



Child Law Practice

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Helping Lawyers Help Kids

BABY BRIEFS

Visitation with Infants and Toddlers in Foster Care: What Judges and Attorneys Need to Know*

by Margaret Smariga

Introduction

One-third of children entering foster care are zero to three years of age, and 15 percent are babies under age one. Children are removed from their parents and placed in out-of-home care because a court has found it unsafe for them to live at home. However, children who are removed from home, particularly those who are very young, are exposed to a new danger—the emotional and developmental harm that can result from separation.

Children at different stages in life react differently to separation from a parent, based primarily on their ability to understand the reasons for separation and the range and maturity of their coping strategies. The younger the child and the longer the period of uncertainty and separation from the primary caregiver, the greater the risk of harm to the child. Therefore, frequent, meaningful parent-child visits are critical for infants and toddlers in foster care.

Visitation is planned, face-to-face contact between a child in out-of-home care and his/her parents and siblings. This article:

- explains why visitation is important for very young children,

- emphasizes the role of visitation in permanency planning,
- highlights key elements of successful visitation plans for infants and toddlers,
- suggests strategies for addressing barriers to visitation,
- reviews the judge’s role in supporting parent-child visits, and
- shares promising community approaches to visitation.

Understanding Attachment and Separation

The first few years of life are a time of unparalleled growth. A child’s experiences and relationships during these critical years build the foundation for future social, emotional, and cognitive development. Infants and toddlers are completely dependent on the adults in their lives, and the care that they receive and the attachments that they form “are critical building blocks for future development and adult well-being.”

During the first few months of life, babies begin to show a marked preference for one or two primary caregivers. By about four months, babies communicate this preference

through their behaviors (e.g., following with the eyes, smiling, quieting more easily) in the presence of the familiar caregiver. As babies get older (age 7 to 14 months), the attachment intensifies, and they often cry or protest when separated from the primary attachment figure. In addition, they may initially protest or avoid their caregiver when reunited. By age three, children begin to generalize attachment (that is, they can feel secure with other attachment figures such as relatives). Attachment behaviors are still present in older children but are less urgent than those shown by infants.

Attachment theory provides a framework within which to understand the effects of separation on very young children and the importance of

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*This article is based on a policy brief prepared by the ABA’s Improving the Understanding of Maternal and Child Health Project. Citations have been omitted. To view the full brief with citations, visit www.abanet.org/child/baby-health.shtml

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CASE LAW UPDATE

Domestic Violence History is Always Relevant in Custody and Visitation Decisions

Wilkins v. Ferguson, Nos. 05-FM-1555 & 05-FM-1556 (D.C. Ct. App.)

A couple divorced and joint legal custody of their daughter was awarded to both parents. Primary physical custody of their daughter went to the mother, with visitation rights to the father. The court cited evidence showing the mother had suffered domestic violence by the father throughout the marriage that had taken a considerable toll.

A few months later, the trial court issued a temporary protection order in response to a motion by the mother. It also suspended the father's visits with his daughter after the court made findings to confirm statements by the daughter that he touched her inappropriately during visits.

Supervised visits were later permitted for several months based on a recommendation from the child's therapist. These were followed by unsupervised visits for a short time before the mother obtained another temporary protection order, which again temporarily suspended visits.

The mother then sought to modify the visitation order to suspend the father's visitation until he completed therapy, including treatment for child sexual offenders. She also requested that any later visits be supervised to protect the child.

The trial court found insufficient evidence that the father had sexually abused the child since the most recent visitation order was issued, but that the child's continued claims of sexual abuse by the father constituted a substantial change in circumstances. Although four mental health professionals had recommended that visitation be supervised, the court concluded that it would be in the child's best interests to limit visits with her father to unsupervised day visits every other weekend.

On appeal, the mother claimed that

in visitation modification proceedings in which a party has committed domestic violence, District of Columbia statute requires the offending party to prove visitation will not harm the child's physical or emotional development. She claimed the trial court's holding that there was insufficient evidence of sexual abuse placed the risk of error on the child, rather than on the offender. She also claimed the trial court misapplied the best interests analysis under the modification statute by failing to consider several factors, including the mental and physical health of those involved and evidence of domestic violence.

The District of Columbia Court of Appeals reversed, finding the record did not support the trial court's factual findings, and that the trial court should have ensured the child's safety before awarding visitation, as required by statute. The court emphasized that the District of Columbia legislature clearly intended that evidence of domestic violence be considered in all custody/visitation proceedings. This intent was reflected in the statutory requirement that courts make written findings that awarding visitation to a person who has committed domestic violence is in the child's best interest. The legislature also placed no restrictions on how long a domestic violence offense could be considered in custody and visitation decisions.

The court explained that the person seeking to modify a custody or visitation award must always prove a substantial and material change in circumstances has occurred and that the modification is in the child's best interests. In cases involving domestic violence, once the changed circumstances/best interests findings are made, the burden then shifts to the

perpetrator to prove visitation/custody will not harm the child. Therefore, a domestic violence history is always a relevant in every custody/visitation proceeding in which the perpetrator is involved.

In addition to the trial court's

Hospital's Response the Child's Abuse Questioned *Becker v. Mayo Foundation*, 737 N.W.2d 200 (Minn. 2007).

The adoptive parents of a child who suffered lifelong injuries as an infant as a result of physical abuse by her biological father sued the treating hospital for negligence. The adoptive parents claimed the hospital failed to prevent the child's ongoing abuse because it did not assess and document the child's injuries, recognize and treat signs of head trauma, and comply with mandatory reporting requirements.

The district court struck the allegations relating to mandatory reporting requirements and excluded all reporting-related evidence, concluding that the Minnesota child abuse reporting act does not create a civil cause of action for failure to report suspected child abuse. Based on a jury verdict, the district court entered judgment for the hospital, finding its negligence did not directly cause the child's injuries. The court of appeals affirmed.

The Supreme Court of Minnesota granted review and affirmed in part and reversed in part. The court first considered whether Minnesota's child abuse reporting act creates a cause of action for failure to report suspected child abuse. While the reporting act mandates hospital staff to report suspected child abuse and neglect, it did not impose civil penalties for failing to report. The court found the legislature clearly imposed criminal but not civil penalties for mandatory reporters who fail to report.

The adoptive parents countered that health care providers must be encouraged to report suspected abuse

failure to require the father to prove that resuming visits would not harm the child, the evidence did not support granting unsupervised visits. No experts testified that unsupervised visits were appropriate and, in fact, all expressed concerns that unsupervised

and the threat of civil liability supports that goal. They claimed criminal penalties alone do little to promote reporting since mandatory reporters are rarely prosecuted. Citing a Minnesota statute that grants civil and criminal immunity to good faith reporters of child abuse, the adoptive parents claimed this showed the legislature's intent to impose civil liability for failure to report abuse. The supreme court disagreed, finding the reporting statute did not expressly create civil liability and no precedent supported the claim that civil liability should be imposed when criminal sanctions are not adequately being enforced.

The adoptive parents also claimed the hospital had a special relationship with the child that gave rise to a duty to protect her from her parents. The hospital argued it had no special relationship because the child was injured at home, not at the hospital. Generally, a person does not owe a duty to protect a person from harm caused by a third party. An exception exists when the harm is foreseeable and a special relationship exists between the actor and the person seeking protection.

Assessing whether a special relationship exists under this exception involves considering the vulnerability and dependency of the person requiring protection, the power exerted by the defendant, and the degree to which the defendant has deprived the individual of ordinary means of protection. While the child in this case was vulnerable, the hospital lacked absolute control over her and had no control over the biological father's abusive actions, which occurred outside the hospital. In

visits would harm the child's emotional development. Finally, the court's best interests analysis overlooked required factors, including the mental and physical health of those involved and evidence of domestic violence.

addition, the hospital did not deprive the child of ordinary means of protection since she never had such means. Therefore, a special relationship giving rise to a duty to protect did not exist.

The adoptive parents finally claimed that the hospital departed from accepted standards of medical practice by failing to report the child's injuries to authorities. Because the trial court excluded all reporting-related evidence, the adoptive parents were blocked from presenting evidence showing the hospital's failure to conform to accepted standards of medical practice. The supreme court found this exclusion was improper and that the adoptive parents' allegation that the hospital was negligent for failing to recognize and treat signs of head trauma supported introducing this evidence.

Further, the court found the jury's verdict likely would have differed if the evidence had been admitted. The court found that the adoptive parents had made a sufficient offer of proof that notifying authorities earlier would have prevented the child's abuse. Specifically, they had offered testimony by two physicians and statements from medical journals establishing that the hospital failed to meet minimum standards of care in responding to the child's abuse and reporting it to appropriate authorities.

The court therefore reversed and requested a new trial to consider this evidence in evaluating the adoptive parents' claim that the hospital failed to follow accepted standards of care.

Alabama

A.J.H.T. v. K.O.H., 2007 WL 2142350 (Ala. Ct. App.). TERMINATION OF PARENTAL RIGHTS, IN CAMERA EXAM

Although trial court conducted in camera interview with children without recording it, decision to terminate mother's parental rights should not have been reversed; all parties agreed to the interview and understood that it would not be recorded.

Alaska

Alyssa B. v. State, 2007 WL 2333330 (Alaska). TERMINATION OF PARENTAL RIGHTS, DUE PROCESS

Conducting termination of parental rights hearing without mother present did not violate her procedural due process rights since court had attempted to notify mother many times, mother had caused trial delay with her numerous filings in case, and delaying termination trial again would have harmed child; mother chose to waive her right to appointed counsel, to take vacation during scheduled trial, and to refuse to participate by phone at hearing.

J.J. v. Lee County Dep't of Human Res., 2007 WL 2332972 (Alaska Ct. App.). TERMINATION OF PARENTAL RIGHTS, MENTAL ILLNESS

Trial court correctly terminated mother's parental rights based on evidence that her chronic schizophrenia rendered her unable to adequately care for her child; no treatment could control her condition and rehabilitation was impossible.

Josephine B. v. State, 2007 WL 2405209 (Alaska). DEPENDENCY, MENTAL INJURY

Trial court correctly adjudicated children dependent based on evidence of mental injury; children had chronic fear at home, and were routinely threatened, verbally assaulted, bullied, and physically abused.

Arkansas

Burt v. Arkansas Dep't of Health and Human Servs., 2007 WL 2481949 (Ark. Ct. App.). ADOPTION, INTERVENTION

Grandparents did not have right to intervene in adoption case where mother's rights had been terminated; any rights they had to intervene were extinguished with the termination.

California

In re Corrine W., 2007 WL 2380078 (Cal. Ct. App.). DEPENDENCY, INSURANCE

Trial court correctly denied motion to compel agency to pay for car liability insurance for child in foster care; state and federal law requiring agency to pay for "liability insurance" for dependent youth does not include car liability insurance.

In re Y.R., 60 Cal. Rptr. 3d 820 (Ct. App. 2007). TERMINATION OF PARENTAL RIGHTS, ADOPTABILITY

Evidence showed children were adoptable to support termination of their parents' rights; daughter's behavior problems, which generally occurred when father and mother were involved in her life, subsided while in her second foster home and she showed improvement in school and adoptive parents were committed to adopting both daughter and son, which addressed mother's concern that son would not be adopted because he was part of a sibling group.

District of Columbia

In re L.H., 925 A.2d 579 (D.C. 2007). DEPENDENCY, EVIDENCE

Evidence was insufficient to support dependency adjudication; mother slapped child's face and threw her to the ground, but there was no evidence that child suffered more than temporary marks.

Florida

In re A.W., 2007 WL 2069470 (Fla. Dist. Ct. App.). TERMINATION OF PARENTAL RIGHTS, CRIMINAL CONDUCT

Father's parental rights could not be terminated based on ground that he engaged in conduct that showed continuing parent-child relationship would threaten child's life, safety, well-being, or health; although father had murdered child's mother during child's first year of life, there was no nexus between his crime and harm to child and evidence showed child suffered no effects from being in the house at the time of the murder.

In re J.H., 2007 WL 1452172 (Fla. Dist. Ct. App.). DEPENDENCY, MALNUTRITION

Evidence did not support trial court's finding that parents neglected their daughter by depriving her of proper medical care and nutrition; doctor's and parents' testimony established that child received regular medical care while in parent's custody, and evidence that child gained more weight in her parents' care than in foster care refuted finding that parents failed to provide proper nutrition.

L.P. v. Dep't of Children and Family Servs., 2007 WL 2188630 (Fla. Dist. Ct. App.). DEPENDENCY, SUBSTANCE ABUSE

Evidence of mother's cocaine use during her third trimester was not sufficient to adjudicate child dependent; state statute requires evidence of a connection between drug use and harm to the child.

Illinois

In re P.C.M. and J.L.C., 2007 WL 2264614 (Ill. App. Ct.). TERMINATION OF PARENTAL RIGHTS, FITNESS

Trial court's determination of father's unfitness was improper where based solely on his denial of sexual abuse of his child; trial court found father failed to participate in meaningful counseling to address his sex offender issues because he had refused to admit that he sexually molested his daughter and therefore was unable to move to the final stage of counseling.

Indiana

In re D.A., 869 N.E.2d 501 (Ind. Ct. App. 2007). TERMINATION OF PARENTAL RIGHTS, DUE PROCESS

Trial court violated father's due process rights by terminating his parental rights at hearing where he was not present and was not represented by counsel; trial court granted father's counsel the right to withdraw, but had not given notice to father and had not appointed another attorney.

In re M.W., 869 N.E.2d 1267 (Ind. Ct. App. 2007). DEPENDENCY, FINDINGS

Evidence of mother's alcohol abuse and physical abuse of children was unsupported and was therefore insufficient to substantiate allegations that children's physical or mental condition was impaired or endangered to support dependency petition; child welfare agency presented no evidence of mother's physical abuse or alcohol use and not witnesses testified to either issue.

Kentucky

T.N.H. v. J.L.H., 2007 WL 2460645 (Ky. Ct. App.). TERMINATION OF PARENTAL RIGHTS, ATTORNEY'S FEES

Trial court erred where it ordered agency to pay mother's private attorney's fees for her termination proceedings because she was also a ward of the state; court's holding that she was in custody of state and therefore not indigent, and thus that

the agency was required to pay a private attorney to represent her, was an abuse of discretion.

Massachusetts

In re Amalie, 2007 WL 2380155 (Mass. App. Ct.). TERMINATION OF PARENTAL RIGHTS, POSTADOPTION CONTACT
Trial court properly gave preadoptive parents discretion to permit postadoption contact between child and biological mother since evidence showed child had formed secure attachment with preadoptive parents and did need visits with mother to transition to new family; judge generally exercises power to require postadoption contact only “where no preadoptive family has yet been identified, and where a principal, if not the only, parent-child relationship in the child’s life remains with the biological parent.”

Missouri

In re B.T., 2007 WL 655478 (Mo. Ct. App.). TERMINATION OF PARENTAL RIGHTS, BEST INTERESTS
Terminating mother’s parental rights was in child’s best interests since mother refused custody of child upon his release from behavioral facility, barely visited child or financially supported him for more than one year before termination judgment, and showed inability to care for child despite many social services.

In re F.C., 211 S.W.3d 680 (Mo. Ct. App. 2007). TERMINATION OF PARENTAL RIGHTS, CORPORAL PUNISHMENT
Termination of parental rights was in children’s best interests where evidence showed father used military discipline practices that caused children to fear him and affected their behavior after visits, mother permitted father to use discipline even though she was told not to during unsupervised home visits, and children showed marked improvement during 11 months during which they had no contact with parents.

In re W.J.S.M., 2007 WL 1975913 (Mo. Ct. App.). TERMINATION OF PARENTAL RIGHTS, PRESENCE AT TRIAL
Trial court properly denied mother’s attorney’s request to have mother attend termination of parental rights hearing in person or by alternate means so she could testify on her own behalf since evidence showed mother’s mental condition would prevent her from participating or assisting

counsel at trial; when a client is disabled or incapacitated, appointed counsel represents the client’s interests and there is no legal requirement that parent be physically present at termination of parental rights proceeding.

Montana

In re K.J.B., 2007 WL 2482255 (Mont.). TERMINATION OF PARENTAL RIGHTS, PRIOR TERMINATION
In parental rights revocation proceeding, trial court properly found that circumstances surrounding prior termination of parental rights to child’s siblings were relevant to its determination of parent’s ability to care for child at issue in revocation proceeding; conclusions of law supporting revocation order cited extensive witness testimony.

New Hampshire

In re N.H., 2007 WL 2332347 (N.H.). TERMINATION OF PARENTAL RIGHTS, DUE PROCESS
Father’s claim that his due process rights had been violated in his termination of parental rights proceedings were invalid; although he had not been involved with factors contributing to his children entering care, there was sufficient evidence to support terminating his parental rights.

New York

In re Angelique L., 2007 WL 2190570 (N.Y. App. Div.). DEPENDENCY, DOMESTIC VIOLENCE
Neglect finding was supported by evidence showing children were subject to actual or imminent danger of injury or impairment of their emotional and mental condition through exposure to domestic violence in mother’s home; mother failed to protect children from harmful effects of domestic violence, minimized its effects on children, and did not ask abusive companion to leave the home.

In re Ian H., 840 N.Y.S.2d 202 (App. Div. 2007). DEPENDENCY, HEARSAY
In neglect proceeding brought against father alleging he sexually abused his twin sons in wife’s home-based day care center, children’s prior out-of-court statements, including videotape interview by seven year old who claimed sons’ father sexually abused her when she was four, were admissible as evidence; children’s statements were corroborated in record, were

reliable, and were spontaneously made.

In re Natasha RR., 839 N.Y.S.2d 623 (App. Div. 2007). DEPENDENCY, INTELLECTUAL LIMITATIONS
Parents’ intellectual limitations did not prevent them from regaining custody of child who had been placed in foster care; a parent who requires ongoing assistance and social supports to care for child is not prevented from doing so, although several issues must first be addressed, including extent of services needed, parent’s ability to recognize need for services, and parent’s cooperation with services.

North Dakota

In re B.B., 735 N.W.2d 855 (N.D. 2007). DEPENDENCY, HEARSAY
Social worker’s child protection service report was not admissible in neglect proceeding under business records exception to hearsay rule because it contained statements of third parties who were not acting in regular course of business and social worker lacked first-hand knowledge of events described by third parties’ testimony; admission of hearsay was harmless, however.

Utah

In re B.W.G., 2007 WL 2324956 (Utah Ct. App.). ADOPTION, RIGHT TO COUNSEL
District court had jurisdiction to terminate mother’s parental rights in proceeding brought by child’s aunt and uncle under the Adoption Act seeking to adopt child and terminate mother’s parental rights and district court had no obligation to inform mother of her statutory right to counsel; when termination of parental rights arises in context of adoption proceeding filed under the Adoption Act, district court may exercise jurisdiction and there is no duty to inform parent of right to counsel.

Vermont

In re M.W., 2007 WL 2458774 (Vt.). DEPENDENCY, GUARDIANSHIP
After finding mother was unable to parent and it was in child’s best interests to be freed for adoption by grandmother, trial court properly rejected mother’s request for permanent guardianship since evidence showed child’s adoption by grandmother was reasonably likely; permanent guardianship is “last resort” and appropriate only when reunification and adoption have been considered and ruled out.

Benefits of Frequent Visitation¹

- Promotes healthy attachment and reduces the negative effects of separation for the child and parents.
- Establishes and strengthens the parent-child relationship.
- Eases the pain of separation and loss for the child and parent.
- Keeps hope alive for the parent(s) and enhances parents' motivation to change.
- Involves parents in their child's everyday activities and keeps them abreast of the child's development.
- Helps parents gain confidence in their ability to care for their child and allows parents to learn and practice new skills.
- Provides a setting for the caseworker or parenting coach to suggest how to improve parent-child interactions.
- Allows foster parents to support birth parents and model positive parenting skills.
- Provides information to the court on the family's progress (or lack of progress) toward their goals.
- Facilitates family assessments and can help the court determine whether reunification is the best permanency option for the child.
- Helps with the transition to reunification.

1. Dougherty, Susan. *Promising Practices in Reunification*. New York: National Resource Center for Foster Care and Permanency Planning, Hunter College School of Social Work, 2004. October 23, 2006 <<http://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/promising-practices-in-reunification.pdf>>; Ohio Caseload Analysis Initiative and ProtectOhio Initiative. *Visitation/Family Access Guide: A Best Practice Model for Social Workers and Agencies*. Ohio Caseload Analysis Initiative in Partnership with ProtectOhio Initiative, 2005. October 23, 2006 <<http://www.pcsao.org/CLA/VisitationGuidefinal.pdf>>; Ginther, Norma M. and Jeffrey D. Ginther. "Family Interaction: The Expressway to Permanency—Facilitating Successful Visitation." Presentation prepared for Western Training Partnership at the University of Wisconsin River Falls, July 2005, 12–13; Wright, Lois E. *Toolbox No. 1: Using Visitation to Support Permanency*. Washington, DC: CWLA Press, 2001, 15–18.

(Continued from front page)

frequent visitation for infants and toddlers in foster care. Child development specialists regard attachment relationships as "one of the primary goals of infancy." Secure and stable attachments with a primary caregiver form the foundation for a child's social, emotional, and cognitive development. Children who develop secure attachments show a greater capacity for self-regulation, effective social interactions, self-reliance, and adaptive coping skills later in life.

Researchers have found that up to 82 percent of maltreated infants have disturbed attachment patterns. Babies who learn that they cannot consistently depend upon their caregiver to provide nurturing, protection, and security often develop unhealthy attachments. For example, a

baby might turn away from or appear indifferent to the caregiver, alternate between seeking closeness with the caregiver and resisting contact, or freeze or show fear when the caregiver approaches. Research has shown that infants and toddlers who do not develop secure attachments produce elevated levels of cortisol (a stress hormone), which may alter the developing brain circuits and cause long-term harm. In addition, young children with unhealthy attachments are at much greater risk for delinquency, substance abuse, and depression later in life.

Even children with secure attachments can be harmed by the loss or disruption of a primary relationship (e.g., through death, military deployment, or placement in foster care). Children's reactions to and ability to cope with separation from a parent depend upon

their age and developmental stage. For example, infants who enter foster care before the age of six months—when placed in a stable, nurturing relationship with a foster parent—may not experience harm to their social and emotional functioning. Children placed in care between six months and three years of age are particularly vulnerable to separation and more likely to experience subsequent emotional disturbances. Children older than age three or four when they enter foster care are able to use language to help them cope with loss and adjust to change. Because multiple placements and attachment disruptions are likely to be harmful at any age, and because infants are less likely to be reunified with their parents than they are to be adopted, concurrent planning should be used at the outset of each case. To limit attachment disruptions, very young children should be placed in what could become a new permanent home if reunification efforts fail.

Professionals working with very young children in foster care often do not understand the extent of the child's distress over being removed from the parent and placed in a strange environment. It is important to remember that very young children grieve the loss of a relationship. Even though the parent has maltreated the child, she or he is the only parent the child has known, and separation evokes strong and painful emotional reactions.

To promote attachment and strengthen the parent-child relationship, very young children in foster care need frequent and consistent contact with their parents. They need to know that their parent cares for and is there for them. In many jurisdictions, visits consist of brief, weekly encounters, in a neutral setting, under the supervision of a caseworker. According to the American Academy of Pediatrics:

For younger children, this type of visit is not conducive to optimal parent-child interaction and may minimally serve the parents' needs for ongoing contact with the child or may even be harmful for the

child. A young child's trust, love, and identification are based on uninterrupted, day-to-day relationships. Weekly or other sporadic "visits" stretch the bounds of a young child's sense of time and do not allow for a psychologically meaningful relationship with estranged biological parents. . . . For parent-child visits to be beneficial, they should be frequent and long enough to enhance the parent-child relationship.

Visitation in Permanency Planning

Visitation, which has been called "the heart of permanency planning," is a key strategy for reunifying families and achieving permanency. To preserve and strengthen parent-child attachment, promote permanency, and reduce the potentially damaging effects of separation, attorneys who represent very young children in foster care or their parents should make visitation that ensures the child's safety and well-being a focus of their advocacy. Because children in foster care often come from families where the parent-child attachment is unhealthy, visitation should be viewed as a *planned, therapeutic intervention* and the best possible opportunity to begin to heal what may be a damaged or troubled relationship. In addition, visits offer a real-life opportunity to view parental capacity and provide critical information to the court about the parent-child relationship. In this regard, visitation is a *diagnostic tool* to help determine as quickly as possible if reunification is the best permanency option for the child.

Because the term *visitation* does not adequately describe the quality and quantity of time that families need to spend together when children are removed from the home, child welfare experts have begun using other terms, such as *family time*, *family access*, and *family interaction*. Research shows that regular, frequent visitation increases the likelihood of successful

reunification, reduces time in out-of-home care, promotes healthy attachment, and reduces the negative effects of separation for the child and the parent.

Visitation plays an important role in concurrent planning. While frequent visits allow parents to show their motivation for getting their child back and demonstrate new skills, they also provide evidence when a parent is not making progress toward case goals. For example, when a parent repeatedly does not show up for scheduled visits or fails to make required behavioral changes during visits, this information can help the court decide more quickly to order an alternative permanency plan for the child.

Promoting Successful Visits

Family visitation is a cooperative venture, and all participants (parents, foster parents, relatives, caseworkers, the court, lawyers, and service providers) must work together to ensure that visits "meet the attachment and connectedness needs of children and their families . . . [and] support parenting and case decisionmaking." Address the following recommendations when advocating for visitation for young children in foster care.

Ensure that visits are in the child's best interest. Visitation should be considered a conditional right of parents and children. Unless the court finds substantial evidence to believe that visitation or supervised visitation would place the child's life, health, or safety at risk, the parent should be allowed to visit his or her child. For example, the court might deny or discontinue visitation when there is danger that the parent will again physically or psychologically abuse the child, even during supervised visits, or when the parent's visits are extremely traumatic to the child.

When there is any doubt about the safety or benefit of visitation, there should be thorough assessments of the child, the parent(s), and the relationship between the child and parent (known

as an attachment assessment). Mental health clinicians can provide important information to attorneys and the court about what is in a child's best interest.

Ensure the placement decision supports frequent, meaningful visits. Successful visitation begins with the child's placement. If reunification is a permanency option, very young children should be placed in out-of-home care as near to their biological parent(s)' home as possible to allow frequent visitation. Traveling long distances to visits is inconvenient for everyone involved and is hard on young children. Infants and toddlers who arrive at a visit after a lengthy confinement in their car seat may be cranky or sleepy from the trip, which detracts from the quality of the visit.

Foster parents can be critical partners in successful visits. Foster parents of infants and toddlers should understand the importance of the child's relationship with his/her parents and the role they can play to help strengthen that relationship. In a growing number of communities, foster parents receive training and support to supervise visits in their home so birth parents can be involved in the child's daily routines.

When a child is placed in kinship foster care (in the home of a relative or another adult who has a kinship bond with the child), the kinship caregiver should receive training and assistance so they can be involved in concurrent planning, support the parent-child relationship, and teach and model parenting skills. In addition, the caregiver must be willing to support the formal visitation plan.

Ensure the visitation plan is individualized and promotes permanency. The written visitation plan should be tailored to the circumstances and needs of each family and the reason for removal of the child from the home. The plan, which the caseworker should develop in consultation with the child's parent(s) and foster parent(s), should be based upon a thorough assessment of the family

(including an assessment of the child's needs and the parent's ability to respond to those needs) and reviewed and updated frequently. The plan should specify the frequency, length, participants, location, if and how visits are to be supervised, expected behaviors of parents during visits, visitation services, and planned activities of family visits. A well-crafted plan that clearly states what is expected of parents during visits reduces mistakes and misunderstandings.

Lawyers for the child and the parent(s) should review the written plan to make sure it serves their client's best interests and that only necessary restrictions and supervision are imposed. The judge who oversees visitation should ensure that the plan best serves the child and promotes permanency. The judge should stipulate in the court order the specific frequency, duration, and location of visits, thereby ensuring that visitation begins promptly and is permitted frequently. Visitation should be reviewed at every court hearing to determine whether terms and conditions need to be modified. The court should require the child welfare agency to submit periodic reports about implementation of the plan and the impact on the young child and should hold all parties accountable for meeting plan requirements.

The visitation plan should be guided by careful and ongoing assessment of the parent's ability to safely care for and appropriately interact with the child. The plan may require the parent to meet conditions related to visits (for example, to refrain from a behavior that contributed to the child's removal). If the parent does not comply, it is appropriate to impose restrictions (such as increased level of supervision) to protect the safety and well-being of the child. However, visits should never be used to reward or to punish. Increased or reduced visitation should be a direct consequence of reduced or increased danger to the child and not linked to some other measure (such as engagement in other

court-ordered services or drug test results).

Visitation planning is ongoing and should correspond to the child's placement phase in the child welfare system. Although the underlying goal of visitation (to preserve and enhance the parent-child relationship while providing for the safety and well-being of the child) remains the same through all phases, each phase emphasizes different purposes and uses different visitation arrangements.

1. *Initial phase.* This phase focuses on maintaining ties between parent and child, assessing the parent's capacity to care for her child, and goal planning. To ensure the child is safe and appropriately cared for, visits are generally supervised and controlled for location and length. This phase generally lasts from four-to-eight weeks, but the length varies from family to family.

If, after the initial visitation phase, the caseworker and other professionals working with the family continue to have concerns about moving to less supervision, it may be time to reconsider whether reunification is an appropriate goal for the child. If the court changes the permanency plan to adoption, the visitation plan might call for a gradual decrease in visits and a focus on grief work rather than parenting skills.

2. *Intermediate phase.* During this phase, the parent is working to meet his or her case goals, and visitation activities allow the parent to learn and practice new skills and behaviors. Visits typically occur more frequently, for longer periods, in a greater variety of settings, and with gradually reduced supervision as the parent assumes more and more responsibility for the child.

3. *Transition phase.* This phase focuses on smoothing the transition from placement to home and determining what services are required to support the child's needs and the

parent's ability to meet those needs following reunification. Visits should provide maximum opportunities for parent-child interaction. After the child leaves the foster parent's care, it is important to arrange visits between the child and foster parent, recognizing the value of that relationship to the child.

Ensure the frequency, length, and timing of visits promote attachment. Because physical proximity with the caregiver is central to the attachment process for infants and toddlers, an infant should ideally spend time with the parent(s) daily, and a toddler should see the parent(s) at least every two-to-three days. To reduce the trauma of sudden separation, the first parent-child visit should occur as soon as possible and no later than 48 hours after the child is removed from the home.

Visits should be long enough to promote parent-child attachment. The length of visits should gradually increase as the parent shows she is able to respond to her child's cues in consistent and nurturing ways, soothe her child, and attend to her child's needs. During the initial phase, limiting visits to one-to-two hours allows the parent to experience small successes without becoming overwhelmed. By the transition phase, as the family approaches reunification, unsupervised all-day, overnight, and weekend visits should be completed.

Visits should be scheduled at a convenient time for the parents and the foster parents. For example, if a parent works during the day, it may be necessary to schedule visits during the evening. However, the visitation plan must also consider the child's daily schedule. If a toddler goes to bed at a certain time, it would not be reasonable for the parent to expect to visit after bedtime.

Advocate for visits to occur in the least restrictive setting that ensures the child's safety and well-being. The visitation plan should encourage the birth parent to directly

care for the child as much as possible, and family visits should take place in the least restrictive, most natural setting that can ensure the safety and well-being of the child.

In a growing number of communities, the parent visits the child in the foster home. This model of care, known as *inclusive practice*, regards the foster parent as a temporary caregiver for the child and a supportive role model to the parent. Researchers have found strong links between inclusive visiting practices and (1) frequency of mothers' visits and (2) chances of reunification. Parent-child visits in foster homes can only succeed if the foster parents' role as mentor to the parent is clearly defined from the outset and the foster parents are trained and supported. Similarly, birth parents must have clear guidance about what is expected from them during visits in the foster home. For example, they should be instructed not to say inappropriate things that could jeopardize their child's relationship with foster parents.

For infants and very young children, other appropriate settings for parent-child visitation may include:

- the parent's home (with in-home supervision or in later phases of placement)
- the home of a family member who can supervise and support the parent and model positive parenting skills
- a service provider's office (particularly if the parent is receiving therapy or parenting instruction)
- an early childhood program such as Early Head Start
- parenting classes that include the child
- a supervised visitation center (during the initial phase of placement or if significant safety concerns exist)
- the child welfare agency (This setting should be used only as a last resort. Often agency offices are sterile and uninviting, and

How Visitation Helps Meet Federal Permanency Planning Requirements

Well-crafted visitation plans are a key part of permanency planning and can actively support the permanency goals of the Adoption and Safe Families Act of 1997 (ASFA) (P.L. 105-89). ASFA emphasizes moving quickly toward permanency so that children who enter foster care do not grow up in temporary living situations. Among other things, the Act:

1. Provides a timeframe for states to achieve permanency for children in state care. Visitation that helps develop and support a parent's caretaking abilities can help her complete the requirements of the case plan and work toward reunification if that is the child's permanency goal. The court may order reunification as the permanent plan at the 12-month permanency hearing if the parent has been diligently working toward that goal and reunification is expected in a timeframe consistent with the child's developmental needs.
2. Requires states to make reasonable efforts to finalize a permanency plan, in addition to the initial reasonable efforts to prevent removal of the child from home. Proof that the agency devised a thoughtful, individualized visitation plan can support a judicial finding that reasonable efforts were made.
3. Encourages concurrent planning. Frequent visitation facilitates family assessments and can help the court determine whether reunification is the best permanency option. Although ASFA does not directly address visitation, it is clear that visitation supports its goals of timely permanency for all children in foster care.¹

1. Wright, Lois E. *Toolbox No. 1: Using Visitation to Support Permanency*. Washington, DC: CWLA Press, 2001, 41-43; Leathers, Sonya J. "Parental Visiting and Family Reunification: Could Inclusive Practice Make a Difference?" *Child Welfare* 81(4), 2002, 596; Allen, MaryLee and Mary Bissell. "Safety and Stability for Foster Children: The Policy Context." *The Future of Children* 14(1), 2004, 49-73.

many do not provide private rooms or age-appropriate toys and activities for visiting families. Also, this environment can remind parents of their failure as parents and the agency's power over their lives, a sentiment that does not promote good visits.)

In addition, the parent should be encouraged to accompany the child to medical appointments and therapy sessions. Involvement in the child's professional appointments keeps the parent informed about the child's developmental progress and special needs, teaches the parent to respond more effectively to the child's needs, and reinforces the parent's continuing involvement in and responsibility for the child's well-being.

Ensure visitation activities promote parent-child attachment and support the child's development.

Because many maltreated infants and toddlers show developmental delays and many parents of children in foster care do not know how to interact appropriately with their child, parents often need coaching about how to care for their child and how to plan appropriate activities during visits. Many parents simply do not know how to perform daily caregiving routines, play with their child, comfort their child, respond to their baby's nonverbal cues, respond to their child's special medical or developmental needs, or enjoy their child's company. In such cases, the child's attorney can request and the court can order parents to receive services that educate them about their infant or toddler's specific needs.

Services such as home visiting programs, Early Head Start and other high-quality early childhood education programs, and early intervention programs provide an opportunity for the parent to interact with her child in a supervised setting while learning to support the child's development.

In addition, caseworkers, foster parents, or parent aides can help parents select visitation activities. These activities should allow parent and child to enjoy each other's company and to develop a healthy relationship. For example, during the first phase the parent might visit at playtime when the child is well rested and then begin visiting at increasingly challenging times such as bedtime or when the child is sick and fussy. This strategy allows parents to gain competence and self-confidence in limit setting and effective discipline.

Parents need to understand that a key goal of visitation is to strengthen their relationship with their child and the importance of this brief time they have together. While it is beneficial for young children to have siblings and family caregivers (such as grandparents) present at some visits, parents should be discouraged from bringing friends, significant others who lack a relationship with the child, and extended family members to visits.

Request the appropriate supervision level. Plans for supervising parent-child visits should be individualized, ensure the child's safety and well-being, and further the goals of the family's case plan. Visitation plans should never impose unnecessary supervision and restrictions. If supervision is required during parent-child visits, the visitation plan should specify the reason(s) (e.g., to protect the child, observe and evaluate interactions between parent and child, or model positive parenting behaviors).

The visitation plan should state who will supervise the visits. Depending upon the purpose of supervision and the degree of supervision necessary, a range of people may do this, including a caseworker, therapist, foster

parent, relative, parent aide, or early intervention home visitor. Foster parents or family members who supervise visits should receive training on the child's developmental/attachment needs, mentoring/coaching parents, and knowing when and how to intervene.

Be sensitive to participants' emotions around visitation. Judges and lawyers need to understand that a young child's emotional dysregulation following a visit does not necessarily mean the parent did something harmful during the visit. Visitation can be extremely upsetting for children, and it is important to understand the developmental context of their feelings and behaviors. Very young children cannot understand the separation, and they tend to respond with bewilderment, sadness, and grief. During visits, they may cling or cry, act out, or withdraw from their parent. At the end of a visit, when another separation is imminent, they may become confused, sad, or angry. Following visits, infants and toddlers may show regressive behaviors, depression, physical symptoms, or behavioral problems.

Parents also find visits to be a time of emotional upheaval, particularly during the first phase of placement. Parents often experience pain and sadness resulting from the separation. They may feel shame, guilt, depression, denial that there is a problem, anger, and/or worry about the child. During the first visits, the parent is likely to be awkward, tense, and uncertain. All parties must help the parent process her emotions and help her interact with her child. For guidance on interpreting behaviors of young children and parents during visits, see the full brief on these issues, available at www.abanet.org/child/baby-health.shtml

Ensure visits are well documented. Caseworkers and other professionals must carefully document the family's progress (or

lack of progress) during visits, emphasizing the objectives of the visitation plan, behaviors of and interactions between the parent and child, and assessment of risk to the child and the parent's capacity to care for the child. This information provides important evidence for the court to order reduced or increased restrictions, reunification, or termination of parental rights.

Overcoming Barriers

Because child welfare agencies and juvenile courts are often overwhelmed by high caseloads and lack funding for supervision, many communities lack adequate visitation services for families of infants and toddlers in foster care. Working together, the court, the child welfare agency, child advocates, early childhood mental health specialists, and other service providers should analyze the availability of visitation and explore how visitation resources can safely and realistically be expanded in their community. General strategies for expanding visitation include:

- *Examine supervision policies.* Assess and develop criteria for unsupervised visitation and relative or third-party supervision. These practices will promote visitation and reduce the burden on caseworkers.
- *Prioritize cases.* For example, if a child welfare agency does not have the resources to overhaul its visitation practices for all infants and children in foster care, it could set aside additional visitation resources for the families that are most likely and those that are least likely to be reunified. When reunification appears likely, frequent, successful visits can provide evidence to support timely reunification. In cases where reunification appears unlikely, frequent visits can provide evidence of parental disinterest, which can lead toward a timely decision to move to an alternative permanency plan and

termination of parental rights.

- *Involve foster parents.* Recruit and train foster parents who are willing to mentor birth parents and supervise visits within their homes.
- *Use volunteers.* Recruit and train volunteers to serve as visitation monitors and parent mentors.
- *Collaborate with community stakeholders.* Partner with other groups in the community to address gaps in visitation services. (See “Promising Practices” below)
- *Explore alternative funding for visitation services.* A number of federal and state agencies and nonprofit, charitable, and professional organizations offer grants to improve child welfare services and the court process as it relates to children in foster care.

The Judge’s Role

Judges hearing cases involving children in foster care play a critical role ensuring the child has full opportunities for meaningful visitation with the family. Although it is counterproductive for judges to order daily visitation if the community does not have the resources to support this practice, judges are in a unique position to inform the community about the gaps in services and to mobilize community leaders and resources to address these gaps.

To encourage improved visitation practices, Judge Leonard P. Edwards of the Superior Court in San Jose, California, and a former president of the National Council of Juvenile and Family Court Judges, suggests judges take a number of steps:

- Oversee the child’s initial placement decision to ensure it supports frequent, meaningful visitation.
- Develop clear, enforceable, written visitation orders for each case.
- Develop local rules that address visitation issues.

- Encourage cross-systems training for all participants in the juvenile dependency court to address child development principles and strategies to improve the quality and quantity of visitation.
- Examine best practices and draw from model programs to improve visitation practices.
- Facilitate collaborative community efforts to improve visitation practices and overcome barriers to successful visitation.

See the full brief for a useful checklist for judges to refer to when considering visitation for infants and toddlers in foster care, available at www.abanet.org/child/baby-health.shtml.

Promising Practices

Lawyers and judges should be familiar with the resources and services for children and families in their community and think creatively to improve visitation practices. In many communities across the country, courts, child welfare agencies, service providers, nonprofit organizations, and faith-based or community organizations are partnering to enhance the visitation experience and promote permanency. Working together, community partners can develop creative solutions to overcome barriers to successful visitation. Promising practices include:

- *Therapeutic Visitation Programs.* Because many parents of infants and toddlers in foster care did not experience positive, nurturing relationships in their own childhoods, they must learn new parenting approaches. Therapeutic visitation programs promote attachment and help parents improve their parenting skills.
- *Supervised Visitation Centers.* Supervised visitation centers serve families of children in foster care who can only visit when an impartial supervisor is present. The centers provide a warm, homelike environment where

parents can visit with their children in a safe and supervised setting. The Supervised Visitation Network (www.svnetwork.net) is a helpful resource for advocates interested in learning more about supervised visitation centers.

- *Around-the-Clock Visitation.* Recognizing the importance of parent-child contact, several programs are pushing the envelope on visitation practices and providing what could be regarded as around-the-clock visitation in a controlled setting. For example, shared family care is an arrangement in which the parent is placed with her child in a foster home. The foster family is trained to mentor and support the parent as she develops the skills to care for her child and move toward independent living.

See the full brief for examples of these visitation practices, available at www.abanet.org/child/baby-health.shtml

Conclusion

Parent-child interaction is critical to the healthy development of infants and toddlers, and visitation is an essential component of family reunification and permanency planning. When reunification is a permanency option, judges and those who represent children in foster care and their parents should advocate for frequent, safe, and high-quality visitation.

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This article is one in a series of issue briefs designed to improve health outcomes for infants and toddlers in the child welfare system. These briefs are part of a five-year collaborative grant from the Department of Health and Human Services Maternal and Child Bureau. For more information, visit: www.abanet.org/child/baby-health.shtml

New York Law Lowers Caseloads for Children's Attorneys

by Claire Sandt Chiamulera

When Tamara Steckler started as attorney-in-charge at the New York Legal Aid Society's Juvenile Rights Practice (JRP), her marching orders were clear: reduce crushing caseloads that weigh down children's attorneys.

"Overloaded attorneys is a virus that once it kicks in affects everything," said Gary Solomon, JD, director of legal support for the New York Legal Aid Society's JRP. "So many things cannot happen when caseloads are high. When Tamara came on, I pretty much told her she would fail unless she turned the caseloads around. That's how bad it was."

That was the spark that fired Steckler's efforts to jumpstart legislation to cap New York children's attorneys' caseloads. The legislation, the result of seven months of relentless advocacy, was signed by New York Governor Eliot Spitzer on August 28, 2007 (S-4025, A-6847-B).

Steckler, Solomon and Karen Fisher Gutheil, a staff attorney in the special litigation and law reform unit of the JRP, shared the story behind this legislative reform at the National Association of Counsel for Children's 30th National Conference in Keystone, Colorado, August 18, 2007.

Rising Caseloads

To understand the need for the legislation, it helps to step back in time. According to Solomon, the New York Legal Aid Society started in the 1960s as a model organization that was funded adequately by the state Office of Court Administration (OCA). Solomon enjoyed an enviable caseload of 50 to 70 cases (100 – 140 clients). The office functioned effectively, with social workers assisting in a substantial percentage of the cases, said Solomon.

In the 80s, the child welfare climate shifted and court filings rose. This was due in part to the crack cocaine epidemic that swept

the city and caused record levels of children to flood the child welfare system. The growing sophistication of the child representation field also

"Overloaded attorneys is a virus that once it kicks in affects everything."

played a part in rising workloads. "Standards for children's attorneys were going up and more was being demanded of them," said Solomon. Where many children's attorneys once played a more passive role in legal proceedings, allowing the child welfare agency to take the lead, attorneys were increasingly being expected to do more for their child clients and to advocate more aggressively for their interests. Higher expectations led to more duties in cases, adding to workloads.

Despite a hiring push in the late 80s, Legal Aid struggled to manage the growth in work. "We were hiring attorneys all the time and our staff increased, but it wasn't enough to keep up with the cases," said Solomon. "We were in a crisis phase."

At one point in the 1980s, OCA became disenchanted with Legal Aid and solicited proposals from other legal services providers. However, Legal Aid preserved its contract. Since then, the relationship with OCA has developed in a positive way, but there was a sense that OCA was not sufficiently concerned about rising caseloads, said Solomon. This may

have been because OCA feared that if it increased Legal Aid's funding, it would create an infrastructure that would be hard to tear down when the crisis was over.

Legal Aid struggled to "look good" and put on a positive face, despite its structural problems. "We put band aids in place," said Solomon. Supervising attorneys were taking cases to divert them from staff attorneys, and attorneys started putting in longer hours to do quality work.

Band aids were never enough. The percentage of abuse and neglect filings in 2006 rose 147 percent higher than in 2005, according to OCA data. The attorneys' union was always upset about caseloads, said Solomon. This prompted a slew of attorney grievance filings, but the fear of losing jobs and questions over the fate of clients prevented attorneys from taking their grievances to arbitration or going on strike, said Gutheil. In a field in which self-sacrifice is the norm, putting clients and jobs on the line didn't come easily, she said.

The decision not to arbitrate took a toll. Gutheil compared her daily routine to an Olympic event. "The bell would go off at 9:30 a.m. and I would go to nine different court parts for court hearings throughout the day. Prep work was done before the bell, at lunch or after hours," she said. The number of kids Gutheil was representing was enormous.

Also, the federal Adoption and Safe Families Act had passed in 1997. The act's push for greater court oversight over child welfare proceedings and strict permanency timeframes led to more required permanency hearings, and more petitions to terminate parental rights. Additionally, New York legislation enacted in 2006 required attorneys to be in court every six months post-disposition to review each child's case.

The clincher came in January 2006, according to Solomon, with the highly publicized death of seven-year-old Nixzmary Brown, who was allegedly beaten to death by her stepfather. The child's fatality caused a public outcry and boosted abuse and neglect filings throughout the city. The overwhelming negative attention the case drew to child welfare created the right environment to instigate change.

Acting through Legislation

With caseloads skyrocketing, it was time to act. In Spring 2006, the union president persuaded Brooklyn Senator Diane Savino to draft a bill to reduce caseloads. The original legislation provided that law guardians appointed to represent children in New York could decline any new court appointments when their caseloads exceeded 100 active cases. The 2006 bill did not pass and Senator Savino planned to reintroduce it in 2007.

In January 2007, the union drafted an amended version of the bill. This version permitted attorneys to decline appointments once they reached 125 clients and required them to do so once their caseload reached 150 clients.

Steckler's strategy for gaining support for the bill focused on how children were being failed. "We were concerned about the services we were providing children," she said. "We stopped saying, 'We're terrific and we're doing a great job' and changed our message to how we were *not* serving kids." While a huge risk, Steckler said it was important for the legislature to know why the attorneys couldn't do their jobs effectively. Steckler stressed the need for better funding so that Legal Aid could serve children well. "We doubled our budget request," said Steckler, and justified the request by spelling out how kids were not being served.

Finding Allies

Fortunately, the chairs of the judiciary committees in both houses, Helene Weinstein (assembly) and John DeFrancisco (senate), signed on as

bill sponsors, providing key advocates for the legislation. Steckler also informed New York's chief administrative judge that Legal Aid was submitting a bill in Albany and told him that as management they had to support, not oppose, it. The chief judge understood their position.

Looking back, Steckler realized that the bill moved forward so quickly that there wasn't enough time to contact and speak with those who should know about the bill and who would be affected by it. Steckler stressed the

"We stopped saying, 'We're terrific and we're doing a great job' and changed our message to how we were *not* serving kids."

need to identify all allies when working on such legislation. Although the chief administrative judge was informed, Steckler would have appreciated having more time to have conversations with OCA and to do the preliminary work needed before the bill started moving forward so quickly.

Sticking it Out

As they went about getting legislators to sign on to the bill, Steckler experienced firsthand the politics behind moving a bill through the legislative process. Not all of it was pretty. "It was a frustrating process. It was all about politics," said Steckler. While legislators initially looked at the bill and said it was something they wanted to attach their names to, Steckler said the overarching goal of helping kids was sometimes overshadowed by the political atmosphere. "While you can't underestimate the power of children, when you're up there, they're not talking about kids," she said.

To help navigate the legislative politics, Steckler engaged Legal Aid's lobbyist. This proved to be critical to getting the bill passed in both houses. The lobbyist was at the legislature all the time, and had good connections in

both parties. He knew who to contact, how to speak the language, when to back away, and when to try different approaches. With Steckler's help, the lobbyist quickly learned the issues, became committed to them, and worked to persuade the legislators to support the bill.

While the bill received widespread support, there were concerns that New York City's caseloads were not representative of all jurisdictions throughout the state and that providing uniform caps statewide was unnecessary. As a result, the bill was changed. Instead of capping caseloads once attorneys exceeded a set number of clients, the bill was changed to require the development of workload standards that set maximum numbers of children who could be represented at once. These workload standards were to be based on several factors, including case type, stage of proceeding, availability of support staff, differences in local practice, and representation type. The bill also required the chief administrator of the courts to issue court rules with guidelines for developing the workload standards.

Success at Last

The revised bill passed the assembly in June 2007, and the senate in July 2007. With the governor's signature in August 2007, it became law. Steckler, Solomon, and Gutheil can consider their efforts a success. The children they represent will soon benefit from the quality representation they deserve. And practitioners throughout the country can learn from their efforts to use legislation to bring change to their daily practice. "We underestimated for a number of years how we could go to the legislature and make this issue attractive," said Steckler. If New York can make it happen, perhaps other states can too.

Claire Sandt Chiamulera is the editor of *ABA Child Law Practice*.

To view this legislation, visit:
<http://assembly.state.ny.us/leg/?bn=A06847>

Understanding and Preventing Compassion Fatigue

by Angelea Panos

Most child law attorneys enter this field to assist others in need. Yet our capacity for compassion, along with the intensity of our work can, at times, leave us vulnerable for “compassion fatigue.” This is a term that was coined to describe the set of symptoms experienced by caregivers who become so overwhelmed by the exposure to the feelings and experiences of their clients that they themselves experience feelings of fear, pain, and suffering including intrusive thoughts, nightmares, loss of energy, and hypervigilance. It can be cumulative (from the effects helping many clients) or occur in response to a particularly challenging or traumatic individual case. This extreme state of anxiety and preoccupation with the suffering of those being helped becomes traumatizing for the helper. For this reason it is sometimes called “vicarious traumatization” or “secondary traumatization.”

Who is at risk?

While our training, professionalism, and good boundaries within our helping roles are protective, really anyone with the capacity for true compassion, empathy, concern and caring is vulner-

able to compassion fatigue. In other words, the greatest strength that you have to bring to your occupation—your capacity to develop a compassionate connection with your clients—is also your greatest vulnerability. Therefore, it is not a characteristic that you would choose to give up, rather it is more logical to educate yourself so you understand compassion fatigue and know what you can do if you begin experiencing symptoms. Realize that the more prolonged exposure to traumatic events you experience (working too many hours), the more personal life demands you have, and the more isolated you become from others, collectively increase your vulnerability for compassion fatigue.

Warning signs and symptoms

The symptoms of compassion fatigue are similar to those of Posttraumatic Stress Disorder, only instead of the symptoms being based upon a trauma that you directly experienced, they are due to the trauma that your client(s) have experienced. Additionally, there is a cynical, discouraged or hopeless attitude about your work or your career that begins to set in. Paradoxically, you may find it difficult to leave your work at the end of the day. You may have thoughts that preoccupy you about a particular case.

Being aware of what these symptoms mean and how they are affecting you is important. You can evaluate yourself with an excellent self-assessment tool that can be found at: <http://www.isu.edu/~bhstamm/tests.htm>

While this checklist is more comprehensive, a few of the predominant symptoms of compassion fatigue are listed below:

- Feeling estranged from others (Having difficulty sharing or describing feelings with others.)
- Having difficulty falling or

staying asleep.

- Expressing anger or irritability with little provocation.
- Startling easily.
- Thinking about violence or retribution against the person or persons who victimized while working with a victim.
- Experiencing flashbacks connected to clients and families.
- Needing more close friends—feeling there is no one to talk with about highly stressful experiences.
- Working too hard for your own good.
- Being frightened of things traumatized people and their family have said or done.
- Experiencing troubling dreams similar to a client and their family.
- Experiencing intrusive thoughts of sessions with especially difficult clients and their families.
- Suddenly and involuntarily recalling a frightening experience while working with a client or their family.
- Being preoccupied with a client or their family.
- Losing sleep over a client and their family’s traumatic experiences.
- Feeling trapped by work as a helper.
- Feeling a sense of hopelessness associated with working with clients and their families.
- Feeling weak, tired, or rundown as a result of work as a helper.
- Feeling depressed as a result of work as a helper.
- Having difficulty separating work from personal life.

Websites: Compassion Fatigue

- **Gift From Within**
www.giftfromwithin.org
- **When Helping Hurts: Preventing & Treating Compassion Fatigue (DVD)**
www.giftfromwithin.org/html/video4.html#4b
- **Idaho State University Institute of Rural Health**
www.isu.edu/~bhstamm/tests.htm
- **Green Cross Foundation**
www.greencross.org

- Feeling little compassion toward most co-workers.
- Thinking you are not succeeding at achieving life goals.
- Feeling like you are working more for the money than for personal fulfillment.
- Having a sense of worthlessness/disillusionment/resentment associated with work.

Prevention, resiliency and treatment

Early recognition and awareness is crucial in being able to be resilient to compassion fatigue. Compassion fatigue is treatable! Keeping your life in balance or getting it back in balance, by taking some time off work, or enhancing your self-care are critical techniques. Keeping your body and your health in good shape is essential. You are not going to be resilient if you are not well rested. You may need medical attention if the symptoms of compassion fatigue, such as sleep disturbance, start interfering with your ability to function. If you are eating poorly and not exercising, you are more vulnerable physically and emotionally to the effects of distress. Therefore, keeping a healthy balance in your life is a requirement to prevent and treat compassion fatigue. Caregivers that have a structured schedule that allow them time to organize and do good self-care are more resilient.

Another essential factor to prevent and treat compassion fatigue is to have some good relationships with either colleagues, a supervisor, or a therapist that you can safely and confidentially discuss the distresses you are experiencing. Isolation is a symptom of compassion fatigue and is ultimately dangerous. To be resilient you need to have good support and connections with others.

Many counselors report that creative therapies such as writing in a journal, or expressing their feelings through music or art are helpful. Diversions and recreation that allow you

to take mini-escapes from the intensity of your work is absolutely essential—not optional as some may think. Research on resiliency in pediatric healthcare workers show that those that have the ability to “turn their thoughts about work off” are more resilient throughout their career. Sometimes this involves developing a little ritual at the end of the day to transition into your life outside of work, while leaving your cares and stresses in the workplace.

What to do if you have symptoms of compassion fatigue:

- Have a recognition and awareness of the symptoms of compassion fatigue in yourself.
- Restore a healthy balance in your life, including good sleep, good nutrition, and exercise.
- Get medical treatment for those symptoms that are interfering with your daily functioning.
- Use your positive supportive connections with others to process your feelings.
- Implement regular mini-escapes in your life, like recreation, creative therapies, or other healthy diversions from the intensity of your work.
- Don't medicate yourself with drugs or alcohol! Don't use other self-defeating addictions! Get professional help for yourself if needed to get back on track.

Conclusion

Unrecognized and untreated compassion fatigue causes people to leave their profession, fall into the throes of addictions, or in extreme cases become self-destructive or suicidal. It is important that we all understand this phenomenon for our own well-being, but also for our colleagues. If you notice a colleague in distress—reach out to them. Give them this article and let them know you care and are available to talk if they need.

Angelea Panos, Ph.D. is a therapist who specializes in trauma and grief.

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Children of Single Fathers Often Miss Out on Health Care

Children living in the custody of single fathers are less likely to have access to affordable health care and visit the doctor less often compared to children living in families with a single mother or both parents.

A study in the journal *Health Services Research* finds that many children in single-father families are slipping through the cracks when it comes to access to health care.

Although single fathers are less likely to be poor and generally earn more money than single mothers, their children are more likely to visit the doctor only when sick. Of the more than 62,000 children in the study, about 80 percent of children in single-father families visited the doctor in the past year, compared with 86 percent in single-mother families and 87 percent in two-parent families.

Nearly half of the children of single fathers did not visit the doctor for a check-up during the year, while more than two-thirds of children in single-mother households visited the doctor when well, according to the meta-analysis of several published studies.

“It might be that men are more risk-taking,” said Kathleen M. Ziol-Guest, study co-author. Ziol-Guest, the Robert Wood Johnson Health and Society Scholar at the Harvard Center for Society and Health, said that the difference also might be the result of men thrust into solo parenting with little information about public programs available to them. “Men are more likely to get their children as a result of a divorce,” than they were in the past, she said.

Regardless, single-father families are no longer just a footnote in health policy studies. In fact, the number of single-father families in the United States quintupled between 1970 and 2003 to approximately 6 percent of all families, and single-father families are one of the types of families that are growing fastest.

Until recently, most research on single-parent families focused on single mothers and the effects of an absent father on children.

“The public safety net seems to be working for single-mom families,” said Mikaela Dufur, an assistant professor of sociology at Brigham Young

University.

Single fathers, however, have not gotten much attention from scholars, health policy advocates and social service agencies that coordinate public health insurance. “They may be cut off from that information,” said Dufur, who was not part of the study.

Besides reduced access to health care, children in single-father families have a higher risk of drug use, have more problems in school and take part in risky behavior more frequently than children in families with a single mother or both parents do, according to the study.

There is much work to do with this quickly growing type of family unit, Ziol-Guest said. “We need to think where we might intervene.”

Source: Leininger L.J. & K.M. Ziol-Guest. “Reexamining the Effects of Family Structure on Children’s Access to Care: the Single-Father Family.” *Health Services Research online*, 2007, available online at www.blackwell-synergy.com/loi/hesr.

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