Concurrent Planning: Benefits and Pitfalls

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Concurrent planning—working with families toward reunification while developing alternative permanency plans—was designed to fit an out-of-home care population much like that projected for the year 2000 and beyond: very young, chronically neglected children from multiproblem families. As large-scale programs begin to develop nationally, those implementing concurrent planning must be aware of the pitfalls that can undercut its effectiveness, while keeping in mind the benefits it can bring by reducing the trauma experienced by children in placement.

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Concurrent planning: To work towards family reunification while, at the same time, developing an alternative permanent plan. [Katz et al. 1994]

As the child welfare field prepares for the new millennium, it is timely to consider ways in which practice might be adapted to better serve children in placement in the future. Concern over the growing national foster care census and continuing dissatisfaction among social work professionals and government leaders with efforts to improve outcomes for children in care add further impetus to such efforts. Additional support is found in the Adoption and Safe Families Act of 1997 (ASFA) (P.L. 105–89), which reduces from 18 to 12 months the scheduling of the permanency hearing, defines parental conduct that obviates the need for reunification efforts, and cites concurrent planning as an appropriate practice. Concurrent planning, pioneered in Washington State in the early 1980s, was specifically designed for the population expected to be in out-of-home care after the year 2000: the very young child whose family’s chronic pathology (often drug/alcohol related) has left the child drifting in out-of-home care [Katz & Robinson 1991]. The concurrent planning model addresses this difficult-to-treat family constellation by combining vigorous family outreach, expedited timelines, and potentially permanent family foster care placements to improve the odds of timely permanency for young children.

Roots of the Model

Between 1959 and 1979, a number of clinicians and researchers published seminal works on the existence of foster care drift and suggested solutions. Heymann and her colleagues in Chicago produced two reports that led directly to the present model, suggesting that an agency’s focus on permanency from intake and a diagnostic use of parental visiting patterns could greatly reduce drift and facilitate earlier permanency [Epstein & Heymann 1967;
Chestang & Heymann 1973]. This clinical perspective fit well with the overwhelming statistical evidence showing the scope of foster care drift between 1950 and 1980, the extraordinary length of time needed to effect an adoption for a child in out-of-home care, the diminishing options for those children still in care after one year, the particularly slow process of case resolution for infants entering care, and the efficacy of court review in speeding case movement [Maas & Engler 1959; Festinger 1976; Fanshel 1978, 1979].

During this fertile period in child welfare’s evolution, attachment theorists entered into the out-of-home care field, spotlighting the psychic damage caused by repeated placements, which were endemic to the system [Littner 1972; Bowlby 1979]. Their theories caused a tidal wave of controversy when presented as a basis for redesigning the way courts handle children’s cases (e.g., the proposal that case movement be determined by “the child’s sense of time,” rather than adult and organizational considerations [Goldstein et al. 1973]).

In a related development, placement agencies began to report on their efforts to create a hybrid program, called foster/adoption, that would benefit children in care who were unlikely to return home [Gill 1975; Gill & Amadio 1983; Mica & Vosler 1990]. Although many positive outcomes were described, the concept had its critics, who were concerned with possible inherent ethical dilemmas [Lee & Hull 1983]. Nevertheless, the child welfare field continued to move in this direction of experimentation, in hopes of forging a case management method that would specifically speed planning for young children placed out of dire circumstances, and that would reduce moves and trauma.

The concurrent planning model of the 1990s is built on a foundation of 30 years of data on out-of-home care length of stay. It is informed by a large body of clinical insights on childhood attachment, and implemented through programmatic innovations tailored to meet the needs of children.
The Population

What will the out-of-home care population in the United States look like in the years beyond 2000? Using existing information, it is possible to construct a picture of the children child welfare will be serving and for whom policies and programs will need to be designed.

The number of children in out-of-home care has increased every year between 1983 and 1994, due to the failure of discharges to keep pace with admissions [Wulczyn et al. 1997]. Furthermore, there has been a “striking increase in the percentage of infants entering care... balanced by a noticeable decrease in the percentage of children entering care as adolescents” [Wulczyn et al. 1997: 16]. Wulczyn and colleagues also note that children who enter foster care under the age of one year have the longest length of stay of all age groups, and are disproportionately represented in the approximately 30% of children in care more than 30 months. This has come as a surprise to the child welfare field, which is accustomed to regarding infants in out-of-home care as less problematic than older, more disturbed children. “One way to quickly summarize this finding is that the foster care population can be conceptualized as two or more distinct subpopulations. One subgroup fits the permanency planning model and moves through the system fairly rapidly, with most exits resulting in reunifications. At the same time, other subgroups do not fit that model, and apparently stay in the system a long time” [Wulczyn et al. 1997: 64]. This latter subgroup comprises those who enter care under one year of age; its members tend to be disproportionately African American, American Indian, or Latino, and to come from families trapped in chronic poverty, substance abuse, and violence.

The out-of-home care population is made up predominately of children whose families live below the poverty line [Berrick et al. 1998]. Although physical and sexual abuse have been docu-
mented at high rates in poor families, the statistically clearest and strongest relationship is that between child neglect and poverty [Petit & Curtis 1997]. These authors show an increase in child poverty from 14% in 1969 to 21% in 1995, with the result that for American children under the age of 6, the present poverty rate is one in four [Petit & Curtis 1997: 195]. As poverty rates continue to rise, the child welfare field will need to prepare for an increase in child neglect.

To predict the future of out-of-home care, it is necessary to add to these data what is known about this country's present public policy. For example, what conclusions can be drawn from the decline in poverty among the elderly in our country (from 27% in 1966 to 12% in 1994), the same period of time that saw a dramatic acceleration in child poverty [Petit & Curtis 1997]? Clearly, national policy decisions about income distribution have proven to be detrimental to children. The movement away from public housing supports for poor families, the increase in food stamp and school lunch restrictions, the changes wrought by welfare reform, and the tightening of disability definitions under SSI contribute to this trend [Freundlich 1997; Lindsey 1997]. If there is no shift in the national policy climate, and if the connection between poverty and child neglect is accepted, then it seems reasonable to expect the child poverty rate to continue to grow, and with it, child neglect and maltreatment leading to out-of-home care. As ASFA indicates, concurrent planning will be needed to produce better outcomes for such a population.

A Lesson

Given the population in out-of-home care and its congruence with the concurrent planning model (designed for young children from chronically distressed families), there is a danger of expecting more than can reasonably be delivered. As with any paradigm addressing a complex social problem, overgeneralizations about
what concurrent planning can do in treating society’s symptoms should be avoided. Too often, promising new methods have been oversold, inaccurately predicting significant cost savings and reductions in placement rates. A useful history lesson results when one considers the fanfare that introduced intensive family preservation services (another innovation initiated in Washington State). The Homebuilders model, when reproduced on a large scale in states such as Michigan, Illinois, and California, was not able to show placement prevention at anything like the rate projected [Warsh et al. 1995; Wells & Tracy 1996]. Placements were, however, postponed, shortened, and made less restrictive (and thus less expensive). Evaluators, clinicians, and politicians sought to explain the “lack of success” of family preservation services. It was said the wrong families had been referred, the intensive services watered down, the clinicians poorly trained, the service not sufficiently standardized, or the wrong outcomes measured [Rossi et al. 1996].

In fact, family preservation is a necessary and useful element along the continuum of child welfare services. Programs are being developed all over the country that help prevent placement for certain families and reduce the extent of placement for others. These programs help fulfill the 1980 reasonable efforts mandate of P.L. 96-272, requiring the provision of preventive services before out-of-home placement whenever possible. In the haste to claim more than could actually be accomplished, disappointment was created where none was warranted.

Similarly, concurrent planning will not produce miracles. What it can legitimately claim to do is give case planning a clearer sense of direction and measurable goals. It has the potential to reduce the number of temporary placements children go through, to shorten the length of time in care overall by clarifying and respecting timelines, and to increase the candor and respect given to biological families and relatives by drawing them into case planning early. It can help keep out-of-home care temporary, as it was intended to be.
Evaluation Efforts

Attempts to build an evaluation component into concurrent planning programs are in an embryonic stage and existing outcome reports are scarce. Early published results showed the success of the original program (1981) at Lutheran Social Services (LSS) of Washington and Idaho at eliminating foster care drift for high-risk young children [Katz 1990]. At the time of that article’s publication, the agency was showing an average length of care from intake to permanency resolution of 13.1 months, with 82% of the children having only one placement. All the children were placed in permanency planning family foster homes, and foster parent adoption was by far the most frequent outcome. By 1998, the program results had evolved somewhat: The length of care was even shorter, the rate of return home higher, and the placement disruption rate had declined [Spoonemore 1977].

A second published evaluation report describes the efforts of New York City’s Children’s Aid Society (CAS), which replicated the LSS model [Children’s Aid Society 1993]. The children served were similar to those in the LSS program in age and family circumstances but unlike the LSS population, predominately African American and Latino. CAS’s success in timely case resolution was notable: within 12 months, 25% of children returned home, 32% were adopted by foster parents, and 42% were placed with relatives.

Since both LSS and CAS are private nonprofit agencies with controlled caseloads, and both of their programs involved small numbers of children, the question of transferability to the public agency setting is critical. Recently, the public sector has begun to take on concurrent planning experimentation as well.

Three state agency concurrent planning efforts have produced unpublished preliminary reports. A one-year public agency project, modeled on Lutheran Social Services, operated in central Seattle from September 1988 through September 1989 [Robinson 1989], which coincided with the peak of Seattle’s crack cocaine...
epidemic. Criteria for inclusion in the project mirrored those of
the LSS program; the population served, however, was more
heavily African American. The project began with the transfer-
ring in of 65 children with open cases. Within one year, 55 of those
cases were completed (50 children had parental rights terminated
for foster parent adoption or guardianship, four children returned
home, and one child’s placement converted to guardianship with-
out a termination). At that point, funding for the project ended.

Sedgwick County, Kansas (Wichita), began a pilot “dual case
planning” project in January 1996, using a privatized model with
three nonprofit agencies contracting with the public agency to
provide family support, permanency planning, and adoption ser-
VICES [Schmidt-Tieszen 1996]. The goal was reduced length of care
and fewer placements, building conceptually on the LSS model.
Cases chosen for the pilot generally met the LSS criteria. The only
available report to date, produced eight months into the project,
noted a slower than hoped for rate of placement of children due
to a lack of sufficient permanency planning foster homes to re-
ceive them at the project’s inception. Although nothing can yet
be said about final resolution of the cases, no child has experi-
enced more than one placement.

Combining new state-expedited permanency legislation with
the concurrent planning method, Colorado is tracking its success
county-by-county as it widens the scope of its implementation
[Schene 1997]. Its first report compares two counties 18 months
into the project, duplicating the LSS-recommended age of the
children and their family circumstances and adding the research
enhancement of control groups in each county. Early data show
a high rate of achievement of early permanency in the experi-
mental groups, a surprisingly high rate of family reunification,
and a very low placement disruption rate.

Two sites beginning sizable three-year projects in 1998 have
formal evaluation components. The Manchester (England) Adop-
tion Society has begun a permanency partnership with several
local authorities (public agency branches) built on the LSS model. At the same time, the Administrative Office of the Court in Frankfort, Kentucky, is implementing a concurrent planning project in three counties across the state through a federal Adoption Opportunities grant, also drawing on the LSS approach.

As programs are established, it will be important to provide for data collection on length of care, number of placement moves, percent of children returned home, and percent of adoption plans made voluntarily by biological parents, as well as the effects of ethnicity and geographic diversity on outcomes. Beyond immediate outcome data, follow-up studies on disruption rates in later years will be essential.

### Implementing the Concurrent Planning Model

#### Components of the Model

While concurrent planning is a simple concept, its successful practice requires casework sophistication and attention to detail. It should be viewed as a discipline that takes into account every placed child’s long-term prospects from the first day of placement [Ichikawa 1997]. To achieve the desired goals, all of the following must be reflected in practice.

**Differential Diagnosis.** Within the first 90 days of placement, the agency completes a standardized assessment of the family’s likelihood of being reunited within the next two months, based on the family’s history, relationship with the child, and demonstrated progress to date. Families with a poor prognosis are given a concurrent plan.

**Full Disclosure.** All families are given information about the detrimental effects of out-of-home care on children, the urgency of reunification, and the agency’s concurrent plan to safeguard the child from drifting in care. The family’s options are thoroughly
and repeatedly reviewed with them, including the use of extended family resources and the option of voluntary relinquishment for adoption.

**Timelines.** The entire case plan is structured by the legal requirements for timely permanency. These timelines are explained to families as part of the “full disclosure.”

**Visiting.** Vigorous efforts are made to institute frequent parental visiting, *even with ambivalent or unresponsive parents.* The agency’s zeal in promoting visiting will result in either faster reunification or early decisionmaking in favor of an alternative permanent plan.

**Plan A/Plan B.** In every poor prognosis case, children are placed with a family willing and able to work cooperatively with the biological parents but also prepared to become the children’s permanent family if needed. This could be a relative or a foster family. Such a placement is acknowledged openly to the parents and supported by the agency and the court.

**Written Agreements.** Parents are helped by workers to reduce the overall case plan to small steps, written down with or by them, on a weekly or monthly basis. This facilitates observable compliance and improvement, and provides documentation for the court of unsatisfactory progress if it should be needed.

**Behavior (Not Promises).** The agency and the court proceed based only on the progress (or lack of progress) documented by observations, service provider reports, and expert testimony.

**Forensic Social Work.** The agency provides its staff with ongoing legal training, consultation, and support, so that its social workers produce legally sound case plans, concise court reports, and competent testimony.

**Success Redefined.** The agency and the court define their primary goal as *timely permanency,* with family reunification as the first, but not only, option.
Common Initial Concerns

Agencies now beginning to integrate concurrent planning into their foster care programs often express at least three initial concerns: potential judicial disapproval, doubts that the appropriate children can be identified early, and fears that foster family recruitment will be unsuccessful. Based on the experiences of Washington State, these concerns should not be deterrents.

Judges' Views. While agencies certainly must develop their programs in collaboration with the courts, and educate their judges, judicial resistance has not been a major obstacle to concurrent planning. In fact, judges have been advocates for concurrent planning, even as they continue to hold agencies to a high standard for reasonable efforts.

Selection of Appropriate Children. Experienced workers and supervisors, using the "Strengths in Families" and "Poor Prognosis" assessment tools [Katz et al. 1994], have little difficulty identifying children unlikely to return home in the near future. Furthermore, these tools provide a uniform standard, substantiated in practice, for addressing legal concerns over the equitable application of prognostic assessments.

Recruitment of Foster Parents and Relatives to Take the Role of "Plan B." Recruitment of any kind of foster parents is a challenge, but not more so in concurrent planning. Agencies must prepare to educate the public on the concept and to offer enhanced training and support to caregivers. The foster parents' role is difficult, often painful, but families do come forward.

Pitfalls in Implementation

Experience in implementing concurrent planning has revealed a number of pitfalls to be avoided if programs are to be legally sound, honest, fair to all participants, and supported by effectively trained workers, relatives, and foster parents—the source of this model's success thus far. As programs move into large-
scale implementation across the country, avoidance of these mistakes will be critical to their success.

**Equating Concurrent Planning with Adoption and Minimizing Reunification Efforts.** Child welfare’s responsibility to provide services to parents must be fulfilled in good faith or we violate both ethical and legal standards. Concurrent planning is not mere window dressing for expedited adoption. If it becomes that, it will have sacrificed all integrity.

**Failing to Accommodate Cultural Differences.** In designing case plans, assessing attachment, and making service referrals, cultural differences must be acknowledged, not ignored. Failing to do so can set up minority families to lose their children. This fear has strong historical roots. Cultural competence is as necessary in concurrent planning as in any other instance of state intervention in families’ lives.

**Using Assessment Tools to Assess Child Safety, Rather Than the Potential for Foster Care Drift.** Risk assessment models that measure the likelihood of physical harm or neglect are in wide use nationally to answer the specific question: Is placement necessary? [Fluke 1994]. Concurrent planning begins with placement, not with a determination as to whether placement will be necessary. Following placement, the early assessment phase clarifies a child’s likelihood of leaving care quickly. The worksheets, “Strengths in Families” and “Poor Prognosis Indicators,” do not assess child safety [Katz et al. 1994].

**Assuming That Assessment Tools Will Infallibly Predict Case Outcomes.** When a hypothesis is constructed that a particular child is at high risk for drifting in out-of-home care, it is a generalization of past experience over many cases; ultimately, however, it will be supported or proved wrong by the child’s parents. Either way, through placement in a potentially permanent home, the child has stability while in care.
Investing in One Particular Outcome, Either Reunification or Not, Rather Than Allowing the Result to Evolve from the Family’s Decisions and Actions. Cases sometimes stall because of a worker’s (or a judge’s) continuing wish for an outcome that seems remote. When early permanency is defined as the appropriate goal, the focus is kept on the child’s situation.

Defining Staff as Primarily Enforcers, Rather Than Social Workers with Case Management Responsibilities. Goal-oriented case management is essential, but engaging parents in the process of decisionmaking for their family requires sound casework skills.

Designing Case Plans That Are Not Family Centered (i.e., the agency takes on responsibility the family should have). Parents have both rights and responsibilities. Concurrent planning supports their active role in visiting, engaging in services, and planning for their child’s future.

Interpreting 12 Months as an Absolute Limit on Reunification, Regardless of Parental Progress. There is a fine line between the judicious use of time limits to prevent foster care drift, and a rote enforcement that ignores the full picture of parental motivation, effort, incremental progress, and a foreseeable reunification.

Alienating Community Treatment Providers by Not Collaborating with Them in Early Program Planning. Mental health and substance abuse treatment services have a different clientele than do child welfare services. Conflict over goals and timelines can arise unless all work to find common ground through joint staffings, multidisciplinary collaboration, family group conferencing, etc.

Expecting Workers to Implement Concurrent Plans without Solid Legal Training and Ongoing Consultation. Efficacy in the legal arena is critical. Workers must be provided with the necessary knowledge and legal personnel to mold their case plans into workable legal plans.
Offering Foster Parents and Relatives an Estimate of “Legal Risk.” When asking a family to promise stability to a baby or toddler, without knowing if that child will eventually return home, it must be made clear that the level of “risk” being taken is not quantifiable. There is no guarantee, except that the child will have the least detrimental experience in care possible.

Failing to Train and Support Relatives and Foster Parents. Caregivers taking on concurrent planning need specialized training to help them support the child’s biological parents. Within the tenets of state confidentiality laws and policy, caregivers should be informed of the case plan. If the caregivers are not related to the child, they need to meet and get acquainted with the child’s biological family. In all cases, they must support the treatment plan while the agency works toward reunification over a planned, limited period of time. Keeping the time period controlled makes this possible for caregivers. If the caregivers work against the parents, it is the agency’s responsibility to intervene.

Benefits of Implementation

Clearly, the concurrent planning model is built upon an expectation of high-functioning foster families, social workers, and supervisors. To this end, training and workload levels must be congruent with these expectations. Application of the full model of concurrent planning as it was intended has the potential to yield a number of benefits for children and families [Katz 1990].

- The average number of placements per child will come down.
- The average length of stay in out-of-home care will come down.
- There will be more voluntary relinquishments, specifically for foster parent adoption and open adoption.
- Foster parents will keep in touch with a child returned to his or her biological parents, providing continuity of relationships.
• Biological parents who have previously relinquished a child will return with a later child, often seeking placement of the siblings together.

Converging Themes

As work in family foster care continues to evolve after the year 2000, common threads can be seen among the many programmatic innovations, including concurrent planning. For example, consider the assumptions underlying family-centered practice, family preservation services, family group conferencing, concurrent planning, and open adoption. All are strength-based and look for ways to support parents’ abilities to solve problems and make decisions. All seek to diminish agency formality by providing services in the family’s home, scheduling visits in the evenings and on weekends, and involving large groups of relatives in case planning. Confidentiality is deemphasized so that everyone involved in the child’s life can contribute information and solutions. In addition, there is a growing comfort with close, personal communication between biological parents, relatives, and caregivers, and a willingness to assume the best about families meeting this challenge for the sake of the child’s well-being. In these ways, knowledge about the nature of children’s attachments and the importance of continuity in their lives is being operationalized in program design [Katz 1996].

A well-run concurrent planning program can minimize the enduring psychological harm caused to children by multiple placements and years in the limbo of out-of-home care. Although such efforts may not be a “miracle,” they are an improvement that is sorely needed and worth our best efforts.

References


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