & Quinton, 2004; Gupta, 2009).

Professional assessment, planning and support for children and carers to optimise positive outcomes in long-term foster care are essential. Sinclair’s et al (2005) model of permanence clearly shows what issues need to be considered, planned for, or addressed.

- Objective permanence – for a child to have a placement, which would last for his/her childhood, would provide back-up and, if needed, accommodation after the age of 18.
- Subjective permanence - for a child to feel that they belong in the family.
- Enacted permanence - for all concerned to behave as if the child was a family member (e.g. the child was included in family occasions).
- Uncontested permanence for a child not to feel a clash of loyalties between foster and birth family (Sinclair et al 2005; cited in Schofield, 2009, p. 149).
Guardianship

Children permanently residing with kin or in foster care may also achieve legal permanency by the use of guardianship orders. Kinship carers are the most prevalent group of legal guardians (AIHW, 2016). The benefit of guardianship is that it does allow children to retain their legal connections with birth parents but also affords guardians with additional legal stability and decision making (Testa, 2004). The appointment of guardians does however require careful assessment as ongoing support/monitoring of a child’s wellbeing may not continue from child welfare authorities once guardianship orders have been made.

From 2018 the Child Protection Act 1999 provides a number of options for guardianship to be granted to a suitable person. Long term guardianship to a suitable person (kin or foster carer) is available with annual follow-up from Child Safety to see the child, capacity to review the case plan and with parents retaining the right to apply to vary or revoke the order. A Permanent Care Order is another option. Permanent guardians must be committed to preserving the child’s identity, connection to community/culture and relationships with members of the child’s family. This order differs from other long term care options in that only the Director of Child Protection Litigation can apply for a variation or revocation of this order. Whilst there is no requirement for the department to have ongoing contact with the child, the child and/or the guardian can request a review of the case plan and a parent may make a complaint through the department’s complaints process if they have concerns.

Adoption

Adoption is another option for achieving permanency for children (Simmonds, 2009). However, it terminates parental rights, creates new legal relationships for a child and caregiver and can have profound impacts on all parties involved (Simmonds, 2009). Because of this, it is an option that requires significant consideration. Even for birth parents who cannot safety parent their children many still desire to ‘parent successfully’ and remain connected and involved in their children’s lives (Simmonds, 2009, p.223).

Adoption as a permanency option is recognised as affording a number of benefits to children. It can provide children with high levels of stability, a sense of belonging and wellbeing (Triseliotis, 2002; cited in Howard, Smith & Ryan, 2004; Quinton & Selwyn, 2009). Children adopted before the age of 18 months of age have, as adolescents reported the advantages of identity, attachment, child mental health and family functioning (Benson, Sharma, & Roehlkepartain, 1994; cited in Howard, Smith & Ryan, 2004). Others have reported satisfaction with being adopted and able to have a ‘new start’ (Dance & Ruston, 2005, p. 26) Adoption can aid in facilitating developmental catch-ups for children (Juffer & van Ijzendoorn, 2005; cited in Simmonds,
Adoption may be suitable for a small minority of children. Be aware of factors that may result in disruption and delay.

Adoption disruption

One of the main concerns about adoption has been disruption (breakdown of adoptive placement prior to finalisation). The impacts of disruption on young people can be deleterious. Effects may be compounded by their previous experiences of family loss and severing of ties. Adoption disruption rates are not high, meaning many adoptions are successful, but reported statistics do vary due to differences in research definitions, methodologies and demographic variations. Reported disruption rates range between 2.8 to 47%. However, most research reports between 6 and 11% (Coakley & Berrick, 2008). Although not conclusive, a number of child, family and service factors have been identified as relevant to either increasing the likelihood or conversely mitigating adoption disruption. These are helpful in terms of risk assessment and support planning.

Younger children (ages 0-2 years) are less likely to experience adoption disruption compared to children aged 2-6 years or older (Coakley & Berrick, 2008, p. 107). “With all other variables holding constant, for each one-year increment in age, there is a 6% increased likelihood of disruption” (Smith, Howard, Garnier & Ryan 2006, p. 36).

Children who have been maltreated, have special needs and/or significant behavioural/emotional problems are overrepresented in adoption disruptions (Coakley & Berrick, 2008, p. 107).

Children who have an emotional attachment to their birth parents or have not developed a bond with their adoptive parents are more likely to experience adoption disruption. For instance, older children may have significant memories of their birth parents which can make adjustment to adoption more difficult. Also maltreated children often experience difficulty with forming new relationships and attachment (Keagy & Rall, 2007; Howe, 2006).

Some research has suggests that siblings adopted together have a higher likelihood of adoption disruption than a single child (Smith et al, 2006). Other research has found little difference between sibling groups and single children (Coakley & Berrick, 2008, p. 108).
Some research suggests that *ethnic* children are less likely to experience disruptions whilst other research has reported the contrary. Adoption by *kin* complicates these findings as kin placements can be more stable (Coakley & Berrick, 2008, p. 108). Notably, adoption by kin is not supported under Queensland’s Adoption Act, 2009.

An association between length of *couple marriage time* and stable adoption has been reported (Coakley & Berrick, 2008, p. 108).

Mothers with *more education* are more likely to experience adoption disruption. This may be due to (1) mothers spending more time out of the home due to employment, and (2) having less parenting experience (Coakley & Berrick, 2008, p. 108).

*A previous relationship* between child and adopted parent has been linked to adoption stability (Smith et al, 2006; Ryan, Hinterlong, Hegar & Johnson, 2010).

Adoption *preparation and adoption support* services to families can strengthen stability and prevent disruption. Quality preparation and transparency about a child’s background and support pre and post adoption has been identified as vital for achieving permanency (Coakley & Berrick, 2008, p. 108).

From this, adoption may afford particular benefits to younger children requiring long-term out-of-home care as adoption disruption rates are likely to be significantly lower than foster care rates particularly if the factors that lessen the likelihood of disruption are present.

**Adoption delay**

Besides factors that can influence disruption it is also important to be aware of what issues/factors may lead to delays or long waits for children being adopted. These factors add complexity to permanency planning if adoption is considered. Delays directly contravene the goal of timeliness in permanency planning. A number of factors have been reported in the literature, however these factors are untested in the Queensland context² and should be considered cautiously. Children who wait the longest for adoption are:

- children from ethnic minorities
- sibling groups
- children with severe medical problems
- children with severe emotional difficulties or challenging behaviour
- older children
- children with maltreatment histories, particularly sexual abuse
- children with previous multiple placement histories
- children whose parents oppose adoption
- children in systems that have a slow legal process
- children and families who work with inexperienced or untrained staff

² In Queensland adoption delay for children relate to factors such as: complexity regarding establishing paternity; satisfying grounds for an order for dispensation of parental consent; and extreme disability (Scott, K, Personal Communication, 8th February, 2011).

(Wigfall et al, 2006, p. 42; Butler, 2001; Snowden, Leon & Sieracki, 2008; McDonald, Press, Billings & Moore, 2007).
Practice implications

For practitioners aiming to offer quality permanency planning practice they must also be aware of and consider the following practice implications.

The need for thorough, comprehensive assessments

In order to make good permanency decisions with families and children in a timely manner, quality assessment is imperative. The Structured Decision Making (SDM) Family Reunification Assessment Tool can assist with decision making. A thorough assessment is required. Thoroughness means reading all documentation/reports on a family and observations of and interviews with the child and family. This process should result in you knowing well the families you are assessing and working with, all of which takes time and commitment. Assessment areas that may be considered include:

- family strengths and capacities, history, functioning, psychosocial circumstances, family environment and conditions
- quality, integrity and attachment of the parent-child relationship (consider history of relationship; reaction to separation; reactions to carers; reaction to contact visits) (See Gauthier, Fortin & Jeliu, 2004)
- child’s attachment to significant others (e.g. siblings, carers)
- quality, nature and commitment of parents to contact
- parents demonstrated progress and commitment towards goals
- child’s current care arrangements and level of stability
- child’s opportunity for continuity with important social systems in a child’s life
- risk and safety factors
- needs of the child (physical, social and emotional) and family members. The age of the child and developmental level are also important considerations (e.g. infant compared to adolescent)
- parental attitude toward and expectations of the child
- extent to which maintaining a child’s legal relationship with their birth family is in the child’s best interests
- determining which long-term out-of-home care option provides sufficient permanency to promote a child’s long-term security in the placement.

(Tilbury & Osmond, 2006; Risley-Curtiss et al., 2004; Maluccio, Fein & Olmstead, 1986; Tilbury, Osmond, Wilson & Clark, 2007).

In addition, when undertaking permanency planning, particular specialist assessments such as kinship, adoption, carer, medical, developmental and psychological may be required to aid in decision making.
John is currently in foster care. You are thinking about his permanency needs. Questions you might ponder over are:

What are John's current positive relationships (i.e. siblings, family, carers, professionals*)?  
How can these be nurtured and sustained?  
What opportunities does John have to build new positive relationships?  
What is John currently involved in?  
What can be done to maintain these activities/connections in a continuous manner?  
How can a sense of belonging be achieved for John?  
How can John be best assisted to recover from pre-care harm?  
What is in place to ensure John has the opportunity to develop a positive sense of self and cultural and personal identity?  
How can stability be achieved for John?  
What is important to John in terms of permanency?  
What type of placement or physical permanence might suit John?  

*Selwyn (2010, p. 35)

The need to match intervention/support and service delivery to client needs

Part of quality assessment involves identifying client needs and what supports, interventions and/or services may be required to address those needs. Needs can be addressed in a number of ways: family or support network, other people or systems in the network (e.g. schools, community) and professional services (Tilbury, Osmond, Wilson & Clark, 2007). When undertaking permanency planning work you need to consider the needs of children, families and carers.

Different permanency options and dimensions (i.e. relational, physical and legal) will require different support and service responses. The central task is to ensure that intervention responses are: congruent with assessed needs; flexible; culturally sensitive; and “reasonable and achievable” (McSherry, 2006, p. 231). Also, that families are collaboratively involved in goal discussion and the identification of what strategies work best for them. Individualised assessment and intervention is required – not a one size fits all approach. Quality professional work should involve thinking critically, creatively and with evidence about how goals/issues can be addressed to produce positive outcomes. If goals and interventions have been collaboratively developed with families, this can lead to greater commitment and motivation by all involved.

For instance, parents who took part in Farmer’s (2009, p. 96) research reported that in relation to supporting reunification they needed “earlier recognition of their difficulties with their children; assistance to build up their self-confidence and skills as parents; monitoring of their progress that is combined with emotional warmth; treatment for substance misuse combined with clarity about the consequences of their taking no action about their addiction; direct help for their children (such as mental health assistance, anger management and mentoring) and respite care”. Carers have reported needing information on what services and assistance is available, help with navigating other systems (e.g. legal, welfare, education, services), and financial and practical assistance.
Identifying relevant intervention also involves understanding what particular permanency options are required to optimise the likelihood of positive outcomes. For instance, earlier it was highlighted the importance of: pre- and post-reunification support; quality assessment and support of carers; addressing objective, subjective, enacted and uncontested permanence in care arrangements; and ensuring quality pre- and post-support for adoptive placements.

Keep in mind that intervention may need to target particular family issues (e.g. poverty, anger management, parenting skills, counseling for personal difficulties). Intervention may be required to address particular issues that can strengthen the likelihood of family reunification/preservation (rebuilding of positive relationships, quality contact experiences). A focus should also be on ensuring that children are having their permanency needs met via explicit case-planning.

The need to use language about permanency planning that is clear and understandable

How permanency planning is discussed and explained to relevant stakeholders (i.e. parents, carers, children) is an important practice consideration and skill. Some research has found that those directly involved did not have a clear understanding of permanency planning (Freundlich, Avery, Munson & Geustenzang 2006). Many were confused and had no idea of what permanency meant or alternatively understood it incorrectly. The term ‘permanency’ can be very confusing (Freundlich et al, 2006b). It can be a barrier to effective, collaborative work. Therefore it is important to:

- use simple, non-jargonistic language to explain permanency (Freundlich et al 2006b)
- permanency should be discussed encompassing its multifaceted nature: relational, physical and legal permanence (Freundlich et al 2006a)
- allow sufficient time to discuss the different dimensions and regularly check and double check understanding (Osmond & Tilbury, 2012 2010, in progress)
- obtain stakeholders’ views on permanency and find out what is particularly important to them. Research has found that different stakeholders may perceive different aspects of permanency as more important than others. For example, in Osmond and Tilbury’s (2012) research they found that for some parents maintaining a positive relationship with their child, and for their child to be well looked after (i.e. staying in their current placement) were the most important permanency issues to them (Osmond & Tilbury, 2012).

How permanency options are discussed with families can have a significant impact on permanency outcomes. For instance, two particular casework activities that are associated with concurrent planning is full disclosure of alternative plan if reunification fails and discussions of voluntary relinquishment – adoption. De’Andrade (2009) found that “such discussions dishearten parents and hinder reunification, regardless of the skill with which they are undertaken” (p. 453). It is also reported that discussion of voluntary relinquishment (for adoption) resulted in “an almost doubled likelihood of adoption. Supporting the idea that specifically articulating this option to parents facilitates the use of it” (De’Andrade, 2009, p. 455-456). Care should be taken that parents truly understand the consequences of such a decision. However, it is not clear from this research whether these results would occur when discussing other permanency options e.g. kin care, foster care.
Talking about permanency...

When talking about permanency with others it can be broken down into: long term stability, security, good, close relationships with others, sense of belonging, personal sense of identity, and a place called home.

Some possible statements and questions that can be considered (not to be used verbatim as they have not been empirically verified) are:

As you know children need a stable place to live and a secure, loving and close relationship with someone....

What are your hopes for your child in the long-term in relation to these needs?
What does stability mean to you in relation to your child?

Prompt: somewhere stable to live – a place that feels homely
Prompt: somewhere regular and stable to play, go to school, friends, clubs etc

What is the best way for your child to feel a sense of belonging and being loved?

What is the best way to involve you in planning for your child’s stability and security needs?

In planning for your child in both the short-term and long-term what do you consider he/she needs?

How do you think these needs can be best met?

Can we discuss why stability, quality relationships, continuity and a child’s sense of who they are - are important? (Adapted from Osmond & Tilbury, 2012; Freundlich et al, 2006 a & b)
The need to actively seek service users’ views and work in a collaborative and participatory manner

The importance of participation and collaborative practice with families and children is well established and is embedded in the department’s *Strengthening Families Protecting Children Framework for Practice*. Participatory practice is deemed important because: of the human and child rights implications; of the value of client self-determination; it can improve assessments; and it can lead to improved client outcomes (Healy & Darlington, 2009; Darlington, Healy & Feeney, 2010).

Participatory practice is complex and challenging work in a statutory context due to the social control aspects of the role (Healy & Darlington, 2009). However, a style of practice that engages and facilitates participation for families and children is essential to permanency planning. For example, it was reported earlier that a worker’s attitude and manner of engaging a family can impact on reunification likelihood. Further, as Altman (2008) adds “parents felt that dealing with workers who were empathetic, reliable, and supportive helped them to engage in services. They believe workers who have good knowledge of their situation and are on top of case details help them the most to engage in change efforts” (p. 50).

Factors identified from both child protection and other practice contexts, which can facilitate participation are:

- power recognition – managing the imbalance (Hernandez, Robson & Sampson, 2010)
- relationship building (Darlington et al, 2010, p. 1021)
- assisting parents to understand his/her child’s needs and connecting to relevant services (Darlington et al, 2010)
- practical needs – e.g. providing transport (Hernandez, Robson & Sampson, 2010)
- integrating participation into everyday practice (Hernandez, Robson & Sampson, 2010)
- gaining support for families who are involved with a statutory child protection service (e.g. via non-government service) ( Darlington et al, 2010)
- using a range of strategies (Tilbury et al, 2007)
- being sensitive to client needs (Hernandez, Robson & Sampson, 2010)
- being flexible (Hernandez, Robson & Sampson, 2010)
- having organisational support (Hernandez, Robson & Sampson, 2010)
- ensuring that clients feel valued and encouraged to be involved (Hernandez, Robson & Sampson, 2010)
• respecting all involved and seeking their views (Hernandez, Robson & Sampson, 2010)
• having an organisational culture where participation is positively promoted (Hernandez, Robson & Sampson, 2010)
• ensuring appropriateness of options (achievable and responsiveness to client needs e.g. age appropriate, culturally sensitive, working with strengths) (Healy & Darlington, 2009, p. 426-427)
• being transparent (being open about purpose and process) (Healy & Darlington, 2009, p.427)
• re-balancing contingency factors (barriers to participation) and
• adequately preparing all parties prior to meetings (Darlington et al, 2010).

Conclusion

Permanency planning does require substantial professional consideration and action. How practitioners go about permanency planning can make a fundamental difference to the lives of children and families. Professional staff should actively consider how to ensure stability, sense of belonging, attachment to significant others and continuity for children in their case-planning. Ensuring parties truly understand what permanency means, listening carefully to their views, aiming for participatory practice and having quality assessment and interventions can heighten the likelihood of positive permanency outcomes.

Considering the right to self-determination and the five elements of the Child Placement Principle are a critical part of permanency planning for Aboriginal and Torres Strait Islander Children. Additional attention should be paid to their need for connection to family, community, culture and country when determining permanency for a child.
References


Main M & Solomon J (1986). Discovery of a disorganized/disorientated attachment pattern, In Braxelton TB & Yogman, MW (eds), Affective Development in Infancy (pgs. 95-124), Ablex: Norwood NJ


Appendix 1

Return breakdown

Farmer (2009, p. 92-95) reviewed research on return breakdown and has identified the following factors associated with this issue:

- previous failed returns are strongly related to later return breakdown
- social and environmental factors such as poverty, housing difficulties, income support from public authorities and exposure to drugs are related to return breakdown
- older age at return, longer periods in care are related to return breakdown
- initial separation was the result of parental mental illness or alcohol or drug misuse are related to return breakdown
- limited parental skill is related to return breakdown
- neglect as the presenting problem is related to return breakdown
- lack of support from extended family, friends and community is related to return breakdown
- different factors are related to return breakdown for younger and older children.

Re-maltreatment predictors

Connell et al. (2009, p. 219-220) reviewed research on predictors of re-maltreatment and the following was identified:

- younger children (infants and preschoolers) are at the greatest risk of recurrent maltreatment
- mixed reports on ethnicity and re-maltreatment some report higher risk, others report the converse. Caucasian children have been identified as higher risk compared to African American children
- child mental health and physical disability linked with recurrent maltreatment
- children in single parent home compared to other family structures appear to be at greater risk of re-maltreatment
- neglect has been linked to risk of re-maltreatment compared to physical or sexual abuse
• repeated foster care episodes can increase the risk of re-maltreatment

• children in foster care for less than 2 months are more likely to have recurrent maltreatment

• placements with relatives are associated with lower risk of recurrent maltreatment.